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

THURSDAY, MARCH 19, 2026
3:00 P.M.

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

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

CHIEF EXECUTIVE OFFICER	OUTSIDE GENERAL COUNSEL KENNADAY LEAVITT	CLERK OF THE BOARD
Michael Hunn	Troy R. Szabo	Sharon Dwiers

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

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

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

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
Participate via Zoom Webinar at:
https://us02web.zoom.us/webinar/register/WN_gxCgL9S0RjiGYjkHrSZwYg
and Join the Meeting.
Webinar ID: **861 3668 0967**
Passcode: **966800** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

ADVISORY COMMITTEE UPDATES
1. Program of All-Inclusive Care for the Elderly Member Advisory Committee Update

2. Whole-Child Model Family Advisory Committee Update

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

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

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

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

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

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

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

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

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

INFORMATION ITEMS

10. Quality Improvement Program Updates
    a. Quality Improvement Health Equity Committee Report
    b. Health Equity Accreditation Update
    c. Hospital Quality Program Update
    d. Quality Improvement Strategies
11. Grant Management Activities and Updates
12. Quarterly Reports to the Quality Assurance Committee
    a. Quality Improvement Health Equity Committee Report
    b. Member Grievances and Appeals Report

COMMITTEE MEMBER COMMENTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Special Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee on March 19, 2026 at 3:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us02web.zoom.us/webinar/register/WN_gxCgL9S0RjiGYjkHrSZwYg

To **Join** from a PC, Mac, iPad, iPhone or Android device:
Please click this URL to join. .
https://us02web.zoom.us/s/86136680967?pwd=MHN0jcLzeFj29zYHn5oGm2DD87drr2.1

Phone one-tap:
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+16694449171,,86136680967#,,,,*966800# US

Join via audio:
+1 669 900 9128 US (San Jose)
+1 669 444 9171 US
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
+1 719 359 4580 US
+1 253 205 0468 US
+1 360 209 5623 US
+1 386 347 5053 US
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+1 564 217 2000 US
+1 646 558 8656 US (New York)
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Webinar ID: 861 3668 0967
Passcode: 966800
International numbers available: **https://us02web.zoom.us/u/kzsYkbM7**

Board of Directors'
Quality Assurance Committee Meeting
March 19, 2026

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

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

December 17, 2025: PMAC Meeting Summary

Updates from the Director
Director Monica Macias-Garcia thanked PMAC members for attending the meeting in person. She provided updates on the program's current status, open positions, transportation, and scheduling. The Director welcomed new members attending for the first time and announced that CalOptima Health's PACE program is transitioning to a new electronic medical records system. She asked members to notify PACE staff immediately if they notice any incorrect information so staff can ensure a smooth transition.

Participants raised concerns about difficulties reaching a live person through the phone system. The Director thanked participants for bringing this to her attention and stated that she will work with CalOptima Health staff to review the issue and report back on the cause and the steps needed to resolve it.

Participants noted that transportation services have improved and that there appear to be more program participants. The Director confirmed this observation, stating that the program is indeed growing. The Director also shared that CalOptima Health is exploring strategies to support continued growth of PACE services, which may include establishing a second location.

PMAC Member Forum

- Participants concluded with positive comments, noting that PACE is a good program, provides excellent services, and has helped them address their medical needs.
- The Director will review the concerns raised regarding the phone system and will provide an update at the next PMAC meeting.

Back to Agenda

Board of Directors'
Quality Assurance Committee Meeting
March 19, 2026

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

On February 24, 2026, the Whole-Child Model Member Family Advisory Committee (WCM FAC) held its quarterly meeting, which was conducted both in person and via Zoom Webinar.

Reny Sims, Manager, Adolescent to Adult Program, and Michael Wise, M.D., Vice President, Population Health, both of Rady's Children's Health of Orange County (CHOC), presented on Rady's CHOC Adolescent to Adult Bridge (A2B) Program. Ms. Sims reviewed key information about the healthcare transition for youth moving from pediatric to adult care, a period characterized by increased emergency use, more hospitalizations, reduced self-management, and poorer outcomes. She noted that a 2022–2023 national survey showed that over 86% of California parents of teens ages 12–17 reported receiving no transition support. She noted that the transition was viewed as a long-term developmental process rather than a single event and that at Rady's CHOC, the process begins at age 12 and can extend to age 26. Early chart reviews in 2020 revealed that only 10% of contacted patients had completed an adult visit within the prior year, highlighting the need for improvement.

Ms. Sims defined the healthcare transition as a planned move from family-centered pediatric care to patient-centered adult care. She discussed the difference between transition (the entire process) and transfer (the final handoff). Dr. Weiss and Ms. Sims also reviewed the impacts of poorly organized transitions and noted that research showed significant increases in complications among young adults with type 1 diabetes, higher hospitalization mortality for people with sickle cell disease, more emergency visits and admissions for individuals with spina bifida, and increased emergency department use among young adults with cerebral palsy.

Dr. Weiss emphasized that the challenges families face during the transition from pediatric to adult care are systemic and multi-layered. Key barriers include difficulty finding adult providers who are comfortable managing childhood-onset conditions, a lack of wraparound services typically available in pediatrics, and general access issues. He highlighted that although UCI has internal medicine and pediatrics physicians well-qualified to care for these young adults, many cannot see Medi-Cal patients due to insurance restrictions.

Jennifer Heavener, a consumer advocate on the committee, shared her experience navigating Medicare and Medi-Cal after her daughter transitioned. Despite living near a UCI clinic, she reported that no providers would accept her daughter's coverage, creating significant gaps in care continuity. She also noted that her daughter sees different practitioners at each visit and that insurance barriers persist even with Medicare as the primary payer.

Dr. Weiss further emphasized that these issues are compounded when transition is treated as a last-minute task rather than a long-term process. Families need years of preparation to build skills, understand their conditions, and navigate adult care effectively. Structured, early, and formal transition programs have been shown to improve outcomes.

Board of Directors Vice-Chair Maura Byron, in attendance at the meeting, noted that the systemic nature of these challenges has been discussed for years and suggested presenting this information at a full board meeting for broader discussion and awareness.

Reni Sims outlined evidence-based approaches that improve outcomes, including early, structured transition curricula and validated readiness assessments to identify gaps in patient and family preparation. She highlighted the importance of dedicated transition navigators who understand both pediatric and adult systems, build partnerships with adult providers, and help families manage complex medical, educational, and community transitions.

Reni also described the model at Rady Children's, which includes a multidisciplinary transition team of social workers, nurse practitioners, case managers, and psychologists. She noted that other institutions use varying models, but the essential component is having dedicated staff committed to guiding patients and families through the transition process.

The A2B Program presentation elicited extensive feedback from the committee members.

Jenny Claros, Manager, Case Management for CalOptima Health's Whole Child Model Program, presented CalOptima Health's new Transition Planning Playbook. The playbook is designed to address the confusion and overwhelming experiences families face when moving from pediatric to adult care. It consolidates key information, member and insurance details, primary and secondary coverage, conservatorship, DME processes, and provider contacts into a single, portable document. The goal is to help families stay informed and supported throughout the transition. The document is currently in draft form, and feedback from committee members is being requested to ensure it is comprehensive and inclusive.

Ms. Claros emphasized that the playbook is meant to be used collaboratively, with case managers guiding families through the material rather than simply handing it off. It is intended to empower families with the knowledge they need when case managers are not immediately available. The draft has already been reviewed by internal teams, leadership, CCS, provider networks, regional centers, and waiver agencies, and will be shared with the full group for additional input.

Alice Chang, Director of Provider Relations, presented on a new Primary Care Physician (PCP) incentive model to improve access to adult primary care. Since specialists already receive enhanced

reimbursement, the incentive focuses on encouraging adult PCPs to accept and establish care for members aging out of pediatrics. PCPs will receive enhanced payments when they see transitioning members within 90 days of turning 21, with continued incentives for two years to promote stable care relationships. The model also incorporates quality metrics and enhanced support for complex care management.

Kelly Giardina, Executive Director, Medical Management, closed by noting that both the playbook and incentive model are still in their design phase. She invited further feedback and said draft documents will be sent to the committee members. She also acknowledged the personal experiences shared during the meeting and committed to following up individually on identified concerns.

Andrew Kilgust, Director, Program Management, presented a CalAIM Transitional Rent Overview. He noted that transitional rent was a state-required benefit intended to support eligible members for up to six months and that the service was not limited to Whole Child Model members. He discussed how members must meet behavioral health criteria for county mental health or substance use services, be experiencing or are at risk of being homeless, and fall within a defined transitioning population, such as those exiting institutional settings, interim housing, foster care, or post-hospital programs. Members must also have remaining days within their federally defined six-month cap and a viable long-term housing plan outlining how rent will be sustained after the transitional period.

Mr. Kilgust also noted that transitional rent can be used for permanent housing, which is the program's goal, or for interim housing when necessary. Because eligible members are connected to county behavioral health services, CalOptima Health has contracted directly with the County of Orange to serve as the transitional rent provider, noting that this aligns with updated state funding rules that allow the county to cover rent beyond month seven. A network of community-based housing navigation providers partners with the county to help members identify housing options and maintain stable tenancy.

When transitional rent is authorized, members must also be enrolled in Enhanced Care Management and a relevant housing support service, such as housing navigation or tenancy-sustaining services. Members may also use housing deposits up to $5,000, with a lifetime limit, to assist with move-in costs or essential household items. Referrals can be made by anyone, including members, through CalOptima Health's website or the Connect portal used by contracted providers. If a referred member lacks a viable housing plan, CalOptima Health coordinates with housing providers to develop one before proceeding.

Yunkyung Kim, Chief Operating Officer, expressed her appreciation to the family members and guest speakers who shared their experiences, noting that their input highlighted specific barriers in the transition process. Because the issues raised are urgent, staff is committed to continuing discussions well before the committee's next scheduled meeting in May. Director Byron offered to convene additional sessions, and the team expressed readiness to collaborate promptly.

Ms. Kim also shared operational updates from CalOptima Health with the committee.

Richard Pitts, D.O., Ph.D., Chief Medical Officer, reminded the committee that measles remains a significant public health concern in the United States. After a dramatic drop in cases during the COVID-19 pandemic, numbers have risen sharply from 58 cases to over 2,200 in recent years, and

current trends suggest the country may soon exceed previous peaks. While California maintains a high childhood immunization rate of about 95%, outbreaks continue to occur, including a recent cluster in Shasta County with no identifiable travel source, unlike most other cases linked to international travel. Dr. Pitts emphasized that individuals traveling abroad without measles immunity pose a major risk of reintroducing the virus, especially when visiting densely populated regions with weaker public health systems. Historically, measles vaccination nearly eliminated the disease, and Dr. Pitts urged committee members to act as vaccination ambassadors and strongly recommend the measles vaccine when questions arise.

Members of the committee questioned whether the pediatric care system was equipped to handle a major outbreak, as many hospitals no longer admit pediatric patients, and children's hospitals, where most pediatric care is now concentrated, serve large numbers of immunocompromised children, making them particularly vulnerable, and a large surge in cases could overwhelm these facilities. Dr. Pitts noted that the United States had once achieved measles-free status, but the country now risks losing that designation due to ongoing outbreaks affecting more than 1,000 people.

Michael Hunn, Chief Executive Officer, thanked everyone for attending and noted that CalOptima Health's motto is "Better Together," and that he was ready to jump in and assist the team with the transition challenges.

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

Board of Directors'
Quality Assurance Committee Meeting
March 19, 2026

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

On October 28, 2025, the Whole-Child Model Member Family Advisory Committee (WCM FAC) held its quarterly meeting, which was conducted both in person and via Zoom Webinar.

Michelle Laba, MD, MS, FAAP, Deputy Director of Medical Services for the California Children's Services (CCS) program in Orange County, presented an update, noting two key updates to be aware of: one affecting the General Medical Program and the other impacting the Medical Therapy Program. She noted that the focus areas for the general medical program included the Whole-Child Model, the Neonatal Intensive Care Unit (NICU), and High-Risk Infant Follow-Up. Eligibility for these services had been thoroughly discussed with managed care plans, such as CalOptima Health, the Orange County Health Care Agency (OCHCA), which operates the CCS programs, and the Department of Health Care Services (DHCS). She noted that recently, DHCS had developed new workflows that define the responsibilities of both the County and the managed care plans. These workflows clarify that the County will remain responsible for determining eligibility, while managed care plans and their provider networks must adhere to specific timeliness requirements for submitting referrals. As a result, both the County and managed care plans will need to adjust their internal workflows. Although CCS is expected to follow the current guidance, DHCS has indicated that further modifications may be forthcoming. CCS will continue to monitor for any changes and share relevant updates as they arise.

Dr. Laba also discussed the Medical Therapy Program and noted that CCS wanted to raise awareness that the interagency agreements between school districts and CCS are currently being updated. These updates are being made in accordance with requirements set by DHCS. Although no immediate action is needed, it is essential to stay informed as these agreements evolve.

Cheryl Meronk, Director, Medicare Program Development, presented a OneCare update and reviewed OneCare changes that would take effect in 2026. She noted that one of the most significant changes was that CalOptima Health would be moving from two plans in 2025 back to a single plan in 2026 due to the sunsetting of the Value-Based Insurance Design (VBID) program on December 31, 2025, and that CalOptima Health would no longer have the flexibility of offering two separate plans. As a result, OneCare Complete will be the only plan available in 2026. The VBID program allowed CalOptima

Health to offer different benefits across the two plans; however, due to its conclusion, CalOptima Health will revert to a single plan.

Ms. Meronk reviewed the changes that would occur on January 1, 2026, with the committee and discussed that the flex benefit cards would increase from $135 to $167 per quarter in 2026, but that there would be no rollover of unused funds. She also discussed how members can continue using the card for over-the-counter items and that only those with qualifying chronic conditions (about 22 identified by CMS) would be eligible to use it for healthy food and produce. Members would be pre-qualified based on claims data and notified before the new year.

She also noted that OneCare will continue to offer in-home support and companionship services, up to 90 hours per year for eligible members, and will continue the fitness benefit through Silver & Fit, providing unlimited access to participating gyms. Members also receive up to $100,000 in worldwide, reimbursable emergency and urgent care coverage. In 2026, the annual physical exam will continue as a supplemental benefit, along with comprehensive dental services. Part D coverage is being adjusted to combine features from both 2025 plans. In 2026, OneCare Complete will offer $0 copays for generic drugs, and copays for brand-name drugs will align with the member's Extra Help level. Additionally, the dental benefits included in OneCare through Liberty Dental will be briefly discussed.

Yunkyung Kim, Chief Operating Officer, provided a verbal report, noting that CalOptima Health currently has approximately 9,000 members in the Whole-Child Model program. Ms. Kim noted that while the number seemed low, it reflected a steady decline in the pediatric population across Orange County over the past several years. The trend appears to be demographic in nature, rather than the result of any unusual enrollment or disenrollment activity. Of the 9,000 members, approximately 6,000 are served by CHOC Health Alliance, making it the largest health network for this population. Additionally, approximately 1,000 members are in CalOptima Health's direct network, with Optum serving approximately 800 members. She noted that the remaining members are distributed among other health networks, as all networks are required to support Whole-Child Model members, and the families have the flexibility to choose any network. She noted that each network was fulfilling its obligation.

Ms. Kim also provided a transportation update, noting that CalOptima Health had partnered with ModivCare to offer both medical and non-medical transportation services. Although ModivCare filed for Chapter 11 bankruptcy earlier this year, it is a financial restructuring, and CalOptima Health had not observed any decline in service levels. CalOptima Health is closely monitoring the situation from both legal and operational perspectives. While transportation is a challenging benefit to manage, ModivCare has remained consistent in delivering services, and a plan B was in place should service levels drop. ModivCare was aware of this contingency. She asked the members if they or anyone they knew was experiencing transportation issues, and asked them to report them so CalOptima Health could address the problems promptly and prevent further impact.

Lastly, Ms. Kim shared that Providence Health System will officially become a health network effective November 1, 2025, and that the transition is expected to be seamless for members. Those members already with Providence primary care providers would continue receiving care without interruption, as this change was primarily administrative and would not affect access to services, particularly for pediatric members, as Providence works closely with CHOC on pediatric care.

Richard Pitts, D.O., Ph.D, Chief Medical Officer, discussed how there has been a lot of conflicting information circulating about vaccines, especially from Washington and other sources and noted that the best course of action is to continue following your vaccination schedule in consultation with your trusted healthcare provider. Dr. Pitts also provided an update on COVID-19 immunizations, noting that recommendations had shifted. He discussed how, for individuals aged 6 months to 64 years, the decision should be made through shared decision-making with a physician. He strongly recommended that members over 65 or with serious health conditions such as diabetes, heart failure, or cystic fibrosis should receive the vaccine.

Dr. Pitts noted a rise in the recreational use of nitrous oxide. Though often perceived as harmless, chronic use can cause severe spinal cord damage, and it is noted that medically, nitrous oxide remains a valuable tool for pain relief and anesthesia. Still, its abuse was concerning, and the County health office had encountered discarded canisters in public areas.

Veronica Carpenter, Chief Administrative Officer, reminded members that CalOptima Health's Strategic Development and Equity departments were still gathering information for the Member and Population Health Needs Assessment survey, and that the survey would remain available until mid-December. This web-based survey aims to gather insights into our members' health needs, lived experiences, and priorities. Approximately 25,000 members will receive an email or mail communication from the Social Science Research Center at California State University, Fullerton, on behalf of CalOptima Health. Participation is encouraged, and members will be offered a gift card.

Ms. Carpenter also reviewed the Get Care Now Campaign, which responds to HR 1 and state-level changes affecting Medi-Cal eligibility. She noted that the CalOptima Health Board had recently approved $19 million, in addition to a previous $800,000, to fund a comprehensive communication strategy. This strategy includes a multilingual advertising campaign and a toolkit to help members navigate changes and continue accessing care. The campaign will feature print ads in English, Spanish and Vietnamese, as well as transit ads and bus shelter placements. The toolkit would include flyers, frequently asked questions, newsletter articles and social media content to support community partners, elected officials and members in spreading the word.

Ms. Carpenter also reviewed the FY 2025-2026 Public Policy Priorities with the members. She noted that these priorities have been broadened to reflect the advocacy needed for the Centers for Medicare & Medicaid Services (CMS), especially as the work requirements in HR 1 are implemented.

Michael Hunn, Chief Executive Officer, provided a CEO Report and reviewed the enrollment numbers with the committee members, noting that for FY 2025-2026, CalOptima Health had budgeted for an average enrollment of 840,000 members. The current numbers remain well above that, keeping CalOptima Health in a strong financial shape. Additionally, with board approval, CalOptima Health maintains reserves to protect against any disruptions in funding from the federal government, the state, or CMS, particularly for our OneCare program. Maintaining 120 to 140 days of cash on hand ensures that CalOptima Health can continue funding care for its members during any fiscal uncertainty. He noted that CalOptima Health continues to operate with exceptional efficiency, and that between $0.91

and $0.94 of every dollar is spent directly on member care. He also noted that the administrative overhead remains the lowest among public and private health plans in California, around 5.2% to 5.3%.

Mr. Hunn also discussed the current concern in the potential disruption of CalFresh benefits due to the federal government shutdown noting that over 300,000 Orange County residents rely on CalFresh for food assistance and that while CalOptima Health does not administer these benefits, it is working closely with the County Social Services Agency to support affected families and that starting Saturday, November 1, 2025 individuals in need of food resources should call 2-1-1, where multilingual staff from the United Way of Orange County would help them locate food pantries and banks. CalOptima Health will also publish a comprehensive list of food resources on its website within the next day. Although CalFresh benefits may be delayed, once the program is reactivated and funded, members will receive their full benefits retroactively. EBT cards will be reloaded accordingly. This delay also impacts local grocery stores, as CalFresh provides $62 million in monthly food assistance in Orange County.

Mr. Hunn also noted that as the year-end approaches, CalOptima Health must continue to evaluate how to simplify care navigation for members, especially for families transitioning their children to adult care or managing CCS-related services. He noted that CalOptima Health is aware of how the transition to aging out places significant stress on families and that CalOptima Health remains committed to improving systems and support.

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

Board of Directors'
Quality Assurance Committee Meeting
March 19, 2026

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

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

The WCM FAC welcomed new authorized family members: Fabiana Avendano, April Johnston, Mayra Ortiz, and Katya Aguilar, as the Community-Based Organization Representative. The Board appointed all at their August 7, 2025, meeting. This was the committee's first time accommodating two Spanish-only members, and CalOptima Health successfully held the meeting with interpreter support via Zoom and in person.

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

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

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

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

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

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

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

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

Dr. Rose also discussed how to ensure inclusivity. CalOptima Health was engaging its Member and Provider Advisory Committees and 18 community partners. A member survey translated into threshold languages will gather feedback on care barriers, service gaps, and health experiences. It will be distributed to 25,000 randomly selected members and at community events, with gift cards offered as incentives. Dr. Rose also noted that a provider survey was launched in July 2025 and had already

received over 240 responses from a wide range of healthcare professionals. Providers are encouraged to complete the survey regardless of their network.

Focus groups, facilitated by Community Action Partnership of Orange County (CAP OC), will begin in late fall 2025, both in person and virtually. Special sessions will be held for parents of children in the Whole Child Model and children with disabilities. Dr. Rose requested help identifying participants and host locations.

Veronica Carpenter, Chief Administrative Officer, provided an overview of state and federal budget updates and their implications for CalOptima Health members. She highlighted that her department oversees Government Affairs, Communications, Community Relations, Strategic Development, and the Clerk of the Board. A handout titled Fiscal Year 2025–2026 Enacted State Budget was distributed, summarizing the key changes. She noted that Governor Newsom had released the revised state budget on May 14, 2025, and that the state legislature passed it on June 13, 2025. Ms. Carpenter reviewed the key changes, including a freeze on new enrollment for undocumented individuals aged 19 and older, effective January 1, 2026, and the reinstatement of the asset limit test on the same date, setting a threshold of $130,000 for individuals and $65,000 for each additional household member. She noted that other changes included pharmaceutical policy updates and that beginning on July 1, 2027, a $30 monthly premium for undocumented individuals aged 19–59 would take effect. Ms. Carpenter emphasized that no immediate changes are in effect and encouraged members to continue accessing care, including well-child and wellness visits. CalOptima Health's communications team will ensure timely updates as changes are implemented.

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

Zeinab Dabbah, M.D., JD, MPH, FACP, Deputy Chief Medical Officer, provided key updates from the American Academy of Pediatrics (AAP) vaccination recommendations released in July 2025. As a reminder, immunizations remain the safest and most cost-effective way to prevent disease, disability, and death. She noted that COVID-19 continues to circulate, and the AAP recommends an annual, strain-matched COVID-19 vaccine for all children aged 6 months and older, as this ensures protection against the currently circulating variant. Dr. Dabbah also discussed the new high-dose Influenza vaccine, which is recommended for high-risk individuals aged 6 years and older, especially as flu season begins in early fall. She also noted that the Human Papillomavirus (HPV) vaccination is now recommended starting at age nine to improve early protection against cervical cancer and that Meningococcal B vaccination is now routinely recommended for all adolescents aged 16 to 18.

Dr. Dabbah also provided an update on the Respiratory Syncytial Virus (RSV), and that prevention has expanded significantly. She noted that for infants, a single intramuscular dose is recommended for all babies aged 8 months or younger during the RSV season (October–March). This protects for up to five

months, and a second dose is advised for high-risk infants aged 8–19 months, including those with chronic lung disease, congenital heart disease, or who are immunocompromised. For pregnant individuals, the maternal RSV vaccine is now recommended between 32 and 36 weeks of gestation during RSV season. This approach, endorsed by the American College of Obstetrics and Gynecology, helps transfer immunity to the unborn child. If the maternal vaccine is given, the infant dose is not needed except for high-risk infants. Dr. Dabbah also discussed the new updated catch-up schedules, which are available for children with interrupted vaccine series, immunocompromised children, and those with uncertain vaccination histories, such as refugees and immigrants.

Veronica Carpenter, Chief Administrative Officer, provided an update on how CalOptima Health is preparing to launch its Covered California line of business in 2027, with a go-live date set for January 1, 2027. She noted that the Strategic Development team is collaborating across departments, including clinical, operations, and customer service, to support this major initiative. She also noted that on the regulatory front, the Board approved the submission of the licensure application at the state level in June and that since then, the team has been actively engaged in reviewing and responding to feedback on the application, which will continue as an ongoing process.

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

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

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

MINUTES

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

CALOPTIMA HEALTH
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

October 8, 2025

A Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee (Committee) was held on October 8, 2025, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health's website under Past Meeting Materials.

Chair Jose Mayorga called the meeting to order at 3:00 p.m., and Director Catherine Green led the Pledge of Allegiance.

CALL TO ORDER

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

Members Absent: None.

Others Present: Michaell Rose, DrPH, LCSW, Chief Health Equity Officer; Troy R. Szabo, Outside General Counsel, Kennaday Leavitt; John Tanner, Chief Compliance Officer; Linda Lee, Executive Director, Quality Improvement; Sharon Dwiers, Clerk of the Board

The Clerk announced that PACE leadership is attending a previously scheduled Electronic Medical Records (EMR) training and will not be able to provide verbal updates today; however, the written reports are included in the meeting materials.

ADVISORY COMMITTEE UPDATES

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

As the Clerk noted, the written reports for this item are included in the meeting materials.

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

Lori Sato, Chair, WCM FAC, shared highlights from the August 26, 2025, meeting, noting the successful inclusion of two new Spanish-speaking members on the WCM FAC and effective interpreter support. Ms. Sato noted that committee members received updates from Dr. Lava regarding the California Children's Services (CCS) program at the August meeting. She also reported that the committee members received reports from Kim Goll, Chief Executive Officer at

First Five OC, noting that Ms. Goll highlighted the Protect and Connect OC collaborative as a key strategy to support families and early development. Ms. Sato reported that committee members appreciated the reports from Dr. Michaell Rose, Chief Health Equity Officer, on health equity and Veronica Carpenter, Chief Administrative Officer, on the implications of recent federal budget developments.

Director Byron thanked Ms. Sato for her work on the WCM FAC and the issues around eligibility as it is important to the community and committee members serving on the WCM FAC.

PUBLIC COMMENTS

- Rolando Chavez, AltaMed Health Services: Oral report regarding Report Item 5.

CONSENT CALENDAR

3. Approve the Minutes of the June 18, 2025 Special Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

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

REPORTS/DISCUSSION ITEMS

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

Linda Lee, Executive Director, Quality Improvement, provided a high-level overview of the modifications to policies GG.1650 and GG.1651.

Policy GG.1650: Credentialing and Re-credentialing of Practitioners. Ms. Lee reported that there were three key updates to this policy. First, the policy includes qualified autism services providers, which means that applied behavioral health providers are now subject to credentialing requirements, aligning with broader provider standards. Second, Federally Qualified Health Center (FQHC)-only practitioners who exclusively operate under FQHCs are now excluded from CalOptima's credentialing process as they are already subject to rigorous federal credentialing standards. Lastly, the policy removes the requirement for all practitioners to be enrolled in Medicare and instead clarifies that only fee-for-service providers must meet this federal requirement.

Policy GG.1651: Assessment and Reassessment of Organizational Providers. Ms. Lee reported that this policy was updated in parallel to GG.1650 and includes: (1) the addition of qualified autism service providers to the list of entities requiring full credentialing; and (2) makes updates to the categories of organizational providers that must be enrolled in the Medicare program, ensuring alignment with federal guidelines.

Action: ***On motion of Director Green, seconded and carried, the Committee recommended that the Board of Directors approve modifications to the following CalOptima Health policies pursuant to CalOptima Health's annual review process: GG.1650: Credentialing and Recredentialing of Practitioners;***

and GG.1651: Assessment and Re-Assessment of Organizational Providers. (Motion carried 3-0-0)

Chair Mayorga noted for the record that he would not be participating in Agenda Item 5 due to his role as Senior Vice President and Chief Quality Officer at AltaMed Health Services and will leave the room during the discussion and vote and passed the gavel to Director Byron.

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

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

Ms. Lee introduced the item and started by providing an overview of the Pay-for-Value (P4V) Program enhancements. She noted that CalOptima Health has long operated a P4V Program to incentivize high-quality care and, while the program has driven improvements, recent performance has varied across products and networks. Ms. Lee reported that one of the notable changes has been that the Medi-Cal line of business' performance has consistently outpaced OneCare, partly due to larger incentive pools and greater focus. Ms. Lee reported that the OneCare line of business' Medicare Star Rating (Star Rating) has declined from 4.0 in 2022 to 2.5 in 2025, prompting a need for stronger alignment and accountability.

Ms. Lee reviewed the proposed incentive structure for Measurement Year 2026 to address the performance gaps, including a proposal to link OneCare performance to Medi-Cal incentives. She added that health networks will earn a percentage of their Medi-Cal incentive based on their OneCare Star Rating, with both upside and downside adjustments. For example, a OneCare 5-Star Rating could yield 125% of the Medi-Cal incentive, while ratings below 3 stars could reduce it to 80%. This structure will phase in over three years, gradually increasing performance expectations.

Ms. Lee reported that the OneCare incentive pool will also shift to include both rewards and penalties. A 5-Star Rating will earn 120% of the incentive, while performance below 3 stars will receive no incentive and trigger compliance concerns with the Centers for Medicare & Medicaid Services (CMS). She added that sustained low performance may result in sanctions, including contract termination.

She provided details on the measurement and methodology, reporting that CalOptima Health's P4V Program will retain alignment with the Department of Health Care Services (DHCS) and CMS quality measures. Medi-Cal will use the Managed Care Accountability Set (MCAS), while OneCare will focus on CMS Star Rating measures most influenced by health networks. Measures will be weighted by impact, with clinical outcomes weighted highest. Performance will be assessed using administrative data and the Integrated Healthcare Association methodology, which rewards either benchmark attainment or year-over-year improvement.

Ms. Lee also provided details on accountability and corrective actions for any health network scoring below 3 stars or below the 50th percentile for Medi-Cal, which will be subject to corrective action plans. She added that a new proposal includes panel closure for persistently low-performing networks, with quarterly reassessments to protect members from substandard care.

Back to Agenda

Ms. Lee provided details on the incentive pool and possible quality grants, noting that the Medi-Cal incentive pool will remain at 10% of professional capitation (approximately $73 million), and OneCare at $20 PMPM (approximately $4.3 million). Unearned funds may be redistributed as quality grants to support targeted improvement efforts. Networks must submit a report on quality improvement plans, and CalOptima Health will also invest in system-wide interventions.

Committee members Byron and Green heard public comment on this item as noted above under the Public Comments section of the agenda.

Ms. Lee responded to Committee members' questions and comments, which included considerable discussion related to the small population size for the OneCare population and concerns on the effectiveness of prior P4V incentives. Committee members directed staff to provide details regarding improvement in the quality of care for both Medi-Cal and OneCare members in prior and current P4V incentive programs.

After robust discussions, the committee directed staff to come back to the Committee with a revised Measurement Year 2026 P4V Incentive Programs for Medi-Cal and OneCare delegated health networks. The Committee also asked staff to look into separating the two lines of business and requested a report on the Star Rating performance by the next Committee meeting.

The committee split the three recommended actions for this Agenda Item into three separate actions:

Action: ***On motion of Director Byron, seconded and carried, the Committee recommended that staff revise the original recommended action 1 (below) to separate the Medi-Cal and OneCare lines of business, remove the gateway, and bring a report on the Star Rating performance by the next QAC. (Motion carried; 2-0-0; Chair Mayorga recused)***

No Action: ~~***1. Approve CalOptima Health Measurement Year 2026 Medi-Cal and OneCare Delegated Health Network Pay for Value Performance Programs effective January 1, 2026, through December 31, 2026.***~~

Action: ***On motion of Director Byron, seconded and carried, the Committee recommended that the Board of Directors 2) Approve CalOptima Health Measurement Year 2027 Covered California Health Network Pay for Value Performance Program effective January 1, 2027, through December 31, 2027. (Motion carried; 2-0-0; Chair Mayorga recused)***

Action: ***On motion of Director Byron, seconded and carried, the Committee recommended that the Board of Directors 3) Approve Measurement Year 2026 Medi-Cal and OneCare Primary Care Provider Pay for Value Performance Programs, one-time provider incentives for digital technology improvements and utilization of physician incentive software***

to provide a real-time, point-of-care approach that rewards physicians for the completion of specific value-based care actions. (Motion carried; 2-0-0; Chair Mayorga recused)

Director Byron passed the gavel back to Chair Mayorga.

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

Ms. Lee introduced the item and provided an overview of the proposed changes to the Member Health Rewards program for Calendar Year (CY) 2026.

Ms. Lee noted that for Program Overview and Delivery Enhancements, CalOptima Health's Member Incentive Program continues into 2026 with minor modifications. In 2025, the program included 11 Medi-Cal and 7 OneCare health rewards. Medi-Cal incentives were delivered via physical gift cards, while OneCare rewards transitioned to the Flex Card, enabling faster access and integration with existing member benefits.

For 2026, there were no changes proposed for automated incentives based on claims and encounter data. However, provider attestation-based rewards proposed changes included the following:

- Breast Cancer Screening: CalOptima Health updated the age criteria to align with current clinical guidelines, with flexibility for provider-recommended screenings outside standard age ranges;
- Colorectal Cancer Screening: CalOptima Health expanded to include multiple screening types – $15 for Fecal Immunochemical Test/Fecal Occult Blood Test kits, $25 for computed tomography colonography or flexible sigmoidoscopy, and $50 for colonoscopy;
- Osteoporosis Screening: Now includes medication treatment as a qualifying activity, in addition to bone density scans; and
- Annual Wellness Visit (OneCare): CalOptima Health shifted from automated to self-attestation to improve member awareness of healthy behaviors linked to incentives.

Ms. Lee also provided an update on a retired incentive and the fiscal impact. The attention-deficit/hyperactivity disorder follow-up care incentive for children in the Medi-Cal program will be retired due to low participation. The projected fiscal impact includes a $1.3 million increase for Medi-Cal and $370,000 for OneCare, based on an estimated 15%-member participation rate. Detailed budget breakdowns and reward values are available in the appendix of the meeting materials.

Chair Mayorga asked if staff had received input from CalOptima Health's legal counsel on the dollar amounts for different screenings. Ms. Lee responded that CalOptima Health has had legal reviews of all the quality incentives.

Troy Szabo, Outside General Counsel, Kennaday Leavitt, responded to Chair Mayorga's question noting that he is happy to go back at look at this again, but everything in this action is accurate and consistent with the law.

Chair Mayorga thanked Mr. Szabo and moved the item.

Action: ***On motion of Chair Mayorga, seconded and carried, the Committee recommended that the Board of Directors: 1.) Approve CalOptima Health's Calendar Year 2026 Member Health Rewards for Medi-Cal and OneCare. (Motion carried; 3-0-0)***

INFORMATION ITEMS

7. Credentialing Update

Ms. Lee provided an update on the credentialing process for the fourth quarter of 2025. She noted that CalOptima Health has made significant progress in addressing its credentialing backlog.

Beginning in April 2025, a focused initiative was launched to resolve the issue, including the hiring and training of temporary staff and a company-wide call for overtime support. Over 20 employees contributed outside regular hours, including weekends, to reduce the backlog. As a result, by June 2025, the backlog was fully cleared.

Credentialing volumes peaked at nearly 3,000 files in March but have since been reduced to a manageable inventory of 759 files, aged within 60 days – half the industry standard for turnaround times. To sustain progress, CalOptima Health hired a new Director of Credentialing, Charlie LeBlue, along with two additional full-time staff. Process improvements and automation efforts are underway to further streamline provider onboarding and reduce manual workload.

Ms. Lee provided a regulatory update related to credentialing, noting that in May 2025, DHCS introduced a new pathway for Applied Behavior Analysis (ABA) providers to become Medi-Cal enrolled. Prior to this, no formal enrollment process existed, although CalOptima Health continued credentialing these providers. Following the DHCS announcement, CalOptima Health notified all impacted providers of the requirement to enroll by October 1, 2025.

To support compliance, CalOptima Health conducted a comprehensive outreach campaign, including email communications, webinars, formal letters, and direct phone calls. As a result, the majority of ABA providers are now compliant, with continued follow-up underway for remaining providers. Further clarification was issued by DHCS during a September 30 webinar. Effective November 17, 2025, individual Board-Certified Behavior Analysts who bill solely for their own services and do not supervise other professionals may use their residential address as their administrative location. This change addresses a key barrier for solo practitioners. Additionally, DHCS clarified that only group entities are required to enroll in Medi-Cal; individual providers may choose to enroll. CalOptima Health will update its credentialing policy to reflect these changes accordingly.

Ms. Lee noted that CalOptima Health will send a certified letter to providers who have not completed the credentialing process informing them they have 30 days to complete the process or risk contract termination.

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

8. National Committee for Quality Assurance Accreditation Update

Ms. Lee provided a Health Plan and Health Equity Accreditation update, noting that CalOptima Health is currently accredited by the National Committee for Quality Assurance (NCQA) for its

health plan. In alignment with a DHCS directive, all health plans are required to obtain Health Equity Accreditation through NCQA by January 1, 2026. These requirements have informed the timelines outlined in meeting materials for accreditation tracking. CalOptima Health is presently in the look-back period for its health plan re-accreditation, which spans from April 2025 through April 2027.

Ms. Lee reported that CalOptima Health's Health Equity Accreditation is underway and noted that it successfully submitted all required documentation to NCQA on October 7, 2025. These documents have been uploaded and accepted for review. NCQA will assess the submission and notify CalOptima Health of any gaps, and CalOptima Health will have a 110-day window to address and resolve any identified issues. Currently, CalOptima Health does not anticipate any challenges with the accreditation process.

In August, NCQA released new health plan standards, which include substantial updates. In response, CalOptima Health has conducted comprehensive training for both internal staff and delegated entities to ensure alignment with the revised standards. CalOptima Health completed its year-one of a three-year document review, and all required materials for the first year of the look-back period are currently under internal review. Additionally, CalOptima Health has scheduled a file review to confirm full compliance of all documentation.

In summary, CalOptima Health is well-positioned to maintain its NCQA Health Plan Accreditation and is on track to achieve NCQA Health Equity Accreditation by the January 2026 deadline.

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

10. Utilization Management Committee and Clinical Operations Updates

Kelly Giardina, Executive Director, Clinical Operations, provided an update on CalOptima Health's continued advancement in its strategic initiatives through the work of its Utilization Management Committee Sub-workgroups. Ms. Giardina's update highlighted key milestones and outcomes from Quarter 2 of 2025, with a focus on over- and under-utilization, high-risk/high-need care, and health network oversight.

Ms. Giardina noted that the High-Risk, High-Need Care Workgroup implemented an enhanced Usher text campaign, resulting in a 7.58% improvement in transitional care services outreach from Quarter 1 to Quarter 2. She also noted the launch of urgent care technology tools and resources on the CalOptima Health website contributed to improved member access and engagement.

For the Over- and Under-Utilization Initiatives, Ms. Giardina reported that CalOptima Health has removed prior authorization requirements for preventive screenings to streamline access to essential services. She added that in response to provider feedback, CalOptima Health transitioned to portal rule automation for approving preventive screening requests, contingent on criteria fulfillment. Ms. Giardina also reported that staff conducted enhanced clinical oversight and retraining for the utilization management team on specialty imaging criteria review, ensuring consistency and quality in decision-making.

Ms. Giardina provided updates on tools available for Early and Periodic Screening, Diagnostic and Treatment for use by private duty nurses.

Back to Agenda

Ms. Giardina also reviewed in detail the current utilization trends with the Committee. She turned the presentation over to Robin Hatam, M.D., Medical Director, Medical Management at CalOptima Health.

Dr. Hatam reported that as part of CalOptima Health's ongoing efforts to strengthen oversight and improve performance across its delegated health networks, it has implemented several key initiatives through the Office of Medical Management. These initiatives are designed to ensure regulatory compliance, enhance clinical quality, and support continuous improvement.

Dr. Hatam noted that during a recent Delegation Oversight Committee meeting, staff presented updates on CalOptima Health's Delegation Oversight Dashboard. This tool enables continuous monitoring of delegated entities across critical domains, including utilization management, case management, credentialing, claims, and customer service.

Dr. Hatam added that these metrics are reviewed monthly with each health network and are aligned with regulatory requirements. When a network falls below established performance thresholds, CalOptima Health staff initiate a structured remediation process. This includes completion of a root cause analysis and submission of a remediation plan with defined timelines, ongoing monitoring of performance against corrective action plans, and if needed, escalation to sanctions for persistent noncompliance. These findings are reported monthly at CalOptima Health's Delegation Oversight Committee meetings and quarterly at CalOptima Health's various clinical quality meetings.

Dr. Hatam reported on the grievance and appeals trends, which are reported at CalOptima Health's quarterly clinical meetings. CalOptima Health also shares trends in grievances and appeals with its health networks. This allows CalOptima Health to engage directly with health network medical directors and staff to ensure alignment in decision-making and to support continuous process improvement.

Dr. Hatam also shared details on delegation oversight report cards, hospital and facility rounds, and skilled nursing facility Engagement. He noted that this work has been instrumental in fostering collaboration and improving outcomes for our members in post-acute settings.

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

10. Quarterly Reports to the Quality Assurance Committee

a. Quality Improvement Health Equity Committee Report

Ms. Lee provided an update on the Quarter 4 2025 activities of the Quality Improvement and Health Equity Committee (QIHEC). She noted that the QIHEC oversees multiple subcommittees that support CalOptima Health's clinical, member experience, and business functions. This includes monitoring quality performance measures such as OneCare Star Ratings, the MCAS for Medi-Cal, and NCQA accreditation status.

Regarding quarterly evaluations and program oversight, the QIHEC evaluated key quality functions, including potential quality issues, provider credentialing, and facility site reviews. The committee also reviewed performance improvement projects focused on access, availability, and member experience. This included a comprehensive analysis of customer service metrics, grievance data, and

member experience survey results. Coordination of care was also assessed to ensure seamless service delivery across the continuum.

Ms. Lee reported on committee actions and policy updates, noting the QIHEC approved prior meeting minutes and updates to the committee's work plan. Additionally, the committee reviewed and approved the proposed 2026 P4V Program. Policy updates included revisions to the QIHEC committee structure, the Quality Improvement Program Description, and the policy for reporting provider preventable conditions.

For quarter 2 2025, Ms. Lee reported that there were key findings and outcomes to improve medication adherence. Over 1,000 interactive voice response calls were conducted, resulting in 283 prescriptions filled for 19 members. The 100-Day Conversion Program extended 54 prescriptions for 34 members. In August 2025, Russian was added as a threshold language to better serve our diverse member population.

Ms. Lee reviewed the Performance Metrics and Quality Results, noting that the preliminary HEDIS results from Quarter 2 2025 for the Medi-Cal line of business indicated that several measures did not meet the minimum performance level (MPL), including asthma medication ratio (now retired by NCQA) and two behavioral health measures – follow-up after emergency department visits for substance use disorder and mental illness. These measures also fell below the MPL in the prior year. In contrast, measures in children's and reproductive health domains met the MPL for OneCare. However, the OneCare measure for Care for Older Adults and Transitions of Care were rated below three stars for Measurement Year 2024.

Ms. Lee highlighted the improvement in member assessments. Notably, 84% of new Dual Eligible Special Needs Plan members in OneCare completed health risk assessments (HRA) in 2024, marking a significant improvement over prior years. Additionally, the rate of individual care plan completion within 90 days also showed measurable progress.

b. Member Grievances and Appeals Report

Heather Sedillo, Director, Grievances, Appeals, and Resolution Services (GARS), provided an overview of the member grievances and appeals report for the second quarter. She reviewed the definitions, executive summary, grievance volume and trends, grievance actions taken, and noted that she would do the same for appeals.

Ms. Sedillo reviewed the executive summary for Quarter 2 2025, noting that CalOptima Health received 5,056 grievances and 501 appeals for Medi-Cal and OneCare combined. CalOptima Health's average closure rate was 21 days, which meets the 30-day turnaround time per regulatory standards for grievances.

Medi-Cal Grievances

Ms. Sedillo noted that CalOptima Health went from 3,675 grievances in Quarter 1 2025 to 4,506 in Quarter 2 2025 for the Medi-Cal line of business, which was a 23% increase, with the main reasons attributed to provider/staff attitude, plan customer service, referral delays, and appointment availability.

Back to Agenda

OneCare Grievances
For the OneCare line of business, it saw a 48% increase from 371 in Quarter 1 to 550 in Quarter 2 for grievances, with the main reasons attributed to provider/staff attitude, plan customer service, transportation services, and telephone accessibility.

Medi-Cal Appeals
Ms. Sedillo reported that for the Medi-Cal line of business, appeals saw an increase of 53%, going from 265 in Quarter 1 to 406 in Quarter 2, with a 28% overturn rate. The main reasons for the appeals were attributed to CalAIM personal care hours, housing deposits, day habilitation services, and specialty care requests related to out-of-network and UC Irvine tertiary level of care requests.

OneCare Appeals
For the OneCare line of business, appeals increased from 59 in Quarter 1 to 96 in Quarter 2, which is a 61% increase, with a decrease in overturn rate from 47% in Quarter 1 to 33% in Quarter 2. The main reasons for the appeals were attributed to inpatient hospital care with non-contracted providers, outpatient services related to imaging and labs, and out-of-network specialty care requests.

Ms. Sedillo presented a detailed breakdown of grievances and appeals for each line of business, noting the current trends, circumstances leading to the grievances and appeals, as well as actions taken to address the circumstances.

Ms. Sedillo noted that monitoring the grievances and appeals process is an ongoing process where staff meet internally and with external providers to address the issues. She added that CalOptima Health takes all complaints seriously with continuous follow-up.

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

c. Program of All-Inclusive Care for the Elderly Report
No verbal report was provided given that PACE leadership attended an EMR training but the PACE Report was included in the meeting materials for review.

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

ADJOURNMENT
Hearing no further business, Chair Mayorga adjourned the meeting at 4:44 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: March 19, 2026

Back to Agenda

MINUTES

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

CALOPTIMA HEALTH
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

November 13, 2025

A Special Meeting of the CalOptima Health Board of Directors' (Board) Quality Assurance Committee (Committee) was held on November 13, 2025, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill (AB) 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. Due to a technical error, no meeting recording is available.

Director Maura Byron called the meeting to order at 3:00 p.m., and Director Catherine Green led the Pledge of Allegiance.

CALL TO ORDER

Members Present: Maura Byron; Catherine Green, R.N.

Members Absent: Jose Mayorga, M.D., Chair

Others Present: Yunkyung Kim, Chief Operating Officer; Troy R. Szabo, Outside General Counsel, Kennaday Leavitt; Linda Lee, Executive Director, Quality Improvement; John Tanner, Chief Compliance Officer; Sharon Dwiers, Clerk of the Board

ADVISORY COMMITTEE UPDATES

None

PUBLIC COMMENTS

There were no public comments.

CONSENT CALENDAR

None

REPORTS/DISCUSSION ITEMS

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

Linda Lee, Executive Director, Quality Improvement, provided an update on the Measurement Year (MY) 2026 Pay for Value (P4V) program. Ms. Lee explained that CalOptima Health's P4V program is structured to financially reward high-performing health networks (HNs) for delivering quality care. While the program has historically offered only upside incentives, performance levels have varied across products and among HNs. Ms. Lee clarified that the Medi-Cal measure sets are aligned with

the Department of Health Care Services (DHCS), including the Managed Care Accountability Set minimum performance levels (MPL), and quality withhold measures, which incorporate Healthcare Effectiveness Data and Information Set (HEDIS) and DHCS clinical metrics.

In contrast, the OneCare measure sets align with Centers for Medicare & Medicaid Services Star measures, which have a greater impact at the HN level. These measures include Part C HEDIS, Consumer Assessment of Healthcare Providers and Systems, and Part D metrics to assess performance.

Ms. Lee stated that the P4V performance methodology and benchmarks are based on the Integrated Healthcare Association scoring system, which evaluates current performance against established benchmarks and prior year results. She noted that the incentive calculations are based on the higher of the two scores: either the benchmark comparison or the improvement over the previous year's performance. Ms. Lee added that CalOptima Health anticipates alignment of measures once DHCS releases final measure sets, expected in January 2026, and that the current plan reflects DHCS draft measures.

Ms. Lee further explained that HNs performing below the MPL for Medi-Cal or below a 3.0 Star Rating for Medicare must submit a corrective action plan. She emphasized that CalOptima Health will incorporate applicable impacts from the DHCS quality withhold program, noting a 1.0% capitation withhold for MY 2026. The P4V program budget is set at 10% of the professional capitation for Medi-Cal (base rate only) and $20 per member per month (PMPM) for OneCare. Additionally, Ms. Lee noted that CalOptima Health will allocate quality-improvement grants from unearned incentive funds to support targeted improvements in individual or group performance measures. She noted that each HN is required to submit a formal improvement plan and demonstrate progress to maintain continued access to these funds. Ms. Lee also noted that industry standards would be used to measure patient satisfaction through surveys at both the network and practice level.

Ms. Lee continued with an overview of the Covered California program components for MY 2027. She stated that the program will incorporate the Covered California Quality Transformation Initiatives measure sets, with equal weighting across all measures. Additionally, Ms. Lee explained that performance will be evaluated against the National Committee for Quality Assurance Exchange percentiles, based on benchmark attainment. The P4V program budget for this component will also include 10% of professional capitation.

Ms. Lee followed with an outline of the MY 2026 Primary Care Provider (PCP) P4V Program. She explained that incentive funds have been carved out from the HN P4V allocations to support PCP efforts to close care gaps. In August 2025, CalOptima Health issued a request for proposals to identify a vendor to support program implementation. The selected system will provide incentive-tracking software to aggregate key information and help CalOptima Health and providers meet incentive goals. Furthermore, Ms. Lee noted that the item was brought back to the Special Quality Assurance Committee Meeting due to changes in the P4V application outline.

Ms. Lee stated that PCPs will be eligible for incentives for both performing activities intended to close care gaps and delivering services that directly support gap closure. The software would enable more efficient data collection and more timely reporting to providers. She also announced the launch of a one-time provider incentive initiative to enhance digital technology, including $1,000 payments

for adopting electronic funds transfer, using the provider portal, and implementing electronic medical records (EMR).

As a concluding remark, Ms. Lee confirmed that the implementation of Cozeva Payer One remains on schedule, supporting expanded access to EMR and facilitating care-gap tracking.

Committee members recommended encouraging providers to use a checklist during patient visits to ensure that required measures are accurately captured and updated at the member level.

Action: ***On motion of Director Byron, seconded and carried, the Committee recommended that the Board of Directors: 1.) Approve CalOptima Health Measurement Year 2026 Medi-Cal Delegated Health Network Pay for Value Performance Program effective January 1, 2026, through December 31, 2026; 2.) Approve CalOptima Health Measurement Year 2026 OneCare Delegated Health Network Pay for Value Performance Program, effective January 1, 2026, through December 31, 2026; 3.) Approve CalOptima Health Measurement Year 2027 Covered California Health Network Pay for Value Performance Program effective January 1, 2027, through December 31, 2027; and 4.) Approve Measurement Year 2026 Medi-Cal and OneCare Primary Care Provider Pay for Value Performance Programs, one-time provider incentives for digital technology improvements and utilization of physician incentive software to provide a real-time, point-of-care approach that rewards physicians for the completion of specific value-based care actions. (Motion carried 2-0-0; Director Mayorga absent)***

INFORMATION ITEMS

2. OneCare Stars Update

Ms. Lee provided an update on the OneCare Star Ratings. She highlighted a downward trend in overall performance for CalOptima Health. Part C ratings declined from 3.5 in 2022 to 2.5 in 2026, and Part D ratings decreased from 4.5 to 3.0 over the same period. Despite the overall decline, Ms. Lee highlighted several areas of improvement, including increased performance in breast cancer screening and annual flu vaccinations. She also reported significant declines in measures such as care for older adults and transitions of care. In contrast, measures including colorectal cancer screening and diabetes-related eye exams remained relatively stable.

Ms. Lee reviewed CalOptima Health's quality improvement priorities and outlined proposed strategies to address areas of decreased performance.

On the member side, proposed initiatives include deploying an at-home visit vendor to support care for older adults, expanding at-home lab testing for adults, and expanding at-home lab testing to include HbA1c and kidney health evaluations for members with diabetes.

On the provider side, strategies include sharing care gap lists with the top 25 PCPs within each HN, collaborating with gastroenterology specialists to improve colorectal cancer screening rates, and deploying mobile mammography services at high-volume OneCare practices.

Back to Agenda

Finally, Ms. Lee noted that CalOptima Health is preparing to launch Cozeva Payor One to improve electronic data exchange with HNs and enable access to historical laboratory results from partnering lab vendors.

COMMITTEE MEMBER COMMENTS

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

ADJOURNMENT

Hearing no further business, Director Byron adjourned the meeting at 4:14 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: March 19, 2026

Back to Agenda

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 19, 2026
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

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

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, Medical Management, (714) 246-8491
Linda Lee, MPH, Executive Director, Quality Improvement, (714) 867-9655

Recommended Actions

Recommend that the Board of Directors:

1. Receive and file the 2025 CalOptima Health Quality Improvement and Health Equity Transformation Program Evaluation; and
2. Approve the 2026 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan.

Background

CalOptima Health's Quality Improvement and Health Equity Transformation Program (QIHETP) encompasses all clinical care, health and wellness services, and customer service provided to its members, aligning with CalOptima Health's vision to deliver an integrated, well-coordinated system of care that ensures optimal health outcomes for all members. QIHETP is designed to identify and analyze significant opportunities for improvement in care and service, to develop improvement strategies, and to assess whether adopted strategies achieve defined benchmarks.

CalOptima Health's QIHETP is reviewed, evaluated, and approved annually by the Board of Directors. The QIHETP defines the structure within which quality improvement and health equity activities are conducted and establishes objective methods for systematically evaluating and improving the quality of care for all CalOptima Health members.

The 2025 QIHETP Evaluation analyzes the core clinical and service indicators to determine if the 2025 QIHETP achieved its key performance goals during the year.

CalOptima Health had the following achievements in 2025:

- January 2025: The Orange County Board of Supervisors approved a revision to the ordinance that will allow participation in Covered California.
- March 2025: The CalOptima Health Board of Directors approved the expansion of the Street Medicine Program to Santa Ana.

Back to Agenda

- August 2025: CalOptima Health organized the second annual Back-to-School Health and Wellness Event that attracted more than 3,500 attendees, held for the first time in Westminster.
- October 2025: The CalOptima Health Board of Directors approved $19.8 million to expand outreach efforts to ensure Orange County's vulnerable residents understand how to maintain their health coverage.
- November 2025: CalOptima Health added a 10th health network by partnering with Providence.
- December 2025: CalOptima Health achieved Health Outcomes Accreditation from the National Committee for Quality Assurance (NCQA).

In 2025, CalOptima Health (i) exceeded the 50th percentile for all children's preventive measures and (ii) closed maternity care disparity for Black and Native American persons by 50%. CalOptima Health remains committed to improving quality of care and quality of service and will continue to focus on (i) meeting or exceeding the minimum performance levels (MPLs) for the Medi-Cal Managed Care Accountability Set (MCAS), and (ii) attaining a four-star rating for Medicare.

Discussion

CalOptima Health staff updated the 2026 QIHETP and Work Plan to ensure that the QIHETP is aligned with health network and strategic organizational changes. This will ensure that CalOptima Health consistently meets all regulatory requirements and NCQA accreditation standards across all lines of business.

The 2026 QIHETP and Work Plan will be flexible and aligned with the strategic goals and objectives defined by the Board of Directors. Staff will remain agile in the shifting health care landscape while continuing to stay focused on providing members with timely access to quality health care services in a compassionate and equitable manner.

The 2026 QIHETP describes (i) the scope of services provided; (ii) the population served; (iii) key business processes; and (iv) important aspects of care and service for all lines of business to ensure they are consistent with regulatory requirements, NCQA standards, and CalOptima Health's strategic initiatives.

The revisions to the QIHETP for 2026 are summarized as follows:

1. Updated existing program initiatives to align with health equity and current operational practices.
2. Continued priority areas and goals for 2026 for CalOptima Health's lines of business as follows:

- Medi-Cal:
    - Meet and exceed the MPLs for the MCAS;
    - Maintain NCQA Health Plan and Health Outcomes Accreditation; and
    - Attain a 4.5 NCQA Health Plan Rating.
- OneCare
    - Attain a four-star rating for Medicare.
- Covered California
    - Attain operational readiness to launch the Covered California product on January 1, 2027.

3. Added the Covered California product.
4. Added the Behavioral Health Integration Pay for Value Program.
5. Updated the committee structure organization chart to remove the Population Health Management Committee. CalOptima Health will report items previously reported to that committee to the Utilization Management Committee or the Quality Improvement Health Equity Committee, as applicable.
6. Updated the Quality Improvement Program Staffing and Resources to reflect the current organizational structure, including:
    - Addition of a Senior Director of Provider Network Strategy, Manager of Quality Improvement (NCQA), Director of Quality Improvement (Credentialing), and Director of Medical Management.
7. Removed programs that sunset in 2025.
8. Updated sections in the QIHETP to reflect current operational processes and workflows.

2026 QIHETP recommendations focus on the following goals:

1. Preventive measures and screenings identified in the Department of Health Care Services (DHCS) Comprehensive Quality Strategy;
2. Social Determinants of Health factors and analysis of health disparities in the strategic plan for targeted quality initiatives and population health programs; and
3. Expanding quality initiatives to improve member experience, focused on increasing member access to care.

The recommended changes to CalOptima Health's QIHETP reflect current clinical operations and are necessary to meet the requirements of the Centers for Medicare & Medicaid Services (CMS), DHCS, Department of Managed Health Care, and NCQA accreditation standards.

Back to Agenda

Fiscal Impact

The recommended actions have no additional fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2025-26 Operating Budget. Staff will include updated expenditures for the period of July 1, 2026, through December 31, 2026, in the FY 2026-27 Operating Budget.

Rationale for Recommendation

CalOptima Health's QIHETP outlines the health plan's annual strategy, programs, and activities to ensure members receive quality care in accordance with regulatory and contractual requirements. The QIHETP is aligned with national and state quality standards and defines the system to monitor, evaluate, and improve quality of care and health equity. Through ongoing monitoring and evaluation, the QIHETP identifies opportunities for improvement, plans quality improvement projects, and assesses the effectiveness of these activities.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. 2025 Quality Improvement Health Equity Transformation Program Evaluation
    a. 2025 QIHETP Work Plan Q1-Q4
    b. 2025 Cultural and Linguistically Appropriate Services (CLAS) Evaluation
2. Proposed 2026 Quality Improvement and Health Equity Transformation Program and Work Plan
    a. CalOptima Health's QIHETP Support Positions and Job Descriptions
    b. 2026 QIHETP Work Plan
        i. HEDIS MY2025 Medicaid Goals
        ii. HEDIS MY2025 Medicare Goals
    c. 2026 Population Health Management Strategy
    d. 2026 Culturally and Linguistically Appropriate Services (CLAS) Program Description
    e. CalOptima Health Measurement Year 2026 Medi-Cal and OneCare Pay for Value Programs
    f. CalOptima Health Measurement Year 2026 Behavioral Health Integration Pay for Value Program
3. PowerPoint Presentation: 2025 QIHETP Evaluation, 2026 QIHETP and Work Plan

/s/ Michael Hunn *03/12/2026*
Authorized Signature **Date**

Back to Agenda

2025 QUALITY IMPROVEMENT AND HEALTH EQUITY PROGRAM EVALUATION

QAC 03.19.2026

Back to Agenda Back to Item

2025 QUALITY IMPROVEMENT AND HEALTH EQUITY PROGRAM EVALUATION SIGNATURE PAGE

Quality Improvement Health Equity Committee Chair:

_____ _____

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

Board of Directors' Quality Assurance Committee Chair:

_____ _____

José Mayorga, M.D. **Date**

Board of Directors Chair:

_____ _____

Supervisor Vicente Sarmiento **Date**

QAC 03.19.2026

Back to Agenda Back to Item

Table of Contents

Section 1: CalOptima Health Overview 6
1.1. Our Strategic Plan 6
Section 2: Executive Summary 7
2.1 2025 Achievements 7
2.2 Review of 2025 Quality Improvement Health Equity Transformation Program Goals 8
2.3 Recommendations for 2026 9
Section 3. Program Oversight 11
3.1 2025 Quality Improvement Health Equity and Transformation Program (QIHETP) Program Documents 11
3.2 Quality Improvement Health Equity Committee (QIHEC) 14
3.3 Credentialing Peer Review Committee (CPRC) Oversight 16
3.4 Grievance and Appeals Resolution Services (GARS) Committee 20
3.5 Member Experience (MEMX) Committee Oversight 22
3.6 Population Health Management Committee (PHMC) Oversight 23
3.7 Utilization Management Committee (UMC) Oversight 25
3.8 Whole Child Model Clinical Advisory Committee (WCM CAC) 30
3.9 Assessment of QI Staff and Resources 34
3.10 Review of System Resources 35
3.11 Review of Program Structure 36
3.12 Overall Review of the QIHETP 37
3.13 Care Management (CM) Program 37
3.14 Complex Case Management Program 41
3.15 Population Health Management (PHM) Strategy and Program 50
3.16 Disease Management Program 59
3.17 Health Education 64
3.18 CalAIM Community Supports and Enhanced Care Management (ECM) 72
3.19 Street Medicine Program 74
3.20 Long-Term Support Services (LTSS) 78
3.21 Delegation Oversight 81
3.22 National Committee for Quality Assurance (NCQA) Accreditation 83

OAC 03.19.2026

Back to Agenda Back to Item

3.23 Quality Performance Improvement: Managed Care Accountability Set (MCAS), OneCare STAR Measures, DHCS Quality Withhold, Health Plan Accreditation (QI3), Health Plan Rating 88
3.24 Value-Based Payment Program 90
Section 4: Quality of Clinical Care 91
4.1 Facility Site Review (including Medical Record Review and Physical Accessibility Review) 91
4.2 Potential Quality Issues Review 96
4.3 Provider Credentialing and Recredentialing 100
4.4 Special Needs Plan (SNP) Model of Care (MOC) 104
4.5 Pediatric and Adolescent Wellness: EPSDT/Children's Preventive and Screening Services 110
4.6 Adult Wellness: Preventive and Screening Services 118
4.7 CalOptima Health Comprehensive Community Cancer Screening Program (CCCSP) 134
4.8 Maternal and Child Health: Prenatal and Postpartum Services 139
4.9 Maternal and Child Health: Prenatal and Postpartum Depression Screening 146
4.10 Maternal and Child Health: Maternity Care for Black Members 152
4.11 Chronic Conditions: Members with Diabetes 157
4.12 Chronic Conditions: Members with Heart Health (Hypertension) 165
4.13 Chronic Conditions: Members with Osteoporosis 170
4.14 Chronic Conditions: Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions 174
4.15 Behavioral Health Services: Child and Adolescent Health on Antipsychotics 176
4.16 Behavioral Health Services: Depression 179
4.17 Behavioral Health Services: Schizophrenia 184
4.18 Behavioral Health Services: Care Coordination and Follow-up Care 190
4.19 Behavioral Health Services: Medication Management 197
4.20 Behavioral Health Services: School-Based Services Mental Health Services 202
4.21 Medication Management: Pharyngitis and Bronchitis 205
4.22 Medication Adherence: Cholesterol (Statins), Hypertension (RAS Antagonists) and Diabetes 208
4.23 Performance Improvement Projects (PIPs) Medi-Cal 213
4.24 Performance Improvement Projects (PIPs) Medi-Cal Behavioral Health 215
4.25 Chronic Care Improvement Projects (CCIPs) OneCare: Diabetes Emerging Risk 219
Section 5: Quality of Service 221

OAC 03.19.2026

Back to Agenda Back to Item

5.1 Improve Network Adequacy: Reducing Gaps in Provider Network 221
5.2 Improve Timely Access: Appointment Availability/Telephone Access 229
5.3 Network Adequacy Regulatory Submission and Audits 237
5.4 Increase Primary Care Utilization - Initial Health Appointment 243
5.5 Improve Member Experience/CAHPS 252
5.6 Grievance and Appeals Resolutions Services 260
5.7 Customer Service Call Center 262
Section 6: Safety of Clinical Care 264
6.1 Plan All Cause Readmission 264
6.2 Emergency Department Member Support 267
6.3 Transitional Care Services (TCS) 270

QAC 03.19.2026

Back to Agenda Back to Item

Section 1: CalOptima Health Overview

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

1.1. Our Strategic Plan

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

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

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

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

The four Strategic Priorities:

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

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

OAC 03.19.2026

Section 2: Executive Summary

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

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

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

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

2.1 2025 Achievements

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

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

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

OAC 03.19.2026

Back to Agenda Back to Item

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

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

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

2.2 Review of 2025 Quality Improvement Health Equity Transformation Program Goals
Goal 1: Maternal Health

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

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

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

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

Goal 2: Children's Preventive Care

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

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

Goal 3: Behavioral Health Care

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

Back to Agenda Back to Item

0AC03.19.2026

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

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

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

Goal 4: Program Goals

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

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

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

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

2.3 Recommendations for 2026

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

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

Back to Agenda Back to Item

OAC 03.19.26

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

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

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

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

Medi-Cal QIHETP Goals

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

QAC 03.19.2026

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

OneCare QIHETP Goal

- Attain a four-star rating for Medicare

Covered California QIHETP Goal

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

Section 3. Program Oversight

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

I. Purpose or Background:

CalOptima Health develops the following quality documents each year:

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

a. 2025 Quality Improvement Health Equity Transformation Work Plan
b. 2025 Population Health Strategy
c. 2025 Culturally and Linguistically Appropriate Services Program
d. 2025 Pay for Value Program

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

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

II. Data Sources and Methodology

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

III. Program Results

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

IV. Actions/Interventions Implemented in 2025:

Quarters	Interventions

QAC 03.19.2026

Back to Agenda Back to Item

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

V. Qualitative Analysis

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

Causal/Barrier Analysis:

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

VI. Opportunities for Improvement:

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

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

Back to Agenda Back to Item

QAC 03.19.2026

MC = Medi-Cal; OC= OneCare

VII. Conclusion:

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

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

I. Committee Purpose

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

II. Committee Background

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

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

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

III. Committee Meetings in 2025

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

IV. Committee Changes in 2025

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

QAC 03.19.2026

- External members must report changes in professional status within 30 days.
- Quarterly summaries of QIHEC activities will be sent to the Board and DHCS and made public on the website.
- Enhanced collaboration with compliance committees to improve the quality of care.
- Committee minutes to include all documents presented at meetings.
- Health equity as a core goal, with equity integrated into the Charter and meeting purpose.

- The committee maintained a quarterly meeting schedule, with published dates for the Calendar Year 2025 to review QIHETP progress and compliance metrics

V. Committee Actions in 2025

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

Quarter 1:

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

Quarter 2:

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

Quarter 3:

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

QAC 03.19.2026

Back to Agenda Back to Item

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

Quarter 4:

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

VI. Identified Barriers and Opportunities for Improvement

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

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

VII. Conclusion

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

3.3 Credentialing Peer Review Committee (CPRC) Oversight	
Author: Laura Guest	Department(s): Quality Improvement

QAC 03.19.2026

Responsible Parties: Laura Guest (Manager, Quality Improvement); Sharlee LeBleu (Director, Quality Improvement); Rick Quinones (Manager, Quality Improvement); Katy Noyes (Manager, Quality Improvement)

I. Committee Purpose

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

II. Committee Background

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

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

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

III. Committee Meetings in 2025

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

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

IV. Committee Changes in 2025

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

V. Committee Actions in 2025

Quarter 1:

Back to Agenda Back to Item

OAC 03.19.2026

Informed

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

Approved

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

Quarter 2:

Informed

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

Approved

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

QAC 03.19.2026

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

Quarter 3:

Informed

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

Approved

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

Quarter 4: (October Only)

Informed

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

QAC 03.19.2026

Back to Agenda Back to Item

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

Approved

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

VI. Identified Barriers and Opportunities for Improvement

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

VII. Conclusion

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

Activities/Interventions to continue/add next year:

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

3.4 Grievance and Appeals Resolution Services (GARS) Committee	
Author: Heather Sedillo	Department(s): Grievance & Appeals Resolution Services (GARS)

OAC 03.19.2026

Back to Agenda Back to Item

Responsible Parties: Heather Sedillo (Director, Grievance & Appeals); Ismael Bustamante (Manager, Grievance & Appeals)

I. Committee Purpose

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

II. Committee Background

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

III. Committee Meetings in 2025

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

IV. Committee Changes in 2025

In 2025, there were no changes to the committee.

V. Committee Actions in 2025

Quarter 1:

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

Quarter 2:

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

Quarter 3:

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

Quarter 4:

- Committee meeting scheduled for February 10, 2026.

VI. Identified Barriers and Opportunities for Improvement

Identified Barriers	Opportunities for Improvement

QAC 03.19.2026

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

VII. Conclusion

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

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

I. Committee Purpose

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

II. Committee Background

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

III. Committee Meetings in 2025

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

IV. Committee Changes in 2025

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

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

V. Committee Actions in 2025

The following recommendations were made by the committee in 2025.

Quarter 1:

QAC 03.19.26

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

Quarter 2:

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

Quarter 3:

- Explore PCP expansion to improve access.

Quarter 4:

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

VI. Identified Barriers and Opportunities for Improvement

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

VII. Conclusion

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

3.6 Population Health Management Committee (PHMC) Oversight	
Author: Katie Balderas	Department(s): Case Management
Responsible Parties: Katie Balderas (Director, Case Management); Stefanie Johnson (Program Manager, Case Management)	

I. Committee Purpose

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

II. Committee Background

QAC 03.19.2026

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

III. Committee Meetings in 2025

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

IV. Committee Changes in 2025

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

V. Committee Actions in 2025

Quarter 1:

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

Quarter 2:

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

Quarter 3:

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

Quarter 4:

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

VI. Identified Barriers and Opportunities for Improvement

Identified Barriers	Opportunities for Improvement

QAC 03.19.2026

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

VII. Conclusion

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

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

I. Committee Purpose

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

II. Committee Background

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

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

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

III. Committee Meetings in 2025

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

IV. Committee Changes in 2025

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

Added:

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

Revised:

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

V. Committee Actions in 2025

Quarter 1: Ad Hoc: January 23, 2025

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

QAC 03.19.2026

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

Quarter 1: February 20, 2025

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

Quarter 2: May 22, 2025

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

QAC 05.19.2026

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

Quarter 3: August 21, 2025

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

Quarter 4: November 20, 2025

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

GAC 03.19.2026

Back to Agenda Back to Item

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

Quarter 4: December 18, 2025

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

VI. Identified Barriers and Opportunities for Improvement

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

QAC 03.19.2026

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

VII. Conclusion

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

Enhance reporting

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

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

I. Committee Purpose

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

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

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

QAC 01.19.2026

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

II. Committee Background

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

III. Committee Meetings in 2025

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

IV. Committee Changes in 2025

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

V. Committee Actions in 2025

Quarter 1:

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

Quarter 2:

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

QAC 03.19.2026

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

Quarter 3:

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

Quarter 4:

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

CAC 03.19.2026

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

VI. Identified Barriers and Opportunities for Improvement

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

DRAFT 03.19.2026

VII. Conclusion

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

3.9 Assessment of QI Staff and Resources	
Author(s): Marsha Choo	Department(s): Quality Improvement

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

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

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

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

In 2025, CalOptima Health added the following:

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

In 2025, CalOptima Health filled the following vacant positions:

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

QAC 03.19.2026

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

3.10 Review of System Resources	
Author(s): Marsha Choo	Department(s): Quality Improvement

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

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

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

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

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

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

3.11 Review of Program Structure	
Author(s): Marsha Choo	Department(s): Quality Improvement

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

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

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

The organization receives adequate feedback from its community practitioners about the development and implementation of the QIHE initiatives and programs. There are physicians participating in the QIHEC, representatives from the SSA,
HCA, CalOptima Health delegated health networks and community-based organizations. In addition, network providers participate in the subcommittees that report to the QIHEC.
Staff present QIHETP activities to the Member Advisory Committee (MAC) and the Provider Advisory Committee (PAC). CalOptima Health engages members through the MAC to seek input, advice and guidance related to QIHETP goals. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs, needs assessment, member survey results, access to health care, and preventive services to ensure that the QIHETP meets the needs of the population. The PAC provides advice and recommendations to the Board on CalOptima Health

Back to Agenda Back to Item

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

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

3.12 Overall Review of the QIHETP	
Author(s): Marsha Choo	Department(s): Quality Improvement

CalOptima Health had adequate staffing and resources in 2025 to meet the QIHETP requirements. CalOptima Health will continue to evaluate the needs of the program on a quarterly basis through the Work Plan, and add staffing and resources, as needed, to supplement the departments supporting the QI Program.

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

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

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

I. Purpose or Background:

Back to Agenda Back to Item

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

II. Data Sources and Methodology

A. Basic PHM/CM: Completed HRAs are stored in the Jiva Medical Management platform and shared with the Health Networks through the sFTP file sharing process. Health Networks are then required to share with the provider.
B. EPSDT/CM: Coordination and facilitation of identified needs from EPSDT workgroup meetings
    a. Quality Analytic evaluation of performance for preventive and screening services seen in link D.

    b. Methodology for data on dental, vision, and hearing reflects members who are overdue for all three screening services; have been enrolled for at least 12 months; and are under 21 years of age. Claims data for the prior 12 months is used in conjunction with the required screening based on age according to the American Academy of Pediatrics (AAP) periodicity schedule. Members are identified as either having qualified or being overdue for services.

III. Program Results and Quantitative Analysis:

Medi-Cal Members

Graph A

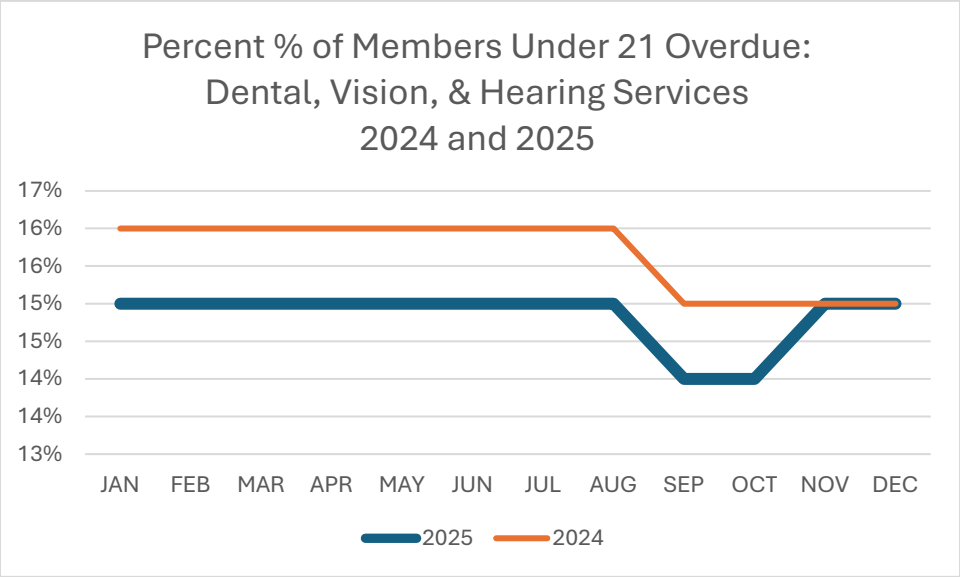


Chart caption: Percent % of Members Under 21 Overdue: Dental, Vision and Hearing services 2024 and 2025

Back to Agenda Back to Item

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

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

IV. Actions/Interventions Implemented in 2025:

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

OAC 03.19.26

Back to Agenda Back to Item

V. Effectiveness of Interventions:

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

VI. Qualitative Analysis

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

Causal/Barrier Analysis:

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

VII. Opportunities for Improvement:

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

QAC 8.19.26

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

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

A. Basic/PHM: Risk stratification of members will continue for the identification of members in need of HRA outreach. When collected, HRAs will be shared with Health Networks, who are then required to share with the member's PCP.

B. EPSDT: Case Management will continue to facilitate and coordinate the ongoing interdepartmental EPSDT workgroup for improvement of oversight efforts to identify and address gaps in EPSDT services.

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

I. Purpose or Background:

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

II. Data Sources and Methodology

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

QAC 9.18.2026

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

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

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

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

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

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

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

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

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

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

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

III. Program Results and Quantitative Analysis:

Results:

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

QAC 03.19.2026

Back to Agenda Back to Item

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

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

Audit results include extensive feedback and areas for improvement.

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

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

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

DAC 03.19.2026

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

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

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

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

Table C: Member Satisfaction Survey Results January – December 2025

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

Table C:

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

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

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

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

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

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

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

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

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

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

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

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

DAC 01.2026

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

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

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

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

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

IV. Actions/Interventions Implemented in 2025:

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

Back to Agenda Back to Item

QAC 03.19.2026

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

QAD 9.19.2025

Back to Agenda Back to Item

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

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

V. Effectiveness of Interventions:

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

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

QAC 03.19.2026

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

VI. Qualitative Analysis

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

Causal/Barrier Analysis:

Goal 1 Barriers

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

Goal 2 and 3 no barriers identified

VII. Opportunities for Improvement:

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

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

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

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

QAC 03.19.2026

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

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

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

I. Purpose or Background:

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

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

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

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

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

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

QAC 03.19.26

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

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

II. Data Sources and Methodology

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

Internal Data Sources

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

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

Quality Performance Benchmarks

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

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

Supplemental External Data Sources

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

OAC 03.19.2026

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

Risk Stratification and Screening

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

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

PHM Work Plan and Performance Monitoring

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

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

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

III. Program Results and Quantitative Analysis:

PHM Strategy Overall Assessment

The outcomes of the PHM goals are outlined below.

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

Back to Agenda Back to Item

QIC 03.19.2026

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

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

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

HIF-Met Return Rates January through June 2024 and 2025

Chart A

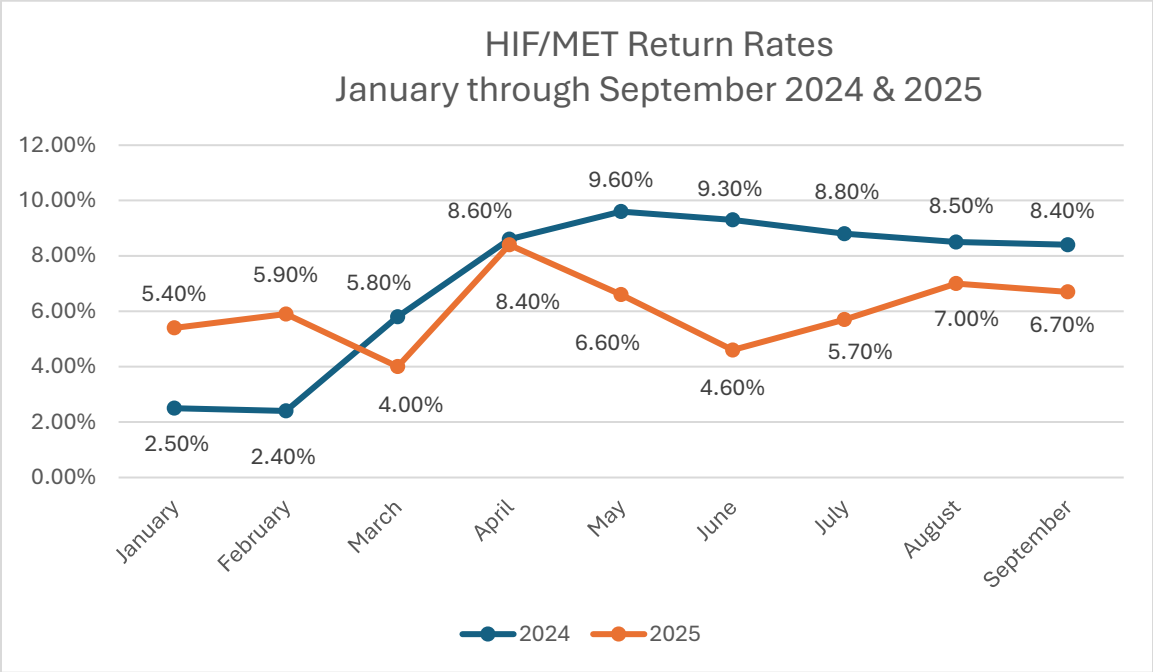


Chart caption: HIF/MET Return Rates January Through September 2024 & 2025

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

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

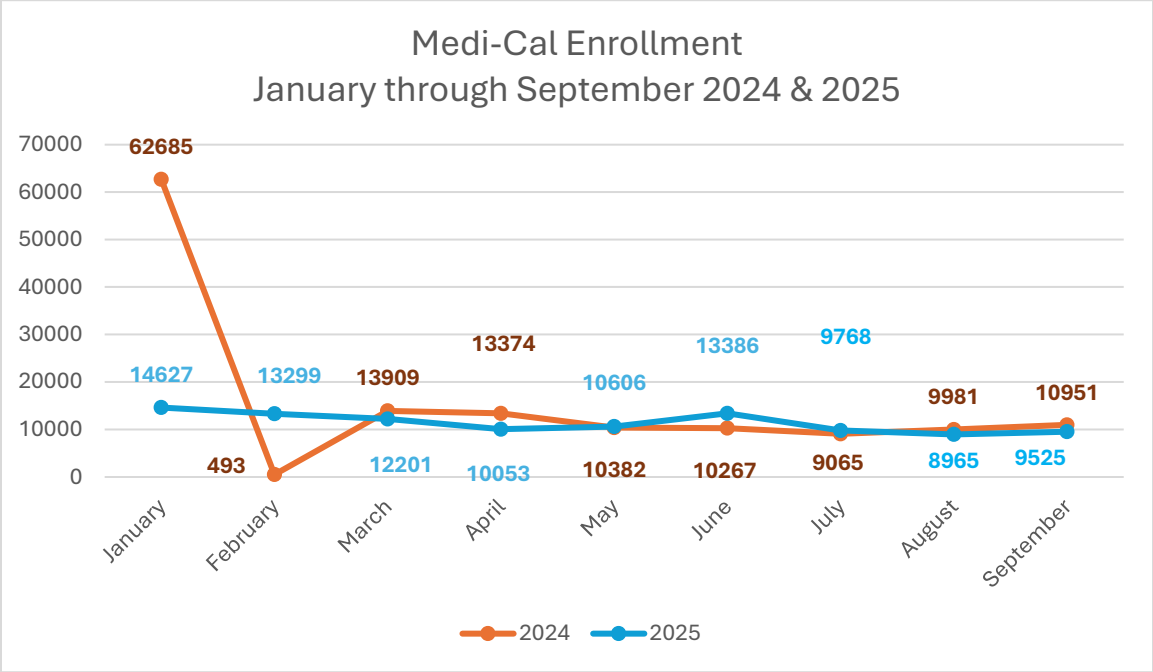


Chart caption: Medi-Cal Enrollment January through September 2024 & 2025

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

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

Medi-Cal Risk Stratification by Risk Level:

Table A

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

Chart caption: Medi-Cal Risk Stratification by Risk Level

Indicator/Goal(s): Observational and monitoring

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

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

Medi-Cal Risk Stratification by % Risk Level:

Chart A

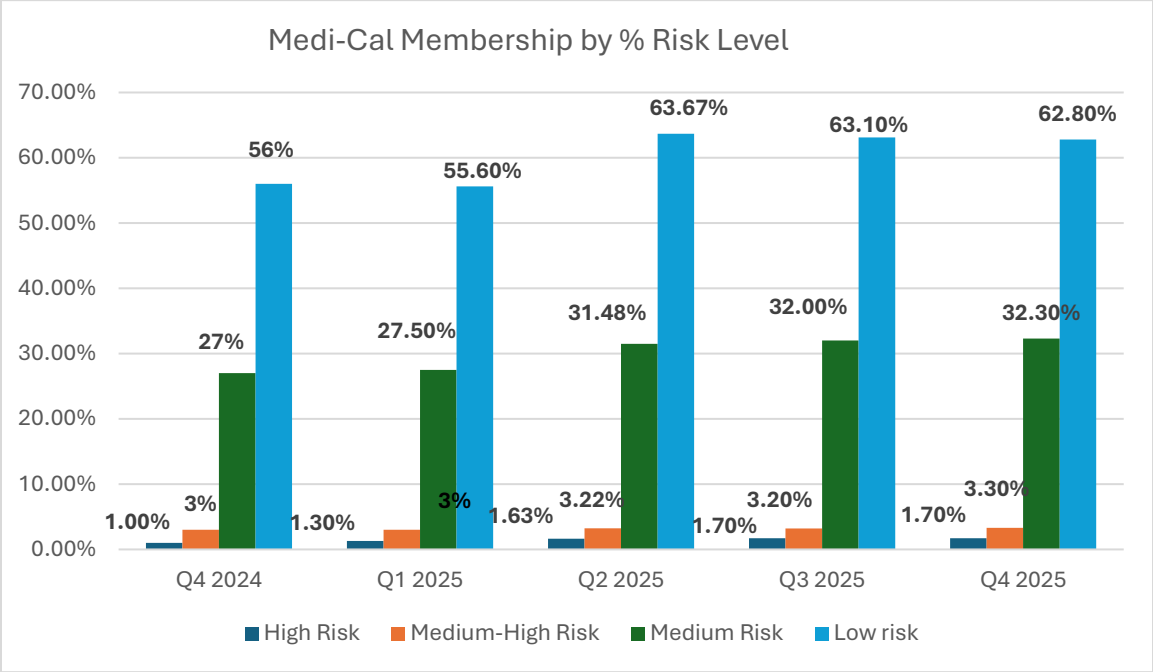


Chart caption: Medi-Cal Risk Stratification by % Risk Level

Indicator/Goal(s): Observational Monitoring.

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

Medi-Cal High Risk Members with and without intervention:

Table B

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

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

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

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

IV. Actions/Interventions Implemented in 2025:

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

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

V. Effectiveness of Interventions:

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

VI. Qualitative Analysis

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

Top physical health conditions among CalOptima Health members include:

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

Top behavioral health conditions among CalOptima Health members include:

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

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

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

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

Key Achievements:

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

Program Highlights:

QAC 03.19.2026

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

Targeted Interventions:

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

Causal/Barrier Analysis:

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

VII. Opportunities for Improvement:

Back to Agenda Back to Item

OAC 8.19.2026

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

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

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

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

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

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

3.16 Disease Management Program	
Author(s): Elisa Mora	Department(s): Case Management

Back to Agenda Back to Item

QAC 08.19.26

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

I. Purpose or Background:

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

II. Data Sources and Methodology

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

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

III. Data Stratification Results and Quantitative Analysis:

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

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

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

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

PAC 03.19.26

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

IV. Actions/Interventions Implemented in 2025:

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

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

V. Effectiveness of Interventions:

1. **Two-Way Text Messaging Campaign for Stratified Members**
   This intervention aimed to boost member engagement. Members who opted in via text messaging demonstrated a 40% engagement rate, which is significantly higher than the 15%–20% typically seen with cold calls.
2. **Real-Time Satisfaction Survey via Ushur**
   Implementing real-time surveys through Ushur led to a 41% response rate, compared with less than 10% via traditional mail. Notably, the overall satisfaction rate for Disease Management services is 97%**.**
3. **Refined Stratification Criteria**
   Stratification logic was enhanced using utilization, clinical and quality data to better identify high-

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

4. **Streamlined Assessments**
   DM assessment tools were shortened and simplified, reducing completion time by more than 50% without compromising the quality of member engagement.
5. **Pre-Call Dashboard**
   A centralized dashboard now provides staff with essential clinical information about members with diabetes, reducing pre-call preparation time from 15 minutes to 5 minutes.

DM Satisfaction Survey

Goal: 85% satisfaction

The Disease Management Satisfaction Survey conducted between March and November 2025 yielded highly positive results. Out of 369 texted surveys, 153 responses were received, reflecting a 41% response rate — substantially higher than the previous mailed survey rate of under 10%. Quantitatively, satisfaction rates across all measured dimensions were exceptionally high: 98% of respondents agreed that their health coach helped manage health needs, followed doctor recommendations and provided useful resources. Additionally, 96% of participants felt included in care plan decisions, and 97% reported meeting their care plan goals. Overall satisfaction with the CalOptima Health wellness program reached 98%, surpassing the target benchmark of 85%. These results indicate strong member engagement and the effectiveness of the health coaching model.

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

VI. Qualitative Analysis

Casual/Barriers Analysis

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

Key Interventions and Strategic Insights:

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

QAC 3.19.2026

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

Barriers:

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

VII. Opportunities for Improvement:

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

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

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

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

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

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

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

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

I. Purpose or Background:

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

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

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

II. Data Sources and Methodology

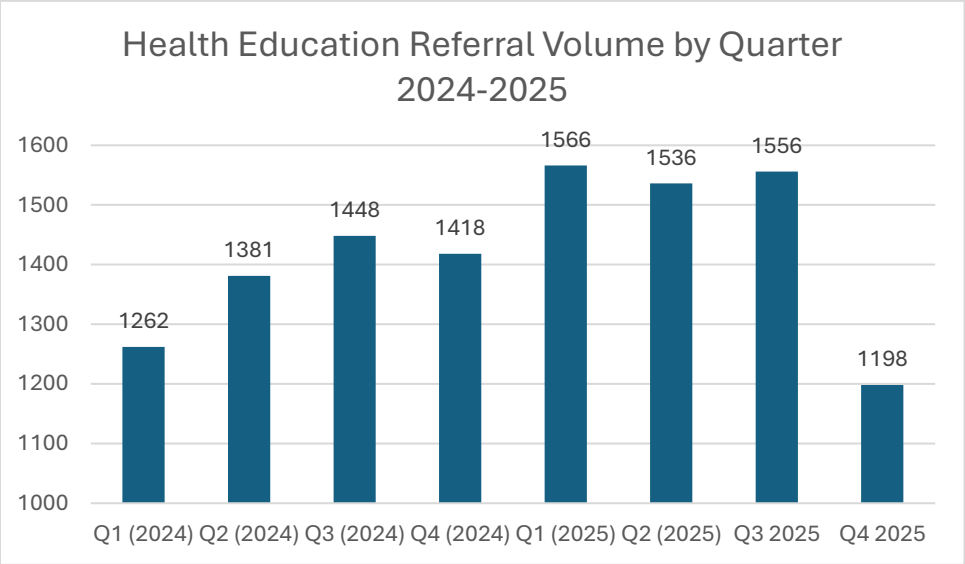
Health education referrals for health education services come primarily from provider and member self-referrals. Additional sources include internal referrals, health networks, claims or encounter data, and member surveys, such as the Health Risk Assessment. Triage of health education referrals provides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

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

III. Program Results and Quantitative Analysis:

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

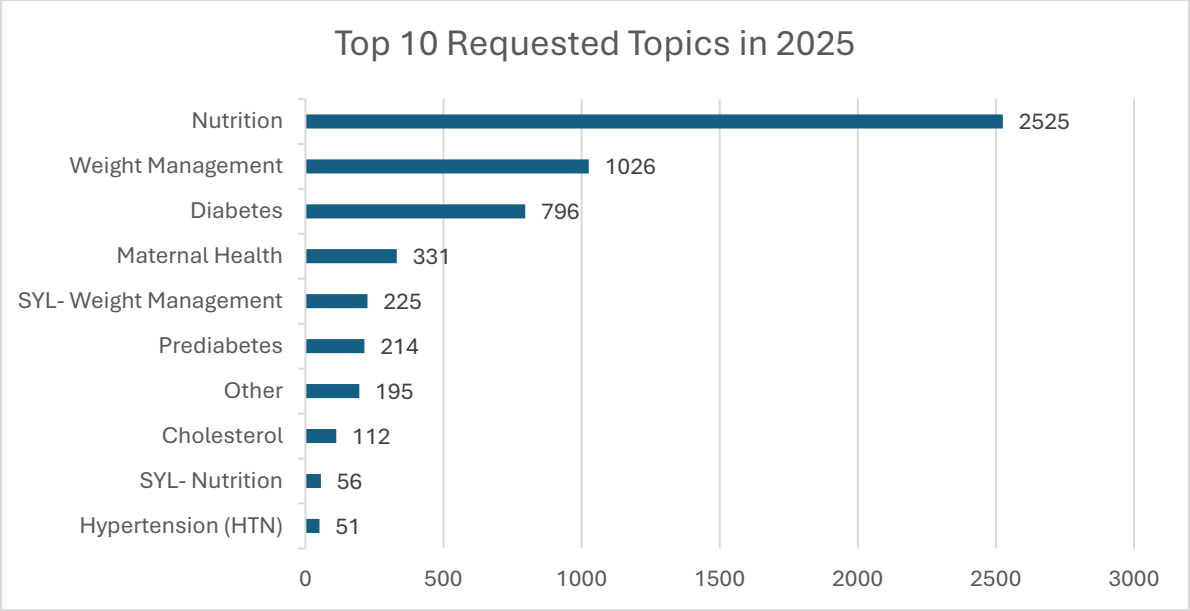
Chart 1



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

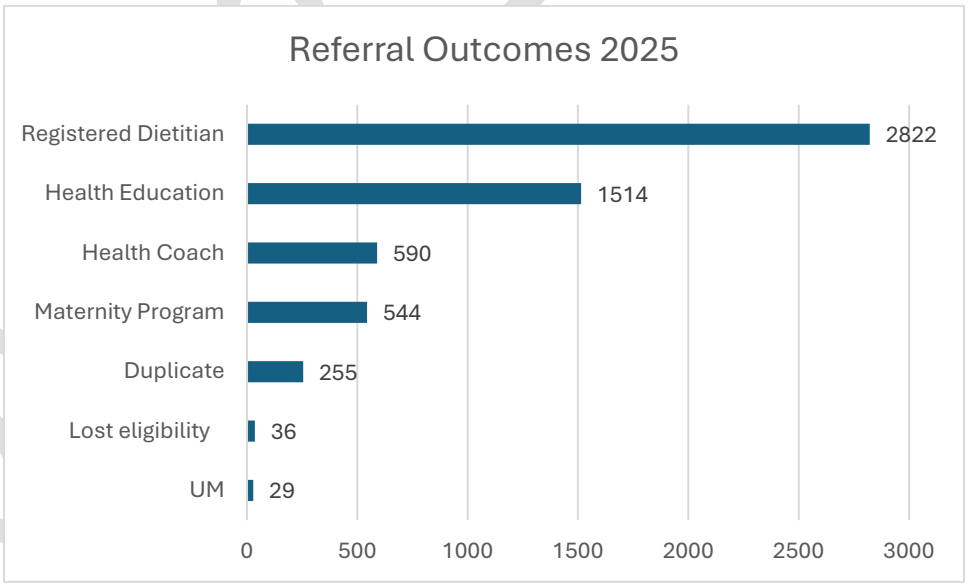
Chart 2

Back to Agenda Back to Item



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

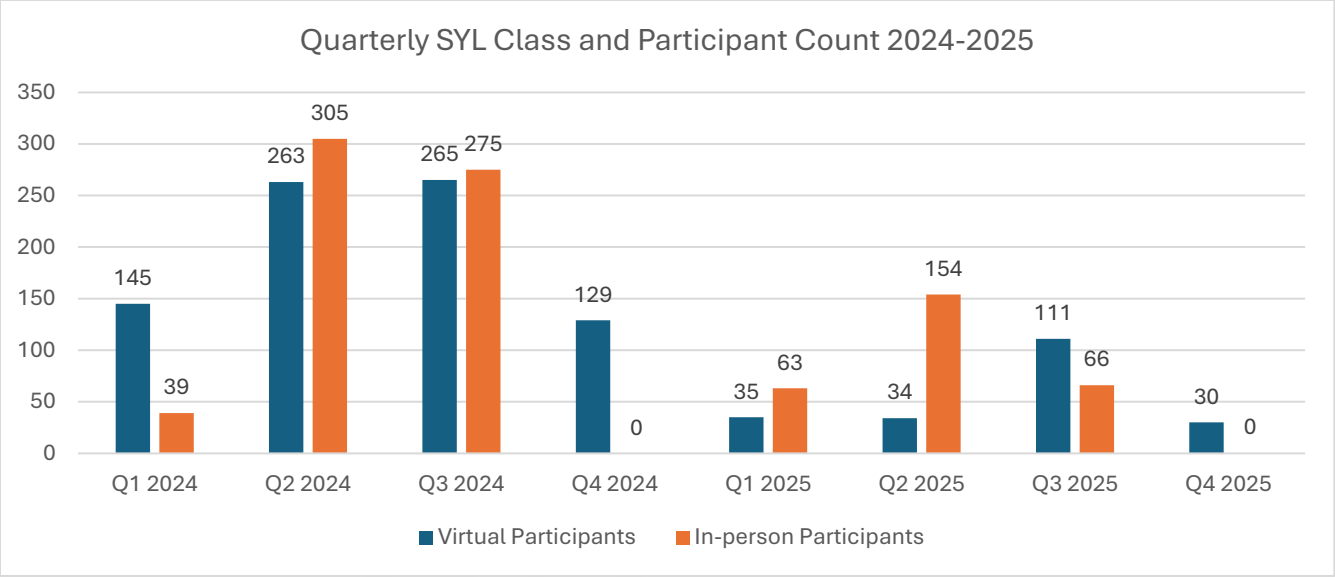
Chart 3



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

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

Chart 4



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

Table 1

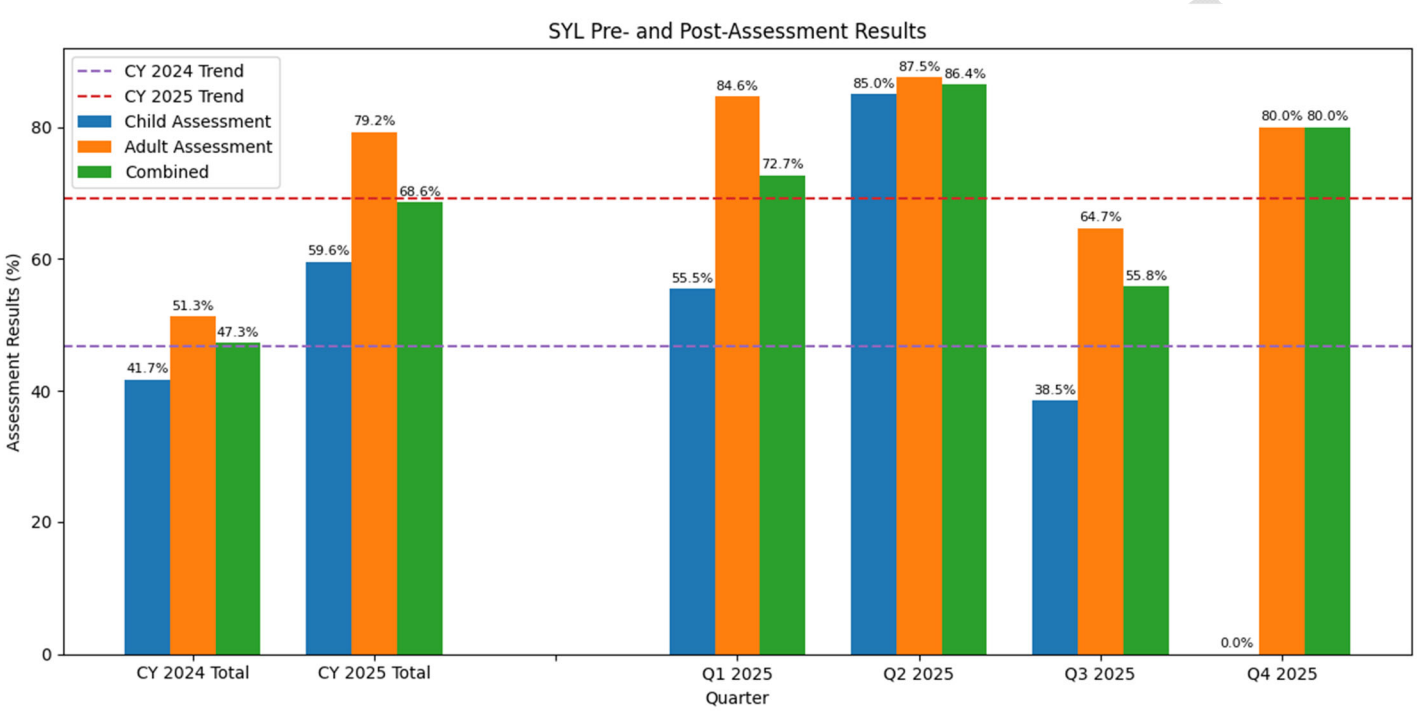
SYL Pre and Post Assessment Results

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

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

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

Chart 5



IV. Actions/Interventions Implemented in 2025:

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

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

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

V. Effectiveness of Interventions:

Highlights:

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

DAC 03.19.2026

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

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

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

VI. Qualitative Analysis

Analysis:

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

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

Causal/Barrier Analysis:

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

Back to Agenda Back to Item

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

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

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

VII. Opportunities for Improvement:

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

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

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

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

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

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

I. Purpose or Background:

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

II. Data Sources and Methodology

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

III. Program Results and Quantitative Analysis:

Medi-Cal

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

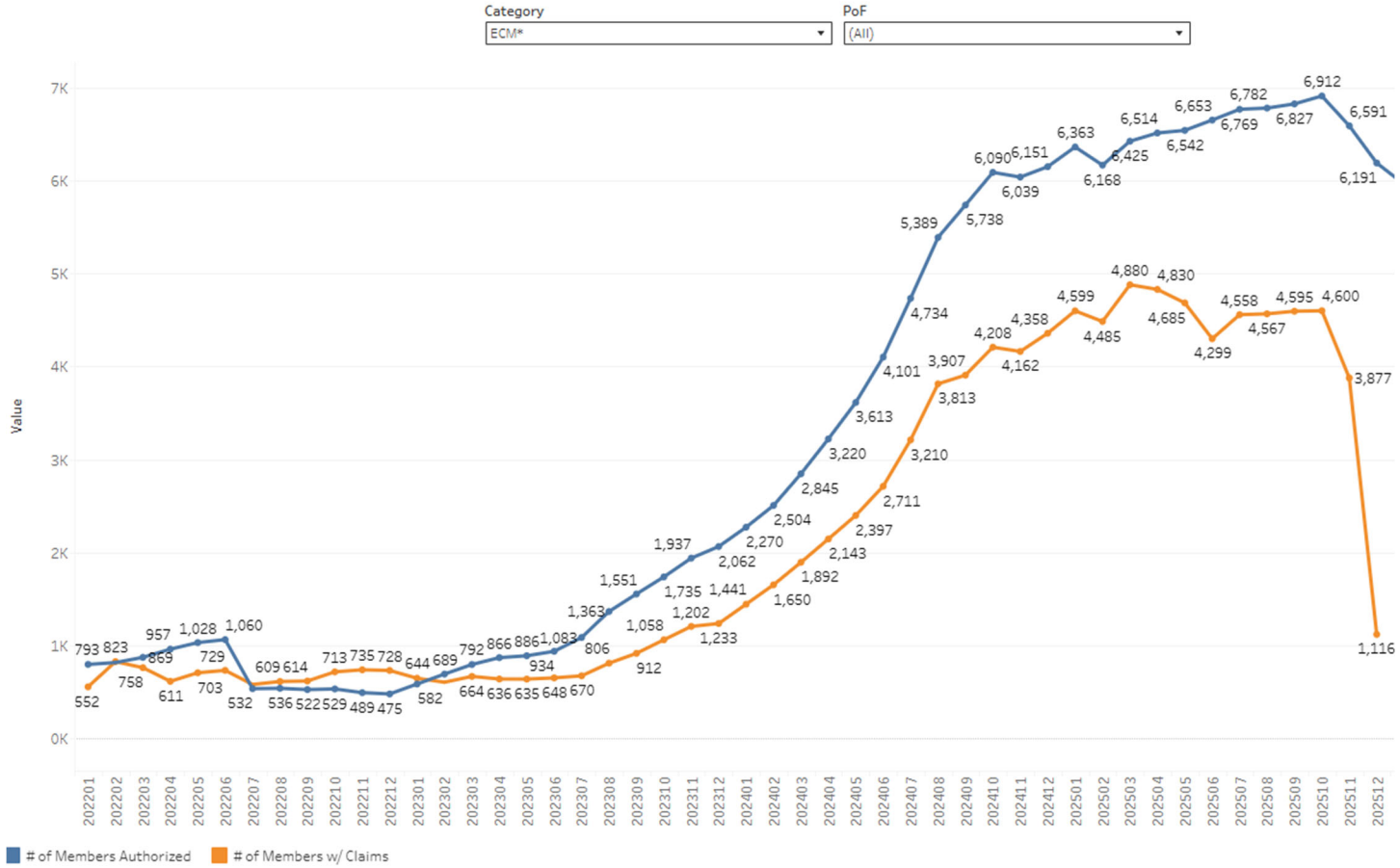
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Goal not met; the Medi-Cal & CalAIM Department moved the start date of the Housing Transition Navigation, Housing Deposits, and Housing Tenancy and Sustaining services audit to 1/1/26 to give providers six months to incorporate standardized templates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

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

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

Enhanced Care Management Summary: January 2022 – December 2025



IV. Actions/Interventions Implemented in 2025:

Back to Agenda Back to Item

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

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

V. Qualitative Analysis

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

Causal/Barrier Analysis:

- None identified

VI. Conclusion:

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

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

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

Back to Agenda Back to Item

QIHEC 03.19.2026

Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

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

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

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

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

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

II. Data Sources and Methodology

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

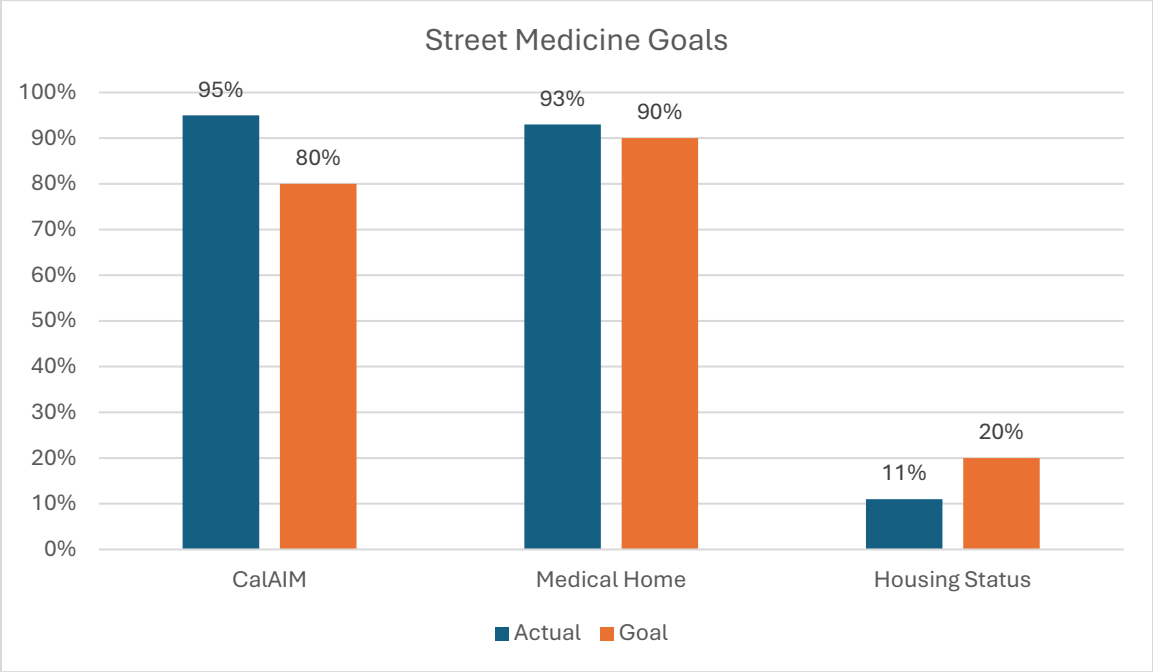
OAC 03.19.26

Back to Agenda Back to Item

III. Program Results and Quantitative Analysis:

Medi-Cal

Chart A



Indicator/Goal(s):

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

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

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

IV. Actions/Interventions Implemented in 2025:

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

Back to Agenda Back to Item

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

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

V. Effectiveness of Interventions:

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

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

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

VI. Qualitative Analysis

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

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

Causal/Barrier Analysis:

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

VII. Opportunities for Improvement:

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

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

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

VIII. Conclusion:

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

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

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

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

I. Purpose or Background:

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

II. Data Sources and Methodology

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

III. Program Results and Quantitative Analysis:

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

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

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

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

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

Quantitative Analysis

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

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

Community-Based Adult Services (CBAS):

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

IV. Actions/Interventions Implemented in 2025:

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

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

V. Effectiveness of Interventions:

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

DAC 01.19.2026

VI. Qualitative Analysis

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

Causal/Barrier Analysis:

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

VII. Opportunities for Improvement:

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

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

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

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

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

I. Purpose or Background:

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

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

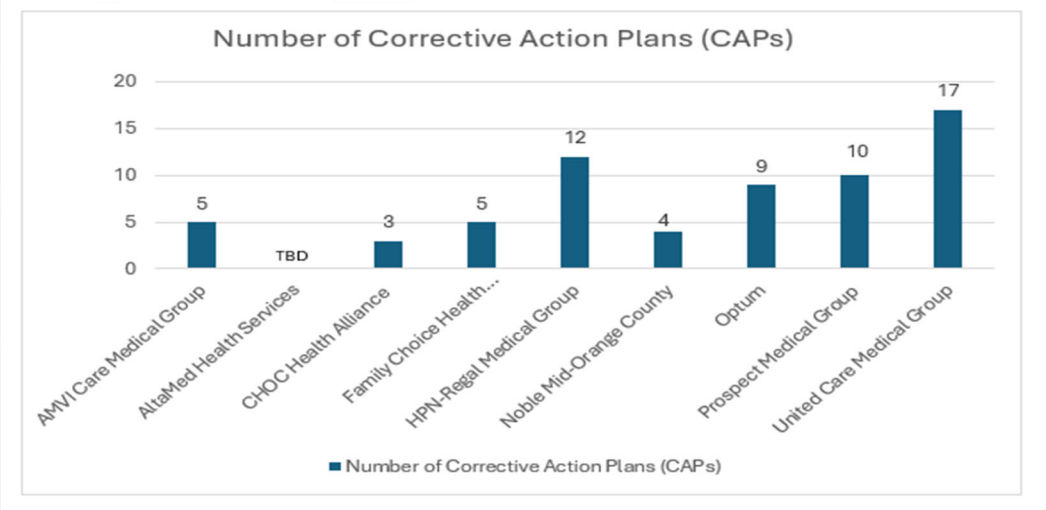
II. Data Sources and Methodology

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

III. Program Results and Quantitative Analysis:

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

Chart A



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

Back to Agenda Back to Item

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

All audits were completed timely.

IV. Qualitative Analysis

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

Causal/Barrier Analysis:

- There were no barriers identified for 2025.

V. Conclusion:

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

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

I. Purpose or Background:

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

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

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

II. Data Sources and Methodology

QAC 05.15.2026

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

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

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

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

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

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

III. Program Results and Quantitative Analysis:

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

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

Back to Agenda Back to Item

QAC 03.19.2026

IV. Actions/Interventions Implemented in 2025

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

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

V. Effectiveness of Interventions:

Health Plan (HP) Accreditation:

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

Back to Agenda Back to Item

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

Health Equity (HE) Accreditation:

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

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

VI. Opportunities for Improvement:

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

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

Back to Agenda Back to Item

OAC 03.19.2026

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

MC = Medi-Cal; OC = OneCare

VII. Conclusion:

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

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

Back to Agenda Back to Item

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

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

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

I. Purpose or Background:

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

II. Data Sources and Methodology

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

III. Program Results and Quantitative Analysis:

MY2024 MCAS MPL measures

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

OAC 03.19.2026

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

MY2024 HEDIS Star measures

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

MY2024 DHCS Quality Withhold measures

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

MY2024 Health Plan Rating measures

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

IV. Effectiveness of Interventions:

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

QAC 8.19.2026

Back to Agenda Back to Item

V. Qualitative Analysis

Details can be found in the individual measures/programs.

VI. Opportunities for Improvement:

Details can be found in the individual measures/programs.

VII. Conclusion:

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

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

I. Purpose or Background:

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

II. Data Sources and Methodology

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

III. Program Results and Quantitative Analysis:

MY2024 Medi-Cal P4V Quality Rating by Health Network

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

OAC 03.19.26

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

MY2024 OneCare P4V Quality Rating by Health Network

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

IV. Qualitative and Quantitative Analysis

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

V. Opportunities for Improvement:

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

VI. Conclusion:

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

Section 4: Quality of Clinical Care

4.1 Facility Site Review (including Medical Record Review and Physical Accessibility Review)	
Author(s): Katy Noyes	Department(s): Quality Improvement
Responsible Party(ies): Marsha Choo (Director, Quality Improvement); Katy Noyes (Manager, Quality Improvement)	

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

I. Purpose or Background:

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

II. Data Sources and Methodology

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

III. Program Results and Quantitative Analysis

Table A

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

Quantitative Analysis:

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

QAC 9.19.2025

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

Table B

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

Quantitative Analysis:

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

Table C

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

Quantitative Analysis:

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

Table D

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

Quantitative Analysis:

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

IV. Actions/Interventions Implemented in 2025:

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

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

V. Effectiveness of Interventions:

Interventions implemented to meet site review requirements are effective.

VI. Qualitative Analysis

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

Causal/Barrier Analysis:

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

QAC 03.19.2026

VII. Opportunities for Improvement:

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

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

VIII. Conclusion:

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

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

I. Purpose or Background:

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

Back to Agenda Back to Item

QAC 03.19.2026

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

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

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

II. Data Sources and Methodology

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

III. Program Results and Quantitative Analysis:

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

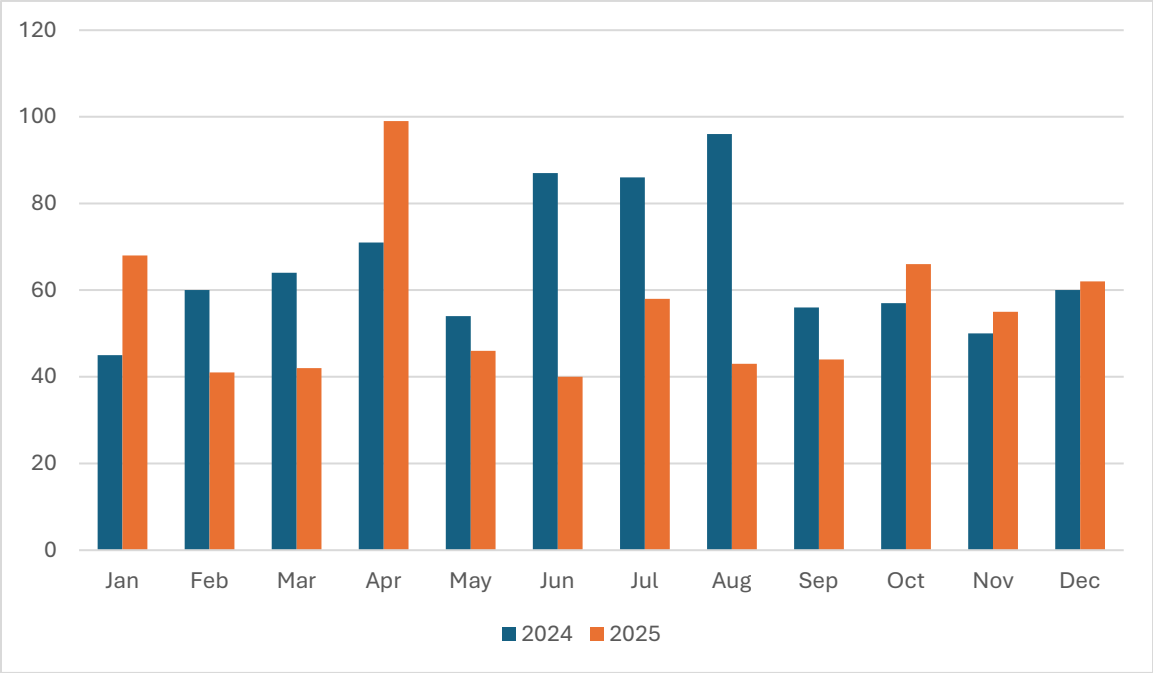


Chart caption: This chart displays the number of PQI cases opened each month in 2024 and 2025 (through October).

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

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

Chart B - Number of Closed PQIs by Month

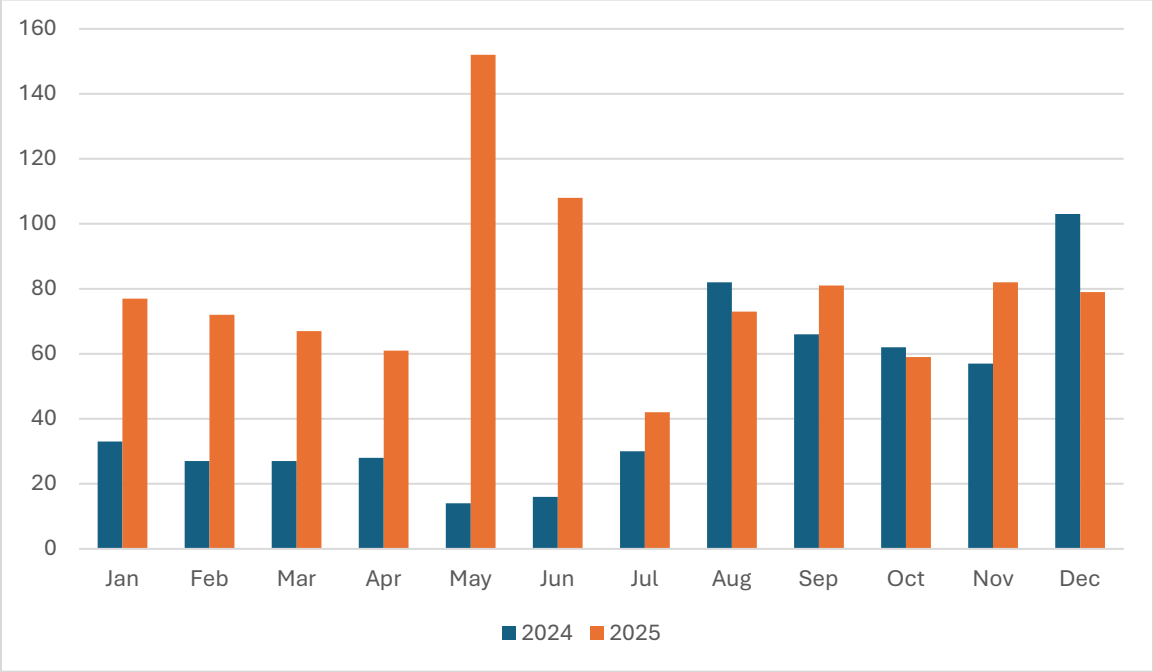


Chart caption: This chart displays the number of PQI cases closed each month in 2024 and 2025 (through October).

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

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

IV. Actions/Interventions Implemented in 2025:

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

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

V. Effectiveness of Interventions:

Goal:

Back to Agenda Back to Item

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

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

II. Develop a workgroup to address providers with a high number of grievances.
Established the Provider Action Workgroup co-chaired by the medical director, quality improvement and the director, provider relations.

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

VI. Qualitative Analysis

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

Causal/Barrier Analysis:

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

VII. Opportunities for Improvement:

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

OAC 03.19.26

Back to Agenda Back to Item

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

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

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

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

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

I. Purpose or Background:

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

II. Data Sources and Methodology

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

III. Program Results and Quantitative Analysis:

Results:

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

Table A - CalOptima Health Credentialing and Recredentialing Statistics

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

Quantitative Analysis:

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

IV. Actions/Interventions Implemented in 2025:

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

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

V. Effectiveness of Interventions:

Back to Agenda Back to Item

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

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

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

VI. Qualitative Analysis

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

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

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

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

Causal/Barrier Analysis

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

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

Back to Agenda Back to Item

0A03.19.2026

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

VII. Opportunities for Improvement:

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

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

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

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

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

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

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

I. Purpose or Background:

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

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

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

II. Data Sources and Methodology

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

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

QAC 03.19.2026

Back to Agenda Back to Item

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

III. Program Results and Quantitative Analysis:

OneCare HRA Internal KPI

Table A

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

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

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

OneCare Star Status

Table B

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

QAC 03.19.26

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

Indicator/Goals: A higher Star rating is preferred.

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

OneCare DHCS Initial ICP

Table C

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

Chart Caption: OneCare Initial ICP

* Q4 2025 data collection in process.

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

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

OneCare ICP Face to Face

Table D

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

DAC 03.19.26

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

Chart caption: OneCare Face to Face

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

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

IV. Actions/Interventions Implemented in 2025:

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

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

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

V. Effectiveness of Interventions:

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

VI. Qualitative Analysis

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

QAC 03.19.2026

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

Causal/Barrier Analysis:

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

VII. Opportunities for Improvement:

Back to Agenda Back to Item

QAC 03.19.2026

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

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. SNPE Universe remediation for ICT status	Universe remediation for ICT date in conjunction with IT to 1. Integrate data when members transition between CHCN and external health networks and2. Differentiate between informal and formal ICT processes.	☐ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L
2. Supplemental gaps in care and medications with HRA bundle	Implementation of gaps in care notification to health networks when HRA is generated.	☐ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ H ☒ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

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

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

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

I. Purpose or Background:

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

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

CalOptima Health focused on the following measures:

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

II. Data Sources and Methodology:

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

III. Quantitative Analysis:

Medi-Cal

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

DAC 03.19.2026

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

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

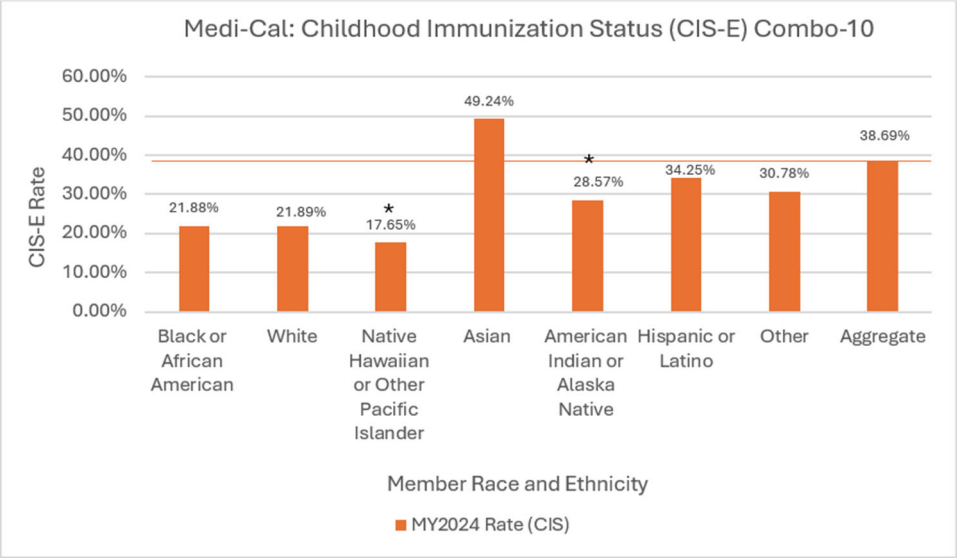
IV. Data Stratification Data Source and Methodology:

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

V. Data Stratification Results and Quantitative Analysis:

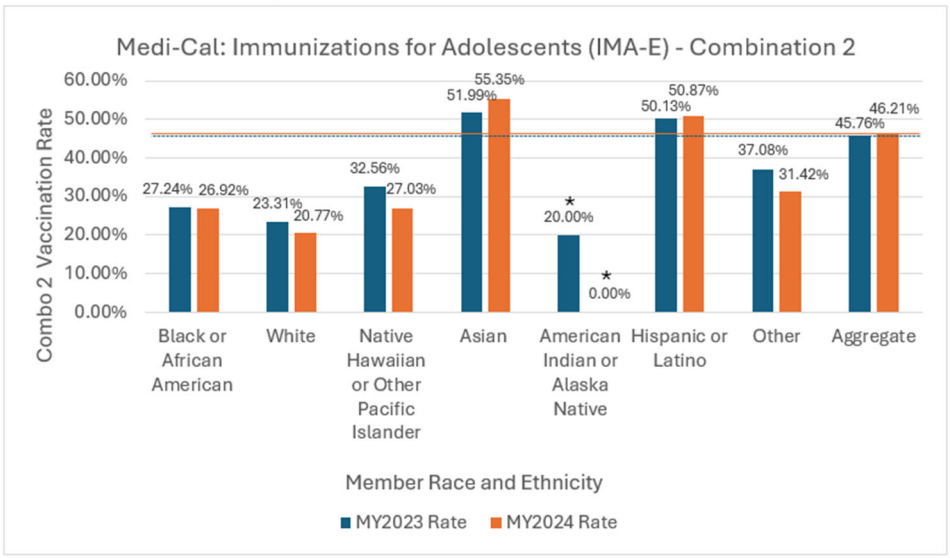
Indicator/Goal: The total or aggregate rate or better **Medi-Cal**

QAC 03.19.2026



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

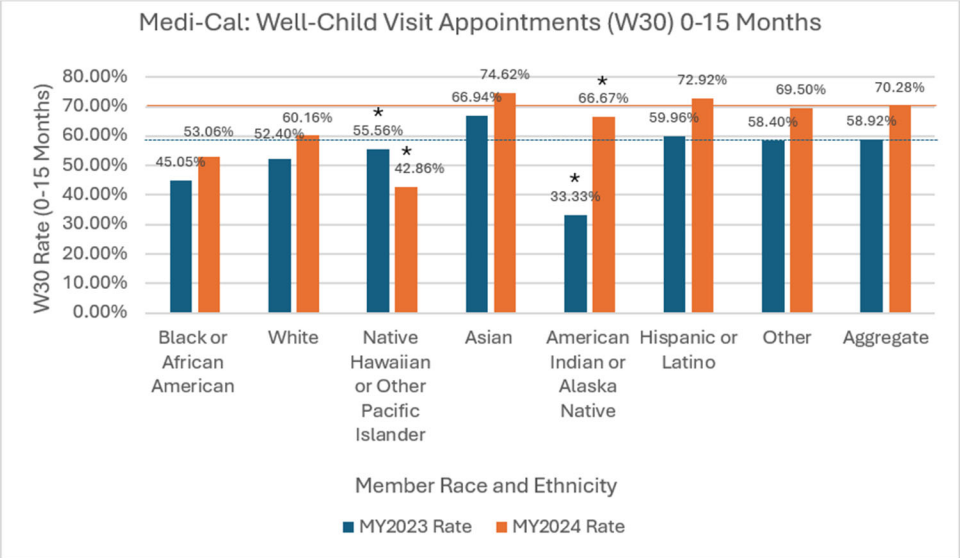
- Across all race and ethnicity groups, the Asian group's performance of 49.24% surpassed both the aggregate and all other groups' performance.
- The Hispanic/Latino group followed as the group with the second-highest performance at 34.25%.
- The following three groups performed below the MPL (27.49%):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



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

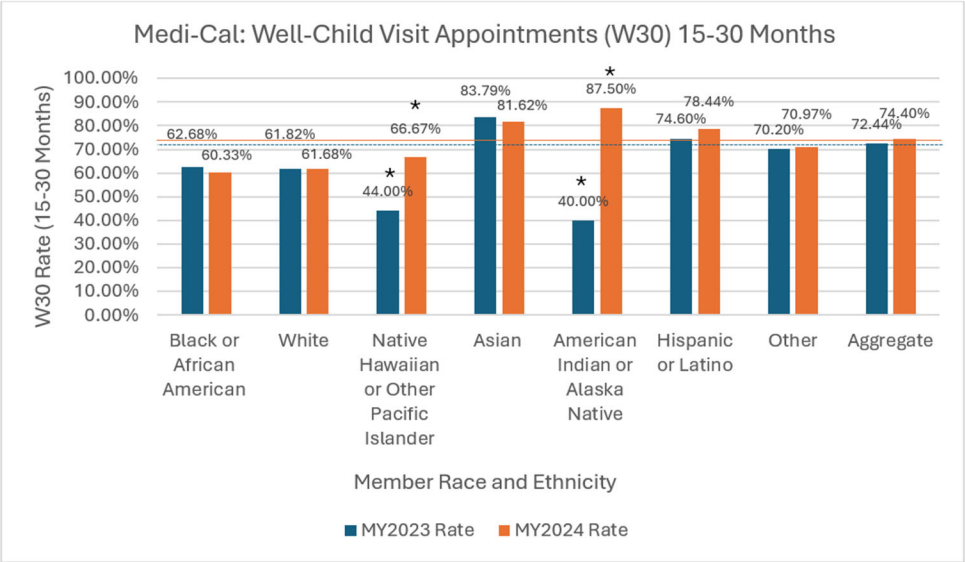
- Across aggregate performance, there was a slight improvement of 0.45 percentage points from the previous year.

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



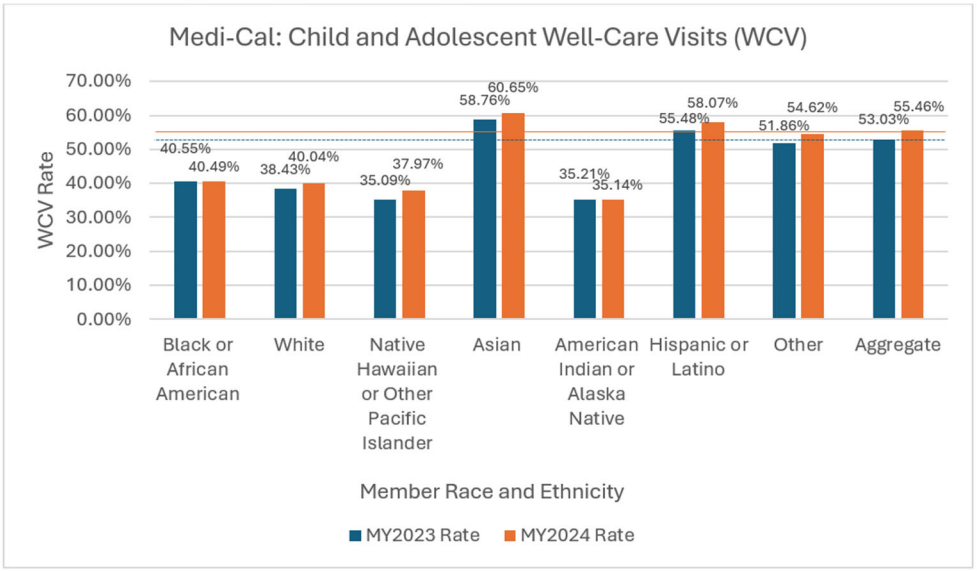
The rates shown in the bar chart were calculated by dividing the number of Medi-Cal members who completed a well-child visit between 0 and 15 months of age by the total number of eligible members in that age group, stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator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

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



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

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



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

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

VI. Actions/Interventions Implemented in 2025:

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

Back to Agenda Back to Item

			☐ Data ☐ Other	☐ Incomplete	LSC

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

VII. Effectiveness of Interventions:

Prospective Rates

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

MC = Medi-Cal

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

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

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

VIII. Qualitative Analysis:

Causal/Barrier Analysis:

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

IX. Opportunities for Improvement:

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

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

QAC 03.19.2026

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

MC = Medi-Cal; OC = OneCare

X. Conclusion:

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

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

QAC 03.19.2026

Back to Agenda Back to Item

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

I. Purpose or Background:

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

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

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

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

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

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

QAC 03.19.2026

Back to Agenda Back to Item

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

II. Data Sources and Methodology:

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

III. Quantitative Analysis:

Medi-Cal

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

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

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

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

OneCare

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

The COL measure did not meet the MY 2024 OneCare goal of 70.33%. The MY 2024 OneCare rate was 66.94% which is higher than the MY 20224 rate of 66.84%. The BCS measure did not meet the MY 2024 OneCare goal of 75.00%. The MY 2024 OneCare rate was 68.52% which is higher than the MY 2023 rate of 66.88%.

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

IV. Data Stratification Data Source and Methodology:

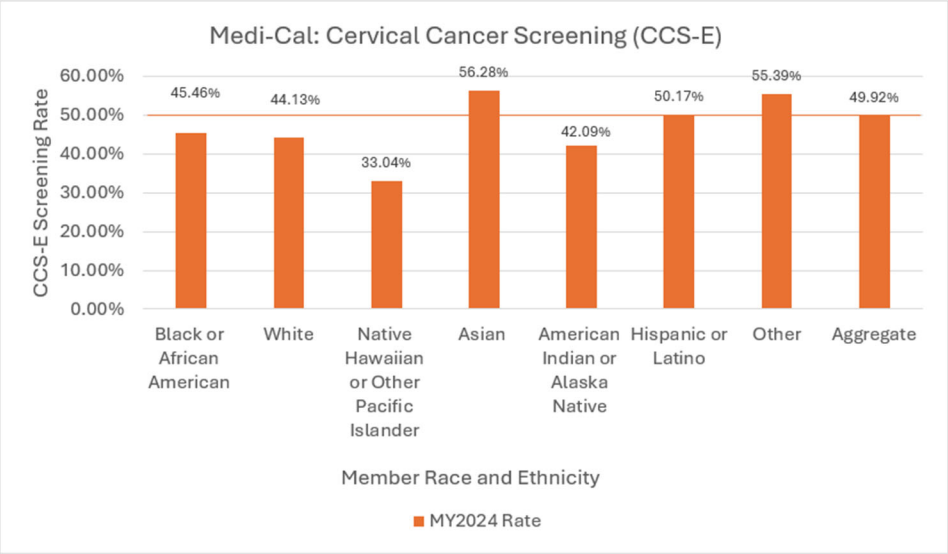
Data pulled from claims and encounters using the HEDIS software engine, CitiusTech, from January 1, 2024, to December 31, 2024. Data is stratified by race and ethnicity.

V. Data Stratification Results and Quantitative Analysis:

Indicator/Goal: The total or aggregate rate or better

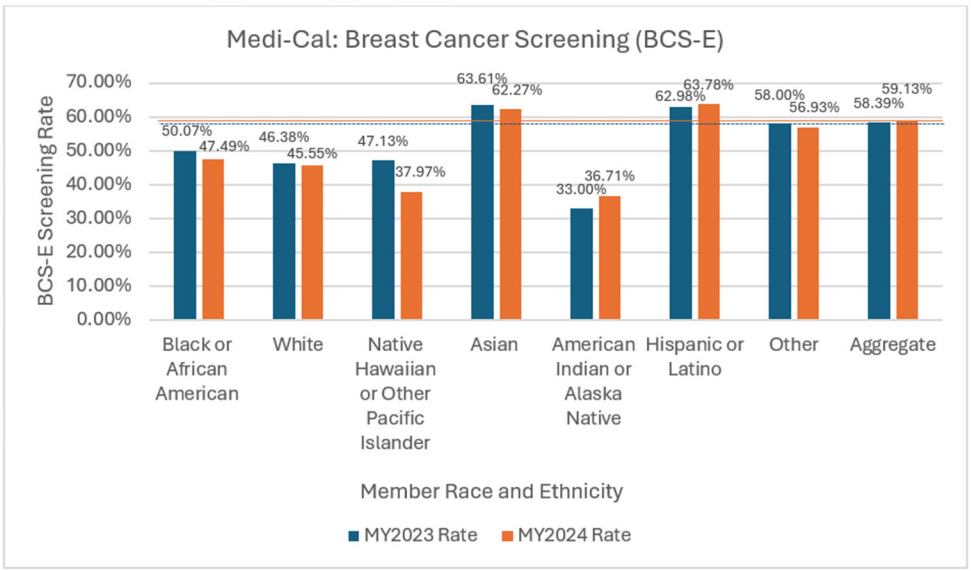
Medi-Cal

QAC 05.19.2026



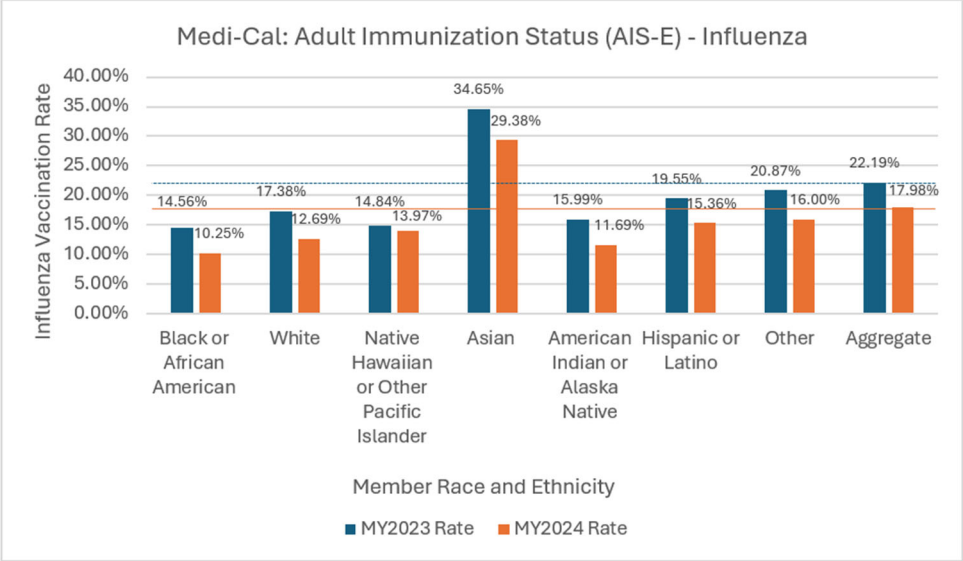
This bar chart shows the percentage of eligible Medi-Cal members who are up to date with cervical cancer screening, based on HEDIS specification. Rates are calculated by dividing the number of members meeting screening criteria and who are up to date with their cervical cancer screening by the total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

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



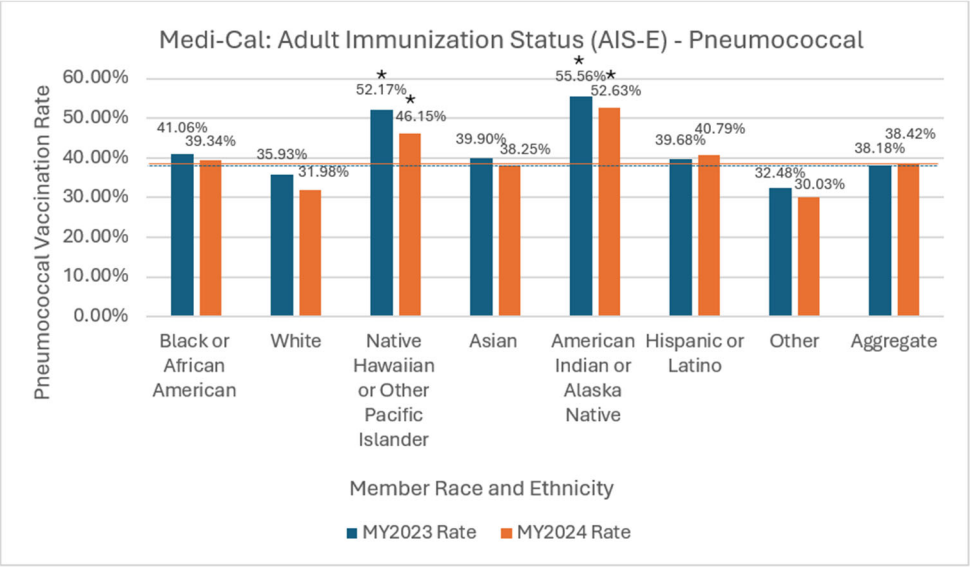
This bar chart shows the percentage of eligible Medi-Cal members who are up to date with breast cancer screening, based on HEDIS specification. Rates are calculated by dividing the number of members meeting screening criteria and who are up to date with their breast cancer screening by the total eligible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

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



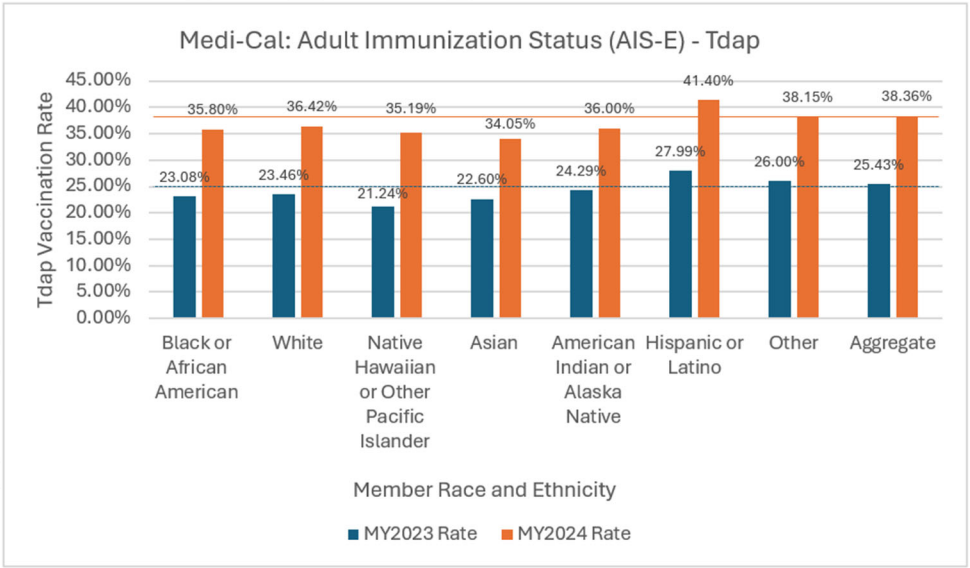
This bar chart displays the percentage of Medi-Cal adult members who received an influenza vaccine during the measurement period, based on HEDIS specification. Rates are calculated among eligible members within the specified age range and are stratified by race and ethnicity.

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



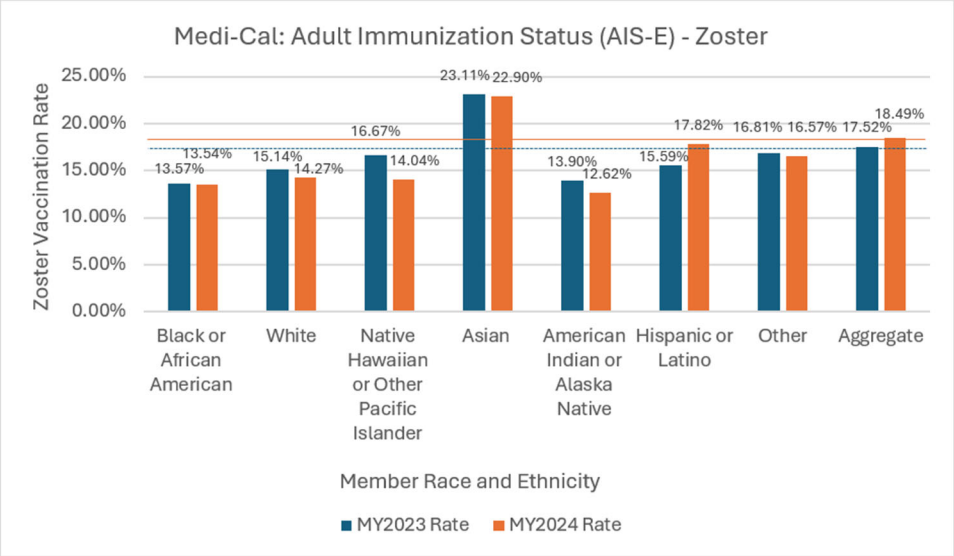
This bar chart displays the percentage of Medi-Cal adult members who received a Pneumococcal vaccine during the measurement period, based on HEDIS specification. Rates are calculated among eligible members within the specified age range and are stratified by race and ethnicity. An asterisk (*) in the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

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



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

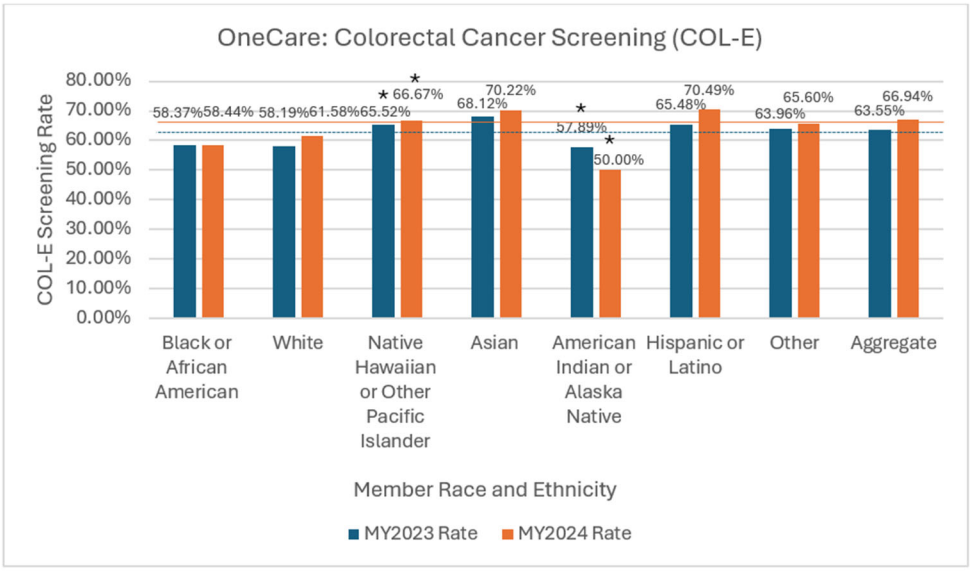
Overall Improvement: All groups showed a substantial increase in rates from MY 2023 to MY 2024, reflecting positive progress in Tdap vaccination rates. Hispanic or Latino consistently outperformed the aggregate in both years, with the highest rates overall (41.40% in MY 2024). The Other racial/ethnic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



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

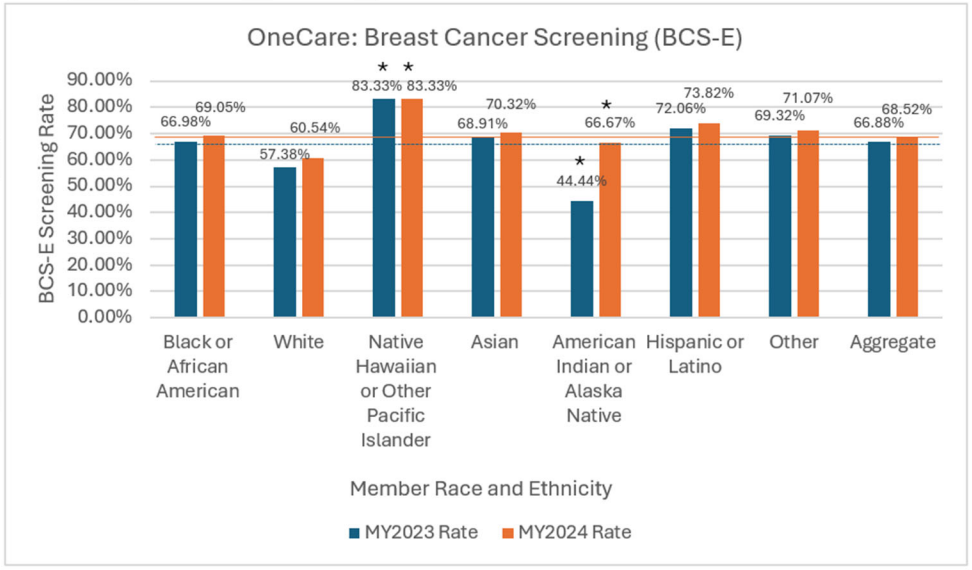
Overall Trend: The aggregate rate increased from 17.52% in MY 2023 to 18.49% in MY 2024, indicating a modest improvement in Zoster vaccination uptake. The Asian group consistently outperformed the aggregate in both years, with the highest rates (22.90% in MY 2024). No other group met or exceeded the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

OneCare



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

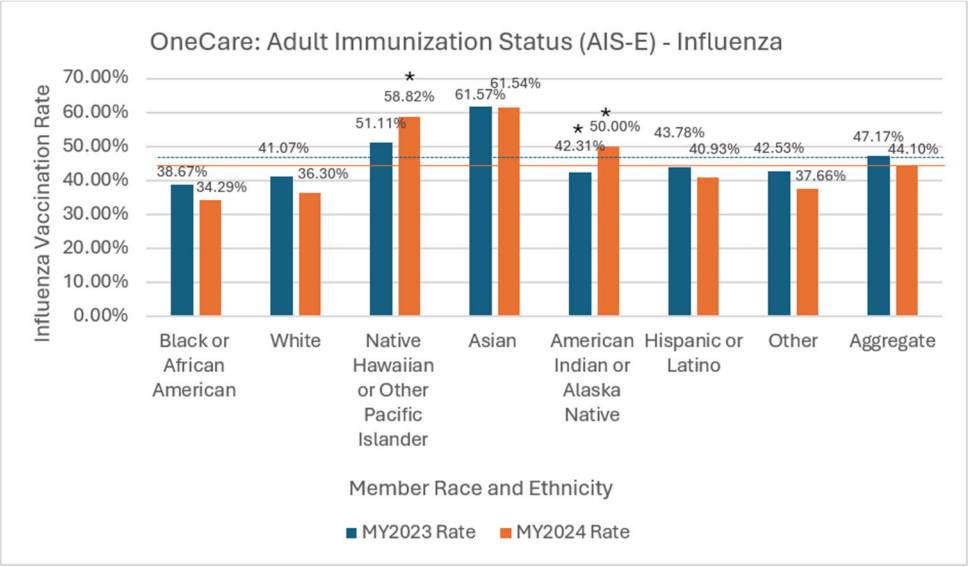
The analysis of the stratified data for the OneCare COL measure indicates differences across various racial and ethnic groups. Disparities are evident when examining the stratified rates. Members identified as Asian and Hispanic or Latino show higher rates of colorectal cancer screening compared to the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



Back to Agenda Back to Item

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

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



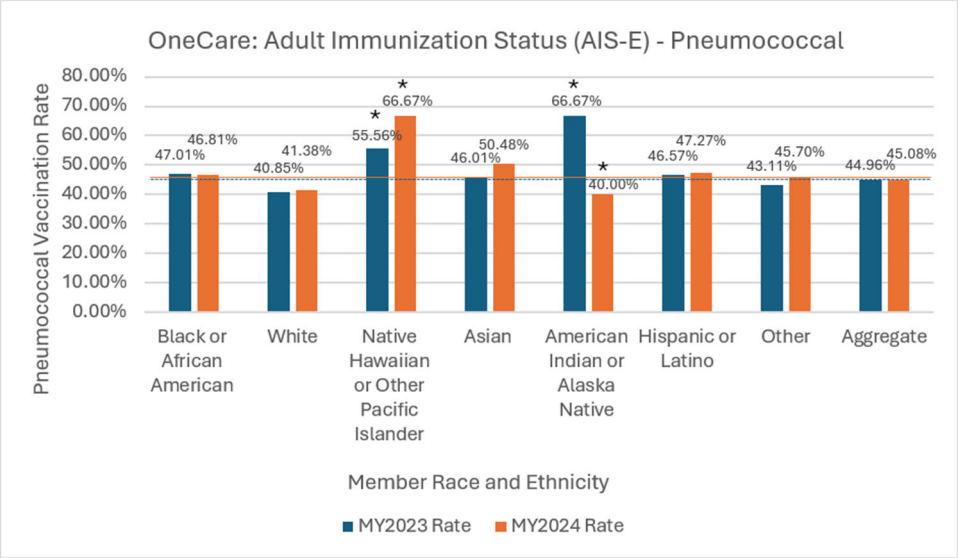
This bar chart displays the percentage of OneCare adult members who received an influenza vaccine during the measurement period, based on HEDIS specification. Rates are calculated among eligible members within the specified age range and are stratified by race and ethnicity. An asterisk (*) in the graphs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

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

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

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

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



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

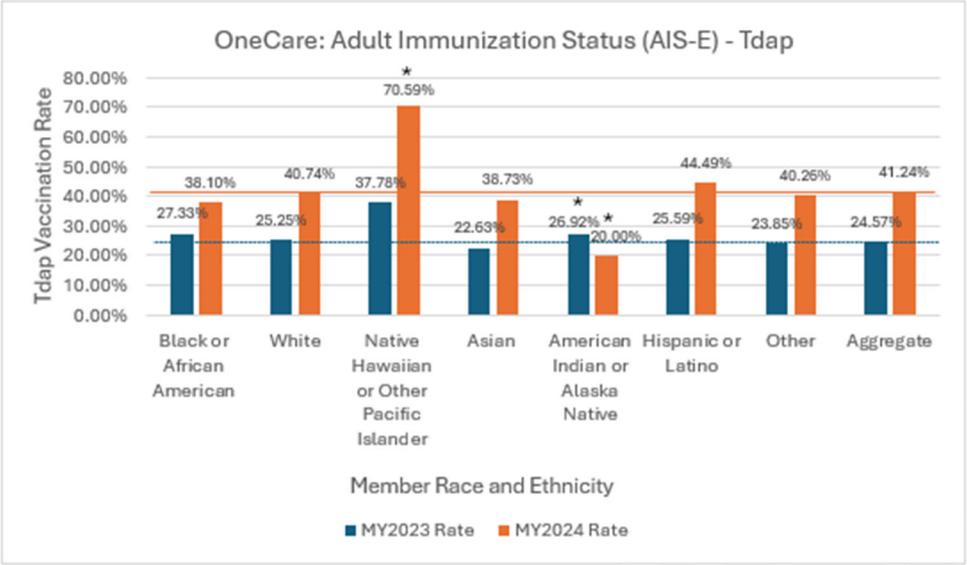
Overall Stability: The aggregate rate remained relatively stable, increasing slightly from 44.96% in MY 2023 to 45.08% in MY 2024.

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

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

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

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



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

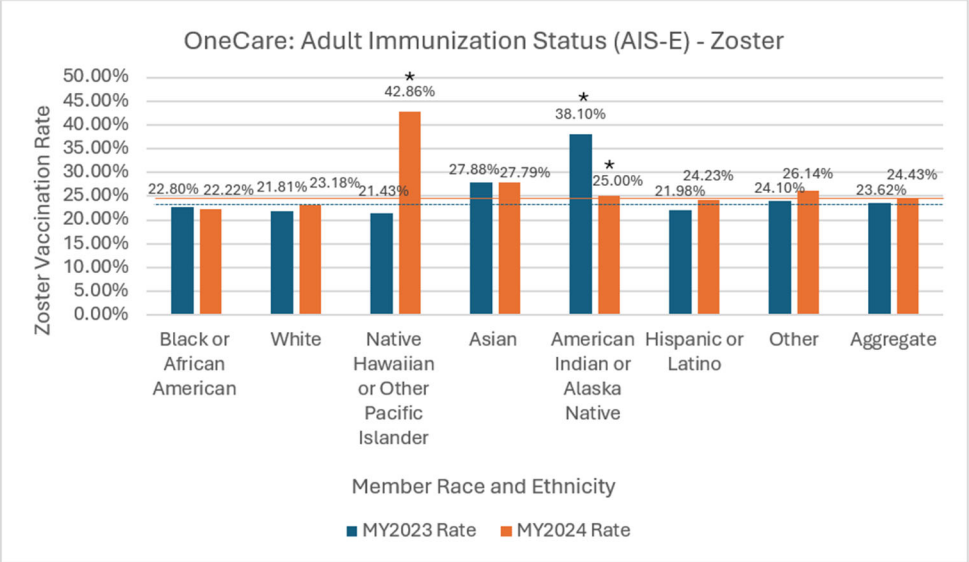
Overall Improvement: The aggregate Tdap immunization rate improved significantly from 24.57% in MY2023 to 41.24% in MY2024, a gain of +16.67 percentage points.

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

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

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

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

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

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

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

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

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

VI. Actions/Interventions Implemented in 2025:

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

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

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

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

VII. Effectiveness of Interventions:

Prospective Rates

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

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

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

Cancer Screenings:

As of September 2025:

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

AIS:
Strong Projected Improvements:

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

Moderate Gains:

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

OneCare Outperforms MC:

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

Focus Areas:

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

Qualitative Analysis:

Causal/Barrier Analysis:

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

VIII. Opportunities for Improvement:

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

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

Back to Agenda Back to Item

OAC 3.19.2026

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

MC = Medi-Cal; OC = OneCare

IX. Conclusion:

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

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

I. Purpose or Background:

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

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

II. Data Sources and Methodology:

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

III. Quantitative Analysis:

FQHC Community Grants (Medi-Cal)

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

The number of screenings conducted by each FQHC Community Grant has increased monthly. Screenings for cervical, breast, and colorectal cancers have met or surpassed program goals, reflecting strong outreach and engagement. Lung cancer screening, not part of current HEDIS measures, remains a focus as community grantees establish baselines in Year 1 and aim for improvement in Year 2.

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

IV. Actions/Interventions Implemented in 2025:

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

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

V. Effectiveness of Interventions:

Prospective Rates

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

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

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

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

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

VI. Qualitative Analysis:

Causal/Barrier Analysis:

QAC 03.19.2026

Back to Agenda Back to Item

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

VII. Opportunities for Improvement:

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

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

Back to Agenda Back to Item

	Collaborate with QI to reach out to these clinics and coordinate mobile mammogram events.				

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

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

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

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

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

I. Purpose or Background:

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

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

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

OAC 03.19.2026

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

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

II. Data Sources and Methodology:

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

III. Quantitative Analysis:

Medi-Cal

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

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

IV. Data Stratification Data Source and Methodology:

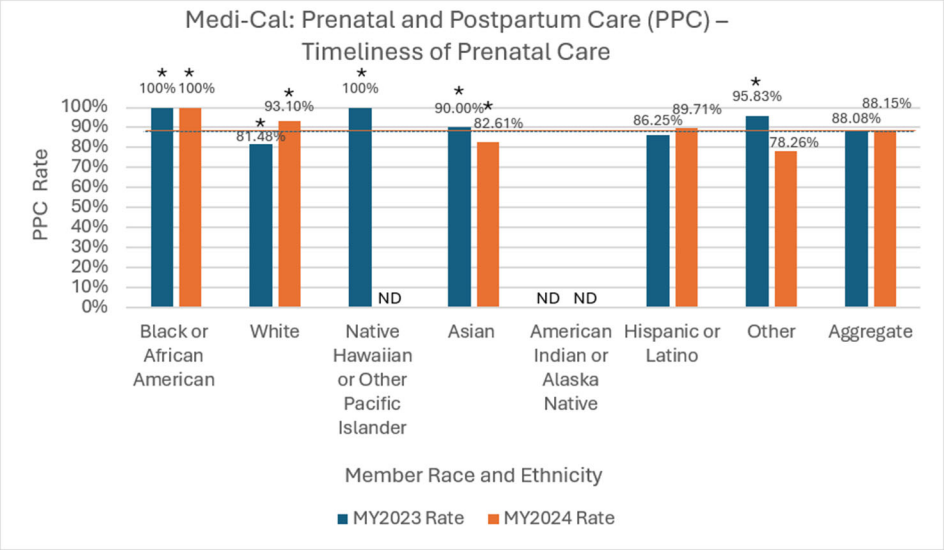
Data pulled from claims and encounters using HEDIS software engine, CitiusTech, from January 1, 2024, to December 31, 2024. Data is stratified by race and ethnicity.

V. Data Stratification Results and Quantitative Analysis:

Indicator/Goal: The total or aggregate rate or better

Medi-Cal

OAC 03.19.2026



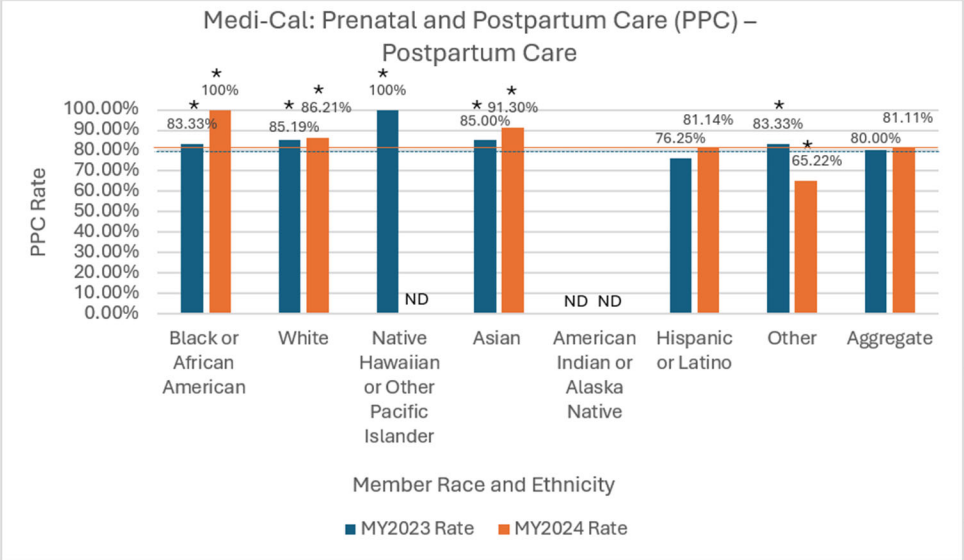
The bar chart displays the percentage of deliveries by Medi-Cal members who received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in CalOptima Health. Rates are stratified by race and ethnicity. An asterisk (*) in the graphs indicates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

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

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

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

QAC 03.19.25.0



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

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

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

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

VI. Actions/Interventions Implemented in 2025:

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

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

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

VII. Effectiveness of Interventions:

Prospective Rates

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

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

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

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

Postpartum Care Call Campaign Effectiveness

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

Doula Integration at CalOptima Health Effectiveness

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

VIII. Qualitative Analysis:

Causal/Barrier Analysis:

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

IX. Opportunities for Improvement:

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

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

Back to Agenda Back to Item

OAC 03.19.2026

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

MC = Medi-Cal; OC = OneCare

X. Conclusion:

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

QAC 03.19.2026

Back to Agenda Back to Item

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

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

I. Purpose or Background:

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

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

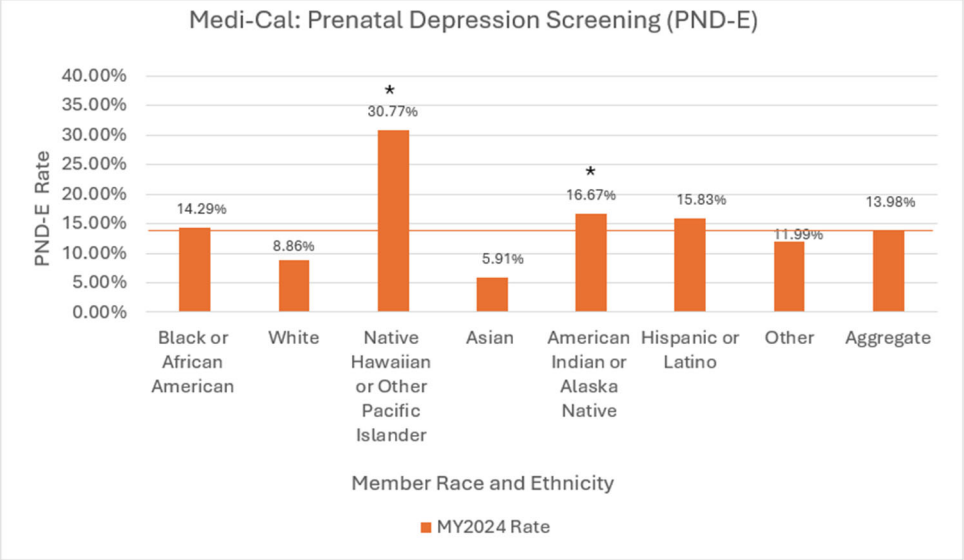
II. Data Sources and Methodology:

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

III. Quantitative Analysis:

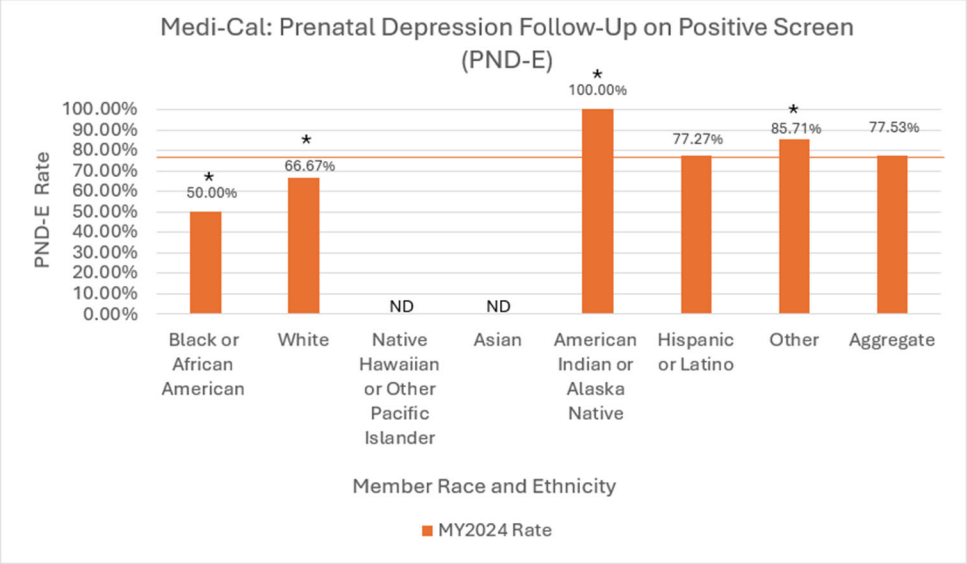
Medi-Cal

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



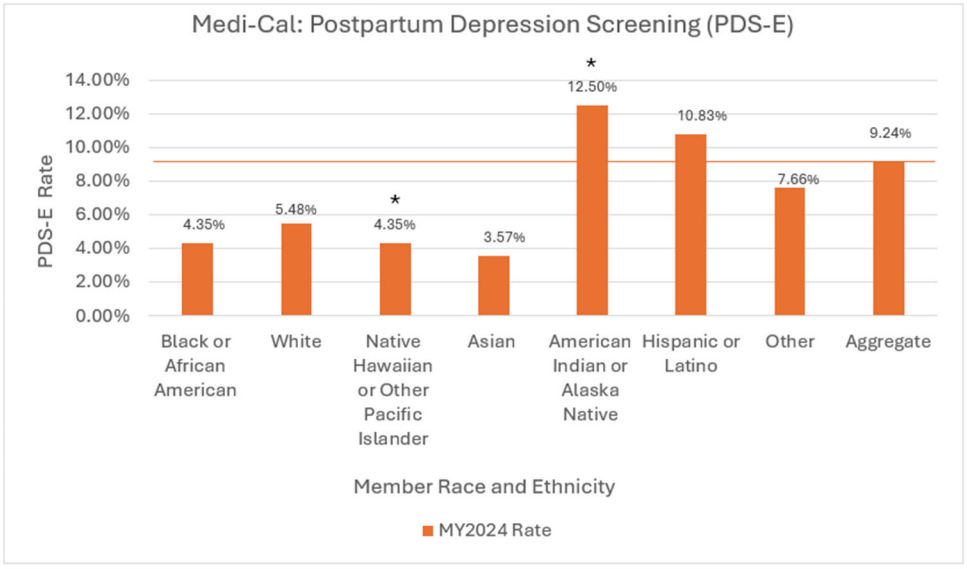
This bar chart shows the percentage of deliveries in which Medi-Cal members were screened for clinical depression using a standardized instrument during pregnancy, based on HEDIS specification. Rates are stratified by member race and ethnicity. An asterisk (*) in the graphs indicates that the denominator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

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



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

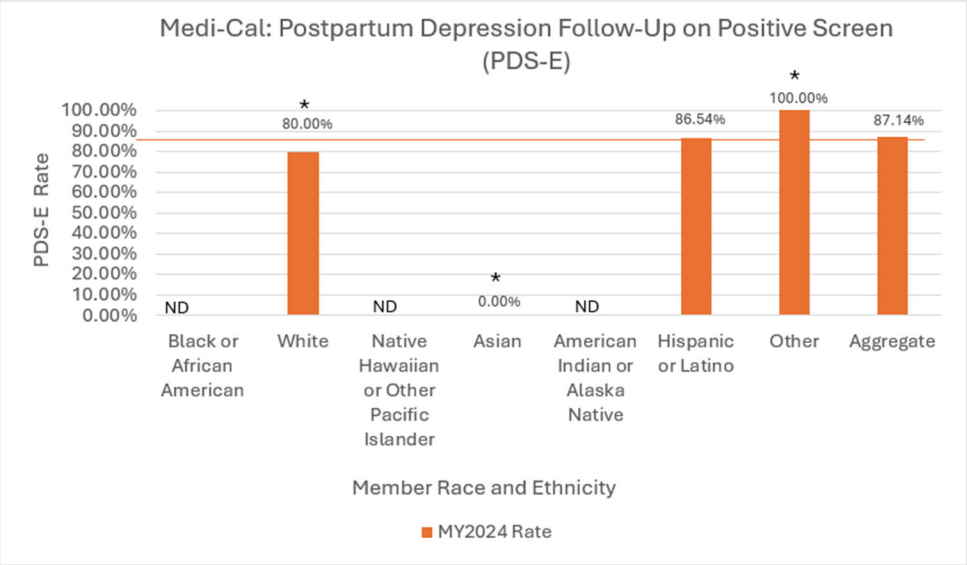
The Medi-Cal PND-E data for MY 2024 shows generally strong follow-up rates among members who screened positive for depression, though some variations exist by race and ethnicity. Follow-up rates ranged from 50.00% for Blank or African American members to 100% among both American Indian or Alaska Native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



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

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

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



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

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

IV. Actions/Interventions Implemented in 2025:

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

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

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

V. Effectiveness of Interventions:

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

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

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

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

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

Prospective Rates

QAC 03.19.2026

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

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

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

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

VI. Qualitative Analysis:

Causal/Barrier Analysis:

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

VII. Opportunities for Improvement:

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

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

OAC 03.19.2026

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

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

Overall, the data demonstrated that CalOptima Health is making measurable progress in improving both prenatal and postpartum depression screenings and follow-up rates. Year-over-year trends show consistent upward movement across the HEDIS measures, indicating greater integration of behavioral health screening into routine perinatal care. The increase in screening rates reflects stronger provider engagement, enhanced documentation practices and more effective care coordination between obstetric, behavioral health and case management teams.

Telephonic outreach has improved member identification and timely follow-up after positive screens, while provider training and resource dissemination have contributed to a more consistent approach to screening and referrals. Engagement in community collaboratives further strengthens systemwide alignment on maternal mental health priorities.

While opportunities for continued improvement remain, particularly in documentation accuracy, member engagement and follow-up after positive screens, the overall trend demonstrates meaningful progress toward HEDIS goals. These results affirm that the current intervention is effective and that CalOptima Health's comprehensive, coordinated approach is yielding positive outcomes for the Medi-Cal perinatal population. Sustained focus on provider partnership, data quality and equitable access to behavioral health services will be essential to maintain momentum and achieve further gains in the next measurement year.

4.10 Maternal and Child Health: Maternity Care for Black Members	
Author(s): Ann Mino & Katie Balderas	Department(s): Case Management/ Medical Management/ Cal AIM/ Quality Analytics
Responsible Party(ies): Megan Dankmyer (Sr. Director, Medical Management); Kelli Glynn (Director, Quality Initiatives); Katie Balderas (Director, Case Management)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Medi-Cal 1. Increase timeliness of prenatal care (TOPC) for CalOptima Health's Black members from 75.71% to 84.55% by December 31, 2025. 2. Increase postpartum care (PPC) for CalOptima Health's Black members from 71.43% to 80.23% by December 31, 2025.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

Specific populations of women in the United States experience disproportionately higher rates of maternal morbidity and mortality compared to women of other racial and ethnic groups. Contributing

Back to Agenda Back to Item

factors include barriers to accessing timely and culturally responsive care, implicit bias within the healthcare system, and social determinants of health that affect perinatal outcomes. Improving access to timely prenatal and postpartum care is critical to supporting maternal health, early identification of complications, and the overall well-being of both mother and baby.

CalOptima Health is committed to advancing health equity and improving outcomes for the identified population through focused quality improvements. Efforts center on connecting members with culturally aligned support programs, including doulas, ECM services and Black Infant Health program, while strengthening collaboration between community organizations and clinical partners.

II. Data Sources and Methodology:

Data was collected through HEDIS reporting, claims and encounter data for the Medi-Cal Black population. Rates reflect the percentage of Black members who received timely prenatal and postpartum care according to HEDIS definitions. Data from the Quality Improvement and Medical Management teams were analyzed to identify trends.

III. Quantitative Analysis:

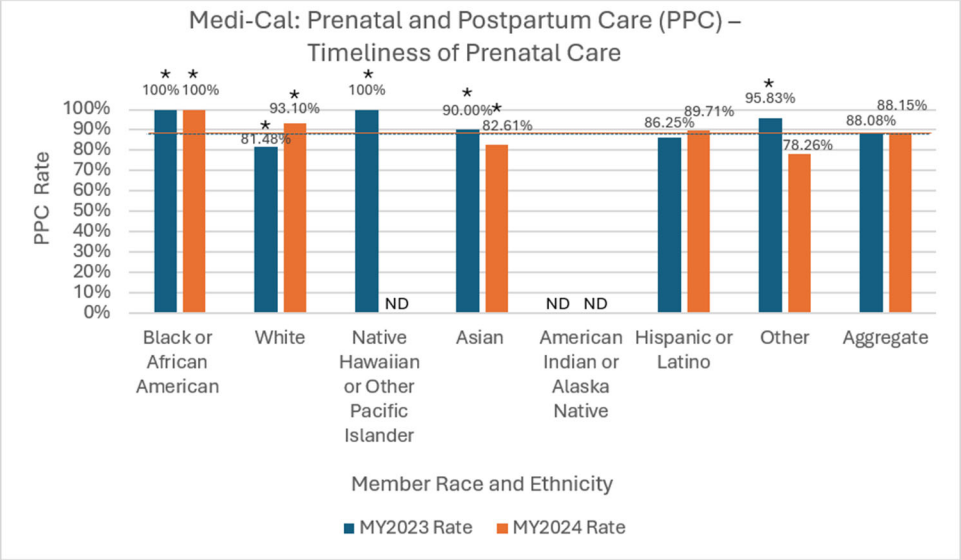
Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
PPC	Timeliness of prenatal care (TOPC) for CalOptima Health's Black members	50.00%	75.71%	100.00%	84.55%	☒ Y ☐ N
PPC	Postpartum care (PPC) for CalOptima Health's Black members	100.00%	71.43%	100.00%	80.23%	☒ Y ☐ N

The table above indicates final hybrid rates for the prenatal and postpartum care measures for Black members.

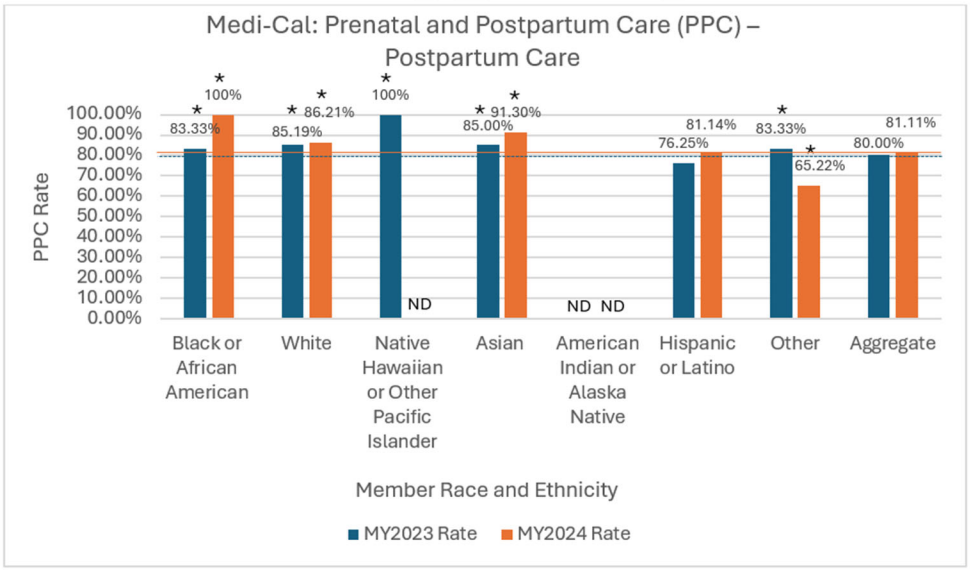
Medi-Cal

QAC 03.19.2026



The bar chart displays the percentage of deliveries by Medi-Cal members who received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in CalOptima Health. Rates are stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The data shows the PPC prenatal rate for Black or African American has remained steady from MY 2023 to MY 2024, surpassing the annual goal, indicating the initiatives focused on this population are effective.



The bar chart displays the percentage of deliveries that had a post-partum visit on or between seven and 84 days after delivery for Medi-Cal members. Rates are stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The data shows the PPC postpartum rate for Black or African American has improved from 83.33% in MY2023 to 100% in MY 2024. Full rate compliance suggests barriers that may have contributed to delays in care in MY 2023 are likely not impacting members in MY 2024. To ensure high compliance in future measurement years, targeted outreach and culturally responsive engagement are essential.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
Targeted outreach to Black members to promote and offer doula support, Black Infant Health program referral and ECM Services	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	PPC
Community engagement/ promotion of services at community events	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	PPC
Improve date coordination to support member engagement in services	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	PPC

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

Multiple targeted interventions were implemented to improve the timeliness of prenatal and postpartum care among Black members, with a focus on reducing disparities and strengthening culturally responsive engagement. These interventions combine direct members' support, provider and community collaboration, and exploration of innovative digital tools to enhance access to care.

Connection to doula, ECM and Black Infant Health (BIH) Programs: CalOptima Health prioritized member connection to culturally aligned and supportive services by referring eligible members to HCA for outreach, education and engagement in ECM, BIH and doula support. These referrals ensured members received person-centered support addressing both clinical and social needs. Forty members within this population of focus have been enrolled in ECM services, receiving individual care coordination and access to community-based resources. Members connected to doula services receive ongoing emotional, educational and advocacy support, which helps increase comfort with prenatal care and confidence in navigating the health system. The coordinated referral approach between CalOptima Health, HCA and community programs improved care continuity and strengthened member trust in their perinatal journey.

Community Outreach Events: Community engagement was a central strategy in increasing awareness and access to timely prenatal and postpartum care. While CalOptima Health implemented and participated in several community events to connect members with services, provided education on the importance of perinatal care and built relationships with trusted community organizations, one event was specifically focused on this targeted population: the OC Black History Parade and Unity Festival. This event provided an opportunity to engage directly with community members and distribute culturally relevant health material and resources.

Exploration of Digital Perinatal Health Tools: Recognizing the growing importance of technology in supporting access to care, CalOptima Health explored digital methods to support best practices and future implementation.

OAC 03.19.2026

Collectively, these interventions contributed to measurable improvements in member engagement and care coordination for Black members. The referral pathways to ECM, doula and BIH programs helped address both clinical and social determinants of health, resulting in improved adherence to prenatal and postpartum appointments. Community participation efforts increase visibility and connection to trusted resources.

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
PPC	MC: Timeliness of Prenatal Care	67.39%	81.84%
PPC	MC: Postpartum Care	67.15%	68.77%

Indicator/Goal: The performance rate from the same month of the previous year

When comparing current September 2025 performance against the same time last year:

- Timeliness of Prenatal Care saw a significant improvement of +14.45 percentage points, indicating better early engagement with prenatal services.
- Postpartum Care experienced a slight increase of 1.62 percentage points, indicating an improvement in members receiving timely postpartum care.

VI. Qualitative Analysis:

Causal/Barrier Analysis:

- The completion rate of prenatal and postpartum care is lowest amongst members who are 18 years of age or younger. Younger birthing populations are likely to face greater barriers (e.g., complications, transportation access issues). Inadequate care can lead to poorer developmental outcomes for infants.
- Doulas are positioned as a key strategy to improve prenatal and postpartum care rates, especially for Black and Native American members. Doulas support culturally appropriate outreach and can integrate with programs like BIH and ECM. Currently, there is a limited volume of members who are actively utilizing doula services.
- Lack of data to support identification of low-performing versus high-performing OB/GYN providers.
- Members may not be aware of available ECM, doula or BIH programs or how to access them.
- Complex health care and referral systems can delay or prevent timely engagement in prenatal or postpartum visits and support.
- Historical inequities and experience of bias in healthcare can create hesitancy to seek early or follow-up care.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
1. Analyze current efforts and align new activities with findings	To be determined based on outreach results	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L	PPC
2. Increase doula promotion	Develop targeted campaigns and activities to increase benefit awareness and utilization	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ H ☒ M ☐ L	PPC
3. Strengthen community partnerships	Leverage culturally relevant partners and contracted providers to collaboratively improve measures for the targeted population.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	PPC

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

Our targeted interventions for Black members, including referrals to connect them with doula, ECM and BIH programs, as well as the implementation of community events, such as culturally relevant events like the OC Black History Parade and Unity Festival, have shown promise in improving prenatal and postpartum engagement. These efforts have helped address barriers to care, promote a community of maternal health services and foster trust within the community. Continued focus on culturally tailored outreach and supportive care management is essential to sustain improvements in maternal and infant health outreach and to reduce disparities among our Black members.

4.11 Chronic Conditions: Members with Diabetes	
Author(s): Melissa Morales	Department(s): Medical Management and Quality Analytics
Responsible Party(ies): Kelli Glynn (Director, Quality Initiatives); Katie Balderas (Director, Case Management); Melissa Morales (Quality Improvement Specialist, Quality Analytics); Elisa Mora (Manager, Case Management)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Eye Exam for Patients with Diabetes (EED) MC EED 64.06% Increase from 63.52% to 64.06% by 12/31/2025. OC: EED 77.00%; Increase from 75.14% to 77.00% by 12/31/2025. Glycemic Status Assessment for Patients with Diabetes (GSD): Glycemic Status (this measure evaluates percentage of members with glycemic status of <8.0% (control-higher rate is better) and glycemic status (>9.0%) (poor control-lower rate is better) (>9.0%) MC GSD (>9.0%): Decrease from 29.34% to 27.01% by 12/31/2025. OC GSD (<8.0%): Increase from 77% to 92.00% by 12/31/2025.	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

Back to Agenda Back to Item

I. Purpose or Background:

According to the CDC, diabetes raises the risk for high blood pressure, which increases a person's chances of heart disease, stroke, vision loss and kidney disease. Tests and screenings are necessary for people with diabetes to catch any changes before they turn into major health problems. They can also help providers create personalized treatment plans tailored to their patients' specific needs.

The following is an evaluation of HEDIS measures related to diabetes care. The Glycemic Status Assessment for Patients with Diabetes (>9%) (GSD) measure is part of DHCS' Medi-Cal MCAS for annual reporting by Medi-Cal managed care plans. This measure is held to the MPL established by NCQA Quality Compass Medicaid 50th percentile. The GSD measure and the Eye Exam for Patients with Diabetes (EED) measure are part of CMS' Five-Star Quality Rating System.

II. Data Sources and Methodology:

The source of the data is CalOptima Health's HEDIS engine, CitiusTech. The goal methodology for MY 2024 is based on the current reported performance and the most current available benchmark. Medi-Cal measure goal setting for MY 2024 is based on MY 2022 reported performance results compared to the national percentile from the MY 2022 NCQA Quality Compass. If the current reported rate reached the NCQA Quality Compass percentile, the goal was set to the next percentile. OneCare measure goal setting for MY 2024 is based on the MY 2022 reported performance results compared to the Star Rating cutoff. If the current reported rate reached the Star cutoff, then the goal was set to the next Star cutoff.

III. Quantitative Analysis:

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
EED	Eye Exam for Patients with Diabetes	62.63%	63.52%	64.34%	64.06%	☒ Y ☐ N
HBD/GSD	Glycemic Status Assessment for Patients with Diabetes – Glycemic Status > 9.0%	30.41%	29.34%	30.92%	27.01%	☐ Y ☒ N

OneCare

Acronym	Measure	MY 2022 OneCare Rate	MY 2023 OneCare Rate	MY 2024 OneCare Rate	MY 2024 OneCare Goal	MY 2024 Goal Met / Not Met
EED	Eye Exam for Patients with Diabetes	73.00%	75.00%	78.00%	77.00%	☒ Y ☐ N
GSD	Glycemic Status Assessment for Patients with Diabetes – Glycemic Status <8.0%	78%	85%	84%	90.00%	☐ Y ☒ N

The EED measure met the MY 2024 Medi-Cal goal of 64.06%. The MY 2024 Medi-Cal rate was 64.34%, which is higher than the MY 2023 Medi-Cal rate of 63.52%. The GSD (>9%) measure did not meet the MY 2024 Medi-Cal goal of 27.01%. The MY 2024 Medi-Cal rate was 30.92%, which is higher than the MY 2023 Medi-Cal rate of 29.34% (lower is better).

The EED measure met the MY 2024 OneCare goal of 77.00%. The MY 2024 OneCare rate was 78.00%, which is higher than the MY 2023 OneCare rate of 75.00%. The GSD (<8%) measure did not meet the MY 2024 OneCare goal of 90%. The MY 2024 rate was 84%, which is lower than the MY 2023 OneCare rate of 85% (higher is better).

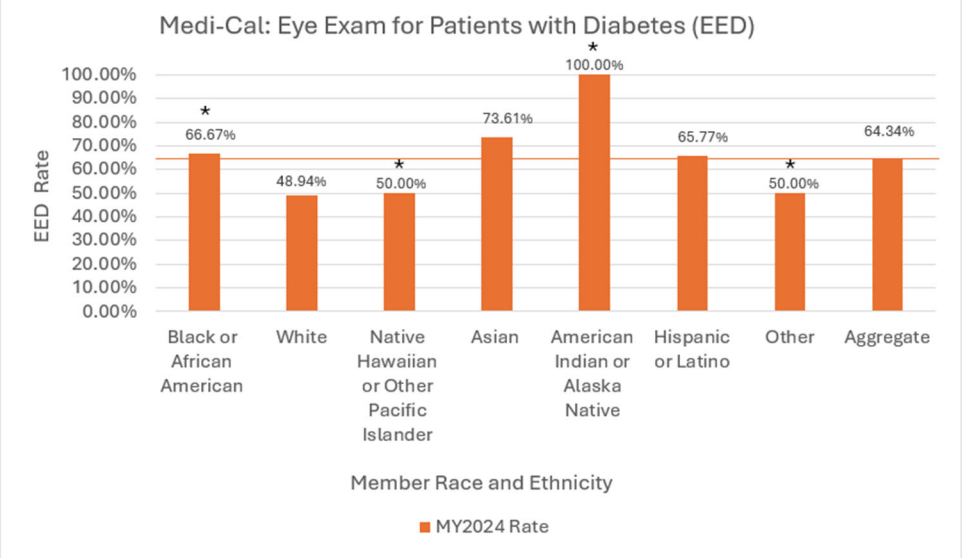
IV. Data Stratification Data Source and Methodology:

Data pulled from claims and encounters using HEDIS software engine, CitiusTech, from January 1, 2024, to December 31, 2024. Data is stratified by race/ethnicity.

V. Data Stratification Results and Quantitative Analysis:

Indicator/Goal: The total or aggregate rate or better

Medi-Cal



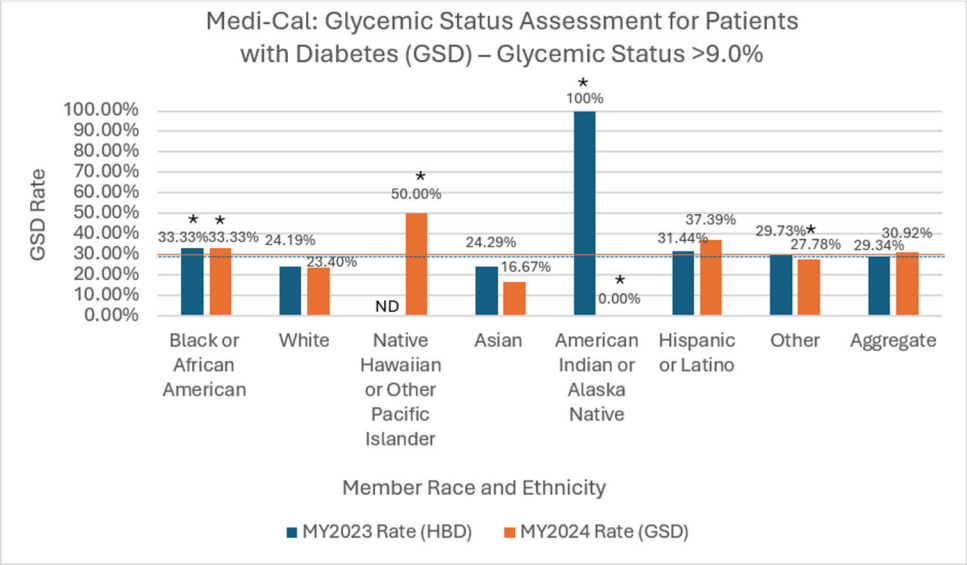
This bar chart shows the percentage of Medi-Cal members within a specified age range with diabetes (types 1 and 2) who had a retinal exam by an eye care professional during the measurement year. Rates are stratified by member race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The analysis of the stratified data for the Medi-Cal EED measure indicates differences across various racial and ethnic groups. The overall aggregate rate of 64.34% for the EED measure met the MY 2024 goal, indicating that the majority of Medi-Cal members with diabetes had a retinal exam during the measurement year. However, disparities are evident when examining the stratified rates.

Members identified as Hispanic or Latino, Black or African American, Asian and American Indian or Alaska Native show higher rates of retinal eye exam completion compared to the aggregate rate, which

Back to Agenda Back to Item

suggests better access to or utilization of eye care services. In contrast, the rates for White, Native Hawaiian or Other Pacific Islander, and Other members fell below the overall aggregate rate, indicating potential obstacles in accessing eye care or variations in service delivery that need to be addressed.

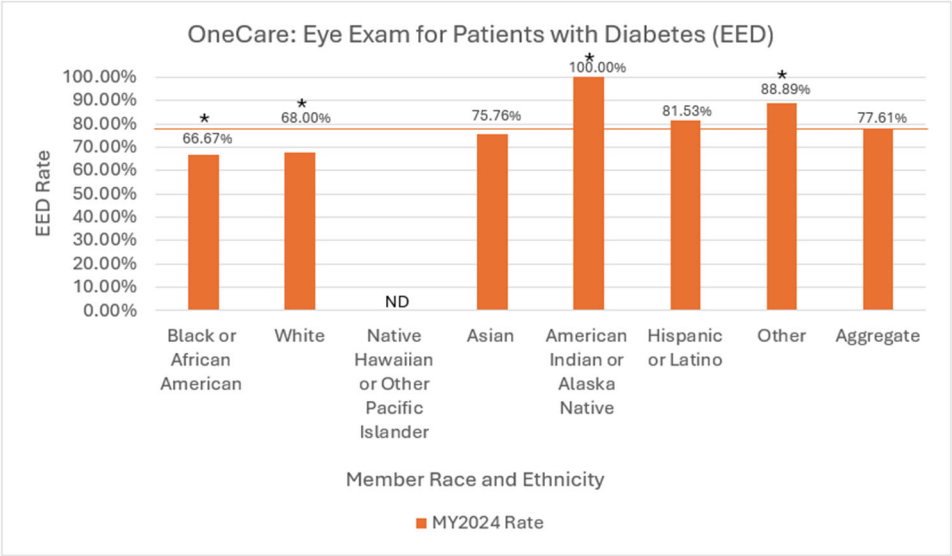


The bar chart illustrates the percentage of Medi-Cal members within a specified age range who have diabetes (type 1 or type 2) and whose most recent glycemic status was above 9.0% during the measurement period. In Measurement Year 2023, the metric used was Hemoglobin A1C Control for Patients with Diabetes (HBD), which exclusively considered HbA1C values. In contrast, Measurement Year 2024 uses the Glycemic Status for Diabetes (GSD) measure, which includes both HbA1C and GMI values. This broader inclusion may offer a more comprehensive view of glycemic control and could contribute to observed variations between the two years. Rates are stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The analysis of the stratified data for the Medi-Cal GSD (>9.0%) measure indicates differences across various racial and ethnic groups. Disparities are evident when examining the stratified rates. Members identified as Asian, White and Other show lower rates of glycemic assessment compared to the aggregate rate of 30.92%, which suggests these groups benefit from better diabetes management programs or have higher compliance with recommended care protocols.

In contrast, the rates for Black or African American, Hispanic or Latino, and Native Hawaiian or Other Pacific Islander members are above the overall aggregate rate. These findings highlight the need for targeted interventions to address gaps in diabetes care, enhance education on glycemic management and ensure equitable access to essential health services.

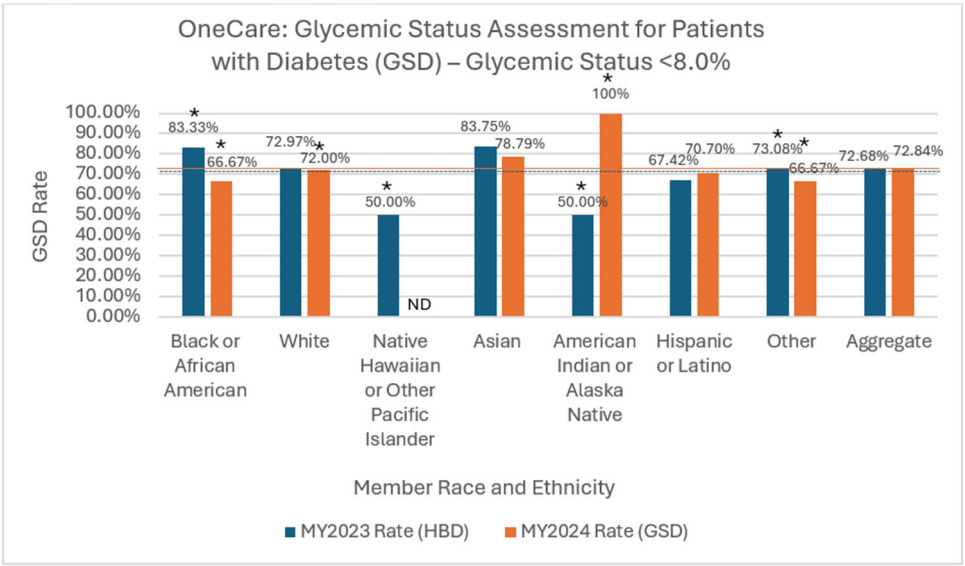
OneCare



This bar chart shows the percentage of OneCare members within a specified age range with diabetes (types 1 and 2) who had a retinal exam by an eye care professional during the measurement year. Rates are stratified by member race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The analysis of the stratified data for the OneCare EED measure indicates differences across various racial and ethnic groups. The overall aggregate rate of 77.61% for the EED measure met the MY 2024 goal, indicating that the majority of OneCare members with diabetes had a retinal eye exam during the measurement year. However, disparities are evident when examining the stratified rates.

Members identified as Hispanic or Latino, Other, and American Indian or Alaska Native show higher rates of retinal eye exam completion compared to the aggregate rate, which suggests these groups have better access to or utilization of eye care services. In contrast, the rates for Black or African American, White, and Asian members fell below the overall aggregate rate, pointing toward potential obstacles in accessing eye care or variations in service delivery that need addressing.



Back to Agenda Back to Item

The bar chart illustrates the percentage of OneCare members within a specified age range who have diabetes (type 1 or type 2) and whose most recent glycemic status was below 8.0% during the measurement period. In Measurement Year 2023, the metric used was Hemoglobin A1C Control for Patients with Diabetes (HBD), which exclusively considered HbA1C values. In contrast, Measurement Year 2024 uses GSD measure, which includes both HbA1C and GMI values. This broader inclusion may offer a more comprehensive view of glycemic control and could contribute to observed variations between the two years. Rates are stratified by race and ethnicity. An asterisk (*) in the graphs indicates that the denominator for that specific measure is less than or equal to 30.

The analysis of the stratified data for the OneCare GSD (<8.0%) measure indicates differences across various racial and ethnic groups. Disparities are evident when examining the stratified rates. Members identified as Asian and American Indian or Alaska Native have higher rates of glycemic assessment compared to the aggregate rate of 30.92%, which suggests that these groups benefit from better diabetes management programs or have higher compliance with recommended care protocols.

In contrast, the rates for Black or African American, Other, and Hispanic or Latino members are below the overall aggregate rate. These findings highlight the need for targeted interventions to address gaps in diabetes care, enhance education on glycemic management, and ensure equitable access to essential health services.

VI. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
Member health reward	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	GSD, EED
Member mailing	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	GSD, EED
Text messaging	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	GSD, EED
Telephonic outreach	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	GSD, EED
VSP Vision Care Data Exchange	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	EED
Ophthalmologist Provider Outreach Project	☐ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	EED
Home test kit	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Othe	☐ Completed ☒ Ongoing ☐ Incomplete	GSD
Gap-in-care reporting	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	GSD, EED

Back to Agenda Back to Item

Quality Improvement Grant Program	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	GSD, EED
P4V Program	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	GSD, EED

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

VII. Effectiveness of Interventions:

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
EED	MC: Eye Exam for Patients with Diabetes	40.70%	48.24%
EED	OC: Eye Exam for Patients with Diabetes	58.64%	67.34%
GSD	MC: Glycemic Status Assessment for Patients with Diabetes – Glycemic Status > 9.0%	59.98%	42.72%
GSD	OC: Glycemic Status Assessment for Patients with Diabetes – Glycemic Status >9.0%	52.74%	34.20%

Indicator/Goal: The performance rate from the same month of the previous year

As of September 2025:

- The MC Eye Exam for Patients with Diabetes prospective rate was 48.24%, which is higher than the September 2024 prospective rate of 40.70% by 7.54 percentage points.
- The OC Eye Exam for Patients with Diabetes prospective rate was 67.34%, which is higher than the September 2024 prospective rate of 58.64% by 8.7 percentage points.
- The MC Glycemic Status Assessment for Patients with Diabetes - Glycemic Status >9% prospective rate was 42.72%, which is lower than the September 2024 prospective rate of 59.98% by 17.26 percentage points (lower is better).
- The OC Glycemic Status Assessment for Patients with Diabetes - Glycemic Status >9% prospective rate was 34.2%, which is lower than the September 2024 prospective rate of 52.74% by 18.54 percentage points (lower is better).

VIII. Qualitative Analysis:

Causal/Barrier Analysis:

- The ability to reach members (mail, phone, text) creates challenges around providing members with information on diabetes care.

DAC 03.19.26

- Members did not visit their PCP during MY 2024 and did not receive assistance for their diabetes management.
- Lack of knowledge of the importance of A1C testing and retinal eye exam completion.
- Appointment access could be limited due to scheduling ability and/or staff shortage, resulting in long waiting times for appointments.
- Lack of document sharing (e.g., consult notes with the results of diabetic retinal eye exams) between eye care professionals and PCPs.
- Lack of data sharing between VSP due to contract restrictions between CalOptima Health and the VSP provider network, prohibiting direct data sharing with any health network and only permitting data sharing via the health plan.

IX. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
Member outreach: Use of disparity analysis to develop targeted interventions.	• Bidirectional SMS campaign and email development via Ushur • Telephonic outreach via Carenet and internal resources • Diabetes management mailing	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ H ☒ M ☐ L	GSD, EED
Access	• At-home testing for A1C and potentially a retinal eye exam. • Establish partnerships with ophthalmologists to perform member outreach and schedule members for eye exams.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	GSD, EED
Training and education	Continued provider education on HEDIS diabetes care measures.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	GSD, EED
Grant programs	Quality improvement grants to health network partners will focus on GSD and EED.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ H ☒ M ☐ L	GSD, EED
Member health reward	Continuing existing member health rewards for A1C testing and retinal eye exam completion.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☐ M ☒ L	GSD, EED
P4V Program	Continue performance-based incentives to prioritize and encourage diabetes management.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☐ M ☒ L	GSD, EED
Data optimization	The Cozeva data bridge will enable bidirectional data exchange with health network partners and facilitate	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	GSD, EED

OAC 03.19.2026

Back to Agenda Back to Item

	the timelier identification of members due for diabetic screenings.				

MC = Medi-Cal; OC = OneCare

X. Conclusion:

We met the internal CalOptima Health goal for the EED measure, but not for the GSD measure. GSD will remain on the QIHETP work plan for 2026. Both the GSD and EED Medi-Cal measures achieved the 75th percentile for MY 2024. For the OneCare population, the GSD CMS Stars measure reached the 4-Star cutoff, while the EED measure reached the 3-Star cutoff. Because reporting is changing from a hybrid methodology to Electronic Clinical Data Systems (ECDS) reporting, it is important to continue to monitor these measures year-round. CalOptima Health will continue to focus on diabetic care and pursue multiple quality improvement initiatives, as listed in the table above.

4.12 Chronic Conditions: Members with Heart Health (Hypertension)	
Author(s): Elisa Mora	Department(s): Case Management
Responsible Party(ies): Katie Balderas (Director, Case Management); Elisa Mora (Manager, Case Management)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: Controlling High Blood Pressure (CBP) MC CBP: Maintain the 90th percentile (72.75%) or higher by December 31, 2025. OC CBP: Increase from 74.87% to 80.00% by 12/31/2025. Controlling High Blood Pressure (CBP) - CLAS and Health Disparity for Medi-Cal 1. Increase CBP rate among Black and African American Medi-Cal members from 39.21% to 64.48% by 12/31/2025. 2. Increase CBP rate among Black and African American Medicare members from 47.24% to 77% by 12/31/2025. 3. Increase CBP rate among Korean-speaking Medi-Cal members from 24.87% to 64.48% by 12/31/2025. 4. Increase CBP rate among Vietnamese-speaking Medicare members from 50.56% to 77% by12/31/2025.	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

Hypertension, or high blood pressure, is the second most common condition among CalOptima Health members, affecting over 122,000 individuals. Left uncontrolled, it can lead to serious health complications such as heart disease and kidney disease. Research shows that home monitoring of blood pressure can improve control rates by 25–30%, making it a powerful tool in managing this condition. Additionally, findings from the OC Black and African American Health Equity Survey revealed that 70% of participants were unaware of their current blood pressure reading, highlighting a significant gap in awareness and self-management. These factors collectively underscore the urgent need for a targeted initiative to improve blood pressure control, reduce health disparities, and enhance overall population health outcomes.

II. Data Sources and Methodology:

Members are identified through the CalOptima Health HEDIS engine, CitiusTech, to track both compliant and non-compliant members with respect to HEDIS and STAR measures.

III. Quantitative Analysis:

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
CBP	Controlling High Blood Pressure (CBP)	65.85%	76.33%	67.54%	72.75%	☐ Y ☒ N

OneCare

Acronym	Measure	MY 2022 OneCare Rate	MY 2023 OneCare Rate	MY 2024 OneCare Rate	MY 2024 OneCare Goal	MY 2024 Goal Met / Not Met
CBP	Controlling High Blood Pressure (CBP)	67.82%	74.32%	77.26%	80.00%	☐ Y ☒ N

IV. Data Stratification Results and Quantitative Analysis:

Indicator/Goal: The total or aggregate rate or better

Population	LOB	2025 Rate (November)	2024 Rate	Goal
Black and African American	Medi-Cal	35.21%	39.21%	64.48%
2025 Black and African American	Medicare	38.98%	47.24%	77%
Korean Speaking Population	Medi-Cal	19.29%	24.87%	64.48%
Vietnamese-Speaking Population	Medicare	42.76%	50.56%	77%

Rates as of November 2025

While final rates are not yet available, a comparison of preliminary data shows an improvement:

Medi-Cal: 36% in September 2024 to 41% in September 2025

OneCare: 38% in September 2024 to 43% in September 2025

The data indicates a 5-percentage point increase for each line of business (LOB), which suggests we are trending in the right direction.

Although current rates for Black and African American, Korean, and Vietnamese populations are below 2024 levels, it's important to note that the final 2025 data will be captured through December 31. Because this is a hybrid measure, full data capture typically lags due to the nature of claims and encounter reporting. In the first half of the year, outreach efforts focused on community events targeting

these populations; however, attendance was lower than anticipated. As we transitioned to telephonic outreach, we encountered a high rate of unable to contact (UTC) outcomes, which further impacted early performance. Despite these challenges, the remaining weeks of the year present a valuable opportunity to close the gap and continue engagement efforts.

V. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Outreached to non-compliant members for blood pressure screenings at community events; shared results with PCPs. Hosted county-wide BP check-ins and offered virtual/in-person hypertension education	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
2. Standing order program was launched to allow staff to order blood pressure monitors for members with hypertension.	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
3. Training for CalOptima Health staff on BP monitor access	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
4. Health network training on CBP STAR measure and BP monitor access	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
5. In July 2025, interventions shifted from community events to telephonic outreach and virtual classes.	☐ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

VI. Effectiveness of Interventions:

The interventions implemented to improve blood pressure control have demonstrated meaningful progress and infrastructure-building. Outreach to noncompliant members through community events enabled screenings and timely sharing of results with PCPs, while countywide BP check-ins and hybrid hypertension education sessions expanded access to care. A key success was the launch of a standing order program, which enabled over 500 members with hypertension to receive BP monitors, removing a critical barrier to self-management. Additionally, targeted trainings for CalOptima Health staff and health networks on CBP STAR measures and device access helped strengthen systemwide capacity. The mid-year shift to telephonic outreach and virtual classes ensured continuity of engagement.

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
CBP	MC: Controlling High Blood Pressure	35.96%	40.92%
CBP	OC: Controlling High Blood Pressure	38.31%	42.93%

Indicator/Goal: The performance rate from the same month of the previous year

When comparing prospective rates from September 2024 to September 2025, we observed measurable improvements across both lines of business:

OneCare: The performance rate increased from 38.31% in September 2024 to 42.93% in September 2025. Goal: 4 Star, 82%

Medi-Cal: The rate improved from 35.96% to 40.92% over the same period. Goal: 50th Percentile, 67.88%

These gains reflect the effectiveness of our targeted interventions and sustained outreach efforts.

VII. Qualitative Analysis:

The Controlling Blood Pressure initiative has demonstrated strong engagement and adaptability across multiple phases. In the early stages, community-based outreach created meaningful opportunities for face-to-face education and screening, helping to build trust and awareness among members.
In Q1 and Q2, we targeted community events with higher concentrations of African American, Vietnamese and Korean populations, such as Black History Unity Parade, the Vietnamese American Cancer Foundation Community Events and the Korean Community Services Resource Fair. While these events were well attended, participation from CalOptima Health members varied, despite outreach efforts that included text message invitations.

The launch of the standing order program in Q2 further empowered members by providing tools for self-monitoring. Staff identified this as a key driver of increased member confidence and accountability. As a result of the internal BP standing order program, more than 600 members have gained access to a blood pressure monitor as of December 5, 2025.

As the initiative transitioned to telephonic outreach in Q3 and Q4 due to organizational restructuring, health coaches continued to deliver personalized support, reinforcing healthy behaviors and connecting members to their PCPs. This shift also expanded our reach, allowing us to engage members who may not have been able to attend in-person events.

Between Q3 and Q4, 1,900 OneCare members received outreach calls due to non-compliance with CBP measures. These calls aimed to educate members on self-management strategies for blood pressure control and to facilitate connections with their PCPs.

Overall, the initiative has improved access to and awareness of hypertension management while fostering a culture of proactive health engagement.

Causal/Barrier Analysis:

Barrier:

- Despite active outreach efforts by staff, the rate of UTC remains high, limiting the effectiveness of interventions aimed at improving blood pressure control among noncompliant members.

QAC 03.19.2026

Back to Agenda Back to Item

- Outreach to African American, Vietnamese, and Korean communities may have been hindered by a lack of culturally tailored messaging or language support.
- Even when members are referred to PCPs, they may face:
    - Long wait times
    - Lack of insurance clarity
    - Transportation issues
    - Additional barriers related to the political climate (e.g., immigration concerns, fear of system engagement)

Causal Consideration:

- Because this is a hybrid measure, final outcomes are dependent on both administrative data and medical record review. As a result, the full impact of interventions will not be visible until after the measurement period has closed, potentially delaying real-time performance insights.
- CBP outreach was expanded to include Medical Management and Case Management staff, increasing member touchpoints.
- Staff demonstrated adaptability and continued support despite organizational restructuring, helping maintain program continuity.

VIII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
Standardize BP data collection during outreach	Standardize BP data collection during outreach	☐ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L	CBP
Integrate BP monitoring process/access in the care continuum	Provide ongoing refresher training for staff to ensure consistent use of tools and protocols, and to reinforce the importance of timely documentation and follow-up.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L	CBP
High UTC rates	Implement multi-channel outreach (text, calls, mailing)	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L	CBP

MC = Medi-Cal; OC = OneCare

IX. Conclusion:

While the CBP measures did not meet the goal and will remain on the QIHETP work plan for 2026, the data clearly indicate that the Controlling Blood Pressure initiative is yielding positive results. Both the OneCare and Medi-Cal LOB have shown year-over-year improvements in prospective rates, reflecting the effectiveness of our targeted interventions. From community outreach and the standing order program to telephonic coaching and virtual education, each phase of the initiative has contributed to increased

QAC 01.19.2026

Back to Agenda Back to Item

member engagement, improved access to self-monitoring tools and greater awareness of hypertension management. While some barriers — such as high UTC rates and disparities across racial and ethnic groups — remain, the overall trend is one of progress.

4.13 Chronic Conditions: Members with Osteoporosis	
Author(s): Mahmoud Elaraby	Department(s): Medical Management (Case Management)/ Quality Analytics
Responsible Party(ies): Megan Dankmyer (Sr. Director, Medical Management); Kelli Glynn (Director, Quality Initiatives); Sherry Hickman (QI Nurse Specialist, Case Management); Mahmoud Elaraby (Program Manager, Quality Analytics)	
Products: ☐ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: Osteoporosis Management in Women Who Had a Fracture (OMW) OC Total: Increase from 34.67% to 39.00% by 12/31/2025.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

Osteoporosis is the most common bone disease and greatly increases the risk of fractures from minor injuries. While medication can lower the risk of fractures by 30–50%, follow-up care and treatment rates remain low. The Osteoporosis Management in Women Who Had a Fracture (OMW) HEDIS measure tracks whether women ages 67 to 85 with a fracture receive appropriate follow-up care, such as a bone mineral density (BMD) test or prescription for a drug to treat osteoporosis, in the 180 days (six months) after the fracture. Improving OMW performance at CalOptima Health is critical because osteoporotic fractures are associated with pain, disability, loss of independence and increased mortality. Improving this measure supports healthy aging, reduces the risk of repeat fractures and enhances member outcomes.

II. Data Sources and Methodology:

HEDIS OMW performance for MY 2022 to MY 2024 was evaluated using data from CalOptima Health's HEDIS engine, CitiusTech. The measurement period for each year was July 1 of the year prior to the measurement year to June 30 of the measurement year, in accordance with the HEDIS specification.

The denominator includes women aged 67 to 85 years who experienced an eligible fracture and met the continuous enrollment criteria. The numerator includes members who, on the day of the fracture or in the 180 days following, received either:

- A BMD test, in any setting
- A dispensed prescription to treat osteoporosis

Data was extracted and reported by the Quality Analytics team in accordance with NCQA HEDIS technical specifications. The data was analyzed to identify qualifying fractures and numerator-qualifying events. Trend analysis was completed quarterly to evaluate progress toward the annual goal.

III. Quantitative Analysis:

QAC 03.19.2026

OneCare

Acronym	Measure	MY 2022 OneCare Rate	MY 2023 OneCare Rate	MY 2024 OneCare Rate	MY 2024 OneCare Goal	MY 2024 Goal Met / Not Met
OMW	Osteoporosis Management in Women Who Had a Fracture	33.33%	34.67%	43.64%	39.00%	☒ Y ☐ N

For OneCare, the OMW rate improved from 34.67% in MY 2023 to 43.64% in MY 2024, an increase of approximately 9 percentage points. One Care met the organizational goal for MY 2024 of 39.00%. This upward trend demonstrates the positive impact of member outreach, provider notification, and increased coordination with case management and health network partners.

IV. Data Stratification Data Source and Methodology:

Data source: CalOptima Health's HEDIS engine, CitiusTech.

Stratified OMW results were produced by race and ethnicity for the OneCare population using the same HEDIS MY 2024 administrative data set described above. Race/ethnicity values were derived from eligibility and enrollment records and supplemented, where available, by health network data. Only records with a valid race/ethnicity category were included in the stratified analysis; members with missing or unknown race/ethnicity are shown as a separate category.

V. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
Case Management led telephonic outreach to members identified as needing follow-up for OMW.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Quality team performed outreach to noncompliant members via SMS, mail and telephone.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Members were provided with facility listings to improve access to BMD testing.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Sent PCPs notification of noncompliant members to support timely follow-up post fracture.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Case Management completed email outreach to health network partners to identify members requiring follow-up.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☒HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Medical director led provider outreach to increase awareness of OMW requirements and discuss any barriers.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm	☐ Completed ☒ Ongoing

OAC 01.15.2026

Back to Agenda Back to Item

			☐ Data ☐ Other	☐ Incomplete
Case Management flags OMW noncompliance as a member-specific care gap on outbound bundles when a OneCare member declines or cannot be reached for an HRA, providing additional visibility for the health networks.	☐ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
When health networks reported OMW compliance, but CalOptima Health data did not, evidence was requested and shared with the Quality team for care gap closure in CalOptima Health's HEDIS engine.	☐ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
34. Case Management implemented notification for OMW emergency room ER visit through the Key Event notification process.	☐ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

VI. Effectiveness of Interventions:

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
OMW	OC: Osteoporosis Management in Women Who Had a Fracture	20.00%	42.11%

Indicator/Goal: The performance rate from the same month of the previous year

Prospective OMW performance using continuous enrollment data demonstrates the effectiveness of the above interventions. The September 2023 prospective rate of 20.00% increased to 42.11% in September 2024, an improvement of 22.11 percentage points and a more than 100% relative increase at the same point in time. This substantial gain can be attributed to intensified member outreach efforts, expanded provider notifications and enhanced data sharing with health networks.

Overall, the prospective trend supports that:

- Member telephonic and mail/SMS outreach is increasing awareness and completion of follow-up services.
- Provider and health network notifications are enabling earlier and more focused gap closure.
- Ongoing collaboration between the Quality and Case Management teams is helping to address access barriers for members with mobility or transportation challenges.

VII. Qualitative Analysis:

The Case Management team identified barriers, including member disengagement, inaccurate contact information, limited provider familiarity with OMW requirements, and low awareness of osteoporosis medication benefits. These insights support ongoing improvement in communication and provider education.

OAC 05.19.2026

Causal/Barrier Analysis:

The causal and barrier analysis was conducted collaboratively by Quality Analytics, Case Management and health network partners. Quality Analytics led the data review and identified performance trends; Case Management and health network leadership provided operational insights regarding member access, outreach challenges and provider engagement barriers.

- Member contact information: Inaccurate or outdated phone numbers and limited member responsiveness reduce the effectiveness of telephonic outreach.
- Access to BMD testing: Some at-home testing vendors do not meet HEDIS diagnostic criteria, and some members do not have easy access to contracted imaging sites, particularly those with mobility limitations or transportation barriers.
- Knowledge and acceptance of osteoporosis therapy: Members may be unfamiliar with the benefits of osteoporosis medications or may be concerned about side effects, leading to delays in starting treatment even when prescribed.
- PCPs manage multiple chronic conditions and may not always prioritize OMW at the time of fracture follow-up, especially when information about the fracture is delayed.
- Data timeliness: Claims lag can delay the appearance of eligible fractures and completed services in monitoring reports, making it more difficult for health networks to track progress in real time.

VIII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
Improve member reach rate and contact accuracy	Implement expanded contact search to enhance telephonic outreach success	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
Strengthen osteoporosis medication education and initiation	Collaborate with the Pharmacy department to launch a program to educate members, coordinate prescriptions with PCPs, and follow up.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
Increase provider education efforts	Create and distribute provider-facing educational materials.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
Explore at-home bone mineral density testing	Partner with vendors to provide at-home bone mineral density testing to members.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC = OneCare

QAC 03.19.2026

IX. Conclusion:

The OMW data shows a significant improvement over the past two years, with the OneCare rate increasing from 34.67% in MY 2023 to 43.64% in MY 2024. These results reflect the success of coordinated member outreach, provider notifications and improved reporting to health networks. Continued collaboration among the Quality team, Case Management team, Pharmacy team, and health networks will be essential to sustain and further improve performance. Targeted interventions remain necessary to improve equity, member adherence and provider engagement.

4.14 Chronic Conditions: Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	
Author(s): Megan Dankmyer and Sherry Hickman	Department(s): Case Management
Responsible Party(ies): Megan Dankmyer (Sr. Director, Medical Management); Sherry Hickman (QI Nurse Specialist, Case Management)	
Products: ☐ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC) OC Total: Increase from 51.27% to 53.00% by 12/31/2025.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

This measure assesses emergency department (ED) visits for Medicare members aged 18 years and older who have multiple high-risk chronic conditions and who received a follow-up service within seven days of an ED visit.

The importance of this measure relates to Medicare beneficiaries are at particular risk following ED visits because of their functional limitations, audio and visual impairments and use of multiple medications.

II. Data Sources and Methodology:

Data source: Data from Claims, Encounters and Citius platform.

Stratified results were produced by race and ethnicity for the OneCare population using the same HEDIS MY 2024 administrative data set described above. Race/ethnicity values were derived from eligibility and enrollment records and supplemented, where available, by health network data. Only records with a valid race/ethnicity category were included in the stratified analysis; members with missing or unknown race/ethnicity are shown as a separate category.

III. Quantitative Analysis:

OneCare

Acronym	Measure	MY 2022 OneCare Rate	MY 2023 OneCare Rate	MY 2024 OneCare Rate	MY 2024 OneCare Goal	MY 2024 Goal Met / Not Met

Back to Agenda Back to Item

DAC 03.19.26

FMC	Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	47.40%	51.27%	55.62%	53.00%	☒ Y ☐ N

For OneCare, the FMC rate improved from 47.40% in MY 2022 to 51.27% in MY 2023. The organizational goal for MY 2024, 53%, was achieved with the final MY 2024 HEDIS result of 55.62% demonstrating improvement year over year. Quarterly QI work-plan monitoring in 2025 showed higher performance for MY 2025 when compared to the same point in time for MY 2025 in two quarters:

- Quarter Two: 48% in May 2025 versus 40% in May 2024
- Quarter Three: 50% in July 2025 versus 43% in July 2024

Current projections, per Hyperlift based on October Citius data, signal we are on track to achieve the MY 2025 goal of 53%.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
Sharing key event reminders and education for emergency visits with health networks, March 6, 2025, and November 13, 2025	☐ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
Continue to share emergency visits with health networks through key event reporting.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
Case Management implemented notification for FMC ER visit through the key event notification process	☐ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
FMC	OC: Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	45.34%	50.17%

Indicator/Goal: The performance rate from the same month of the previous year

Prospective FMC performance using continuous enrollment data demonstrates the effectiveness of the above interventions. The MY 2024 September prospective rate of 45.34% increased to 50.17% in MY 2025 September. This represents an improvement of 4.83% and aligns with the following interventions:

- Sharing key event reminders and education for emergency visits with health networks.

QIC 03.19.2026

- Ongoing key event reporting that identifies FMC members for prioritization

VI. Qualitative Analysis:

Case Management identified a barrier to provider access within seven days of an ED visit. Based on current projections, per Hyperlift based on October Citius data, we are on track to exceed the goal.

Causal/Barrier Analysis:

Provider access within seven days from ED visit

- Limited visibility to this specific subset of members prevented prioritization. This visibility enhanced in Q4 2025 through specific identification of FMC members on daily key event reporting.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
Education reminder for health networks on FMC visibility on key event reporting.	Remind health networks of enhanced visibility and encourage prioritization of members who qualify for FMC. Provide this education twice in 2026.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ H ☒ M ☐ L
Collaboration with Emergency Department Diversion staff at UCI.	Explore collaboration with Emergency Department Diversion staff at UCI to assist with appointment scheduling for FMC-identified members.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

While we are projected to meet this goal for 2025, the measure is performing below the 75th percentile and will remain on the work plan for 2026. There is overall improvement with this measure, despite barriers. The value of enhanced identification on key event reporting for prioritization of FMC qualifying members will continue to be seen in 2026.

4.15 Behavioral Health Services: Child and Adolescent Health on Antipsychotics	
Author(s): Mary Barranco	Department(s): Behavioral Health Integration
Responsible Party(ies): Diane Ramos (Sr Manager, Behavioral Health Integration); Natalie Zavala (Director, Behavioral Health Integration); Carmen Katsarov (Executive Director, Behavioral Health Integration); Mary Barranco (Program Specialist, Behavioral Health Integration)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) MC Glucose and Cholesterol Combined-All Ages: Increase from 36.76% to 41.41% by December 31, 2025.	

Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

This measure is vital because antipsychotic medications can lead to serious metabolic complications in children and adolescents, such as elevated blood sugar and cholesterol levels, which increase the risk of cardiovascular disease later in life. This measure ensures that healthcare providers consistently monitor these young patients through routine metabolic testing, helping to detect and address issues early on. By standardizing care practices across health plans, APM enhances behavioral health management and safeguards vulnerable youth from long-term cardiometabolic harm, ultimately improving the quality and safety of care.

II. Data Sources and Methodology:

The data is uploaded to Citius by CalOptima Health's Quality Analytics team. Behavioral Health Integration (BHI) retrieves and downloads the data, filtering it to evaluate the measure's needs. Data is drawn from HEDIS results and health care claims. HEDIS rates are used to establish performance trends.

III. Quantitative Analysis:

Despite the outreach efforts, we did not meet the goal of 41.41%. The final rate was 34.58% for Total Blood Glucose and Cholesterol Monitoring. The decline from the previous year is due to timely access to data.

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics	37.41%	36.76%	34.58%	41.41%	☐ Y ☒ N

The performance did not meet the established benchmark of 41.41%. MY 2022 to MY 2025: A gradual decline in performance from 37.41% to 34.58%, indicating a downward trend in compliance or monitoring efforts.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Created a draft to update the prescriber tip tool sheet. 2. Updated the Best Practices Prescriber letter—pending management approval. 3. Created a Quick Reference Guide (QRG) and PowerPoint presentation for providers and staff on how to use the Provider Portal. Pending report availability.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete

Back to Agenda Back to Item

QAC 03.19.2026

4. Created a social media post for this HEDIS measure. 5. Created article for Fall member newsletter.				
1. Prescribing provider letter finalized June 9, 2025. 2. HEDIS provider tool tip sheet finalized June 6, 2025. 3. Social media post, posted on April 14, 2025. 4. Article for the Fall member newsletter approved and going through the MMA process. 5. Text campaign sent out a. April 10, 2025 — 75 texts sent b. May 8, 2025 — 52 texts sent 6. Created a QRG and PowerPoint presentation for providers and staff on how to use the Provider Portal. Pending report availability.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
1. PCP provider mailout: a. July 29, 2025 — 103 letters b. August 28, 2025 — 75 letters 2. Request submitted to add codes to the provider tip tool sheet. 3. Text Campaign sent out: a. June 12, 2025 b. July 10, 2025 c. August 14, 2025 4. HEDIS provider tool tip sheet finalized and sent to providers in the Health Network Weekly Communication on August 11, 2025.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

The prospective rate for APM-E increased slightly from 26.05% in September MY 2024 to 27.06% in September MY 2025, indicating a modest improvement in metabolic monitoring for individuals on antipsychotics. While the increase is positive, the rate remains below typical HEDIS benchmarks.

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
APM-E	MC: Blood Glucose and Cholesterol Testing (Total) — All Ages	26.05%	27.06%

Indicator/Goal: The performance rate from the same month of the previous year

The prospective rate increased by 1.01% from MY 2024 to MY 2025. While there was an increase, the goal was not met.

VI. Qualitative Analysis:

BHI program specialists are responsible for processing the data and implementing targeted interventions.

Causal/Barrier Analysis:

The implementation of a new software system during the measurement year impacted the timeliness and completeness of data capture. This affected:

QAC 03.19.2026

Back to Agenda Back to Item

- Real-time tracking of metabolic monitoring compliance
- Provider visibility into member testing status
- Accuracy of prospective rates, potentially underreporting actual performance

This barrier likely contributed to delayed interventions and missed opportunities for follow-up testing. It may have also limited the effectiveness of outreach efforts by BHI program specialists due to incomplete or lagging data.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
• Improve collaboration with network providers	• Share aggregate performance data with provider groups to highlight trends and encourage alignment with quality goals.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
• Improve provider engagement	• Share provider-level performance reports to increase awareness and accountability. • Offer targeted training on the importance of metabolic monitoring.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
• Enhance member targeting and outreach	• Use stratified data to identify non-compliant members and prioritize outreach based on risk level or historical gaps in care.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

The data indicates a modest year-over-year improvement for the APM-E measure, with the prospective rate increasing from 26.05% in MY 2024 to 27.06% in MY 2025, a 1.01% percentage point gain. While this reflects a positive trend, the goal for the measure was not met and the measure will remain on the work plan for 2026. The program, led by BHI program specialists, has shown some success, with early signs of progress likely impacted by barriers such as limited data availability resulting from the new software implementation. Continued efforts are necessary to enhance member outreach and support internal coordination, thereby accelerating improvement and achieving future performance targets.

4.16 Behavioral Health Services: Depression	
Author(s): Mary Barranco	Department(s): Behavioral Health Integration
Responsible Party(ies): Diane Ramos (Sr Manager, Behavioral Health Integration); Natalie Zavala (Director, Behavioral Health Integration); Carmen Katsarov (Executive Director, Medical Management); Mary Barranco (Program Specialist, Behavioral Health Integration)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: Antidepressant Medication Management (AMM) MC Acute Phase - 63.35% Increase from 68.06% to 68.35% by December 31, 2025. MC Continuation Phase - Increase from 48.06% to 48.16% by December 31, 2025.	

OC Acute Phase - 63.35% Increase from 75.52% to 78.39% by December 31, 2025. OC Continuation Phase - Increase from 60.77% to 62.58% by December 31, 2025. Depression Screening and Follow-up for Adolescents and Adults (DSF-E) MC Screening Total: Increase from 6.57% to 16.22% by December 31, 2025. OC Screening Total: Maintain the 90th percentile (54.28%) or higher by December 31, 2025.
Goal Met: ☐ Yes ☒ No ☐ Partial | Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

AMM assesses the percentage of members aged 18 years and older with a diagnosis of major depression who were newly treated with antidepressant medication and remain on the medication for an effective duration during the measurement year.

DSF-E assesses the percentage of members aged 12 years and older who were screened for depression using a standardized tool during the measurement year.

II. Data Sources and Methodology:

The data is uploaded to Citius by CalOptima Health's Quality Analytics team. BHI retrieves and downloads the data, filtering it to evaluate the measure's needs. Data is drawn from HEDIS results and healthcare claims. HEDIS rates are used to establish performance trends.

III. Quantitative Analysis:

AMM — The final rate for effective acute phase treatment was 68.35%, exceeding the goal of 67.21%. The final rate for effective continuation phase treatment was 48.16%, which fell short of the goal of 50.64%. Year-over-year changes were minimal, indicating stable performance in the acute phase but ongoing challenges in maintaining adherence during the continuation phase. It is important to note that, effective in MY 2024, NCQA retired the AMM measure due to its limited alignment with current clinical practices and overlap with other behavioral health measures that better reflect integrated, patient-centered care.

DSF-E— The MC final rate was 8.65% and did not meet the goal of 16.22%. The OC final rate was 78.09%, which exceeded the goal of 54.28%. The increase from year to year may be due to an increased ability to capture supplemental data that reflects completed screening scores.

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
AMM	Antidepressant Medication Management — Effective Acute Phase Treatment	67.00%	68.08%	67.21%	68.35%	☐ Y ☒ N
AMM	Antidepressant Medication Management — Effective Continuation Phase Treatment	48.62%	48.06%	50.64%	48.16%	☒ Y ☐ N

OAC 03.19.2026

DSF-E	Depression Screening and Follow-up for Adolescents and Adults — Depression Screening (Total)	1.98%	6.57%	8.65%	16.22%	☐ Y ☒ N

AMM — Antidepressant Medication Management (Acute Phase Treatment)

The performance did not meet the goal of 68.35%. In MY 2024, the rate was 67.21%, remaining just below target. Between MY 2022 to MY 2024 the rate fluctuated slightly, from 67.00% to 68.08%, then declined to 67.21%, indicating a need for renewed focus on early-phase medication adherence.

AMM – Antidepressant Medication Management (Continuation Phase Treatment)

The performance met and exceeded the goal of 48.16%, reaching 50.64% in MY 2024. From MY 2022 to MY 2024, after a slight dip from 48.62% to 48.06%, the measure improved to 50.64%, showing a positive upward trend suggesting that interventions to support long-term medication adherence have been effective.

DSF-E – Depression Screening and Follow-Up (Depression Screening Total)

The performance did not meet the goal of 16.22%. In MY 2024, the rate was 8.65%, remaining below target. From MY 2022 to MY 2024, the measure improved from 1.98% to 6.57%, and then to 8.65%, reflecting a steady upward trend. While the goal was not met, the data indicates growing adoption of depression screening practices, and continued progress is expected with sustained efforts.

OneCare

Acronym	Measure	MY 2022 OneCare Rate	MY 2023 OneCare Rate	MY 2024 OneCare Rate	MY 2024 OneCare Goal	MY 2024 Goal Met / Not Met
AMM	Antidepressant Medication Management – Effective Acute Phase Treatment	75.51%	75.52%	73.71%	78.39%	☐ Y ☒ N
AMM	Antidepressant Medication Management – Effective Continuation Phase Treatment	55.10%	60.77%	58.22%	62.58%	☐ Y ☒ N
DSF-E	Depression Screening and Follow-up for Adolescents and Adults – Depression Screening (Total)	0.04%	62.38%	78.09%	54.28%	☒ Y ☐ N

AMM – Antidepressant Medication Management (Acute Phase Treatment)

The performance did not meet the goal of 78.39%. In MY 2024, the rate declined to 73.71%, remaining below target. From MY 2022 to MY 2024, performance remained stable between 75.51% and 75.52%, but dropped in MY 2024 to 73.71%, indicating a downward trend.

AMM – Antidepressant Medication Management (Continuation Phase Treatment)

The performance did not meet the goal of 62.58%. In MY 2024, the rate was 58.22%, just short of the goal. From MY 2022 to MY 2024, the measure improved from 55.10% to 60.77% in MY 2023, but declined to 58.22% in MY 2024, reflecting a partial regression.

DSF-E – Depression Screening and Follow-Up (Depression Screening Total)

The performance met and exceeded the goal of 54.28%, achieving a rate of 78.09% in MY 2024. From MY 2022 to MY 2024 the measure showed a large, sustained increase, rising from 0.04% in MY 2022 to 62.38% in MY 2023, and further to 78.09% in MY 2024. This reflects a highly successful upward trend, indicating strong and effective adoption of depression screening practices across the OneCare population.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
1. Created a draft to update the prescriber tip tool sheet 2. Updated prescriber letter 3. Created a QRG and PowerPoint presentation for providers and staff on how to use the Provider Portal 4. Created a social media post for this HEDIS measure 5. Created article for Fall member newsletter	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	AMM
1. HEDIS provider tool tip sheet finalized June 6, 2025 2. Prescribing provider letter finalized June 9, 2025 3. Created social media posts	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	DSF-E
1. Provider letter: a. Presented provider letter to Behavioral Health Quality Improvement (BHQI) Workgroup on August 14, 2025 b. BHQI finalized on August 26, 2025 2. PCP provider mailout: a. August 28, 2025 - 595 letters. 3. HEDIS Provider Tool Tip Sheet Finalized and sent to providers in the Health Network Weekly Communication on August 11, 2025.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	DSF-E

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

AMM: NCQA retired the measure, and it was removed from the QI workplan in Q2.

DSF-E: For the Medi-Cal population, the rate increased significantly from 0.02% in September MY 2024 to 3.94% in September MY 2025, indicating that recent interventions are beginning to take effect. Although the rate remains low, the relative increase reflects positive momentum.

For the OneCare population, no data was reported in MY 2024, but a prospective rate of 4.56% was captured in MY 2025, suggesting that screening efforts are now being tracked. While the goal/MPL targets were not specified, the data suggests that the program is moving in the right direction, and continued

QAC 03.19.26

focus on provider engagement, data capture, and member outreach will be essential to sustain and build on this progress

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
DSF-E	MC: Depression Screening:12 years and older (Total)	0.02%	3.94%
DSF-E	OC: Depression Screening:12 years and older (Total)	N/A	4.56%

Indicator/Goal: The performance rate from the same month of the previous year

Q2 Intervention – Data and Provider Focused (Completed)

- HEDIS Provider Tool Tip Sheet finalized on June 6, 2025
- Prescribing Provider Letter finalized on June 9, 2025

Effectiveness: These Q2 interventions were foundational tools that may have laid the groundwork for the Q3 gains.

Member and Provider Engagement (Completed)

Social media posts were created and targeted both members and providers.

Effectiveness: While difficult to quantify directly, this outreach likely supported broader awareness and engagement, reinforcing the importance of depression screening among both audiences.

Q3 Intervention – Direct Provider Outreach (Ongoing)

- Provider letter presented to BHQI Workgroup on August 14, 2025, and finalized on August 26, 2025
- PCP mailout: 595 letters sent on August 28, 2025
- HEDIS Provider Tool Tip Sheet included in Network Weekly Communication on August 11, 2025.

Effectiveness: These Q3 interventions align closely with the observed increase in the September MY 2025 rate. The timing suggests that direct provider communication and education had an impact on screening behavior and documentation.

VI. Qualitative Analysis:

BHI program specialists are responsible for processing the data and implementing targeted interventions.

OAC 08.19.2026

Causal/Barrier Analysis:

- Data collection remains the primary barrier. Currently, information is being captured through supplemental data sources. The BHQI Workgroup is exploring additional methods to obtain supplemental data that more accurately reflects completed screenings and follow-up visits.
- Additional provider engagement strategies may be needed to increase awareness among both providers and members, such as implementing a member text messaging campaign.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
Sustain and expand provider education	• Continue distributing HEDIS Tool Tip Sheets, ensuring they are accessible through provider portals and our website • Offer virtual training or review DSF-E requirements and documentation tips • Collaborate on office visits with Provider Relations for provider outreach and education	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	DSF-E
Increase member awareness and engagement	• Targeted social media campaign to members who may need a depression screening • Partner with community-based organizations to amplify the importance of depression screenings	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ H ☒ M ☐ L	DSF-E

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

The data indicates we are making measurable progress in improving depression screening rates among the Medi-Cal population. The prospective rate for DSF-E increased significantly from 0.02% in September MY 2024 to 3.94% in September MY 2025, reflecting a positive response to recent interventions. The upward trend suggests we are gaining traction. Interventions such as provider tool tip sheets, targeted mailouts and social media outreach appear to be contributing to increased awareness and documentation. Although the overall goal has not yet been met and the measure will remain on the work plan for 202, the data shows that the initiative is moving in the right direction. Continued focus on provider engagement, data capture and member outreach will be essential to sustain this momentum and achieve future performance targets.

4.17 Behavioral Health Services: Schizophrenia	
Author(s): Nathalie Pauli	Department(s): Behavioral Health Integration
Responsible Party(ies): Diane Ramos (Sr Manager, Behavioral Health Integration); Natalie Zavala (Director, Behavioral Health Integration); Carmen Katsarov (Executive Director, Medical Management); Nathalie Pauli (Program Specialist, Behavioral Health Integration)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No

QAC 03.19.26

Workplan Goal/Objective: Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) MC SSD: Increase from 74.96% to 79.51% by 12/31/2025. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) MC: Increase from 70.19% to 74.83% by 12/31/2025. OC: Increase from 77.37% to 77.93% by 12/31/2025.	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

CalOptima Health's program assesses the percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. Members with severe mental illness who use antipsychotics are at increased risk of diabetes. In the United States, diabetes is one of the leading causes of death. Lack of care for individuals with diabetes who use antipsychotic medications can lead to deteriorating health and death. Screening and monitoring these conditions are important.

CalOptima Health's program monitors the percentage of members aged 18 and older within the measurement year who have been diagnosed with schizophrenia or schizoaffective disorder and who received antipsychotic medication consistently. Consistently defined as having the medication for at least 80% of their treatment period. This measure aims to support treatment adherence and improve health outcomes for individuals with serious mental illness. Up to 60% of individuals with schizophrenia do not consistently take their antipsychotic medication, which is essential for managing symptoms and avoiding hospitalization. Poor adherence can lead prescribers to misinterpret treatment effectiveness, resulting in unnecessary changes to medication or dosage

II. Data Sources and Methodology:

Diabetes Screening (SSD – MC)

CalOptima Health promotes diabetes screening for early detection and management for members who take antipsychotic medication and are diagnosed with schizophrenia, schizoaffective disorder or bipolar disorder. Antipsychotic medications raise the risk of developing diabetes. This measure focuses on the percentage of members aged 18-64 who fall under the SSD criteria and complete a diabetes screening during MY 2025 (January 1, 2025, to December 31, 2025). Data is drawn from HEDIS results and health care and pharmacy claims.

Antipsychotic Medication Adherence (SAA – MC and OC)

CalOptima Health encourages members aged 18 and older diagnosed with schizophrenia or schizoaffective disorder and who receive antipsychotic medication to remain on their medication for at least 80% of their treatment period. Poor adherence may cause prescribers to mistakenly adjust medication or dosage. This measure tracks the percentage of members aged 18 and older who adhered

OAC 03.19.2026

to their medication during MY 2025 (January 1, 2025, to December 31, 2025). HEDIS rates are used to identify performance trends and are reported based on data collected during the measurement period.

III. Quantitative Analysis:

The Medi-Cal performance data for MY 2022 through MY 2024 highlights mixed trends across two key behavioral health quality measures: Diabetes Screening for Individuals with Schizophrenia or Bipolar Disorder (SSD) and Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA).

Diabetes Screening (SSD – MC)

The SSD measure showed a positive trajectory in MY2024, increasing from 74.69% in MY 2023 to 76.86%, surpassing its MY 2022 level of 75.97%. This improvement reflects progress in preventive care for individuals prescribed antipsychotic medications. However, despite the upward trend, the measure did not meet the MY 2024 goal of 79.51%, falling short by 2.65 percentage points. Continued efforts are necessary to close this gap, particularly in care coordination and outreach for screening.

Antipsychotic Medication Adherence (SAA – MC)

In contrast, the SAA measure has experienced a steady decline over the three-year period. From 72.27% in MY 2022, the rate dropped to 70.19% in MY 2023 and further to 69.86% in MY 2024. This downward trend resulted in a 4.97 percentage point shortfall from the MY 2024 goal of 74.83%. The consistent decline suggests persistent challenges in medication adherence, possibly related to access, engagement or continuity of care.

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	75.97%	74.96%	76.86%	79.51%	☐ Y ☒ N
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	71.27%	70.19%	69.86%	74.83%	☐ Y ☒ N

OneCare

Acronym	Measure	MY 2022 OneCare Rate	MY 2023 OneCare Rate	MY 2024 OneCare Rate	MY 2024 OneCare Goal	MY 2024 Goal Met / Not Met
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	79.63%	77.37%	79.47%	77.93%	☒ Y ☐ N

Antipsychotic Medication Adherence (SAA – OC)

The OneCare program's performance on the SAA measure, which evaluates adherence to antipsychotic medications for individuals with schizophrenia, has remained consistently strong over a three-year period, with a notable rebound in MY 2024.

The MY 2024 performance not only reversed the previous year's decline but also exceeded the OneCare goal by 1.54 percentage points, representing a 1.98% relative improvement over the target.

The data reflects high-quality performance and resilience, positioning OneCare as a leader in behavioral health outcomes for individuals with schizophrenia.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
• Best Practice PCP Letter approved on August 6 • Launched a mailing campaign to PCPs, featuring the SSD Best Practice PCP Letter, Tool Tip Sheet and Member Reward Flyer on: o August 6 to 162 PCPs o October 30 to 117 PCPs o November 21 to 109 PCPs • Mailed SSD reward flyer on o August 6 to 2,391 members o October 30 to 90 members o November 21 to one member • Text messaging campaign launched to 1,100 members on July 17, August 21 • Social media reminder about no-cost diabetic screenings posted July 15 • Spring member newsletter mailed on April 22, 2025; article on notice of SSD member health reward of $25 • Fall member newsletter mailed on September 15, 2025; article on important reminders for members prescribed psychotropic medicine, notice of the SSD member health reward of $25	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	SSD
• Best Practice PCP Letter approved on September 8 • Launched a mailing campaign featuring the SAA Provider Letter and Tool Tip Sheet on: o September 8 to 114 PCPs o October 30 to 257 PCP's for both Medi-Cal and Medicare o November 21 to 170 PCP's for both Medi-Cal and Medicare • Fall member newsletter mailed on September 15, 2025; article on important reminders for members prescribed psychotropic medicines	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	SAA

MC = Medi-Cal; OC= OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

The year-over-year improvements in prospective rates for key behavioral health measures suggest that recent interventions are beginning to yield measurable results.

QRC 03.19.26

The SSD measure for the Medi-Cal population also showed improvement, rising from 68.67% to 69.50%. While the 0.83 percentage point increase may appear modest, it reflects consistent upward movement in diabetes screening rates for individuals with serious mental illness, a population that often faces barriers to preventive care. This suggests that interventions aimed at integrating behavioral and physical health services, or improving provider follow-up, are contributing to better screening compliance.

In contrast, the SAA measure for the Medi-Cal population saw only a 0.24 percentage point increase, from 39.55% to 39.79%. This minimal change highlights a continued opportunity for improvement. It may indicate that current interventions are not sufficiently addressing the unique challenges faced by this group, such as medication side effects, stigma or fragmented care systems. Additional strategies, such as peer support, case management or digital adherence tools, may be necessary to drive more meaningful progress.

The most notable improvement was observed in the SAA measure for the OneCare population, where adherence to antipsychotic medications increased from 40.54% in MY 2024 to 46.41% in MY 2025, a 5.87 percentage point gain, representing a 14.49% relative increase.

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
SSD	MC: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	68.67%	69.50%
SAA	MC: Adherence to Antipsychotic Medications for Individuals with Schizophrenia	39.55%	39.79%
SAA	OC: Adherence to Antipsychotic Medications for Individuals with Schizophrenia	40.54%	46.41%

Indicator/Goal: The performance rate from the same month of the previous year

VI. Qualitative Analysis:

The BHQI Workgroup is a multidisciplinary team responsible for overseeing the evaluation and improvement of behavioral health performance measures. This group plays a central role in conducting both qualitative and quantitative analyses, as well as identifying barriers that impact the achievement of quality goals. A qualitative analysis was conducted by BHI program specialists in collaboration with clinical leadership, executive management and data analysts. This team is collectively responsible for identifying barriers to achieving performance goals.

Causal/Barrier Analysis:

SSD

- No data for quarters 1 and 2 from the ITS Data Warehouse team.
- Member compliance is a challenge with this population due to:
    - Some members with this diagnosis may not see their PCP regularly

- Some members may refuse to get their lab work completed
- Inability to conduct prescribing provider outreach due to missing data

SAA

- Due to a lack of data from the county, we are unable to track and trend accurate analysis for this measure
- Inability to conduct prescribing provider outreach due to missing data.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
• Use the provider portal to communicate follow-up best practices and guidelines for follow-up visits • Mail out member health rewards flyers to eligible members • Mail out all prescribing providers with the following: o Medical Director Letter o List of members/patients in need of screening o Provider Tool Tip Sheet	• Continue to track members in need of a glucose screening test • Use the provider portal to communicate follow-up best practices and guidelines for follow-up visits • Continue to follow up on data pull for text messaging campaign • Mail out member health rewards flyers to eligible members • Continue to mail out to all PCP offices the following: o Best Practice PCP Letter o Provider Tool Tip Sheet o Member Reward Flyer • Schedule listening sessions with providers to educate/train on how to obtain BH data. Pending report availability.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ H ☐ M ☐ L	SSD
• Use the provider portal to communicate follow-up best practices and guidelines for follow-up visits • Mail out all prescribing providers with the following: o Medical Director Letter o List of members/patients in need of screening o Provider Tool Tip Sheet	• Use the provider portal to communicate follow-up best practices and guidelines for follow-up visits • Mail out all prescribing providers with the following: o Medical Director Letter o List of members/patients in need of screening o Provider Tool Tip Sheet • Schedule listening sessions with providers to educate/train on how to obtain BH data. Pending report availability	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ H ☐ M ☐ L	SAA

CAC 09.19.26

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

The prospective rates for MY 2025 show modest but positive trends across all three measures. The SSD MC measure, which tracks diabetes screening for individuals with schizophrenia or bipolar disorder on antipsychotic medications, increased slightly from 68.67% to 69.50%, indicating continued progress in preventive care. While we have seen improvements, the SSD measure will remain on the work plan for 2026. The SAA MC measure, reflecting adherence to antipsychotic medications, also saw a marginal improvement from 39.55% to 39.79%, suggesting stability in medication management efforts. Notably, the SAA OC measure demonstrated a more substantial increase from 40.54% to 46.41%, highlighting a significant improvement in adherence outcomes. These trends suggest that targeted interventions and sustained efforts may be contributing to better health outcomes for individuals with serious mental illness.

4.18 Behavioral Health Services: Care Coordination and Follow-up Care	
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Responsible Party(ies): Diane Ramos (Sr Manager, Behavioral Health Integration); Natalie Zavala (Director, Behavioral Health Integration); Carmen Katsarov (Executive Director, Medical Management); Jeni Diaz (Program Specialist Sr, Behavioral Health Integration); Valerie Venegas (Program Specialist, Behavioral Health Integration)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Follow-Up After Emergency Department Visit for Mental Illness (FUM) MC 30-Day: Increase from 35.76% to 53.82% by 12/31/2025. MC 7-day: Increase from 21.38% to 33.01% by 12/31/2025. Follow-Up After Emergency Department Visit for Substance Use (FUA) MC 30-Day: Increase from 21.12% to 36.18% by 12/31/2025. MC 7-Day: Increase from 11.23% to 18.76% by 12/31/2025. Follow-up After High-Intensity Care for Substance Use Disorder (FUI) MC 30-Day: Increase from 20.25% to 44.53% by 12/31/2025. MC 7-Day: Increase from 7.99% to 26.90% by 12/31/2025.	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

For the Follow-Up After Emergency Department Visit for Mental Illness (FUM) measure, CalOptima Health's QIHETP monitors the proportion of ED visits among members aged 6 years and older who present with a principal diagnosis of mental illness or intentional self-harm, and who subsequently receive follow-up care for mental health conditions. The program reports on two specific performance measures:

1. The percentage of ED visits followed by a mental health follow-up within seven days.
2. The percentage of ED visits followed by a mental health follow-up within 30 days

The Follow-Up After Emergency Department Visit for Substance Use (FUA) measure is the percentage of ED visits among members aged 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. Two rates are reported:

1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
2. The percentage of ED visits for which the members received follow-up within seven days of the ED visit (eight total days).

The reason why CalOptima Health focuses on the FUA measure is that many individuals with SUD face barriers to care (e.g., stigma, lack of access, housing instability). Proactive follow-up helps address these disparities by ensuring equitable access to treatment and support.

The Follow-Up After High-Intensity Care for Substance Use Disorder (FUI) measure is the percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. Two rates are reported:

1. The percentage of visits or discharges for which the members received follow-up for substance use disorder within the 30 days after the visit or discharge.
2. The percentage of visits or discharges for which the members received follow-up for substance use disorder within the seven days after the visit or discharge.

Focusing on the FUI measure helps CalOptima Health ensure that treatment for SUD is not just a one-time event, but part of a comprehensive, ongoing recovery process. It is about saving lives, improving health outcomes and building a more responsive and equitable healthcare system.

II. Data Sources and Methodology:

The data used for this analysis is derived from HEDIS for MY 2025 (January 1, 2025, through December 31, 2025). Data is collected through administrative claims and encounter records submitted by providers and facilities. CalOptima Health utilizes Citius as its HEDIS engine to extract, process and validate data in alignment with HEDIS technical specifications, ensuring accuracy and consistency in reporting.

For the purposes of this analysis, data is reported and trended on a quarterly basis to monitor performance over time and identify opportunities for improvement. The HEDIS methodology, including measure definitions, eligible population criteria and follow-up timeframes, is applied to assess compliance with follow-up care after ED visits.

III. Quantitative Analysis:

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met

Back to Agenda Back to Item

QAC 03.19.2026

FUM	Follow-Up After Emergency Department Visit for Mental Illness – 30 days (Total)	58.83%	35.73%	52.33%	53.82%	☐Y ☒ N
FUM	Follow-Up After Emergency Department Visit for Mental Illness – 7 days (Total)	38.78%	21.38%	32.96%	33.01%	☐Y ☒ N
FUA	Follow-Up After Emergency Department Visit for Substance Use – 30 days (Total)	24.05%	21.41%	28.63%	36.18%	☐Y ☒ N
FUA	Follow-Up After Emergency Department Visit for Substance Use - 7 days (Total)	12.98%	11.23%	16.81%	18.76%	☐Y ☒ N
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder – 30 days (Total)	22.33%	20.25%	30.69%	44.53%	☐Y ☒ N
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder – 7 days (Total)	8.07%	7.99%	13.65%	26.90%	☐Y ☒ N

In MY 2024, performance on the FUA measures demonstrated a notable increase following a decline in MY 2023. Both the seven-day and 30-day follow-up rates improved year-over-year, reflecting renewed efforts to re-engage members in timely SUD treatment following emergency care. The FUA-30 Day rate increased from 21.41% in MY 2023 to 28.63% in MY 2024, a 7.22 percentage point improvement, and a 4.58 percentage point gain over the MY 2022 rate. Similarly, the FUA seven-day rate rose from 11.23% to 16.81%, marking a 5.58-percentage point increase from the prior year and a 3.83-percentage point improvement over MY 2022. Despite this positive trajectory, neither measure met the MY 2024 Medi-Cal performance goals. The 30-day follow-up rate fell short of the 36.18% target by 7.55 percentage points, while the seven-day rate was 1.95 percentage points below the 18.76% goal. These gaps highlight the continued need for system-level improvements in post-ED care coordination and access to timely SUD treatment services.

In MY 2024, performance on the FUI measures showed modest improvement, but both the seven-day and 30-day follow-up rates remain below Medi-Cal performance goals. The FUI 30-day follow-up rate increased from 20.25% in MY 2023 to 30.69% in MY 2024, representing a 10.44 percentage point improvement and an 8.36 percentage point gain over the MY 2022 rate of 22.33%. This upward trend suggests that efforts to improve care transitions following inpatient or residential SUD treatment are beginning to take effect. Similarly, the FUI seven-day rate rose from 7.99% in MY 2023 to 13.65% in MY 2024, a 5.66 percentage point increase year-over-year and a 5.58 percentage point improvement from MY 2022. While this growth is encouraging, the measure remains below the MY 2024 Medi-Cal goal of 26.90%, with a gap of 13.25 percentage points. The 30-day measure also falls short of its 44.53% goal, with a 13.84-percentage point gap.

Between MY 2023 and MY 2024, there was a significant improvement in both the seven-day and 30-day FUM measures. The 30-day follow-up rate increased from 35.76% to 52.33%, achieving 97.2% of the MY 2024 goal of 53.82%. Similarly, the seven-day follow-up rate rose from 21.38% to 32.96%, reaching 99.8% of the MY 2024 goal of 33.01%. These substantial year-over-year gains suggest that recent interventions have been highly effective. While both measures are just shy of their respective goals, the minimal gaps

Back to Agenda Back to Item

indicate that with continued focus and targeted efforts, full attainment of the goals is within reach. Sustaining these improvements and identifying the key drivers behind this progress will be essential for long-term success.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
1. Participation in DHCS/HCA BH collaboration project which is focusing on improving the rates for FUA/FUM measures	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	FUA/FUM
2. Member outreach via BH telehealth vendor to assist with scheduling follow-up appointments. Outreach based on daily ED data feed	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	FUA/FUM
3. Weekly text message campaign to remind members who have visited the ER to contact their providers to schedule a follow-up appointment	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	FUA/FUM
4. Sharing FUA/FUM data with HNs via sFTP	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	FUA/FUM
5. BHI Quality team attended HN Quality Meetings to educate and remind HNs on the importance of ED follow-up.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	FUA/FUM
6. Importance of follow-up visit after ED articles shared in Spring and Fall member newsletter	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☐ Completed ☐ Ongoing ☐ Incomplete	FUA/FUM
7. Emailed the HEDIS Provider Tool Tip Sheet to providers in the HN Weekly Communication	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	FUA/FUM/FUI

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

Throughout the measurement year, a multipronged strategy was implemented to improve performance on FUA and FUM measures. These interventions targeted both members and providers, leveraging data-driven outreach, collaborative partnerships and educational efforts.

1. Member-Focused Interventions

Several initiatives were designed to directly engage members and encourage timely follow-up after ED visits:

Back to Agenda Back to Item

- Telehealth outreach: A behavioral health telehealth vendor conducted proactive outreach based on daily ED data feeds. This real-time approach enabled the timely scheduling of follow-up appointments, reducing barriers to care.
- Text message campaigns: Weekly text reminders were sent to members who had recently visited the ED, prompting them to contact their providers.
- Newsletter articles: Educational content was included in both Spring and Fall member newsletters, emphasizing the importance of follow-up visits after ED discharges. This helped raise awareness and normalize follow-up care as part of the recovery process.

These member-focused strategies have shown positive engagement trends and improved member awareness of the importance of follow-up care.

2. Provider and Health Network Engagement

To support provider compliance and reinforce the importance of timely follow-up, several interventions were implemented:

- HEDIS Tip Sheet Distribution: Providers received a targeted tip sheet via the Health Network Weekly Communication. This resource offered actionable guidance on improving FUA/FUM/FUI performance, indicating successful dissemination.
- Participation in HN Quality Meetings: The BHI Quality team actively participated in HN quality meetings to educate and remind HNs of the importance of ED follow-up. These sessions fostered collaboration and accountability.
- Data Sharing via sFTP: FUA/FUM data was shared regularly with HNs, enabling them to identify gaps and take corrective action. This transparency has supported data-driven decision-making and performance monitoring.

These provider-facing efforts have contributed to greater alignment across the care continuum, with improved provider awareness and responsiveness to follow-up care requirements.

3. Collaborative Partnerships

The organization's participation in the DHCS/HCA Behavioral Health collaboration project has been instrumental in aligning local and state-level efforts to improve behavioral health outcomes. This collaboration has facilitated shared learning, the dissemination of best practices and system-level improvements.

The combination of real-time data use, member engagement, provider education and interagency collaboration has created a robust framework for improving FUA and FUM performance. While most interventions are ongoing, early indicators suggest increased follow-up rates, enhanced provider engagement and greater member awareness. Continued monitoring and refinement of these strategies will be essential to sustaining and building on these gains.

QAC 03.19.2026

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
FUM	MC: Follow-Up After Emergency Department Visit for Mental Illness – 30 Days (Total)	26.98%	39.23%
FUM	MC: Follow-Up After Emergency Department Visit for Mental Illness – 7 Days (Total)	14.76%	23.25%
FUA	MC: Follow-Up After Emergency Department Visit for Substance Use – 30 Days (Total)	21.12%	25.87%
FUA	MC: Follow-Up After Emergency Department Visit for Substance Use – 7 Days (Total)	11.33%	13.94%
FUI	MC: Follow-Up After High-Intensity Care for Substance Use Disorder – 30 Days (Total)	N/A	25.97%
FUI	MC: Follow-Up After High-Intensity Care for Substance Use Disorder – 7 Days (Total)	11.40%	8.76%

Indicator/Goal: The performance rate from the same month of the previous year

A review of the September prospective rates for MY 2024 and MY 2025 reveals notable improvements in follow-up care after ED visits for behavioral health conditions. The data reflects the impact of targeted interventions implemented across member outreach, provider engagement, and data sharing strategies.

The most significant gains were observed in the FUM measure:

- 30-day follow-up improved from 26.98% to 39.23%, an absolute increase of 12.25 percentage points.
- Seven-day follow-up rose from 14.76% to 23.25%, an 8.49-percentage point increase.

These results suggest that interventions such as telehealth outreach, text message reminders and provider education have been highly effective in promoting timely follow-up care for mental health.

FUA measures also demonstrated positive momentum:

- 30-day follow-up increased from 21.12% to 25.87%, a 4.75-percentage point gain.
- Seven-day follow-up rose from 11.33% to 13.94%, a 2.61 percentage point increase.

While the gains are more modest compared to FUM, the upward trend indicates that member-facing interventions and data-driven outreach are contributing to improved substance use follow-up rates.

The FUI measure presented mixed results:

- The 30-day follow-up rate was newly reported in MY 2025 at 25.97%, establishing a strong baseline.

OAC 03.19.2026

- However, the seven-day follow-up rate declined from 11.40% to 8.76%, a 2.64 percentage point drop.

This decline highlights a potential gap in early engagement following high-intensity care for SUD. It suggests a need for targeted intervention refinement, such as earlier outreach, improved discharge planning or enhanced provider coordination.

The data demonstrates that the implemented interventions are driving measurable improvements, particularly in mental health follow-up (FUM). Continued focus on real-time data use, member engagement and provider alignment will be essential to improve the rate and address areas of concern, especially the early follow-up for high-intensity substance use care (FUI seven-day).

VI. Qualitative Analysis:

The analysis of the 2025 interventions was conducted by the BHI Quality Team. This team is responsible for monitoring performance trends, assessing the effectiveness of implemented strategies and identifying barriers to achieving targeted rates. Findings from the analysis are shared with the BHQI Workgroup, a multidisciplinary workgroup that includes the BHI medical director, executive director, director, managers from Quality and Programs, Behavioral Health Utilization Management and Call Center Operations. Leadership from GARS, Quality Improvement, Quality Analytics, Provider Relations, and Equity and Community Health, internal medical directors, and representatives from other member-facing and provider-facing departments. regularly participate in promoting cross-functional collaboration and ensuring alignment of behavioral health quality initiatives.

Causal/Barrier Analysis:

In 2025, while the overall FUM and FUA rates showed significant improvement, ongoing challenges were identified through qualitative feedback and data review. Barriers included:

- Member disengagement or difficulty reaching members post-ED visit due to inaccurate contact information
- Data lags or inconsistencies in ED encounter reporting
- Variability in health network engagement regarding post-ED member outreach
- Technology limitations in provider access to real-time FUA/FUM data (addressed by the development of daily reports for the Provider Portal)

The BHI Quality team remains responsible for tracking these barriers, engaging stakeholders in solution development and adjusting strategies as needed to sustain and further improve FUM and FUA performance.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

OAC 03.19.2026

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
Ensure that all data exchanges continue to follow the established processes between CalOptima Health and HCA	Continue participation in the IHI Collaborative through August 2026 to support ongoing quality improvement efforts	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	FUM/FUA
Use stratified data (e.g., by diagnosis, age, geography) to identify high-risk members and tailor outreach efforts	Use of decision point insights to obtain stratified data.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	FUM/FUA

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

Overall, the analysis supports the conclusion that the interventions implemented have created a strong foundation for sustained improvement in behavioral health follow-up care. By centering the member experience, engaging providers, and fostering system-level collaboration, CalOptima Health is well-positioned to continue driving progress on FUA and FUM measures. However, opportunities remain, particularly in addressing the decline in FUI seven-day follow-up rates. This suggests a need to revisit early engagement strategies for members discharged from high-intensity substance use care, possibly through enhanced discharge planning or more immediate outreach. All measures (FUM, FUA and FUI) will remain on the work plan for 2026.

4.19 Behavioral Health Services: Medication Management	
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Responsible Party(ies): Diane Ramos (Sr Manager, Behavioral Health Integration); Natalie Zavala (Director, Behavioral Health Integration); Carmen Katsarov (Executive Director, Medical Management); Jaylene Ramirez (Program Specialist, Behavioral Health Integration); Valerie Venegas (Program Specialist, Behavioral Health Integration)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) MC Total: Increase from 28.95% to 54.55% by 12/31/2025. Pharmacotherapy for Opioid Use Disorder (POD) MC Total: 21.36% Increase from 7.79% to 21.36% by 12/31/2025.	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP): While antipsychotic medications are effective for a specific subset of psychotic disorders affecting children and adolescents, their use frequently extends beyond these indications to include nonpsychotic conditions. For these latter conditions, psychosocial interventions are typically recommended as the first-line treatment. CalOptima Health assesses the rate of children receiving psychosocial care prior to being prescribed an antipsychotic medication.

Back to Agenda Back to Item

Pharmacotherapy for Opioid Use Disorder (POD): The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event. Focusing on the POD measure is essential because treatment retention is directly linked to improved health outcomes. Research consistently shows that individuals who remain on medications such as buprenorphine, methadone or extended-release naltrexone for six months or longer experience significantly lower rates of relapse, overdose and mortality. The 180-day benchmark is not arbitrary; it represents a meaningful threshold for treatment stability and long-term recovery. This measure also provides insight into the effectiveness of care coordination and access to services. Low performance may signal barriers such as limited provider availability, stigma, transportation challenges or gaps in follow-up care. By identifying and addressing these issues, health plans and providers can improve continuity, reduce avoidable ED visits and support members in achieving recovery goals.

II. Data Sources and Methodology:

APP: The data is pulled from Citius. The data is updated monthly, and we download a quality report to review and evaluate the members who are not in compliance with the measure. Data is drawn from claims.

POD: The data used for this analysis is derived from HEDIS for MY 2025 (January 1, 2025, through December 31, 2025). Data is collected through administrative claims and encounter records submitted by providers and facilities. CalOptima Health utilizes Citius as its HEDIS engine to extract, process and validate data in alignment with HEDIS technical specifications, ensuring accuracy and consistency in reporting. For the purposes of this analysis, data is reported and trended on a quarterly basis to monitor performance over time and identify opportunities for improvement.

III. Quantitative Analysis:

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	25.00%	28.95%	53.10%	54.55%	☐ Y ☒ N
POD	Pharmacotherapy for Opioid Use Disorder	20.77%	7.79%	4.93%	21.36%	☐ Y ☒ N

APP: The APP measure for Medi-Cal showed a significant year-over-year improvement, increasing from 25.00% in MY 2022 to 53.10% in MY 2024. This reflects a strong upward trend in performance. While the MY 2024 goal was set at 54.55%, the current rate is just 1.45 percentage points below target, indicating that the team is very close to achieving its goal and demonstrating substantial progress over the past year.

QIC 03.19.2026

POD: This measure serves as a critical indicator of how effectively the health system is supporting individuals with OUD through access to and retention in evidence-based medication treatment. An analysis of Medi-Cal performance from MY 2022 through MY 2024 reveals a concerning downward trend and a significant gap in meeting the established performance goal.

In MY 2022, the POD rate stood at 20.77%, reflecting relatively strong engagement in pharmacotherapy among eligible members. However, in MY 2023, the rate dropped sharply to 7.79%, a decline of nearly 13 percentage points. This downward trajectory continued into MY 2024, with the rate falling further to 4.93%, representing a total decrease of 15.84 percentage points over the two-year period.

The MY 2024 goal for this measure was set at 21.36%, underscoring the importance of sustained treatment engagement in combating the opioid crisis. With a current rate of 4.93%, the organization is 16.43 percentage points below its target.

This trend suggests systemic challenges in maintaining continuity of care for members with OUD. Potential contributing factors may include:

- Limited access to providers offering medication-assisted treatment (MAT)
- Stigma associated with OUD and its treatment
- Gaps in care transitions following ED or inpatient discharges
- Barriers related to transportation, housing or social support
- Incomplete or delayed data capture of pharmacotherapy events

The consistent decline over three years signals an urgent need for targeted intervention. Strategies such as expanding MAT provider networks, enhancing member outreach and education, improving care coordination, and strengthening data systems are essential to reversing this trend.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
In Quarter 3, we began to mail out monthly provider tip tool sheets and best practices letters. An app text message campaign was also drafted, with the hope of sending it to members in 2026. Provider tip tool sheets were submitted to communications for editing with CPT/HPCS codes	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	APP
HEDIS Provider Tool Tip Sheet sent to providers in the Health Network Weekly Communication.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	POD

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

APP: The APP measures's September prospective rate for MY 2025 (37.92%) shows a substantial improvement over the same month in MY 2024 (22.73%), reflecting a 66.8% year-over-year increase. This

Back to Agenda Back to Item

ON 03.19.2026

indicates that intervention is driving meaningful progress. However, the current rate remains 16.63 percentage points below the MPL of 54.55%, suggesting that while the intervention is effective, further enhancements are needed to fully close the performance gap.

POD: To support improvement in this measure, CalOptima Health implemented a provider-focused intervention during Q3 of the measurement year. A HEDIS Provider Tool Tip Sheet was distributed through the Health Network Weekly Communication, targeting providers with concise, actionable guidance on how to support members with OUD through evidence-based pharmacotherapy.

This intervention aimed to:

- Increase provider awareness of the POD measure and its clinical importance
- Encourage consistent prescribing and follow-up practices
- Reinforce the value of MAT as a standard of care

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
APP	MC: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	22.73%	37.92%
POD	MC: Pharmacotherapy for Opioid Use Disorder	9.72%	5.29%

Indicator/Goal: The performance rate from the same month of the previous year

APP: The APP measure's September prospective rate improved significantly year-over-year, rising from 22.73% in MY 2024 to 37.92% in MY 2025. This marks a 15.19 percentage point increase, or a 66.8% relative improvement. The data indicates a strong positive trend in performance, with the MY 2025 rate showing substantial progress compared to the same point in the previous year.

POD: This measure continues to serve as a critical indicator of how well the health system is supporting members with OUD through access to and retention in evidence-based medication treatment. However, the September prospective rates for MY 2025 reveal a concerning decline in performance. In MY 2024, the POD prospective rate was 9.72%. By MY 2025, that rate had dropped to 5.29%, representing a 4.43 percentage point decrease in performance. This means that fewer than six out of every 100 eligible members are maintaining pharmacotherapy for OUD, a significant gap in care for a population at high risk of relapse, overdose and mortality. The significant decline in POD performance between MY 2024 and MY 2025 highlights a critical area for improvement. Addressing this issue is not only a quality metric priority but also a public health imperative in the ongoing response to the opioid crisis.

VI. Qualitative Analysis:

APP: The analysis of the 2025 APP interventions was conducted by the BHI Quality team. This team is responsible for monitoring performance trends, assessing the effectiveness of implemented strategies

and identifying barriers to achieving targeted APP rates. Findings from the analysis are shared with the BHQI Workgroup, a multidisciplinary workgroup that includes the BHI medical director, executive director, director, managers from Quality and Programs, Behavioral Health Utilization Management and Call Center Operations. Leadership from GARS, Quality Improvement, Quality Analytics, Provider Relations, and Equity and Community Health, internal Medical Directors, and representatives from other member-facing and provider-facing departments regularly participate to promote cross-functional collaboration and ensure alignment of behavioral health quality initiatives.

POD: The analysis of the 2025 POD interventions was conducted by the BHI Quality team. This team is responsible for monitoring performance trends, assessing the effectiveness of implemented strategies and identifying barriers to achieving targeted POD rates. Findings from the analysis are shared with the BHQI Workgroup, a multidisciplinary workgroup that includes the BHI medical director, executive director, director, managers from Quality and Programs, Behavioral Health Utilization Management and Call Center Operations. Leadership from GARS, Quality Improvement, Quality Analytics, Provider Relations, and Equity and Community Health, internal Medical Directors, and representatives from other member-facing and provider-facing departments regularly participate to promote cross-functional collaboration and ensure alignment of behavioral health quality initiatives. The qualitative insights into the POD measure performance underscore the need for a comprehensive, multilevel strategy that addresses both clinical and nonclinical barriers to care. Improving this measure is not only a quality improvement priority but also a public health imperative. With focused action and cross-sector collaboration, CalOptima Health can begin to close the treatment gap and improve outcomes for individuals living with OUD.

Causal/Barrier Analysis:

APP:

- Due to system changes and updates, we did not have access to data for the first two quarters
- Lack of data in Quarter 1 and Quarter 2 prohibited CalOptima Health from beginning our interventions

POD:

- The barrier with POD is that pharmacy claims data for Medi-Cal members comes through the state, as it; pays for those prescriptions. However, sometimes the claims are not being billed through the state. If a member is getting their prescription at the county, CalOptima Health does not know the process for them obtaining their prescription outside of the state's coverage.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

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MC = Medi-Cal; OC= OneCare

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
More accessibility and transparency for providers to access the data and view which of their members are not compliant	In 2026, we will continue to send out monthly provider mailouts. We also hope to send out an APP text message campaign to members starting in January 2026	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	APP
Re-engaging providers through education, performance feedback and support for MAT integration.	Educate providers on the measure and best practice guidelines	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	POD
Collaborating with community partners to extend the reach of interventions and address social determinants of health.	Educate providers on the measure and best practice guidelines	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	POD

VIII. Conclusion:

APP: While the APP measure prospective rate met the goal for the year 2025, the MY2024 rate did not meet goal and the measure will remain on the work plan for 2026. Despite the prospective rate goal being met, we are still planning new interventions in 2026 to ensure that more members are compliant and receiving quality care as directed by the NCQA.

POD: The continued decline in the POD measure highlights a critical gap in the health care system's ability to support individuals with opioid use disorder through sustained, evidence-based treatment. Quantitative data shows a sharp drop in performance, while qualitative insights point to systemic, operational and behavioral barriers that are limiting access, engagement and retention in care. Despite these challenges, the path forward is clear. The POD measure will remain on the work plan for 2026 and improving POD performance will require a coordinated, multilevel strategy that includes expanding provider capacity, enhancing member outreach, strengthening care transitions and addressing social determinants of health. It also calls for a renewed focus on data accuracy, real-time monitoring and cross-sector collaboration. Ultimately, improving this measure is not just about meeting a benchmark; it is about saving lives, reducing harm and ensuring that every member with opioid use disorder has access to the care and support they need to recover and thrive. With intentional action and sustained commitment, meaningful progress is both possible and necessary.

4.20 Behavioral Health Services: School-Based Services Mental Health Services	
Author(s): Sherie Hopson	Department(s): Behavioral Health Integration
Responsible Party(ies): Diane Ramos (Sr Manager, Behavioral Health Integration); Natalie Zavala (Director, Behavioral Health Integration); Carmen Katsarov (Executive Director, Medical Management); Sherie Hopson (Project Manager, Behavioral Health Integration)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No

Back to Agenda Back to Item

DAC 8.19.2025

Workplan Goal/Objective: Develop and deliver a comprehensive final report that highlights key accomplishments and outcomes of the SBHIP initiative.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☒ Completed ☐ Ongoing

I. Purpose or Background:

The Student Behavioral Health Incentive Program (SBHIP) was established by state law and administered by the DHCS over its three-year timeline, from January 1, 2022, to December 31, 2024. During this period, Medi-Cal managed care plans (MCPs) across California were eligible to receive up to $389 million in incentive payments for developing programs aimed at increasing access to preventive care, early intervention and behavioral health services delivered by school-affiliated behavioral health providers. These payments were tied to the achievement of specific performance metrics. As part of this initiative, DHCS allocated up to $25,459,676 to CalOptima Health, the MCP serving Orange County. CalOptima Health successfully earned the full allocation by meeting all program requirements and performance metrics.

II. Data Sources and Methodology:

CalOptima Health, in partnership with the Orange County Department of Education (OCDE), all 28 school districts, Hazel Health, Western Youth Services (WYS), Children's Hospital of Orange County (CHOC), part of Rady Children's Health, and HCA, implemented and supported key focus areas under SBHIP.

- Improve coordination of behavioral health services for children and adolescents by enhancing communication among Medi-Cal MCPs, schools, providers and county behavioral health plans.
- Increase access to behavioral health services for K–12 students enrolled in Medi-Cal through schools and affiliated partners.
- Expand availability of nonspecialty behavioral health services on or near school campuses.
- Addresses health equity gaps and disparities in access to behavioral health services.

III. Program Results:

OCDE and the 28 Public School Districts

- School districts initiated new partnerships with community-based organizations to expand access to behavioral and mental health support for students and families across the county.
- SBHIP funding increased behavioral health staffing by 38.45% over the 2023–24 and 2024–25 school years, expanding capacity to serve more students.
- Training for school personnel in behavioral health significantly improved, strengthening early identification and support for student needs.
- Screening and referral processes were streamlined and enhanced, resulting in more timely and effective connections to care for students.
- Districts modernized IT infrastructure and systems, improving data sharing, service coordination and overall program efficiency.

OAC 03.19.2026

Hazel Health (Telehealth services)

- 20 of the 28 school districts signed direct contracts with Hazel Health
- More than 260,000 students have access to telehealth services
- Hazel Health extended its services through the 2025–2026 school year

WYS

- Developed an on-demand Behavioral Health Training Program for Orange County school staff, focused on trauma-informed, brain-based strategies.
- 65% of the 28 school districts' personnel have accessed the training via live sessions, workshops or the Learning Management System platform.
- WYS continues to provide post-training consultative support to school behavioral health staff.

CHOC, part of Rady Children's Health

- CHOC expanded its School Reintegration Program by hiring a dedicated coordinator to support students transitioning back to school after acute mental health care, ensuring continuity and collaboration between clinical teams and schools.
- CHOC's Mental Health Crisis Clinic (MHCC) expanded access to timely care, providing evaluations within 72 hours followed by up to three stabilization sessions specifically for youth experiencing suicidal ideation who do not have a current therapist.
- Through SBHIP, a deaf psychologist was hired to support Orange County school districts in addressing the mental health needs of deaf and hard-of-hearing students.
- Launched the Autism Comprehensive Care Program in Q1 2025, serving students aged 12–17 with autism and severe mental health needs.
- Installed 10 WellSpaces across Orange County school districts to support the mental health and well-being of Medi-Cal eligible youth, including those with private insurance.

IV. Actions/Interventions Implemented in 2025:

CalOptima Health continues to lead and collaborate with SBHIP partners by supporting school districts as they modernize billing systems and prepare to submit claims under the Children and Youth Behavioral Health Initiative (CYBHI) Multi-Payer Fee Schedule Program. In partnership with Carelon Behavioral Health, the DHCS-designated third-party administrator, CalOptima Health is working to ensure accurate and timely reimbursement for the eligible fee schedule mental health services delivered in Orange County schools and by their school-affiliated providers.

V. Conclusion:

The approval of CalOptima Health's SBHIP Project Outcome Reports by DHCS marked a significant milestone. By earning the full $25.5 million allocated to Orange County, CalOptima Health demonstrated its capability to deliver measurable results that align with the program's goals. This achievement reflects

OAC 03.19.2026

notable progress and sets the stage for continued collaboration with our partners to support expanding access to mental health services for students throughout Orange County.

4.21 Medication Management: Pharyngitis and Bronchitis	
Author(s): Dexter Dizon	Department: Quality Analytics
Responsible Party(ies): Kelli Glynn (Director, Quality Initiatives); Dexter Dizon (Quality Improvement Specialist, Quality Analytics)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: Appropriate Testing for Pharyngitis (CWP) MC Total: Increase from 43.66% to 76.71% by 12/31/2025. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) MC Total: Increase from 47.55% to 56.73% by 12/31/2025.	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

According to the CDC, inappropriate antibiotic prescribing remains a critical public health concern, contributing to the rise of antibiotic-resistant bacteria and avoidable adverse drug events. Acute respiratory infections, such as pharyngitis and acute bronchitis, are among the most common conditions for which antibiotics are often prescribed unnecessarily, despite clinical guidelines recommending against this practice.

CMS and NCQA emphasize the importance of evidence-based prescribing practices through HEDIS quality measures such as Appropriate Testing for Pharyngitis (CWP) and Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB). These measures aim to reduce the misuse of antibiotics by promoting diagnostic stewardship and adherence to clinical guidelines.

The CWP measure evaluates the percentage of episodes for members aged 3 years and older with a diagnosis of pharyngitis who were dispensed an antibiotic and received a group A streptococcus (strep) test. The AAB measure assesses the percentage of episodes for members aged 3 months and older with a diagnosis of acute bronchitis/bronchiolitis who were not dispensed an antibiotic. Both measures are critical for improving care quality, minimizing unnecessary medication use and promoting efforts to prevent antimicrobial resistance.

For Medi-Cal and OneCare populations, performance on these measures is tracked annually and benchmarked against DHCS MCAS goals and NCQA Quality Compass percentiles.

II. Data Sources and Methodology:

The source of the data is CalOptima Health's HEDIS engine, Citius. Goal methodology for MY 2024 is based on the current reported performance and the most current available benchmark. Medi-Cal measure goal setting for MY 2024 is based on MY 2022 reported performance results compared to the national percentile from the NCQA Quality Compass. If the current reported rate reached the NCQA Quality Compass percentile, the goal was set to the next percentile.

OAC 03.19.2026

III. Quantitative Analysis:

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
CWP	Appropriate Testing for Pharyngitis	35.21%	43.66%	52.38%	76.71%	☐ Y ☒ N
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis	43.91%	47.55%	39.70%	56.73%	☐ Y ☒ N

For CWP: This measure shows consistent year-over-year improvement, with a 17.17 percentage point increase from 2022 to 2024. However, the current rate (52.38%) still falls short of the 2024 goal (76.71%).

For AAB: After a slight improvement in 2023, the 2024 rate declined to 39.70%, which is not only below the goal but also lower than the 2022 baseline. This suggests a potential area for targeted quality improvement.

Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
1. Create provider educational materials for AAB and CWP	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	AAB, CWP
2. Identify the top 10 lowest performing providers	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	AAB, CWP
3. Send HEDIS measure information and invitation to review measure-level data (noncompliant members) with our Quality medical director to the lowest performing providers	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	AAB, CWP

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

IV. Effectiveness of Interventions:

Prospective Rates

Acronym	Measure	MY 2024 September Prospective Rate	MY 2025 September Prospective Rate
CWP	MC: Appropriate Testing for Pharyngitis - Ages 3 years and Older (Total)	51.72%	51.74%
AAB	MC: Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	39.51%	37.14%

Indicator/Goal: The performance rate from the same month of the previous year

DAC 03.19.2026

CWP (Pharyngitis Testing):

- MC rates are stable, showing a slight increase from 51.72% to 51.74%.

AAB (Antibiotic Avoidance):

- MC rates declined slightly from 39.51% to 37.14%.

V. Qualitative Analysis:

Analysis of the 2025 CWP and AAB interventions was conducted by the Quality Analytics team.

AAB

- **Clinical practice variation:** Providers may continue to prescribe antibiotics for acute bronchitis/bronchiolitis despite guidelines, due to diagnostic uncertainty or perceived patient expectations.
- **Patient expectations:** Members may expect antibiotics for respiratory symptoms, pressuring providers to prescribe even when not clinically indicated.
- **Lack of provider education or reinforcement**: Inconsistent reinforcement of evidence-based guidelines may lead to overprescribing, especially in urgent care or telehealth settings.
- **Documentation gaps**: Incomplete or inaccurate coding may misclassify encounters, affecting measure performance.
- **Access to Non-antibiotic symptom relief**: Limited access to supportive care (e.g., cough suppressants, inhalers) may lead providers to default to antibiotics for symptom management.

CWP

- **Low testing rates**: Underutilization of strep testing before prescribing antibiotics.
- **Workflow barriers**: In fast-paced clinical environments, providers may skip testing due to time constraints or lack of immediate test availability.
- **Telehealth limitations**: Increased use of telehealth may hinder the ability to perform in-person strep testing, leading to empirical antibiotic prescribing.
- **Member reluctance for testing**: Discomfort with throat swabs or a lack of understanding of their importance may reduce member compliance with testing.
- **Data lag and reporting gaps**: Delays in claims data submission or incomplete encounter documentation may underrepresent actual testing rates.

Causal/Barrier Analysis:

AAB

- **Clinical practice habits:** Despite guidelines, some providers may continue prescribing antibiotics for bronchitis/bronchiolitis due to habit, diagnostic uncertainty or perceived patient satisfaction pressures.
- **Patient expectations**: Members may expect antibiotics for respiratory symptoms, leading to overprescribing when providers aim to meet patient demands.

QAC 03.19.2026

- **Documentation and coding issues:** Inaccurate or incomplete coding of diagnoses and prescriptions may misrepresent actual clinical decisions, affecting measure performance.
- **Access to alternative treatments:** Limited access to nonantibiotic symptom relief options (e.g., inhalers, cough suppressants) may lead providers to prescribe antibiotics as a default.
- **Health literacy:** Members may lack understanding of when antibiotics are appropriate, reducing their acceptance of nonantibiotic treatment plans.

CWP

- **Operational barriers**: In busy clinical settings, providers may skip testing due to time constraints or lack of immediate test availability.
- **Telehealth limitations:** Increased use of telehealth may hinder the ability to conduct in-person strep tests, leading to empirical antibiotic prescribing without confirmation.
- **Member reluctance:** Discomfort with throat swabs or a lack of understanding of their importance may reduce members' willingness to undergo testing.
- **Data lag and reporting gaps:** Delays in claims data submission or incomplete encounter documentation may underreport actual testing rates, skewing performance metrics.

VI. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
1. Continued provider education/training	Targeted provider outreach via faxes/teleconference	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	AAB, CWP
2. Patient education	Education on antibiotic avoidance	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☐ M ☒ L	AAB

MC = Medi-Cal; OC = OneCare

VII. Conclusion:

The evaluation of the AAB and CWP HEDIS measures reveals a mixed picture of performance and progress and will remain on the work plan for 2026. CWP did not meet the goal and remains a critical area for improvement. AAB shows prior success but signs of regression in prospective data. CalOptima Health will explore provider refresher training on the measures, as well as provide patient education on the appropriate use of antibiotics.

4.22 Medication Adherence: Cholesterol (Statins), Hypertension (RAS Antagonists) and Diabetes	
Author(s): Nicki Ghazanfarpour, Pharm.D.	Department(s): Pharmacy Management

OAC 1.9.2026

Responsible Party(ies): Nicki Ghazanfarpour, Pharm D. (Manager, Pharmacy Management); Susan Vigil, Pharm.D. (Clinical Pharmacist)	
Products: ☐ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☒ No
Workplan Goal/Objective: Improve medication adherence for Cholesterol (Statins), Hypertension (RAS Antagonists) and Diabetes	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

CMS Medicare Part D Star Ratings incentivize high-quality care and improve health outcomes for beneficiaries. CMS specifically focused on adherence for three classes of medications due to the high clinical impact of managing these conditions and strong evidence linking adherence to improved health outcomes: oral antidiabetic medications (excluding insulin), renin-angiotensin system (RAS) antagonists (for hypertension) and, statins (for high cholesterol).

II. Data Sources and Methodology:

Real-time data using pharmacy claims data (starting January 2025) in combination with monthly Acumen Patient Safety Reports (first report available April 2025). Pharmacy claims data is obtained through the data warehouse, and Acumen reports are downloaded from the Patient Safety Analysis Web Portal. Data is analyzed at a minimum of once a month.

III. Quantitative Analysis:

OneCare

Measure	MY 2023 Star Rating	MY 2024 Star Rating
Medication Adherence for Diabetes Medications	87.0%	87.0%
Medication Adherence for Hypertension (RAS antagonists)	86.0%	87.0%
Medication Adherence for Cholesterol (Statins)	83.0%	85.0%

Medication Adherence for Diabetes Medications remained stable at a high level, with an adherence rate of 87.0% in both MY 2023 and MY 2024.

Medication Adherence for Hypertension (RAS antagonists) improved slightly, increasing from 86.0% in MY 2023 to 87.0% in MY 2024.

Medication Adherence for Cholesterol (Statins) showed a notable improvement, rising from 83.0% in MY 2023 to 85.0% in MY 2024.

IV. Data Stratification Data Source and Methodology:

Patient Safety Report results, based on claims from October 2025, were used to compare performance across health networks. Internal efforts have included all health networks; however, high-touch efforts for

QAC 1-19-2026

1Q 2025–3Q 2025 have been focused on CHCN. Results demonstrate the effectiveness of high outreach in CHCN as compared to other comparably sized health networks. All health networks have been included in high-touch outreach efforts during Q4 2025.

Medication Adherence for Diabetes (MAD)		
Health Network	**% Adherent**	**Denominator**
AltaMed	89%	218
AMVI Care	93%	98
CHCN	92%	847
Family Choice	92%	466
HPN - Regal	84%	51
Noble	86%	85
Optum	89%	1501
Prospect	87%	552
United Care	94%	214
Disenrolled	92%	235
Overall	90%	4267

Medication Adherence for Hypertension (MAH)		
Health Network	**% Adherent**	**Denominator**
AltaMed	89%	396
AMVI Care	92%	144
CHCN	90%	1377
Family Choice	90%	878
HPN - Regal	89%	100
Noble	80%	122
Optum	89%	2682
Prospect	90%	924
United Care	92%	342
Disenrolled	92%	340
Overall	90%	7305

Medication Adherence for Cholesterol		
Health Network	**% Adherent**	**Denominator**
AltaMed	88%	469
AMVI Care	90%	185
CHCN	90%	1641
Family Choice	89%	1101
HPN - Regal	87%	123
Noble	78%	137
Optum	86%	3146
Prospect	85%	1020
United Care	90%	433
Disenrolled	89%	388

QAC 03.19.2026

Back to Agenda Back to Item

Overall	87%	8643

V. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
1. Medication adherence outreach calls for members, providers, and pharmacies (daily calls and provider faxes)	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete	MAD, MAH, MAC
2. Monthly member IVR refill reminders	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	MAD, MAH, MAC
3. Targeted reports for health networks to intervene to positively impact medication adherence and convert members to a 100-day supply	☐ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	MAD, MAH, MAC
4. Targeted outreach to promote free prescription mailing services to reduce barriers for medication adherence	☐ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	MAD, MAH, MAC
5. Member mailing on the importance of medication adherence (targeted for the highest part D utilizers)	☐ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	MAD, MAH, MAC
6. Provide a newsletter distributed via fax and posted to the CalOptima Health provider page on strategies to improve medication adherence. Content with best practices is also shared with health network partners	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	MAD, MAH, MAC
7. Member text refill reminder	☐ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	MAD, MAH, MAC

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

VI. Effectiveness of Interventions:

Prospective Rates

Acronym	Measure	MY 2024 October Prospective Rate	MY 2025 October Prospective Rate
MAD	Medication Adherence for Diabetes	88.8%	90.1%
MAH	Medication Adherence for Hypertension (RASA)	88.6%	89.7%
MAC	Medication Adherence for Cholesterol (Statins)	86.2%	87.5%

OAC 03.19.26

All three measures are performing slightly higher than at the same time last year. Projected cut points from vendor Hyperlift for the 2027 Stars year (CY 2025) are included below for reference.

Hyperlift 2027 Stars Estimated Cut Points (2025 Data)				
	2	**3**	**4**	**5**
MAD	84% to <87%	87% to <89%	89% to <92%	≥92%
MAH	85% to <89%	89% to <92%	92% to <94%	≥94%
MAC	85% to <88%	88% to <90%	90% to <93%	≥93%

VII. Qualitative Analysis:

Causal/Barrier Analysis:

- Members picking up medications at the pharmacy
- Lack of real-time analytics to support more targeted interventions due to Acumen data lag
- Call attempts are very labor-intensive and require multiple outreaches to successfully speak to members who have valid contact information
- Members are overwhelmed by the volume of prescriptions they have to manage
- Members have misconceptions about the side effect profile of certain medications and often do not think the medications are working when they don't experience immediate results
- Providers often lower dosages without rewriting the prescription; therefore the member has ample medication at home and does not need additional supply
- Many members decline mailing service due to current pharmacy satisfaction

VIII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will address high-priority issues first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
1. Improve data analytics capabilities for real-time targeted outreach	Implementation with a new software vendor to support internal workflow and external health network needs.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	MAD, MAH, MAC
2. Mail order prescription services	New contract for mail-order prescription services. Targeted advertisement via postcard mailing will commence in January 2026	☐ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L	MAD, MAH, MAC
3. Targeted medication adherence outreach program	Continue adherence outreach calls to target members, providers and pharmacies that need action	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	MAD, MAH, MAC

OA 03.19.2026

MC = Medi-Cal; OC = OneCare

IX. Conclusion:

The data indicate that the multifaceted approach is effective; however, it requires a broader partnership within the health network to further enhance outcomes. Consistently, adherence rates among internally managed health network members have exceeded those of other large-volume health networks due to our comprehensive intervention strategy and member engagement efforts. The projected increases in Stars cut points, as forecasted by vendor Hyperlift, present a challenge for performance improvement. Despite continuous year-over-year advancements, our projections indicate that the Star rating for medication adherence will remain the same in CY 2024 (Stars 2026) and, as a result, will remain on the work plan for 2026. The implementation of higher-quality Stars analytics reports for internal and external use in 2026 will help support a more expansive partnership.

4.23 Performance Improvement Projects (PIPs) Medi-Cal	
Author(s): Leslie Vasquez	Department(s): Quality Analytics
Responsible Party(ies): Kelli Glynn (Director, Quality Initiatives); Leslie Vasquez (Manager, Quality Analytics)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Increase well-child visit appointments for Black/African American members (0-15 months) from (final rate TBD) to 55.78% by 12/31/2025.	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

The California 2020 Health Disparities Report revealed that African American children experienced worse health outcomes than other groups across all six key measures in DHCS's children's health domain. To address this, DHCS required MCPs to establish a Performance Improvement Project (PIP) to reduce racial and ethnic disparities in well-child visits (the W30 HEDIS measure).

Key barriers addressed:

- Parent/guardian gaps in knowledge about the purpose and value of well-child visits
- Lack of reminders for parents/guardians to complete the well-child visits
- Limited resources for health networks to coordinate well-child visit appointments with a PCP for African American child members

II. Data Sources and Methodology:

Data pulled from claims and encounters using HEDIS engine, Citius, from January 1, 2024, to December 31, 2024. Data is stratified by race and ethnicity. Rates were identified for Black/African American child members.

III. Quantitative Analysis:

Medi-Cal

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
W30	Well-Child Visits in the First 30 Months of Life for Black/African American Members (First 15 Months)	N/A	45.05%	53.06%	55.78%	☐ Y ☒ N

- Well-child visits in the first 15 months of life have shown steady improvement from MY 2023.
- The MY 2024 rate is 2.72 percentage points below the goal of 55.78%.
- While there is progress toward the goal, additional efforts are needed to close the remaining gap.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
1. Telephonic outreach to remind families of the importance of scheduling well-child visits and assess for barriers to completion	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	W30
2. Care coordination support to help African American families schedule and complete visits in accordance with the AAP periodicity schedule	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	W30

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

Indicator/Goal: The success rate in delivering well-child visit information and coordinating well-child visit appointments.

Well Child Call Campaign Effectiveness

- Between March and July 2025, 125 unique members were contacted. Of those, 48 (38.4%) were successfully reached by phone and received information about the recommended well-child visit tailored to the member's current age and its importance.
- None of the members contacted accepted appointment coordination for the well-child visit.

VI. Qualitative Analysis:

Causal/Barrier Analysis:

- Limited engagement with the health care system: Parents/guardians may lack knowledge about the importance and benefits of well-child visits for preventive care and early detection.
- Trust and cultural factors: Historical mistrust of the health care system impacts willingness to seek preventive care.
- Segment of parents that perceive well-child visits as vaccine-only visits: For families who prefer to delay or skip vaccines, these visits may not be seen as offering additional benefits.

DAC 03.19.26

- Socioeconomic constraints may play a role: Competing priorities such as work schedules, childcare for other children and financial stress can reduce the ability to attend these visits.
- Communication gaps: Insufficient reminders or follow-up from health plans and providers to prompt parents about upcoming visits. Communication efforts are also hindered by bad contact information. Organizational efforts are needed to improve member contact information and thus the reach rate.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
1. Improved partnerships with health networks and providers	Outreach to members' assigned providers	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L	W30
2. Improved community engagement	Collaborate with trusted community leaders and organizations to promote well-child visits (e.g., Black Infant Health)	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	W30
3. Multimodal outreach campaigns to improve compliance for CIS, IMA and WCV	Collaboration with multiple departments to improve compliance for pediatric measures among Black, White, and Native Hawaiian/Other Pacific Islander populations Revised member-facing materials that address the scope and importance of well-child visits	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	W30

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

- While improvements were seen in MY 2023 versus MY 2024, W30 performance amongst the target population, the improvement was not statistically significant. This suggests the need for more targeted, high-impact strategies to close care gaps.
- Appointment coordination was not successful. This suggests that members require multiple touchpoints to ensure that all members receive recommended care. This also suggests that improving child visit completion rates requires increased engagement during the pregnancy period. Early connection allows the plan to establish trust, identify barriers sooner and support a stronger continuum of care for underserved members.

4.24 Performance Improvement Projects (PIPs) Medi-Cal Behavioral Health	
Author(s): Diane Ramos, Jeni Diaz, Mary Barranco	Department(s): Behavioral Health Integration/ Quality Analytics

Responsible Party(ies): Diane Ramos (Sr Manager, Behavioral Health Integration); Natalie Zavala (Director, Behavioral Health Integration); Carmen Katsarov (Executive Director, Medical Management); Jeni Diaz (Program Specialist Sr, Behavioral Health Integration); Mary Barranco (Program Specialist, Behavioral Health Integration)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) FUM and FUA for complex case management.	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

CalOptima Health aims to achieve a 2% increase in the percentage of Medi-Cal-only members (aged 21 and older) with CHCN or COD who are enrolled in care management (CM), complex care management (CCM) or ECM within 14 days of an ED visit where a diagnosis of serious mental illness (SMI) or SUD was made.

The goal is to strengthen the timely linkage to provider follow-up appointments post-ED visit and to ensure prompt initiation of referrals to CalOptima Health's CM, CCM or ECM programs.

II. Data Sources and Methodology:

An internal report was developed to identify members who enroll in CM, CCM or ECM after being diagnosed with SMH/SUD during an ED visit.

Measure Description	The percentage of CHCN and COD CalOptima Health Medi-Cal only members enrolled into CM, CCM or ECM, within 14 days of a provider ED visit where the member was diagnosed with SMH/SUD.
Numerator Description	Members aged 21 years or older, identified by an ED visit with a diagnosis of SMH/SUD, who are enrolled in CM, CCM or ECM. The member should be enrolled within 14 days of the ED visit.
Denominator Description	Members 21 years or older identified by the ED visit with a diagnosis of SMH/SUD. The members already enrolled in the CM, CCM and ECM programs will be excluded from the denominator.
Baseline Measurement Period	January 1, 2023, to December 31, 2023
Remeasurement 1 Period	January 1, 2024, to December 31, 2024
Remeasurement 2 Period	January 1, 2025, to December 31, 2025

III. Quantitative Analysis:

Medi-Cal

Measurement Period Dates	Performance Indicator Measurement Period	Numerator	Denominator	Percentage	MY 2024 Goal	MY 2024 Goal Met / Not Met
January 1, 2023-December 31, 2023	Baseline	29	2679	1.08%	N/A for baseline	N/A for baseline

QAC 6.19.2025

January 1, 2024–December 31, 2024	Remeasurement 1	65	2807	2.32%	MY 2024 goal 2% increase from baseline	☒ Y ☐ N

CalOptima Health significantly exceeded its goal of a 2% increase in enrollment into CM/CCM/ECM within 14 days of an ED visit for members with SMI/SUD. The actual rate improved from 1.08% in 2023 to 2.32% in 2024, representing a 114.8% relative increase, well above the targeted 2% improvement.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Member outreach via BH telehealth provider to schedule follow-up appointments after an ED visit	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
2. Monthly collaboration meetings with stakeholders to develop workflow for member outreach and engagement.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
3. Collaboration with HCA and CalOptima Health IT regarding 837 data exchange	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

The interventions implemented in 2024 were instrumental in improving the BH Nonclinical PIP outcome, resulting in an increase in the enrollment rate from 1.08% in 2023 to 2.32% in 2024. Member outreach through the BH telehealth provider played a key role by proactively scheduling follow-up appointments after ED visits, ensuring timely engagement and increasing the likelihood of enrollment into CM, CCM or ECM within the 14-day target. Monthly collaboration meetings with internal and external stakeholders helped streamline workflows, align outreach strategies and address operational barriers, resulting in more efficient and coordinated member engagement. Additionally, collaboration with HCA and CalOptima Health IT to improve the 837 data exchange enhanced the accuracy and timeliness of identifying eligible members, allowing outreach teams to act quickly and effectively. Together, these interventions created a more responsive, data-driven and collaborative approach that significantly contributed to the more than doubling of the enrollment rate and the overall success of the PIP.

VI. Qualitative Analysis:

In 2024, key interventions contributed to the improvement of the BH Nonclinical PIP, including member outreach via a BH telehealth provider, monthly stakeholder collaboration meetings, and enhanced 837 data exchange with HCA and CalOptima Health IT. Telehealth outreach enabled timely follow-up scheduling after the ED visit, increasing member engagement and enrollment in CM, CCM or ECM. Regular collaboration meetings helped align workflows and address barriers, while improved data sharing allowed for faster identification of eligible members. These efforts led to more coordinated, data-

driven outreach, resulting in significantly improved outcomes. Ongoing monitoring will focus on sustaining progress and addressing remaining challenges, such as member responsiveness and provider availability.

Causal/Barrier Analysis:

Barrier Analysis – BH Nonclinical PIP

- **Data Integrity Issues**
  - Ineligible members were included due to incorrect coding
  - Resolution: Codes were reviewed and corrected to ensure only eligible members are included in the dataset
- **Internal Stakeholder Coordination**
  - Difficulty engaging departments due to competing priorities
  - Resolution: Regular collaboration meetings helped maintain alignment and communication
- **Challenges Engaging Member Population**
  - Difficulty connecting with members diagnosed with SMI/SUD
  - Resolution: Partnered with a BH telehealth provider to automate real-time ED data sharing and support timely outreach
- **Implementation of New Care Management System (February 2024)**
  - Transition required staff to learn new referral processes
  - Resolution: Staff were trained, and a new referral workflow was implemented
- **Delays in PHI Data Sharing with Community Partners**
  - Approvals for sharing protected health information caused delays
  - Resolution: Automated daily ED data sharing via sFTP was established to improve coordination
- **Delay in Data Exchange with County Behavioral Health System**
  - Lack of infrastructure and agreements delayed data sharing
  - Resolution: An MOU was executed, a data dictionary was developed, and testing was completed to ensure data accuracy and integrity

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Use stratified data (e.g., by diagnosis, age, geography) to identify high-risk members and tailor outreach efforts	Conduct member outreach through the behavioral health telehealth provider to coordinate follow-up appointments after the ED visit	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L

OAC 03.19.2026

Back to Agenda Back to Item

2. Implement targeted strategies to address disparities in access and outcomes.	Facilitate monthly collaboration meetings with key stakeholders to design and refine workflows for member outreach and engagement	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
3. Ensure 837 data exchange continues to follow the established process between HCA and CalOptima Health	Ongoing partnership with HCA and CalOptima Health IT teams to support the exchange of data files	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC= OneCare

VIII. Conclusion:

The BH Nonclinical PIP in 2024 marked a significant turning point in the approach to care coordination and member engagement. Through a series of targeted, collaborative and data-informed interventions, the project achieved a remarkable increase in enrollment from 1.08% in 2023 to 2.32% in 2024, demonstrating the power of strategic innovation in behavioral health outreach. At the heart of this success was the integration of a BH telehealth provider, which enabled timely and proactive follow-up with members after they visited the ED. This not only improved the speed of engagement but also increased the likelihood of members enrolling in appropriate care management programs within the critical 14-day window. Monthly collaboration meetings with internal and external stakeholders further strengthened the initiative by aligning workflows, addressing operational barriers and fostering a shared commitment to member-centered care. Equally transformative was the improved 837 data exchange process, developed in partnership with HCA and CalOptima Health IT. This enhancement allowed for more accurate and timely identification of eligible members, empowering outreach teams to act swiftly and effectively. Despite challenges such as data integrity issues, internal coordination hurdles and the complexities of implementing a new care management system, each barrier was addressed with thoughtful and sustainable solutions. Together, these efforts created a more agile, responsive and collaborative system, one that not only improved outcomes but also laid a strong foundation for continued progress. As the project progresses, ongoing monitoring and refinement will be crucial to sustaining these improvements and addressing persistent challenges, such as member responsiveness and provider availability.

4.25 Chronic Care Improvement Projects (CCIPs) OneCare: Diabetes Emerging Risk	
Author(s): Melissa Morales	Department(s): Quality Analytics
Responsible Party(ies): Kelli Glynn (Director, Quality Initiatives); Melissa Morales (Quality Improvement Specialist, Quality Analytics)	
Products: ☐ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: By December 31, 2025, 5% of members identified as emerging risk* and who participated in program will lower HbA1c to less than 8.0%. *Emerging risk is defined as members with a result of A1C 8.0% to A1C 9.0% who were previously in good control A1C less than 8.0% in previous 12 months.	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☒ Completed ☐ Ongoing

I. Purpose or Background:

CMS requires all Medicare Advantage plans and SNPs to conduct a Chronic Care Improvement Project (CCIP) as part of their required QI Program over a three-year period. The purpose of the CCIP is to promote effective chronic disease management and improve care and health outcomes for members with chronic conditions. For the three-year CCIP program, beginning in 2023 and ending in December 2025, CalOptima Health chose to focus on diabetes as the target condition, with a primary emphasis on improving diabetes management. The target population for the CCIP intervention is OneCare members identified as having diabetes (Type 1 and Type 2). CalOptima Health chose to focus on members who fall in the category of emerging risk. Emerging risk is defined as members who were previously controlled (<8.0% A1C) but had a recent A1C level of 8.0% to 9.0%. These members were chosen because targeting those with A1C levels between 8.0% and 9.0% is more likely to improve outcomes than targeting those above 9.0%

II. Data Sources and Methodology:

A two-year lookback period for members' A1C results (2023–2024) and the current measurement year. Quality Analytics generated an A1C report and identified members who were below 8.0%, between 8.0% and 9.0%, and above 9.0%. Also included was whether the A1C result had decreased, increased, remained the same or no prior result was available. A QI specialist filtered the list to identify the target population. QI worked with the Diabetes Management Program to finalize the outreach list. The outreach included members who were part of the emerging risk category and the Diabetes Management stratification to keep the outreach list manageable. The health coaches outreached to emerging risk members, and their efforts were documented in the Jiva application. The emerging risk member list was refreshed quarterly.

III. Quantitative Analysis:

OneCare

Data	Emerging Risk List OneCare members	Outreach	Outreach Rate
MY 2025	175 members	155	88.57%

QI identified 175 members that met emerging risk criteria. According to Jiva reporting, there were 155 successful interactions, resulting in an outreach rate of 88.57%.

Successful interaction	A1C result	Outreach	Change of A1C
155	<8.0%	59	38.06%
	≥8.0%	36	23.23%
	No Result	60	38.71%

Of the 155 successful interactions identified, there were 59 members with a reported A1C result of <8.0% (as compared to the initial A1C reported measurement), 36 members with a reported A1C result that was ≥8.0% (as compared to the initial A1C reported measurement) and 60 members that had no A1C result update or reporting available (as compared to the initial A1C reported measure).

Actions/Interventions Implemented in 2025:

QAC 03.19.2026

Back to Agenda Back to Item

Interventions	Product	Quarter	Type	Status	Measures (Acronym)
1. Telephonic outreach by health educators	☐ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	GSD

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

IV. Qualitative Analysis:

Causal/Barrier Analysis:

- The outreach rate included any interaction outcome that was included in Jiva reporting and thus was not solely based on health coaching outreach.
- Refresh of the emerging risk list was impacted by the organization's transition to a new HEDIS engine.
- Data issues, e.g., missing A1C values, may have affected emerging risk assignment.
- The outreach list included members who were already assigned to CM, so they were not outreached (by a health educator).
- Unable to contact emerging risk category members.

V. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
1. Planning	Develop intervention strategies and create new CCIP program.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	GSD, EED, KED, SPD, BPD

MC = Medi-Cal; OC= OneCare

VI. Conclusion:

This three-year CCIP has concluded. The program, which ran from 2023 to 2025, focused on improving diabetes management among OneCare members identified with Type 1 and Type 2 diabetes, particularly those in the emerging risk category (A1C levels 8.0%-9.0%). The interventions targeted members who had previously controlled A1C levels but recently exhibited levels between 8.0% and 9.0%, recognizing the high potential for improvement within this group. A new CCIP program will be created in MY 2026.

Section 5: Quality of Service

5.1 Improve Network Adequacy: Reducing Gaps in Provider Network	
Author: Cathy dela Cruz	Department(s): Provider Data Operations

Back to Agenda Back to Item

OAC 3.19.2026

Responsible Party(ies): Quynh Nguyen (Director, Provider Data Operations); Cathy Dela Cruz (Manager, Provider Data Operations)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Increase provider network to meet regulatory access goals	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

CalOptima Health routinely assesses the provider network for all programs, including Medi-Cal and OneCare, to ensure our members have appropriate access to care. This includes evaluating trends, identifying gaps in a particular HN or specific practitioner specialties, pinpointing opportunities for improvement, prioritizing those opportunities, and taking actions to enhance the network.

CalOptima Health established network adequacy in accordance with state and federal law and regulations to ensure members have adequate accessibility to available services at both the plan and HN levels. Network adequacy applies to both Medi-Cal and OneCare, with mandatory provider types (MPTs standards applicable only to the Medi-Cal Program.

II. Data Sources and Methodology

CalOptima Health conducted network adequacy gap analysis using the following methodology:

1. Time period was from January 1, 2025, through December 31, 2025
2. CalOptima Health used the 274 file as the provider network data for network adequacy gap analysis.
3. Provider network data is pulled quarterly to run an analysis for Medi-Cal for MPT, network capacity ratio (FTE), provider-to-member ratio (PMR) and compared with standards used to ensure members have the appropriate types of providers and an adequate number of practitioners in the network to access care. This analysis is used to determine whether CalOptima Health is compliant with the standards identified in CalOptima Health Access and Availability Policy: GG.1600.
4. For the OneCare plan, the minimum number of providers varies per provider type according to the CMS annual Health Service Delivery (HSD) reference table and specified in CalOptima Health Access and Availability Policy MA.7007.
5. CalOptima Health uses the Quest Analytics Suite to conduct accessibility analyses and mapping to meet time/distance standards identified in CalOptima Health Access and Availability Policies referenced. The accessibility analyses must demonstrate coverage of the entire service area. CalOptima Health establishes network adequacy standards in accordance with state and federal regulations.
    a. Medi-Cal 99% compliance with time and distance standards for primary and specialty care
    b. OneCare: 90% compliance with time and distance standards for primary care and specialty care

CAC 08.19.2026

III. Program Results and Quantitative Analysis:

Medi-Cal: Key Performance Indicators

Medi-Cal LOB *unless otherwise noted* Network Adequacy	Goal	Data Source	Q1	Q2	Q3	Q4
Time/Distance Primary Care (Adult and Ped) 10 miles OR 30 minutes from any member or anticipated member's residence	99%	274 File	100%	100%	100%	100%
Time/Distance Core Specialty Care (Adult and Ped) 15 miles OR 30 minutes from any member's or anticipated member's residence	99%	274 File	100%	100%	100%	100%
Time/Distance OB/GYN (Adult and Ped) 15 miles OR 30 minutes from any member's or anticipated member's residence	99%	274 File	100%	100%	100%	100%
Time/Distance Hospitals (Adult and Ped) 15 miles OR 30 minutes from any member's or anticipated member's residence	99%	274 File	100%	100%	100%	100%
Mandatory Provider Types for FQHCs: Minimum Number of Providers: 1	Min 1 (100%)	274 File	100%	100%	100%	100%
Mandatory Provider Types for Certified Nurse Midwives (CNM): Minimum Number of Providers: 1	Min 1 (100%)	274 File	100%	100%	100%	100%
Network Capacity and Ratios (FTE) — Primary Care Practitioner to Members: 1:2,000	1:2,000 (100%)	274 File	100%	100%	100%	100%
Network Capacity and Ratios (FTE) — Physician to Members: 1:1,200	1:2,000 (100%)	274 File	100%	100%	100%	100%

Medi-Cal: Provider to Member Ratios by Specialty Type

Indicator/Goal(s)

A. PCP: 1:2,000 or better
B. Specialists:
1. OB/GYN is 1:2,000 or better
2. Nephrology, pulmonology and psychiatry is 1:10,000 or better
3. All other specialist to member is 1:5,000 or better

Provider Type	Quarter in 2024	Q1		Q2		Q3		Q4	
	Medi-Cal Specialty	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met
PCP	General/Family Medicine	1:1767	Met	1:1745	Met	1:1798	Met	1:1731	Met
PCP	Internal Medicine	1:1915	Not Met	1:1921	Met	1:2016	Not Met	1:1968	Met
PCP	Pediatric	1:883	Met	1:874	Met	1:869	Met	1:858	Met
PCP	**Total PCP**	**1:770**	**Met**	**1:761**	**Met**	**1:784**	**Met**	**1:766**	**Met**
Specialist	Cardiology/Interventional Cardiology	1:2776	Met	1:2672	Met	1:2651	Met	1:2259	Met
Specialist	Gastroenterology	1:4985	Met	1:4692	Met	1:4680	Met	1:4078	Met
Specialist	General Surgery	1:2038	Met	1:919	Met	1:1850	Met	1:1692	Met
Specialist	Hematology/Oncology	1:2708	Met	1:2491	Met	1:2340	Met	1:2073	Met

Specialist	Nephrology	1:6577	Met	1:5920	Met	1:5549	Met	1:5098	Met
Specialist	Neurology	1:3933	Met	1:3927	Met	1:4004	Met	1:3461	Met
Specialist	OB/GYN	1:1064	Met	1:1049	Met	1:1045	Met	1:971	Met
Specialist	Ophthalmology	1:4301	Met	1:4275	Met	1:3963	Met	1:3526	Met
Specialist	Orthopedic Surgery	1:6115	Not Met	1:5744	Not Met	1:5754	Not Met	1:4518	Met
Specialist	Pulmonology	1:5218	Met	1:5063	Met	1:5044	Met	1:4775	Met
Specialist	Urology	1:7906	Not Met	1:7620	Not Met	1:7193	Not Met	1:6859	Not Met

Quantitative Analysis:

Medi-Cal

- CalOptima Health was compliant with the following standards:
    - Network capacity ratio (FTE) for primary care and all physicians
    - Time or distance for primary care, OB/Gyn, specialty care and hospitals
    - MPT (FQHC, CNM and Licensed Midwife [LM])
- PMR
    - Internal medicine did not meet standards in Q3 but the gap was remediated in Q4 and now meets the standard
    - Total primary physician aggregate type was not affected by the Q3 gap in internal medicine, consistently meeting the standards all year.
    - Specialty type of orthopedic surgery did not meet standards in Q1, showed significant improvement in Q2, then increased slightly in Q3, finally closing the gap in Q4
    - Specialty type urology does not meet standards since being added in Q1; however, quarter after quarter data shows the gap is improving and trending downward.
    - Most ratios are trending downward, showing fewer members per provider except for general medicine, internal medicine, neurology and orthopedic surgery.

OneCare: Key Performance Indicators

OneCare LOB **Network Adequacy (New for 2024)**	**MPL**	**Data Source**	**Q1**	**Q2**	**Q3**	**Q4**
Time/Distance Primary Care Five miles AND 10 minutes from any member's residence	90%	FACETS	99.9%	99.9%	99.9%	99.9%
Time/Distance Allergy and Immunology 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Cardiology 10 miles AND 20 minutes from any member's residence	90%	FACETS	99.9%	99.9%	99.9%	99.9%
Time/Distance Chiropractor 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Dermatology 10 miles AND 20 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Endocrinology 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance ENT/Otolaryngology 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%

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Time/Distance Gastroenterology 10 miles AND 20 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance General Surgery 10 miles AND 20 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Gynecology, OB/GYN 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Infectious Diseases 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Nephrology 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Neurology 10 miles AND 20 minutes from any member's residence	90%	FACETS	97.4%	96.8%	96.8%	96.8%
Time/Distance Neurosurgery 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Oncology - Medical, Surgical 10 miles AND 20 minutes from any member's residence	90%	FACETS	97.1%	97.1%	97.1%	97.1%
Time/Distance Oncology - Radiation/Radiation Oncology 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Ophthalmology 10 miles AND 20 minutes from any member's residence	90%	FACETS	100.0%	99.8%	99.8%	99.8%
Time/Distance Orthopedic Surgery 10 miles AND 20 minutes from any member's residence	90%	FACETS	98.4%	98.4%	98.4%	98.4%
Time/Distance Physiatry, Rehabilitative Medicine 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Plastic Surgery 15 miles AND 30 minutes from any member's residence	90%	FACETS	97.9%	97.9%	97.9%	97.9%
Time/Distance Podiatry 10 miles AND 20 minutes from any member's residence	90%	FACETS	99.9%	99.9%	99.9%	99.9%
Time/Distance Psychiatry 10 miles AND 20 minutes from any member's residence	90%	FACETS	98.8%	98.8%	98.8%	98.8%
Time/Distance Pulmonology 10 miles AND 20 minutes from any member's residence	90%	FACETS	99.7%	99.7%	99.7%	99.7%
Time/Distance Rheumatology 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Urology 10 miles AND 20 minutes from any member's residence	90%	FACETS	98.3%	98.3%	98.3%	98.3%
Time/Distance Vascular Surgery 15 miles AND 30 minutes from any member's residence	90%	FACETS	98.4%	98.4%	98.4%	98.4%
Time/Distance Cardiothoracic Surgery 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Clinical Psychology 10 miles AND 20 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Clinical Licensed Social Work 10 miles AND 20 minutes from any member's residence	90%	FACETS	100.0%	100.0%	99.8%	99.8%
Time/Distance Acute Inpatient Hospitals 10 miles AND 20 minutes from any member's residence	90%	FACETS	98.5%	98.5%	98.5%	98.5%
Time/Distance Cardiac Surgery Program 15 miles AND 30 minutes from any member's residence	90%	FACETS	98.0%	98.0%	98.0%	98.0%
Time/Distance Cardiac Catheterization Services 15 miles AND 30 minutes from any member's residence	90%	FACETS	99.3%	99.3%	99.3%	99.3%
Time/Distance Critical Care Services – Intensive Care Units (ICU) 10 miles AND 20 minutes from any member's residence	90%	FACETS	97.1%	97.1%	97.1%	97.1%
Time/Distance Surgical Services (Outpatient or ASC) 10 miles AND 20 minutes from any member's residence	90%	FACETS	97.7%	98.7%	98.7%	98.7%

Back to Agenda Back to Item

Time/Distance Skilled Nursing Facilities 10 miles AND 20 minutes from any member's residence	90%	FACETS	99.8%	99.8%	96.3%	96.3%
Time/Distance Diagnostic Radiology 10 miles AND 20 minutes from any member's residence	90%	FACETS	99.9%	98.6%	98.6%	98.6%
Time/Distance Mammography 10 miles AND 20 minutes from any member's residence	90%	FACETS	99.9%	99.9%	99.9%	99.9%
Time/Distance Physical Therapy 10 miles AND 20 minutes from any member's residence	90%	FACETS	99.9%	99.9%	99.9%	99.9%
Time/Distance Occupational Therapy 10 miles AND 20 minutes from any member's residence	90%	FACETS	85.9%	100.0%	100.0%	100.0%
Time/Distance Speech Therapy 10 miles AND 20 minutes from any member's residence	90%	FACETS	98.0%	98.0%	99.8%	99.8%
Time/Distance Inpatient Psychiatric Facility Services 15 miles AND 30 minutes from any member's residence	90%	FACETS	100.0%	100.0%	100.0%	100.0%
Time/Distance Outpatient Infusion/Chemotherapy 10 miles AND 20 minutes from any member's residence	90%	FACETS	97.1%	97.1%	97.1%	97.1%

Year-over-Year Trending of Time AND Distance Compliance for Specialty and Facility Contracted Providers

Count of Noncompliant Specialty Contracted Provider for Time AND Distance								
	Q1 Specialties		**Q2 Specialties**		**Q3 Specialties**		**Q4 Specialties**	
	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met
2025	0	Met	0	Met	0	Met	0	Met
2024	0	Met	0	Met	0	Met	0	Met

Count of Noncompliant Facility Contracted Provider for Time AND Distance								
	Q1 Facilities		**Q2 Facilities**		**Q3 Facilities**		**Q4 Facilities**	
	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met
2025	1	Not Met	0	Met	0	Met	0	Met
2024	0	Met	0	Met	0	Met	0	Met

Quantitative Analysis:

<u>OneCare</u>

- Provider count data show OneCare consistently meeting standards. Quarterly data shows an upward trend overall, indicating that the provider network is expanding. Primary care, ophthalmology and psychiatry are the top specialties that experienced the highest increase in provider count from Q1 to Q4. Neurology, podiatry and cardiothoracic surgery, however, showed the most significant decrease by four providers.
- Time and distance standards for the specialty type were met consistently quarter over quarter
- Time and distance standards for facility type were met except for occupational therapy in Q1. The occupational therapy gap was closed in Q2, resulting in a 100% success rate.
- 2025 showed one quarter with a time and distance gap in comparison to 2024; however, the gap was immediately closed the following quarter.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
• Recruitment outreach to address gaps in urology	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
• Provider network review and recruitment outreach to increase occupational therapy providers	☐ MC ☒ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
• Issued and monitored CAP to health networks with time or distance and provider-to-member ratio gaps for closure	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
• Recruitment outreach to address the gap in orthopedic surgery	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• Network Adequacy Workgroup moved forward with expanding specialty care access via telehealth and partnered with other departments to expand the TeleMed2U contract.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• Establish orthopedic subspecialty and area of focus to help with orthopedic surgery access gaps	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

CalOptima Health deployed interventions to address and close identified gaps in network adequacy. Below is the analysis of the effectiveness of the interventions.

1. Recruitment intervention for urology did not yield enough contracts to close the gap. However, in combination with the CAP issued to health networks with gaps in urology, the efforts CalOptima Health and the health networks combined were effective in decreasing the gap, as shown by the downward trend of the PMR ratio from Q1 to Q4.
2. The recruitment efforts to close the occupational therapy gap for OneCare did not yield an increase in the provider network and were not successful. However, PDO audited the providers' full scope of specialties and identified additional occupational therapy facilities that were not previously counted. This effort successfully closed the gap.
3. The CAP issued to health networks helped to improve and lessen the gap in orthopedic surgery from Q1 to Q4 in general. CalOptima Health's recruitment outreach is in progress, with results to be evaluated in Q1 2026.
4. Expansion of the TeleMed2U contract to include specialty care services that would cover urology and orthopedic surgery (nonsurgical appointments only) is in progress, to be implemented first in the OneCare LOB. The effectiveness will be determined after implementation in Medi-Cal, the date of which will be determined at a later time.

Back to Agenda Back to Item

5. Establishing the orthopedic surgery subspecialty and area of focus is currently ongoing; we will not know the effectiveness of this intervention until it is deployed in 2026.

VI. Qualitative Analysis

Qualitative Analysis was conducted by the Provider Network Operations senior director, Provider Data Operations director, Provider Relations director, executive director Medicare Programs, Contracting director, medical director, Care Management director, Provider Data Operations senior manager, Analytics, Provider Relations manager Provider Data Operations manager to identify barriers to closing the gaps through interventions deployed.

Causal/Barrier Analysis:

- CalOptima Health continues to meet time or distance standards, but South County remains an area where time or distance gaps and access challenges continue to occur due to the low count of providers practicing in this region of Orange County.
- CalOptima Health's recruitment outreach for urology, led by the Provider Relations director, Provider Relations manager, Provider Data Operations director and Provider Data Operations manager, trended on providers either not interested or no longer at the location listed per DHCS FFS database. The DHCS FFS database is where all providers are listed that are Medi-Cal approved.
- CalOptima Health has implemented ways to help speed up the contracting process at each step of the way, but this remains a multistep (contracting, credentialing) process, which will always take a minimum of a couple of months to add a provider to the network to help close a gap.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Better collaboration between Credentialing, Contracting and Provider Data Operations regarding providers approaching recredentialing deadlines	Reimagine a new timeline for receiving data on providers with expiring credentialing to avoid termination of providers that belong to specialties experiencing network adequacy gaps	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L
2. Provider termination network adequacy assessment	Create a new network assessment process to determine if terming providers will affect overall network adequacy compliance	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L
3. Continue to find new ways to address gaps in network adequacy	Continue to conduct gap analysis, implement efforts to reduce gaps, and examine the effectiveness of the intervention to find new solutions	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L

DRAFT 03.19.2026

MC = Medi-Cal; OC= OneCare

VIII. Conclusion:

CalOptima Health conducted a gap analysis of our network to identify opportunities with providers and expand our network. It conducted multiple outreach efforts and implemented recruiting initiatives to address network gaps and increase access to care for our members. It has been successful at closing gaps in the OneCare program, as well as improving upon the gaps identified in the Medi-Cal program. Partnering closely with our health networks has been key to improving and expanding our provider network, while also addressing identified gaps in the provider-to-member ratio.

Establishing the Network Adequacy Workgroup as a forum to discuss gaps cross-functionally has helped the organization operate collaboratively, with better visibility one the what and why for gaps, leading to more thoughtful solutions with better visibility to outcomes and barriers.

CalOptima Health will continue to monitor ongoing interventions and conduct network adequacy gap assessments to evaluate the effectiveness of these interventions, as well as ensure the plan meets all network adequacy components under Medi-Cal and OneCare. CalOptima Health will continue to implement various strategies to address network gaps and increase access for its members.

5.2 Improve Timely Access: Appointment Availability/Telephone Access	
Author: Karen Jenkins	Department(s): Quality Analytics
Responsible Party(ies): Kelli Glynn (Director, Quality Initiatives); Helen Syn (Manager, Quality Analytics); Karen Jenkins (Project Manager, Quality Analytics)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Improve Timely Access compliance with Appointment Wait Times to meet 70% MPL	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

CalOptima Health engaged a professional health care survey vendor to conduct its annual appointment access survey for MY 2024. The primary objective of this survey was to ensure that members have timely access to appointments and care. Additionally, it aimed to verify that all contracted providers comply with access to care standards mandated by contract, and in alignment with regulations from the DMHC, DHCS and the CMS.

The survey encompassed both Medi-Cal and OneCare lines of business and was conducted from October 15 to December 5, 2024. Utilizing a direct survey methodology, callers identified themselves as representatives of CalOptima Health. The survey universe included contracted providers across various provider types, including primary care (FQHCs and community clinics), specialty care, behavioral health, and ancillary care groups.

II. Data Sources and Methodology

QAC 03.19.2026

The Timely Access Survey is fielded annually. For the 2024 survey results, the survey monitoring process changed from a three-year escalation cycle to a one-year cycle to support the timelier issuance of CAPs and noncompliance notices to providers. Noncompliance notices were issued for deficiency with one appointment standard, and CAPs were issued for deficiency with two or more appointment standards. Additionally, CalOptima Health adjusted the MPL threshold from 80% to 70% to align with the DHCS-recommended guidelines.

The survey data collection methodology included both census and sampling data. Census data was utilized for provider types with universes of less than 100 providers, while sampling was applied for provider types with universes of 100 or more providers. Providers were not contacted on weekends or holidays, and each contact attempt was limited to a maximum of three attempts to reach a live person.

The survey employed a direct script methodology to gather appointment times, with callers adhering strictly to the script. The surveyor collected the availability of other providers at the same location who could potentially see the patient sooner. Notably, from 2023 to 2024, the follow-up criteria for Medi-Cal Non-physician BH changed from 20 calendar days to 10 business days.

In 2025, after an in-depth analysis, it was determined that telephone measures are not a regulatory requirement. Consequently, the CalOptima Health Timely Access Workgroup decided not to hold providers accountable for compliance purposes and will not issue notices of noncompliance. However, the workgroup agreed to continue surveying, monitoring and educating providers on the importance of the "instruct caller to ER or dial 911 in case of emergency" telephone measure, as it is considered best practice.

A new survey question regarding PCP after-hours availability was added to the survey script in 2024 for NCQA purposes. The survey question asks, “Does the office have an on-call provider or answering service available for after-hours calls 24 hours, seven days a week?” Since this is not a DHCS nor DMHC requirement, individual providers will not be monitored for compliance. At this time, results will be used for NCQA purposes only.

Appointment Standards

2024 Medi-Cal	2024 OneCare
Primary Care Nonurgent – 10 business days Primary Care Urgent – 48 Hours	Primary Care - Services Not Emergent or Urgently Needed but Require Medical Attention – 7 business days Primary Care Routine and Preventive Care (Physical Exam) – 30 business days
Specialists Nonurgent – 15 business days Specialists Urgent with Prior Authorization – 96 hours OB/Gyn Nonurgent – 15 business days OB/Gyn Urgent – 48 hours Psychiatrists Nonurgent – 15 business days Psychiatrists Urgent – 48 hours	 Psychiatrist Routine and Preventive Care – 30 business days

QAC 03.19.2026

Back to Agenda Back to Item

Psychiatrists Follow-up Care – 30 calendar days	
Nonphysician BH Nonurgent –10 business days Nonphysician BH Urgent – 48 hours Nonphysician Follow-up Care – 10 business days	Nonphysician BH Routine and Preventive Care – 30 business days
Ancillary Nonurgent – 15 business days	Not Applicable

Telephone Standards

Description	Standard
Telephone access after/during business hours for emergencies	The phone message and/or live person must instruct members to dial 911 or go to the nearest emergency room in case of an emergency
After-hours access	A PCP or designee will be available 24/7 to respond to after-hours member calls or to a hospital emergency room practitioner

III. Program Results and Quantitative Analysis:

The following tables include Timely Access results for both Medi-Cal and OneCare from 2021 to 2024. Starting in 2023, multiple appointment times were collected; however, when determining compliance, CalOptima Health selects the highest rate. To simplify the data in the tables, only the highest rate for 2023 is shown.

Medi-Cal

Appointment Types	2021	2022	2023	2024 Individual Provider	2024 Another Office Provider	Met MPL	Difference*
Primary Care Nonurgent (10 business days)	72%	61%	88%	82%	97%	Met	+9
Primary Care Urgent (48 hours)	63%	59%	75%	67%	85%	Met	+10
Specialists Nonurgent	59%	49%	74%	64%	86%	Met	+12
Specialists Urgent (96 hours)	64%	55%	59%	64%	80%	Met	+21
OB/GYN Nonurgent (15 business days)	81%	81%	74%	73%	89%	Met	+15
OB/GYN Urgent (48 hours)	76%	70%	64%	44%	75%	Met	+11
Psychiatrist Nonurgent (15 business days)	54%	59%	89%	73%	100%	Met	+11

Psychiatrists Urgent (48 hours)	24%	86%	47%	29%	55%	Not Met	+8
Psychiatrists Follow-Up (30 calendar days)	59%	32%	85%	56%	33%	Not Met	-29
Nonphysician BH Nonurgent (10 business days)	75%	67%	83%	83%	100%	Met	+17
Nonphysician BH Urgent (48 hours)	57%	69%	70%	62%	76%	Met	+6
Nonphysician BH Follow-Up (2024: 10 business days) (2021-23: 20 calendar days)	71%	67%	81%	70%	72%	Met	-9
Ancillary Nonurgent (15 business days)	85%	73%	64%	97%	100%	Met	+36

*2023 versus highest rate for 2024

OneCare

Appointment Types	2023	2024 Individual Provider	2024 Another Office Provider	Met MPL (Highest rate for 2024)	Difference*
Primary Care - Services Not Emergent or Urgently Needed but Require Medical Attention (seven business days)	79.6%	70%	90%	Met	+10
Primary Care Routine and Preventive Care - Physical Exam (30 business days)	92.8%	86%	97%	Met	+4
Psychiatrist Routine and Preventive Care (30 business days)	96.8%	92%	100%	Met	+3
Nonphysician BH Routine and Preventive Care (30 business days)	94.7%	96%	100%	Met	+5

*2023 versus highest rate for 2024

Telephone – Medi-Cal and OneCare

Telephone Call Type	2021	2022	2023	2024	Met MPL	Difference*
Instructs Caller to ER/911	20.8%	19.7%	62.1%	56%	Not Met	-6
After-Hours Care 24/7	n/a	n/a	n/a	76.2%	Met	n/a

*2023 versus highest rate for 2024

Quantitative Analysis

Starting in 2023, CalOptima Health's survey methodology takes into account the appointment availability of other providers who can see the patient sooner at the same location. Therefore, to determine compliance, the highest rate is selected between the provider who was selected to participate in the survey and the availability of the other provider. To simplify the analysis for 2023, the data table includes only the highest compliance rates.

Medi-Cal

There are 13 appointment standards CalOptima Health monitors providers on to ensure our members have appropriate and timely access to care. The 2024 compliance rates for another office provider were the highest, ranging from 72% to 100%, with the exception of the Follow-up Appointment for Psychiatrist. In addition, Follow-up Appointments for Psychiatrist and Psychiatrist Urgent did not meet the 70% MPL threshold. When analyzing the data for trends between 2023 and 2024, it is evident that there has been a significant improvement, as most standards showed an increase ranging from 8 to 36 percentage points. However, follow-up appointments for both psychiatrist and non-physician BH decreased by 29 and 9 percentage points, respectively.

OneCare

The analysis for 2024 reflects impressive performance outcomes across various indicators. All performance standards exceeded the 70% MPL. Compliance rates for another office provider were the highest, ranging from 90% to 100%. This indicates a positive trend and consistent improvement compared to the previous year, where the rates were marginally lower. The 100% target achievement showcases the effectiveness of the implemented strategies and the commitment to maintaining high standards of care.

Telephone – Medi-Cal and OneCare

The measure "Instruct caller to ER or dial 911 in case of emergency," did not meet the 70% MPL threshold. This trend is consistent with the performance of prior years. The compliance rate decreased, dropping from 62.1% in 2023 to 56% in 2024, marking a decline of more than six percentage points.

In 2024, the availability of after-hours care among PCPs successfully met the 70% MPL threshold. However, since this question was newly introduced in the 2024 survey, no trend analysis is available at this time.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
• Contracted with a new survey vendor in July 2025 and streamlined the survey process to be completed within a year from annual survey to annual survey a. Follows Provider Appointment Availability Survey (PAAS) methodology b. Inclusive of vendor education to noncompliant providers	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

Back to Agenda Back to Item

QAC 03.19.2026

c. Survey process includes five distinct phases, and noncompliant providers are given up to three opportunities to resurvey d. Continued noncompliance to be escalated to the Compliance Committee for further review and potential disciplinary action				
• Engaged in quarterly health network patient experience meetings to collaborate on processes, opportunities, and interventions including CAHPS, Access and Customer Service	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• Offered Access webinar trainings and Q & A sessions a. Appointment Access- The Song that Never Ends b. CHCN Network Lunch and Learn c. Community Health Centers Monthly Forum	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
• Issued noncompliance letters to: a. Providers: i. CAPs: 73 ii. Noncompliance: 184 b. Health Networks: 4 CAPs	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
• CAP Follow-up Outreach a. Health networks were assigned certain providers for outreach to confirm receipt of CAP, provide guidance for thorough root cause analysis and ensure the response is returned to CalOptima Health b. The Quality Analytics team conducted outreach through multiple modalities to collect outstanding CAP responses, including phone, fax and email.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
• MPL has been adjusted from 80% to 70% to align with the recommended guidelines provided by DHCS	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☒ Other (Plan Level)	☒ Completed ☐ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

The effectiveness of the first three interventions cannot be determined yet because the 2025 access survey results have not been received. This survey is conducted annually, and the interventions began implementation in the third quarter.

Adjusting the MPL from 80% to 70%, as recommended by DHCS guidelines, has significantly improved compliance for CalOptima Health and its individual health networks. In 2023, CalOptima Health met only five out of 13 standards for the Medi-Cal LOB. However, in 2024, 11 standards were met. Similarly, for the OneCare LOB, three out of four standards were met in 2023, and all standards were met in 2024.

The changes in requirements for issuing CAPs and noncompliance notices, along with the removal of monitoring telephone measures for compliance, have significantly reduced the number of noncompliance notices issued to providers for MY 2024.

VI. Qualitative Analysis

Back to Agenda Back to Item

Appointment Access:

Initial analysis of the access survey results was conducted by the Quality Analytics project manager and the manager. The data was presented at Timely Access Workgroup meetings for review, development of interventions and determination of next steps. The workgroup met five times in 2025 and includes representation from the following departments: Medical Management, Provider Relations, Health Network Relations, Behavioral Health, Quality Analytics, Provider Data Operations and Quality Improvement.

Appointment Standard:

CalOptima Health met the MPL threshold for all standards with the OneCare LOB. For Medi-Cal, most standards were met except for two BH standards:

- Psychiatrist Urgent Appointment: 55%, which is 15 percentage points below the threshold.
- Psychiatrists Follow-up Appointment: 56%, which is 14 percentage points below the threshold.

These compliance rates were notably lower compared to the 2023 rates. The decrease in performance may be attributed to a smaller size surveyed in 2024.

Overall, when compared year-to-year, the steady increase in performance rates suggests an adequate system of care delivery, except for certain specialties. This consistent rise can be attributed to enhanced training, improved resource allocation and more effective patient engagement strategies.

Moving forward, it's essential to continue monitoring these trends to ensure sustained high performance. Identifying areas of opportunity and potential challenges early on will enable proactive measures, thereby maintaining the momentum of positive outcomes.

Telephone Standards:

In 2024, CalOptima Health's compliance rate for the telephone measure "Instruct caller to ER or dial 911, in case of emergency" was 56%, 14 percentage points below the MPL. Additionally, the compliance rate trended downward from 2023 to 2024, which could be due to the smaller pool of providers surveyed in 2024.

Findings show that PCP after-hours care successfully met the 70% MPL threshold.

Overall Causal/Barrier Analysis:

- Providers may not be familiar with the access standards, leading to noncompliance.
- Providers and others may not realize that participation in the survey is a federal and state requirement, resulting in nonparticipation when called upon.
- Providers were not notified of their noncompliance status until months later, after they were surveyed.
- Providers do not submit a response to the CAP in a timely manner.

QAC 03.19.2026

- Provider offices have limited appointment availability due to a lack of staffing.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Educate providers on the importance of the Access Survey	• Issue a notice of noncompliance within four to five weeks after being surveyed • Vendor to educate noncompliant providers on standards • Include updates on the new survey process in CalOptima Health's Provider Update communication • Offering appointment access, webinars and trainings in collaboration with the SullivanLuallin Group • Encourage health networks to take action with noncompliant providers	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
2. Issue noncompliance notices via the CalOptima Health Provider Portal	• Incorporate noncompliance survey results and CAPs into CalOptima Health's Provider Portal to enhance tracking and follow-up communication	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ H ☐ M ☒ L
3. Provider offices to maximize the office schedule	• Offer extended office hours at least once a week • Schedule appointments so there is availability for walk-in/same-day appointments • Expand office capacity by hiring additional staff, including nonphysician medical practitioners	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
4. Change the fielding period to a more practical time of year for provider offices	• Survey scheduled for Q3	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ H ☒ M ☐ L
5. Expansion of specialist and behavioral health provider network through telehealth options.	• Telehealth efforts to increase provider accessibility, especially for key specialties	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC= OneCare

VIII. Conclusion:

The 2024 survey findings indicate that the interventions implemented have proven effective, as evidenced by the increase in rates for both Medi-Cal and OneCare standards. However, it is important to note that exceptions were observed in the areas of Psychiatrist Urgent and Psychiatrist Follow-up Appointments, and this area will remain on the work plan for 2026.

Despite these improvements, significant work remains as we continue to implement and monitor the new 2025 survey process. Ongoing efforts will focus on addressing the areas where standards have not yet been met, including the "Instruct caller to the ER or dial 911 in case of an emergency" telephone

measure, and ensuring that the positive trends observed in other areas are maintained and further enhanced.

5.3 Network Adequacy Regulatory Submission and Audits	
Author: Cathy dela Cruz	Department(s): Provider Data Operations
Responsible Party(ies): Quynh Nguyen (Director, Provider Data Operations); Cathy Dela Cruz (Manager, Provider Data Operations)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Comply with regulatory requirements • Annual Network Certification (ANC) • Subdelegate Network Certification (SNC) • Network Adequacy Validation (NAV) Audit	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

DHCS APL 21-006 and 23-001: Network Certification Requirements, established network adequacy standards, the Annual Network Certification (ANC) process, which assesses and certifies CalOptima Health for network adequacy at least annually, to ensure CalOptima Health's provider network meets state and federal network adequacy and access requirements.

DHCS APL 23-001: Delegation and Subcontractor Network Certification (SNC) added additional network adequacy requirements, requiring CalOptima Health to undergo a separate and distinct certification process from the ANC, to provide the state with assurances that each subcontractor's and downstream subcontractor's provider network meets state and federal network adequacy and access requirements.

In addition to the annual schedule, CalOptima Health must undergo a separate SNC if CalOptima Health's network experiences a change that substantially affects how it services members or enters into a new subcontractor agreement.

II. Data Sources and Methodology

CalOptima Health's ANC, SNC and Network Adequacy Validation (NAV) Audit covers the time period from January 1, 2025, through December 31, 2025. The monthly 274 file comprises the provider data used for ANC, SNC certifications and the NAV audit. CalOptima Health conducts quarterly monitoring of its plan's provider network against anticipated membership for all of Orange County. CalOptima Health conducts quarterly monitoring and reporting of its subcontracted networks or health networks against the health network's assigned membership.

A. CalOptima Health complies with the following ANC requirements:

1. Mandatory provider type (including cancer center)
2. Network Capacity (FTE)
    a. PCP: 1:2,000 ratio
    b. Physician: 1:1,2000 ratio

OAC 03.19.2026

3. Time or distance
    a. Starting in Plan Year 2024, DHCS changed the compliance rate to 99%

B. For SNC, CalOptima Health uses the November 274 and November member data for the health network to run the analyses for each health network. These analyses are used to determine whether the health network complies with the network adequacy standard, as outlined in policy GG.1600: Access and Availability. The results are then used for CalOptima Health's annual SNC submission in accordance with policy GA.7111 Health Network Certification.

C. CalOptima Health uses the Quest Analytics Suite to conduct accessibility analyses and mapping to meet time/distance standards identified in the CalOptima Health Access and Availability Policies referenced earlier. The accessibility analyses must demonstrate coverage of the entire service area at the plan level and of the members covered at the health network level, according to the standards mentioned in sections A and B.

III. Program Results and Quantitative Analysis:

Indicator/Goals: Comply with regulatory requirements for ANC, SNC, NAV Audit

Actions Completed	
Quarter 1	• CalOptima Health issued 2024 SNC CAPs to HNs that did not meet requirements • Quarterly monitoring of ANC requirement and gap analysis • Quarterly monitoring of HNs for SNC requirement and gap analyses • Completed 2024 ANC and Alternative Access Standards (AAS) submission in March 2024 • Worked on posting approved 2023 AAS from DHCS on the website
Quarter 2	• Quarterly monitoring of ANC requirement and gap analysis • Quarterly monitoring of HNs for SNC requirement and gap analyses • CalOptima Health submitted NAV Audit ISCAT questionnaire and all required supporting documents • CalOptima Health authorized the use of Telehealth and Alternative Access Standard to close remaining HN 2024 SNC Gaps
Quarter 3	• Quarterly monitoring of ANC requirements and gap analysis • Quarterly monitoring of HNs for SNC requirement and gap analyses • Closed all 2024 SNC CAPs issued to HNs and certified all HNs for RY 2024 SNC. • Completed RY 2024 NAV Virtual Audit with HSAG, including additional document submission requested at the end of the audit.
Quarter 4	• Completed 2025 SNC Landscape Analysis submission to DHCS • Quarterly monitoring of ANC requirements and gap analysis • Quarterly monitoring of HNs for SNC requirement and gap analyses • Annual in-depth analysis of HN compliance with requirements will be conducted in December to determine whether the HN has met SNC requirements for certification or will need to be issued a CAP for Reporting Year 2025.

Results:

- DHCS 2024 ANC assessment in Q1 found CalOptima Health in full compliance with the following requirements:
    - MPT — Hospital, Cancer Treatment Validation

- MPT, LTSS, OB/Gyn PCPs
- Network Capacity Ratio (PCP, Total Physician, Outpatient NSMHS)

- DHCS 2024 ANC assessment found CalOptima Health did not meet time and distance requirements for 21 zip codes; therefore, CalOptima Health completed the required ANC submission, which includes recruitment efforts and Alternative Access Standards Request, which was approved by DHCS in Q4.
- CalOptima Health completed the NAV Virtual Audit with HSAG in Q3 and received confirmation in Q4 that the audit is fully closed. The final plan-specific validation rating determination will be shared in January 2026.
- CalOptima Health completed the 2025 SNC Landscape Analysis submission to DHCS with a correction that TeleMed2U is not exempt from the next step, which is the annual SNC submission, due to mental health services having network adequacy standards. CalOptima Health will include TeleMed2U in the upcoming 2025 SNC submission, in February 2026.
- CalOptima Health 2025 SNC Assessment found Health Networks non-compliant with Time or Distance and Provider-to-Member Ratio standards, all other components were met. Those found non-compliant will be issued a CAP in January 2026. The assessment showed one health network without deficiency, which is Providence.
- DHCS completed the 2025 ANC and found CalOptima Health in compliance with Time or Distance Standards.

SNC Components	Directory Review	Network Capacity/Ratio (FTE)	Provider to Member Ratio (PMR)	Time or Distance	Whole-Child Model Program
Subcontracted Health Network	**Q3**	**Q4**	**Q4**	**Q4**	**Q4**
AltaMed Health Services	Met	Met	Not Met	Not Met	Met
AMVI Care Health Network	Met	Met	Not Met	Not Met	Met
CHOC Physicians Network	Met	Met	Met	Not Met	Met
Family Choice Health Services	Met	Met	Not Met	Not Met	Met
Heritage Provider Network	Met	Met	Met	Not Met	Met
Nobel Mid-Orange County	Met	Met	Met	Not Met	Met
Optum	Met	Met	Not Met	Not Met	Met
Prospect	Met	Met	Not Met	Not Met	Met
Providence*	N/A	Met	Met	Met	Met
United Care Medical Group	Met	Met	Not Met	Not Met	Met

C 19.2026

**Providence became a health network effective Q4 on November 1, 2025. They will be part of the semiannual Directory Review starting in 2026*

IV. Data Stratification Results and Quantitative Analysis:

Indicator/Goal: CalOptima Health must ensure that its subcontractors or health networks meet network adequacy standards at both the state and federal levels through the SNC process.

- All health networks meet the required Network Capacity Ratio for PCP (1:2000) and All Physician (1:1200) in Q4. This has been a consistent result throughout 2025.
- All health networks meet the Directory Review requirements as applicable
- Providence, a new health network effective November 1, 2025, met time or distance standards. The rest of the health networks did not meet time or distance standards in Q4.
- In 2025, the aggregate health network time or distance gaps decreased from Q1 to Q4, due largely to CalOptima Health's SNC process, which requires contracting and recruiting efforts to close gaps. Due to the lengthy nature of the recruiting process, we are now seeing the results of the health networks' efforts that began in Q1.
- 2025 Q4 gaps are also less compared to 2024 Q4 time or distance aggregate gap count.
- Data results for Q4-PMR are not yet available

V. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. PDO and PR performed recruitment outreach to address the time or distance gaps identified in the 2024 ANC package received from DHCS	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
2. Issued CAPs to HNs who did not meet SNC standards for Time or Distance and PMR	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
3. PDO created a NAV Workplan to facilitate the completion of the NAV submission elements from multiple departments	☐ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
4. Changed the department owner for recruitment outreach from PR to Contracting to help expedite the contracting process.	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

VI. Effectiveness of Interventions:

CalOptima Health implemented interventions throughout the year to address the network adequacy gaps identified in 2025. Below is the analysis of the effectiveness of each intervention deployed.

1. The recruitment outreach intervention deployed to close gaps identified in DHCS's ANC time or distance analysis of CalOptima Health's provider network was not successful in closing the gaps in time for submission. This is because the information on the DHCS FFS website for providers

OAC 03.19.2026

that can close the gaps proved to be outdated. Most providers are no longer practicing at the indicated location, having retired or lost interest. This is why the AAS request had to be submitted.

2. Issuing CAPs to health networks not meeting SNC standards was effective at decreasing the gaps of the health networks via contracting efforts, and in turn expanding CalOptima Health's plan-level provider network.
3. Creating a NAV Workplan to execute the collection of over 30 supporting documents and completing the ISCAT questionnaire was effective in being able to provide an in-depth and complete submission. This paved the way for a smooth Virtual Audit, with no follow-up questions or additional new documentation requested after the audit.
4. The process change for recruitment outreach was recently implemented in Q4, and the effectiveness cannot be measured until the end of Q1 2026.

VII. Qualitative Analysis

DHCS's 2024 ANC Assessment showed CalOptima Health did not meet time or distance standards. CalOptima Health deployed interventions to address the identified gaps and completed the required submission to ensure regulatory compliance with the ANC.

Qualitative Analysis was conducted by the Provider Data Operations director, Provider Data Operations Analytics senior manager, Provider Data Operations manager, Provider Relations director, Provider Relations manager, and Contracting director to drill down and identify barriers that prevented CalOptima Health's interventions from being successful at closing the time or distance gaps.

Causal/Barrier Analysis Results:

1. CalOptima Health used the DHCS Fee-for-Service database to find providers to close ANC gaps. The outreach results were unsuccessful in closing gaps due to a significant number of providers with inaccurate practice locations, invalid contact information or who were not interested in contracting.
2. DHCS and CalOptima Health do not use the same geomapping methodology, leading to different assessment results between CalOptima Health's plan monitoring and DHCS assessment. DHCS does not require CalOptima Health to switch geomapping vendors, but this means we may not know about a gap until DHCS completes its assessment, despite our own monitoring efforts.
3. It takes months to recruit and contract providers, which means gaps may continue to remain open for multiple months.

VIII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

OAC 03.19.2026

Back to Agenda Back to Item

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. CalOptima Health is exploring ways to have a geomapping methodology that is closer to DHCS	The Provider Data Operations team is requesting a software upgrade to Quest QES Cloud product that offers more detailed geomapping features	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L
2. CalOptima Health will explore how to prevent our provider network from losing providers through terminations, given the length of the process to recruit new ones	Provider Data Operations will work with Credentialing, Contracting and Provider Relations to create a process to assess network adequacy impact early to prevent providers from terming due to recredentialing nonsubmission	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L
3. Provide support to the health networks to help them better understand and address network adequacy requirements and gaps	Revise the current health network certification policy to provide more information to health networks about the SNC process	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L
4. Improve the SNC process for health networks	Review and revise the process and materials as needed to better align with DHCS's processes for uniformity and to shorten the length of time to complete the certification.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC = OneCare

IX. Conclusion:

CalOptima Health continues to fulfill its goal of meeting regulatory submission requirements for ANC, SNC and the NAV Audit. It successfully completed the NAV Virtual Audit with HSAG, requiring no additional documentation requests or questions.

For ANC regulatory requirements, CalOptima Health successfully completed all required monitoring and submission requirements throughout the year, while also meeting most of the standards. As for time or distance, CalOptima Health will not be able to fully replicate DHCS's time or distance analysis results when conducting monitoring activities due to different software, but it has a software upgrade planned for 2026, which will help improve our analyses and intervention efforts.

Nevertheless, CalOptima Health meeting 2025 ANC time or distance standards shows that consistent work monitoring its own network as whole and its health networks, can be an effective way to ensure that CalOptima has an adequate network to serve our members, without having to use a different software.

Regarding SNC regulatory requirements, CalOptima Health has successfully completed all 2025 SNC Landscape Analysis submissions and is poised to meet the 2025 SNC submission timeline and data requirements provided by DHCS. Furthermore, CalOptima Health continues to look to DHCS as a guide on how to better provide guidance, education and further support to all health networks during its own SNC process, so that the health networks continue to have a provider network that is adequate to meet the needs of its assigned members.

OAC 03.19.2026

Moving forward, CalOptima Health will continue its monitoring activities and review its processes and procedures to provide clear guidance and support to health networks, while also exploring other ways to support the overall expansion of the plan provider network. This will enable the continued meeting of network adequacy regulatory requirements.

5.4 Increase Primary Care Utilization - Initial Health Appointment	
Author: Stefanie Johnson	Department(s): Case Management
Responsible Party(ies): Katie Balderas (Director, Case Management); Stefanie Johnson (Program Manager, Case Management)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Increase the IHA completion rate for all new Medi-Cal members from 33% to 50% by December 31, 2025. To support this goal, CalOptima Health continued its efforts to promote primary care utilization and preventive screenings for unengaged members. This initiative aligns with CalOptima Health's broader commitment to strengthening primary care and advancing prevention and wellness for all members. In accordance with DHCS guidance, primary care visits and screenings continue to serve as proxy measures for IHA completion. To operationalize this objective, CalOptima Health focused on the following priority areas: 1. Member Education and Engagement Enhance methods of informing new members about the importance of completing their IHA and participating in preventive screenings through multimodal outreach (e.g., IVR calls, newsletters, new member packets, and staff scripts). 2. Health Network Compliance and Oversight Collaborate with delegation oversight to improve IHA compliance across Health Networks. This includes regular performance monitoring, feedback loops, and support to meet the 50% benchmark. 3. Provider and Health Network Training Deliver targeted education to providers and Health Networks to support timely IHA completion and ensure new member screening for Social Determinants of Health (SDOH) within 120 days of enrollment.	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

DHCS requires that all newly enrolled Medi-Cal members be offered and provided access to an IHA within 120 days of their enrollment date. The IHA is a comprehensive assessment conducted during the members' first visit with their assigned or selected PCP and must be delivered in a culturally and linguistically appropriate manner.

For members under age 21, the IHA must be offered within 120 days of enrollment or in accordance with the Bright Futures periodicity schedule established by the AAP—whichever is sooner.

The IHA includes a review of the member's physical and behavioral health history, identification of health risks, assessment of preventive care needs and the development of a treatment plan for any identified

OAC 03.19.26

conditions. In 2023, DHCS clarified that primary care visits and screenings may serve as proxy measures for IHA completion, reinforcing the importance of early engagement in primary care.

This program supports CalOptima Health's broader commitment to prevention, wellness and health equity by ensuring that new members are connected to care early and comprehensively.

II. Data Sources and Methodology

CalOptima Health utilizes a combination of claims and encounter data, along with quality performance measures, to monitor IHA completion and track progress toward the 2025 goal.

1. Claims and Encounters for IHA Completion

The IHA Performance Report continuously extracts and processes claims data to identify completed IHAs for eligible members. This report aligns claims with member enrollment dates and filters for specific billing codes to confirm IHA completion. Data is aggregated monthly and integrated into the Delegation Oversight Committee (DOC) Dashboard, which is used to monitor IHA completion rates across health networks.

In 2025, CalOptima Health maintained the IHA KPI benchmark at 50% for all health networks, reinforcing accountability and alignment with DHCS expectations. The Delegation Oversight Dashboard (Medi-Cal DOC by health network and month) also serves as a feedback tool, enabling health networks to track their performance and identify areas for improvement.

2. Quality Measures as Proxy for IHA Completion

CalOptima Health leverages MCAS and HEDIS quality measures as proxy indicators for IHA completion, particularly for preventive care and primary care utilization. The MY 2025 Prospective Rate Report, produced by the Quality Analytics team, is shared monthly with each health network and CHCN to track performance on these measures.

Key measures used as IHA proxies include:

- Depression Screening and Follow-Up for Adolescents and Adults
- Child and Adolescent Well-Care Visits
- Childhood Immunization Status – Combination 10
- Developmental Screening in the First Three Years of Life
- Immunizations for Adolescents – Combination 2
- Lead Screening in Children
- Topical Fluoride for Children
- Well-Child Visits in the First 30 Months of Life (0–15 Months and 15–30 Months)
- Chlamydia Screening in Women
- Breast Cancer Screening
- Cervical Cancer Screening

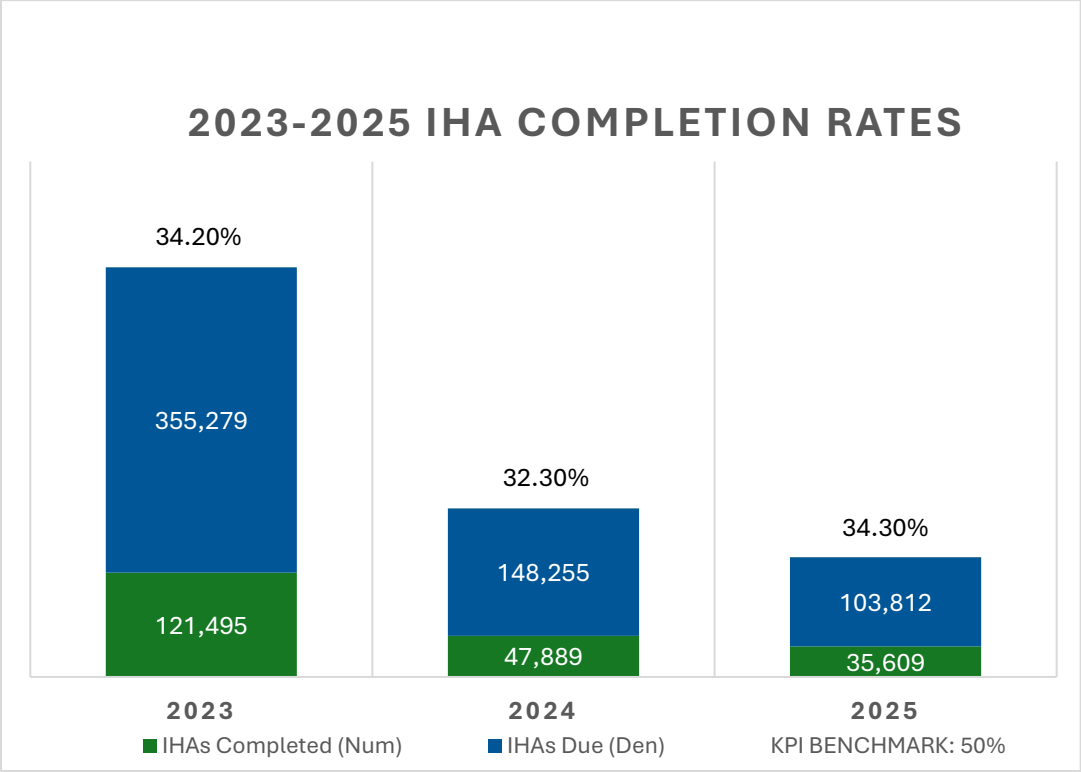
OAC 03.19.2026

- Adults' Access to Preventive/Ambulatory Health Services

These measures are primarily reviewed during scheduled Joint Operations Meetings (JOMs) and bimonthly Quality Update Meetings with health networks to support continuous improvement and alignment with IHA-related goals.

III. Program Results and Quantitative Analysis:

Chart A: 2023–2025 IHA Completion Rates: Three Consecutive Annual Trends of IHA Compliance Rates



* Please note data was generated on December 4, 2025 from Report CC0163B. IHA completion rates are retrieved from claims data and require at least three months to be retrieved after the reporting period to account for any lag in claims data; data pulled for 2025 is preliminary.

Table A: 2025 IHA Completion Performance: Quarterly Rates for All Ages Versus Members ≤18 Months Compared to 50% KPI Benchmark

2025 IHA Performance												
	Num	**Den**	**Qtr. 1**	**Num**	**Den**	**Qtr. 2**	**Num**	**Den**	**Qtr. 3**	**Num**	**Den**	**Qtr. 4**
All Ages	10,863	31,482	34.51%	19,657	74,289	26.46%	9,487	28,119	33.74%	10,018	25,903	38.68%
≤18 Months	2,079	3,080	67.50%	1,701	2,053	82.58%	2,136	3,020	70.73%	1,881	2,628	71.58%
* Please note data was generated on December 4, 2025 from Report CC0163B. IHA completion rates are retrieved from claims data and require at least three months to be retrieved after the reporting period to account for any lag in claims data; data pulled for Q4 2025 is preliminary.												

Table B: 2023-2025 Annual Rates for IHA Completion Over Three Consecutive Years

2023–2025 IHA Completion Rates			
	2023	2024	2025
IHAs Completed (Num)	121,495	47,889	35,609
IHAs Due (Den)	355,279	148,255	103,812
IHA Completion Rate	34.20%	32.30%	34.30%
* Please note data was generated on December 4, 2025 from Report CC0163B. IHA completion rates are retrieved from claims data and require at least three months to be retrieved after the reporting period to account for any lag in claims data; data pulled for 2025 is preliminary.			

Table C: 2025 IHA Completion Rates by Health Network: Quarterly Performance Against 50% KPI Benchmark

2025 IHA Performance				
	Quarter 1	**Quarter 2**	**Quarter 3**	**Quarter 4**
CHCN	47.48%	51.36%	49.13%	51.32%
COD	63.29%	71.91%	82.84%	86.11%
AltaMed	23.83%	22.84%	23.48%	24.13%
AMVI	27.09%	21.43%	20.91%	21.03%
CHOC	57.21%	60.87%	63.25%	64.42%
Family Choice	30.98%	23.44%	22.64%	23.64%
HPN-Regal	20.61%	19.98%	16.11%	16.01%
Noble	21.92%	21.09%	20.44%	19.79%
Optum	29.84%	28.24%	27.53%	27.24%
Prospect	23.53%	23.00%	21.81%	24.83%
United Care	34.51%	26.90%	24.41%	29.32%
* Please note data was generated on December 4, 2025 from Report CC0163B. IHA completion rates are retrieved from claims data and require at least three months to be retrieved after the reporting period to account for any lag in claims data; data pulled for Q4 2025 is preliminary.				

IV. Quantitative Analysis and Performance Trends:

Indicator/Goals: 50% IHA Completion Rate

Quantitative Analysis

Quantitative Analysis

A collective review of IHA performance, including completion and compliance rates, provides a comprehensive view of the quantity of IHAs due and completed, validated through claims data. This analysis reflects CalOptima Health's efforts to improve member engagement, as well as health network and provider compliance with IHA requirements.

Annual Performance Trends:

In 2025, the overall IHA completion rate was 34.3%, reflecting a modest gain over 2024's 32.3%, despite a

decrease in absolute volume compared to the prior year. The number of IHAs completed totaled 35,609, while the number of IHAs due was 103,812, indicating stabilization after the surge in Medi-Cal enrollment in 2024. This improvement in rate, despite lower volumes, suggests that the operational strategies implemented in 2025 — such as enhanced outreach and provider education — helped offset the challenges from the prior year's expansion.

Quarterly Performance:
Table A shows quarterly trends for 2025. Q2 reflected the largest denominator compared to other quarters, driven by a surge in new member enrollments early in the year. This increase in IHAs due placed additional operational demands on health networks and providers, contributing to lower completion rates during that period. Despite this challenge, subsequent quarters showed recovery as outreach and provider engagement strategies were reinforced.

Health Network Performance:
Table C highlights variation across health networks. Top performers included COD and CHOC, which consistently exceeded 50% in multiple quarters. CHCN demonstrated steady improvement, achieving near-benchmark performance by Q4. Other networks, such as AltaMed and Optum, remained below target but exhibited incremental gains compared to 2024.

Key Observations:

- Stabilization Post-Expansion: Unlike 2024, when Medi-Cal expansion drove a sharp increase in IHAs due, 2025 reflected normalized enrollment patterns, reducing operational strain.
- Incremental Rate Improvement: Despite fewer IHAs completed in absolute terms compared to 2024, the completion rate improved slightly, indicating better efficiency and engagement.
- Persistent Outreach Challenges: For IHAs not completed, documentation of outreach attempts remained inconsistent, highlighting opportunities for improvement in member engagement and provider follow-up.

Summary Against Goals:
In 2025, the overall IHA completion rate was 34.3%, reflecting a modest gain over 2024's 32.3%, despite a lower volume of IHAs completed. Quarter-to-quarter trends showed recovery following a Q2 dip, and three health networks — COD, CHOC and CHCN — demonstrated strong or improving performance, with COD and CHOC consistently exceeding the 50% benchmark. However, most networks remained below target, indicating that while progress has been made, further interventions are needed to achieve additional improvements.

V. Actions/Interventions Implemented in 2025:

Interventions	Product	Qtr.	Type	Status
• CHCN Virtual Learn Meeting: Ongoing quarterly presentations are provided to CHCN contracted providers to offer IHA updates, performance and reminders. Presentation at Q1 CHCN Virtual Learn Meeting held on March 24, 2025.	☒ MC ☐ OC	☒ Q1 ☐ Q2	☐ Mem ☒ Prov	☐ Completed ☐ Ongoing ☐ Incomplete

Back to Agenda Back to Item

QAC 03.19.2026

• IHA Reference Guide for PCPs: A guide for PCPs to complete the IHA within 120 days from the member's enrollment date with CalOptima Health. This document is shared on the www.caloptima.org website and provided as a resource during trainings.		☐ Q3 ☐ Q4	☐ HN ☐ Comm ☐ Data ☐ Other	
• QIHEC Meeting: Meeting with CalOptima Health leaders to provide direction and oversight of quality improvement processes related to regulatory requirements. IHA updates shared on January 14, 2025, and March 11, 2025. • PHMC Meeting: Quarterly meeting to provide overall direction for continuous process improvement and oversight of the PHM Program, ensure PHM activities are consistent with CalOptima Health's strategic goals and priorities, and monitor compliance with regulatory requirements. IHA updates presented February 20, 2025. • DOC Meeting: Monthly oversight meetings focused on monitoring health network compliance with key performance indicators KPIs, including IHA completion rates. These meetings provide a forum for reviewing performance dashboards, discussing corrective actions, and sharing updates on regulatory requirements and quality initiatives. IHA updates were provided at the March meeting.	☒ MC ☐ OC	☒ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• Member Interactive Voice Response (IVR) Calls: Automated phone calls are sent twice a month, tailored to new members enrolled in CalOptima Health, designed to welcome them and inform them about the next steps to take after enrollment.	☒ MC ☐ OC	☒ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• JOM: Ongoing monthly presentations are provided to all health networks to offer IHA updates, performance rates and reminders. IHA was presented at three JOMs in Quarter 2. • Health Network Quality Update Meeting: Bimonthly quality presentations are delivered to all health networks to provide IHA updates, performance rates, and reminders. IHA was presented at six meetings in May.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☐ Q3 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• DOC Meeting: IHA updates were provided at the May and June meetings. • QIHEC Meeting: IHA updates shared on April 8, 2025, May 13, 2025, and June 10, 2025. • PHMC: IHA updates shared at meeting held on May 16, 2025.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☐ Q3 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Complete ☒ Ongoing ☐ Incomplete
• CHCN Virtual Learn Meeting: Presentation at Q2 CHCN Virtual Learn Meeting held on June 25, 2025. • Provider Update: Monthly CalOptima Health updates to providers. IHA updates are shared in the March Provider Update. • Provider Onboarding: Training is provided to all new CHCN-contracted providers. Training was reviewed and updated in the overall presentation given to newly contracted CHCN providers. This training was updated in April and uploaded to the Provider section of www.caloptima.org. • Provider Annual Training: Yearly training for CHCN contracted providers to discuss updates and ongoing education. This training was updated in April and uploaded to the Provider section of www.caloptima.org.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☐ Q3 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Complete ☒ Ongoing ☐ Incomplete
• Member Interactive Voice Response (IVR) Calls: Automated phone calls are sent twice monthly • Implementation of the New Member Welcome – Two-way texting campaign, designed to guide new CalOptima Health Medi-Cal members through essential onboarding steps to help them get started with their health care.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Complete ☒ Ongoing ☐ Incomplete

HCO 5.19.2026

• Health Network Newsletter: Weekly newsletter sent out to all health networks with important updates and upcoming events from CalOptima Health. Notification on IHA updates sent in Health Network Weekly Newsletter for the week of August 5-9, 2025. • Health Network Delegation Oversight Meeting: Oversight meetings focused on health network compliance and performance. The IHA discussion on completion rates was presented at eight meetings in September. • JOM: IHA was presented at six JOMs in Quarter 3.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☐ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Complete ☒ Ongoing ☐ Incomplete
• DOC Meeting: IHA updates were provided at the August and September meetings. • QIHEC Meeting: IHA updates shared on July 8, 2025, August 12, 2025, and September 9, 2025. • PHMC: IHA updates shared at meeting held on August 21, 2025.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Complete ☒ Ongoing ☐ Incomplete
• Continuing Medical Education: An annual webinar for medical professionals to learn more about the IHA requirements and best practices to complete the IHA with their patients. The webinar was held on August 6, 2025. • CHCN Virtual Learn Meeting: Presentation at Q3 CHCN Virtual Learn Meeting held on September 25, 2025.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Complete ☒ Ongoing ☐ Incomplete
• DOC Meeting: IHA updates were provided at the October and November meetings. • QIHEC Meeting: IHA updates are planned for December 9, 2025.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Complete ☒ Ongoing ☐ Incomplete
• JOM: IHA was presented at three JOMs in Quarter 3.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Complete ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

VI. Effectiveness of Interventions:

Throughout 2025, CalOptima Health implemented a series of interventions to improve IHA completion rates, including enhanced member outreach, provider education, and regular performance monitoring through DOC and JOM meetings. To evaluate the effectiveness of these efforts, Q1 2025 was used as a baseline and compared to Q4 2025 performance for the general Medi-Cal population (all ages).

Key Findings:

- Overall Improvement: The IHA completion rate for all ages increased from 34.51% in Q1 to 38.68% in Q4, indicating a modest but positive trend over the course of the year.
- Top Performing Networks:
    - CHOC improved from 57.21% in Q1 to 64.42% in Q4, consistently exceeding the 50% benchmark, largely attributed to their pediatric population.
    - CHCN increased from 47.48% in Q1 to 51.32% in Q4, crossing the benchmark by yearend.

QAC 03.19.26

- Limited Gains in Other Networks: Most other health networks remained below the 50% benchmark throughout the year, with minimal quarter-over-quarter improvement. For example, AltaMed's rate increased from 23.83% to 24.13%, and Optum's rate decreased from 29.84% to 27.24%, suggesting that interventions had varying levels of impact across networks.

Considerations:
While outreach and engagement strategies were emphasized throughout the year, it is important to note that member outreach attempts are not currently captured through claims data and, therefore, cannot be used as a proxy for IHA completion. As such, the effectiveness of outreach-specific interventions may be underrepresented in this analysis.

Conclusion:
The 2025 interventions were associated with measurable improvements in IHA completion rates among a subset of health networks. However, the overall systemwide rate remains below the 50% benchmark, and performance varied significantly across networks. IHA will remain on the work plan for 2026 and continued monitoring and refinement of strategies will be important to support broader improvement in 2026.

VII. Qualitative Analysis

This analysis was conducted by the Case Management team based on 2025 IHA performance data, internal reporting and feedback received through oversight activities. The purpose was to identify barriers that contributed to underperformance against the 50% IHA completion benchmark and to inform future improvement strategies.

Causal/Barrier Analysis:

Operational Barriers

- Enrollment Surge in Early 2025: A spike in new Medi-Cal enrollments in Q2 increased the volume of IHAs due, placing strain on operational capacity.
- Outdated Member Contact Information: Difficulty reaching members due to incorrect or missing contact details continues to be a barrier.
- Outreach Documentation Gaps: While outreach is encouraged and often conducted, these efforts are not captured through claims data and therefore cannot be reflected in IHA completion metrics.

Health Network Barriers

- Inconsistent Accountability Structures: Some health networks lack clearly defined roles or escalation pathways for IHA oversight and follow-up.
- Staffing: Without a designated point person responsible for IHA performance, follow-through on improvement plans may be inconsistent or delayed. Furthermore, ongoing turnover within health networks has led to gaps in training and continuity of IHA processes.

QAC 03.19.2026

- Competing Priorities: Health networks may be balancing multiple regulatory or operational demands, which can deprioritize IHA completion efforts — especially if not tied to financial incentives or contractual penalties.
- Delays in Member Assignment: The current auto-assignment process delays the timeframe in which new members are assigned to a health network, reducing the window available to complete the IHA within the required 120-day period.

Provider Barriers

- Awareness and Access Issues: Some providers remain unaware of how to access or interpret IHA performance reports.
- Clinic Staffing Constraints: Staffing shortages continue to impact the ability of clinics to prioritize and complete IHAs.
- Variability in Data Submission: Differences in how clinics submit chart review records or encounter data can affect the accuracy and timeliness of reporting.
- Lack of Integration Between EHR and Reporting Systems: In some clinics, EHR systems may not be configured to flag IHA-eligible patients or capture the necessary data elements for reporting, leading to missed or delayed documentation.
- No Mechanism to Report Outreach Attempts: Providers currently have no way to report outreach attempts through claims when they are unable to reach a member. As a result, these efforts, though encouraged, are not reflected in IHA completion metrics.

VIII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
IHA rate only captures completed visits via claims/encounters and does not incorporate health network or provider efforts to reach out to members.	Evaluate the feasibility of capturing outreach attempts for future reporting and incorporation into IHA performance reporting.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☐ Q4	☒ H ☐ M ☐ L
Health networks' performance is consistently below the goal for members of all ages.	Re-evaluate the 50% IHA benchmark Evaluate whether the current benchmark is realistic and aligned with those of peer health plans.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☐ Q3 ☐ Q4	☒ H ☐ M ☐ L
Short timeframe for member outreach once the member is assigned to the health network.	Evaluate opportunities to reduce the timeframe for members to be assigned to a health network	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☐ Q4	☐ H ☒ M ☐ L

MC = Medi-Cal; OC = OneCare

IX. Conclusion:

In 2025, CalOptima Health continued its efforts to improve IHA completion rates through targeted outreach, provider education and performance monitoring. While the overall IHA completion rate (34.3%)

remained below the 50% benchmark, it reflected a modest improvement from 2024 and a return to 2023 levels. A few health networks, most notably CHOC and CHCN, demonstrated meaningful progress, with CHCN crossing the benchmark by Q4.

Despite these gains, the majority of health networks remained below target, and performance varied significantly across the system. Barriers, including staffing constraints, competing priorities, delayed member assignment and limited mechanisms for capturing outreach efforts, continue to impact IHA completion. These challenges underscore the need for ongoing evaluation of operational processes and performance expectations.

Looking ahead, CalOptima Health will continue to assess the feasibility of capturing outreach activity, review the auto-assignment process to reduce delays in member attribution and reevaluate appropriate benchmarks to ensure they are realistic and aligned with quality measures and regulatory expectations. These efforts will support more equitable and achievable performance goals as we work toward improving early engagement in primary care for Medi-Cal members.

5.5 Improve Member Experience/CAHPS	
Author(s): Carol Matthews	Department(s): Quality Analytics
Responsible Party(ies): Kelli Glynn (Director, Quality Initiatives); Carol Matthews (Project Manager, Quality Analytics); Helen Syn (Manager, Quality Analytics)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Increase CAHPS performance to meet goal of OC: One Star Improvement MC: One Star Improvement	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

CalOptima Health is committed to annually monitoring member experience and identifying areas for improvement for all lines of business. By actively seeking feedback from members, CalOptima Health assesses the current state of member satisfaction and experiences and identifies specific areas for improvement. Collecting valid data ensures that the insights gained are reliable, which allows for the development and implementation of evidence-based interventions. The goal is to improve the overall member experience by more effectively meeting our members' needs.

II. Data Sources and Methodology:

CalOptima Health utilizes the CAHPS survey to measure member experience. The CAHPS program is overseen by the United States Department of Health and Human Services, and the surveys are a nationally recognized tool developed by the Agency for Healthcare Research and Quality (AHRQ). The CAHPS process has standardized tools, questionnaires and data collection protocols. CalOptima Health

submits CAHPS rates to NCQA for accreditation and to CMS as part of the CMS's Five-Star Quality Rating System.

III. Quantitative Analysis:

Medi-Cal: Adult

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
RHC	Rating of All Health Care	51.61	55.67	55.21	57.32	☐Y ☒ N
RPD	Rating of Personal Doctor	61.71	69.88	66.30	70.89	☐Y ☒ N
RS	Rating of Specialist	62.50	63.70	69.67	66.34	☒Y ☐ N
RHP	Rating of Health Plan	52.34	57.22	60.22	62.18	☐Y ☒ N
GNC	Getting Needed Care	79.72	76.26	81.39	80.82	☒Y ☐ N
GCQ	Getting Care Quickly	76.04	75.35	77.93	80.23	☐Y ☒ N
CS	Customer Service	87.05	87.89	82.38	89.41	☐Y ☒ N
CC	Coordination of Care	79.55	79.53	NA	84.78	☐Y ☐ N
HWDC	How Well Doctors Communicate	88.10	90.80	91.09	92.57	☐Y ☒ N

Analysis Against Goals and Year-Over-Year Trends

The analysis of the Medi-Cal Adult measures for MY 2022, MY 2023 and MY 2024 indicates a mixed performance against the established goals.

RHC: There was a slight improvement from 51.61 in MY 2022 to 55.67 in MY 2023, followed by a marginal decline to 55.21 in MY 2024. Despite these gains, the rate did not meet the NCQA Quality Compass (QC) 50th percentile goal.

RPD: Significant improvement was observed from 61.71 in MY 2022 to 69.88 in MY 2023, though a decrease to 66.30 was noted in MY 2024. The measure fell short of reaching the QC 50th percentile goal.

RS: There was a notable year-over-year increase, from 62.50 in MY 2022 to 63.70 in MY 2023, and a further rise to 69.67 in MY 2024. This measure surpassed the QC 33rd percentile goal.

RHP: The rate increased steadily from 52.34 in MY 2022 to 57.22 in MY 2023, and then to 60.22 in MY 2024, achieving the QC 33rd percentile goal.

GNC: Despite a slight dip from 79.72 in MY 2022 to 76.26 in MY 2023, the rate improved to 81.39 in MY 2024, meeting the QC 33rd percentile goal.

GCQ: This measure remained relatively stable, with 76.04 in MY 2022 and 75.35 in MY 2023, followed by an increase to 77.93 in MY 2024. However, it did not meet the QC 33rd percentile goal.

QAC 03.19.2026

Back to Agenda Back to Item

CS: There was a consistent performance with a slight improvement from 87.05 in MY 2022 to 87.89 in MY 2023, though a decline to 82.38 in MY 2024. The measure still achieved the QC 50th percentile goal.

CC: The rates remained steady at 79.55 in MY 2022 and 79.53 in MY 2023, with no available data for MY 2024. The measure did not meet any goals.

HWDC: This measure saw a positive trend, increasing from 88.10 in MY 2022 to 90.80 in MY 2023 and 91.09 in MY 2024. Despite this improvement, it did not meet the QC 33rd percentile goal.

Overall, while several measures have shown improvement over the years, there are still areas that require focused interventions to meet and surpass the set goals.

Medi-Cal: Child

Acronym	Measure	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2024 Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Met / Not Met
RHC	Rating of All Health Care	64.20	67.94	68.67	71.07	☐ Y ☒ N
RPD	Rating of Personal Doctor	72.27	67.34	69.97	76.52	☐ Y ☒ N
RS	Rating of Specialist	NA	NA	71.43	70.49	☒ Y ☐ N
RHP	Rating of Health Plan	66.51	63.61	66.01	69.91	☐ Y ☒ N
GNC	Getting Needed Care	77.80	75.18	75.08	82.32	☐ Y ☒ N
GCQ	Getting Care Quickly	82.29	77.81	79.65	85.02	☐ Y ☒ N
CS	Customer Service	88.08	85.17	88.76	87.16	☒ Y ☐ N
CC	Coordination of Care	76.42	77.97	75.68	83.09	☐ Y ☒ N
HWDC	How Well Doctors Communicate	93.99	91.34	92.97	92.91	☒ Y ☐ N

Analysis Against Goals and Year-Over-Year Trends for Medi-Cal Child

RHC: The RHC measure increased from 64.20 in MY 2022 to 67.94 in MY 2023 and then rose slightly to 68.67 in MY 2024. Despite this improvement, it did not meet the QC 50th percentile goal. This indicates a positive upward trend, although efforts are needed to reach the set benchmark.

RPD: There was a decrease from 72.27 in MY 2022 to 67.34 in MY 2023, followed by a slight improvement to 69.97 in MY 2024. The measure did not meet the QC 33rd percentile goal. The downward trend in the earlier years requires focused intervention to ensure consistent improvement.

RS: Data for MY 2022 and MY 2023 is not available. However, in MY 2024, the RS measure was recorded at 71.43, surpassing the QC 33rd percentile goal.

QAC 03.19.26

RHP: The RHP measure declined from 66.51 in MY 2022 to 63.61 in MY 2023, but recovered to 66.01 in MY 2024. Despite the recovery, it did not meet the QC 33rd percentile goal, pointing to the need for sustained improvements in health plan ratings.

GNC: The GNC measure decreased from 77.80 in MY 2022 to 75.18 in MY 2023, and slightly declined further to 75.08 in MY 2024. It did not meet the QC 33rd percentile goal, indicating consistent challenges in accessing needed care.

GCQ: This measure decreased from 82.29 in MY 2022 to 77.81 in MY 2023, but rose to 79.65 in MY 2024. Despite the improvement, it fell short of the QC 33rd percentile goal, suggesting the need for enhancements in the timeliness of care.

CS: The CS measure declined from 88.08 in MY 2022 to 85.17 in MY 2023, then improved to 88.76 in MY 2024, meeting the QC 33rd percentile goal. This fluctuation underscores the importance of maintaining high standards in customer service.

CC: The CC measure saw a slight improvement from 76.42 in MY 2022 to 77.97 in MY 2023, but it dropped to 75.68 in MY 2024, failing to meet the QC 33rd percentile goal. Continuous efforts are needed to enhance care coordination.

HWDC: There was a slight decline from 93.99 in MY 2022 to 91.34 in MY 2023, but it improved to 92.97 in MY 2024. This measure met the QC 33rd percentile goal, indicating strong performance in doctor-patient communication.

Overall, the analysis reveals varied performance across different measures, with some areas showing positive trends while others require focused efforts to meet and surpass the set goals.

OneCare

Acronym	Measure	MY 2022 OneCare Rate/	MY 2023 OneCare Rate	MY 2024 OneCare Rate	MY 2024 OneCare Goal	MY 2024 Goal Met / Not Met
RHC	Rating of All Health Care	86	83	84	84 - 85	☒ Y ☐ N
RHP	Rating of Health Plan	86	84	86	85 - 86	☒ Y ☐ N
GNC	Getting Needed Care	75	75	75	78 - 79	☐ Y ☒ N
GCQ	Getting Appointments and Care Quickly	73	76	77	80 - 81	☐ Y ☒ N
CS	Customer Service	87	86	85	88	☐ Y ☒ N
CC	Coordination of Care	80	83	82	85	☐ Y ☒ N
GNPD	Getting Needed Prescription Drugs	88	86	86	87	☐ Y ☒ N
RDP	Rating of Drug Plan	88	85	87	86 - 87	☒ Y ☐ N

QAC 03.19.2026

Flu	Annual Flu Vaccine	68	68	71	86 - 72	☒ Y ☐ N

Analysis Against Goals and Year-Over-Year Trends for OneCare

RHC: The RHC measure declined from 86 in MY 2022 to 83 in MY 2023, followed by a slight increase to 84 in MY 2024. The goal was met.

RHP: The RHP measure decreased from 86 in MY 2022 to 84 in MY 2023, then returned to 86 in MY 2024, regaining its previous performance level. The goal was met.

GNC: The GNC measure remained constant across all three years, maintaining a steady level of 75 from MY 2022 through MY 2024. The goal was not met.

GACQ: The GACQ measure improved from 73 in MY 2022 to 76 in MY 2023, and continued to rise to 77 in MY 2024, showing a consistent upward trend. The goal was not met.

CS: The CS measure experienced a gradual decline, dropping from 87 in MY 2022 to 86 in MY 2023, and further to 85 in MY 2024. The goal was not met.

COC: The COC measure increased from 80 in MY 2022 to 83 in MY 2023, followed by a slight decrease to 82 in MY 2024. The goal was not met.

GNPD: The GNPD measure declined from 88 in MY 2022 to 86 in MY 2023, and remained stable at 86 in MY 2024. The goal was not met.

RDP: The RDP measure dropped from 88 in MY 2022 to 85 in MY 2023, then rose to 87 in MY 2024, nearly returning to its original level. The goal was met.

AFV: The AFV measure held steady at 68 in both MY 2022 and MY 2023, then increased to 71 in MY 2024, indicating a modest improvement. The goal was met.

Across the nine reported measures, performance exhibited a mixed trend, with areas of improvement, stability and a slight decline. GNC is a measure that has consistently maintained the same performance level for the past three years.

IV. Data Stratification Data Source and Methodology for Race, Ethnicity and Gender:

CalOptima Health's survey vendor uses collected CAHPS data and conducts analysis of selected demographic categories for the CAHPS overall ratings and composites to better understand differences in member experience. The categories are gender, age (18-44 and 45+), education (low education: through high school graduate or GED), ethnicity (Hispanic or Latino and not Hispanic or Latino), the language the survey was fielded in (English or Spanish), and race (White, Black, or African American, Asian, American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander and Other). The

variables are coded for performance: scores equal to or higher than 85%, scores less than 85% but equal to or higher than 75%, and scores less than 75%.

Adult CAHPS Survey Overall Ratings and Composites by Race, Ethnicity and Gender

Ratings	Aggregate Rate	White	Black	Asian	Hawaiian	American Indian	Other Race	Male	Female	Hispanic or Latino	Not Hispanic or Latino
Rating of all health care	76.7	77.3	100*	**67.5**	100*	100*	**71.4**	76.8	76.6	85.9	**66.2**
Rating of personal doctor	87	86.3	100*	86.7	100*	100*	87.5	90.1	85	88.9	85.9
Rating of specialist talked to most often	82.8	90.4	100*	**67.9**	-	100*	75.9	89.6	78.4	88.7	76.7
Rating of health plan	75.5	80.2	**50***	**59.1**	100*	100*	80	79.1	**73**	84.1	**66.7**
Composites	Aggregate Rate	White	Black	Asian	Hawaiian	American Indian	Other Race	Male	Female	Hispanic or Latino	Not Hispanic or Latino
Getting needed care	81.4	85.2	100*	**64.3**	100*	83.3*	87.8	80.1	82.1	89.1	**72.9**
Getting care quickly	77.9	77.4	100*	**54.3**	**50***	100*	82.5	**69.8**	82.7	88.8	**64.5**
How well doctors communicate	91.9	88.1	-	91.2	100*	100*	92.6	90.1	91.7	90.7	91.4
Customer service	82.4	87.7	-	**56.5**	-	100*	93.9	81.3	83	90.4	**71.3**
Coordination of care	84.7	83.3	-	81.8	100*	100*	84.6	83.3	85.5	83.7	85.7

Bold <75%; *Score based on < 11 cases; -no respondents met the criteria

Analysis of the Medi-Cal adult survey results, stratified by race, ethnicity and gender, showed that members of Asian descent scored lower on many measures. For this population, overall rating of personal doctor and how well doctors communicate performed above 85%, coordination of care performed above 75% but below 85%, and the following six overall ratings and composites performed below 75%: rating of all health care, rating of specialist talked to most often, rating of health plan, getting needed care, getting care quickly and customer service.

V. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status	Measures (Acronym)

Conduct outreach to members in advance of 2025 CAHPS survey.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	All
Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	All
Launch eight listening post campaigns via two-way Ushur SMS and provide year-round service recovery in collaboration with multiple departments.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	All
Launch a recurring meeting series with health network partners dedicated to member experience improvement strategy.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	All
Propose mapping of member responses to CAHPS categories in support of the organization adopting a voice of member reporting system.	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☒ Incomplete	All
Train member-facing roles on the Decision Point Insights platform to review and address CAHPS risk during member discussions.	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☒ Incomplete	All

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

VI. Effectiveness of Interventions:

The various interventions enabled CalOptima Health to develop better member feedback mechanisms for improving CAHPS scores. These interventions have been effective in providing member-level feedback to teams, enabling them to develop strategies.

VII. Qualitative Analysis:

Initial analysis of the CAHPS survey results was conducted by the CAHPS project manager. Data was presented at CalOptima Health's Member Experience Committee meetings for review. The committee is an executive team whose purpose is to improve the member experience and drive initiatives that achieve member experience goals. It is responsible for identifying barriers and recommending solutions. The committee met four times in 2025 and included representation from the following departments: Medical Management, Provider Relations, Health Network Relations, Behavioral Health, Quality Analytics, Quality Improvement, Customer Service, Provider Data Operations, Grievance and Appeals, Medicare Operations, Equity and Community Health, Utilization Management and Quality Improvement.

Causal/Barrier Analysis:

- Response rates continue to decline, or remain stagnant, for CAHPS surveys.
- Appointment timeliness and availability:

- Members are unable to obtain timely appointments for routine, specialty and urgent care.
  - There is a lack of providers who offer extended office hours for urgent appointments.
  - Provider offices do not employ mid-level providers to increase appointment availability.
  - Specialist appointments may be delayed for months due to referral submission delays and the need to coordinate with PCPs.
  - Delay in authorization requests.
- Member visits with their doctor: Members experienced challenges due to:
  - Long office wait times
  - Feeling rushed in their visits with their provider
  - Providers do not fully address the members' health concerns
  - Results of tests not being provided at office visits
- Provider efficiency: Members expressed not being able to reach providers for a variety of reasons, including:
  - Provider not seeing new patients
  - Provider cancelled appointment
  - Phone calls not being answered
  - Unable to reach the provider due to outdated contact information
- Referrals: Expired because patients could not get an appointment, or the provider canceled/changed the appointment.
- Specialists: There are not enough specialists in the CalOptima Health network for rheumatology, neurology, endocrinology and urology, delaying access for members.
  - Members do not receive referrals to specialty care due to the limited number of specialists and/or access in certain geographic areas for additional specialties.

VIII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority	Measures (Acronym)
Improve specialty access	Complete the contract and begin implementation to expand access via telemedicine for neurology, rheumatology, endocrinology and urology.	☐ MC ☒ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L	RS
Identification of positive and negative member cohorts for outreach via phone and mailing to improve CAHPS performance.	Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L	All
Improvement in CAHPS measures	Launch additional listening post campaigns via two-way Ushur SMS and provide year-round service recovery in collaboration with multiple departments.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	All

Back to Agenda Back to Item

QRC 03.19.2026

Complete member education and outreach related to specialty care	A specialist referral strategy educates members via email and SMS with a flyer on the referral/prior authorization process, and provides support throughout the process to facilitate access to care.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ H ☒ M ☐ L	RS
Improve access to primary care/education re: how to get care	A high-risk access outreach campaign is an email and SMS campaign that includes a flyer targeting members at high risk for access issues, directing them to where they can find appropriate care.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ H ☒ M ☐ L	RPD
Outreach to members who are at high risk for dissatisfaction and disenrollment to improve satisfaction and retention	Pre-Annual Enrollment Period AEP outreach in collaboration with Customer Service.	☐ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☒ H ☐ M ☐ L	All
Improve health network CAHPS performance	Launch a recurring meeting series with health network partners dedicated to member experience improvement strategy.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L	All
Improvement in CAHPS measures through year-round member feedback and monitoring	Mapping of member responses to CAHPS categories in support of the organization adopting a voice of member reporting system.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	All
Improvement in CAHPS measures	Train member-facing roles on the Decision Point Insights platform to review and address CAHPS risk during member discussions. Share Decision Points Insights with health network partners.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L	All

MC = Medi-Cal; OC = OneCare

IX. Conclusion:

CalOptima Health has adopted a structured, multipronged strategy to improve CAHPS scores, with varied results across different domains. The organization has implemented a range of systems and processes, emphasizing that sustained improvement requires collaboration across all departments. Internal education efforts have reinforced the message that achieving strong CAHPS outcomes is a shared responsibility, with each area playing a critical role in driving success. Success can be measured in terms of operational readiness, and CalOptima Health is moving in a positive direction. CalOptima Health's goal was a one-star improvement for both Medicare Stars and a one-star improvement for the NCQA Health Plan Rating for Medi-Cal. Unfortunately, neither goal was achieved, highlighting the continued need to prioritize member experience

5.6 Grievance and Appeals Resolutions Services	
Author: Heather Sedillo– Director, Grievance & Appeals	Department(s): Grievance and Appeals Resolutions Services (GARS)
Responsible Party(ies): Heather Sedillo (Director, Grievance & Appeals); Ismael Bustamante (Manager, Grievance & Appeals)	

OAC 03.19.2026

Back to Agenda Back to Item

Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Implement grievance and appeals and resolution process and report key findings and/or activities, analyze barriers, and improvement efforts. Maintain the grievance and appeals and resolution process while meeting all regulatory requirements for timely processing of appeals and grievances at a target goal of 95%.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

GARS handles all members and provider complaints and appeals for Medi-Cal and OneCare LOB. GARS data helps achieve improved care and access to services for our members, while also monitoring provider satisfaction by identifying and addressing provider-related concerns and reporting on remediation efforts.

II. Data Sources and Methodology

All member and provider appeals and grievances received in 2025.

III. Program Results and Quantitative Analysis:

Medi-Cal Grievances

	MC GRIEVANCES				
	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025
Quality of Service	2,702	2,485	2,337	2,917	3,261
Quality of Care	586	480	364	518	213
Access	882	875	821	899	851
Billing	217	178	153	172	222
TOTAL	4,387	4,018	3,675	4,506	4,547

OneCare Grievances

	OneCare Grievances				
	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025
Quality of Service	371	334	302	444	507
Quality of Care	51	22	25	39	20
Access	49	49	33	57	54
Billing	15	14	11	10	3
TOTAL	486	419	371	550	584

Indicator/Goals: Report key findings, analyze barriers and trends.

Medi-Cal and OneCare Appeals

Both Medi-Cal and OneCare saw significant decreases in quality of care (QOC) grievances, which is an outcome of our process improvements.

The overall grievance volume increased in 2025 for OneCare and remained consistent in 2025 for Medi-Cal.

Consistent reporting of trends during quarterly GARS Committee meetings has played a pivotal role in guiding targeted interventions and driving measurable performance outcomes when patterns and opportunities for improvement are identified.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
• Implementation of nurse triage for identification of QOC grievances.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☐ Ongoing ☐ Incomplete
• Jiva system enhancements to improve tracking and trending of appeals and grievances.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐Comm ☐ Data ☐ Other	☐ Completed ☐ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

Implementation of nurse triage for identification of QOC grievances assisted in earlier identification, action and resolution, which increased overall member satisfaction.

Jiva system enhancements to improve tracking and trending of appeals and grievances contributed to the production of more meaningful data for reporting and interventions.

VI. Qualitative Analysis

The analysis was conducted by the GARS department director, managers and senior data analyst. These individuals remain responsible for identifying and addressing GARS QIHE goals.

VII. Conclusion:

The data indicates that the program is making overall improvements, particularly in the areas of QOC and billing, and has met its goal. These outcomes affirm that GARS department remediations were successful in improving both member and provider experiences while supporting continuous quality improvement.

5.7 Customer Service Call Center	
Author: Andrew Tse	Department(s): Customer Service
Responsible Party(ies): Andrew Tse (Director, Customer Service); Mike Erbe (Manager, Customer Service)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: The telephonic wait time shall not exceed ten minutes for members to speak with a customer service representative.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

Back to Agenda Back to Item

The Customer Service department provides telephonic assistance to CalOptima Health members.

II. Data Sources and Methodology

Inbound call data from the contact center system

III. Program Results and Quantitative Analysis:

KPI Goal: The telephonic wait time will not exceed 10 minutes for members to speak with a customer service representative.

Q1 2025	Q2 2025	Q3 2025	Q4 2025
2:56	1:34	0:38	4:35

The average speed of answering threshold, not exceeding ten minutes, is consistently achieved.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Hire additional staff to help with the inbound call volume	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
2. Leverage the callback offering for those who do not want to wait in the queue.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
3. Partner with various departments to stagger their member engagement campaigns	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

By hiring additional call center staff to support inbound calls, continuing to ensure the contact center callback feature is enabled and partnering with various departments to stagger their member engagement campaigns, the call center has achieved an average speed of answering threshold — not exceeding 10 minutes — throughout each quarter.

VI. Qualitative Analysis

There are no barriers, and the analysis was conducted by the Customer Service call center director and managers, who remain responsible for identifying and addressing call center KPI goals.

VII. Conclusion:

On a quarterly basis, the average speed of answer threshold has not exceeded 10 minutes.

OAC 03.19.2026

Section 6: Safety of Clinical Care

6.1 Plan All Cause Readmission	
Author: Michelle Evans	Department(s): Utilization Management
Responsible Party(ies): Michelle Evans (Sr Director, Utilization Management)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Plan All-Cause Readmissions 18-64 (PCR) MC: Decrease from 0.8983 to 0.8937 by 12/31/2025. OC: Decrease from 10.00% to 8.00% by 12/31/2025.	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

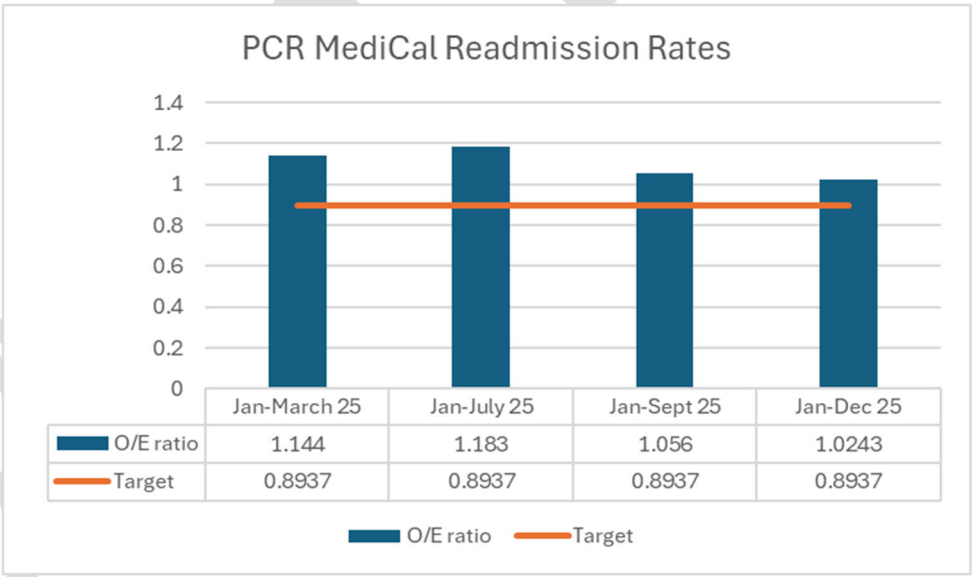
Prioritizing readmission reduction not only enhances patient outcomes but also optimizes resource utilization and elevates the overall quality of care for members.

II. Data Sources and Methodology

The data source is administrative HEDIS data for MY 2024 and MY 2025, which is trended quarterly for both OneCare and Medi-Cal LOB for readmission rates.

III. Program Results and Quantitative Analysis:

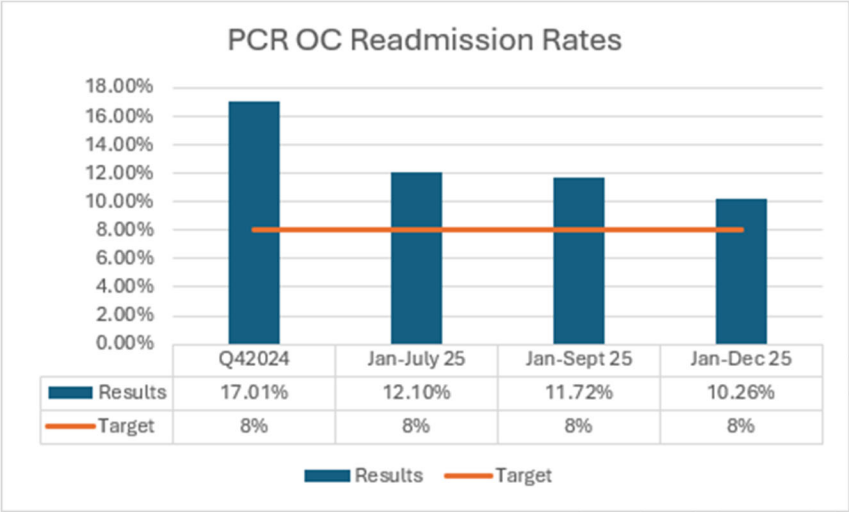
Medi-Cal



Indicator/Goals: Target was readmission rate of 0.8937 by December 31, 2025

Overall, readmissions are trending downward. We did not meet the goal at the end of the fourth quarter for both LOBs.

OneCare



Indicator/Goals: Target was readmission rate of 8% by December 31, 2025.

While we continued to trend downward in both LOBs, we did not meet the goal for Medi-Cal or OneCare across all-plan readmission rates.

IV. Actions/Interventions Implemented in 2025:

To support improvement efforts, extensive education was provided to providers and health networks during JOMs, focusing on:

- Transitional Care Management (TCM) services (CPT Codes 99495 & 99496).
- Post-discharge ambulatory follow-up rates within seven days for both health network and facility JOMs.
- Readmission rate transparency, with data shared regularly with health networks and facilities.
- Best practices for reducing readmissions, discussed and reinforced during sessions.
- Usher text campaign for admissions (MC) — provides TCS number for support
- Member resources created:
    - Services to support your care
        - CalOptima Health Behavioral Health line
        - Transportation
        - ECM and Community Supports
    - Get the care you need
        - How to use primary care, urgent care, emergency services and CalOptima Health Nurse Advice Line
    - Doctor visit form
    - Readmission review during high-risk subgroup
    - ED diversion program focuses on high utilizers

QAC 03.19.2026

- Implemented maternal health and multiple payor TCS workflows for high-risk members in 2025.

V. Effectiveness of Interventions: Medi-Cal: Comparing program results from Q4 2024 shows a significant downward trend; will validate Q3 2025 data for accuracy due to a large disparity. For Q3; the O/E ratio was inadvertently reported as 0.0933, the correct O/E ratio 1.0566 reflected in chart. Both MC and OC show a downward trend. Q4 2025 performance reflects end of year goal not met, continued improvement efforts planned for 2026.

VI. Qualitative Analysis:

Barriers to meeting readmission goals include:

- A lack of insight into readmission strategies from health network and facility partners, despite data sharing.
- A lack of member engagement or a decline in transitional care services.
- Members are unable to reach for post-discharge outreach and support.

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. During HN JOMs, seek out readmission strategies HN are using to support this measure	Staff will attend HN JOMs and request readmission strategies HN are using to support readmission reduction.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L
2. Continue to share readmission rates at the facility and HN JOMs for transparency and opportunities.	Each quarter will share readmission rates at the facility and HN JOMs.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
3. Continue to share post-discharge ambulatory follow-up rates within seven days of discharge for HN and facility Continue TCS activities and program enhancements supporting member outreach and engagement	Post-discharge ambulatory follow-up rates within seven days will be shared quarterly with HN and facility JOMs. Continue TCS activities supporting member engagement, and PCP follow-up after discharge.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

While successes demonstrated year-over-year improvement in readmission rates, PCR will remain on the work plan for 2026. Staff implemented a broad range of interventions and improved awareness from external stakeholders (health networks and hospital partners). Challenges continue to persist despite shared data and strategies to increase member engagement for TCS services. Although the numerical target was not met, the program demonstrated meaningful progress and laid a foundation for future

Back to Agenda Back to Item

success. The implemented strategies showed a downward trend in readmissions, resulting in a partially successful program.

6.2 Emergency Department Member Support	
Author: Michelle Evans	Department(s): Utilization Management
Responsible Party(ies): Michelle Evans (Sr Director, Utilization Management)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: Launch the Emergency Department (ED) Program in 2025 and track utilization of services and report key findings and/or activities, analyze barriers, and improvement efforts.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

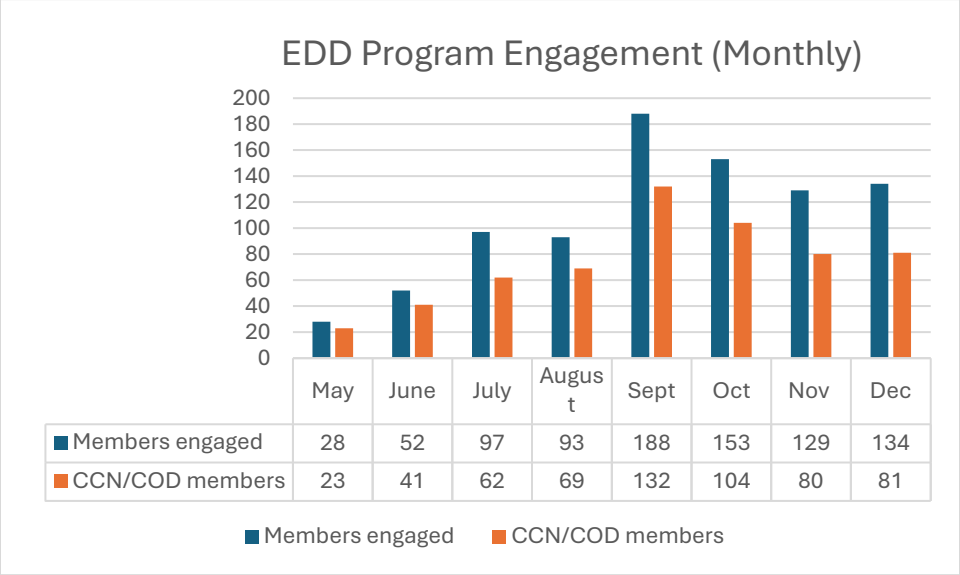
I. Purpose or Background:

Launch the ED Program in 2025 and track utilization of services and report key findings and/or activities, analyze barriers and improvement efforts.

II. Data Sources and Methodology

The data source is manual tracking, utilizing an Excel spreadsheet within a tracking tool. Jiva ED assessment was created for use with member outreach.

III. Program Results and Quantitative Analysis:



Indicator/Goals: Increased month-over-month member engagement since program inception.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Program implementation and onboarding of staff	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
1. Continue onsite activities 2. Weekly workgroup: Identify trends/opportunities/barriers 3. Continue real-time member recommendations during weekly meetings 4. Program enhancements supporting increased member engagement 5. Warm handoff to delegated HN/CM/TCS/ECM providers 6. Member resources and referrals (CalAIM, housing, TCS, CM, etc.)	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
1. Continue onsite activities 2. Added BH to the weekly workgroup: Identify trends/opportunities/barriers, real-time follow-up on member recommendations 3. Evaluate Jiva assessment as a reporting enhancement and consistent documentation practice 4. Continue refining workflows and processes	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

V. Effectiveness of Interventions:

The month-over-month increase in member engagement reflects the effectiveness of outreach, real-time coordination and post-discharge member outreach. The integration of BH enhances the program's ability to address complex member needs. The Jiva ED assessment tool improved consistency in member assessment. Warm handoffs to health network, TCS and CM staff help streamline communication. SNF placements help streamline transitions and reduce ED boarding times and unnecessary admissions. Referral pathways ensure members are connected to appropriate support services.

VI. Qualitative Analysis:

Causal/Barrier Analysis:

- Limited engagement from ED facility staff reduced opportunities for collaborative, on-site intervention
- Reliance on real-time identification of CalOptima Health members for outreach limited proactive engagement, as support was often initiated by the program rather than by ED staff
- Challenges in member engagement, including frequent declination of services and difficulty reaching members post-ED visit, hindered the effectiveness of follow-up efforts

VII. Opportunities for Improvement:

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will act on high priorities first.

OAC 03.19.2026

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Enhance member engagement strategies to increase participation and satisfaction 2. Strengthen resource support and referral processes during member interactions to ensure timely access to services. 3. Maintain real-time member-focused recommendations through consistent weekly workgroup meetings and follow-up actions 4. Create automated reporting capabilities to reduce manual tracking of program interventions and improve data accuracy	• Maintain weekly workgroup meetings and follow up on real-time interventions and recommendations • Continuously refine workgroup processes to improve efficiency and outcomes • Proactively engage members during ED visits to support care coordination • Provide proactive post-ED engagement with members as needed to ensure continuity of care • Monitor and adjust outreach strategies based on performance and member needs • Collaborate and communicate with member engagement teams and delegated HN/CM/TCS/ECM providers to strengthen care continuity and member support • Facilitate member resources and referrals (e.g., CalAIM, housing, TCS, CM) during member interactions to address social and clinical needs • Create automated reporting capabilities to reduce manual tracking of program interventions and improve data accuracy	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L
1. Start scheduling ED post-discharge follow-up appointments for OneCare members to ensure continuity of care 2. Develop a standardized process for identifying eligible OC members immediately after ED discharge	• Implement a standardized process for identifying OC members for ED post-discharge follow-up appointments • Establish and continuously refine workflows to support this process • Monitor and optimize member outreach activities to improve engagement • Track and analyze outreach success rates to ensure effectiveness • Monitor and report on PCP appointment completion following ED discharge	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
1. Expand onsite staff presence into additional emergency departments to strengthen program impact and improve member engagement	• Identify opportunities for program expansion into additional emergency departments • Select target emergency departments for program implementation and develop a standardized onboarding process • Continuously refine processes and onsite activities to ensure ongoing improvement and efficiency	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

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The program is meeting member engagement goals and has established a strong operational foundation since its inception. The program will continue to refine and enhance workflows, opportunities to engage members with needed services and support.

6.3 Transitional Care Services (TCS)	
Author: Mimi Cheung and Michelle Evans	Department(s): Utilization Management
Responsible Party(ies): Michelle Evans (Sr. Director, Utilization Management); Mimi Cheung (Project Manager, Medical Management)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% by end of December 31,2025. [New goal will be established Q1 2025]	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

Beginning January 1, 2023, CalOptima Health has implemented TCS to ensure members receive support from discharge through connection to necessary services, including medication reconciliation at discharge and follow-up care. The goal is to reduce medication errors and ensure continuity of care across all settings. CalOptima Health's QI Work Plan includes a KPI from the CalAIM PHM policy: the percentage of high-risk member transitions with at least one care manager interaction within seven days post-discharge.

CalOptima Health goal is to improve care coordination by increasing successful interactions for TCS high-risk members within seven days of their discharge by 10% (66.77%) from baseline, by the end of December 31, 2025.

II. Data Sources and Methodology

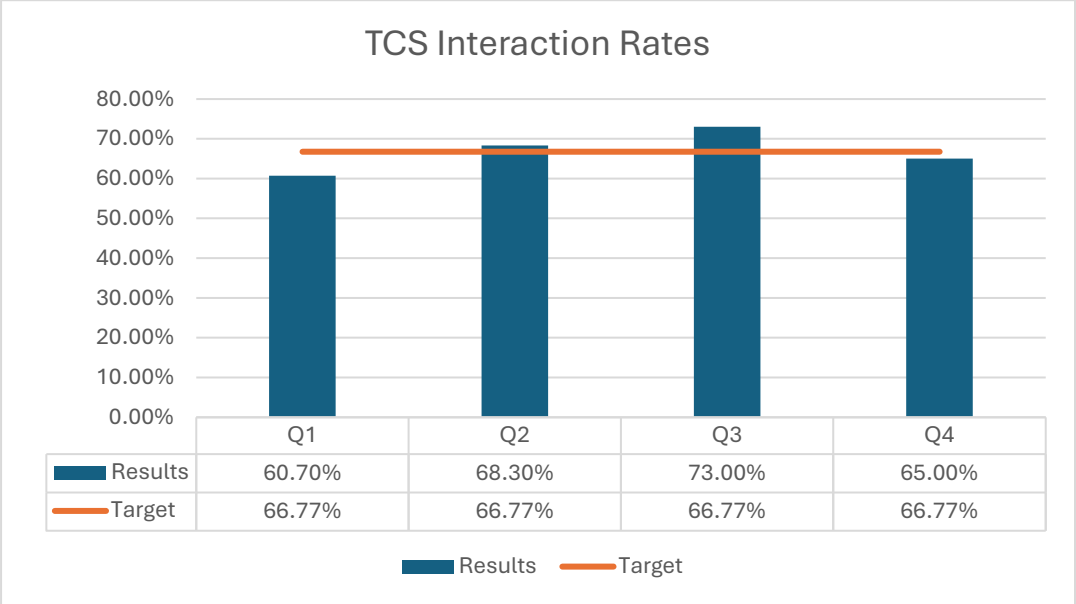
Jiva was the data source used to track TCS-eligible members. Data is tracked quarterly using Jiva to monitor progress and ensure timely follow-up care.

A random sample of 30 members was selected monthly to assess the rate of interactions between the care manager and members within seven days of discharge.

III. Program Results and Quantitative Analysis:

Medi-Cal: Transitional Care Services

QAC 03.19.2026



2025	Rate	Percentage Point Change (from baseline)	Percentage change (from baseline)	Goal Met (from baseline)
Quarter 1	60.7%	---	---	---
Quarter 2	68.3%	+7.6 pp	12.52%	Yes
Quarter 3	73.0%	+12.3 pp	20.28%	Yes
Quarter 4	65.0%	+4.3 pp	7.08%	No

Indicator/Goals: The goal is to increase this rate by 10% from baseline (60.7% to 66.77%) by the end of Quarter 4, 2025. Based on the random sampling audit, there was a 4.3 percentage point increase from Quarter 1 (60.7%) to Quarter 4 (65.0%) of 2025, representing a 7.08% percentage change. CalOptima achieved the 10% improvement target during Quarters 2 and 3.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Continue TCS texting campaign 2. Established TCS phone audit log to capture any missed opportunities to outreach to members 3. Designated staff for TCS maternal health outreach 4. Promotion TCS services at facility/hospital JOMs and SNF quarterly meetings 5. IT support for Jiva Report	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
1. Continue TCS Texting campaign. 2. Established TCS phone audit log to capture any missed opportunities to outreach to members 3. Designated staff for TCS maternal health outreach 4. Promotion TCS services at facility/hospital JOMs and SNF quarterly meetings. 5. IT support for Jiva Report updates	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete

Interventions	Product	Quarter	Type	Status
1. DHCS TCS report restarted again (July 2025 - pending final tech/specs) 2. Moved to three staff covering mental health TCS activities (end of July) 3. Moved to member outreach daily for the first seven days post-discharge, mid-August	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

The interventions conducted by CalOptima Health this year have shown improvements from Quarter 1 to Quarter 4. Continued focus on real-time outreach, identification and follow-up on missed opportunities (phone audit log), and targeted staffing (for BH population) has supported successful member interactions quarter over quarter.

1. Texting campaigns:
    a. Continued throughout the year, supporting member engagement and contact number for support post-discharge.
2. TCS phone audit log:
    a. Helped to identify and address missed outreach opportunities
    b. Strengthened program accountability and follow-through
3. Promotion of TCS services at facility/hospital JOMs and SNF quarterly meetings:
    a. Increased awareness of TCS services among provider partners
    b. Reinforced program visibility and alignment with care partners
4. IT support for Jiva Report updates:
    a. Provides continuous monitoring of the interaction with members.
5. Daily outreach conducted for the first seven days post-discharge:
    a. Shifted to daily member contact within the first seven days post-discharge
    b. Strengthened early intervention and care continuity

VI. Qualitative Analysis

Strengths and Positive Impact:

- Expansion of Outreach: The shift to daily member outreach within the first seven days post-discharge (starting mid-August) reflects a proactive approach to care continuity.
- Targeted Staffing Enhancements: Assigning dedicated staff for maternal health outreach and expanding TCS coverage to three team members by July improved the program's ability to address high-risk populations with specialized needs.
- Operational Infrastructure Improvements: The creation of a TCS phone audit log and IT support for Jiva report updates enhanced internal tracking, accountability and data accuracy — critical for identifying missed opportunities and refining workflows. Jiva report continues to be in development.

OAC 03.19.2026

- Collaborative Promotion: Regular promotion of TCS services at facility/hospital JOMs and SNF quarterly meetings helped increase awareness and fostered alignment with external partners.
- Cross-Functional Coordination: The inclusion of BH in the weekly workgroup and the reactivation of the DHCS TCS report (pending final specs) demonstrate a commitment to integrated care and long-term sustainability.

Causal/Barrier Analysis:

- Although improvements were observed, continued refinement of data collection tools (e.g., Jiva reports) and audit processes (currently manual) will be essential to maintain momentum and validate outcomes.
- Member Engagement Barriers:
    - Many members lacked access to a working phone or had disconnected numbers.
    - A significant number of members did not return calls or declined outreach efforts.
    - Declined TCS services

VII. Opportunities for Improvement:

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Reporting dashboard	• Create and implement a reporting dashboard for DHCS reporting requirements with IS. • Implement a real-time dashboard to identify opportunities for member outreach within seven days of discharge. • Automate ECM reporting for successful interaction.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L
2. Continue workflow enhancements and efficiencies	• Continue TCS activities and program/ workflow enhancements, increasing member engagement opportunities. • Reduce manual processes through system integration and automation. • Support member engagement and PCP follow-up. • Maintain TCS activities focused on connecting members with PCP after discharge.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L
3. Jiva enhancements that support automation of TCS activities instead of manual creation	• Jiva enhancements to include creation of TCS activity with creation of an Inpatient episode	☐ MC ☐ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L
4. Implement readmission strategies for the MC and OC Plan All-Cause readmissions	• Collaborating on Readmission Strategies: Attend Health Network (HN) Joint Operating Meetings (JOMs). • Share Readmission Rates for Transparency: Provide quarterly updates on facility-level and HN readmission rates during JOMs.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L

Back to Agenda Back to Item

	• Implement post discharge program with Papa and share with all health networks. • PointClickCare discharge sharing (implemented 9/18/2025) • PointClickCare admission notifications (live 12/15/2025) • Provider Portal enhancement- PCP notification for admissions and discharges (implemented 10/2025) • Assisting OneCare members discharged form ED with their PCP after discharges. • UM notification to PCP of all admissions and discharges.			

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

Overall, the program demonstrated strong performance and meaningful progress toward the goal of successful interaction, achieving the targeted 10% improvement in Quarters 2 and 3. From Quarter 1 to Quarter 4, performance increased by 7.08%. While the measure met goal, it is still below the 66th percentile and will remain on the work plan for 2026. Moving forward, the program will continue to invest in member contact strategies, technology enhancements, and partner collaboration to further strengthen member engagement.

QAC 03.19.2026

APPENDIX:

A. 2025 QIHETP Work Plan Q1-Q4
B. 2025 CLAS Evaluation
C. Medicare MY2024 HEDIS Goals and Rates
D. Medicaid MY2024 HEDIS Goals and Rates

QAC 03.19.2026

Back to Agenda Back to Item

I. PROGRAM OVERSIGHT

1 2025 Quality Improvement Health Equity and Transformation Program (QIHETP) Description and Annual Work Plan
2 2024 QIHETP Description and Work Plan Evaluation
3 2025 Integrated Utilization Management (UM) and Case Management (CM) Program Description
4 2024 Integrated UM CM Program Evaluation
5 2025 Population Health Management (PHM) Strategy and PHM Work Plan
6 2024 PHM Strategy Evaluation
7 2025 Cultural and Linguistic Accessibility Services (CLAS) Program
8 2024 CLAS Program Evaluation
9 Population Health Management Committee (PHMC) Oversight
10 Credentialing Peer Review Committee (CPRC) Oversight
11 Grievance and Appeals Resolution Services (GARS) Committee
12 Member Experience (MEMX) Committee Oversight
13 Utilization Management Committee (UMC) Oversight
14 Whole Child Model - Clinical Advisory Committee (WCM CAC)
15 Care Management Program
16 Complex Case Management Program
17 Population Health Management (PHM) Strategy and Program
18 Disease Management Program
19 Health Education
20 CalAIM Community Supports and Enhance Care Management (ECM)
21 Street Medicine Program
22 Long-Term Support Services (LTSS)
23 Delegation Oversight
24 National Committee for Quality Assurance (NCQA) Accreditation
25 Quality Performance Improvement
26 Value Based Payment Program

II. QUALITY OF CLINICAL CARE: Quality Management and Oversight

27 Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance
28 Potential Quality Issues Review
29 Provider Credentialing and Recredentialing
30 Special Needs Plan (SNP) Model of Care (MOC)

III. QUALITY OF CLINICAL CARE: Wellness and Preventive Care

31 Pediatric and Adolescent Wellness: EPSDT/Children's Preventive Services

QAC 03.19.2026

Back to Agenda Back to Item

32 Adult Wellness: Preventive and Screening Services
33 CalOptima Health Comprehensive Community Cancer Screening Program (CCCSP)

IV. QUALITY OF CLINICAL CARE- Maternal Child Health

34 Maternal and Child Health: Prenatal and Postpartum Care Services
35 Maternal and Child Health: Prenatal and Postpartum Depression Screening
36 Maternity Care for Black Persons

V. QUALITY OF CLINICAL CARE- Chronic Conditions

37 Members with Diabetes
38 Members with Heart Health (Hypertension)
39 Members with Osteoporosis
40 Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions

QAC 03.19.2026

VI. QUALITY OF CLINICAL CARE - Behavioral Health

41 Behavioral Health Services: Child and Adolescent Health on Antipsychotics
42 Behavioral Health Services Depression
43 Behavioral Health Services: Schizophrenia
44 Behavioral Health Services: Care Coordination and Follow-up Care
45 Behavioral Health Services: Medication Management
46 Behavioral Health Services: School-Based Services Mental Health Services

VI. QUALITY OF CLINICAL CARE: Medication Management

47 Medication Management: Pharyngitis and Bronchitis
48 Medication Adherence

VI. QUALITY OF CLINICAL CARE: Improvement Plans

49 Medi-Cal Customer Service Performance Improvement Project
50 Performance Improvement Projects (PIPs) Medi-Cal BH
51 Chronic Care Improvement Projects (CCIPs) OneCare: Diabetes Emerging Risk

IX. QUALITY OF SERVICE- Access

52 Improve Network Adequacy: Reducing Gaps In Provider Network
53 Improve Access: Timely Access (Appointment Availability) / Telephone Access
54 Network Adequacy Regulatory Submission and Audits
55 Increase Primary Care Utilization - Initial Health Appointment

X. QUALITY OF SERVICE- Member Experience

56 Improve Member Experience/CAHPS
57 Grievance and Appeals Resolution Services
58 Customer Service Call Center

XI. SAFETY OF CLINICAL CARE

59 Plan All Cause Readmission
60 Emergency Department Member Support
61 Transitional Care Services (TCS)

XII. Cultural and Linguistic Appropriate Services (CLAS)

62 Language Services: Cultural and Linguistics and Language Accessibility

QAC 03.19.2026

63 Network Cultural Responsiveness: Data Collection on Member Demographic Information
64 Network Cultural Responsiveness: Data Collection on Practitioner Demographic Information
65 Experience with Language Services
66 Network Cultural Responsiveness: Diversity, Equity and Inclusion Training

QAC 03.19.2026

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
1	Program Oversight		2025 Quality Improvement Health Equity and Transformation Program (QIHETP) Description and Annual Work Plan	Obtain Board Approval of 2025 QIHETP Description and Workplan by April 30, 2025	QIHETP Description and Annual Work Plan will be adopted on an annual basis; QIHEC-QAC-BOD Development of the QIHETP Work Plan will include a review of the following: 1.Comprehensive Quality Strategy Report 2. Technical Report 3. Health Disparities Report 4. Preventive Services Report 5. Focus Studies 6. Encounter Data Validation Report	QIHEC: 01/14/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Quality Improvement	Program Specialist of Quality Improvement	Quality Improvement	The 2025 QIHETP Description and Annual Work Plan was presented and approved at QIHEC (2/11/2025) and QAC (3/12/2025) .	QI staff found that a QI staff position was missing in the Org Chart and updated the document to include Chief Administrative Officer.	Updated document was prepared and submitted to the Clerk of the Board for approval (4/3/2025)	N/A	The 2025 QIHETP Description and Annual Work Plan was submitted for approval by the BOD (04/3/2025).	
2	Program Oversight		2024 QIHETP Description and Work Plan Evaluation	Complete Evaluation of the 2024 QIHETP Description and Work Plan by April 30, 2025	2024 QIHETP Description and Work Plan will be evaluated for effectiveness on an annual basis; QIHEC-QAC-BOD. 2025 QIHETP Evaluation will be drafted in Q4 of 2025	QIHEC: 02/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Quality Improvement	Program Specialist of Quality Improvement	Quality Improvement	2024 QIHETP Description and Work Plan Evaluation was presented and approved at QIHEC (2/11/2025) and QAC	None noted.	None	N/A	2024 QIHETP Description and Work Plan Evaluation was presented for approved at the BOD	

QAC 03.19.2026

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					and approved in Q1 2026.					(3/12/2025) .				(04/3/2025).	
3	Program Oversight		2025 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2025 Integrated UM and CM Program Description by April 30, 2025	Integrated UM and CM Program will be adopted on an annual basis; UMC-QIHEC-QAC-BOD	UMC: 01/23/2025 QIHEC: 2/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Executive Director of Clinical Operations	Director of Utilization Management	Utilization Management	The 2025 Integrated Utilization Management (UM) and Case Management (CM) Program Description was presented to the Committee's/BOD as indicated in Column H. Final approval by the BOD on 4/3/2025.	The 2025 Integrated Utilization Management (UM) and Case Management (CM) Program Description was approved by the BOD on 4/3/25.	None	None	Continue with plan as defined for 2025	

QAC 03.19.2026

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4	Program Oversight		2024 Integrated UM CM Program Evaluation	Complete Evaluation of 2024 Integrated UM CM Program Description by April 30, 2025	Integrated UM CM Program Description will be evaluated for effectiveness on an annual basis; UMC-QIHEC-QAC-BOD 2025 UM CM Program Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	UMC: 01/23/2025 QIHEC: 2/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Executive Director of Clinical Operations/Director Case Management	Director of Utilization Management	Utilization Management	The 2024 Integrated UM CM Program Evaluation was presented to the Committee's/BOD as indicated in Column H . Final approval by the BOD on 4/3/2025.	The 2024 Integrated UM CM Program Evaluation was approved by the BOD on 4/3/2025.	None	None	Continue with plan as defined for 2025	
5	Program Oversight	PHM	2025 Population Health Management (PHM) Strategy and PHM Work Plan	Obtain Board Approval of 2025 PHM Strategy and PHM Work Plan by April 30, 2025	PHM Strategy will be adopted on an annual basis; PHMC-QIHEC-QAC-BOD	QIHEC: 01/14/2025 PHMC: 02/20/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	2025 PHM Strategy and PHM Work Plan were presented at PHMC (2/20/2025) and approved by QIHEC (2/11/2025) and QAC (3/12/2025)	2025 PHM Strategy and PHM Work Plan was approved by BOD on 4/3/2025.	Implemented the progression of approvals	N/A	Seek BOD approval and adopt the 2025 PHM Strategy and PHM work Plan. Provide quarterly progress updates or as requested	

QAC 03.19.2026

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6	Program Oversight	PHM	2024 PHM Strategy Evaluation	Complete the Evaluation of the 2024 PHM Strategy by April 30, 2025	PHM Strategy will be evaluated for effectiveness on an annual basis (PHMC-QIHEC-QAC-BOD) and will include the following: 1. Develop collaborative evaluation process 2. Facilitate development of the evaluation process 3. Produce evaluation 4. Present evaluation to the appropriate governing committees 2025 PHM Strategy Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	QIHEC: 02/11/2025 PHMC: 02/20/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	2024 PHM Evaluation was presented at PHMC (2/20/2025) and approved by QIHEC (2/11/2025) and QAC (3/12/2025)	BOD approved at the 4/3/25 meeting.	Implemented the progression of approvals	N/A	Seek BOD approval and file the 2024 PHM Evaluation	
7	Program Oversight	CLAS	2025 Cultural and Linguistic Accessibility Services (CLAS) Program	Obtain Board Approval of 2025 CLAS Program by April 30, 2025	CLAS Program will be adopted on an annual basis; QIHEC-QAC-BOD	QIHEC: 01/14/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Customer Service	Manager of Cultural and Linguistics	Customer Service/Cultural and Linguistic Services	QIHETP Description and Annual Work Plan presented for BOD approval on 4/3/2025.	BOD approved at the 4/3/25 meeting.	None	N/A	Seek BOD approval	

QAC 03.19.2026

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8	Program Oversight	CLAS	2024 CLAS Program Evaluation	Complete the Evaluation of the 2024 CLAS Program by April 30, 2025	The CLAS Program will be evaluated for effectiveness on an annual basis; QIHEC-QAC-BOD 2025 CLAS Program Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	QIHEC: 02/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Customer Service	Manager of Cultural and Linguistics	Customer Service/Cultural and Linguistic Services	QIHETP Description and Annual Work Plan presented for BOD approval on 4/3/2025.	BOD approved at the 4/3/25 meeting.	None	N/A	Seek BOD approval	
9	Program Oversight	PHM	**Population Health Management Committee (PHMC)** - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Workplan progress and outcomes. 2. Provide overall direction for the continuous improvement process and oversee that activities are consistent with CalOptima Health's PHM strategic goals and priorities. 3. Facilitate	PHMC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/9/2025 Q4 12/9/2025	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	The Q1 2025 PHM Committee Meeting was held on February 20, 2025 which included both internal CalOptima Health updates on the PHM Program and a community spotlight presentation from Access California Services. The Chief Health Medical Officer (or designee) was	N/A	Continue to assist the committee by reviewing relevant guidance, agenda setting, presentation development, and deliverables shared with QIHEC.	N/A	Next PHM Committee meeting is scheduled for May 2025. Report committee update to QIHEC in May 2025.	

QAC 03.19.2026

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					quarterly meetings 4. Report PHMC activities to the QIHEC quarterly.					officially added as a voting member of the committee through PHMC Charter amendment. The Committee reviewed and approved Q4 2024 PHMC Meeting Minutes. Staff provided a PHM Committee update for QIHEC in March 2025.					

QAC 03.19.2026

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10	Program Oversight		**Credentialing Peer Review Committee (CPRC) Oversight** - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review to ensure quality of care delivered to members	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. 2. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Manager of Quality Improvement	Manager of Quality Improvement	Quality Improvement	The Committee met on 01/23/2025, 02/27/2025 and 03/27/2025. In addition, there were two ad hoc meetings on 03/06/2025 and 03/20/2025 for the development of questions to ask of two physicians undergoing Fair Hearing who will be attending CPRC in Q2.	Three physicians continue undergoing the Fair Hearing process. Twenty-one PQIs leveled as 1 or 2 were presented to CPRC for leveling and actions; there were no level 3 cases in Q1. There were 3 quality-of-service cases presented and 2 level-2 PQIs re-presented. One Ob/Gyn was presented for on-going monitoring. The PQI trends (6-month) and statistics for Q4 were presented. There were two hospitals, one transportati	Three providers with issues were presented and approved for recredentialing; there were no providers with issues presented for credentialing. Approved the Credentialing Clean Lists for the following dates: 12/12/2024, 12/31/2024, 01/17/2025, 01/31/2025, 02/07/25, 02/14/2025, 02/19/2025, 02/21/2025, 02/25/2025 and 02/28/2025. Approved the Practitioner Closure Lists for the following dates: 12/31/2024, 01/31/2025 and 02/28/2025. Credentialing, FSR, MRR, and Incident Reporting was presented for Q4.	N/A	It was suggested that the ABA groups receive additional training by the BH Department. It was recommended that a policy be developed to address egregious incidents immediately.	

QAC 03.19.2026

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											on vendor, one orthopaedic surgeon, and six ABA groups that trended from 07/01/2024 - 12/31/2024 . Most of the ABA groups received PQIs related to documentation.				
11	Program Oversight		**Grievance and Appeals Resolution Services (GARS) Committee** - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health networks. 2. Trends and results are presented by product time to the committee quarterly. 3. Committee	GARS Committee Report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Associate Director of Grievance and Appeals	Manager of Grievance and Appeals	GARS	1) MC and OC grievances resolved timely 2) MC and OC appeals resolved timely	1) Grievance trends: Provider/Staff Attitude, Timely Access, Treatment Concerns 2) Appeal Trends- Modifications to In-Network who cannot treat, Integrated Medicare and Medi-Cal criteria not utilized during initial UM decision.	1) Tracking and trending of specific providers quarter over quarter	1) Tracking and trending of specific providers quarter over quarter	1) Tracking and trending of specific providers quarter over quarter	

QAC 03.19.2026

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					meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.										
12	Program Oversight		**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. The MEMX Committee reviews the annual results of CalOptima Health's CAHPS surveys, monitors the provider network including access and availability (CCN and the HNs), reviews customer service metrics and evaluates complaints, grievances, appeals, authorizations and referrals for the "pain	MemX Committee report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Project Manager Quality Analytics / Manage of Quality Analytics	Quality Analytics	Committee met on 1/28/25 and accepted minutes from the10/15/24 meeting. The 2025 charter was updated and adopted with the addition of 3 new voting members. Follow up item was presented about CalOptima members access to home blood pressure	QIHEC accepted the MemX update and did not have additional questions, comments or feedback.	Strategic priorities will include expansion of drill down to issue.	None noted.	Next meeting 4/15/2025	

QAC 03.19.2026

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					points" in health care that impact our members. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.					monitors. The meeting focus was on strategic priorities for 2025. Timely access, network adequacy, customer service, behavioral health survey results , complex case managmen t survey results and GARS data were moved to consent items. A MemX update was provided to QIHEC on 3/11/25 with submission of 2025 Charter, approved minutes and consent calender.					

QAC 03.19.2026

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13	Program Oversight		**Utilization Management Committee (UMC) Oversight -** Conduct internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. UMC reviews medical necessity, cost-effectiveness of care and services, reviews utilization patterns, monitors over/under-utilization, and reviews inter-rater reliability results. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	UMC Committee report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Executive Director of Clinical Operations/Director Case Management	Director of Utilization Management	Utilization Management	Internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care was presented to the CalOptima Health UMC on Jan. 23, 20205 and Feb. 22, 2025. Next meeting is scheduled for May 22, 2025.	Continue with planned activities. UM presented UMC actions & recommendations from the Feb. 20, 2025 UMC meeting. *UMC minutes for Jan. 23, 2025 *Increase in oncology readmissions *Final Rule Health Equity Analysis of the Use of Prior Authorization data. GARS to review the root cause for overturns *Russian treshold language to be added July 2025 *4 revised policies presented & approved *Expansion, TANF18+	Continue track/trend data.	None	Continue with plan as defined for 2025	

QAC 03.19.2026

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											& OC ALOS & readmission above goal. TANF under 18 admits above goal *IP TAT Q4 2024 above goal of 95% *PA TAT Q4 2024 above goal of 95%				

QAC 03.19.2026

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14	Program Oversight		**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for eligible children with California Children Services (CCS) are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee key findings/updates, activities, and recommendations to QIHEC.3	Conduct and report on the following activities: 1. WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. 3. Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	WCM CAC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Medical Director of Whole Child Model / Director of Case Management	Program Specialist of Quality Improvement	Medical Management	WCM met 2/18/25.	Quarter 1, met all goals	Collected annual Conflict of Interest and Confidentiality Forms. Discussed Newborn Gateway, Timely Access, 7-day vs 30 day Readmission, ED Re-admit, TAT for all HN's, data for Telemed2U Mental health non ABA WCM vs non-WCM	Meaning ful data for 7 day vs 30 days.	Action items is timely Access Data, 7day Readmiss ion rate, ED Readmiss ion rate, TAT for all HN's, future report of Autism Compreh ensive Care Program.	
15	Program Oversight	PHM	Care Management (CM) Program	Report on key activities of CM program, analyze CM data compared to goal, and improvement efforts.	Report on the following activities: 1. Basic PHM/CM 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Medical Management (Case Management)	Quality Improvement Nurse	Medical Management	Report on the following activities: 1. Basic PHM/CM: Ongoing HRA assesment s which are being shared with PCP.	Quarter 1, met all goals	Report on the following activities: 1. Basic PHM/CM: Ongoing HRA assesments which are being shared with PCP. 2. Early and Periodic Screening,	None	Report on the following activities: 1. Basic PHM/CM: Continue to share assessme nts collected with the PCP.	

QAC 03.19.2026

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										2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM: Continued meeting in workgroup and review collected data to address potential gaps in delivery of EPSDT services, including vision, dental, and BH screenings. 3. Medical Directors re-reviewed EPSDT requirements in Caloptima Clinical Ops meeting with delegated HNs on 3/6/2025 4. Medical Director met with CHOC on 3/31 and		Diagnostic and Treatment (EPSDT) CM: Continued meeting in workgroup and review collected data to address potential gaps in delivery of EPSDT services, including vision, dental, and BH screenings. 3. Medical Directors re-reviewed EPSDT requirements in Caloptima Clinical Ops meeting with delegated HNs on 3/6/2025 4. Medical Director met with CHOC on 3/31 and Optum on 3/17 to discuss EPSDT reviews.		2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) 3. CM: Future meeting with HN to review EPSDT. 4. Continued meeting in workgroup and review collected data to address potential gaps in delivery of EPSDT services, including vision, dental, and BH screenings.	

QAC 03.19.2026

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										Optum on 3/17 to discuss EPSDT reviews.					
16	Program Oversight	PHM	Complex Case Management Program	Implement Complex Case Management Program and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: (1) Ensure provision of CCM services resulting in optimal care coordination as evidenced through monthly auditing of 5 files or 5% of files for each health network resulting in a minimum score of 90% through December 31, 2025. (2) Obtain 85% member satisfaction in CCM program by December 31st, 2025. (3) 85% of members surveyed who participated in CCM between January 1, 2024-December 31, 2025, will report that the case management process helped them meet their care plan goals.	Conduct and report on the following activities: 1. Continue training and educational opportunities to staff on the 2025 PHM5 Element D and E and complex conditions/situations (Goal 1) 2. Member Satisfaction scores will be shared with the CCN and the delegates to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, member outcomes, and improve the member experience of	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Medical Management (Case Management)	Nurse Specialist of Utilization Management	Case Management	Conduct and report on the following activities: 1. Continue training and educational opportunities to staff on the 2025 PHM5 Element D and E and complex conditions/ situations (Goal 1): Trainings provide for both CCN and Health Networks on 2/27/2025 and 3/4/2025. 2. Member Satisfaction scores will be shared with the	Quarter 1, met all goals	Conduct and report on the following activities: 1. Continue training and educational opportunities to staff on the 2025 PHM5 Element D and E and complex conditions/situations (Goal 1): Trainings provide for both CCN and Health Networks on 2/27/2025 and 3/4/2025. 2. Member Satisfaction scores will be shared with the CCN and the delegates to provide valuable insight to help identify strengths and areas for improvement	None	Conduct and report on the following activities: 1. Continue training and education al opportunit ies to staff on the 2025 PHM5 Element D and E and complex conditions /situations (Goal 1): Ongoing. 2. Member Satisfacti on scores will be shared with the CCN and the delegates	

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Back to Agenda Back to Item

QAC 03.19.2026

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					CM programs (Goal 2) 3. Ongoing training and support for new and existing staff. (Goal 2) 4. Continue to gather member feedback to improve outcomes. (Goal 3) 5. Training and Education on member centric care plans. (Goal 3)					CCN and the delegates to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, member outcomes, and improve the member experience of CM programs (Goal 2) Quarter 1 results pending and being finalized. 3. Ongoing training and support for new and existing staff. (Goal 2) 4. Continue to gather member feedback to improve outcomes. (Goal 3)		to enhance the quality of care, member outcomes, and improve the member experience of CM programs (Goal 2) Quarter 1 results pending and being finalized. 3. Ongoing training and support for new and existing staff. (Goal 2) 4. Continue to gather member feedback to improve outcomes. (Goal 3) Conduct and report on the following activities: Quarter 1 results pending and being finalized. 5. Training and Education on member centric care plans. (Goal 3): Develop training for CCN team to be provided in Quarter 2.		to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, member outcomes, and improve the member experience of CM programs (Goal 2) Q1 results to be shared. 3. Ongoing training and support for new and existing staff. (Goal 2) Ongoing. 4. Continue to gather member feedback to improve outcomes. (Goal 3)	

QAC 03.19.2026

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										Quarter 1 results pending and being finalized. 5. Training and Education on member centric care plans. (Goal 3) Develop training for CCN team to be provided in Quarter 2.				Ongoing. 5. Training and Education on member centric care plans. (Goal 3) Future training planned for Q2 on ICP: Report on date of training.	
17	Program Oversight	PHM	Population Health Management (PHM) Strategy and Program	Implement initiatives for the 2025 PHM program starting January 1, 2025.	Conduct and report the following activities: 1. Population Needs Assessment (PNA) 2. Develop and implement a PHM Work Plan and includes the following: a. Risk stratification b. Screening and Assessment c. Wellness and prevention	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Equity and Community Health	Manager of Population Health Management/ Sr. Director Medical Management	Equity and Community Health	1. Drafted the 2025 PNA 2. Implementation of 2025 PHM work plan is in progress 3. Quarterly 2025 PHM work plan monitoring is in progress	N/A- work in progress	1. Internal review and approval of 2025 PNA 2. Obtained approval of the 2025 PHM work plan 3. Developed quarterly reporting process to avoid duplication	N/A	1. Finalize and seek approval of 2025 PNA from PHMC; NCQA submission 2. Continue implementing the 2025 PHM work plan 3. Continue monitoring progress	

QAC 03.19.2026

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					3. Collect quarterly progress reports from PHM Work Plan implementation owners										
18	Program Oversight	PHM	Disease Management Program	Implement 2025 Disease Management Program and report key findings and/or activities, analyze barriers, and improvement efforts and meet the following goal: 1. By December 31, 2025, 85% of members who participate in Disease Management program from January 1 – December 31, 2025 will report satisfaction	Conduct and report on the following activities: 1. Evaluation of current utilization of disease management services 2. Enhance identification of gaps in care to better promote quality care across all Disease Management interventions. 3. Use multimodal methods of outreach to identify members in need of Disease Management services and	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	1.Two-Way Text Campaign Launched: 5,200 diabetes members and 5,900 asthma members were contacted through two-way text messages, demonstrating scaled outreach efforts 2.Initiated Stratification Criteria Revision: Stratification and risk-level criteria to better	1.Increased Reach Through Text Campaigns: •For members with diabetes and asthma to opt in to health coaching services 2.Real-Time Feedback Improves Response Rate: •The Disease Management Satisfaction survey received in just 2	1.Continue two-way text message campaigns: For member with diabetes and asthma 2.Monthly Stratification Criteria Logic Updates: Revisions include removing members already engaged with other departments and improving visibility of care gaps across Disease Management interventions. 3.Expansion of Disease Management Satisfaction	There have been ongoing issues with staff not being able to launch the text message satisfaction survey. Issue is being addressed by vendor.	Continue to implement activities.	

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Back to Agenda Back to Item

QAC 03.19.2026

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					reduce cold calls. 4. Integrate new methods to measure and improve member satisfaction.					target low to moderate-risk members and avoid duplicative outreach. 3.Launch of Disease Management Satisfaction Survey: Survey is a text-based survey delivered to members after a via text after follow-up session. The Disease Management Satisfaction survey received 57 responses out of 131 texts sent.	months — over half of the previous annual total (100), indicating a likely improvement in response rates using this new survey method.	Survey: Planning to supplement with a paper survey included in the education packet sent by health coaches following telephonic outreach.			

QAC 03.19.2026

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19	Program Oversight	PHM	Health Education	Implement interventions for the 2025 Health Education program and report key findings and/or activities, analyze barriers, and improvement efforts. 2025 Health Education program focuses on promoting early detection, fostering healthy habits, and empowering members to be proactive with preventive care.	Conduct and report on the following activities: 1. Evaluation of current utilization of health education services 2. Enhance methods for outreaching, promoting, and enrolling members in Health Education services and classes (e.g. text message outreach, member self-referral, etc.) 3. Expand health education offerings in various community classes and events (e.g. clinic days, virtual and in-person classes, etc.) and tech-based modalities (app/web-based services).	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	Total referrals in Q1 2025 to ECH for health education was 1580. Shape Your Life held 26 classes with 96 total attendees, with 6 in person and 20 virtual classes.	Referrals increased in Q1 2025 by 25% compared to Q1 2024 and were 29% higher than Q4 2024.	None this quarter. Please see barriers.	In Q1 2025, there was an issue with the text messaging vendor which caused 11,900+ members to receive duplicate text messages. The outcome was 2,700+ opted out of text messages. Changes implemented to prevent this from happening again include no text messages to be sent on the weekends or overnight.	1. Decide when DHCS approved text messages regarding classes and ECH services can send and to what population. 2. Determine the day and time for monthly hypertension classes offered virtually in English, Spanish and Vietnamese going forward.	

QAC 03.19.2026

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20	Program Oversight	PHM	CalAIM Community Supports and Enhance Care Management (ECM)	Implement CalAIM and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: 1. By December 31, 2025, enhance community support services (e.g., housing transition navigation services, housing deposits, and housing tenancy and sustaining services) to achieve optimal care coordination, as demonstrated by auditing the performance of 10 providers. 2. Increase number of members authorized for ECM services by 10%, from 2,500 to 2,842 by December 31, 2025.	Community Supports Activities: 1. Conduct housing transition navigation services audits. 2. Conduct housing deposits audits. 3. Conduct housing tenancy and sustaining services audits. ECM Activity: Track ECM outreach, authorizations and services.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Medi-Cal and CalAIM	Director of Medi-Cal and CalAIM	Medi-Cal and CalAIM	1. As of February 20, 2025, Community Supports audit oversight process, templates, and report for Housing are in development and will be implemented by July 2025 (Q4). 2. Goal has been met for 2025.	1. There are a total of 47 Housing Providers that will be audited on services rendered from 01/01/24 - 06/30/25. 2. High demand for ECM Services.	1. Community Supports: • Developed required Housing Assessment Tools and Plan that will be standardized • Scheduled Office Hours for Community Support Providers by Community Support Services 2. ECM: • Increased the ECM Network.	1. No barriers at this time. 2. No barriers.	1. Finalize Housing Assessment Tools and Plan and Housing Audit Monitoring Template 2. None as goals have been met.	

QAC 03.19.2026

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21	Program Oversight	PHM	Street Medicine Program	Implement Street Medicine Program and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: (1) By December 31, 2025, connect 80% of unhoused participating members to an active Primary Care Physician (PCP). (2) By December 31, 2025, connect 90% of unhoused participating members with CalAIM ECM and Housing Navigation. (3) By December 31, 2025, connect 20% of unhoused participating members to a shelter or other housing option.	Conduct and report on the following activities: Goal 1: ▪ Offer all members the opportunity to utilize the Street Medicine Provider as their PCP. ▪ Utilize Releases of Information when member has active PCP to increase collaboration and communication. ▪ Support member with PCP change, as needed. ▪ Care scheduling and delivery. Goal 2: ▪ Make attempts to engage with members weekly. ▪ Provide ECM and/or Housing Navigation appointments face to face at least every other week. ▪ Care scheduling and	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director, CalAIM Outreach Operations	McKenzie Rodriguez	Medi-Cal and CalAIM	By February 20, 2025, 84% of unhoused participating members were connected to an active Primary Care Physician (PCP). By February 20, 2025, 98% of unhoused participating members were connectced to CalAIM ECM and Housing Navigation. By February 20, 2025, 16% of unhoused participating members were connected to a shelter or another housing option.	The outcome for connecting unhoused participating members was 4% higher than the goal of 80%. The outcome of unhoused participating members connected to CalAIM ECM and Housing Navigation was 8% higher than the goal of 90%. The outcome of unhoused participating memebers connected to shelter or other housing option was 4% less than the goal of 20%.	Goal 1: ▪ Offered all members the opportunity to utilize the Street Medicine Provider as their PCP. ▪ Utilized Releases of Information when member has active PCP to increase collaboration and communication. ▪ Supported member with PCP change, as needed. Goal 2: ▪ Made attempts to engage with members weekly. ▪ Provided ECM and/or Housing Navigation appointments face to face at least every other week. ▪ Documented all encounters. Goal 3: ▪ Outreached and engaged unsheltered individuals ▪ Provided	Affordable and availabl e permanent housing coninue to be a barrier for all unsheltered individuals.	Continue to deliver compassionate and whole person care services to unsheltered members within the cities our Street Medicine Program operates. Continue to carry out the goals and objectives of the program.	

QAC 03.19.2026

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					delivery. ▪ Document all encounters. Goal 3: ▪ Outreach to and engage unsheltered individuals ▪ Provide ECM and/or Housing Navigation ▪ Enter members in to the Coordinated Entry System ▪ Connect individuals to local shelters ▪ Work with members on completing housing documentation							ECM and/or Housing Navigation ▪ Entered members in to the Coordinated Entry System ▪ Connected individuals to local shelters ▪ Worked with members on completing housing documentation			

QAC 03.19.2026

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22	Program Oversight		Long-Term Support Services (LTSS)	Implement LTSS Program and meet the 95% compliance with the following TATs: (1) CalAIM Turnaround Time (TAT): Determination completed within 5 business days (2) CBAS Inquiry to Determination (TAT): Determination completed within 30 calendar days (3) CBAS Turnaround Time (TAT): Determination completed within 5 business days (4) LTC Turnaround Time (TAT): Determination completed within 5 business days	Assess and report the following activities: 1. Evaluation of current utilization of LTSS 2. Maintain business for current programs and support for community 3. Improve process of handling member and provider requests 4. Meet goal/TATs	Report to UMC Q1: 02/20/2025 Q2: 05/22/2025 Q3: 08/22/2025 Q4:11/20/2025	Director of Long Term Support Services	Manager of Long Term Support Services	Long Term Support Services	Jan-25 Feb-25 Mar-25 CBAS Inquiry to Determination: 99.04%; 100.00%; 99.03% CBAS TAT: 99.88%; 99.82%; 100.00% LTC TAT: 98.72%; 98.57%; 98.59% CalAIM TAT: 79.17%: 99.36%: 99.85%	LTSS utilization remains stable/unchanged. CalAim volume of referrals continues to grow primarily in housing navigation and personal care services. January the TAT in CalAim fell below the compliance threshold.	CalAim: Implemented staffing (OT, Temps, recruitment)and process changes to improve and stablize compliance with TAT which resulted in complaint TAT in February and March.	Unfilled staff positions. Process efficiencies	Fill open positions. Update all 14 community support workflows.	
23	Program Oversight		Delegation Oversight	Implement annual oversight and performance monitoring for delegated activities and report key findings and/or activities, analyze barriers, and improvement efforts.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accreditation standard compliance that, at minimum, include comprehensive annual audits and corrective actions.	Report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/9/2025 Q4 12/9/2025	Director of Delegation Oversight	Manager of Delegation Oversight	Delegation Oversight	Delegate: • Family Choice Medical Group (83)/Family Choice Health Services (21)/Conifer Health Solutions • Family Choice Medical Group (83)/Family Choice Health Services (21)/Family Choice Manageme	Family Choice Medical Group (83)/Family Choice Health Services (21)/Conifer Health Solutions: • Claims (Medi-Cal) – Not accepted • Claims, Provider Dispute Resolutions (Medi-Cal) – Not accepted • Utilization	Continue to remediate Corrective Action(s) as applicable.	None noted.	As per Corrective Action Plan agreed upon monitoring date(s).	

QAC 03.19.2026

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										nt Services/Altura MSO Area(s) Assessed: • Case Management • Claims • Compliance • Credentialing • Customer Service • Provider Network Contracting • Provider Relations • Sub-Contractual • Utilization Management	Management (Medi-Cal) – Not accepted • Claims (OneCare) – Not accepted • Utilization Management (OneCare) – Not accepted Family Choice Medical Group (83)/Family Choice Health Services (21)/Altura MSO: • Compliance (All Lines of Business) – Accepted • Provider Relations (All Lines of Business) – Accepted • Customer Service – Accepted				

QAC 03.19.2026

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24	Program Oversight		National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan (HP) Accreditation and NCQA Health Equity (HE) Accreditation by January 1, 2026	1. Implement activities for NCQA Standards compliance for HP and HP Renewal Submission by April 6, 2027. 2. Implement activities for NCQA Standards compliance for Initial HE Accreditation Survey and submit requirement documents to NCQA by October 7, 2025.	1) By December 31, 2025 2) By October 7, 2025 Report program update to QIHEC Q1:01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director Quality Improvement	Program Manager of Quality Improvement (NCQA)	Quality Improvement	The Quality Improvement (QI) Department has a National Committee for Quality Assurance (NCQA) team consisting of three Program Managers who oversee both Health Plan Accreditation and Health Equity Accreditation. The Health Equity accreditation focuses on five key workstreams, which involve the review and collection of documents necessary for the upcoming accreditation. Here is the current status update for	Health equity and health plan accreditations are on schedule, with preparations underway for the start of the look-back periods on April 6, 2025 (HPA) and April 7, 2025 (HEA). 1) Several annual reports have been reassigned to new owners. 2) A few health plan policies required clarification.	1) Complete the required website screenshots for both Health Equity and Health Plan accreditation by April 15. 2) NCQA Program Managers will set up meetings with each stakeholder to review the work plan, the documents due, and the deadlines for each deliverable. 3) Finalize all documents for the upcoming Health Equity Accreditation submission by October 7, 2025. 4) Collaborate with stakeholders to review and collect the Year one documents for Health Plan Accreditation to meet the lookback period from April 6, 2025, to April 6, 2026.	No barriers have been identified for both Health Equity and Health Plan accreditation.	**Health Plan Accreditation (HPA)**: Continue submitting year one documents for consultant review. NCQA has released a list of proposed standards for 2026. The final 2026 NCQA standards will be released after July 2025, with an effective date of July 1, 2026. Please note that for the HPA 2027 submission, we will be assessed based on the 2026 HPA standards. **Health**	

QAC 03.19.2026

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										each accreditation: 1. **Health Plan Accreditation:** All policies, annual programs, evaluations, and work plans have been reviewed and approved by NCQA consultants. Some documents from 2024 and the present have been evaluated against the latest standards. The NCQA consultants have trained stakeholders on the 2025 Health Plan Standards. Additionally, the NCQA team met with stakeholders responsible for writing		5) Purchase the 2026 Health Plan Standards and provide training to stakeholders on these standards, as there are several changes in the upcoming version, standards will be available for purchase July/Aug.		**Equity Accreditation (HEA)**: Consultants will continue to review documents as they become available or finalized, guiding the team until identified gaps are addressed. CalOptima will revise and finalize all documents and share them with consultants until submission.	

QAC 03.19.2026

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										analytical reports to establish due dates. A comprehensive work plan is currently being developed. 2. **Health Equity Accreditation**:The consultants have conducted reviews that include policies and procedures, desktop-level procedures, training materials, survey materials, language services contracts, reports, program descriptions, and program evaluations. The current assessment score is 66.67% out of a					

QAC 03.19.2026

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										possible 100 points					

QAC 03.19.2026

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25	Program Oversight		Quality Performance Improvement: Managed Care Accountability Set (MCAS) OneCare STAR measures DHCS Quality Withhold Health Plan Accreditation (QI3) Health Plan Rating	Track and report quality performance measures required by regulators against the following goals: (1) Achieve 50th percentile MPL or above (2) Achieve 4 Stars or above (3) Achieve 100% of withhold (4) Achieve 3 or higher (5) Achieve 5.0	1. Track rates monthly 2. Share final results with QIHEC annually 3. Review and identify measures for focused improvement efforts after each monthly refresh 4. Streamline data validations of monthly refresh data. HEDIS software vendor is currently solving medical record review tool issues and cannot work on concurrent data processing which delays processing of monthly data. Anticipating improvement once issues are resolved.	By December 2025 Report program update to QIHEC Q1: 01/14/2025 Q2: 05/13/2025 Q3: ~~07/08/2025~~ 08/12/25 Q4: 11/04/2025 Q1: 02/10/2026	Director of Quality Analytics/Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	As of 4/14/2025, the most recent data set available is January 2025. Member-measure level detail for data through January 2025 was provided in Q1 to Health Network and CHCN providers for both lines of business.	As of 4/14/2025, summary level data has not yet been provided to CHCN providers for both lines of business.	As of 4/14/2025, OneCare summary level data has been provided to Health Networks but not MediCal.	Challenges running reports with the new system.	Working with EDI and Financial Analysis to automate the new prospective rate report format (member-measure level and summary reports) in Q2.	

QAC 03.19.2026

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26	Program Oversight		Value Based Payment Program	Implement a value-based payment program and report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	Assess and report the following activities: 1. Share HN performance on all P4V HEDIS measures via prospective rates report each month. 2. Share hospital quality program performance 3. Develop monthly P4V report to show HNs the estimated amount of P4V dollars based on current performance	Report program update to QIHEC Q1: 01/14/2025 Q2: 05/13/2025 Q3: 07/08/2025 Q4: 11/04/2025	Executive Director of Quality Improvement	Director of Quality Analytics	Quality Analytics	HN performance of P4V measures are shared with HN. Estimated P4V dollar amount will be developed in Q3 because of the calculation fomular changed.	None	Data is available.	New HEDIS software and new P4V score calculation method.	Data is available and waiting for generating reports.	
27	Quality of Clinical Care		Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	Monitor PCP, High Volume Specialist and ancillary sites utilizing the DHCS audit tool and methodology and report any findings, barriers and improvement efforts.	Review and report initial and periodic reviews conducted for PCP, high volume specialists and ancillary sites and ensure periodic reviews are conducted every three years. Tracking and trending of reports are reported quarterly.	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	Site Review, PARS, Community-based Adult Services (CBAS), and Nursing Facilities (NF) Oversight: A. FSR: Initials FSRs=7; Periodic FSRs=42; On-site Interims=17; Failed	**FSR/MRR:** The number of Periodic and Initial FSRs and MRRs completed decreased slightly from Q4 2024 to Q1 2025. The number of Periodic FSRs completed timely increased slightly from 92%	Please refer to results for site reviews conducted in the quarter.	N/A	Continue implementing work plan	

QAC 03.19.2026

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										FSRs=0; 93% of Periodic FSRs were completed timely. B. MRR: Initial MRRs=11; Periodic MRRs=54; Failed MRRs=6 C. CAPs: Critical Element (CE)=33; FSR=43; MRR=61 D. PARS: Completed PARS=74; Basic Access=38 ; Limited Access=36 E. CBAS Oversight: Critical Incidents=1 ; Non-Critical Incidents=42; Falls=15; Audits Completed =8; CAPs Issued=6; Unannounced Visits=1 F. NF Oversight: Critical Incidents=1 ; On-site	in Q4 2024 to 93% in Q1 2025. The number of failed FSRs decreased from 3 in Q4 2024 to 0 in Q1 2025. The number of failed MRRs decreased significantly from 19 in Q4 2024 to 6 in Q1 2025. **CAPs**: The number of CE CAPs issued decreased from 44 in Q4 2024 to 33 in Q1 2025. The number of FSR CAPs issued decreased from 60 in Q4 2024 to 43 in Q1 2025. The number of MRR CAPs remained stable from Q4 2024 and Q1 2025. **PARS:** The number of				

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										Visits=16; Unannounced Visits=0	PARS completed decreased slightly from 82 in Q4 2024 to 74 in Q1 2025. The number of PARS with BASIC access increased from 32% in Q4 2024 to 51% Q1 2025. **CBAS Oversight:** The number of Critical Incidents reported decreased from 2 in Q4 2024 to 1 in Q1 2025. The number of Non-Critical Incidents reported increased from 31 in Q4 2024 to 42 in Q1 2025. The number of Falls reported remained stable from Q4 2024 to Q1 2025. The				

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											number of audits completed decreased from 12 in Q4 2024 to 8 in Q1 2025. The number CAPs issued decreased from 9 in Q4 2025 to 6 in Q1 2025. **NF Oversight:** The number of Critical Incidents reports received increased from 4 in Q4 2014 to 13 in Q1 2025. The number on on-site visits completed increased from 14 in Q4 2024 to 16 in Q1 2025.				

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28	Quality of Clinical Care		Potential Quality Issues Review	PQIs are reviewed timely to ensure care and services provided fall within the range of professionally recognized standards of health care.	Review and report quality-of-care cases for peer review (CPRC), determine appropriate severity level and make recommendations for actions based on findings.	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Quality Improvement	Manager of Quality Improvement	Quality Improvement	Twenty-one PQIs leveled as 1 or 2 were presented to CPRC for leveling and actions; there were no level 3 cases in Q1. There were 3 quality-of-service cases presented and 2 level-2 PQIs re-presented. The PQI trends (6-month) and statistics for Q4 were presented. There were two hospitals, one transportation vendor, one orthopaedic surgeon, and six ABA groups that trended from 07/01/2024 - 12/31/2024.	The number of PQIs closed in Q4 increased over all of 2023 and 2024, though the number of cases presented to CPRC remained steady. Quality of Care grievances declined but declined grievances increased. Medical Care remained the greatest category of PQIs. Most of the ABA groups received PQIs related to documentation.	We are working on developing a plan address the PQI backlog.	The number of open PQIs was 710 at the end of Q4.	It was suggested that the groups receive additional training by the BH Department. Continue to reduce the overall number of open PQIs. Further develop the Provider Action Workgroup.	

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29	Quality of Clinical Care		Provider Credentialing and Recredentialing	All providers are credentialed and recredentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements: • No more than 180 days between verification and approval • Providers are recredentialed within 36 months	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Quality Improvement	Manager of Quality Improvement	Quality Improvement	Initial BH Credentialing Q1 = 643 Initial CCN Credentialing Q1 = 56 BH Recredentialing - Q1 = 48 CCN Recredentialing Q4 = 122 For Q1 we did not have any recredentialing files out of compliance	Initial credentialing/Recredentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliness of the initial and recredentialing files.	We are working on developing a plan address the credentialing backlog.	Need resources	2 FTEs hiring in process. Aquiring help from other Depts per leadership request.	
30	Quality of Clinical Care		Special Needs Plan (SNP) Model of Care (MOC)	Increase the number of members completing an HRA, and ICP and ICT to meet the following goal: Percent of Members with Completed HRA: Goal 100% Percent of Members with ICP: Goal 100% Percent of Members with ICT: Goal 100%	Assess and report the following activities: 1. Monthly communication process with Networks on ICP development 2. DHCS HRA1 and ICP1 Quarterly reporting 3. HRA Star status 4. MOC Updates 5. Face to	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Medical Management	QI Nurse Specialist	Medical Management	Assess and report the following activities: 1. Monthly communication process with Networks on ICP development: ICP dashboard being updated with MOC updates and MOC	Quarter 4 2025 and 2024 annual DHCS reports submitted to DHCS 2025 MDVA for CY 2024 data file submitted to CMS	Assess and report the following activities: 1. Monthly communication process with Networks on ICP development: ICP dashboard being updated with MOC updates and MOC tracking file additions. MOC tracking file implemented two additional	Members who are UTC or decline to participate in the HRA or the ICP.	Assess and report the following activities: 1. Resume monthly communication process with Networks on ICP development: -add ICT status 2. Submit DHCS	

QAC 08.19.2026

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					Face interactions					tracking file additions. 2. DHCS HRA1 and ICP1 Quarterly/Annual Reporting 2024: Q4 2024 HRA1 Completed 84% Non-adjusted Q4 2024 ICP1 Complete 82% Non-adjusted 2024 ICP2 Element D: 82% Total number of members with a ICP completed within 365 days of the most recent ICP completed (Subset of C) 2024 HRA2 Element D: 93% Total number of members with a reassessment completed within 365 days of the most recent		columns to track sharing of ICP with Member and PCP. 2. DHCS HRA1 and ICP1 Quarterly reporting and annual reporting 2024: Q4 2024 HRA1 Completed 84% Q4 2024 ICP1 Complete 82% 2024 ICP2 Element D: 82% Total number of members with a ICP completed within 365 days of the most recent ICPcompleted (Subset of C) 2024 HRA2 Element D: 93% Total number of members with a reassessment completed within 365 days of the most recent assessment completed (Subset of C) 3. HRA Star status: as of 3/31/2025 Completed		HRA1 and ICP1 Q1 2025 Quarterly reporting. 3. Assesses HRA Star status for Q2. 4. MOC Updates: Report on changes or trainings; continue quarterly audits. 5. Face to Face interactions: Reports status for Q2 2025 to date. 6. ICP dashboard as of 4/14/2025: 97% initial Care Plan; 95.4% annual care plan 7. Finalize SNPE universe testing and begin reporting Q2	

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										assessment completed (Subset of C) 3. HRA Star status: as of 3/31/2025 Completed 28.83% had qualifying HRA in 2025 4. MOC Updates: MOC 2025 updated and approved Palliative Care Contract for OC/CCN LOB. 5. Face to Face interactions: as of 3/31/2024 40% of OC members had an interaction in 2025. 6. ICP dashboard as of 4/14/2025: Members with 97% initial Care Plan; Members with 95.4%		28.83% had qualifying HRA in 2025 4. MOC Updates: MOC 2025 updated and approved Palliative Care Contract for OC/CCN LOB. 5. Face to Face interactions: as of 3/31/2024 40% of OC members had an interaction in 2025. 6. ICP dashboard as of 4/14/2025: 97% initial Care Plan; 95.4% annual care plan		members with ICT.	

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										annual care plan					

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31	Quality of Clinical Care	PHM - LSC	Pediatric and Adolescent Wellness: EPSDT/Children's Preventive and Screening Services	Childhood Immunization Status (CIS) MC Combo 10: 42.34% Increase from 36.50% to 42.34% by 12/31/2025. Immunizations for Adolescents (IMA) MC Combo 2: Increase from 47.45% to 48.66% by 12/31/2025. Well-Child Visits in the First 30 Months of Life (W30) MC First 15 Months: Increase from 58.92% to 63.38% by 12/31/2025. MC 15 to 30 Months: Increase from 72.44% to 73.09% by 12/31/2025. Child and Adolescent Well-Care Visits (WCV) MC Total: Increase from 53.03% to 55.29% by 12/31/2025. Lead Screening in Children (LSC) MC LSC: Increase from 63.75% to 63.84% by 12/31/2025.	Goal not met - W30. Continue to assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored and age-appropriate messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs (e.g. provide insight into CIS Combo 10 status for each vaccine) 4. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone) 5. For CIS Combo 10, identify members missing only the first Hep B vaccine and	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/14/2025 Q3: 08/12/2025 Q3: 11/04/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics	Quality Analytics	Childhood Immunization Status (CIS) MC Combo 10: 21.50% Immunizations for Adolescents (IMA) MC Combo 2: 38.25% Well-Child Visits in the First 30 Months of Life (W30) MC First 15 Months: 15.54% MC 15 to 30 Months: 62.45% Child and Adolescent Well-Care Visits (WCV) MC Total: 6.38% Lead Screening in Children (LSC) MC Total: 65.77% Rates are as of 2/28/25. We currently do not have rates for the first quarter (data through	Year over year comparison between 2024 and 2025 to be reported as part of quarter 2 updates. Vaccine hesitancy post COVID continues to be a common barrier reported by health networks. Quality Analytics team will explore best practices to share with providers in support of vaccine hesitancy.	1. Vendor supported member outreach to provide education and care coordination with PCP. 2. Vendor supported SMS messaging to provide education and reminders about the importance of care (well-child/well-care visits, lead testing, vaccination) 3. Standing Orders Program participation: 14 CHCN providers have opted into the program.	1. Standing Orders Program is currently being operationalized. Agreement for one major lab is projected to be received in Q2 2025 for Contracting department review. Step is needed prior to operationalizing data exchange between lab and CalOptima Health. 2. Year round chart chase efforts for 1st Hep B vaccine pending.	1. Q2 - finalize the mailing materials to be personalized with each vaccine status. 2. Create provider and member materials to address vaccine hesitancy. 2a. A Communication Strategies for Promoting Adolescent Vaccinations article is scheduled for the April 2025 provider monthly update.	

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					complete chart chase efforts year-round 6. Begin prospective outreach to members that will age into the measure for the following year (i.e. message 1 year old members to ensure compliance with recommended vaccine schedule thus far) 7. Create educational materials for addressing vaccine hesitancy and distribute to providers and members 8. Drive provider participation in the Standing Orders Program to place lab orders for blood lead testing 9. Provide point-of-care lead testing equipment and supplies to providers via the Quality Improvement Grant Program 10. Early Identification and Data Gap					March) due to a system upgrade. The most recent data available is reflective of claims/encounters processed through January 2025.					

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					Bridging Remediation for early intervention										

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32	Quality of Clinical Care		Adult Wellness: Preventive and Screening Services	Cervical Cancer Screening (CCS) MC: Increase from 58.31% to 60.10% by 12/31/2025. Colorectal Cancer Screening (COL) OC: Increase from 66.84% to 70.33% by 12/31/2025. Breast Cancer Screening (BCS-E) MC: Increase from 58.39% to 59.51 % by 12/31/2025. OC: Increase from 66.88% to 75.00 % by 12/31/2025. Immunization Status - Flu, Pneu, Tdap, Zoster MC Flu Total: Increase from 22.19% to 26.40% by 12/31/2025. OC Flu Total: Increase from 47.17% to 49.12% by 12/31/2025. MC Pneumococcal 66+: Increase from 38.18% to 38.73% by 12/31/2025. OC Pneumococcal 66+: Increase from 44.96% to 56.76% by 12/31/2025. MC Tdap Total: Increase from 25.43% to 33.40% by 12/31/2025. OC Tdap Total: Increase from 24.57% to 31.56% by 12/31/2025. MC Zoster Total: Increase from 17.52% to 20.56% by 12/31/2025. OC Zoster Total: Increase from 23.62% to 40.94% by 12/31/2025.	Assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs 4. Provide facility listings for services completed outside the PCP office setting, such as diagnostic sites for mammography 5.Provide mobile mammography services in collaboration with other departments, Health Network partners, and CHCN providers 6. Provide at-home Cologuard testing for	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Quality Analyst of Quality Analytics / Manager of Quality Analytics	Quality Analytics	Cervical Cancer Screening (CCS) MC: 42.21% Colorectal Cancer Screening (COL) OC: 52.55% Breast Cancer Screening (BCS-E) MC: 46.75% OC: 53.49% Immunization Status - Flu, Pneu, Tdap, Zoster (AIS-E) MC Flu Total: 16.64% OC Flu Total: 41.62% MC Pneumococcal 66+: 36.89% OC Pneumococcal 66+: 45.31% MC Tdap Total: 35.98% OC Tdap Total: 39.54% MC Zoster Total: 17.19%	CCS MC: A 5.37 percent point increase compared to March 2024. COL OC: A 2.55 percent point increase compared to March 2024. BCS MC: A 6.14 percent point increase compared to March 2024. BCS OC: A 0.49 percent point increase compared to March 2024. MC Flu Total: A 1.33 percent point decrease compared to March 2024 OC Flu Total: A 2.48 percent point decrease compared to March	General Cancer Screening Texting Campaign (approx 290K MC Members) Updated CCS, BCS, COL cover letter for member screening reminder mailing Completed facility listing for CHCN MC and OC members for mobile mammography location Flu Thank You Postcard Care gap member outreach to commence Q3 and Q4	None identified.	Continue Outreach modalities for CCS, BCS and COL (text, IVR, mailing, telephone) Standing Order telephonic and mailing member outreach for BCS Initiate 2025 Cologuard Campaign Initiate of mobile mammography events Continue Flu Postcard for members TBD Q3/Q4 Relaunch IVR robocall campaign TBD Q3/Q4 Relaunch Texting Campaign TBD Q3/Q4	

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					Colorectal Cancer Screening 7. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone)					OC Zoster Total: 24.62%	2024 MC Pneumococcal 66+: A 1.5 percent point decrease compared to March 2024 OC Pneumococcal 66+: A 0.26 percent point increase compared to March 2024 MC Tdap Total: A 2.35 percent point decrease compared to March 2024 OC Tdap Total: A 1.69 percent point decrease compared to March 2024 MC Zoster Total: A 1.28 percent point decrease compared to March 2024 OC Zoster Total: A 0.2 percent point increase				

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											compared to March 2024				

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2025 QIHETP Appendix A – 2025 QIHETP Work Plan
05/12/2025

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33	Quality of Clinical Care		CalOptima Health Comprehensive Community Cancer Screening Program (CCCSP)	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer report key findings and/or activities, analyze barriers, and improvement efforts.	Assess and report the following: 1. Establish the Comprehensive Community Cancer Screening and Support Grants program and monitor Grantees' progress to measure impact 2. Develop and implement a comprehensive plan for other initiatives under CCCSP.	Report Program update to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Chief Medical Officer	Manager of Medical Management	Medical Management	1) Hosted the quarterly grantee meeting on January 21, 2025, to review Q1 (Sep-Nov 2024) progress. 2) Received the Q2 progress reports (Dec 2024 - Feb 2025) from all grantees. 3) Received feedback on the Research and Eval component from both City of Hope and UCI Chao Family Comprehensive Cancer Center. 4) Created a prototype dashboard to view grantees' baseline, goals, and progress toward their goals.	1) Not all grantees reported baseline data for Q1 2024 (Jan 1 - Mar 31, 2024). Several non-health system grantees are unable to report on or connect their outreach efforts to screening measures yet. 2) Need to tailor each grantee's goals and progress into measurable formats. 3) 1-way GCA Results: Total messages sent: 1,276,774 to 215,207 unique members. Delivery rate: 91% Opt-out rate: 4%	Met with individual grantees alongside CalAIM's Director of Program Development to understand their progress and introduce the idea of newly formatted goal/progress reports.	Lack of consistent baseline data and goals displayed as percentages without a clear indication of the numerator and denominator.	1) Conduct the quarterly grantee meeting in April to review Q3 (Mar-May 2025) progress. 2) Release the RFP for the Research & Evaluation component of the program.	

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										5) Started collaborating with CalAIM's Program Development team to enhance the grant management process. 6) Launched the 1-way General Cancer Awareness (GCA) texting campaign on February 18 and 25, 2025. 7) Started working with Alinea to schedule mobile mammography services for CHCN members.					

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34	Quality of Clinical Care	CoC - PPC	Maternal and Child Health: Prenatal and Postpartum Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). MC Prenatal: Increase from 88.08% to 88.58% by 12/31/2025. MC Postpartum: Increase from 80.00% to 80.23% by 12/31/2025.	Assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Implement a comprehensive outreach strategy utilizing multiple modalities timed with the member meeting denominator-qualifying criteria 4. Launch an interdepartmental maternal health workgroup focused on improving outcomes and addressing disparities 5. Provide bundled code education to high volume providers	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	Activity 1 is in progress (2024 data 'deep dive'). Preliminary discussions re: activity 6 have been held with the Equity & Community Health team and the Financial Analysis team. File layout / dashboard fields have been drafted.	N/A at this time	Activity 1 is in progress (2024 data 'deep dive'). Preliminary discussions re: activity 6 have been held with the Equity & Community Health team and the Financial Analysis team. File layout / dashboard fields have been drafted.	Lack of time and resources; QA focus in Q1 has been on providing support for prospective rate reporting post Citius transition. Measure-specific reporting is slated for Q2.	Complete activities as listed.	

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					6.Create a comprehensive dashboard / report that refreshes weekly to ensure timely member identification and intervention 7. Collaborate with OBGYN specialty groups to perform member outreach and schedule services 8. Expand on collaborative efforts with community-based organizations, providers, and health networks.										

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35	Quality of Clinical Care	PHM	Maternal and Child Health: Prenatal and Postpartum Depression Screening	Prenatal Depression Screening and Follow-Up (PND-E) MC Screening: Increase from 14.52% to 16.03% by 12/31/2025. MC Follow-up: Increase from 52.80% to 53.33% by 12/31/2025. Postpartum Depression Screening and Follow-Up (PDS-E) MC Screening: Increase from 17.33% to 29.84% by 12/31/2025. MC Follow-up: Increase from 56.84% to 61.70% by 12/31/2025.	PND-E & PDS-E Activities: 1. Provider maternal mental health training 2. Enhance CalOptima Health Maternal Depression Program and support referral to Behavior Health Integration when screened at risk. 3. Conduct or promote depression screening at community events.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director Equity and Community Health	Manager of Equity and Community Health/Manager of Behavioral Health Integration	Equity and Community Health	1. Provided a maternal mental health training through Postpartum Support International to clinics/providers and community-based partners. 58 providers and partners are registered. 2. Conducted maternal mental health screenings at community-based events including Santa Ana College and Maternal Presentations to 45 members.	N/A- work in progress	1. Provided a maternal mental health training opportunity to clinics/providers and community-based partners. 2. Conducted maternal mental health screenings at community-based events. 3. Receive contracted provider list for providers that self-identified as specializing in maternal mental health to assist members with connecting to services. 4. Maternal Health focused TeleMed2U flyer is included in maternal health member mailings.	N/A	1. Implement maternal mental health screenings at stroller walks and other community-based activities.	

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36	Cultural and Linguistic Appropriate Services	PHM CLAS HE	Maternity Care for Black Members	Medi-Cal 1. Increase timeliness of prenatal care (TOPC) for CalOptima's Black members from 75.71% to 84.55% by December 31, 2025. 2. Increase postpartum care (PPC) for CalOptima's Black members from 71.43% to 80.23% by December 31, 2025.	Assess and report the following activities: 1. Connect members to doula, Enhanced Care Management (ECM) services, and Black Infant Health (BIH) programs. 2. Implement community and clinic events that focus on improving prenatal and postpartum appointments. 3. Explore digital methods of providing perinatal assessments, education, and resource navigation for pregnant and postpartum members.	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics/Manager of CalAIM/Director of Equity and Community Health	Equity and Community Health/ Cal AIM/Quality Analytics	Per data through February 2025, the current compliance rate for the Black or African American population for the Timeliness of Prenatal Care measure is 0.97%, and 0.69% for the Timeliness of Postpartum Care measure. The data source is CitiusTech with non-continuous enrollment applied.	Based on February 2025 data, the Black or African American population is trending lower (in terms of compliance rate for both prenatal and postpartum care) as compared to Asian and White members.	1) 22 Black members with open authorization for Enhanced Care Management (ECM) Birth Equity Population of Focus. 7 Black members received doula services in Jan-Feb 2025, comprising 32% of all members engaged in doula services during the same period, March data to be pulled in Q2. 2) Promoted prenatal/postpartum education and doula services at OC Black History Parade and Unity Festival will be held February 1, 2025. 3) Received presentations from three maternal health digital vendors to identify best practices and features.	Fragmented services and coordination of member care.	1) Continue to promote ECM and doula services to population of focus. Establish data sharing with Black Infant Health program.	

QAC 03.19.2026

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37	Quality of Clinical Care	PHM CoC-EED	Chronic Conditions: Members with Diabetes	Eye Exam for Patients with Diabetes (EED) MC EED 64.06% Increase from 63.52% to 64.06% by 12/31/2025. OC: EED 77.00%; Increase from 75.14% to 77.00% by 12/31/2025. HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates Percentage of members with poor A1C control-lower rate is better) (>9.0%) MC HBD: Decrease from 29.34% to 27.01% by 12/31/2025. OC HBD: 10.00% decrease from 15.30% to 10.00% by 12/31/2025.	Assess and report the following activities (Quality Analytics): 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs 4. Explore at-home testing for HBD via lab vendor 5. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone) 6. Drive provider participation in the Standing Orders program to place A1c lab orders on behalf of	By December 2025 Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Quality Analytics (Medicare Stars and Quality Initiatives)/Director of Equity and Community Health	Manager of Quality Analytics	Equity and Community Health and Quality Analytics	Eye Exam for Patients with Diabetes (EED) EED MC: 28.42% EED OC: 40.54% HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates Percentage of members with poor A1C control-lower rate is better) (>9.0%) HBD MC: 81.05% HBD OC: 79.01%	EED MC: A 0.08 percent point increase compared to March 2024. EED OC: A 2.46 percent point decrease compated to March 2024. HBD MC: A 3.45 percent point decrease compared to March 2024. (lower is better) HBD OC: A 3.99 percent point decrease compared to March 2024. (lower is better)	Complete build of Ushur Two way text campaign for Diabetes. CareNet Telephonic member outreach VSP Eye Exam mailing reminder		Continue Outreach modalities for EED, HBD (text, IVR, mailing, telephonic, emailing) Update EED/HBD cover letter for member remind mailing. Standing Orders program to place A1c lab orders on behalf of physicians Partner with VSP to educate providers on EED CPT II code submission to capture testing results	

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					physicians 7. Collaborate with OPH and OPT providers on member outreach and scheduling of services for EED 8 Regularly review members with evidence of A1c testing but no result and address via supplemental data capture 9. Partner with VSP to educate providers on EED CPT II code submission to capture testing results 10. Explore offering EED testing at community based events Assess and report the following activities: 1. Enhance Diabetes Education: Launch virtual and group education classes to improve member engagement by FY 2025. 2. Leverage Technology: Use digital apps and web-										

QAC 03.19.2026

					based tools to support diabetes prevention, management, and interactive engagement. 3. Strengthen Support Services: Link members to medically tailored meals, health coaching nutrition services, community/clinic events.										

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38	Quality of Clinical Care	PHM CLAS HE	Chronic Conditions: Members with Heart Health (Hypertension)	Controlling High Blood Pressure (CBP) MC CBP: Maintain the 90th percentile (72.75%) or higher by December 31, 2025. OC CBP: Increase from 74.87% to 80.00% by 12/31/2025. Controlling High Blood Pressure (CBP) - CLAS and Health Disparity for Medi-Cal 1. Increase CBP rate among Black and African American Medi-Cal members from 39.21% to 64.48% by 12/31/2025. 2. Increase CBP rate among Black and African American Medicare members from 47.24% to 77% by 12/31/2025. 3. Increase CBP rate among Korean speaking Medi-Cal members from 24.87% to 64.48% by 12/31/2025. 4. Increase CBP rate among Vietnamese speaking Medicare members from 50.56% to 77% by12/31/2025.	Assess and report the following activities: 1. Expand Hypertension Program to offer both virtual and in-person Hypertension Education.	Report to PHMC: Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	1. Education on blood pressure control were provided at the Black History and Unity parade on 2/1/2025. Over 50 members were screened and received education. Hosted a table with information on high blood pressure at the 2nd Annual Ethiopian Day Celebration hosted by Ethio American Generational Bridge on 3/2. 2. A hypertension class was conducted on 2/28 at the Vietnamese American Cancer Foundation	1)Community events are effective engagement points, particularly those centered around cultural identity and inclusion. 2)Members are receptive to health education when delivered through trusted community organizations. 3)There is an ongoing need to reduce equipment access barriers, such as blood pressure monitors, to support chronic condition management. 4)Internal	1. Identified OC members with CBP health gap to provide targeted outreach for education and blood pressure screening clinics 2. Finalized hypertension class curriculum 3. A standing order was created to increase access to BP monitor for CalOptima members. Training for CalOptima staff will take place in April. 4. Meeting with providers and community based organizations to schedule blood pressure clinics 5. Increased screening opportunities at community events	N/A	Several classes and BP screening are scheduled for Q2.	

QAC 03.19.2026

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										. Total attendees: 16 3. A standing order was created to increase access to blood pressure monitors for CalOptima members. Training for CalOptima staff will take place in Q2.	training and protocol implementation are necessary next steps to operationalize expanded member access.				

QAC 03.19.2026

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39	Quality of Clinical Care		Chronic Conditions: Osteoporosis	Osteoporosis Management in Women Who Had a Fracture (OMW) OC Total: Increase from 34.67% to 39.00% by 12/31/2025.	1.Case management to collaborate with Quality to identify members who need follow-up. 2.Quality to outreach to noncompliant members via SMS, mail, and/or telephone. 3.Quality to pursue at-home DEXA testing via vendor. 4.Quality to provide timely notifications to the member's PCP via fax. 5.Quality to explore collaboration with the Pharmacy team to provide education on the importance of taking a medication to treat osteoporosis (e.g. bisphosphonate). 6.Quality and Case Management coordinate to provide more timely data and	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Sr. Director Medical Management/Manager of Quality Analytics	Quality Improvement Nurse/Program Manager Quality Analytics	Medical Management (Case Management) /Quality Analytics	Denominator: 48 Numerator: 11 Rate is 22.92% as of 2/28/25 Not applicable due to system upgrade. We currently do not have rates for the first quarter (data through March). The most recent data available is reflective of claims/encounters processed through January 2025.	Rate is 22.92% as of 2/28/25 and reflective of claims/encounters processed through January 2025. Year over year comparison between 2024 and 2025 to be reported as part of quarter 2 updates.	**Member focused:** 1. CM telephonic outreach to CHCN members 2. QA outreach to all members via mail **Provider/Health Network focused:** 1. Notifications to providers via fax 2. Data enhancements to HN and CHCN reports to include insight into the compliance deadline date 3. CalOptima Health collaboration with Health Network Case Management Leadership regarding identified members. **Other:** 1. Exploration of at-home DEXA vendor in progress for CHCN OC members. 2. QA enhancement 3. QA -	Visibility into members for MY2025 Quality Team has partnered with Finance team to create OMW specific reports to allow for visiblity of fractures occurring as of July 1, to allow for enhanced member identification and outreach.	1. Continue to pursue at-home DEXA testing via vendor, or purchase equipment and utilize internal resources to complete test at home. 2. Targeted provider outreach for medical record submission if member is compliant 3. Member education to emphasize the importance of osteoporosis medication 4. Provider Education: Develop provider	

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					insight to the member's compliance deadline date to Health Network partners.							Standing Orders Program for DEXA		tip sheet/ explore CE/CME for osteoporosis screening and treatment. 5. Add pharmacy component to member outreach and/or member communication materials. 6. Continued CM follow-up with appropriate HN Case Management Leadership regarding identified members. 7. Continued CM telephonic outreach to CHCN members 8. Year over year comparison	

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														between 2024 and 2025 to be reported as part of quarter 2 updates.	
40	Quality of Clinical Care	CoC - FMC	Chronic Conditions: Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) OC Total: Increase from 51.27% to 53.00% by 12/31/2025.	1. Review and update the Key Events for Emergency Visits 2. Continue to share Emergency Visits with Health Networks through Key Event reporting.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director Medical Management	Quality Improvement Nurse	Case Management	Denominator: 307 Numerator: 116 Rate is 37.79% as of 2/28/25	Rate is 37.79% as of 2/28/25	1. Key Event logic reviewed and reshared with Health Networks. 2. Daily Key Event Reporting. 3. CM outreach to all members	1. Ability to differentiate on key event report for ER visits those members who qualify for FMC so networks may prioritize. 2. short turn-around time for visit 7 days	1. Continue Daily Key Event Reporting. 2. Continue CM outreach to all member	

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41	Quality of Clinical Care		Behavioral Health Services: Child and Adolescent Health on Antipsychotics	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) MC Glucose and Cholesterol Combined-All Ages: Increase from 36.76% to 41.41% by December 31, 2025.	Goal not met. Continue to assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primary Care Providers (PCP) for members in need of metabolic monitoring. 2) Work collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in need of screening. 3) Monthly mailing to prescribing providers to remind of best practices for members in need of screening. 4) Send	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	1) Created a draft to update the Prescriber tip tool sheet. 2) Updated the Best Practices Prescriber letter-pending management approval. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for Providers and staff on how to use the Provider Portal. Pending report availability. 4) Created Social media post for this HEDIS measure. 5) Created article for Fall Member Newsletter.	1) Due to lack of the Prospective Rate report we are unable to track and trend any analysis for this measure. 2) Unable to send text messages to members due to system upgrade.	1) If data is received, Disseminate prescriber letter. 2) If data is received, Disseminate prescriber tip tool sheet. 3) If data is received, resume Text message campaign. 4) If data is received, resume mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to providers on a monthly basis. 5) If data is received, resume collaborati	

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					monthly reminder text message to members (approx 600 mbrs). 5) Information sharing via provider portal to PCP on best practices.									on with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 6) Schedule listening sessions with Providers to educate/train on how to obtain BH data upon BH reports are availability.	

QAC 03.19.2026

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42	Quality of Clinical Care	PHM	Behavioral Health Services: Depression	Antidepressant Medication Management (AMM) MC Acute Phase - 63.35% Increase from 68.06% to 68.35% by December 31, 2025. MC Continuation Phase - Increase from 48.06% to 48.16% by December 31, 2025. OC Acute Phase - 63.35% Increase from 75.52% to 78.39% by December 31, 2025. OC Continuation Phase - Increase from 60.77% to 62.58% by December 31, 2025. Depression Screening and Follow-up for Adolescents and Adults (DSF-E) MC Screening Total: Increase from 6.57% to 16.22% by December 31, 2025. OC Screening Total: Maintain the 90th percentile (54.28%) or higher by December 31, 2025.	AMM Goal not met. Continue to assess and report the following activities: 1) Educate providers on the importance of medication adherence through outreach. 2) Educate members on the importance of medication adherence through newsletters/outreach. 3) Track number of educational events on depression treatment adherence. DSF-E Goal not met. Continue to assess and report the following activities: 1) Educate providers on the importance of screenings and follow-up care after positive screenings. 2) Educate	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	**AMM/DSF-E:** Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	**AMM/DSF_E:** Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	**AMM** 1) Created a draft to update the Prescriber tip tool sheet. 2) Updated Best Practices Prescriber letter-Pending management approval. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for Providers and staff on how to use the Provider Portal. Pending report availability. 4) Created Social media post for this HEDIS measure. 5) Created article for Fall Member Newsletter. DSF-E: 1) Created a draft to update the Prescriber tip tool sheet. 2) Updated Prescriber letter-pending management approval. 3) Created a Quick	AMM/DSF-E: 1) Due to lack of the Prospective Rate report we are unable to track and trend any analysis for this measure. 2) Unable to send text messages to members due to system upgrade.	AMM/DSF-E: 1) If data is received, Disseminate prescriber letter. 2) If data is received, Disseminate prescriber tip tool sheet. 3) If data is received, resume Text message campaign. 4) If data is received, , resume mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to providers on a monthly basis. 5) If data is received,	

QAC 03.19.2026

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					members on the importance of screenings through newsletters/outreach and increase follow up appointments after positive screenings.							Reference Guide (QRG) & Power Point Presentation for Providers and staff on how to use the Provider Portal. Pending report availability.		resume collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 6) Schedule listening sessions with Providers to educate/train on how to obtain BH data upon BH reports availability.	

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43	Quality of Clinical Care	CoC-SSD	Behavioral Health Services: Schizophrenia	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) MC SSD: Increase from 74.96% to 79.51% by 12/31/2025. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) MC: Increase from 70.19% to 74.83% by 12/31/2025. OC: Increase from 77.37% to 77.93% by 12/31/2025.	SSD Goal not met. Continue to assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collaboratively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx 1100 mbrs)	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	**SSD\SAA:** Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	**SSD\SAA:** Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	**SSD:** 1) Updated prescribing provider letter. 2) Created new provider tool tip sheet. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability. 4) Created Social Media Posts for members to receive a diabetic screening. 5) Created an article for the Fall Member Newsletter. SAA: 1) Created new Prescribing Provider Letter. 2) Created a Provider Too Ttip sheet. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation	**SSD\SAA:** 1) Due to lack of the Prospective Rate report we are unable to track and trend any analysis for these measures. 2) Unable to send text messages to members due to system upgrade.	**SSD:** 1) Continue tracking members in need of glucose screening test as soon as we're able to receive data. 2) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 3) Continue to follow up on data pull for text messaging campaign. 4) Mail out member health rewards flyer to eligible members. 5) Mail out to all prescribing provider	

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					5) Member Health Reward Program. SAA Assess and report the following activities: 1) Educate providers on the importance of medication adherence through outreach. 2) Educate members on the importance of medication adherence through newsletters/outreach.							for Providers & Staff on how to use the Provider Portal. Pending report availability. 4) Created an article for the Fall Member Newsletter.		offices the following: a.)Prescribing Provider Letter b.)Provider Tool Tip Sheet c.)Member Reward Flyer 6)Schedule listening sessions with Providers to educate/train on how to obtain BH data. Pending report availability. **SAA:** 1) Will use provider portal to communicate best practices and guidelines for medication adherence and member	

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														follow-up. 2) Discussion of implementing a text messaging campaign. 3) Begin mail out to all prescribing provider offices the following: a.) Prescribing Provider letter b.) Provider Tool Tip Sheet 4) Schedule listening sessions with providers to educate/train on how to obtain BH data. Pending report avialability.	

QAC 03.19.2026

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44	Quality of Clinical Care	PHM CoC-FUM; FUA; FUI	Behavioral Health Services: Care Coordination and Follow-up Care	Follow-Up After Emergency Department Visit for Mental Illness (FUM) MC 30-Day: Increase from 35.76% to 53.82% by 12/31/2025. MC 7-day: Increase from 21.38% to 33.01% by 12/31/2025. Follow-Up After Emergency Department Visit for Substance Use (FUA) MC 30-Day: Increase from 21.12% to 36.18% by 12/31/2025. MC 7-Day: Increase from 11.23% to 18.76% by 12/31/2025. Follow-up After High-Intensity Care for Substance Use Disorder (FUI) MC 30-Day: Increase from 20.25% to 44.53% by 12/31/2025. MC 7-Day: Increase from 7.99% to 26.90% by 12/31/2025.	FUM Goal not met. Continue to assess and report the following activities: 1. Share real-time ED data with our health networks on a secured FTP site. 2. Participate in provider educational events related to follow-up visits. 3. Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4. Bi-Weekly Member Text Messaging (approx. 500 mbrs) 5. IVR calls to members who fall under the FUM measure FUA Goal not met. Continue to assess and report the following activities: 1. IVR calls to members who fall under the FUA measure 2. Continue weekly	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	**FUM/FUA/ FUI:** Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	**FUM/FUA/ FUI:** Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	**FUM:** 1) Member text messages sent weekly. 2) Member outreach via BH Telehealth vendor to assist with scheduling Follow up appointments. Outreach based on daily ED data feed. 3) Reminders regarding importance of FUM/FUA sent in monthly HN Communication. 4) Continued sharing FUM data with HN Networks via sFTP. 5) Attend HN Quality meetings to educate on importance of FUM/FUA measures. 6) Collaboration with OC HCA regarding 837 data exchange 7) Created HEDIS Provider Tip Sheet. FUA: 1) Weekly member text messages. 2) Sharing FUA data with Health Networks via	**FUM/FUA/FUI:** Due to lack of the Prospective Rate report we are unable to track and trend any analysis for this measure.	**FUM:** 1) Start IVR calls for members who meet FUM criteria to remind them of the importance of scheduling a follow up appointment after an ED visit. 2) Continue following up with OC HCA regarding data exchange. 3) Meet with High volume ED's to ensure members are connected to services before they leave the hospital by introducing Telemed2U/NAMI By Your Side. 4) Share FUM data	

QAC 03.19.2026

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					member text messaging 3. Share FUA data with providers through the Provider Portal. 4. Sharing FUA data with Health Networks via sFTP. FUI: This measure was added for monitoring purposes. Opportunities for improvement and/or interventions will be considered upon the ability to obtain data from the Orange County Health Care Agency.							the sFTP. 3) Participate in Quality update meetings with Health Networks to educate the importance of the FUA measure. 4) Send reminders regarding the importance of FUA measure in monthly HN communication. 5) Created HEDIS Provider Tip Sheet. 6) Member outreach via BH Telehealth vendor to assist with scheduling Follow up appointments. Outreach based on daily ED data feed. **FUI:** 1) Opportunities for improvement and/or interventions are being considered upon the ability to obtain data from the Orange County Health Care Agency. 2) Created a HEDIS		via Provider portal. Pending report availability. 5) Schedule listening sessions regarding how to use data from Provider portal. FUA: 1) Continue weekly text messages. 2) Continue sharing data with Health Networks via the sFTP. 3) Continue to collaborate in Quality update meetings with Health Networks. 4) Start IVR calls for members who meet FUA criteria to remind	

QAC 03.19.2026

												Provider Tool Tip Sheet.		them of the importance of scheduling a follow up appointment after an ED visit. 5) Continue following up with OC HCA regarding data exchange. 6) Share FUA data via the Provider Portal. FUI: 1) Continue to monitor measure on a monthly basis. 2) Continue collaborative meetings between teams to identify best practices to implement.	

QAC 03.19.2026

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45	Quality of Clinical Care	CoC - APP	Behavioral Health Services: Medication Management	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) MC Total: Increase from 28.95% to 54.55% by 12/31/2025. Pharmacotherapy for Opioid Use Disorder (POD) MC Total: 21.36% Increase from 7.79% to 21.36% by 12/31/2025.	Assess and report on the following activities: 1) Educate providers on measure and best practice guidelines.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Manager of Behavioral Health Integration	Behavioral Health Integration	**APP/POD:** Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	**APP/POD:** Not applicable due to system upgrade, we currently do not have rates for the first quarter and unable to analyze any findings.	**APP:** 1) Created HEDIS Provider Tip Sheet. 2) Created Provider Best Practice Letter **POD:** 1) Met with Pharmacy on 02/24/25 to discuss collaboration with this measure. Both BH and Pharmacy agreed that data will be needed from Orange County Health Care Agency for tracking purposes.	**APP/POD:** Due to lack of the Prospective Rate report we are unable to track and trend any analysis for this measure	**APP:** 1) Use provider portal to communicate best practices and guidelines. 2) Discuss implementing a text messaging campaign. 3) Plan to mail out to all prescribing provider offices the following: a.) Best Practice Provider letter b.) Provider HEDIS Tool Tip Sheet **POD:** 1) Establish steps to obtain data from OCHA.	

QAC 03.19.2026

2025 QIHETP Appendix A – 2025 QIHETP Work Plan
05/12/2025

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
46	Quality of Clinical Care		Behavioral Health Services: School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report the following Student Behavioral Health Incentive Program (SBHIP) activities/school base mental health services 1 . SBHIP Program Outcome Reporting 2. DHCS CYBHI multi-Payer Fee Schedule	Report program update to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Project Manager of Behavioral Health Integration	Behavioral Health Integration	NA	NA	1) Waiting for DHCS' approval letter for the December submitted project outcome reports. 2) Final two WellSpaces installed March 2025. 3) The Autism Comprehensive Program designed by CHOC through SBHIP launched in March 2025.	NA	1) For the CYBHI Fee Schedule, Carelon Behavioral Health conducting an implementation kick-off meeting for the ASO claims payment process - April 2025.	
47	Quality of Clinical Care		Medication Management	Appropriate Testing for Pharyngitis (CWP) MC Total: Increase from 43.66% to 76.71% by 12/31/2025. OC Total: Increase from 15.77% to 72.50% by 12/31/2025. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) MC Total: Increase from 47.55% to 56.73% by 12/31/2025. OC Total: Increase from 68.97% to 47.50% by 12/31/2025.	1) Identify top 5-10 providers that prescribed antibiotics to members and provide targeted provider education via provider updates/provider newsletter. 2) Provide members with general education on antibiotic avoidance.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Medicare Stars and Quality Initiatives	Program Manager of Quality Analytics	Quality Analytics	Appropriate Testing for Pharyngitis (CWP) MC Total: 52.8% OC Total: 17.22% Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB) MC Total: 37.16% OC Total: 24.82%	CWP MC: A 0.53 percent point increase compared to March 2024 CWP OC: A 7.58 percent point increase compared to March 2024 AAB MC: A 2.51 percent point decrease compared to March 2024	Create provider material on antibiotics avoidance. Identify top 10 lower performing providers	N/A	COH to finalize provider communication plan	

QAC 03.19.2026

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											AAB OC: A 1.60 percent point decrease compared to March 2024				
48	Quality of Clinical Care		Medication Adherence	Improve medication adherence for Cholesterol (Statins), Hypertension (RAS Antagonists) and Diabetes	1) Member IVR, member education, provider education, PDC report to Health Networks.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Pharmacy Management	Manager of Pharmacy Management	Pharmacy Management	1Q25 Overview: Count of Member adherence IVRs: 4,473 Count of Member: 1,088 interventions (pharmacies, members and providers); 283 prescriptions filled (26%) which resulted in successful refills for	CY2025 Star Measure reports unavailable from Acumen for 1Q25. Results of interventions documented in column O.	1) Adherence IVRs 2) Adherence outreach calls to members, pharmacies and providers 3) Health network coaching 4) PDC report enhancements 5) 100-day supply conversion program	1) Members picking up their medications 2) Limited providers signing collaborative practice agreement for 100-day supply program	Continue all interventions outlined.	

QAC 05.19.2026

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										197 members Report distribution Health Networks via provider portal (daily refresh); actionable report for networks to conduct outreach Distribution of best practices document to health networks to assist in intervention design 100-day supply conversion program (19 contracted providers); 54 prescriptions converted for 34 members					

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49	Cultural and Linguistic Appropriate Services	CLAS HE	Performance Improvement Projects (PIPs) Medi-Cal	Increase well-child visit appointments for Black/African American members (0-15 months) from (final rate TBD) to 55.78% by 12/31/2025.	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP – Increasing W30 6+ measure rate among Black/African American Population	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics / Manager of Quality Analytics	Quality Analytics	Denominator: 38 Numerator: 4 Rate is 10.53% as of 2/28/25 Not applicable due to system upgrade. We currently do not have rates for the first quarter (data through March). The most recent data available is reflective of claims/encounters processed through January 2025.	Count of Member IVRs: 4,473	1. PIP Call Campaign to coordinate well-child visit with PCP.	1. Contact Information: bad or disconnected phone numbers poses additional challenges in the ability to contact members and subsquently coordinate care.	1. Following up with PCP offices to identify alternative contact information for members.	

QAC 03.19.2026

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50	Quality of Clinical Care		Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) FUM and FUA for complex case management.	Non Clinical PIP: Improve the percentage of members enrolled into care management, CalOptima Health community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed with SMH/SUD.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration/ Quality Analytics	NA	Count of Member: 1,088 interventions (pharmacies, members and providers); 283 prescriptions filled (26%) which resulted in successful refills for 197 members	1) Receiving daily ED report from vendor which contains Real-Time ED data for CCN and COD members. 2) Collaborate with telehealth provider, Telemed2U, and internal ITS team to develop implementation plan for Member Outreach. Vendor to provide information about case management including ECM and referrals	1) Data integrity has been an issue. Proposed changes may threaten validity of baseline data.	1) Continue collaboration with Case Management and Financial Analysis depts to ensure accuracy of internal data and reports. 2) Continue to conduct barrier analysis 3) Continue Telehealth member outreach.	

QAC 03.19.2026

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51	Quality of Clinical Care		Chronic Care Improvement Projects (CCIPs) OneCare: Diabetes Emerging Risk	By December 31, 2025, 5% of members identified as emerging risk* and who participated in program will lower HbA1c to less than 8.0%. *Emerging risk is defined as members with a result of A1C 8.0% to A1C 9.0% who were previously in good control A1C less than 8.0% in previous 12 months.	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics	Quality Analytics	HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates Percentage of members with poor A1C control- lower rate is better) (>9.0%) HBD OC: 79.01%	Report distribution Health Networks via provider portal (daily refresh); actionable report for networks to conduct outreach	Telephonic outreach via Disease Management department staff for those identified as emerging risk	Data refresh issue due to the HEDIS vendor transition	Case Management and Equity & Community Health teams are currently discussing the approach to Q2-Q4 outreach	
52	Quality of Service: Access		Improve Network Adequacy: Reducing Gaps In Provider Network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/21/2025	Director of Provider Operations	Sr. Program Manager, Provider Operations/Program Specialist	Provider Data Operations	1.Gap analysis showed Plan level meets standards except for PMR, which shows gaps in LMFT, Gastroente	Distribution of best practices document to health networks to assist in intervention design	1. PDO curated target lists for R,U,N and PR Recruitment Outreach is in progress 2. Research to see what caused the new Plan - count gap in Opthalmology	South County is always an area where it's hard to find providers (CCN gaps)	1. Review the results of the outreach and identify next steps 2. Review HN CAP response submission	

QAC 03.19.2026

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					2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members					rology, Ortho Surgery & LMFT 2.CCN met all requirements except for Time or Distance - Q1 showed 3 gaps 3. HNs all had Time or Distance gaps, with some having PMR gaps		3. HNs are to provide CAP response on or before 4/4 to address gaps			
53	Quality of Service: Access		Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Goal not met. Continue to assess and report the following activities: 1) Conduct an evaluation of appointment and telephone access 2) Issue corrective action for areas of noncompliance 3) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/21/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics / Project Manager of Quality Analytics	Quality Analytics	Timely Access CAPs issued to 9 HNs in December 2024, and all networks submitted a response in Q1. Response Rate: 100% As of Q1, 64% of the provider CAPs (109) issued in June-2024 have been closed.	HN CAP submissions for MY-2023 data are currently under review. High level findings noted attributing to non-compliance includes but not limited to: staffing shortages, lack of walk-in availability, and scheduling. MY-2024 Timely	In February issued an RFP for Timely Access Survey and received 6 submission. Selection process is underway. Timely Access workgroup members are working on streamlining the survey process and reviewing standards to ensure they are a regulatory requirement Will continue to collaborate with providers	Vendor issues with data integrity and quality control issues has caused significant delays in releasing results timely to providers and health networks over the last several years.	-2025 Timely Access Survey (MY-2024) non-compliance/CAP notifications to be issued to providers by mid-June. -Continue to educate and collaborate with providers and HNs on Access. -Re-evaluate	

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Back to Agenda Back to Item

QAC 03.19.2026

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					access. 4) Continue to educate providers on timely access standards 5) Develop and/or share tools to assist with improving access to services.						Access Survey concluded December 2024, and QA is in the process of receiving and QC'ng data from the vendor.	to learn more about their challenges and to share best practices.		MPL threshold per DHCS Timely Access recommendations	
54	Quality of Service: Access		Network Adequacy Regulatory Submission and Audits	Comply with regulatory requirements • Annual Network Certification (ANC) • Subdelegate Network Certification (SNC) • Network Adequacy Validation (NAV) Audit	1) Annual participation of ANC, SNC and NAV to DHCS with AAS or CAP 2) Implement improvement efforts 3) Monitor for Improvement 4) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2025 2) By end of Q2 2025 3) By end of Q3 2025 Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/21/2025	Director of Provider Operations	Sr. Program Manager, Provider Operations	Provider Data Operations	1. ANC - 2023 ANC approved AAS website posting in process - 2024 ANC from DHCS showed 21 gaps. - COH submitted completed 2024 ANC submission 3/18 inclusive of revised AAS request for 21 gaps (down from 43 in 2023) 2. SNC - RAC requested update for 2023 CAPs	2024 SNC (HN) found all Health Networks did not meet Network Adequacy Standards based on Q4 Network Adequacy Assessments	1. 2024 ANC Package - PDO and PR performed outreach recruiting efforts and Contracting completed requested information regarding provider network. 2. 2024 SNC - COH issued HN CAPs for Time or Distance and PMR	1. ANC - DHCS FFS database show providers with inaccurate practice locations - DHCS and CalOptima Health do not use the same geomapping software, leading to different assessment	1. COH working on upgrading Quest geomapping software to increase TorD assessment accuracy 2. HN CAP submissions due to COH 4/4/2025 for contracting efforts to close SNC gaps	

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Back to Agenda Back to Item

QAC 03.19.2026

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										issued, submitted document stating COH has closed all CAPS issued to HNs, and found no deficiencies, officially closing out 2023 SNC. 3. RAC has not heard from DHCS regarding 2024 NAV Audit			results for Tor D		
55	Quality of Service: Access	PHM	Increase Primary Care Utilization - Initial Health Appointment	Increase the IHA completion rate for all new Medi-Cal members from 33% to 50% by December 31, 2025.	Assess and report the following activities: 1) Enhance methods of informing members of the importance of IHA and preventive screenings. 2) Collaborate with delegation oversight to improve IHA compliance by Health Network.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Equity and Community Health	Manager of Equity and Community Health/Program Manager Equity and Community Health	Equity and Community Health	1) Member communication: - Member text message campaign went live in December 2024 and is sent to new members monthly. 2) DO Collaboration for HN compliance improvement	N/A- work in progress	Presentations: - PHMC 2/20/25 - CLCHC CalOptima Quality Meeting 2/20/25 - SOS Clinic Quarterly Mtg (held by PR) 3/18/25 - HN Forum 3/20/25 - CHCN Virtual Meeting 3/25/25 - DOC Meeting 3/26/25	N/A	1) Member communication: -Continue text campaign along with existing member outreach efforts 2) DO Collaboration for HN compliance improvement	

QAC 03.19.2026

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					3) Provider and HN education to support new member screening for SDOH screening within 120 days.					-Under DO guidance, ECH is working with HNs to obtain additional information from their submitted DODR Forms - ECH participation in the monthly Delegate Health Network Dashboard Monitoring Workgroup 3) Provider/HN education ECH presented IHA updates at 6 meetings in Q1, listed in Column Q.				- A follow up meeting with ECH/DO will be held to decide the next step to take with HNs not meeting or improving their rates. 3) Provider/HN education Continue educating and supporting HNs and Providers with IHA requirements through various presentations.	

QAC 03.19.2026

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56	Quality of Service: Member Experience		Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal OC: One Star ImprovementMC: One Star Improvement	Assess and report on the following activities: 1) JIT: Conduct outreach to members in advance of 2025 CAHPS survey (Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively).2) Launch 8 Listening Post campaigns via two-way Ushur SMS and provide year-round service recovery in collaboration with multiple departments. 3) Launch a recurring meeting series with Health Network partners dedicated to member experience improvement strategy.4) Propose mapping of member responses to CAHPS	Report to MemX Q1: 01/28/2025Q2: 04/15/2025Q3: 07/15/2025Q4: 10/21/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Project Manager of Quality Analytics / Manage of Quality Analytics	Quality Analytics	1) Just In Time outreach completed2) 3 of the 8 listening posts have been implemented.3) 2 health network meetings have been held focusing on improving member experience. 4) Mapping of CAHPS responses is in progress.5) Meeting was held with one department to review the DPI platform.	1) Average NPS score is > 92) Members would like refill reminders3) health networks vary in member experience improvement efforts	1) Just in Time mailer and calls completed for OneCare in February. Calls will be completed for MediCal in mid-April.2) 3 of 8 Listening Post campaigns are live (missed medication refill, first time medication for med adherence measures, post office visit).3) Meetings launched with HNs in late Q1.4) Mapping in progress for multiple channels.5) Discussed with the Case Managment team on 3/17/25.	Lack of time and resources	Continue with plan as listed	

QAC 03.19.2026

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					categories in support of the organization adopting a Voice of Member reporting system.5) Train member-facing roles to the Decision Point Insights platform to review and address CAHPS risk during member discussions.										

QAC 03.19.2026

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57	Quality of Service: Member Experience		Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process and report key findings and/or activities, analyze barriers, and improvement efforts. Maintain the grievance and appeals and resolution process while meeting all regulatory requirements for timely processing of appeals and grievances at a target goal of 95%.	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs. Improve process of handling member and provider grievance and appeals Identify trends in grievances quarterly to address member needs and systemic issues within the Plan. Utilize feedback provided in our quarterly GARS Committee Meetings to improve overall member experience and plan operations.	Report progress to GARS Q1 02/19/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/13/2025 Q1: 02/10/2026	Director of Grievance and Appeals	Manager of Grievance and Appeals	GARS	1) MC and OC grievances resolved timely 2) MC and OC appeals resolved timely	1) Grievance trends: Provider/Staff Attitude, Timely Access, Treatment Concerns 2) Appeal Trends- Modifications to In-Network who cannot treat, Integrated Medicare and Medi-Cal criteria not utilized during initial UM decision.	1) Tracking and trending of specific providers quarter over quarter	1) Tracking and trending of specific providers quarter over quarter	1) Tracking and trending of specific providers quarter over quarter	

QAC 03.19.2026

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58	Quality of Service: Member Experience		Customer Service Call Center	Implement customer service process and monitor against the following standards: OC Call Center Abandonment Rate 5% or lower OC Call Center Average Speed of Answer 2 minutes or lower MC Call Center Average Speed of Answer 10 minutes or lower Report key findings and/or activities, analyze barriers, and improvement efforts.	Track and trend customer service call center data Comply with regulatory standards Improve process for handling customer service calls	Report progress to QIHEC Q1: 01/14/2025 Report to MemX Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/21/2025	Director of Customer Services	Manager of Customer Service	Customer Service	OneCare Call Center Abandonment Rate: 3.6% OneCare Call Center Average Speed of Answer: 49 seconds Medi-Cal Call Center Average Speed of Answer: 2 minutes and 56 seconds	None noted.	Hired additional staff, collaborate with various departments to stagger their member engagement campaigns, leveraging call back capabilities for inbound calling members opting in.	None noted.	Continue with plan as listed	
59	Safety of Clinical Care		Plan All Cause Readmission	Plan All-Cause Readmissions 18-64 (PCR) MC: Decrease from 0.8983 to 0.8937 by 12/31/2025. OC: Decrease from 10.00% to 8.00% by 12/31/2025.	1. Collaborate with Quality /Data analytics to identify top 5-10 readmission DX – consider adding in top 5-10 member readmission data for targeted education and outreach for member/provider. 2. review of ambulatory Follow up	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Medical Management	None	Case Management	1. MC readmission: 0.087 2. OC readmission (pending as current report only pulls not pulling data for q1 2025 yet)	MC: Readmission Rate with slight downward trend.	1)Report in progress by Data analytics for top 5-10 readmission DX.members. 2) Provider education for E/M's post discharge (99495 & 99496)in process to share @ HN/facility JOMS' and clinical OPs outreach, provider	Member engagement. Limited reporting functionality for visibility into member readmission details for targeted outreach.	Continue planned activities	

QAC 03.19.2026

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
					within 7 days of DC for HN and discharging facilities. 3. Provider education for E/M's post discharge appt's within 7 days: 99495 and 99496. 3. Collaborate with other departments (UM/CM/TCS) for targeted outreach for member outreach for							relations outreach through PR channels. 3) Member resources at HN and Hospital JOM's. 4)TCS (MC) calling members when admitted as IP to make connections for support after discharge 5)HN outreach on ways to impact readmission.			
60	Safety of Clinical Care		Emergency Department Member Support	Launch the Emergency Department (ED) Program in 2025 and track utilization of services and report key findings and/or activities, analyze barriers, and improvement efforts.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Supports Referrals 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Report to UMC Q1: 02/20/2025 Q2: 05/22/2025 Q3: 08/21/2025 Q4: 11/20/2025	Director of Long Term Support Services	Manager of Long Term Support Services	Long Term Support Services	The UCI embedded ED program launched on 2/5/2025 with one RN and MSW in the ED.	February and March had minimal in person Member enagement . Ten members were engaged with and 250 members were followed up telephonically.	An ED workgroup was was established to review barriers to member in person engagement	Staff not located in the ED due to lack of space. Can only make rounds. No full epic access. Needed for epic chat and admission board.	Locate work space in the ED to facilitate case management coordination with members. Get full epic access for chat and admission information. Implement point click care.	

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
61	Safety of Clinical Care		Transitional Care Services (TCS)	UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% by end of December 31,2025. [New goal will be established Q1 2025]	1) Use of Ushur platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High-Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting.	Report to UMC Q2: 05/22/2025 Q3: 08/21/2025 Q4: 11/20/2025	Sr. Director of Utilization Management	Project Manager, Medical Management	Utilization Management	1) Usher text campaign for 2/weekly text to members admitted to hospital 2) TCS support line moved to be managed by all TCS staff. 3) Ongoing audits for outreach for high risk members 4) Creating JIVA report for transarency into successful outreach within 7 days- currently no report- manual sample audit process.	Manual audit finding for successful outreach within 7 days is 49.15% with random sample audit completed monthly. Need reporting into TCS support line for visibility into volume/handled calls.	1) Moved TSC phone support to all TCS staff support 2) Creating TSC phone audit log (transparency into type of calls) and support ability to return missed calls. 3) Report in Jiva in process. 4) Continue random sample audits. 5) Sharing TCS flyer to HN and Hospital JOM's. 6) Creating TCS phone line reporting for visbility and opportunities.	Member engagement. Limited reporting functionality.	Continue planned activities	

QAC 03.19.2026

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
62	Cultural and Linguistic Appropriate Services	CLAS	Language Services: Cultural and Linguistics and Language Accessibility	Implement interpreter and translation services and report key findings and/or activities, analyze barriers, and improvement. For translation services, by August 1st, 2025, CalOptima Health will expand the threshold languages to include Russian to meet requirements established by the California Department of Health Care Services (DHCS).	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards, including Member Material requirements Launch Russian as new threshold language.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	Cultural and Linguistic Services continually tracks and trends interpreter and translation services utilization data while analyzing and identifying language needs, as an ongoing process. Cultural and Linguistic Services continually to complies with regulatory standards, including Member Material requirements for all threshold languages. Cultural and Linguistic Services will lead the launch of Russian as new	In preparation of the Russian threshold language implemenation on August 11, 2025. The following preparations are currently underway for the August launch. • Member facing documents are currently being translated into Russian. • Interviews are underway to identify and onboard a full-time Russian translator.	No interventions or activities planned at this time.	No barriers have been identified for both Health Equity and Health Plan accreditation.	Cultural and Linguistic Services will lead the launch of Russian as new threshold language on August 11, 2025.	

QAC 03.19.2026

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										threshold language on August 11, 2025. The following preparations are currently underway for the August launch. • Member facing documents are currently being translated into Russian. • Interviews are underway to identify and onboard a full-time Russian translator.					

QAC 03.19.2026

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
63	Cultural and Linguistic Appropriate Services	CLAS	Network Cultural Responsiveness: Data Collection on Member Demographic Information	By Dec. 31st, 2025, CalOptima Health will increase the collection of sexual orientation gender identify (SOGI) data by 10% through focused outreach and education, ensuring better representation and inclusion of members.	1) Field a survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age). 2) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks. 3) Develop and implement a survey via the Member Portal, mail to new members and other methods. 4) Share member demographic information with practitioners.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	CalOptima staff continues to collect SOGI data from members through various methods in Quarter 1: > Continue to mail survey's to new members 18+ years of age. > Member Portal > Community Events > New Member Orientation Meetings	Collection of data continues to be a challenge as overall, we have collected 5% of members surveyed.	Expanding SOGI Collection methods > April 2025: Mailing surveys to 186,000+ existing members 18+ years of age. >April 2025: Survey members during the New Member Orientation meetings.	Lack of response to the member surveys	Continue monitoring the collection rate. For now, this goal is on target but will re-evaluate in the next quarter after we assess the collection rate of the 186,000 surveys mailed on April 30th 2025. Collaborate with IT to implement a process to share the data collected with the Health Networks. Target Q3 2025	

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
64	Cultural and Linguistic Appropriate Services	CLAS	Network Cultural Responsiveness: Data Collection on Practitioner Demographic Information	By Dec. 31st, 2025, CalOptima Health will increase the collection of race/ethnicity/languages (REL) data by 10% through focused outreach and education, ensuring better representation and inclusion of providers.	1) Add REL questions to routine forms, including credentialing, provider relations LOI, and provider demographic forms. 2) Enter REL data into the provider data system to ensure it can be retrieved and used for CLAS improvement. 3) Share data on the provider network's capacity to meet the language needs of CalOptima Health members. 4) Assess the provider network's ability to meet CalOptima Health's culturally diverse member needs. 5) Collaborate with other CalOptima Health departments to share SOGI data with	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Director of Provider Operations	Program Manger Provider Data Operations	Provider Data Management Services	1. The REL data collection is embedded into the routine workflow. REL questions are integrated into the Addition, Change, Termination (ACT) form, Provider Relations LOI, and credentialing forms. 2. PR and Health Networks submit REL data via ACT forms, LOIs, and rosters. This information is routed to Provider Data Operations, where it is stored and maintained within the Facets database for use and reporting. 3-5. Data on provider	REL questions have been integrated into routine forms, including ACT and credentialing forms. REL data submission workflows are routed to PR or PDMS via Provideronline@caloptima.org. The data entry process allows REL information to be stored and retrieved for analysis and CLAS reporting. Language and demographic data are visible in the provider directory when shared by providers.	Addition/Change/Termination (ACT), initial credentialing application, Letter of Intent (LOI), and the Language Supplemental Form now capture race/ethnicity, language fluency, and language-service capability.	Provider disclosure of language fluency and race/ethnicity data remains voluntary, resulting in low response rates. Many providers opt not to share this information, limiting the completeness of data available for analysis and reporting.	Continue collecting REL data through ongoing integration in standard forms, ensuring providers are consistently prompted to submit this information during credentialing, updates, and demographic reviews.	

QAC 03.19.2026

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					Health Networks.					language capacity and cultural demographics is displayed in CalOptima Health's online provider directory when shared by the provider. This information is available to CalOptima Health PR and Health Networks upon request; however, no formal requests have been made to date.					

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65	Cultural and Linguistic Appropriate Services	CLAS	Experience with Language Services	Evaluate language services experience from member and staff by implementing at language services survey to member and staff by March 31, 2025. By Dec. 31st, 2025, CalOptima Health will evaluate language services experience by collecting feedback from at least 10% of members and 80% of staff using surveys and will analyze the results to identify improvements to language services.	Goal not met. Continue to assess and report the following activities: 1) Develop and implement a survey to evaluate the effectiveness related to cultural and linguistic services. 2) Analyze data and identify opportunities for improvement.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	1) Develop and implement a survey to evaluate the effectiveness related to cultural and linguistic services. Cultural and Linguistic Services developed and launched a Staff and a Member survey in March 2025, to assess the satisfaction level of the language assistance service experience of CalOptima Health staff and members. • Staff survey – C&L received 72 responses from CalOptima Health staff as of the end of April	• Member survey – C&L received 642 responses as of the end of April 2025, via U.S. Mail, from the 32,480, that were mailed. The responses are still being sorted and tallied. 2) Analyze data and identify opportunities for improvement. • Since the surveys are still in progress, and the responses from the Member survey are still being sorted and tallied, opportunities for improvement will be identified in the following quarters.	No interventions or activities planned at this time.	No barriers have been identified for both Health Equity and Health Plan accreditation.	The responses for the Member Survey are still being sorted and tallied an update will be provided in the following quarters.	

QAC 03.19.2026

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										2025. The survey results were positive responses, with only 3 un-favorable responses. • Member survey – C&L received 642 responses as of the end of April 2025, via U.S. Mail, from the 32,480, that were mailed. The responses are still being sorted and tallied. 2) Analyze data and identify opportunities for improvement. • Since the surveys are still in progress, and the responses from the Member survey are					

QAC 03.19.2026

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
										still being sorted and tallied, opportunities for improvement will be identified in the following quarters.					
66	Cultural and Linguistic Appropriate Services	CLAS	Network Cultural Responsiveness: Diversity, Equity and Inclusion Training	By Dec. 31st, 2025, CalOptima Health will implement and train 90% of staff, health networks, and providers on Diversity, Equity and Inclusion (DEI) training, ensuring compliance with DHCS All Plan Letter (APL) 24-016.	1. Develop a DEI Training and launch pilot training by July 31, 2025	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Chief Health Equity Officer	Manager Human Resources and Provider Relations	HR and Provider Relations	1) DEI and Health Equity Training approved by DHCS (2/14/25) 2) DEI and Health Equity Training to replace other related trainings such as: - Cultural Competency - Disability - DEI-	-Internal Regulatory and Compliance Team confirmed DHCS approval. -Approval marks a key milestone for moving forward with implementation	Submitted DEI and Health Equity training materials to DHCS in December 2024. Received and reviewed approval notification from DHCS. Planning activities began for pilot testing and full-scale rollout.	N/A	Quarter 2, 2025 (April 2025) 1) Pilot launch for CalOptima Health staff (new employees). 2) Pilot launch for Providers via the provider portal. 3) Brief survey to	

QAC 03.19.2026

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
										Unconscious Bias				be administered post-training for feedback collection. 4) Begin evaluating pilot feedback to prepare for full launch.	

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QAC 03.19.2026

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
1	Program Oversight		2025 Quality Improvement Health Equity and Transformation Program (QIHETP) Description and Annual Work Plan	Obtain Board Approval of 2025 QIHETP Description and Workplan by April 30, 2025	QIHETP Description and Annual Work Plan will be adopted on an annual basis; QIHEC-QAC-BOD Development of the QIHETP Work Plan will include a review of the following: 1. Comprehensive Quality Strategy Report 2. Technical Report 3. Health Disparities Report 4. Preventive Services Report 5. Focus Studies 6. Encounter Data Validation Report	QIHEC: 01/14/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Marsha Choo	Gloria Garcia	Quality Improvement	The 2025 QIHETP Description and Annual Work Plan was presented and approval by the BOD on 04/3/2025.	The 2025 QIHETP Description and Annual Work Plan was adopted by BOD on 4/3/2025	Copy of the document was posted on CalOptima Health Website.	None	Implementation and tracking of the QIHETP Description and Work Plan; QIHEC overisight of actiview through regular updates.	On Target
2	Program Oversight		2024 QIHETP Description and Work Plan Evaluation	Complete Evaluation of the 2024 QIHETP Description and Work Plan by April 30, 2025	2024 QIHETP Description and Work Plan will be evaluated for effectiveness on an annual basis; QIHEC-QAC-BOD. 2025 QIHETP Evaluation will be drafted in	QIHEC: 02/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Marsha Choo	Gloria Garcia	Quality Improvement	2024 QIHETP Description and Work Plan Evaluation was presented and approved at the BOD	Evaluation of the 2024 QIHETP Description and Work Plan was completed and presented to BOD on 4/3/2025	Copy of the document was posted on CalOptima Health Website.	N/A	N/A	On Target

QAC 03.19.2026

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					Q4 of 2025 and approved in Q1 2026.					on 04/3/2025.					
3	Program Oversight		2025 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2025 Integrated UM and CM Program Description by April 30, 2025	Integrated UM and CM Program will be adopted on an annual basis; UMC-QIHEC-QAC-BOD	UMC: 01/23/2025 QIHEC: 2/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Kelly Giardina	Stacie Oakley/Jennifer Harlow	Utilization Management	The 2025 Integrated Utilization Management (UM) and Case Management (CM) Program Description was presented to the Committee's/BOD as indicated in Column H. Final approval by BOD on 4/3/2025	The 2025 Integrated Uitlization Management and Case Management Program Description was aprpoved by the BOD on 4/3/25	None	N/A	Continue with plan as defined for 2025	On Target

QAC 03.19.2026

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4	Program Oversight		2024 Integrated UM CM Program Evaluation	Complete Evaluation of 2024 Integrated UM CM Program Description by April 30, 2025	Integrated UM CM Program Description will be evaluated for effectiveness on an annual basis; UMC-QIHEC-QAC-BOD 2025 UM CM Program Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	UMC: 01/23/2025 QIHEC: 2/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Kelly Giardina//Jennifer Harlow	Stacie Oakley	Utilization Management	The 2024 Integrated UM CM Program Description was presented to the Committee's/BOD as idnicated in Column H. Final approval by the BOD on 4/3/2025	The 2024 Integrated UM CM Program Evaluation was approved by the BOD on 4/3/2025	None	N/A	Continue with plan as defined for 2025	On Target
5	Program Oversight		2025 Population Health Management (PHM) Strategy and PHM Work Plan	Obtain Board Approval of 2025 PHM Strategy and PHM Work Plan by April 30, 2025	PHM Strategy will be adopted on an annual basis; PHMC-QIHEC-QAC-BOD	QIHEC: 01/14/2025 PHMC: 02/20/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Katie Balderas	Barbara Kidder	Equity and Community Health	2025 PHM Strategy and Work Plan were approved at the April 3, 2025 Board of Directors meeting	Approval was received	Implemented the progression of approvals	N/A	Implementation and tracking of the PHM Strategy and Work Plan	On Target

QAC 03.19.2026

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6	Program Oversight		2024 PHM Strategy Evaluation	Complete the Evaluation of the 2024 PHM Strategy by April 30, 2025	PHM Strategy will be evaluated for effectiveness on an annual basis (PHMC-QIHEC-QAC-BOD) and will include the following: 1. Develop collaborative evaluation process 2. Facilitate development of the evaluation process 3. Produce evaluation 4. Present evaluation to the appropriate governing committees 2025 PHM Strategy Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	QIHEC: 02/11/2025 PHMC: 02/20/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Katie Balderas	Barbara Kidder	Equity and Community Health	2024 PHM Evaluation was approved at the April3, 2025 Board of Directors meeting	Approval was received	Implemented the progression of approvals	N/A	N/A	On Target
7	Program Oversight		2025 Cultural and Linguistic Accessibility Services (CLAS) Program	Obtain Board Approval of 2025 CLAS Program by April 30, 2025	CLAS Program will be adopted on an annual basis; QIHEC-QAC-BOD	QIHEC: 01/14/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Albert Cardenas	Carlos Soto	Customer Service/Cultural and Linguistic Services	The CLAS Description was approved by QAC and the Board Of Directors on 4/3/25.	The CLAS Description was approved by QAC and the Board Of Directors on 4/3/25.	The QAC bookmarked version was sent to HMA for review and feedback.	No barriers have been identified.	The QAC bookmarked version was sent to HMA for review and feedback.	On Target

QAC 03.19.2026

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8	Program Oversight		2024 CLAS Program Evaluation	Complete the Evaluation of the 2024 CLAS Program by April 30, 2025	The CLAS Program will be evaluated for effectiveness on an annual basis; QIHEC-QAC-BOD 2025 CLAS Program Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	QIHEC: 02/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Albert Cardenas	Carlos Soto	Customer Service/Cultural and Linguistic Services	The CLAS Description was approved by QAC and the Board Of Directors on 4/3/25.	The CLAS Description has been approved by QAC and the Board Of Directors.	The bookmark CLAS Evaluation, will be forward to HMA for review and feedback.	No barriers have been identified.	The bookmark CLAS Evaluation, will be forward to HMA for review and feedback.	On Target
9	Program Oversight		**Population Health Management Committee (PHMC) -** Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Workplan progress and outcomes. 2. Provide overall direction for the continuous improvement process and oversee that activities are consistent with CalOptima Health's PHM strategic goals and priorities. 3. Facilitate	PHMC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/9/2025 Q4 12/9/2025	Katie Balderas	Barbara Kidder	Equity and Community Health	1.The Q2 2025 PHM Committee Meeting was held on May 15, 2025 which included both internal CalOptima Health updates on the Health Education, Care Management, and Complex Case Management. 2.Community spotlight presentation was from the Council on Aging. 3.Committee reviewed and	Committee recommended: 1. Exploring opportunities to increase accessibility and community engagement: •Host community classes in PCP offices •Collaborate with local school districts 2. Revising and shortening member satisfaction surveys to increase response rates	Continue to assist the committee by reviewing relevant guidance, agenda setting, presentation development, and deliverables shared with QIHEC.	N/A	Next PHM Committee meeting is scheduled for August 2025.	On Target

QAC 03.19.2026

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					quarterly meetings 4. Report PHMC activities to the QIHEC quarterly.					approved: • Q1 2025 PHMC Meeting Minutes • 2025 Population Needs Assessment 4.Provided PHM Committee update for QIHEC in May 2025.	3. Explore additional analysis on hyperlipidemia diagnosis amongst Vietnamese population.				
10	Program Oversight		**Credentialing Peer Review Committee (CPRC) Oversight** - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review to ensure quality of care delivered to members	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. 2. Committee	CPRC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Laura Guest	Rick Quinones Katy Noyes	Quality Improvement	The Committee met on 04/24/2025, 05/22/2025 and 06/26/2025 .On 04/25/2025, there was a Closed Session meeting for the physicians to meet with a physician as part of the Fair Hearing process.	Three physicians (Ob/Gyn, PM&R & NS) continued under the Fair Hearing process. One physician (PM&R) was changed to Probation after meeting with him. A fourth physician (PM) was started on the Fair Hearing process. Ten PQI cases were presented	PQI and Credentialing implemented plans to reduce it's backlog.	Need to have a new Ob/Gyn physician added to the Committee since an Ob/Gyn was removed from the Committee last year due to his retirement.	A new Provider Life-Cycle system for credentialing will be implemented in Q3.	On Target

QAC 03.19.2026

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					meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.						to CPRC for leveling and actions; three level 3, seven level 2, no level 1. There were three physicians with issues presented for re-credentialing; three presented for credentialing all for the CCN network.All were recommended for credentialing/recredentialing except for one PM physician who was recommended for termination. Credentialing statistics were presented which showed that close to 1100 providers were credentiale				

QAC 03.19.2026

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											d in Q1; 3 recreds were > 180 days.The following policies were presented and approved: GG.1605, GG.1607, GG.1611, GG.1616, !!.1651, GG.1657 and GG.1658. The credentialing clean lists and closure lists were presented and approved.				
11	Program Oversight		**Grievance and Appeals Resolution Services (GARS) Committee -** Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health networks. 2. Trends and	GARS Committee Report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Heather Sedillo	Ismael Bustamante	GARS	1) MC and OC grievances resolved timely 2) MC and OC grievances resolved timely	Grievances: Provider/Staff Attitude related to access for appointments and telephone accesibility. Appeals: Acess to specialty care.	1) Tracking and trending of specific providers quarter over quarter.	No specific barriers identified.	1) Tracking and trending of specific providers quarter over quarter.	On Target

QAC 03.19.2026

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					results are presented by product time to the committee quarterly. 3. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.										
12	Program Oversight		**Member Experience (MEMX) Committee Oversight** - Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. The MEMX Committee reviews the annual results of CalOptima Health's CAHPS surveys, monitors the provider network including access and availability (CCN and the HNs), reviews customer service metrics and evaluates complaints, grievances, appeals, authorizations and referrals for the "pain	MemX Committee report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Vacant	Carol Matthews/Helen Syn	Quality Analytics	Committee met on 4/15/2025. Meeting minutes from the 1/28/25 meeting were deferred. Regulatory updates were presented: annual network certification, subcontracted network certification, network adequacy, timely access, UM and CAHPS improvement update.	QIHEC accepted the MemX update without further questions feedback.	Continue as planned.	Low customer service scores	CS identify ways to gather specific individual member feedback for members giving low ratings for customer service	On Target

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Back to Agenda Back to Item

QAC 03.19.2026

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					points" in health care that impact our members. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.					A MemX update was provided to QIHEC on 6/10/25.					
13	Program Oversight		**Utilization Management Committee (UMC) Oversight -** Conduct internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. UMC reviews medical necessity, cost-effectiveness of care and services, reviews utilization patterns, monitors over/under-utilization, and reviews inter-rater reliability results. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC	UMC Committee report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Kelly Giardina//Jennifer Harlow	Stacie Oakley	Utilization Management	The UMC met on 5/22/25 & reviewed Q1 2025 over/under utilization patterns. Meetings minutes are drafted & will be approved at the 8/21/25 meeting. UM Leadership will report Q1 2025 findings to the QIHEC on 9/9/25	Medi-Cal Expansion & TANF18+ readmits above goal. TANF under 18 bed days & admits above goal. ED utilzation across all aid codes remains stable with little change. Inpatient & prior authorization turn around time goals met, above 95% compliant. NEMT - Since April	Continue to monitor, track and trend utilization.	None	Continue with plan as defined for 2025	On Target

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QAC 03.19.2026

Back to Agenda Back to Item

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					quarterly. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.						2024 there has been over 2K rides/day.				

QAC 03.19.2026

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14	Program Oversight		**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for eligible children with California Children Services (CCS) are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee key findings/updates, activities, and recommendations to QIHEC.	Conduct and report on the following activities: 1. WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. 3. Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	WCM CAC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Thanh-Tam Nguyen, MD/Hannah Kim	Gloria Garcia	Medical Management	WCM CAC met 5/13/2025. Approved 2/18/25 meeting minutes. Presented follow up on timely Access Data	Met goals for Health Network Adequacy Turn Around Time (TAT) and other Whole Child Model measures except Timely Acess.	Reviewed data and discussed: WCM Network Adequacy,Timely Accesss, Grievances and Appeals, Adverse Childhood Experiences (ACEs), Member Inquiries, Mental Health Utilization, BH Quality Measures, Student Behavioral Health Incentive Program, Pediatric California Advancing & Innovating Medi-Cal, and Pharmacy.	1) Network Adequacy and the lack of certain specialist providers. 2) Whole Child Model case managed members and Enhanced Care Management overlap. 3) Identify challenges related to the reinstitution of prior authorization for Pediatrics	1) Address with CalOptima Health leadership HN Adequacy for specialist serving the aging out WCM members and Timely Access issues. 2) Examine ECM population criteria and Care Coordination; Follow WCM regulatory requirement. 3) Report challenges related to Medi-Cal Rx prior authorization requirement for pediatric Rx. 4) Autism Comprehensive Program	On Target

QAC 03.19.2026

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														update scheduled for the 8/19/25 meeting.	
15	Program Oversight		Care Management (CM) Program	Report on key activities of CM program, analyze CM data compared to goal, and improvement efforts.	Report on the following activities: 1. Basic PHM/CM 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Megan Dankmyer/Hannah Kim	Sherry Hickman	Medical Management	Report on the following activities: 1. Basic PHM/CM 2. Early and Periodic Screening, Diagnostic and Treatment	Interventions and activities were completed for the quarter.	Report on the following activities: 1. Basic PHM/CM: Ongoing Health Risk Assessments are shared with Primary Care Physician. 2. Early and Periodic	None	Report on the following activities: 1. Basic PHM/CM: Continue sharing Health Risk Assessments with Primary Care	On Target

QAC 03.19.2026

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										(EPSDT) CM:		Screening, Diagnostic and Treatment (EPSDT) CM: a. Continue meeting in workgroup and review necessary oversight of PSDT services. b. Preparation for texting campaign to members overdue for vision, dental, and hearing screening. c. Ongoing monitoring with Utilization Management and each Health Network to review EPSDT d. Behavioral Health Integration review of depression and developmental screening codes for oversight needs.		Physician. 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM a. Continue meeting in workgroup and review necessary oversight of PSDT services. b. Texting campaign to members overdue for vision, dental, and hearing screening. c. Ongoing monitoring with Utilization Management and each Health Network to review EPSDT	

QAC 03.19.2026

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16	Program Oversight	Complex Case Management Program	Implement Complex Case Management Program and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: (1) Ensure provision of CCM services resulting in optimal care coordination as evidenced through monthly auditing of 5 files or 5% of files for each health network resulting in a minimum score of 90% through December 31, 2025. (2) Obtain 85% member satisfaction in CCM program by December 31st, 2025. (3) 85% of members surveyed who participated in CCM between January 1, 2024-December 31, 2025, will report that the case management process helped them meet their care plan goals.	Conduct and report on the following activities: 1. Continue training and educational opportunities to staff on the 2025 PHM5 Element D and E and complex conditions/situations (Goal 1) 2. Member Satisfaction scores will be shared with all Health Networks to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, member outcomes, and improve the member experience of CM programs (Goal 2) 3. Ongoing training and support for new and existing staff. (Goal 2) 4. Continue to gather member feedback to improve outcomes. (Goal 3)	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Hannah Kim	Diana Tep	(1) Seven out of the nine Health Networks achieved a score of 90% or higher (Goal 1). (2) A total of 51 members were surveyed. All questions from the member satisfaction survey met the 85% benchmark (Goal 2). (3) 98% of the members surveyed found the case management process helped them meet their care plan goals (Goal 3).	Goal 1 did not meet for Q2 as two Health Networks did not achieve a score of 90% or higher. Goal 2 and 3 met.	1) Continue training and educational opportunities to staff on 2025 PHM Element D/E and complex conditions/ situations. (Goal 1) a. Element D/E training for WCM CCN on 5/12/2025, 5/14/2025, and 5/20/2025 2) Member Satisfaction s Survey (MSS) scores will be shared with CCN and the health networks to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care,	Goal 1: Staff training needed for Elements D and E.	Conduct and report on the following activities: Goal 1. a. Continue training and provide educational opportunities to all Health Network staff on the 2025 PHM5 Element D and E and complex conditions. Goal 2 a. Member Satisfaction scores will be shared with all Health Networks to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, and member outcomes, and improve the member experience in CCM program. b. Continue to gather feedback from MSS to strategize on improving outcomes and	Concern	16	Program Oversight

QAC 03.19.2026

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										member outcomes, and improve the member experience of the CM programs. (Goal 2) a. MSS score shared during the Clinical Ops meeting with the Health Networks on 5/15/2025 and in the CCN CM department meeting on 6/25/2025. b. Ongoing training and support for new and existing staff. (Goal 2) c Continue to gather feedback from MSS to improve outcomes. (Goal 2) d Meeting held with QI Nurse and		share in quarterly meetings with leadership. c. Continue training and support for new and existing staff. Goal 3 a. Continue Member centric care plan training and support for all Health Network staff.			

QAC 03.19.2026

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										leadership on 5/5/2025 to discuss Q1 MSS results. Additional meeting held on 5/19/2025 with QI Nurse, Data Analyst, MA, and Leadership to discuss ways to improve the survey and engage the members in completing the MSS. 3) Training and education on member centric care plans. (Goal 3) a. Care plan training for CCN conducted on 4/18/2025, 6/25/2025, 6/27/2025.					

QAC 03.19.2026

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17	Program Oversight		Population Health Management (PHM) Strategy and Program	Implement initiatives for the 2025 PHM program starting January 1, 2025.	Conduct and report the following activities: 1. Population Needs Assessment (PNA) 2. Develop and implement a PHM Work Plan and includes the following: a. Risk stratification b. Screening and Assessment c. Wellness and prevention 3. Collect quarterly progress reports from PHM Work Plan implementation owners	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Katie Balderas/Megan Dankmyer	Barbara Kidder	Equity and Community Health	1. 2025 PNA was presented at the May 15, 2025 PHMC meeting and was approved; submitted 2025 PNA as NCQA accreditation evidence 2. Implementation of 2025 PHM work plan is in progress 3. Quarterly 2025 PHM work plan monitoring is in progress	N/A- work in progress	1. Review and approval of 2025 PNA 2. N/A- work in progress 3. Quarterly reporting and tracking is in progress	N/A	1. Monitor 2025 PNA feedback survey 2. Continue implementing the 2025 PHM work plan 3. Continue monitoring progress	On Target
18	Program Oversight		Disease Management Program	Implement 2025 Disease Management Program and report key findings and/or activities, analyze barriers, and improvement efforts and meet the following goal: 1. By December 31, 2025, 85% of members who participate in Disease Management program from January 1 – December 31, 2025 will report satisfaction	Conduct and report on the following activities: 1. Evaluation of current utilization of disease management services 2. Enhance identification of gaps in care to better promote quality care across all Disease	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Katie Balderas	Elisa Mora	Equity and Community Health	1. Two-Way Text Campaign: 18,693 diabetes members and 16,106 asthma members were contacted through two-way text messages. 2.	1. Increased Reach Through Text Campaigns: • Text messages are sent to members with diabetes and asthma, allowing them to opt	1. Continue two-way text message campaigns: For member with diabetes and asthma. 2. Monthly Stratification Criteria Logic Updates: Revisions include removing members already engaged with	There have been ongoing issues with staff not being able to launch the text message satisfaction survey. Issue is	Continue to implement activities and monitor outcomes.	On Target

QAC 03.19.2026

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					Management interventions. 3. Use multimodal methods of outreach to identify members in need of Disease Management services and reduce cold calls. 4. Integrate new methods to measure and improve member satisfaction.					Stratification Criteria Revision to better target low to moderate-risk members and avoid duplicative outreach is in progress. 3. Disease Management Satisfaction Survey: survey is text-based and delivered to members via text after follow-up session. Survey received 119 responses out of 278 texts.	in to health coaching services. This approach has increased enrollment rates compared to traditional cold calls. 2. Real-Time Feedback Improves Response Rate: •The Disease Management Satisfaction survey received responses in just 2 months that accounted for over half of the previous annual total (100), indicating a likely improvement in response rates using this new survey method. Notably, within 4	other departments and improving visibility of care gaps across Disease Management interventions. 3. Expansion of Disease Management Satisfaction Survey: Planning to supplement with a paper survey included in the education packet sent by health coaches following telephonic outreach.	being addressed by vendor. A process has been established to ensure that text messages are not sent to the same members on a monthly basis.		

QAC 03.19.2026

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											months of implementing the text message-based surveys, the number of responses has already surpassed the total received in previous years, further demonstrating the effectiveness and efficiency of this new approach in engaging participants.				
19	Program Oversight		Health Education	Implement interventions for the 2025 Health Education program and report key findings and/or activities, analyze barriers, and improvement efforts. 2025 Health Education program focuses on promoting early detection, fostering healthy habits, and empowering members to be proactive with preventive care.	Conduct and report on the following activities: 1. Evaluation of current utilization of health education services 2. Enhance methods for outreaching, promoting, and enrolling members in Health Education services and classes (e.g.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Katie Balderas	Thanh Mai Dinh	Equity and Community Health	1. 1,536 referrals for health education services were received for Q2. There was as slight drop from 1,566 in Q1. 2. 40 virtual and in person Shape Your Life classes	Pilot results for adult Vietnamese virtual classes yielded no participants despite different days and time options. Virtual classes as a primary referral outcome is not realistic for	1. May: Two-way text campaign inviting members to the new virtual adult hypertension class was launched to 30,799 Medi-Cal members ages 18+ with an email address on file (English-20,657 and Spanish-10,142). 2. Virtual adult classes were scheduled and	Some barriers in referring members to the virtual classes include: •availability of virtual classes are not convenient to some members •some	Pilot 2 text campaign approaches to see which one has a larger engagement rate. In July 2025, 97,000 adult Medi-Cal members will be randomly divided into two	On Target

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QAC 03.19.2026

Back to Agenda Back to Item

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					text message outreach, member self-referral, etc.) 3. Expand health education offerings in various community classes and events (e.g. clinic days, virtual and in-person classes, etc.) and tech-based modalities (app/web-based services).					were completed. 188 participants attended sessions successfully. 3. 10 virtual and in person Adult Healthy Living one-time classes were completed in English, Spanish and Khmer. 117 participants attended sessions successfully. 4. 17 virtual and in person Adult Hypertension one-time classes were completed. 89 participants attended classes successfully.	members with low digital literacy.	launched for monthly hypertension and bi-monthly healthy living one-time classes in both English and Spanish, and added to the Events page on the external website. 3. Two in person presentations on healthy living and heart health were provided in Khmer at Cambodian Family Center in April and June in Santa Ana . 4. One in person presentation on hypertension was provided in Vietnamese and Spanish at Southland Integrated Services clinic in Garden Grove. 5. One in person presentation on adult healthy living was provided at Ready Set OC in Los Alamitos. 6. Two mini	members do not have email addresses •digital literacy fluency is low to none for members who do not have home internet service or smart phones	groups. One group will receive a text with the Zoom link to an adult healthy living virtual one-time class in English or Spanish. The other will receive a two way text inviting them to click the next screen in order to get the link for the virtual class.	

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												hypertension presentations were provided at our May BP Screening event at PACE in English and Spanish.			
20	Program Oversight		CalAIM Community Supports and Enhance Care Management (ECM)	Implement CalAIM and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: 1. By December 31, 2025, enhance community support services (e.g., housing transition navigation services, housing deposits, and housing tenancy and sustaining services) to achieve optimal care coordination, as demonstrated by auditing the performance of 10 providers. 2. Increase number of members authorized for ECM services by 10%, from 2,500 to 2,842 by December 31, 2025.	Community Supports Activities: 1. Conduct housing transition navigation services audits. 2. Conduct housing deposits audits. 3. Conduct housing tenancy and sustaining services audits. ECM Activity: Track ECM outreach, authorizations and services.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Mia Arias	Andrew Kilgust	Medi-Cal and CalAIM	1. The CalAIM Team is currently in the process up creating audit templates for the Housing trio of community supports. Most recently, the team created program templates for these services which are required to be utilized as of 7/1. These templates will assist in	No findings to report.	Activities included reasearching and developing a housing assessment and housing support plan template. A draft of these documents were provided to contracted housing providers to collect feedback and input. Much of the feedback was incorporated into the final templates. In addition, the 3rd Cohort of the ECM Academy launched in April 2025 with	None.	Continue to research and develop documents and tools for implemetation of the audit of housing community supports. Use feedback from providers on implemention of the new housing templates to continue to refine	On Target

QAC 03.19.2026

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										monitoring and auditing these services. 2. From January 1, 2025 - May 31, 2025, 6,984 members have received ECM services.		12 providers which will be contracted in December 2025 to provide ECM services.		and update those documents if neccessary.	

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21	Program Oversight		Street Medicine Program	Implement Street Medicine Program and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: (1) By December 31, 2025, connect 80% of unhoused participating members to an active Primary Care Physician (PCP). (2) By December 31, 2025, connect 90% of unhoused participating members with CalAIM ECM and Housing Navigation. (3) By December 31, 2025, connect 20% of unhoused participating members to a shelter or other housing option.	Conduct and report on the following activities: Goal 1: ▪ Offer all members the opportunity to utilize the Street Medicine Provider as their PCP. ▪ Utilize Releases of Information when member has active PCP to increase collaboration and communication. ▪ Support member with PCP change, as needed. ▪ Care scheduling and delivery. Goal 2: ▪ Make attempts to engage with members weekly. ▪ Provide ECM and/or Housing Navigation appointments face to face at least every other week. ▪ Care scheduling and	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Nicole Garcia	None	Medi-Cal and CalAIM		a. MSS score shared during the Clinical Ops meeting with the Health Networks on 5/15/2025 and in the CCN CM department meeting on 6/25/2025.	Offer all members the opportunity to utilize the Street Medicine Provider as their PCP. ▪ Utilize Releases of Information when member has active PCP to increase collaboration and communication. ▪ Support member with PCP change, as needed. ▪ Care scheduling and delivery. Goal 2: ▪ Make attempts to engage with members weekly. ▪ Provide ECM and/or Housing Navigation appointments face to face at least every other week. ▪ Care scheduling and delivery. ▪ Document all encounters. Goal 3: ▪ Outreach to	While all goals were met, affordable, permanent housing opportunities continue to be scarce.	Continue to offer street medicine services in the three identfied service areas.	On Target

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					delivery. ▪ Document all encounters. Goal 3: ▪ Outreach to and engage unsheltered individuals ▪ Provide ECM and/or Housing Navigation ▪ Enter members in to the Coordinated Entry System ▪ Connect individuals to local shelters ▪ Work with members on completing housing documentation							and engage unsheltered individuals ▪ Provide ECM and/or Housing Navigation ▪ Enter members in to the Coordinated Entry System ▪ Connect individuals to local shelters ▪ Work with members on completing housing documentation			

QAC 03.19.2026

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22	Program Oversight		Long-Term Support Services (LTSS)	Implement LTSS Program and meet the 95% compliance with the following TATs: (1) CalAIM Turnaround Time (TAT): Determination completed within 5 business days (2) CBAS Inquiry to Determination (TAT): Determination completed within 30 calendar days (3) CBAS Turnaround Time (TAT): Determination completed within 5 business days (4) LTC Turnaround Time (TAT): Determination completed within 5 business days	Assess and report the following activities: 1. Evaluation of current utilization of LTSS 2. Maintain business for current programs and support for community 3. Improve process of handling member and provider requests 4. Meet goal/TATs	Report to UMC Q1: 02/20/2025 Q2: 05/22/2025 Q3: 08/22/2025 Q4:11/20/2025	Scott Robinson	Cathy Osborn	Long Term Support Services	CalAim TAT: 99.28%, CBAS Inquiry to Detrmination: 100%, CBAS TAT 99.76%, LTC TAT 99.40%	All programs are compliant	Continuous monitoring of daily staff capacity and productivity. Workloads are shifted to staff with capacity as needed.	None	Continue daily stand-up meeting to assess and intervene workloads as needed.	On Target
23	Program Oversight		Delegation Oversight	Implement annual oversight and performance monitoring for delegated activities and report key findings and/or activities, analyze barriers, and improvement efforts.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accreditation standard compliance that, at minimum, include comprehensive annual audits and corrective actions.	Report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/9/2025 Q4 12/9/2025	Stacy Baker	Zulema Gomez John Robertson	Delegation Oversight	Annual oversight audit completed (April 14, 2025) for Children's Hospital Orange County (CHOC)/Rady's Children MSO	Delegate monitored: Children's Hospital Orange County (CHOC)/Rady's Children MSO Areas Assessed: • Case Management • Claims • Compliance • Credentialing	Delegate: • Children's Hospital Orange County (CHOC)/Rady's Children MSO Corrective Action Plan(s) Issued: * Utilization Management (Medi-Cal): Status - Accepted	None	Focused Monitoring for three months until CAP is closed	On Target

QAC 03.19.2026

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											• Customer Service • Provider Network Contracting • Provider Relations • Sub-Contractual •Utilization Management				
24	Program Oversight		National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan (HP) Accreditation and NCQA Health Equity (HE) Accreditation by January 1, 2026	1. Implement activities for NCQA Standards compliance for HP and HP Renewal Submission by April 6, 2027. 2. Implement activities for NCQA Standards compliance for Initial HE Accreditation Survey and submit requirement documents to NCQA by October 7, 2025.	1) By December 31, 2025 2) By October 7, 2025 Report program update to QIHEC Q1:01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Marsha Choo	Veronica Gomez Guy Todd Britney Warren	Quality Improvement	**1) Health Plan Accreditation:** **QI:** 2025 QI program ready for submission ; Q1 of QI Work Plan completed (Q2 will be available 8/1), 2024 QI Eval is ready for submission **UM**: We received and approved 2025 UM/CM Program descriptions, 2024 UM Evaluation, 2024 IRR analysis reports, reviewed	Health Equity and Health Plan accreditation document collections are currently underway, with look-back periods starting on April 6, 2025 (HPA) and April 7, 2025 (HEA). 1) **HPA Accreditation:** There are 6 domains (QI1A-QI4D), UM (UM1A-UM13D), NET (NET1A-NET6D), PHM	**1) Health Plan Accreditation:** - Continue collecting documents due in 3Q2025. - QI/Consultants: We will conduct CR training with our delegates on July 11, 2025and a second training will be held for those who can't attend. - Perform another internal BH denials mock audit to determine if the findings from the 2024 audit have been addressed. - The Quality	A current barrier has been identified for both Health Equity and Health Plan Accreditation. There may be a minor point loss if this issue is not addressed. Specifically, the Delegation Agreem	**1) Health Plan Accreditation (HPA):** - Continue collecting documents required for Year One (April 2025 - April 2026). - Conduct CR training with our delegates on July 11, 2025. A second training will be held for those who can't attend. - Perform another	On Target

QAC 03.19.2026

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										and approved articles scheduled to go out in 4Q on Annual Member newsletter, Policies reviewed by consultant, 2Q2025 external board certification consultant review cases, April 2025 CalOptima Health dated screenshots were completed by end of April. **NET:** Report templates and training with stakeholders were held before the start of the look-back period. Several reports were written in June and	(PHM1A-PHM7D), CR (CR1A-CR9D), MEM (ME1A-ME8D). A total of 29 policies are required to meet specific domains for HPA accreditation. All policies have been reviewed by a consultant and are on track to meet the year-one look-back period (April 2025 to April 2026). Required programs, including Quality Improvement (QI), Utilization Management (UM), Care Management (CM), and Population Health Manageme	Improvement Department, Contractingand Customer Service are working with Contracting and consultants to address the delegation of interpreter services and translation services in the delegation agreements. Policies may need to be updated to fill gaps. 2) **Health Equity Accreditation:** - Continue to work with stakeholders to finalize a few open items. - We will review each domain/area with executive leadership and start uploading final approved documents via the NCQA Submission Tool. Our scheduled submission date is October 7th. - The Quality Improvement	ents are missing provisions for the delegation of Interpreter Services and Translation of Written Materials (Sight). The Quality Improvement team is collaborating with Contracting, Customer Service, and a consultant to make the necessary edits before the Health Equity submission deadline on	internal BH denials mock audit to determine whether the findings from the 2024 audit have been addressed by the end of August 2025. - The 2026 HPA Standards are scheduled to be released in August 2025. Will conduct a webinar to go over changes from 2025 to 2026. **2) Health Equity Accreditation (HEA):** - Close out any open deliverables before the October	

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										are currently going through final revisions. Policies were reviewed by the consultant and the April 2025 CalOptima Health dated screenshots were completed by the end of April. PHM: PHM strategy approved, Multiple Chronic Conditions Program Approved, Population Assessment Approved, Health Appraisals & Managment Tools Approved. Pending delegation currently at 80% completion. **CR:** HMA reviewed and	nt (PHM) Strategy, have been reviewed by a consultant and received final approval by the Board in April 2025. NCQA Program Managers are collaborating with stakeholders to collect the necessary documents to fulfill year one of the look-back period, including reports, DTPand communications for both members and providers. We have several reports that are due by the end of June. 2) HEA Accreditatio	Department, Contracting, and Customer Service are working with Contracting and consultants to address the delegation of interpreter services and translation services on the delegation agreements. Policies may need to be updated to fill gaps.	October 7th.	submission. - HEA submission is scheduled for October 7, 2025. The final review and document loading should be completed by the end of August 2025 - Introductory call with the Accreditation Survey Coordinator (ASC) is scheduled for July 22, 2025. - Submission of the delegation worksheet, and introductory call form	

QAC 03.19.2026

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										approved required policies, ongoing monitoring Grid approved by consultant, April CPRC meeting minutes approved by consultant. **MEM: Pending 9 documents & delegation docuements currently completion rate is at 70%** Consultants received 49 additional documents, all of which were reviewed in a timely manner. **2) Health Equity Accreditation:** HE1: Ready for submission; HE2: Pending HEDIS	n: Health Equity Accreditation has seven domains (HE1-HE7). We have a few domains with open items (HE2B/C, HE6 A, and D). HE 2 and HE 3 are almost complete; the HE6 team is waiting for reports in June (HEDIS reports and member and staff surveys).				

QAC 03.19.2026

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										Reporting. then will be ready for submission ; HE3: Ready for submission . HE3C waiting on one deliverable which is currently under consultant review; HE4: Ready final executive leadership review and submission .; HE5: Ready final executive leadership review and submission ; HE6:Pending HEDIS Reporting. then will be ready for submission ; HE7:Delegation agreements is being reviewed, meeting with consultant, Customer service,					

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										and Contracting to align evidence with the delegation of Interpreter/ Language assistance delegation. The total number of documents reviewed as of June is 79, and the consultant received one additional inquiry. **As of today our NCQA Score is 70.97% out of possible 100%, we must meet 80% be be accredited .**					

QAC 03.19.2026

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25	Program Oversight		Quality Performance Improvement: Managed Care Accountability Set (MCAS) OneCare STAR measures DHCS Quality Withhold Health Plan Accreditation (QI3) Health Plan Rating	Track and report quality performance measures required by regulators against the following goals: (1) Achieve 50th percentile MPL or above (2) Achieve 4 Stars or above (3) Achieve 100% of withhold (4) Achieve 3 or higher (5) Achieve 5.0	1. Track rates monthly 2. Share final results with QIHEC annually 3. Review and identify measures for focused improvement efforts after each monthly refresh	By December 2025 Report program update to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 05/13/2025 Q3: 07/08/2025 Q4: 10/07/2025 11/04/2025	Paul Jiang / Vacant	Kelli Glynn	Quality Analytics	1. Prospective rate reports are generated monthly for overall CalOptima Health, CCN-specific performance, for all HN partners, and for CHCN providers. 3. The QA Strategy team reviews changes in rates at the measure level for both lines of business after each monthly refresh and identifies new improvement activities as needed, or collaborates with the HEDIS team if there are suspected data issues.	PJ: FUA-30day is at the 25th percentile and it is at the risk for not meeting the MPL. FUM-30day is at the 25th percentile and it is at the risk for not meeting the MPL. PPC-postpartum is below the 25th percentile and it is at the risk for not meeting the MPL.	Continue with plan as listed	Lack of automation of prospective rate report process, and some delays with CitiusTech refreshing (e.g. May 2025 data not available until July 2025).	Automation of the prospective rate report process. Implementation of Hyperlift to monitor Stars performance.	On Target

QAC 03.19.2026

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26	Program Oversight		Value Based Payment Program	Implement a value-based payment program and report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	Assess and report the following activities: 1. Share HN performance on all P4V HEDIS measures via prospective rates report each month. 2. Share hospital quality program performance 3. Develop monthly P4V report to show HNs the estimated amount of P4V dollars based on current performance	Report program update to QIHEC Q1: 01/14/2025 Q2: 05/13/2025 Q3: 07/08/2025 Q4: 11/04/2025	Linda Lee	Paul Jiang	Quality Analytics	1. Monthly prospective rate reports provided to all HN partners via email. Member-measure level gap in care reports provided monthly to all HN partners via sFTP.	data collection in progress	Automation of monthly reports in development	1. Lack of automation of HN summary reports requires manual formatting and submission; this process takes one business day to complete across multiple FTEs.	Complete reporting of annual audited plan-level rates. Prepare HN and CHCN provider-level rates.	On Target
27	Quality of Clinical Care		Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	Monitor PCP, High Volume Specialist and ancillary sites utilizing the DHCS audit tool and methodology and report any findings, barriers and improvement efforts.	Review and report initial and periodic reviews conducted for PCP, high volume specialists and ancillary sites and ensure periodic reviews are conducted every three years. Tracking and trending of reports are reported quarterly.	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Marsha Choo	Katy Noyes	Quality Improvement	Site Review, PARS, Community-based Adult Services (CBAS), and Nursing Facilities (NF) Oversight: A. FSR: Initials FSRs=11; Periodic FSRs=47; On-site Interims=2	FSR/MRR: The number of Periodic and Initial FSRs completed increased slightly from Q1 2025 to Q2 2025. The number of Periodic FSRs completed timely increased slightly from 92% in Q1 2025	Provide extensive educational support and technical assistance to sites. This includes but is not limited to review of DHCS FSR and MRR Tools and Standards, U.S. Preventive Services Task Force (USPSTF) A&B recommendati	N/A	Continue to implement work plan.	On Target

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QAC 03.19.2026

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										9; Failed FSRs=2 B. MRR: Initial MRRs=4; Periodic MRRs=42; Failed MRRs=6 C. CAPs: Critical Element (CE)=42; FSR=51; MRR=55 D. PARS: Completed PARS=63; Basic Access=28 (44%); Limited Access=35 E. CBAS Oversight: Critical Incidents=20 (14 COVID); Non-Critical Incidents=8; Falls=12; Audits Completed =11; CAPs Issued=8; Unannounced Visits=0 F. NF Oversight: Critical Incidents=; On-Site Visits=21;	to 93% in Q2 2025. The number of Periodic and Initial MRRs completed decreased from Q1 2025 and Q2 2025. The number of failed FSRs decreased from 3 in Q1 2025 to 0 in Q2 2025. The number of failed MRRs decreased significantly from 19 in Q1 2025 to 6 in Q2 2025. CAPs: The number of CE CAPs issued increased from 33 in Q1 2025 to 42 in Q2 2025. The number of FSR CAPs issued increased from 43 in Q1 2025 to 51 in Q2 2025. The	ons, the American Acedemy of Pediatrics (AAP) periodicity schedule, most current adult and childhood vaccination recommendations from Advisory Committee on Immunization Practices (ACIP). Additionally, a hard copy provider audit packet it sent out to sites before every periodic audit. The packet includes resources to help providers achieve a safe and effective provision of primary care services, to ensure and support the quality of care and documentation of appropriate clinical services, and to improve overall member health outcomes.			

QAC 03.19.2026

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										Unannounced Visits=0	number of MRR CAPs decreased from 61 in Q1 2025 to 55 in Q2 2025. PARS: The number of PARS completed increased significantly from 74 in Q1 2025 to 169 in Q2 2025. The number of PARS with BASIC access decreased from 51% in Q1 2025 to 40% Q2 2025. CBAS Oversight: The number of Critical Incidents reported increased significantly from 1 in Q1 2025 to 20 in Q2 2025. The number of Non-Critical Incidents reported decreased greatly from 42 in				

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											Q1 2025 to 20 in Q2 2025. The number of Falls reported decreased slightly from 15 in Q1 2025 to 12 Q2 2025. The number of audits completed increased from 8 in Q1 2025 to 11 in Q2 2025. The number of CAPs issued increased from 6 in Q1 2025 to 8 in Q2 2025. NF Oversight: The number of Critical Incidents reports received increased from 7 in Q1 2025 to 20 in Q2 2025. The number on on-site visits completed increased				

QAC 03.19.2026

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											from 16 in Q1 2025 to 21 in Q2 2025.				
28	Quality of Clinical Care		Potential Quality Issues Review	PQIs are reviewed timely to ensure care and services provided fall within the range of professionally recognized standards of health care.	Review and report quality-of-care cases for peer review (CPRC), determine appropriate severity level and make recommendations for actions based on findings.	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Marsha Choo	Laura Guest	Quality Improvement	Ten PQI cases were presented to CPRC for leveling and actions; three level 3, seven level 2, no level 1. We closed 321 PQIs in Q2, opened 185 cases and have a total of 363 cases open at the end of Q2.	The number of PQI's closed in Q2 increased significantly due to the PQI Backlog Project in collaboration with the medical directors. We had a higher number (99) of cases opened in April due to Customer Service finding more declined grievances and nursing facilities submitting critical incident	Changes implemented as a result of updates to policy GG.1611 and the Backlog Project: 1)Two nurses may close a PQI to QOS, 2)Nurses are reviewing the provider response to QOC grievances and determining if it is QOS at that time, 3)Nurses are waiting 2 weeks after the grievance closes for the provider's response before opening a PQI, 4)We had the first meeting of the Provider Action Workgroup to address service issues	1)The Provider Action Workgroup is still in development so no actions have been initated as yet, 2)There are still 363 PQIs opened; we'd like to get that number under 200.	1)Hold monthly meetings of the Provider Action Workgroup to develop policy, charter and implement actions on providers reviewed. 2)Implement a nurse in GARS to review grievances when received to determine if QOC to further help to reduce the volume of PQIs	Concern

QAC 03.19.2026

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
											reports in mass.	organizationally. 5)We began presenting a report of all PQIs closed in previous month.		being opened.	
29	Quality of Clinical Care		Provider Credentialing and Recredentialing	All providers are credentialed and recredentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements: • No more than 180 days between verification and approval • Providers are recredentialed within 36 months	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Marsha Choo	Rick Quinones	Quality Improvement	Initial BH Credentialing Q2 = 2291 Initial CCN Credentialing Q2 = 282 BH Recredentialing Q2 = 56 CCN Recredentialing Q2 = 122	Initial/Recredentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliness of the initial and recredentialing files. We have also contracted wiith Salesforce, a vendor to support the end to end functions of multiple	We implemented a Backlog project from Feb-June which required help from other depts per leadership's request.	N/A	Hired two FTEs (Program Specialist and Program Coordinator)	Concern

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Back to Agenda Back to Item

QAC 03.19.2026

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
											departments.				
30	Quality of Clinical Care		Special Needs Plan (SNP) Model of Care (MOC)	Increase the number of members completing an HRA, and ICP and ICT to meet the following goal: Percent of Members with Completed HRA: Goal 100% Percent of Members with ICP: Goal 100% Percent of Members with ICT: Goal 100%	Assess and report the following activities: 1. Monthly communication process with Networks on ICP development 2. DHCS HRA1 and ICP1 Quarterly reporting 3. HRA Star status 4. MOC Updates 5. Face to Face interactions	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Megan Dankmyer	Sherry Hickman	Medical Management	Percent of Members with Completed HRA through 6/30/2025: 49.01% Percent of Members with ICP through 6/30/2025: Initial ICP 73.6% Annual ICP 95.2% DHCS ICP reporting for Q12025 at 79.3%	1. Identified 62 OC members from Q3 2024 through Q2 2025 who did not have ICP completed timely due to	Assess and report the following activities: 1. Network communications: Revised layout for monthly communication Implemented in June 2025. 2. DCHS Reporting: a. DHCS HRA1--This DHCS reporting has been sunset and no longer reported in 2025. b. DHCS ICP1-Q1 2025: 772 of 973 members had ICP developed within 90 days of eligibility for	2. Members who are unable to contact or decline both the HRA and the ICP.	Assess and report the following activities: 1. Ongoing communication with Health Networks on ICP development. 2. Ongoing assessment and reporting of DHCS quarterly ICP reporting (Q2 2025) 3. Ongoing assessment and reporting	Concern

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Back to Agenda Back to Item

QAC 03.19.2026

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												79.3% 3. HRA Star Status: Percent of Members with Completed HRA days through 6/30/2025: 49.01% 4. MOC Updates: No updates 5. Face to Face Interactions with PCP or specialist: 67% at end of Q2.		on HRA Star Status. 4. Ongoing assessment and reporting for MOC updates. 5.Ongoing assessment and reporting for Face to Face interactions.	

QAC 03.19.2026

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31	Quality of Clinical Care		Pediatric and Adolescent Wellness: EPSDT/Children's Preventive and Screening Services	Childhood Immunization Status (CIS) MC Combo 10: 42.34% Increase from 36.50% to 42.34% by 12/31/2025. Immunizations for Adolescents (IMA) MC Combo 2: Increase from 47.45% to 48.66% by 12/31/2025. Well-Child Visits in the First 30 Months of Life (W30) MC First 15 Months: Increase from 58.92% to 63.38% by 12/31/2025. MC 15 to 30 Months: Increase from 72.44% to 73.09% by 12/31/2025. Child and Adolescent Well-Care Visits (WCV) MC Total: Increase from 53.03% to 55.29% by 12/31/2025. Lead Screening in Children (LSC) MC LSC: Increase from 63.75% to 63.84% by 12/31/2025.	Goal not met - W30. Continue to assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored and age-appropriate messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs (e.g. provide insight into CIS Combo 10 status for each vaccine) 4. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone) 5. For CIS Combo 10, identify members missing only the first Hep B vaccine and	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/14/2025 Q3: 08/12/2025 Q3: 11/04/2025	Vacant	Kelli Glynn/Leslie Vasquez	Quality Analytics	Data through May 2025: CIS: 24.6% IMA: 40.7% W30 (6 or more visits): 29.03% W30 (2 or more visits): 64.12% WCV: 19.03% LSC: 66.58%	CIS: already achieved the 33rd %ile and performing significantly higher as compared to same point in time last year (19.52% in May 2024) IMA: already achieved the 50th %ile and performing higher as compared to same point in time last year (37.66% in May 2024) W30: both sub measures are performing higher as compared to same point in time last year (28.1% and 61.31% respectively, in May 2024) WCV: performing higher as compared	Ongoing outreach to parents / guardians / members via Carenet (telephonic) and Ushur (SMS). Creation of a personalized pediatric mailer. One-time telephonic outreach via Carenet to members that are aging in. Vaccine hesitancy presentation to MAC/PAC.	HEDIS engine does not provide all necessary data elements for personalized outreach; creating in-house reporting with Financial Analysis.	Continue with plan as listed and pursue automation where possible. Leverage the upcoming Cozeva PayerOne solution to provide HN and CHCN provider partners with more detailed data for CIS and W30.	On Target

QAC 03.19.2026

					complete chart chase efforts year-round 6. Begin prospective outreach to members that will age into the measure for the following year (i.e. message 1 year old members to ensure compliance with recommended vaccine schedule thus far) 7. Create educational materials for addressing vaccine hesitancy and distribute to providers and members 8. Drive provider participation in the Standing Orders Program to place lab orders for blood lead testing 9. Provide point-of-care lead testing equipment and supplies to providers via the Quality Improvement Grant Program 10. Early Identification and Data Gap						to same point in time last year (17.43% in May 2024) LSC: already achieved the 50th %ile and performing higher as compared to same point in time last year (63.28% in May 2024)				

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					Bridging Remediation for early intervention										

QAC 03.19.2026

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32	Quality of Clinical Care		Adult Wellness: Preventive and Screening Services	Cervical Cancer Screening (CCS) MC: Increase from 58.31% to 60.10% by 12/31/2025. Colorectal Cancer Screening (COL) OC: Increase from 66.84% to 70.33% by 12/31/2025. Breast Cancer Screening (BCS-E) MC: Increase from 58.39% to 59.51 % by 12/31/2025. OC: Increase from 66.88% to 75.00 % by 12/31/2025. Immunization Status - Flu, Pneu, Tdap, Zoster MC Flu Total: Increase from 22.19% to 26.40% by 12/31/2025. OC Flu Total: Increase from 47.17% to 49.12% by 12/31/2025. MC Pneumococcal 66+: Increase from 38.18% to 38.73% by 12/31/2025. OC Pneumococcal 66+: Increase from 44.96% to 56.76% by 12/31/2025. MC Tdap Total: Increase from 25.43% to 33.40% by 12/31/2025. OC Tdap Total: Increase from 24.57% to 31.56% by 12/31/2025. MC Zoster Total: Increase from 17.52% to 20.56% by 12/31/2025. OC Zoster Total: Increase from 23.62% to 40.94% by 12/31/2025.	Assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs 4. Provide facility listings for services completed outside the PCP office setting, such as diagnostic sites for mammography 5.Provide mobile mammography services in collaboration with other departments, Health Network partners, and CHCN providers 6. Provide at-home Cologuard testing for	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Vacant	Melissa Morales/Dexter Dizon/Kelli Glynn	Quality Analytics	Cervical Cancer Screening (CCS) MC:43.97 % Colorectal Cancer Screening (COL) OC: 59% Breast Cancer Screening (BCS) MC: 47.21% OC:57% Immunization Status - Flu, Pneu, Tdap, Zoster (AIS-E) MC Flu Total: 17.12% OC Flu Total: 42.39% MC Pneumococcal 66+: 38.05% OC Pneumococcal 66+: 47.31% MC Tdap Total: 37.99% OC Tdap Total: 42.84% MC Zoster Total: 17.69% OC Zoster	CCS MC: A 5.7 percent point increase compared to May 2024 COL OC: A 7 percent point increase compared to May 2024 BCS MC: A 34.6 percent point increase compared to May 2024 BCS OC: A 1 percent point increase compared to May 2024 MC Flu Total: A 2.79 percent point increase compared to May 2024 OC Flu Total: A 3.14 percent point increase compared to May 2024	Breast Cancer Screening Text Campaign (MC: 75,000) Cervical Cancer Screening Text Campaign (MC 90,000) Colorectal Cancer Screening Text Campaign (MC 90,000) CareNet Live Call campaign for CCS, MC and OC BCS, MC and OC COL Mobile Mammography Events Flu Thank You Postcard Care gap member outreach to commence Q3 and Q4	None identified.	Continue Mobile Mammography Events Continue CareNet Live Call Campaign Q3/Q4 Initiate 2025 Cologuard Campaign Standing Order telephonic and mailing member outreach for BCS Continue Flu Postcard for members TBD Q3/Q4 Relaunch IVR robocall campaign TBD Q3/Q4 Relaunch Texting Campaign TBD Q3/Q4	On Target

QAC 03.19.2026

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					Colorectal Cancer Screening 7. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone)					Total: 25.81%	MC Pneumococcal 66+: A 7.37 percent point increase compared to May 2024 OC Pneumococcal 66+: A 0.33 percent point decrease compared to May 2024 MC Tdap Total: A 19.55 percent point increase compared to May 2024 OC Tdap Total: A 21.89 percent point increase compared to May 2024 MC Zoster Total: A 5.42 percent point increase compared to May 2024				

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											OC Zoster Total: A 7.56 percent point increase compared to May 2024				

QAC 03.19.2026

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33	Quality of Clinical Care		CalOptima Health Comprehensive Community Cancer Screening Program (CCCSP)	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer report key findings and/or activities, analyze barriers, and improvement efforts.	Assess and report the following: 1. Establish the Comprehensive Community Cancer Screening and Support Grants program and monitor Grantees' progress to measure impact 2. Develop and implement a comprehensive plan for other initiatives under CCCSP.	Report Program update to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Dr. Richard Pitts	Joanne Ku	Medical Management	1. Conducted an in-person grantee meeting to review Progress Report #2. 2. With the new HEDIS engine implemented, developed the FQ grantee dashboard showing baseline, progress during the current reporting period, and the number of additional members they need to screen to achieve their grant goal (using prospective data). 3. mPulse (texting campaign): Launched the 2-way texting campaigns: -Breast Cancer Screening	Based on observations and feedback from grantees, the workgroup identified the following challenges: 1. Need to account for "ramp up" and hiring. 2. Most payments are in arrears. 3. Frequent reporting and out of sync with calendar year. 4. Challenge in using HEDIS metrics to evaluate success throughout the process.	Worked with the Senior Director of Grant Programs to identify areas of opportunity and initiated grant amendments to better align with the program's scope: 1. Added a 6-month no-cost extension to the grant program. 2. Increased frequency of payments. 3. Decreased number of reports and sync with calendar year. 4. Added volume of screenings objectives based on attempted HEDIS improvements. Distributed the dashboard to the FQ grantees for monitoring and reference purposes.	1. Identified a data discrepancy during the amendment process. Need to determine the root cause and find a solution to ensure data accuracy. 2. While the workgroup actively worked on refining the scope of work for the Research & Evaluation initiative, the focus has shifted significa	1. Execute grant amendments with all 13 grantees, including a benchmarking table. 2. Conduct an in-person grantee meeting in August 2025 to review the grantees' progress using the newly formatted progress report template. 3. Meet with KCS and the internal Quality Analytics team to resolve the data discrepancy issue. 4. Continue working on the Research & Evaluatio	On Target

QAC 03.19.2026

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
										(unique members: 55,536 | Engagement rate: 22%) -Cervical Cancer Screening (unique members: 81,013 | Engagement rate: 14%) -Colorectal Cancer Screening (unique members: 59,521 | Engagement rate: 14%) Translated trigger responses into threshold languages to obtain more meaningful data.			ntly from the time the initial plan was presented to the Board.	n initiative scope of work and determine the best time to release the RFP.	

QAC 03.19.2026

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34	Quality of Clinical Care		Maternal and Child Health: Prenatal and Postpartum Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). MC Prenatal: Increase from 88.08% to 88.58% by 12/31/2025. MC Postpartum: Increase from 80.00% to 80.23% by 12/31/2025.	Assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Implement a comprehensive outreach strategy utilizing multiple modalities timed with the member meeting denominator-qualifying criteria 4. Launch an interdepartmental maternal health workgroup focused on improving outcomes and addressing disparities 5. Provide bundled code education to high volume providers	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Kelli Glynn	Leslie Vasquez	Quality Analytics	PPC Postpartum Care: 65.39% (data through May 2025) PPC Prenatal Care: 81.86% (data through May 2025)	Both measures are performing higher as compared to same point in time last year (May MY2024)	All planned activities are still in progress.	Resource constraints	Continue to partner with the Maternal Health Team.	Concern

QAC 05.19.2026

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
					6.Create a comprehensive dashboard / report that refreshes weekly to ensure timely member identification and intervention 7. Collaborate with OBGYN specialty groups to perform member outreach and schedule services 8. Expand on collaborative efforts with community-based organizations, providers, and health networks.										

QAC 03.19.2026

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
35	Quality of Clinical Care		Maternal and Child Health: Prenatal and Postpartum Depression Screening	Prenatal Depression Screening and Follow-Up (PND-E) MC Screening: Increase from 14.52% to 16.03% by 12/31/2025. MC Follow-up: Increase from 52.80% to 53.33% by 12/31/2025. Postpartum Depression Screening and Follow-Up (PDS-E) MC Screening: Increase from 17.33% to 29.84% by 12/31/2025. MC Follow-up: Increase from 56.84% to 61.70% by 12/31/2025.	PND-E & PDS-E Activities: 1. Provider maternal mental health training 2. Enhance CalOptima Health Maternal Depression Program and support referral to Behavior Health Integration when screened at risk. 3. Conduct or promote depression screening at community events.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Katie Balderas	Ann Mino	Equity and Community Health	1. Provided a maternal mental health training through Postpartum Support International to clinics/providers and community-based partners. 58 providers and partners are registered. 2. Conducted maternal mental health screenings at community-based events including Santa Ana College and Maternal Presentations to 45 members. 3. Implemented stroller walks to include mental health	N/A- work in progress	1. Provided a maternal mental health training opportunity to clinics/providers and community-based partners. 2. Conducted maternal mental health screenings at community-based events. 3. Receive contracted provider list for providers that self-identified as specializing in maternal mental health to assist members with connecting to services. 4. Maternal Health focused TeleMed2U flyer is included in maternal health member mailings.	1. Community Events due to immediate needs when completing mental health screenings that are very difficult in that situation. 2. Community events due to the current community environment and low attendance at events.	N/A	On Target

QAC 03.19.2026

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										preventative care (physical activity, social interactions, breath work, etc.).					
36	Cultural and Linguistic Appropriate Services		Maternity Care for Black Members	Medi-Cal 1. Increase timeliness of prenatal care (TOPC) for CalOptima's Black members from 75.71% to 84.55% by December 31, 2025. 2. Increase postpartum care (PPC) for CalOptima's Black members from 71.43% to 80.23% by December 31, 2025.	Assess and report the following activities: 1. Connect members to doula, Enhanced Care Management (ECM) services, and Black Infant Health (BIH) programs. 2. Implement community and clinic events that focus on improving prenatal and postpartum appointments. 3. Explore digital methods of providing perinatal assessments, education, and	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Vacant	Kelli Glynn/Katie Balderas	Equity and Community Health/ Cal AIM/Quality Analytics	PPC Postpartum Care: 57.53% compliance rate for Black members compared to 64.41% compliance rate for the entire PPC population (data through May 2025) PPC Prenatal Care: 78.08% compliance rate for Black members compared to 81.06% compliance	Based on May 2025 data, the Black or African American population is trending lower (in terms of compliance rate for both prenatal and postpartum care) as compared to Asian and White members.	1) 24 Black members have open authorization for Enhanced Care Management (ECM) within the Birth Equity Population of Focus in Q2. In that quarter, 3 Black members received doula services, making up 9% of all members who received doula services during the same period. This shows a decrease in utilization compared to Quarter 1 (17.5%). Approval was	1) Limited promotion of Doula Benefit 2) Barriers to data sharing with Black Infant Health and community resources	1) Developing strategy for doula promotion to members. 2) Developing manual workaround until automated data sharing solution is available.	On Target

QAC 03.19.2026

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					resource navigation for pregnant and postpartum members.					rate for the entire PPC population (data through May 2025)		obtained from the CalOptima Health Privacy and Security teams to establish member-level data sharing, which will help OC Black Infant Health program with outreach to eligible members. 2) No activities for this quarter. 3) No activities for this quarter.			

QAC 03.19.2026

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37	Quality of Clinical Care		Chronic Conditions: Members with Diabetes	Eye Exam for Patients with Diabetes (EED) MC EED 64.06% Increase from 63.52% to 64.06% by 12/31/2025. OC: EED 77.00%; Increase from 75.14% to 77.00% by 12/31/2025. HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates Percentage of members with poor A1C control-lower rate is better) (>9.0%) MC HBD: Decrease from 29.34% to 27.01% by 12/31/2025. OC HBD: 10.00% decrease from 15.30% to 10.00% by 12/31/2025.	Assess and report the following activities (Quality Analytics): 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs 4. Explore at-home testing for HBD via lab vendor 5. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone) 6. Drive provider participation in the Standing Orders program to place A1c lab orders on behalf of	By December 2025 Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Vacant/Katie Balderas	Melissa Morales/Kelli Glynn/ Elisa Mora	Equity and Community Health and Quality Analytics	Eye Exam for Patients with Diabetes (EED) MC:37.64 % OC: 52% Glycemic Status Assessment for Patients with Diabetes (GSD): HbA1c Poor Control (>9%) MC Poorly Controlled (Glycemic Status >9%): 62.73% OC Controlled (Glycemic Status <8%):40%	EED MC: A 2.28 percent point increase compared to May 2024 EED OC: A 1 percent point increase compared to May 2024 GSD MC: A 14.61 percent point decrease compared to x 2024 (lower is better) GSD OC: A 5 percent point increase compared to May 2024	Diabetes Member Outreach text campaign (MC, OC approx. 45,000) CareNet Live Call Campaign for MC and OC HbA1c VSP Eye Exam mailing reminder	None identified.	Continue CareNet Live Call Campaign Q3/Q4 Relaunch Diabetes Texting Campaign Q3/Q4 Exploration of at-home A1c testing with lab partners such as Quest	On Target

QAC 03.19.2026

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					physicians 7. Collaborate with OPH and OPT providers on member outreach and scheduling of services for EED 8 Regularly review members with evidence of A1c testing but no result and address via supplemental data capture 9. Partner with VSP to educate providers on EED CPT II code submission to capture testing results 10. Explore offering EED testing at community based events Assess and report the following activities: 1. Enhance Diabetes Education: Launch virtual and group education classes to improve member engagement by FY 2025. 2. Leverage Technology: Use digital apps and web-										

QAC 03.19.2026

					based tools to support diabetes prevention, management, and interactive engagement. 3. Strengthen Support Services: Link members to medically tailored meals, health coaching nutrition services, community/clinic events.									

QAC 03.19.2026

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
38	Quality of Clinical Care		Chronic Conditions: Members with Heart Health (Hypertension)	Controlling High Blood Pressure (CBP) MC CBP: Maintain the 90th percentile (72.75%) or higher by December 31, 2025. OC CBP: Increase from 74.87% to 80.00% by 12/31/2025. Controlling High Blood Pressure (CBP) - CLAS and Health Disparity for Medi-Cal 1. Increase CBP rate among Black and African American Medi-Cal members from 39.21% to 64.48% by 12/31/2025. 2. Increase CBP rate among Black and African American Medicare members from 47.24% to 77% by 12/31/2025. 3. Increase CBP rate among Korean speaking Medi-Cal members from 24.87% to 64.48% by 12/31/2025. 4. Increase CBP rate among Vietnamese speaking Medicare members from 50.56% to 77% by12/31/2025.	Assess and report the following activities: 1. Expand Hypertension Program to offer both virtual and in-person Hypertension Education.	Report to PHMC: Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Katie Balderas	Elisa Mora/Joanna Hoffnagle	Equity and Community Health	1. In Q2, 345 members were screened for blood pressure and received education on blood pressure management, including how to measure it properly, through various community events. Of these, 160 were OneCare members. 2. Eleven hypertension classes were held in Q2, with a total attendance of 150 members. 3. A standing order process was implemented to increase access to blood pressure	1.Community events are effective engagement points, particularly those centered around cultural identity and inclusion. 2.Members are receptive to health education when delivered through trusted community organizations. 3.There is an ongoing need to reduce equipment access barriers, such as blood pressure monitors, to support chronic condition management. 4.Ongoing training, data	1. Identified OC members with CBP health gap to provide targeted outreach for education and blood pressure screening clinics 2. Finalized hypertension class curriculum 3. A standing order was created to increase access to BP monitor for CalOptima members. Training for CalOptima staff will take place in April. 4. Meeting with providers and community based organizations to schedule blood pressure clinics 5. Increased screening opportunities at community events	A1 Pharmacy initially did not carry the XL blood pressure cuff covered under the medical prescription benefit. To ensure continued support for our members, they established a contract with a different manufacturer that provides the XL cuff under medical Rx coverage.	Continue to track and monitor the use the standing order by CalOptima Health staff.	On Target

QAC 03.19.2026

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										monitors for CalOptima Health members. A total of 173 CalOptima Health staff were trained on the new process. 4. Since the implementation of the standing order process, a total of 168 blood pressure monitors have been ordered. 5. A presentation on the CBP STAR measure and how to increase blood pressure monitor access for members through the pharmacy and DME benefits took place on 5/1 at the CalOptima	tracking and protocol implementation are necessary steps to operationalize expanded member access.				

QAC 03.19.2026

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										Health Clinical Ops 2025 Health Network Series (UM/CM) 75 attendees.					

QAC 03.19.2026

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39	Quality of Clinical Care		Chronic Conditions: Osteoporosis	Osteoporosis Management in Women Who Had a Fracture (OMW) OC Total: Increase from 34.67% to 39.00% by 12/31/2025.	1.Case management to collaborate with Quality to identify members who need follow-up. 2.Case Management to outreach to noncompliant members via SMS, mail, and/or telephone. 3.ECH to pursue at-home DEXA testing via vendor. 4.Quality to provide timely notifications to the member's PCP via fax. 5.Quality to explore collaboration with the Pharmacy team to provide education on the importance of taking a medication to treat osteoporosis (e.g. bisphosphonate). 6.Quality and Case Management coordinate to provide more	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Megan Dankmyer/Kelli Glynn	Sherry Hickman Mahmoud Elaraby	Medical Management (Case Management) /Quality Analytics	The OMW measure is performing signficiantly higher as compared to same point in time last year (May 2025: 37% vs. May 2024: 9%).	The OMW measure is performing signficiantly higher as compared to same point in time last year (May 2025: 37% vs. May 2024: 9%).	1.Case management to collaborate with Quality to identify members who need follow-up: a. Members with OMW will be added to Key Event report through Point Click Care Data. IT TIcket/RITM0043625 2.Case Management to outreach to noncompliant members via SMS, mail, and/or telephone. 3.Quality to pursue at-home DEXA testing via vendor: a. ECH researched in home vendors during quarter 2. 4.Quality to provide timely notifications to the member's PCP via fax. 5.Quality to explore collaboration with the Pharmacy team to provide	1. Some in-home vendors do not meet diagnostic criteria for the Star Measure.	1. Case management will continue to collaborate with Quality to identify members who need follow-up: a. Pending Members with OMW to be added to Key Event report through Point Click Care Data. IT Ticket/RITM0043625 2.Case Managementwill continue to outreach to noncompliant members via SMS, mail, and/or telephone. 3. Quality to	On Target

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Back to Agenda Back to Item

QAC 03.19.2026

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					timely data and insight to the member's compliance deadline date to Health Network partners.							education on the importance of taking a medication to treat osteoporosis (e.g. bisphosphonate). Discussion in Stars Workstream Workgroup. 6.Quality and Case Management coordinate to provide more timely data and insight to the member's compliance deadline date to Health Network partner: Ongoing in member - measure level files to Health Networks monthly.		continue timely notifications to the member's PCP via fax. 4. Exploration for education on the importance of taking a medication to treat osteoporosis (e.g. bisphosphonate) is currently on hold. Quality will continue to explore potential pharmaceutical intervention in support of OMW. 5. Quality and Case Management will continue to coordinate to provide more timely data and	

QAC 03.19.2026

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														insight to the member's compliance deadline date to Health Network partners	
40	Quality of Clinical Care		Chronic Conditions: Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) OC Total: Increase from 51.27% to 53.00% by 12/31/2025.	1. Review and update the Key Events for Emergency Visits 2. Continue to share Emergency Visits with Health Networks through Key Event reporting.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Megan Dankmyer	Sherry Hickman	Case Management	The FMC measure is performing higher compared to same point in time last year (May 2025 48% vs May 2024 40%)	The FMC measure is performing higher compared to same point in time last year (May 2025 48% vs May 2024 40%)	1. Review and update the Key Events for Emergency Visits: a. IT Ticket RITM0043625 created for additional identification of members who meet chronic condition criteria to be identified as a Key EventType. 2. Continue to share Emergency Visits with Health Networks through Key Event	Key Event reporting lacked visibility for members who met FMC chronic care condition critiera.	1. Review and update the Key Events for Emergency Visits: a. Pending addition of Members who meet FMC criteria as Key Event Type. IT Ticket RITM0043625. 2. Continue to share Emergency Visits with	On Target

QAC 03.19.2026

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												reporting: Ongoing.		Health Networks through Key Event reporting.	
41	Quality of Clinical Care		Behavioral Health Services: Child and Adolescent Health on Antipsychotics	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) MC Glucose and Cholesterol Combined-All Ages: Increase from 36.76% to 41.41% by December 31, 2025.	Goal not met. Continue to assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primary Care Providers (PCP) for members in need of metabolic monitoring. 2) Work collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Behavioral Health Integration	APM PR HEDIS Rates Q2 (April): MC: 13.08%	APM PR increased from Q1 (March) to Q2 (April) by 1.67%	APM: 1) Prescribing provider letter finalized 06/09/2025. 2) HEDIS Provider tool tip sheet finalized 06/06/2025. 3) Social Media Post, posted on 04/14/2025. 4) Article for the Fall Member Newsletter approved and going through MMA process. 5) Text Campaign sent out a.) 4/10/2025 - 75 texts sent b.) 5/8/2025 - 52 texts sent 6) Created a Quick Reference Guide (QRG) & Power Point	Barriers include: 1) Unable to do provider outreach due to lack/delayed data.	APM: 1) Continue Text message campaign. 2) Resume mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to providers on a monthly basis. 3) Resume collaboration with Provider Relations to conduct in-person provider outreach	At Risk

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Back to Agenda Back to Item

QAC 03.19.2026

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					need of screening. 3) Monthly mailing to prescribing providers to remind of best practices for members in need of screening. 4) Send monthly reminder text message to members (approx 600 mbrs). 5) Information sharing via provider portal to PCP on best practices.							Presentation for providers and staff on how to use the Provider Portal. Pending report availability		with top 10 providers on a monthly basis. 4) Schedule listening sessions with Providers to educate/train on how to obtain BH data upon BH reports are availability.	

QAC 03.19.2026

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42	Quality of Clinical Care		Behavioral Health Services: Depression	~~Antidepressant Medication Management (AMM)~~ ~~MC Acute Phase - 63.35% Increase from 68.06% to 68.35% by December 31, 2025.~~ ~~MC Continuation Phase - Increase from 48.06% to 48.16% by December 31, 2025.~~ ~~OC Acute Phase - 63.35% Increase from 75.52% to 78.39% by December 31, 2025.~~ ~~OC Continuation Phase - Increase from 60.77% to 62.58% by December 31, 2025.~~ Depression Screening and Follow-up for Adolescents and Adults (DSF-E) MC Screening Total: Increase from 6.57% to 16.22% by December 31, 2025. OC Screening Total: Maintain the 90th percentile (54.28%) or higher by December 31, 2025.	~~AMM~~ ~~Goal not met. Continue to assess and report the following activities:~~ ~~1) Educate providers on the importance of medication adherence through outreach.~~ ~~2) Educate members on the importance of medication adherence through newsletters/outreach.~~ ~~3) Track number of educational events on depression treatment adherence.~~ DSF-E Goal not met. Continue to assess and report the following activities: 1) Educate providers on the importance of screenings and follow-up care after positive screenings. 2) Educate	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Behavioral Health Integration	**AMM-Measure retired for MY2025 and MY2026.** DSF-E PR HEDIS Rates Q2 (April): MC: 2.06% OC: 2.48%	**AMM-Measure retired for MY2025 and MY2026.** DSF-E PR increased from Q1 (March) to Q2 (April) by 0.02% for MC and for OC there is no data from Q1 to compare findings for Q2.	**AMM-Measure retired for MY2025 and MY2026.** DSF-E: 1) HEDIS Provider tool tip sheet finalized 06/06/2025. 2) Prescribing provider letter finalized 06/09/2025. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability	Barriers include: 1) Unable to do provider outreach due to lack/delayed data.	**AMM-Measure retired for MY2025 and MY2026.** DSF-E: 1) Share updated draft of prescriber letter with BHQI workgroup If data is received: a.) Disseminate prescriber tip tool sheet, once Prescriber letter is approved b.) Send out a text message campaign. c.) Resume mailings of Provider materials (Best Practices letter and Provider tip tool	At Risk

QAC 03.19.2026

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					members on the importance of screenings through newsletters/outreach and increase follow up appointments after positive screenings.									sheet) to providers on a monthly basis. d.) Resume collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 2) Schedule listening sessions with Providers to educate/train on how to obtain BH data upon BH reports availability.	

QAC 03.19.2026

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43	Quality of Clinical Care		Behavioral Health Services: Schizophrenia	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) MC SSD: Increase from 74.96% to 79.51% by 12/31/2025. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) MC: Increase from 70.19% to 74.83% by 12/31/2025. OC: Increase from 77.37% to 77.93% by 12/31/2025.	SSD Goal not met. Continue to assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collaboratively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx 1100 mbrs)	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Behavioral Health Integration	SSD PR HEDIS Q2 (April): MC 42.4% SAA PR HEDIS Q2 April PR: MC 0.52% OC 1.70%	SSD PR increased from Q1 to Q2 by 3.39% SAA PR increased from Q1 to Q2 for: MC by 0.52% OC by 1.70%	SSD: 1) Prescribing provider letter finalized through CAR process on 06/09/2025. 2) Provider tool tip sheet Finalized through CAR process on 06/06/2025. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability. 4) Article for the Fall Member Newsletter approved and going through MMA process. SAA: 1) Prescribing provider letter finalized through CAR process on 06/09/2025. 2) Provider tool tip sheet Finalized through CAR	Barriers include: 1) Member compliance is a challenge with this population 2) Unable to do member mail out due to lack/delayed data.	SSD: 1) Continue tracking members in need of glucose screening test. 2) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 3) Continue to follow up on data pull for text messaging campaign. 4) Mail out member health rewards flyer to eligible members. 5) Mail out to all prescribing provider offices the following: a.) Prescribin	At Risk

QAC 03.19.2026

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					5) Member Health Reward Program. SAA Assess and report the following activities: 1) Educate providers on the importance of medication adherence through outreach. 2) Educate members on the importance of medication adherence through newsletters/outreach.							process on 06/06/2025.. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for Providers & Staff on how to use the Provider Portal. Pending report availability. 4) Article for the Fall Member Newsletter approved and going through MMA process.		g Provider Letter b.) Provider Tool Tip Sheet c.) Member Reward Flyer 6) Schedule listening sessions with Providers to educate/train on how to obtain BH data. Pending report availability. SAA: 1) Will use provider portal to communicate best practices and guidelines for medication adherence and member follow-up. 2) Discussio	

QAC 03.19.2026

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														n of implementing a text messaging campaign. 3) Begin mail out to all prescribing provider offices the following: a.) Prescribing Provider letter b.) Provider Tool Tip Sheet 4) Schedule listening sessions with providers to educate/train on how to obtain BH data. Pending report avialability.	

QAC 03.19.2026

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44	Quality of Clinical Care		Behavioral Health Services: Care Coordination and Follow-up Care	Follow-Up After Emergency Department Visit for Mental Illness (FUM) MC 30-Day: Increase from 35.76% to 53.82% by 12/31/2025. MC 7-day: Increase from 21.38% to 33.01% by 12/31/2025. Follow-Up After Emergency Department Visit for Substance Use (FUA) MC 30-Day: Increase from 21.12% to 36.18% by 12/31/2025. MC 7-Day: Increase from 11.23% to 18.76% by 12/31/2025. Follow-up After High-Intensity Care for Substance Use Disorder (FUI) MC 30-Day: Increase from 20.25% to 44.53% by 12/31/2025. MC 7-Day: Increase from 7.99% to 26.90% by 12/31/2025.	FUM Goal not met. Continue to assess and report the following activities: 1. Share real-time ED data with our health networks on a secured FTP site. 2. Participate in provider educational events related to follow-up visits. 3. Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4. Bi-Weekly Member Text Messaging (approx. 500 mbrs) 5. IVR calls to members who fall under the FUM measure FUA Goal not met. Continue to assess and report the following activities: 1. IVR calls to members who fall under the FUA measure 2. Continue weekly	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz / Valerie Venegas	Behavioral Health Integration	FUM PR HEDIS Rates Q2 (April): 30 day-49.6%, 7 day-29.21% FUA PR HEDIS RATES Q2 (April): 30-day: 29.16%%, 7-day:16.17 % FUI PR HEDIS Rates Q2 (April): 30-day: 26.26% 7-day: 8.42%	FUM PR increased from Q1 (March) to Q2 (April) for 30-day by 30.67% and for the 7-day the rate increased by 19.13%. FUA PR increased from Q1 (March) to Q2 (April) for 30-day by 6.74% and for the 7-day the rate increased by 4.32%. FUI PR increased from Q1(March) to Q2 (April) for 30-day by 6.56% and for the 7-day the rate increased by 1.85%.	FUM: 1) Member text messages sent weekly. 2) Member outreach via BH Telehealth vendor to assist with scheduling Follow up appointments. Outreach based on daily ED data feed. 3) Reminders regarding importance of FUM/FUA sent in monthly HN Communication. 4) Continued sharing FUM data with HN Networks via sFTP. 5) Collaboration with OC HCA and CalOptima IT regarding 837 data exchange 6) Continued Pilot Program with Providence 7) Identified Top ED's based on claiims and encounter report pulled Dec. 2024. 8) Met with High volume ED's. BHI leadership w/ Michelle Evans (UM) co-presented with	1) Delay in receiving supplemental 837 data from OC HCA 2) Member engagement is a challenge with this population.	FUM: 1) IVR calls for members who meet FUM criteria to remind them of the importnace of schedling a follow up appointment after an ED visit. 2) Continue Text Campaign 3) Continue to meet with High volume ED's to ensure members are connected to services before they leave the hospital by introducing Telemed2U/NAMI By Your Side. 4) Share FUM HEDIS report data via Provider	Concern

QAC 03.19.2026

					member text messaging 3. Share FUA data with providers through the Provider Portal. 4. Sharing FUA data with Health Networks via sFTP. FUI: This measure was added for monitoring purposes. Opportunities for improvement and/or interventions will be considered upon the ability to obtain data from the Orange County Health Care Agency.							NAMI (NAMI By Your Side)/ Telemed2U to ensure members are connected to services before they are discharged from the ED. Meeting Date Facility 5/8/2025 KPC 5/21/2025 Prime 9) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability. FUA: 1) Member text messages sent weekly. 2) Member outreach via BH Telehealth vendor to assist with scheduling Follow up appointments. Outreach based on daily ED data feed. 3) Reminders regarding importance of FUM/FUA sent in monthly HN Communication.		portal. (Pending report availability). 5) Schedule listening sessions regarding how to use data from Provider portal. FUA: 1) IVR and text campaign Pilot will replace the current text campaign in July 2025, this will expand member out reach to include landlines 2) Continue Text Campaign 3) Continue to meet with High volume ED's to ensure members are connected to services before they leave	

QAC 03.19.2026

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												4) Continued sharing FUA data with HN Networks via sFTP. 5) Collaboration with OC HCA and CalOptima IT regarding 837 data exchange 6) Continued Pilot Program with Providence 7) Identified Top ED's based on claiims and encounter report pulled Dec. 2024. 8) Met with High volume ED's. BHI leadership w/ Michelle Evans (UM) co-presented with NAMI (NAMI By Your Side)/ Telemed2U to ensure members are connected to services before they are discharged from the ED. Meeting Date Facility 5/8/2025 KPC 5/21/2025 Prime 9) Created a Quick Reference Guide (QRG) & Power Point Presentation		the hospital by introducing Telemed2U/NAMI By Your Side. 4) Share FUM HEDIS report data via Provider portal. (Pending report availability). 5) Schedule listening sessions regarding how to use data from Provider portal. FUI: 1) Continue to monitor measure on a monthly basis. 2) Continue collaborative meetings between teams to identify best practices to implement.	

QAC 03.19.2026

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												for providers and staff on how to use the Provider Portal. Pending report availability. FUI: 1) Monitoring this measure. 2) Created a HEDIS Provider Tool Tip Sheet.06/06/2025. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability.			

QAC 03.19.2026

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45	Quality of Clinical Care		Behavioral Health Services: Medication Management	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) MC Total: Increase from 28.95% to 54.55% by 12/31/2025. Pharmacotherapy for Opioid Use Disorder (POD) MC Total: 21.36% Increase from 7.79% to 21.36% by 12/31/2025.	Assess and report on the following activities: 1) Educate providers on measure and best practice guidelines.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jaylene Ramirez	Behavioral Health Integration	APP HEDIS Rates Q2 (April): MC: 43.94% POD HEDIS RATES Q2 (April): MC:3.62%	APP increased from Q1 (March) to Q2 (April) by 16.46%. POD PR increased from Q1 (March) to Q2 (April) by 0.03%.	APP: 1) HEDIS Provider Tool Tip Sheet Finalized on 06/06/2025. 2) Prescribing provider letter finalized 06/09/2025. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability POD: 1) HEDIS Provider Tool Tip Sheet Finalized on 06/06/2025. 2) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability.	APP: 1) We are not able to send out the provider letters, as we are still awaiting their approval. 2) We are also waiting for Citius to display provider data such as address, so that we can begin to send out letters once approved. POD: 1) The barrier with POD is that pharmacy claims data for Medi-Cal	APP: 1) Send out the provider letters. 2) Work on text message to send out to members, possible barrier new APL regarding minor consent. POD: 1) Meet with county to disscus POD data gap issue at the next county collaboration meeting on July 16, 2025.	At Risk

QAC 05.19.2026

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													members comes through the state; the state pays for those prescriptions. Sometime the claims are not being billed through the state, so if the member is getting their prescription at county, CalOptima Health does not know the process for members to get thier prescription outside of the states coverage.		

QAC 03.19.2026

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46	Quality of Clinical Care		Behavioral Health Services: School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report the following Student Behavioral Health Incentive Program (SBHIP) activities/school base mental health services 1 . SBHIP Program Outcome Reporting 2. DHCS CYBHI multi-Payer Fee Schedule	Report program update to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Sherie Hopson	Behavioral Health Integration	N/A	N/A	1) There are no activities to report. SBHIP implementation activities and deliverables are all completed; the last incentive payment was received on April 24, 2025. CalOptima Health earned the entire $25M DHCS allotted incentive funding for Orange County.	N/A	1) At this time there are no follow-up actions.	On Target
47	Quality of Clinical Care		Medication Management	Appropriate Testing for Pharyngitis (CWP) MC Total: Increase from 43.66% to 76.71% by 12/31/2025. OC Total: Increase from 15.77% to 72.50% by 12/31/2025. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) MC Total: Increase from 47.55% to 56.73% by 12/31/2025. OC Total: Increase from 68.97% to 47.50% by 12/31/2025.	1) Identify top 5-10 providers that prescribed antibiotics to members and provide targeted provider education via provider updates/provider newsletter. 2) Provide members with general education on antibiotic avoidance.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Kelli Glynn	Dexter Dizon	Quality Analytics	Appropriate Testing for Pharyngitis (CWP) MC Total: 52.67% OC Total: 15.82% Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB) MC Total: 37.34% OC Total: 25.32%	CWP: A 1.72 percent point increase compared to May 2024 AAB: A 3.03 percent point decrease compared to May 2024	Create provider material on antibiotics avoidance. Identify top 10 lower performing providers.	N/A	Finalize provider communication plan in collaboration with the Quality Medical Director.	On Target

QAC 03.19.2026

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48	Quality of Clinical Care		Medication Adherence	Improve medication adherence for Cholesterol (Statins), Hypertension (RAS Antagonists) and Diabetes	1) Member IVR, member education, provider education, PDC report to Health Networks.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Dr. Nicki Ghazanfarpour	Dr. Susan Vigil	Pharmacy Management	2Q25 Overview: -Count of Member adherence IVRs: 4,473 -Adherence intervention calls to providers, members and pharmacies (ongoing) from January 2025 to date: 2,114 (42.8%) of the 4,938 prescriptions intervened on were filled after the intervention -Report distribution Health Networks via provider portal (daily refresh); actionable report for networks to conduct outreach Distribution of best practices document to health	CY2025 Star Measure reports unavailable from Acumen for 2Q25. Results of interventions documented in column O.	1) Adherence IVRs 2) Adherence outreach calls to members, pharmacies and providers 3) Health network coaching 4) PDC report enhancements 5) 100-day supply conversion program	1) Members picking up their medications 2) Limited providers signing collaborative practice agreement for 100-day supply program	Continue all interventions outlined.	Concern

QAC 05.19.2026

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										networks to assist in intervention design -100-day supply conversion program : 230 prescribers outreached, 52 prescribers signed collaborative practice agreement; 67 prescriptions for 42 unique members converted					
49	Cultural and Linguistic Appropriate Services		Performance Improvement Projects (PIPs) Medi-Cal	Increase well-child visit appointments for Black/African American members (0-15 months) from (final rate TBD) to 55.78% by 12/31/2025.	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP – Increasing W30 6+ measure rate among Black/African American Population	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Vacant	Leslie Vasquez/Kelli Glynn	Quality Analytics	10.20% compliance rate for Black members compared to 26.79% compliance rate for the entire W30 population (first 15 months of life) (data through May 2025)	A significant difference in compliance exists for Black members as compared to the performance for the overall population	Telephonic outreach to parents / guardians	1. Contact Information: Bad or disconnected phone numbers continues to be a challenge in the ability to contact members and coordinate care.	To address contact information challenges, outreach staff outreach to the member's assigned primary care doctor and obtain updated contact information, where	Concern

QAC 03.19.2026

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														feasible. Continue telephonic outreach and explore additional initiatives, such as targeted outreach to pediatricians. Will do so in partnership with health networks and/or primary care providers.	
50	Quality of Clinical Care		Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) FUM and FUA for complex case management.	Non Clinical PIP: Improve the percentage of members enrolled into care management, CalOptima Health community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz/Mary Barranco	Behavioral Health Integration/ Quality Analytics	Baseline Measurement: 01/01/2023 - 12/31/2023 -1.08% Remeasurment 1: 01/01/2024 - 12/31/2024 -2.32%	Percentage has increased by 1.24% during Remeasurment Period 1	1) Continued to receive daily ED report from vendor which contains Real-Time ED data for CCN and COD members. 2) Continue collaboration with telehealth vendor. Vendor to continue ED member outreach and to provide information regarding case managment including ECM and referrals.	1) Coordinating/Engaging internal stakeholder departments due to competing priorities. 2) Given the diagnosis there is difficulty in connecti	1) Continue collaboration with Case Managemnt and Financial Analysis depts to ensure accuracy of internal data and reports. 2) Continue to conduct barrier analysis. 3)	On Target

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Back to Agenda Back to Item

QAC 03.19.2026

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					with SMH/SUD.							3) Collaboration with OC HCA and CalOptima Health IT regarding 837 data exchange.	ng with this member populati on. 3) PHI Data Sharing with commun ity partners , for coordina tion of care and outreac h. 4) Lack of data exchang e with the County Mental Health System.	Continue Telehealth member outreach.	

QAC 03.19.2026

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51	Quality of Clinical Care		Chronic Care Improvement Projects (CCIPs) OneCare: Diabetes Emerging Risk	By December 31, 2025, 5% of members identified as emerging risk* and who participated in program will lower HbA1c to less than 8.0%. *Emerging risk is defined as members with a result of A1C 8.0% to A1C 9.0% who were previously in good control A1C less than 8.0% in previous 12 months.	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Vacant	Melissa Morales/Kelli Glynn	Quality Analytics	Glycemic Status Assessment for Patients with Diabetes (GSD): HbA1c Poor Control (>9%) OC Controlled (Glycemic Status <8%):40%	GSD OC: A 5 percent point increase compared to May 2024	Diabetes Member Outreach text campaign CareNet Live Call Campaign OC HbA1c Report distribution Health Networks via provider portal (daily refresh); actionable report for networks to conduct outreach	None identified.	Continue Emerging Risk project in collaboration with Elisa Mora's team. Exploration of at-home A1c testing with lab partners such as Quest.	Concern
52	Quality of Service: Access		Improve Network Adequacy: Reducing Gaps In Provider Network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025	Quynh Nguyen	Cathy Dela Cruz/ Monair Thith	Provider Data Operations	1. Gap analysis showed Plan level met time or distance standards. It also closed gastroenterology PMR gap. meets	1. Recruiting outreach for Rheumatology, Urology and Neurology coincides already addressed the new	1. PR completed new provider outreach for Rheumatology, Urology, Neurology outreach. 2. PDO launched a new outreach with PR to connect with	1. PR outreach trended on providers either not interested or no longer at the location	1. Review the results of the CCN contracted groups for specified specialties 2. Review/Approved	On Target

QAC 03.19.2026

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					2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members					standards except for PMR, which shows gaps in Orthopedic Surgery, LMFT and Urology 2. CCN remains the same at 3 gaps for Time/Distance requirements 3. HNs all had time/distance gaps, and 7 new HNs now have 1 PMR gap in Urology	gap in Urology. The results of the outreach did not yield as many new contracted providers as originally hoped. 2. Urology is a new high volume specialty based on 2024 utilization data which is why it's a new PMR gap at the Plan level and 7 of 10 HNs (includes CCN in the count) 3. PMR Gap trended upward with the inclusion of Urology as a new high volume specialty, therefore creating new standard. Time or	all CCN contracted groups to verify that all providers within the group has been submitted to COH for inclusion 3. COH audited and reviewed all HN CAP responses and opened AAS request/ Telehealth to expand member access to care for the purpose of SNC certification.	listed per DHCS FFS database 2. Network Adequacy Workgroup has identified that certain specialties are seeing COH's rates to be lower and therefore not interested in contracting 3. Contracting new providers take multiple months, therefore HNs are not always able to close the gap within 1 quarter.	AAS/Telehealth request from HNs 3. Network Adequacy Workgroup to discuss other solutions to explanding provider network to address gaps	

QAC 03.19.2026

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											Distance gap trended downward with HNs decreasing gaps from Q1 to Q2, as a direct result of HNs completing CAPs issued for 2024 SNC.				
53	Quality of Service: Access		Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Goal not met. Continue to assess and report the following activities: 1) Conduct an evaluation of appointment and telephone access 2) Issue corrective action for areas of noncompliance 3) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely access. 4) Continue to educate providers on	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025	Vacant	Helen Syn/Karen Jenkins	Quality Analytics	MY-2024 Appointment Access Results: •One-Care Plan- All provider types met MPL •Medi-Cal Plan- All provider types met the MPL with the exception of Psychiatry ○ Urgent at 55% ○Follow-up at 56%:	2024 non-compliance notifications distributed in Q2-2025: •4 HNs were issued a CAP for not meeting 70% MPL •184 Providers were issued a notice of Non-Compliance •74 Providers were issued a CAP (CAP indicates non-compliance of two or more measures)	CareNet Live Call Campaign for MC and OC HbA1c	•Vendor issues with 2024 data quality and reporting •Threshold too high and monitoring of non-regulatory measures •Timely Access analyst resigned at begging of year	Planning for 2025 Timely Access Survey underway. •Targeting initial fielding to start in August •Currently interviewing for new analyst. •Offering access and appointment training to providers and HNs through our contracted vendor, the SullivanL	On Target

QAC 03.19.2026

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					timely access standards 5) Develop and/or share tools to assist with improving access to services.									uallin Group	
54	Quality of Service: Access		Network Adequacy Regulatory Submission and Audits	Comply with regulatory requirements • Annual Network Certification (ANC) • Subdelegate Network Certification (SNC) • Network Adequacy Validation (NAV) Audit	1) Annual participation of ANC, SNC and NAV to DHCS with AAS or CAP 2) Implement improvement efforts 3) Monitor for Improvement 4) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2025 2) By end of Q2 2025 3) By end of Q3 2025 Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025	Quynh Nguyen	Cathy Dela Cruz/ Monair Thith	Provider Data Operations	1. 2024 ANC - DHCS approved and found COH in full compliance with the following requirements: - MPT, Hospital, Cancer Treatment Validation - MPT, LTSS, OB/GYN P7Ps - Provider to Member Ratio (PCP, Total Physician, Outpatient NSMHS) 2. 2024 SNC - All	1. 2024 ANC - the only item remaining to be certified is the outcome of AAS Request for Time or Distance which is still under review 2. 2024 SNC - COH reviewed all HN CAP submissions in April and June. The CAPs closed a considerable amount of gaps across the network	1. 2024 SNC - Telehealth/Alternative Access Request has been authorized to be used by HNs to close remaining gaps and be certified. COH provided office hours to provider an overview and address any questions the HNs may have in completing this step in the SNC process. 2. NAV: PDO operations implemented a workplan to complete the network adequacy validation	1. 2024 SNC - it takes months to recruit providers, which is why some gaps continue to remain open for HNs under Time or Distance requirement. The use of Telehealth/AAS will allow member	1. 2024 SNC - Telehealth /AAS requests are due to COH in July with the goal of certifying all HNs in Q3 to complete this regulatory requirement 2. 2024 NAV Audit package is due to HSAG on 7/17 and Virtual Audit is scheduled for 8/18/25	On Target

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Back to Agenda Back to Item

QAC 03.19.2026

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										HNs completed corrective action plan. COH closed the PMR CAP that were issued. Since this is not a DHCS requirements, COH will no longer include it as part of SNC moving forward. Instead it will continue as an internal monitoring standard for NCQA purposes. 3. DHCS retained HSAG for 2024 NAV Audit and HSAG has kicked off the NAV audit process with COH.	however, no HN closed all Time or Distance gaps to be fully certified. All HNs remain with gaps for Time or Distance. 3. NAV - Review of the NAV package showed that the majority of the questions remained the same compared to last year.	package across multiple departments.	s to gain access to care while the HNs continue their contracting efforts to completion.		

QAC 03.19.2026

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55	Quality of Service: Access		Increase Primary Care Utilization - Initial Health Appointment	Increase the IHA completion rate for all new Medi-Cal members from 33% to 50% by December 31, 2025.	Assess and report the following activities: 1) Enhance methods of informing members of the importance of IHA and preventive screenings. 2) Collaborate with delegation oversight to improve IHA compliance by Health Network. 3) Provider and HN education to support new member screening for SDOH screening within 120 days.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Katie Balderas	Anna Safari/Stephanie Johnson	Equity and Community Health	1) Member communication: •New member text message campaign went live in December 2024 and is sent monthly. •Interactive Voice Response (IVR) campaign goes out to new members twice monthly. 2) Delegation Oversight (DO) Collaboration for HN Compliance Improvement: •ECH & DO Internal Stakeholder Collaborative Meetings: Provider relations and customer service to	1) For April and May 2025, text message campaign member engagement and response rates were both at approximately 10%. 2) N/A; In progress. 3) N/A; In progress.	Presentations: •PHMC 5/15/25 •CLCHC CalOptima Health Quality Meeting: 5/20/25, 6/17/25 •CHCN Virtual Meeting:6/26/25 •DOC Meetings: 5/28/25, 6/24/25 •JOMs: 4/28/25, 5/8/25,6/17/25 •Quality Update Meetings: 5/1/25, 5/6/25, 5/7/25, 5/20/25, 5/22/25 (2), 6/3/25, 6/17/25 •Ad Hoc Meeting with Providence for IHA Onboarding: 6/23/25 •Delegate Health Network Dashboard Monitoring -BU Workgroup: 5/8/25, 7/8/25	N/A	1) Member communication: •Continue with existing member outreach efforts 2) DO Collaboration for HN compliance improvement •Steven Chin, Sr. Director, Provider Relations, to review current IHA interventions and explore best practices to improve the HN IHA completion rate 3) Provider/ HN education Continue educating and supportin	On Target

QAC 03.19.2026

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										review auto-assignment policies and discuss reducing the timeframe for members to be assigned to HN • ECH participation in the monthly Delegation Oversight Committee (DOC) meetings and Delegate Health Network Dashboard Monitoring Workgroup •ECH participates in DO's monthly Delegate Health Network Dashboard Monitoring -Business Unit Workgroup (listed in Column Q) •ECH provides an				g HNs and Providers with IHA requirements through various presentations. IHA CME scheduled for 8/6/25.	

QAC 03.19.2026

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										IHA data monitoring slide to DO monthly for the DOC 3) Provider/HN Education: ECH presented IHA updates at 18 meetings in Q2, listed in Column Q					

QAC 03.19.2026

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56	Quality of Service: Member Experience		Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal OC: One Star Improvement MC: One Star Improvement	Assess and report on the following activities: 1) JIT: Conduct outreach to members in advance of 2025 CAHPS survey (Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively). 2) Launch 8 Listening Post campaigns via two-way Ushur SMS and provide year-round service recovery in collaboration with multiple departments. 3) Launch a recurring meeting series with Health Network partners dedicated to member experience improvement strategy. 4) Propose mapping of member	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025	Vacant	Carol Matthews/Helen Syn	Quality Analytics	1. Closed 2. 2/8 listenting posts active 3. Health Network meetings pending receipt of CAHPS results. 4. Mapping of CAHPS categories is in process. 5. Internal training to CalOptima staff about the DPI platform.	1. 2025 HN CAHPS performance varies for member experience. 2. GARS data difficult to map to one CAHPS meausure for voice of member.	1. Medi-Cal calls were completed in April. 2. Listening posts implementation updates: medication fill within the last month (4/16/2025) and post office visit visit (4/16/2025 and 6/11/2025) 3. HN meetings will be held in Q3 to discuss individual MC HN CAHPS results. 4. Behavioral health categories and GARS data being mapped to CAHPS 5. Training session held July 9.	Lack of time and staffing resources.	Continue with plan as listed.	At Risk

QAC 03.19.2026

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					responses to CAHPS categories in support of the organization adopting a Voice of Member reporting system. 5) Train member-facing roles to the Decision Point Insights platform to review and address CAHPS risk during member discussions.										

QAC 03.19.2026

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
57	Quality of Service: Member Experience		Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process and report key findings and/or activities, analyze barriers, and improvement efforts. Maintain the grievance and appeals and resolution process while meeting all regulatory requirements for timely processing of appeals and grievances at a target goal of 95%.	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs. Improve process of handling member and provider grievance and appeals Identify trends in grievances quarterly to address member needs and systemic issues within the Plan. Utilize feedback provided in our quarterly GARS Committee Meetings to improve overall member experience and plan operations.	Report progress to GARS Q1 03/11/2025 Q2: 05/13/2025 Q3 08/12/2025 Q4 11/13/2025 Q1: 02/10/2026	Heather Sedillo	Ismael Bustamante	GARS	1) MC and OC grievances resolved timely 2) MC and OC grievances resolved timely	Grievances: Provider/Staff Attitude related to access for appointments and telephone accesibility. Appeals: Acess to specialty care.	1) Tracking and trending of specific providers quarter over quarter.	No specific barriers identified.	1) Tracking and trending of specific providers quarter over quarter.	On Target

QAC 03.19.2026

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58	Quality of Service: Member Experience		Customer Service Call Center	Implement customer service process and monitor against the following standards: OC Call Center Abandonment Rate 5% or lower OC Call Center Average Speed of Answer 2 minutes or lower MC Call Center Average Speed of Answer 10 minutes or lower Report key findings and/or activities, analyze barriers, and improvement efforts.	Track and trend customer service call center data Comply with regulatory standards Improve process for handling customer service calls	Report progress to QIHEC Q1: 01/14/2025 Report to MemX Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025	Andrew Tse	Mike Erbe	Customer Service	OneCare Call Center Abandonment Rate: 2.4% OneCare Call Center Average Speed of Answer: 24 seconds Medi-Cal Call Center Average Speed of Answer: 1 minute and 34 seconds		Hired additional staff, collaborate with various departments to stagger their member engagement campaigns, leveraging call back capabilities for inbound calling members opting in.	None noted.	Continue with plan as listed	On Target
59	Safety of Clinical Care		Plan All Cause Readmission	Plan All-Cause Readmissions 18-64 (PCR) MC: Decrease from 0.8983 to 0.8937 by 12/31/2025. OC: Decrease from 10.00% to 8.00% by 12/31/2025.	1. Review of ambulatory Follow up within 7 days of DC for HN and discharging facilities. 2.. Provider education for E/M's post discharge appt's within 7 days: 99495 and 99496. 3. Collaborate with other departments	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Michelle Evans	None	Case Management	1st Qtr: MC 1.1440 OC: 15.91% 2nd Qtr: MC Pending data OC: not avail yet-MY2025 Current performance with Data processed through April 2025 is 2 stars. Decrease	MC readmission rates trending upward. OC readmission rate trending down from 17.88% Q4 2024	1) Readmission best practices shared with HN and Facility JOM's 2)Review of ambulatory Follow up within 7 days of DC for HN and discharging facilities. 3)Creating education for 99495 and 99496-TCS codes post	Member engagement; Limited visibility into readmission details - manual readmission audits	**Continue planned activities** 1) Sharing readmission best practices with HN, Facility JOM's, SNF qtrly meetings 2) Sharing TCS flyer and OC PCC flyers for	Concern

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QAC 03.19.2026

Back to Agenda Back to Item

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
					(UM/CM/TCS) for targeted outreach for member outreach					from 3 stars in March 2025		discharge- higher reimbursement for providers 4) Point Click Care- PAC module added for OneCare- access to Continuing care document, Vital sign, progress notes at SNF partners 5) Impacting readmission and Discharge planning tipsshared at Qtlry SNF meeting and Discharge 6) Shared OC PCC contact flyer for all HN		HN for increased awarenes s how to contact with HN/Facilit y JOM's, SNF qtrly meetings. 3) Provide education for 99495 and 99496 when created with HN/Facilit y JOM's supportin g follow-up after Discharge . 4) Review MC and OC readmissi ons with high risk workgrou p-identify opportunit ies	

QAC 03.19.2026

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60	Safety of Clinical Care		Emergency Department Member Support	Launch the Emergency Department (ED) Program in 2025 and track utilization of services and report key findings and/or activities, analyze barriers, and improvement efforts.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Supports Referrals 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Report to UMC Q1: 02/20/2025 Q2: 05/22/2025 Q3: 08/21/2025 Q4: 11/20/2025	Michelle Evans	None	Long Term Support Services	Member engagement shows qtrly improvement. 1st Qtr: 9 members engagement. 2nd Qtr: 101 members engaged with 28 in delegated networks.Successful communication with Member HN with member outreach (27% of members from delegated networks)	Increased member engagement from from first Qtr.	1) Continue onsite activities 2) Weekly workgroup identify trends/opportunities/barriers 3) Program enhancements supporting increased member engagement 4) Warm Handoff to delegated HN/CM/TCS/ECM providers 5) Member resources and referrals (CalAim, housing, TCS, CM)	Decreased engagement from Facility Staff	**Continue planned activities** 1) Weekly onsite resources provided to UCI ED team 2) Continue onsite activities 3) Evaluate Assessement in Jiva as reporting enhancement and workflow enhancement 4) Continue refining workflows and processes 5) Expand into additional ED for support to mitigate barriers from ED discharge	On Target

QAC 03.19.2026

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61	Safety of Clinical Care		Transitional Care Services (TCS)	UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% by end of December 31,2025. [New goal will be established Q1 2025]	1) Use of Ushur platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High-Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting. 5) Successful outreach with TCS members within 7 days of outreach.	Report to UMC Q2: 05/22/2025 Q3: 08/21/2025 Q4: 11/20/2025	Michelle Evans	Mimi Cheung	Utilization Management	Internal audit results of total volume of cases and successful outreach w/in 7 days: 1st Qtr audit with 60.69% successful outreach within 7 days. 2nd Qtr audit with 68.27% successful outreach within 7 days.	Results of random sample audit completed monthly showed a 7.58% improvement from first quarter.	1) ContinueTCS Texting campaign. 2) Established TCS phone audit log to capture any missed opportunities to outreach to members 3) Designated staff for TCS maternal health outreach 4) Promotion TCS services at Facility/Hospital JOM's & SNF facilities quarterly meetings. 5) IT support for Jiva Report	Manual audit for successful outreach within 7 days-pending Jiva report.	**Continue planned activities** 1) Usher Text TCS discharge text: Developing a quarterly TCS Ushur report. 2) Continue random sample audits and update KPI report for oversight and monitoring and to address manual audit barrier. 3) Developing Jiva reports for TCS. 4) Continue updating workflows and processes 5) Continue the promotion of TCS	On Target

QAC 03.19.2026

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														services at the facility and HN JOMs.	
62	Cultural and Linguistic Appropriate Services		Language Services: Cultural and Linguistics and Language Accessibility	Implement interpreter and translation services and report key findings and/or activities, analyze barriers, and improvement. For translation services, by August 1st, 2025, CalOptima Health will expand the threshold languages to include Russian to meet requirements established by the California Department of Health Care Services (DHCS).	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards, including Member Material requirements Launch Russian as new threshold language.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	During Quarter 2 of 2025, Cultural and Linguistic Services continued to provide interpreter and translation services for members. The utilization data of interpretations and translations were analyzed, tracked and trended, identified and adjusted when	During Q2 Cultural and Linguistic Services continued to provide interpreter and translation services for members, which experienced an increase in translation and interpreter requests from members.	Throughout Quarter 2, all Member Material were translated accurately and on time to comply with regulatory standards.	Barriers previously identified in Quarter 4 for interpreter services were the shortage/lack of interpreters in various languages such as Khmer/ Cambodian. However, C&L vendors have onboarded more Khmer/	Cultural and Linguistic Services will continued to provide interpreter and translation services for members.	On Target

QAC 03.19.2026

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										necessary to ensure members received timely and adequate interpreter and translation services. The following is the data for Telephonic and Face-to-Face interpreter requests for Quarter 2 of 2025: • Quarter 2 – 22,759 Telephonic interpreter requests • Quarter 2 – 4,020 Face-to-Face interpreter requests To follow is the translation total for Quarter 2 of 2025: • Quarter 2 – 4,320 Translations			Cambodian interpreters to support this language.		

QAC 03.19.2026

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63	Cultural and Linguistic Appropriate Services		Network Cultural Responsiveness: Data Collection on Member Demographic Information	By Dec. 31st, 2025, CalOptima Health will increase the collection of sexual orientation gender identify (SOGI) data by 10% through focused outreach and education, ensuring better representation and inclusion of members.	1) Field a survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age). 2) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks. 3) Develop and implement a survey via the Member Portal, mail to new members and other methods. 4) Share member demographic information with practitioners.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	1) Conducted a mailing of 186,000+ existing members 18+ years of age yielded low response. • The mailing resulted in a 1.2% response rate, as of July 15th, we have received 2,245 surveys as a result of the mailing. 2) In May 2025, began offering survey to members during the in-person New Member Orientation meetings. • Response rate is 13% (7 responses of 56 surveys offered).	1) Response rate continues to be low. • Our overall response rate, based on members surveyed, decreased from 5% to 2.8% due to the low response rate from the mailing. • Our average number of mailing surveys to new members is about 10,000 per month and our average return is 490 so about 5% return rate. • Staff reported members were reluctant to complete the survey due to the type of questions.	1) Conducted a mailing of 186,000+ existing members 18+ years of age yielded low response 2) In May 2025, began offering survey to members during the in-person New Member Orientation meetings.	Members reluctant to respond e to the survey.Feedback from staff conducting the New Member Orientations is that members are hesitant to complete the survey stating they do not wish to share this information and possibly and indictation on the reason for the low response rate from the mailing activities.	Continue to monitor and track the collection of all member demographic data and continue to explore additional methods of collection.	Concern

QAC 03.19.2026

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64	Cultural and Linguistic Appropriate Services		Network Cultural Responsiveness: Data Collection on Practitioner Demographic Information	By Dec. 31st, 2025, CalOptima Health will increase the collection of race/ethnicity/languages (REL) data by 10% through focused outreach and education, ensuring better representation and inclusion of providers.	1) Add REL questions to routine forms, including credentialing, provider relations LOI, and provider demographic forms. 2) Enter REL data into the provider data system to ensure it can be retrieved and used for CLAS improvement. 3) Share data on the provider network's capacity to meet the language needs of CalOptima Health members. 4) Assess the provider network's ability to meet CalOptima Health's culturally diverse member needs. 5) Collaborate with other CalOptima Health departments to share SOGI data with	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Quynh Nguyen	Linda Huynh	Provider Data Management Services	REL data collection is embedded in standard workflows (ACT, LOI, credentialing). No measurable increase in REL data was noted for Q2 because most providers do not submit this information.	No significant increase in REL data was observed in Q2. The 10% goal is an ambitious benchmark, and provider participation remains voluntary. Progress continues through the integration of REL fields into standard workflows, and tracking mechanisms are in place to support ongoing improvement. Continued outreach and education efforts are expected to help drive gradual increases over time.	Standard forms continue to include REL fields. Developed trending report to track provider to member ratio.	Provider submission of race/ethnicity and language fluency data remains voluntary, this limits the completeness of demographic data collection.	1. Implement outreach and reminders to Providers to encourage REL submission. 2. Continue to track response rates.	Concern

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QAC 03.19.2026

Back to Agenda

Back to Item

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					Health Networks.										

QAC 03.19.2026

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65	Cultural and Linguistic Appropriate Services		Experience with Language Services	Evaluate language services experience from member and staff by implementing at language services survey to member and staff by March 31, 2025. By Dec. 31st, 2025, CalOptima Health will evaluate language services experience by collecting feedback from at least 10% of members and 80% of staff using surveys and will analyze the results to identify improvements to language services.	Goal not met. Continue to assess and report the following activities: 1) Develop and implement a survey to evaluate the effectiveness related to cultural and linguistic services. 2) Analyze data and identify opportunities for improvement.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	Cultural and Linguistic Services drafted and initiated a Staff and a Member survey to evaluate language services experience from member and staff. The Staff survey resulted in an overall total of 72 responses from CalOptima Health staff. The responses were positive, with only 3 un-favorable responses. CalOptima Health mailed 32,480 member surveys to members via U.S. mail. As of June 30, 2025, we received 1,878	• The Staff survey resulted in an overall total of 72 responses from CalOptima Health staff. The responses were positive responses, with only 3 un-favorable responses. • Out of the 32,480 member surveys mailed to members via U.S. mail, we received 1,878 completed surveys from members. C&L staff are currently logging in the surveys and translating some of the responses to assess the satisfaction	• Some of the responses from members are in other CalOptima Health threshold languages and need to be translated to assess the satisfaction level of the members.	Lack of response to the member surveys.	Will re-evaluate to determine if an additional survey should be mailed to members in the 3rd or 4th quarter.	On Target

QAC 05.19.2026

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
										completed surveys from members. C&L staff are currently logging in the surveys and translating some of the responses to assess the satisfaction level of the members. The target completion date to have a full report/detailed analysis of both the Staff and Member surveys is set for July 24, 2025.	level of the members.				

QAC 03.19.2026

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66	Cultural and Linguistic Appropriate Services		Network Cultural Responsiveness: Diversity, Equity and Inclusion Training	By Dec. 31st, 2025, CalOptima Health will implement and train 90% of staff, health networks, and providers on Diversity, Equity and Inclusion (DEI) training, ensuring compliance with DHCS All Plan Letter (APL) 24-016.	1. Develop a DEI Training and launch training by July 31, 2025	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Michaell Rose	Greta Rice/Adriana Ramos	HR and Provider Relations	No new updates	N/A	N/A	Per the CalOptima Health legal team – CalOptima is a Federal Contractor. We are reviewing our requirements under state and federal law	Per the CalOptima Health legal team – CalOptima is a Federal Contractor. We are reviewing our requirements under state and federal law	On Target

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QAC 03.19.2026

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
1	Program Oversight		2025 Quality Improvement Health Equity and Transformation Program (QIHETP) Description and Annual Work Plan	Obtain Board Approval of 2025 QIHETP Description and Workplan by April 30, 2025	QIHETP Description and Annual Work Plan will be adopted on an annual basis; QIHEC-QAC-BOD Development of the QIHETP Work Plan will include a review of the following: 1. Comprehensive Quality Strategy Report 2. Technical Report 3. Health Disparities Report 4. Preventive Services Report 5. Focus Studies 6. Encounter Data Validation Report	QIHEC: 01/14/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Quality Improvement	Program Specialist of Quality Improvement	Quality Improvement	N/A	N/A	N/A	N/A	N/A	Goal met
2	Program Oversight		2024 QIHETP Description and Work Plan Evaluation	Complete Evaluation of the 2024 QIHETP Description and Work Plan by April 30, 2025	2024 QIHETP Description and Work Plan will be evaluated for effectiveness on an annual basis; QIHEC-QAC-BOD. 2025 QIHETP Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	QIHEC: 02/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Quality Improvement	Program Specialist of Quality Improvement	Quality Improvement	N/A	N/A	N/A	N/A	N/A	Goal met

QAC 03.19.2026

2025 QIHETP Appendix A – 2025 QIHETP Work Plan
10/30/2025

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Back to Agenda

Back to Item

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
3	Program Oversight		2025 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2025 Integrated UM and CM Program Description by April 30, 2025	Integrated UM and CM Program will be adopted on an annual basis; UMC-QIHEC-QAC-BOD	UMC: 01/23/2025 QIHEC: 2/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Executive Director of Clinical Operations	Director of Utilization Management	Medical Management/ Utilization Management	N/A	N/A	None	N/A	N/A	Goal met
4	Program Oversight		2024 Integrated UM CM Program Evaluation	Complete Evaluation of 2024 Integrated UM CM Program Description by April 30, 2025	Integrated UM CM Program Description will be evaluated for effectiveness on an annual basis; UMC-QIHEC-QAC-BOD 2025 UM CM Program Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	UMC: 01/23/2025 QIHEC: 2/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Executive Director of Clinical Operations/Director Case Management	Director of Utilization Management	Medical Management/ Utilization Management	N/A	N/A	None	N/A	N/A	Goal met
5	Program Oversight	PHM	2025 Population Health Management (PHM) Strategy and PHM Work Plan	Obtain Board Approval of 2025 PHM Strategy and PHM Work Plan by April 30, 2025	PHM Strategy will be adopted on an annual basis; PHMC-QIHEC-QAC-BOD	QIHEC: 01/14/2025 PHMC: 02/20/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director Case Management	Program Manager Case Management	Case Management	N/A	N/A	N/A	N/A	N/A	Goal met

QAC 03.19.2026

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6	Program Oversight	PHM	2024 PHM Strategy Evaluation	Complete the Evaluation of the 2024 PHM Strategy by April 30, 2025	PHM Strategy will be evaluated for effectiveness on an annual basis (PHMC-QIHEC-QAC-BOD) and will include the following: 1. Develop collaborative evaluation process 2. Facilitate development of the evaluation process 3. Produce evaluation 4. Present evaluation to the appropriate governing committees 2025 PHM Strategy Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	QIHEC: 02/11/2025 PHMC: 02/20/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director Case Management	Program Manager Case Management	Case Management	N/A	N/A	N/A	N/A	N/A	Goal met
7	Program Oversight	CLAS	2025 Cultural and Linguistic Accessibility Services (CLAS) Program	Obtain Board Approval of 2025 CLAS Program by April 30, 2025	CLAS Program will be adopted on an annual basis; QIHEC-QAC-BOD	QIHEC: 01/14/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Customer Service	Manager of Cultural and Linguistics	Customer Service/Cultural and Linguistic Services	N/A	N/A	N/A	N/A	N/A	Goal met

QAC 03.19.2026

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8	Program Oversight	CLAS	2024 CLAS Program Evaluation	Complete the Evaluation of the 2024 CLAS Program by April 30, 2025	The CLAS Program will be evaluated for effectiveness on an annual basis; QIHEC-QAC-BOD 2025 CLAS Program Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	QIHEC: 02/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Customer Service	Manager of Cultural and Linguistics	Customer Service/Cultural and Linguistic Services	N/A	N/A	N/A	N/A	N/A	Goal met
9	Program Oversight	PHM	Population Health Management Committee (PHMC) - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Workplan progress and outcomes. 2. Provide overall direction for the continuous improvement process and oversee that activities are consistent with CalOptima Health's PHM strategic goals and priorities. 3. Facilitate quarterly	PHMC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/9/2025 Q4 12/9/2025	Director Case Management	Program Manager Case Management	Case Management	PHM Committee met on 8/21/25. Minutes from 5/15/25 were approved with corrections. Q3 PHMC updates included the Member and Population Health Needs Assessment, First 5 OC's early childhood initiatives, and CalOptima's Disease Management program. Quality measure	QIHEC accepted the PHMC update without further questions or feedback.	N/A	N/A	Effective October 2025, CalOptima Health has officially retired the Population Health Management Committee (PHMC) to better align population health efforts within Clinical Operations and the Quality Improvement & Health Equity Committee (QIHEC), aiming to	Goal met

QAC 03.19.2026

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					meetings 4. Report PHMC activities to the QIHEC quarterly.					performance for CBP, diabetes, osteoporosis, and ED follow-up were reviewed. Consent items were approved. PHMC updates were presented at QIHEC on September 9, 2025.				streamline reporting, maintain oversight, and enhance strategic integration.	
10	Program Oversight		Credentialing Peer Review Committee (CPRC) Oversight - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review to ensure quality of care delivered to members	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. 2. Committee	CPRC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Manager of Quality Improvement	Manager of Quality Improvement	Quality Improvement	The CPRC met on 06/26/2025, 07/24/2025, and 08/28/2025 and reported an update on activities to QIHEC in September. On 07/24/2025, there was a CPRC Closed Session meeting for the physicians of CPRC to meet with a physician as part of the Fair	The number of PQIs presented remained stable. The number recredentialed providers with issues remained stable, but the number initial credentials with issue was higher than previous quarters. In PQI trends for Jan-Jun 2025 the number of ABA	PQI implementted changes to reduce the PQI backlog including changes to policy GG.1611. Credentialing implemented plans to reduce it's backlog between 2/2025-6/2025 with an OT Backlog Project, which was successfull. Credentialing also hired a new Director of Credentialing, effective 8/2025.	Need to have a new Ob/Gyn physician added to the Committee since an Ob/Gyn was removed from the Committee last year due to his retirement.	The physicians undergoing Fair Hearing will continue through the process. Those under Probation will be monitored per the conditions of probation. A new Provider Life-Cycle system for credentialing	Goal met

QAC 03.19.2026

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					meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.					Hearing process. Two physicians (Ob/Gyn and NS) continued under the Fair Hearing process. One physician (PM&R) was changed to Probation after meeting with him. Seven PQI cases were presented to CPRC for leveling and actions; three level 3, four level 2, no level 1.There were four physicians with issues presented for re-credentialing; all were approved for recredentialing. Eleven providers presented for initial credentialin	groups was significantly higher than previous years. Credentialing trend still shows a large volume of initial credentialing files requests being received. Actions related to the grievance data were referred to the Provider Action Workgroup. FSRMRR/PARs had no feedback or findings from QIHEC.			implementation has been deferred to 2026.	

QAC 03.19.2026

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										g all for the CCN network. All were recommended for credentialing except for one nurse practitioner who we did not credential. PQI trends for Jan-Jun 2025 were reported which showed 16 ABA groups, 1 practitioner and 6 OPs. No action was taken. The greatest category of PQIs was medical care. The PQI backlog was reduced from 723 in 7/24 to 363 in 7/25. Credentialing statistics were presented which showed					

QAC 03.19.2026

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										that 760 providers were credentialed in Q3; No recreds were > 180 days. On-going monitoring was presented for 6 providers. The following policies were presented and approved: GG.1633 and GG.1643. The credentialing clean lists and closure lists, and the PQI closure lists were presented monthly. In August, practitioner grievance data was presented for those with 15 or more grievances in 6 months					

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										and 5x the rate of their specialty. FSR/MRR/ PARS:Presented update on the Q1 2025 Compliance Report for Facility Site Review, Medical Record Review, and Physical Accessibility Review at the 9/9/25 QIHEC meeting					
11	Program Oversight		Grievance and Appeals Resolution Services (GARS) Committee - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health networks. 2. Trends and results are presented by	GARS Committee Report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Associate Director of Grievance and Appeals	Manager of Grievance and Appeals	GARS	Committee met on 8/12/2025. Meeting minutes from the 5/23/2025 committee meeting were approved on 8/27/2025. Q1 volume updates, trends and remediations were provided for grievances,	Compliance was met for all areas, no additional findings to report.	Continue as planned.	Access issues identified in both member grievances and appeals data.	Continue to work with internal departments to remediate the member access issues.	On Target

QAC 03.19.2026

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					product time to the committee quarterly. 3. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.					member and provider appeals and PDR's.					
12	Program Oversight		Member Experience (MEMX) Committee Oversight - Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. The MEMX Committee reviews the annual results of CalOptima Health's CAHPS surveys, monitors the provider network including access and availability (CCN and the HNs), reviews customer service metrics and evaluates complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members. 2. Committee meets at least quarterly, maintains and	MemX Committee report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Project Manager Quality Analytics / Manage of Quality Analytics	Quality Analytics	Committee met on 7/15/25. Meeting minutes from the 4/15/2025 meeting were approved. Updates presented include network certification, subcontracted network certification, network adequacy, timely access, UM and CAHPS results for Medi-Cal adult and child plan and health network results and OC plan	QIHEC accepted the MemX update without further questions or feedback.	Continue as planned.	Members are challenged by access issues.	Identification of alternative access for members.	On Target

QAC 03.19.2026

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					approve minutes, and reports to the QIHEC quarterly.					interim results were reviewed. MemX update was provided to QIHEC on 9/9/2025.					
13	Program Oversight		Utilization Management Committee (UMC) Oversight - Conduct internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. UMC reviews medical necessity, cost-effectiveness of care and services, reviews utilization patterns, monitors over/under-utilization, and reviews inter-rater reliability results. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	UMC Committee report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Executive Director of Clinical Operations/Director Case Management	Director of Utilization Management	Utilization Management	The UMC met on 8/21/2025 and reviewed medical necessity, cost effectiveness of care, utilization patterns, operational performance, workgroup activities, sub-committee outcomes, and Policy and Procedure updates. Summary of UMC was presented overview to QIHEC on 9/9/2025.	Medi-Cal demonstrated a downward trend in admits, days, ALOS, and readmit in Q1 for all aid categories. OneCare showed upward trend in admits & downward trend in days, ALOS & readmits. WCM showed upward trend in admits, days & ALOS and a downward trend in readmits. No significant change in ED	Continue to monitor, track and trend utilization.	None	Continue with plan as defined for 2025	On Target

QAC 03.19.2026

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											utilization across all groups. Operational performance within 97.7%-99.9% across all programs.				
14	Program Oversight		Whole Child Model - Clinical Advisory Committee (WCM CAC)- Ensures clinical and behavior health services for eligible children with California Children Services (CCS) are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee key findings/updates, activities, and recommendations to QIHEC.3.	Conduct and report on the following activities: 1. WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. 3. Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	WCM CAC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Medical Director of Whole Child Model / Director of Case Management	Program Specialist of Quality Improvement	Medical Management	WCM CAC met 8/12/2025. Approved May 20, 2025, meeting minutes. Discussed clinical and Behavioral Health services for CCS members with WCM CAC committee members.	Presented follow up on 1) Autism Program: CHOC Thompson Autism Center Program was presented along with the ongoing Thompson Autism And Neurodevelopmental Center SBHIP Autism Comprehensive Care Pilot Program. 2) WCM HN	Committee members were invited to submit specific data requests for a future ECM presentation. CHOC Thompson Autism Center Program PowerPoint was requested, received and distributed to committee members.	Limited Pilot slot availability.	Next meeting is scheduled for November 18, 2025. With the sunset of PHMC, anticipate that EPSDT (see TOC #15) will be reported through WCM CAC.	On Target

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											Specialist Access: Pediatric new contract exploration in progress. 3) ECM Data: 4) Auth Requirements for Pediatric Rx: No major issues; supply limits under review				
15	Program Oversight	PHM	Care Management (CM) Program	Report on key activities of CM program, analyze CM data compared to goal, and improvement efforts.	Report on the following activities: 1. Basic PHM/CM 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Medical Management (Case Management)/Director of Case Management	Quality Improvement Nurse	Medical Management	Report on the following activities: 1. Basic PHM/CM: Continue sharing Health Risk Assessments with Primary Care Physician. 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM	Interventions and activities were completed for the quarter.	1. Basic PHM/CM: Ongoing Health Risk Assessments are shared with Primary Care Physician. 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM: a. Continue meeting in workgroup and review necessary oversight of EPSDT services. b. Texting campaign	None	1. Basic PHM/CM: Ongoing Health Risk Assessments are shared with Primary Care Physician. 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM: a. Continue meeting	On Target

QAC 03.19.2026

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												launched to 32047 members overdue for vision, dental, and hearing screening and advising members on services. c. Ongoing monitoring with Utilization Management and each Health Network to review EPSDT d. Behavioral Health Integration review of depression and developmental screening codes for oversight needs.		in workgroup and review necessary oversight of PSDT services. b. Continue texting campaign launched to members overdue for vision, dental, and hearing screening . c. Ongoing monitoring with Utilization Management and each Health Network to review EPSDT 1)EPSDT Provider Training in Q4 d. Behavioral Health Integration review of depression and	

QAC 03.19.2026

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														developmental screening codes for oversight needs. 1)Behavioral Health and Enterprise Analytics working to develop automate dashboard to track screening codes.	
16	Program Oversight	PHM	Complex Case Management Program	Implement Complex Case Management Program and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: (1) Ensure provision of CCM services resulting in optimal care coordination as evidenced through monthly auditing of 5 files or 5% of files for each health network resulting in a minimum score of 90% through December 31, 2025. (2) Obtain 85% member satisfaction in CCM program by December 31st, 2025. (3) 85% of members surveyed who participated in CCM between January 1, 2024-December 31, 2025, will report that the case management process helped them meet their care plan goals.	Conduct and report on the following activities: 1. Continue training and educational opportunities to staff on the 2025 PHM5 Element D and E and complex conditions/situations (Goal 1) 2. Member Satisfaction scores will be shared with the CCN and the delegates to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care,	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Medical Management (Case Management)	Nurse Specialist of Utilization Management	Case Management	(1) 9 out of the 10 Health Networks achieved a score of 90% or higher (Goal 1). (2) A total of 44 members were surveyed. All questions from the member satisfaction survey met the 85% benchmark (Goal 2). (3) 44 of the members	Goal 1 did not meet for Q3 as one Health Networks did not achieve a score of 90% or higher. Goal 2 and 3 met for Q3.	1) Continue training and educational opportunities to staff on 2025 PHM Element D/E and complex conditions/situations. (Goal 1) a. Element D/E training for CCN on 8/19/2025 and 9/16/2025. 2) Member Satisfactions Survey (MSS) scores will be shared with CCN and the health networks to provide valuable insight to help identify	Goal 1: Staff training needed for Elements D and E.	Conduct and report on the following activities: 1. Continue training and educational opportunities to staff on the 2025 PHM5 Element D and E and complex conditions/situations (Goal 1). Planned training in December 2025. 2.	Concern

QAC 03.19.2026

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					member outcomes, and improve the member experience of CM programs (Goal 2) 3. Ongoing training and support for new and existing staff. (Goal 2) 4. Continue to gather member feedback to improve outcomes. (Goal 3) 5. Training and Education on member centric care plans. (Goal 3)					surveyed found the case management program helped them meet their care plan goals (Goal 3).		strengths and areas for improvement to enhance the quality of care, member outcomes, and improve the member experience of the CM programs. (Goal 2) a. MSS score shared during the Clinical Ops meeting with the Health Networks on 9/4/2025 and in the CCN CM department meeting on 9/17/2025. 3) Ongoing training and support for new and existing staff. (Goal 2) 4) Continue to gather feedback from MSS to improve outcomes. (Goal 2) a. Meeting held with QI Nurse and leadership on 7/15/2025 to discuss Q2 MSS results 5) Training and education on		Member Satisfaction scores will be shared with CCN and the health networks to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, and member outcomes, and improve the member experience in CM programs (Goal 2). Ongoing 3. Continue to gather feedback from MSS to improve outcomes. Plan quarterly meetings with	

QAC 03.19.2026

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												member centric care plans. (Goal 3) a. Motivational Interviewing Training provided to CCN on 9/3/2025 and 9/9/2025 to better engage and empower members to achieve their goals.		leadership to review MSS score, member feedback, and collaborate on strategies to improve the outcome (Goal 2). Ongoing 4. Ongoing training and support for new and existing staff (Goal 2). Ongoing 5. Training and Education on member centric care plans (Goal3). Planned training for Health Networks on SMART goals in	

QAC 03.19.2026

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														Q4 2025. Ongoing	
17	Program Oversight	PHM	Population Health Management (PHM) Strategy and Program	Implement initiatives for the 2025 PHM program starting January 1, 2025.	Conduct and report the following activities: 1. Population Needs Assessment (PNA) 2. Develop and implement a PHM Work Plan and includes the following: a. Risk stratification b. Screening and Assessment c. Wellness and prevention 3. Collect quarterly progress reports from PHM Work Plan implementation owners	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director Case Management	Program Manager Case Management	Medical Management/ Case Management	1. 2025 PNA was presented at the May 15, 2025 PHMC meeting and was approved; submitted 2025 PNA as NCQA accreditation evidence 2. Implementation of 2025 PHM work plan is in progress. Conducted review and analysis of Medi-Cal Connect, the new risk stratification and segmentation platform from DHCS. b) Screening and Assessment: January to April 2025 5.7% members with HIF/Met	Analysis of Medi-Cal Connect indicates a number of differences between CalOptima Health's current stratification and Medi-Cal Connect (DHCS' RSST), including significantly more members deemed High Risk. The most common domains leading to the high risk classification include Underutilization of health care services and adverse events. 2 b) Screening and Assessment: 50,703 Medi-Cal	In July 2025, CalOptima Health transitioned the PHM strategy and oversight from the Equity and Community Health department to Clinical Operations as part of a broader care continuum realignment, aiming to streamline member-facing operations, enhance regulatory alignment, and improve member outcomes through a more integrated and efficient structure. 2 b) Ongoing tracking of HIF/MET and HRA completion within 90 days of enrollment.	N/A	CalOptima will continue to implement Medi-Cal Connect throughout Q4 and 2026 to better identify members for outreach and interventions. 2 b) Continue Ongoing tracking of HIF/MET and HRA completionwithin 90 days of enrollment.	On Target

QAC 03.19.2026

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										returned and/or HRA/HNA completed. c) Health and wellness services continue to support members across the care continuum 3. Quarterly 2025 PHM work plan monitoring is in progress.	enrollees from January to April 2025. 2,892 unique members HIF/MET returned within 90 days of enrollment and/or HRA/HNA's completed within 90 days of enrollment.				
18	Program Oversight	PHM	Disease Management Program	Implement 2025 Disease Management Program and report key findings and/or activities, analyze barriers, and improvement efforts and meet the following goal: 1. By December 31, 2025, 85% of members who participate in Disease Management program from January 1 – December 31, 2025 will report satisfaction	Conduct and report on the following activities: 1. Evaluation of current utilization of disease management services 2. Enhance identification of gaps in care to better promote quality care across all Disease Management interventions. 3. Use multimodal methods of outreach to identify	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director Case Management	Case Management	Case Management/ Medical Management	1. Two-Way Text Campaign: 4,361 diabetes members and 3,358 asthma members were contacted through two-way text messages, inviting them to opt-in to health coaching services. 2. In July 2025, CalOptima	1. Q3 outreach numbers for the two-way text message campaign were lower than Q2 due to the removal of duplicate members from the outreach list as part of a data quality improvement; additionally, member response rates	1. DM leadership approved reverting to the original outreach campaign workflow to improve member opt-in rates for health coaching interventions. 2. Tested the 'Tableau: Member List for Member Risk Dashboard' to identify high-risk members with diabetes and elevated A1c levels for	Current barriers include fragmented information that leaves Health Coaches hunting across multiple systems for accurate information. Member assessments are overly	The updated stratification list will consolidate relevant information into a single source, prioritize outreach to the highest-risk members, support the identification of care gaps, streamline and eliminate	On Target

QAC 03.19.2026

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					members in need of Disease Management services and reduce cold calls. 4. Integrate new methods to measure and improve member satisfaction.					Health transitioned the Disease Management program from the Equity and Community Health department to Clinical Operations as part of a broader care continuum realignment, aiming to streamline disease management operations into care management and improve member outcomes through a more integrated and efficient structure. Stratification to be reviewed and updated as part of this transition. 3. Disease Management	declined following a workflow update. 2. Stratification criteria for Disease Management are currently under review in alignment with the ongoing restructuring of the care continuum. 3. 96% of members report satisfaction with the coaching program, indicating a strong positive response and perceived value among participants based on comments.	targeted coaching interventions.	lengthy, and the generated care plans must be manually updated by staff due to the system not being configured to support Disease Management workflows, resulting in limited value for members.	the need for an extensive care planning process.	

QAC 03.19.2026

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										Satisfaction Survey: survey is text-based and delivered to members via text after follow-up session.					
19	Program Oversight	PHM	Health Education	Implement interventions for the 2025 Health Education program and report key findings and/or activities, analyze barriers, and improvement efforts.- 2025 Health Education program focuses on promoting early detection, fostering healthy habits, and empowering members to be proactive with preventive care.	Conduct and report on the following activities: 1. Evaluation of current utilization of health education services 2. Enhance methods for outreaching, promoting, and enrolling members in Health Education services and classes (e.g. text message outreach, member self-referral, etc.) 3. Expand health education offerings in various community classes and events (e.g. clinic days, virtual and in-person classes, etc.) and tech-based modalities	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director Case Management	Director Medical Management	Case Management/ Medical Management	1. Q3 referrals for Health Education services totaled 1,551 which is slightly higher than Q2 at 1,536, but still higher than 2024 (1,448) and 2023 (1,242). 2. Member outreach and engagement continues in response to referrals received daily. Health Education classes as well as Zoom links for direct sign up were added to	1. Nutrition was overwhelmingly the number one requested topic at 41.6% followed by Weight Management at 16% and Diabetes at 14.2%. Health Educators were assigned 447 referrals, accounting for 28.8%. 182 were referred to Health Coaches (11.7%), 657 were referred to RD (42.3%) and 149 to the Maternity Program	To support HEDIS gaps in care, two interventions were implemented in Q3. In July, the team hosted a Mammogram event at Southland Integrated Services FQHC where 27 members completed a mammogram and 18 completed cervical cancer screening. Additionally in September, outreach calls were initiated to non-compliant OC members for glycemic status and/or blood pressure control. This intervention will conclude at the end of October.	In person attendance and utilization of services at established community centers and schools were heavily impacted by recent political events, leading to the cancelation of 3 Shape Your Life family and children series intended to start in Q3.	Request data for two text message campaigns 1. Newly diagnosed members with hypertension in the past year, with an unfilled prescription for hypertensive medication. The virtual hypertension class link for direct sign up will be sent for English and Spanish speakers. 2. A second text	On Target

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Back to Agenda Back to Item

QAC 03.19.2026

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					(app/web-based services).					the external website Events section and shared broadly. Telephonic coaching, mailing, email and virtual classes continue to be offered and advertised with community partners and agencies. 3. Due to restructuring of the Health Education, Health Coach, Registered Dietitian and Maternity Program to Case Management department, planned in-person health education offerings for Q3 and Q4 at community	(14.9%) based on preestablished triage criteria. 3. Adult virtual classes were implemented in Q2 and attendance is growing steadily from 49 in Q2 to 40 in Q3. While community requests for in-person classes were desired, participation at regularly scheduled events were largely impacted by recent political events and engagement dropped drastically, so planned classes were canceled.		Additionally with the restructuring of staff roles and responsibilities within the Case Management department, in person classes and presentations were paused for the remainder of the year.	message campaign will launch satisfaction surveys after group class attendance or after individual coaching sessions with a health educator. Additional strategies for text message campaigns are being evaluated for higher engagement.	

QAC 03.19.2026

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										events were canceled in July.					
20	Program Oversight	PHM	CalAIM Community Supports and Enhance Care Management (ECM)	Implement CalAIM and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: 1.) By March 31, 2026, enhance community support services (e.g., housing transition navigation services, housing deposits, and housing tenancy and sustaining services) to achieve optimal care coordination, as demonstrated by auditing the performance of 10 providers. 2.) Increase number of members authorized for ECM services by 10%, from 2,500 to 2,842 by December 31, 2025.	Community Supports Activities: 1. Conduct housing transition navigation services audits. 2. Conduct housing deposits audits. 3. Conduct housing tenancy and sustaining services audits. ECM Activity: Track ECM outreach, authorizations and services.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Medi-Cal and CalAIM	Director of Medi-Cal and CalAIM	Medi-Cal and CalAIM	1.) Ontrack to start audit of housing transition navigation, housing deposits, and housing tenancy and sustaining services in January 2026. 2.) Currently we have 6,000 open authorizations for ECM	No findings to report.	Finalized the Housing Support Plan template. Presenting Housing Audit Tool to providers in October and will incorporate feedback before finalizing in mid-November.	None.	Use feedback from providers on implementation of the new housing audit templates to continue to refine and update those documents if necessary.	On Target

QAC 03.19.2026

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21	Program Oversight	PHM	Street Medicine Program	Implement Street Medicine Program and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: (1) By December 31, 2025, connect 80% of unhoused participating members to an active Primary Care Physician (PCP). (2) By December 31, 2025, connect 90% of unhoused participating members with CalAIM ECM and Housing Navigation. (3) By December 31, 2025, connect 20% of unhoused participating members to a shelter or other housing option.	Conduct and report on the following activities: Goal 1: ▪ Offer all members the opportunity to utilize the Street Medicine Provider as their PCP. ▪ Utilize Releases of Information when member has active PCP to increase collaboration and communication. ▪ Support member with PCP change, as needed. ▪ Care scheduling and delivery. Goal 2: ▪ Make attempts to engage with members weekly. ▪ Provide ECM and/or Housing Navigation appointments face to face at least every other week. ▪ Care scheduling and delivery. ▪ Document all encounters. Goal 3:	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director, CalAIM Community Outreach	None	Medi-Cal and CalAIM	By September 2025, 98% of unhoused members were enrolled in CalAIM Services. By September 2025, 94% of unhoused members were connected to a Primary Care Physician (PCP). By September 2025, 11% of unhoused members were permanently housed or matched into another housing option.	Goals 1 and 2 were met. Goal 3 is below expected target, but this expected as there is not enough affordable housing in Oange County. The teams will continue to work towards this goal.	Offer all members the opportunity to utilize the Street Medicine Provider as their PCP. ▪ Utilize Releases of Information when member has active PCP to increase collaboration and communication. ▪ Support member with PCP change, as needed. ▪ Care scheduling and delivery. Goal 2: ▪ Make attempts to engage with members weekly. ▪ Provide ECM and/or Housing Navigation appointments face to face at least every other week. ▪ Care scheduling and delivery. ▪ Document all encounters. Goal 3: ▪ Outreach to	While Goal 1 & 2 were met, affordable, permanent housing opportunities continue to be scarce.	Continue to offer street medicine services in the three identified service areas. Launch 4th Street Medicine Program in the city of Santa Ana in January 2026.	On Target

QAC 03.19.2026

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					▪ Outreach to and engage unsheltered individuals ▪ Provide ECM and/or Housing Navigation ▪ Enter members in to the Coordinated Entry System ▪ Connect individuals to local shelters ▪ Work with members on completing housing documentation							and engage unsheltered individuals ▪ Provide ECM and/or Housing Navigation ▪ Enter members in to the Coordinated Entry System ▪ Connect individuals to local shelters ▪ Work with members on completing housing documentation			

QAC 03.19.2026

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22	Program Oversight		Long-Term Support Services (LTSS)	Implement LTSS Program and meet the 95% compliance with the following TATs: (1) CalAIM Turnaround Time (TAT): Determination completed within 5 business days (2) CBAS Inquiry to Determination (TAT): Determination completed within 30 calendar days (3) CBAS Turnaround Time (TAT): Determination completed within 5 business days (4) LTC Turnaround Time (TAT): Determination completed within 5 business days	Assess and report the following activities: 1. Evaluation of current utilization of LTSS 2. Maintain business for current programs and support for community 3. Improve process of handling member and provider requests 4. Meet goal/TATs	Report to UMC Q1: 02/20/2025 Q2: 05/22/2025 Q3: 08/22/2025 Q4:11/20/2025	Director of Long Term Support Services	Manager of Long Term Support Services	Long Term Support Services	(1) CalAIM TAT = 99.37% (2) CBAS Inquiry to DeterminationTAT = 100% (3) CBAS TAT = 100% (4) LTC TAT = 99.34%	All LTSS TAT's met compliance requirements.	None	None	Continue to monitor workloads and compliance activity on a daily basis.	On Target
23	Program Oversight		Delegation Oversight	Implement annual oversight and performance monitoring for delegated activities and report key findings and/or activities, analyze barriers, and improvement efforts.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accreditation standard compliance that, at minimum, include comprehensive annual audits and corrective actions.	Report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/9/2025 Q4 12/9/2025	Director of Delegation Oversight	Manager of Delegation Oversight	Delegation Oversight	2025 Delegation Oversight Annual Audit (DOAA) completed for the following Health Networks: • HPN-Regal Medical Group (July 22, 2025) • AMVI Care Health Network/Prospect MSO (September 8, 2025)	Corrective Action Plan(s) Issued: HPN-Regal Medical Group - Credentialing (ALOB) – closed - Case Management (MC) – 1 finding/1 open - PDR (OC) – closed - UM (MC & OC) – 10 findings/8 open	Monitoring progress of CAPs issued for identified areas of non-compliance until closure	None	For all CAPs issued, Delegation Oversight conducts Focused Monitoring to document demonstrated compliance with the applicable identified issue(s) for three consecutive months until CAP is closed.	On Target

QAC 03.19.2026

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										• Prospect Medical Group/Prospect MSO (September 8, 2025) • United Care Medical Group/Prospect MSO (September 8, 2025) Areas Assessed in the DOAA process: • Case Management • Claims • Compliance • Credentialing • Customer Service • Provider Network Contracting • Provider Relations • Sub-Contractual •Utilization Management	AMVI Care Health Network/Prospect MSO - UM (MC & OC) – open (5 findings) Prospect Medical Group/Prospect MSO - UM (MC & OC) – open (10 findings) United Care Medical Group/Prospect MSO - UM (MC & OC) – open (17 findings)				

QAC 03.19.2026

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24	Program Oversight		National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan (HP) Accreditation and NCQA Health Equity (HE) Accreditation by January 1, 2026	1. Implement activities for NCQA Standards compliance for HP and HP Renewal Submission by April 6, 2027. 2. Implement activities for NCQA Standards compliance for Initial HE Accreditation Survey and submit requirement documents to NCQA by October 7, 2025.	1) By December 31, 2025 2) By October 7, 2025 Report program update to QIHEC Q1:01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/14/2025	Director Quality Improvement	Program Managers of Quality Improvement (NCQA)	Quality Improvement	1) Health Plan Accreditation: QI: The 2025 QI program is ready for submission ; Q1 and Q2 of the QI Work Plan have been completed, and the 2024 QI Eval is ready for submission . Under the 2026 HP Standards, NCQA revised QI3B.C: Demonstration Performance and Improving coordination of Care, and QI2C is the new BH Data Sharing arrangement. UM: NCQA released the 2026 HP Standards in Late August.	Health Equity and Health Plan accreditation document collections are currently underway, with look-back periods starting on April 6, 2025 (HPA) and April 7, 2025 (HEA). 1) HPA Accreditation: There are 6 domains (QI1A-QI4D), UM (UM1A-UM13D), NET (NET1A-NET6D), PHM (PHM1A-PHM7D), CR (CR1A-CR9D), MEM (ME1A-ME8D). NCQA Program Managers are collaborating with stakeholders to collect	1) Health Plan Accreditation: - Continue collecting documents due in 3Q2025. - QI/Consultants: Conducted CR training with our delegates on July 11, 2025. - Perform File Review audits to ensure compliance under current standards on (UM Denials, Complex Case Management, Credentialing, Appeals. - Work with Delegation oversight on the review and updates on all Annual Audit tools to ensure compliance on the delegated functions. 2) Health Equity Accreditation: - Continue to work with stakeholders to finalize a few open items. - Conduct a final review of all documents	We have a report that needs to be finalized before 10/7/2025. Currently working with Stakeholder to get the report finalized and approved by consultant.	1) Health Plan Accreditation (HPA): - Continue collecting documents required for Year One (April 2025 - April 2026). - Conduct 2026 Health Plan Standards training by end of 4Q2025. - Continue to submit year one documents for consultant review. - CalOptima to conduct Appeals and UM Pharmacy denials file review audit in October. - CalOptima will conduct file review	On Target

QAC 03.19.2026

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										There were a few new elements in the domain of Utilization Management.The NCQA Program Manager is currently revising the NCQA work plan to see if any changes are needed to our current documentation and/or new documents will be needed. Will be scheduling meetings with the impacted stakeholders to review newly added requirements. NET: Several reports are going through final revisions. PHM:	the necessary documents to fulfill year one of the look-back period, including reports, DTP and communications for both members and providers. We have several reports that need to be finalized by end of July. 2) HEA Accreditation: Health Equity Accreditation has seven domains (HE1-HE7). We have a few domains we are still working on with stakeholder(s) HE6 A, and C & D).	we will be submitting for HEA with the Director before submitting.		audits with CCN and HNs, on UM non-BH medical denials, UM pharmacy denials (HNs), complex case management, and credentialing by end of November 2) Health Equity Accreditation (HEA): - Close out any open deliverables before the October submission. - HEA submission is scheduled for October 7, 2025. The final review and document loading	

QAC 03.19.2026

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										Program Manager reviewed the 2026 PHM standards. Bookmarked 2026 standards. Created a document showing high level updates for PHM team. Met with and went over all 2026 HPA PHM standards with the PHM team. CR: Policies are being updated to align with upcoming 2026 HP Standards, Continuining to meet with Stakeholders to review and collect year one deliverables. MEM: Program Manager is reviewing 2026 HPA MEM				should be completed by the end of September 2025 - Submit IRT Submission on tool by deadline October 7, 2025.	

QAC 03.19.2026

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										standards. 2) Health Equity Accreditation: HE1-HE5: Ready for final review from QI Director and consultant prior to submission. HE6C/D:Report is being finalized; HE7:Delegation agreements, Annual Audit results are currently being prepared for the four selected delegates. Will need to go to consultant for final review.					

QAC 03.19.2026

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25	Program Oversight		Quality Performance Improvement: Managed Care Accountability Set (MCAS) OneCare STAR measures DHCS Quality Withhold Health Plan Accreditation (QI3) Health Plan Rating	Track and report quality performance measures required by regulators against the following goals: (1) Achieve 50th percentile MPL or above (2) Achieve 4 Stars or above (3) Achieve 100% of withhold (4) Achieve 3 or higher (5) Achieve 5.0	1. Track rates monthly 2. Share final results with QIHEC annually 3. Review and identify measures for focused improvement efforts after each monthly refresh	By December 2025 Report program update to QIHEC Q1: 01/14/2025 Q2: 05/13/2025 Q3: 07/08/2025 Q4: 11/04/2025	Director of Quality Analytics/Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	1. Prospective rate reports are generated monthly 2. The MY2025 reports are planned, the final results will be ready by the end of June 2026. 3. The Quality Analytics team reviews both the Medi-Cal and OneCare Stars prospective rate reports monthly and adjusts strategy as needed	N/A	Continue with plan as listed	Challenges with timely refreshes from Citius / errors with Citius return files; results in delayed prospective rate reports and refreshes of systems such as Hyperlift	Continue with plan as listed	On Target

QAC 03.19.2026

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26	Program Oversight		Value Based Payment Program	Implement a value-based payment program and report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	Assess and report the following activities: 1. Share HN performance on all P4V HEDIS measures via prospective rates report each month. 2. Share hospital quality program performance 3. Develop monthly P4V report to show HNs the estimated amount of P4V dollars based on current performance	Report program update to QIHEC Q1: 01/14/2025 Q2: 05/13/2025 Q3: 07/08/2025 Q4: 11/04/2025	Executive Director of Quality Improvement	Director of Quality Analytics	Quality Analytics	P4V: Medi-Cal MY2024 P4V quality scores for each health network are calculated. Payments are distributed on 10/16/2025. Quality reports with details scores for each measures are sent to each health network's CEO, cc CMO, and quality director. Hospital Quality: No report this quarter	NA	P4V: MY2025 monthly Prospective Report are sent each month. Hospital Quality: No report this quarter	P4V: N/A Hospital Quality: No report this quarter	P4V: N/A Hospital Quality: No report this quarter	On Target
27	Quality of Clinical Care		Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	Monitor PCP, High Volume Specialist and ancillary sites utilizing the DHCS audit tool and methodology and report any findings, barriers and improvement efforts.	Review and report initial and periodic reviews conducted for PCP, high volume specialists and ancillary sites and ensure periodic reviews are conducted every three years. Tracking and trending of	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	Site Review, PARS, Community-based Adult Services (CBAS), and Nursing Facilities (NF) Oversight: A. FSR:	FSR/MRR: The number of Periodic and Initial FSRs completed decreased from Q2 2025 to Q3 2025. The number of Periodic and Initial	Extensive educational support and technical assistance provided to sites. This includes but is not limited to review of DHCS FSR and MRR Tools and Standards,	None identified.	Continue with work plan as defined for 2025.	On Target

QAC 03.19.2026

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					reports are reported quarterly.					Initials FSRs=4; Periodic FSRs=44; On-site Interims=21; Failed FSRs=1 B. MRR: Initial MRRs=6; Periodic MRRs=47; Failed MRRs=5 C. CAPs: Critical Element (CE)=19; FSR=31; MRR=43 D. PARS: Completed PARS=166; Basic Access=68 (41%); Limited Access=98 E. CBAS Oversight: Critical Incidents=22 (20 COVID); Non-Critical Incidents=21; Falls=8; Audits Completed=11; CAPs Issued=9; Unannounced Visits=0 F. NF	MRRs completed increased from Q2 2025 and Q3 2025. The number of failed FSRs decreased from 2 in Q2 2025 to 1 in Q3 2025. The number of failed MRRs decreased from 6 in Q2 2025 to 5 in Q3 2025. CAPs: The number of CE CAPs issued decreased significantly from 42 in Q2 2025 to 19 in Q3 2025. The number of FSR CAPs issued decreased significantly from 51 in Q2 2025 to 31 in Q3 2025. The number of MRR CAPs decreased from 55 in Q2 2025 to	U.S. Preventive Services Task Force (USPSTF) A&B recommendations, the American Academy of Pediatrics (AAP) periodicity schedule, most current adult and childhood vaccination recommendations from Advisory Committee on Immunization Practices (ACIP). Additionally, a hard copy provider audit packet it sent out to sites before every periodic audit. The packet includes resources to help providers achieve a safe and effective provision of primary care services, to ensure and support the quality of care and documentation of appropriate			

QAC 03.19.2026

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										Oversight: Critical Incidents=11; On-Site Visits=21; Unannounced Visits=0	43 in Q3 2025. PARS: The number of PARS completed decreased slightly from 169 in Q2 2025 to 166 in Q3 2025. The number of PARS with BASIC access increased slightly from 40% in Q2 2025 to 41% Q3 2025. CBAS Oversight: The number of Critical Incidents reported increased slightly from 20 in Q2 2025 to 22 in Q3 2025. The number of Non-Critical Incidents reported increased from 16 in Q2 2025 to 29 in Q3 2025. The number of Falls	clinical services, and to improve overall member health outcomes.			

QAC 03.19.2026

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											reported decreased slightly from 12 in Q2 2025 to 8 in Q3 2025. The number of audits completed remained the same with 11 in Q2 2025 and Q3 2025. The number of CAPs issued increased from 8 in Q2 2025 to 9 in Q3 2025. NF Oversight: The number of Critical Incidents reports received increased from 9 in Q2 2025 to 11 in Q3 2025. The number of on-site visits completed remained steady with 21 in Q2 2025 to 21 in Q3 2025.				

QAC 03.19.2026

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28	Quality of Clinical Care		Potential Quality Issues Review	PQIs are reviewed timely to ensure care and services provided fall within the range of professionally recognized standards of health care.	Review and report quality-of-care cases for peer review (CPRC), determine appropriate severity level and make recommendations for actions based on findings.	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Quality Improvement	Manager of Quality Improvement	Quality Improvement	Seven PQI cases were presented to CPRC for leveling and actions; three level 3, four level 2, no level 1. We closed 262 PQIs in Q3, opened 167 cases and have a total of 359 cases open at the end of Q3.	The number of PQI's closed was less than Q2, when we were working on the backlog project. We opened less cases in Q3 than in Q2. The number of cases presented at CPRC is less than Q1 and Q2.	1)PQI is continuing with the interventions implemented in Q2. 2)The Provider Action Workgroup has met 3 times and submitted its first CAP on a physician with a high number of grievances.	1)We still have a large number of PQIs open. 2)Medical Directors are pulled to cover for their colleagues so PQI reviews are delayed.	The BRD for CORE report QI0090 has been completed. We are hoping to have the report updated in Q4 so that the closure date of PQIs will be reflective of the date the case is leveled per policy GG.1611.	Concern
29	Quality of Clinical Care		Provider Credentialing and Recredentialing	All providers are credentialed and recredentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements: • No more than 180 days between verification and approval • Providers are recredentialed within 36 months	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Quality Improvement	Manager of Quality Improvement	Quality Improvement	Initial BH Credentialing Q3 = 295 Initial CCN Credentialing Q3 = 135 BH Recredentialing Q3 = 102 CCN Recredentialing Q3 = 228 For QI, we did not have any recredentialing files	Initial/Recredentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliness of the initial and	1) Per leadership,credentialing implemented an OT Backlog Project from 2/2025-6/2025. 2) Hired a new Director of Credentialing in August 2025	1)We still have a large volume of initial credentialing file requests 2) Need resources	1) 1 FTE hiring in process. 2) 4 temporary positions hiring in process	Concern

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Back to Agenda Back to Item

QAC 03.19.2026

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										out of compliance	recredentialing files.				
30	Quality of Clinical Care		Special Needs Plan (SNP) Model of Care (MOC)	Increase the number of members completing an HRA, and ICP and ICT to meet the following goal: Percent of Members with Completed HRA: Goal 100% Percent of Members with ICP: Goal 100% Percent of Members with ICT: Goal 100%	Assess and report the following activities: 1. Monthly communication process with Networks on ICP development 2. DHCS HRA1 and ICP1 Quarterly reporting 3. HRA Star status 4. MOC Updates 5. Face to Face interactions	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Medical Management	QI Nurse Specialist	Medical Management	Percent of Members with Completed HRA through 9/30/2025: 68% Three Stars Achieved. Percent of Members with ICP* through 9/30/2025: Initial 71.2% Annual 95.1% DHCS ICP reporting for Q2 2025 at 76.8% Face-to-Face Interactions – as of 9/30/2025: 88% *ICP look back is 12 months For Initial ICP: Completed within 30 days of HRA, or	27 OC Members identified in Q2 2025 as not having ICP. Remediated in Q3. All noted in CAP 2025-022 Percent of Members with Completed HRA: Three Stars achieved for MY 2025 ICP performance stable for annuals Q2 vs Q3 (95.2% vs 95.1%. Decrease for Initial Q2 vs Q3 (73.6% vs 71.2%) DHCS ICP Q2 2025 D SNP reporting: Decrease in performanc	Assess and report the following activities: 1. Network communications: a. Ongoing monthly communication. 2. DHCS Reporting: a. DHCS HRA1--This DHCS reporting has been sunset and no longer reported in 2025. b. DHCS ICP1-Q2 2025 1) Communication with Health Networks during CalOptima Health Clinical Ops meetings on 7/24/2025 and 9/4/2025 3. HRA Star Status: a. Continued HRA reminders through texting and postcards b. Targeted outreach to members needing reset	1. Members who are unable to contact for both the HRA and the ICP.	Assess and report the following activities: 1. Network communications: a. Continue monthly communication. 2. DHCS Reporting: a. DHCS HRA1--This DHCS reporting has been sunset and no longer reported in 2025. b. DHCS ICP1-Q2 2025 1) Continue communication with Health Networks during CalOptima Health Clinical Ops meetings in Q4.	On Target

QAC 03.19.2026

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										within 120 days of enrollment if no HRA is collected. For Annual ICP: Completed within 12 months of the prior ICP.	e from Q1 (79.3%) Face-to-Face Interactions: Contrast Q2 to Q3 (84% vs 88%). There was a logic update to credit providers not previously captured.	or catch-up HRA. c. Continued initial and annual outreach. d. QR codes added to HRA cover letters for all threshold languages to allow members to complete by mobile. 4. MOC Updates: The D-SNP Model of Care (MOC) 2026 Matrix was submitted to DHCS in Q3 2025 for review and is pending approval. 5. Face to Face Interactions logic updated for non-physician providers.		3. HRA Star Status: a. Continue HRA reminders through texting and postcards b. Continue targeting outreach to members needing reset or catch-up HRA. c. Continue initial and annual outreach. 4. MOC Updates: The D-SNP Model of Care (MOC) 2026 Matrix was submitted to DHCS in Q3 2025 for review and is pending approval. 5. Face	

QAC 03.19.2026

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														to Face Interactions with PCP or specialist: Outreach to members requiring face-to-face visit.	

QAC 03.19.2026

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31	Quality of Clinical Care	PHM - LSC	Pediatric and Adolescent Wellness: EPSDT/Children's Preventive and Screening Services	Childhood Immunization Status (CIS) MC Combo 10: 42.34% Increase from 36.50% to 42.34% by 12/31/2025. Immunizations for Adolescents (IMA) MC Combo 2: Increase from 47.45% to 48.66% by 12/31/2025. Well-Child Visits in the First 30 Months of Life (W30) MC First 15 Months: Increase from 58.92% to 63.38% by 12/31/2025. MC 15 to 30 Months: Increase from 72.44% to 73.09% by 12/31/2025. Child and Adolescent Well-Care Visits (WCV) MC Total: Increase from 53.03% to 55.29% by 12/31/2025. Lead Screening in Children (LSC) MC LSC: Increase from 63.75% to 63.84% by 12/31/2025.	Goal not met - W30. Continue to assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored and age-appropriate messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs (e.g. provide insight into CIS Combo 10 status for each vaccine) 4. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone) 5. For CIS Combo 10, identify members missing only the first Hep B vaccine and complete chart chase efforts year-round	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/14/2025 Q3: 08/12/2025 Q3: 11/04/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics	Quality Analytics	Data through August 2025: CIS: 26.17% IMA: 44.27% W30 (6 or more visits): 38.90% W30 (2 or more visits): 68.08% WCV: 32.91% LSC: 68.6%	CIS: already achieved the 50th %ile (23.89%) and performing significantly higher as compared to same point in time last year (20.06% in August 2024) IMA: already achieved the 75th %ile (40.19%) and performing higher as compared to same point in time last year (40.37% in August 2024) W30: both sub measures are performing higher as compared to same point in time last year (35.42% and 64.93% respectivel	Ongoing outreach to parents / guardians / members via Carenet (telephonic) and Ushur (SMS). Creation of a personalized pediatric mailer. Revising current pediatric wellness campaigns to increase campaign engagement.	Health networks and providers are reporting declines in patient volumes to concerns influenced by sociopolitical factors.	Continue with plan as listed and pursue automation where possible. Leverage the upcoming Cozeva PayerOne solution to provide HN and CHCN provider partners with more detailed data for CIS and W30. Launch pediatric mailers in Q4 2025 Launch revised pediatric wellness campaigns in Q4 2025	Concern

QAC 03.19.2026

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					6. Begin prospective outreach to members that will age into the measure for the following year (i.e. message 1 year old members to ensure compliance with recommended vaccine schedule thus far) 7. Create educational materials for addressing vaccine hesitancy and distribute to providers and members 8. Drive provider participation in the Standing Orders Program to place lab orders for blood lead testing 9. Provide point-of-care lead testing equipment and supplies to providers via the Quality Improvement Grant Program 10. Early Identification and Data Gap Bridging Remediation for early intervention						y, in August 2024) WCV: performing higher as compared to same point in time last year (29.27% in August 2024) LSC: achieved the 33rd %ile and is on track to meeting the 50th %ile (69.96%) performing higher as compared to same point in time last year (65.03% in August 2024)				

QAC 03.19.2026

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32	Quality of Clinical Care		Adult Wellness: Preventive and Screening Services	Cervical Cancer Screening (CCS) MC: Increase from 58.31% to 60.10% by 12/31/2025. Colorectal Cancer Screening (COL) OC: Increase from 66.84% to 70.33% by 12/31/2025. Breast Cancer Screening (BCS-E) MC: Increase from 58.39% to 59.51 % by 12/31/2025. OC: Increase from 66.88% to 75.00 % by 12/31/2025. Immunization Status - Flu, Pneu, Tdap, Zoster MC Flu Total: Increase from 22.19% to 26.40% by 12/31/2025. OC Flu Total: Increase from 47.17% to 49.12% by 12/31/2025. MC Pneumococcal 66+: Increase from 38.18% to 38.73% by 12/31/2025. OC Pneumococcal 66+: Increase from 44.96% to 56.76% by 12/31/2025. MC Tdap Total: Increase from 25.43% to 33.40% by 12/31/2025. OC Tdap Total: Increase from 24.57% to 31.56% by 12/31/2025. MC Zoster Total: Increase from 17.52% to 20.56% by 12/31/2025. OC Zoster Total: Increase from 23.62% to 40.94% by 12/31/2025.	Assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs 4. Provide facility listings for services completed outside the PCP office setting, such as diagnostic sites for mammography 5.Provide mobile mammography services in collaboration with other departments, Health Network partners, and CHCN providers 6. Provide at-home Cologuard testing for Colorectal Cancer Screening 7. Implement a comprehensive	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Quality Analyst of Quality Analytics / Manager of Quality Analytics	Quality Analytics	Cervical Cancer Screening (CCS) MC: 45.64% Colorectal Cancer Screening (COL) OC: 61% Breast Cancer Screening (BCS) MC: 44.87% OC: 61% Immunization Status - Flu, Pneu, Tdap, Zoster (AIS-E) [data through July 2025] AIS: Adult Imms (Influenza) [Medi-Cal]: 17.13 AIS: Adult Imms (Pneumo) [Medi-Cal]: 46.54 AIS: Adult Imms (Td/Tdap) [Medi-Cal]: 38.68 AIS: Adult Imms (Zoster) [Medi-Cal]: 16.23 OC Flu	CCS MC: A 5.15 percent point increase compared to July 2024 COL OC: A 3 percent point increase compared to July 2024 BCS MC: A 1.09 percent point decrease compared to July 2024 BCS OC: A 6 percent point increase compared to July 2024 AIS: Adult Imms (Influenza) [Medi-Cal]: 2.89 percentage point increase compared to July 2024 AIS: Adult Imms (Pneumo) [Medi-Cal]: 15.26 percentage point increase	CareNet Live Call campaign for CCS, MC and OC BCS, MC and OC COL Flu Postcard Q4 Care gap member outreach to commence Q4	None identified.	Continue Mobile Mammography Events Continue CareNet Live Call Campaign Q4 Initiate 2025 Cologuard Campaign Standing Order telephonic and mailing member outreach for BCS Cancer Treatment Text Campaign Continue Flu Postcard for members Q4 Relaunch Flu Shot IVR robocall campaign Q4 Relaunch Flu Shot Texting Campaign Q4 Launch Flu Shot Email Campaign	On Target

QAC 03.19.2026

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					outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone)					Total: Medicare Prospective Rate Report Not Available OC Pneumococcal 66+: Medicare Prospective Rate Report Not Available OC Tdap Total: Medicare Prospective Rate Report Not Available OC Zoster Total: Medicare Prospective Rate Report Not Available	compared to July 2024 AIS: Adult Imms (Td/Tdap) [Medi-Cal]: 19.33 percentage point increase compared to July 2024 AIS: Adult Imms (Zoster) [Medi-Cal]: 3.56 percentage point increase compared to July 2024			Q4 Launch mammogram orders for CHCN members of providers participating in standing orders Q4.	

QAC 03.19.2026

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33	Quality of Clinical Care		CalOptima Health Comprehensive Community Cancer Screening Program (CCCSP)	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer report key findings and/or activities, analyze barriers, and improvement efforts.	Assess and report the following: 1. Establish the Comprehensive Community Cancer Screening and Support Grants program and monitor Grantees' progress to measure impact 2. Develop and implement a comprehensive plan for other initiatives under CCCSP.	Report Program update to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/14/2025	Chief Medical Officer	Project Specialist Case Management	Medical Management	1. Conducted an in-person grantee meeting to review Progress Report #3 in August 2. Reviewed grantee's budget report expenses and processed the next grant payment 3. Updated the FQ Grantee Dashboard with July HEDIS data 4. mPulse (text campaign): Launched an ad-hoc fundraising campaign for Supervisor Chaffee's Annual Community Bike Ride Event (unique members: 51,436) 5. Alinea	1. Identified data discrepancies within Celebrating Life's self-reported measures against CalOptima's HEDIS measures. 2. As outlined in the amendment, Alinea was not meeting its 7-day TAT to send mammography results to members' PCPs.	1. Met with Celebrating Life to discuss and resolve data discrepancy by submitting a supplemental file and identifying self-reporting methods for cancer screening results. 2. The contract has been amended to updated the TAT requirement from 7 day to 14 day to send mammography results to members' PCPs.	1. Most grantees shared that members were not showing up to their scheduled appointments due to the political climate and fear. 2. While the workgroup actively worked on refining the scope of work for the Research & Evaluation initiative, the focus has shifted significantly from the time the	1. Ask grantees to report the % of the member population who are not coming into clinics or, alternatively, provide data report on members showing up to their scheduled appointment in the next progress report. 2. Continue working on the Research & Evaluation initiative scope of work and determine the best time to release the RFP.	On Target

QAC 03.19.2026

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										Mobile Mammography: Successfully coordinated 5 events from July - September. 6. Shared information re: the cervical cancer screening self-collection test kits and Quality's pilot program to promote this testing through Quest and LabCorp with grantees.			initial plan was presented to the Board.		

QAC 03.19.2026

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34	Quality of Clinical Care	CoC - PPC	Maternal and Child Health: Prenatal and Postpartum Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). MC Prenatal: Increase from 88.08% to 88.58% by 12/31/2025. MC Postpartum: Increase from 80.00% to 80.23% by 12/31/2025.	Assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Implement a comprehensive outreach strategy utilizing multiple modalities timed with the member meeting denominator-qualifying criteria 4. Launch an interdepartmental maternal health workgroup focused on improving outcomes and addressing disparities 5. Provide bundled code education to high volume providers 6.Create a comprehensive dashboard /	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	Data through August 2025 PPC Prenatal Care: 81.49% PPC Postpartum Care: 68.46%	Prenatal Care is performing higher as compared to same point in time last year (August 2024) Postpartum Care is performing significantly higher as compared to the same point in time last year (August 2024)	All planned activities are still in progress. Quality Department is conducting postpartum outreach calls. Quality is partnering with Finance Department to create a comprehensive report	Resource constraints	Continue to partner with the Maternal Health Team.	Concern

QAC 03.19.2026

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					report that refreshes weekly to ensure timely member identification and intervention 7. Collaborate with OBGYN specialty groups to perform member outreach and schedule services 8. Expand on collaborative efforts with community-based organizations, providers, and health networks.										

QAC 03.19.2026

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35	Quality of Clinical Care	PHM	Maternal and Child Health: Prenatal and Postpartum Depression Screening	Prenatal Depression Screening and Follow-Up (PND-E) MC Screening: Increase from 14.52% to 16.03% by 12/31/2025. MC Follow-up: Increase from 52.80% to 53.33% by 12/31/2025. Postpartum Depression Screening and Follow-Up (PDS-E) MC Screening: Increase from 17.33% to 29.84% by 12/31/2025. MC Follow-up: Increase from 56.84% to 61.70% by 12/31/2025.	PND-E & PDS-E Activities: 1. Provider maternal mental health training 2. Enhance CalOptima Health Maternal Depression Program and support referral to Behavior Health Integration when screened at risk. 3. Conduct or promote depression screening at community events.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director Medical Management	Director Medical Management	Medical Management	Provider/partner training has been completed. As of August 27, 2025, a total of 111 individuals (84 in Fall 2024 and 27 in Spring 2025) have attested to completing the 9-session course, led by top experts and trainers in the field of perinatal mental health. Continue to screen members enrolled in the maternal health telephonic program during trimester, postpartum (through 12 months) for maternal mental health. If screened	N/A work in progress	Maternal health outreach through telephonic program with integration of maternal mental health screening.	Community Impact Team was disbanded resulting in screenings not continuing at events. Maternal mental health workgroup (SEEDS) has concluded.	Continue to integrate screenings in maternal health program. Identify opportunities with providers and partners to support enhance activities and services around maternal mental health.	On Target

QAC 03.19.2026

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										at risk members are transferred to BH, provided information on TeleMed2U, or given contact information for services depending on what the members chooses is appropriate for them at the time.					
36	Cultural and Linguistic Appropriate Services	PHM CLAS HE	Maternity Care for Black Members	Medi-Cal 1. Increase timeliness of prenatal care (TOPC) for CalOptima's Black members from 75.71% to 84.55% by December 31, 2025. 2. Increase postpartum care (PPC) for CalOptima's Black members from 71.43% to 80.23% by December 31, 2025.	Assess and report the following activities: 1. Connect members to doula, Enhanced Care Management (ECM) services, and Black Infant Health (BIH) programs. 2. Implement community and clinic events that focus on improving prenatal and postpartum appointments. 3. Explore digital methods of providing perinatal assessments,	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Director Medical Management	Manager of Quality Analytics/Manager of CalAIM/Director of Case Management	Case Management/ Medical Management/ Cal AIM/Quality Analytics	PPC Postpartum Care: 64.79% compliance rate for Black members compared to 69.43% compliance rate for the entire PPC population (data through August 2025) PPC Prenatal Care: 78.87% compliance rate for	Based on August 2025 data, the Black or African American population is trending lower in compliance for prental and postpartum care as compared to the entire population and White members.	OC HCA has received the ECM report for Black perinatal members through their MOU with CalOptima Health. They are attempting outreach to these members to offer ECM, doula, and Black Infant Health (BIH) program (results pending). This *new* process limits the barriers of Q2 with sharing of information.	Limited doula outreach Barriers to sharing information has resulted in workarounds (results pending)	Evaluate results of the OC HCA/ CalOptima Health project and determine next steps for outreach to targeted members	Concern

QAC 03.19.2026

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					education, and resource navigation for pregnant and postpartum members.					Black members compared to 81.54% compliance rate for the entire PPC population (data through August 2025)					

QAC 03.19.2026

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37	Quality of Clinical Care	PHM CoC-EED	Chronic Conditions: Members with Diabetes	Eye Exam for Patients with Diabetes (EED) MC EED 64.06% Increase from 63.52% to 64.06% by 12/31/2025. OC: EED 77.00%; Increase from 75.14% to 77.00% by 12/31/2025. HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates Percentage of members with poor A1C control-lower rate is better) (>9.0%) MC HBD: Decrease from 29.34% to 27.01% by 12/31/2025. OC HBD: 10.00% decrease from 15.30% to 10.00% by 12/31/2025.	Assess and report the following activities (Quality Analytics): 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs 4. Explore at-home testing for HBD via lab vendor 5. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone) 6. Drive provider participation in the Standing Orders program to place A1c lab orders on behalf of physicians 7. Collaborate with OPH and OPT providers on member	By December 2025 Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Quality Analytics (Medicare Stars and Quality Initiatives)/Director Case Management	Manager of Quality Analytics	Medical Management and Quality Analytics	Eye Exam for Patients with Diabetes (EED) MC:43.37 % OC: 61% Glycemic Status Assessment for Patients with Diabetes (GSD): HbA1c Poor Control (>9%) MC Poorly Controlled (Glycemic Status >9%): 54.85% OC Controlled (Glycemic Status <8%):48%	EED MC: A 3.42 percent point increase compared to July 2024 EED OC: A 3 percent point increase compared to July 2024 GSD MC (poor control): A 6.15 percent point decrease compared to July 2024 (lower is better) GSD OC (controlled): A 20 percent point increase compared to July 2024	Diabetes Member Outreach text campaign (MC, OC approx. 22,000) CareNet Live Call Campaign for MC and OC HbA1c VSP Eye Exam mailing reminder	None identified.	Continue CareNet Live Call Campaign Q3/Q4 Relaunch Diabetes Texting Campaign Q4 Exploration of at-home A1c testing with lab partners such as Quest	On Target

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					outreach and scheduling of services for EED 8 Regularly review members with evidence of A1c testing but no result and address via supplemental data capture 9. Partner with VSP to educate providers on EED CPT II code submission to capture testing results 10. Explore offering EED testing at community based events Assess and report the following activities: 1. Enhance Diabetes Education: Launch virtual and group education classes to improve member engagement by FY 2025. 2. Leverage Technology: Use digital apps and web-based tools to support diabetes prevention, management, and interactive engagement. 3. Strengthen Support Services: Link										

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					members to medically tailored meals, health coaching nutrition services, community/clinic events.									

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38	Quality of Clinical Care	PHM CLAS HE	Chronic Conditions: Members with Heart Health (Hypertension)	Controlling High Blood Pressure (CBP) MC CBP: Maintain the 90th percentile (72.75%) or higher by December 31, 2025. OC CBP: Increase from 74.87% to 80.00% by 12/31/2025. Controlling High Blood Pressure (CBP) - CLAS and Health Disparity for Medi-Cal 1. Increase CBP rate among Black and African American Medi-Cal members from 39.21% to 64.48% by 12/31/2025. 2. Increase CBP rate among Black and African American Medicare members from 47.24% to 77% by 12/31/2025. 3. Increase CBP rate among Korean speaking Medi-Cal members from 24.87% to 64.48% by 12/31/2025. 4. Increase CBP rate among Vietnamese speaking Medicare members from 50.56% to 77% by12/31/2025.	Assess and report the following activities: 1. Expand Hypertension Program to offer both virtual and in-person Hypertension Education.	Report to PHMC: Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director Case Management	Manager Case Management	Case Management	Controlling Blood Pressure (CBP) OC: 42% MC: 36.16%	CBP OC: A 4% increase compared to July 2024 CBP MC: A 5.21% increase compared to July 2024	1. In July, the Healthy Heart Program transitioned from in-person community screenings to a telephonic outreach model to maintain continuity of care and education while addressing access barriers. Health Coaches (HCs) and Health Educators contacted OneCare members with BP readings >40/90 mmHg or with no BP readings on file for 2025. In this outreach, the teams provided education on the importance of PCP visits and BP monitoring, strategies for managing BP, collected BP home readings and faxed them to providers for	High rate of members are unable to be contacted	Continue to outreach to members to support blood pressure control. Launch text message program upon DHCS approval.	On Target

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												documentation, and initiated standing order requests for BP monitors when needed. 2. The standing order program continues to reduce barriers to self-monitoring. In Q3, 181 prescriptions for BP monitors were filled through this process (for a total of 350 monitors sent to members across Q1-Q3 2025). 3. A 7-week text message education program has been developed and is currently awaiting DHCS approval. This initiative aims to reinforce BP education and engagement through mobile outreach.			

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39	Quality of Clinical Care		Chronic Conditions: Osteoporosis	Osteoporosis Management in Women Who Had a Fracture (OMW) OC Total: Increase from 34.67% to 39.00% by 12/31/2025.	1.Case management to collaborate with Quality to identify members who need follow-up. 2.Quality to outreach to noncompliant members via SMS, mail, and/or telephone. 3.Quality to pursue at-home DEXA testing via vendor. 4.Quality to provide timely notifications to the member's PCP via fax. 5.Quality to explore collaboration with the Pharmacy team to provide education on the importance of taking a medication to treat osteoporosis (e.g. bisphosphonate). 6.Quality and Case Management coordinate to provide more timely data and insight to the member's	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Sr. Director Medical Management/Manager of Quality Analytics	Quality Improvement Nurse/Program Manager Quality Analytics	Medical Management (Case Management) /Quality Analytics	The OMW measure is performing significantly higher as compared to same point in time last year (Aug 2025: 37% vs. Aug 2024: 17%).	The OMW measure is performing significantly higher compared to the same point last year (Aug 2025: 37% vs. Aug 2024: 17%). The rate also shows improvement from the previous month (35%, reflecting continued progress toward the annual goal.	All planned activities are still in progress. 1.Case management to collaborate with Quality to identify members who need follow-up: a. Initiated incorporating Point Click Care data for Members identified as OMW to incorporate into Key Event reporting 2.Case Management to outreach to noncompliant members via SMS, mail, and/or telephone. 3.Quality to pursue at-home DEXA testing via vendor: 4.Quality to provide timely notifications to the member's PCP via fax. 5.On Hold-Quality to explore collaboration with the Pharmacy	N/A	Continue with the planned activities and coordination with Case Management and vendor partners to sustain improvement. 1.Case management to collaborate with Quality to identify members who need follow-up. a. Continue to work with IT to incorporate Point Click Care data for Members identified as OMW to incorporate into Key Event reporting 2.Quality to continue	On Target

QAC 03.19.2026

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					compliance deadline date to Health Network partners.							team to provide education on the importance of taking a medication to treat osteoporosis (e.g. bisphosphonate). Discussion in Stars Workstream Workgroup. 6.Quality and Case Management coordinate to provide more timely data and insight to the member's compliance deadline date to Health Network partner: Ongoing communication with Health Networks .		outreach to noncompliant members via SMS, mail, and/or telephone . 3.Ongoing Quality to pursue at-home DEXA testing via vendor. 4.Quality to continue to provide timely notifications to the member's PCP via fax. 5.ON HOLD Quality to explore collaboration with the Pharmacy team to provide education on the importance of taking a medication to treat osteoporosis (e.g.	

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														bisphosphonate). 6.Ongoing Quality and Case Management coordinate to provide more timely data and insight to the member's compliance deadline date to Health Network partners.	
40	Quality of Clinical Care	CoC - FMC	Chronic Conditions: Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) OC Total: Increase from 51.27% to 53.00% by 12/31/2025.	1. Review and update the Key Events for Emergency Visits 2. Continue to share Emergency Visits with Health Networks through Key Event reporting.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director Medical Management	Quality Improvement Nurse	Case Management	FMC measure through 7/2025: 50%	FMC shows increase from Q2 reported rate end of 5/2025 (48%) and prior year rate at same time 7/2024 (43%)	1. Review and update the Key Events for Emergency Visits: a. Initiate incorporating FMC data from Point Click Care into Key Event reporting. 2. Emergency Visits shared with Health Networks through Key Event reporting.	N/A	1. Review and update the Key Events for Emergency Visits: a. Continue to work with IT to incorporate Point Click Care data for FMC into Key Event reporting. 2. Continue to share Emergenc	On Target

QAC 03.19.2026

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														y Visits with Health Networks through Key Event reporting.	
41	Quality of Clinical Care		Behavioral Health Services: Child and Adolescent Health on Antipsychotics	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) MC Glucose and Cholesterol Combined-All Ages: Increase from 36.76% to 41.41% by December 31, 2025.	Goal not met. Continue to assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primary Care Providers (PCP) for members in need of metabolic monitoring. 2) Work collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in need of screening. 3) Monthly mailing to prescribing providers to	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/14/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	APM HEDIS Rates Q3 (July) MC: 20.74%	APM increased from Q2 (June) to Q3 (July) by 1.66%	1) PCP Provider Mailout: a. 7/29/2025- 103 letters b. 8/28/2025 - 75 letters 2) Request submitted to add Codes to Provider Tip Tool Sheet. 3) Text Campaign sent out: a. 6/12/25 b. 7/10/25 c. 8/14/2025 4) HEDIS Provider Tool Tip Sheet Finalized and sent to provider in the CalOptima Health, Health Network Weekly Communication on 08/11/2025.	Barriers include: 1) Unable to do prescribing provider outreach due to lack of data. 2) Limited access to timely and regularly updated data hinders our ability to monitor trends, respond proactively, and support data-driven decision-making.	1) Continue Text message campaign. 2) Continue Provider mailout of Best Practices Letter and Tip tool sheet. 2) Resume mailings of Prescribing Povders materials (Best Practices letter and Provider tip tool sheet) to providers on a monthly basis. 3) Resume collaboration with Provider Relations	At Risk

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					remind of best practices for members in need of screening. 4) Send monthly reminder text message to members (approx 600 mbrs). 5) Information sharing via provider portal to PCP on best practices.									to conduct in-person provider outreach with top 10 providers on a monthly basis. 4) Schedule listening sessions with Providers to educate/train on how to obtain BH data upon BH report availability. 5) Coordinate in-person visits with Provider Relations-Drafted an outline on what BH can discuss with providers during in-person visits.	

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42	Quality of Clinical Care	PHM	Behavioral Health Services: Depression	Depression Screening and Follow-up for Adolescents and Adults (DSF-E) MC Screening Total: Increase from 6.57% to 16.22% by December 31, 2025. OC Screening Total: Maintain the 90th percentile (54.28%) or higher by December 31, 2025.	DSF-E Goal not met. Continue to assess and report the following activities: 1) Educate providers on the importance of screenings and follow-up care after positive screenings. 2) Educate members on the importance of screenings through newsletters/outreach and increase follow up appointments after positive screenings.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/14/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	DSF-E HEDIS Rates Q3 (July) MC: 1.92% OC: 2.45%	DSF-E decreased from Q2 (June) to Q3 (July) MC: by 0.08% OC: by 0.05%	1) Provider letter: a. Presented Provider letter to BHQI Workgroup on 08/14/2025. b. BHQI finalized on 8/26/2025 2) PCP Provider Mailout: a. 8/28/2025 - 595 letters 3) HEDIS Provider Tool Tip Sheet Finalized and sent to provider in the CalOptima Health, Health Network Weekly Communication on 08/11/2025.	Barriers include: 1) Data acquisition. 2) Unable to do prescribing provider mail out due to lack of data. 3) Limited access to timely and regularly updated data hinders our ability to monitor trends, respond proactively, and support data-driven decision-making.	DSF-E: 1) Continue Provider Mailout of Provider materials: Best Practices letter and Provider tip tool sheet to providers on a monthly basis. a. Resume collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 2) Schedule listening sessions with Providers to educate/train on how to obtain BH data upon	At Risk

QAC 03.19.2026

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														BH report availability. 3) Commence next steps to send out a text message campaign. 4) Coordinate in-person visits with Provider Relations- Drafted an outline on what BH can discuss with providers during in-person visits.	

QAC 03.19.2026

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43	Quality of Clinical Care	CoC-SSD	Behavioral Health Services: Schizophrenia	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) MC SSD: Increase from 74.96% to 79.51% by 12/31/2025. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) MC: Increase from 70.19% to 74.83% by 12/31/2025. OC: Increase from 77.37% to 77.93% by 12/31/2025.	SSD Goal not met. Continue to assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collaboratively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx 1100 mbrs) 5) Member Health Reward	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/14/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	SSD Q3 (July) PR: MC 61.38% SAA Q3 (July) PR: MC 9.5% OC 13.16%	SSD PR increased from Q2 to Q3 by 18.98% SAA PR increased from Q2 to Q3 for: MC by 8.98% OC by 11.46%	SSD: 1) SSD Best Practice PCP Letter approved on August 6th. 2) Launched a mailing campaign on August 6th to 162 PCPs featuring the SSD Best Practice PCP Letter, Tool Tip Sheet and Member Reward Flyer. 3) Mailed SSD reward flyer to 2,391 members on August 6th. 4) Text messaging campaign launched to 1,100 members on July 17th and August 21st. 5) Social media reminder about no-cost diabetic screenings posted July 15, 2025 6) Fall Member Newsletter mailed on 9/15/2025 - Article on pg.7: Important	SSD Barriers include: 1) Member compliance is a challenge with this population. 2) Inability to conduct prescribing provider outreach due to missing data. 3) Limited access to timely and regularly updated data hinders our ability to monitor trends, respond proactively, and support data-driven decision-making.	SSD: 1) Continue tracking members in need of glucose screening test. 2) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 3) Continue to follow up on data pull for text messaging campaign. 4) Mail out member health rewards flyer to eligible members. 5) Continue to mail out to all PCP offices the following: a.	Concern

QAC 03.19.2026

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					Program. SAA Assess and report the following activities: 1) Educate providers on the importance of medication adherence through outreach. 2) Educate members on the importance of medication adherence through newsletters/outreach.							Reminders for Members Prescribed Psychotropic Medicines, Note: on page 8&9 there's a notice of the SSD Member Health Reward of $25. 7) HEDIS Provider Tool Tip Sheet Finalized and sent to provider in the CalOptima Health, Health Network Weekly Communication on 08/11/2025. SAA: 1) SAA Best Practice PCP Letter approved on September 8th. 2) Launched a mailing campaign on September 8th to PCPs featuring the SAA Provider Letter and Tool Tip Sheet . 3) Fall Member Newsletter mailed on 9/15/2025 -	SAA Barriers Include: 1) Inability to conduct prescribing provider outreach due to missing data. 2) Limited access to timely and regularly updated data hinders our ability to monitor trends, respond proactively, and support data-driven decision-making.	Best Practice PCP Letter b. Provider Tool Tip Sheet c. Member Reward Flyer 6) Schedule listening sessions with Providers to educate/train on how to obtain BH data. Pending report availability. 7) Coordinate in-person visits with Provider Relations- Drafted an outline on what BH can discuss with providers during in-person visits.	

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												Article: Important Reminders for Members Prescribed Psychotropic Medicines. 4) HEDIS Provider Tool Tip Sheet Finalized and sent to provider in the CalOptima Health, Health Network Weekly Communication on 08/11/2025.		SAA: 1) Will use provider portal to communicate best practices and guidelines for medication adherence and member follow-up. 2) Discussion of implementing a text messaging campaign. 3) Continue mail out to all prescribing provider offices the following: a. Best Practice PCP letter b. Provider Tool Tip Sheet 4) Schedule listening sessions with	

QAC 03.19.2026

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														providers to educate/train on how to obtain BH data. Pending report avialability. 5) Coordinate in-person visits with Provider Relations- Drafted an outline on what BH can discuss with providers during in-person visits.	

QAC 03.19.2026

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44	Quality of Clinical Care	PHM CoC-FUM; FUA; FUI	Behavioral Health Services: Care Coordination and Follow-up Care	Follow-Up After Emergency Department Visit for Mental Illness (FUM) MC 30-Day: Increase from 35.76% to 53.82% by 12/31/2025. MC 7-day: Increase from 21.38% to 33.01% by 12/31/2025. Follow-Up After Emergency Department Visit for Substance Use (FUA) MC 30-Day: Increase from 21.12% to 36.18% by 12/31/2025. MC 7-Day: Increase from 11.23% to 18.76% by 12/31/2025. Follow-up After High-Intensity Care for Substance Use Disorder (FUI) MC 30-Day: Increase from 20.25% to 44.53% by 12/31/2025. MC 7-Day: Increase from 7.99% to 26.90% by 12/31/2025.	FUM Goal not met. Continue to assess and report the following activities: 1. Share real-time ED data with our health networks on a secured FTP site. 2. Participate in provider educational events related to follow-up visits. 3. Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4. Bi-Weekly Member Text Messaging (approx. 500 mbrs) 5. IVR calls to members who fall under the FUM measure FUA Goal not met. Continue to assess and report the following activities: 1. IVR calls to members who fall under the FUA measure 2. Continue weekly member text messaging 3. Share FUA	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	FUM PR HEDIS Rates Q3 (July): 30 day-38.67%, 7 day-22.89% FUA PR HEDIS RATES Q3 (July): 30-day: 25.56%%, 7-day:13.87 % FUI PR HEDIS Rates Q3 (July): 30-day: 27.4% 7-day: 7.89%	FUM PR increased from Q2 (June) to Q3 (July) for 30-day by 1.74% and for the 7-day the rate increased by 1.96%. FUA PR decreased from Q2 (June) to Q3 (July) for 30-day by 0.13% and for the 7-day the rate increased by 0.41%. FUI PR increased from Q2 (June) to Q3 (July) for 30-day by 1.73% and for the 7-day the rate increased by 0.35%.	FUM Interventions 1) Member text messages sent weekly. 2) Member outreach via BH Telehealth vendor to assist with scheduling Follow up appointments. Outreach based on daily ED data feed. 3) Reminders regarding importance of FUM/FUA sent in monthly HN Communication. 4) Continued sharing FUM data with HN Networks via sFTP. 5) BHI Quality Team attend HN Quality meetings. Discussed quality performance, FUA, FUM measures, new Stars updates, text campaigns, and Telemed2U re-introduction. 6) FUA/FUM Daily reports being redevolped for Provider Portal-with a go-live date targeted for October.	Barriers Include: 1) Delay in receiving supplemental 837 data from OC HCA. 2) Member engagement continues to be a challenge with this population. 3) Limited access to timely and regularly updated data hinders our ability to monitor trends, respond proactively, and support data-driven decision-making.	FUM/FUA 1) Assessing the implementation of IVR calls to remind members who meet FUM/FUA criteria to schedule a follow-up appointment after an ED visit. 2) Continue Daily Text Campaign. 3) Continue to meet with High volume ED's to ensure members are connected to services before they leave the hospital by introducing Telemed2U/NAMI By Your Side. 4) Share FUM/FUA HEDIS report data via	Concern

QAC 03.19.2026

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					data with providers through the Provider Portal. 4. Sharing FUA data with Health Networks via sFTP. FUI: This measure was added for monitoring purposes. Opportunities for improvement and/or interventions will be considered upon the ability to obtain data from the Orange County Health Care Agency.							7) Participation in DHCS / OCHCA BH Collaboration Project which is focusing on improving the rates for FUA/FUM measures. 8) BHI Quality Team attend HN Quality meetings. Discussed quality performance, FUA, FUM measures: 7/1/25 - Family Choice 7/2/25 - Noble 7/3/25 - Prospect 7/17/25 - CHOC Health Alliance 7/23/25 - HPN Regal 7/24/25 - Optum 7/24/25 - AltaMed 9) HEDIS Provider Tool Tip Sheet Finalized and sent to provider in the CalOptima Health, Health Network Weekly Communication on 08/11/2025. FUA: 1) Member text messages sent weekly. 2) Member		Provider portal. (Pending report availability.) 5) Continue participation in DHCS/OCHCA BH Collaboration Project. 6) Continue to attend HN Quality Meetings. 7) Coordinate in-person visits with Provider Relations- Drafted an outline on what BH can discuss with providers during in-person visits. FUI: 1) Continue to monitor measure on a monthly basis. 2) Continue collaborative meetings	

QAC 03.19.2026

												outreach via BH Telehealth vendor to assist with scheduling Follow up appointments. Outreach based on daily ED data feed. 3) Reminders regarding importance of FUM/FUA sent in monthly HN Communication. 4) Continued sharing FUA data with HN Networks via sFTP. 5) Participation in DHCS / OCHCA BH Collaboration Project which is focusing on improving the rates for FUA/FUM measures. 6) Sunsetted Pilot Program with Providence on 08/25/2025. 7) BHI Quality Team attend HN Quality meetings. Discussed quality performance, FUA, FUM measures, new Stars updates, text campaigns, and Telemed2U re-introduction.		between teams to identify best practices to implement strategic interventions. 3) Coordinate in-person visits with Provider Relations- Drafted an outline on what BH can discuss with providers during in-person visits.	

QAC 03.19.2026

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												8) FUA/FUM Daily reports being redevolped for Provider Portal-with a go-live date targeted for October. 9) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability. 10) HEDIS Provider Tool Tip Sheet Finalized and sent to provider in the CalOptima Health, Health Network Weekly Communicatio n on 08/11/2025. 11) BHI Quality Team attend HN Quality meetings. Discussed quality performance, FUA, FUM measures: 7/1/25 - Family Choice 7/2/25 - Noble 7/3/25 - Prospect 7/17/25 - CHOC Health Alliance			

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													7/23/25 - HPN Regal 7/24/25 - Optum 7/24/25 - AltaMed FUI: 1) Monitoring this measure. 2) HEDIS Provider Tool Tip Sheet Finalized and sent to provider in the Caloptima Health, Health Network weekly communication on 08/11/2025. 3) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal. Pending report availability.			

QAC 03.19.2026

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45	Quality of Clinical Care	CoC - APP	Behavioral Health Services: Medication Management	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) MC Total: Increase from 28.95% to 54.55% by 12/31/2025. Pharmacotherapy for Opioid Use Disorder (POD) MC Total: 21.36% Increase from 7.79% to 21.36% by 12/31/2025.	Assess and report on the following activities: 1) Educate providers on measure and best practice guidelines.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/14/2025	Manager, Director and Executive Director of Behavioral Health Integration	Manager of Behavioral Health Integration	Behavioral Health Integration	APP HEDIS Rates Q3 (July) MC: 38.36% POD HEDIS RATES Q3 (July): MC:4.63%	APP decreased from Q2 (June) to Q3 (July) by 1.64% POD PR increased from Q2 (June) to Q3 (July) by 0.37%	APP: 1) Sent out 37 Provider Letters and Tip Tool Sheets in July. 2) Submitted the provider Tip Tool Sheets with the codes to CAR on 09/02/25. 3) Drafted the APP text message campaign and presented to the BHQI workgroup on 09/12/25. POD: 1) HEDIS Provider Tool Tip Sheet Finalized and sent to provider in the CalOptima Health, Health Network Weekly Communication on 08/11/2025. 2) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider	Barriers Inculde: APP: 1) We are still waiting on the provider tip tool sheet to be designed and sent back from the communications team. We are also waiting on the approval from DHCS for the APP text message campaign in order to move forward with the next steps. 2) Limited access to timely and regularly updated data	APP 1) Continue to send out provider letters. 2) Coordinate in-person visits with Provider Relations- Drafted an outline on what BH can discuss with providers during in-person visits. POD: 1) Continue to discuss with county the POD data gap issue at the next county collaboration meeting in November. 2) Coordinate in-person	At Risk

QAC 03.19.2026

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												Portal. Pending report availability.	hinders our ability to monitor trends, respond proactiv ely, and support data-driven decision -making. POD: 1) The barrier with POD is that pharma cy claims data for Medi-Cal member s comes through the state; the state pays for those prescript ions. Someti me the claims are not being billed through the state, so if the	visits with Provider Relations- Drafted an outline on what BH can discuss with providers during in-person visits.	

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													member is getting their prescription at county, CalOptima Health does not know the process for members to get thier prescription outside of the states coverage. 2) Limited access to timely and regularly updated data hinders our ability to monitor trends, respond proactively, and support data-driven decision-making.		

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46	Quality of Clinical Care		Behavioral Health Services: School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report the following Student Behavioral Health Incentive Program (SBHIP) activities/school base mental health services 1 . SBHIP Program Outcome Reporting 2. DHCS CYBHI multi-Payer Fee Schedule	Report program update to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/14/2025	Manager, Director and Executive Director of Behavioral Health Integration	Project Manager of Behavioral Health Integration	Behavioral Health Integration	N/A	Final report will be presented on 10/14/2025 .	1) CalOptima Health BHI SBHIP Final Report - completed and being prepared for distribution. 2) Started reimbursing Carelon for the CYBHI Fee Schedule services.	N/A	1) Continue reimbursing Carelon for the CYBHI fee schedule services submitted by the school districts.	On Target
47	Quality of Clinical Care		Medication Management	Appropriate Testing for Pharyngitis (CWP) MC Total: Increase from 43.66% to 76.71% by 12/31/2025. OC Total: Increase from 15.77% to 72.50% by 12/31/2025. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) MC Total: Increase from 47.55% to 56.73% by 12/31/2025. OC Total: Increase from 68.97% to 47.50% by 12/31/2025.	1) Identify top 5-10 providers that prescribed antibiotics to members and provide targeted provider education via provider updates/provider newsletter. 2) Provide members with general education on antibiotic avoidance.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/14/2025	Director of Medicare Stars and Quality Initiatives	Program Manager of Quality Analytics	Quality Analytics	Appropriate Testing for Pharyngitis (CWP) MC Total: 51.67% OC Total: 15.31% Avoidance of Antibiotic Treatment for Acute Bronchitis/ Bronchiolitis (AAB) MC Total: 37.02% OC Total: 24.42%	CWP MC: A 0.04 percent point increase compared to August 2024 CWP OC: 10.41% AAB MC: A 2.39 percent point decrease compared to August 2024 AAB OC 24.90%	Create provider material on antibiotics avoidance. Identify top 10 lower performing providers.	N/A	Finalize provider communication plan in collaboration with the Quality Medical Director.	On Target

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48	Quality of Clinical Care		Medication Adherence	Improve medication adherence for Cholesterol (Statins), Hypertension (RAS Antagonists) and Diabetes	1) Member IVR, member education, provider education, PDC report to Health Networks.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/14/2025	Director of Pharmacy Management	Manager of Pharmacy Management	Pharmacy Management	3Q25 Overview: -Count of Member adherence IVRs: 3,546 -Adherence intervention calls to providers, members and pharmacies (ongoing) from January 2025 to date: 3,865 (37.1%) of the 10,406 prescriptions intervened on were filled after the intervention -Report distribution Health Networks via provider portal (daily refresh); actionable report for networks to conduct outreach Distribution of best practices document to health	CY2025 Star Measure reports from July 2025 data show: MAD=94%, MAH=95.7%, MAC=94.9% (all outperforming last year's July results).	1) Adherence IVRs 2) Adherence outreach calls to members, pharmacies and providers 3) Health network coaching 4) PDC report enhancements	1) Members picking up their medications	Continue all interventions outlined.	Concern

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										networks to assist in intervention design -100-day supply conversion program has sunsetted as of August 2025. Data for program until sunsetting is as follows: 230 prescribers outreached, 52 prescribers signed collaborative practice agreement; 74 prescriptions for 47 unique members converted.					

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49	Cultural and Linguistic Appropriate Services	CLAS HE	Performance Improvement Projects (PIPs) Medi-Cal	Increase well-child visit appointments for Black/African American members (0-15 months) from (final rate TBD) to 55.78% by 12/31/2025.	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP – Increasing W30 6+ measure rate among Black/African American Population	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics / Manager of Quality Analytics	Quality Analytics	Data through August 2025 W30 (first 15 months of life) is 32.26% compared to 46.74% compliance rate for the entire W30 population.	A significant difference in compliance exists for Black members as compared to the performance for the overall population	Telephonic outreach to parents / guardians	Contact Information: Bad or disconnected phone numbers continues to be a challenge in the ability to contact members and coordinate care.	To address contact information challenges, outreach staff outreach to the member's assigned primary care doctor and obtain updated contact information, where feasible. Continue telephonic outreach and explore additional initiatives, such as targeted outreach to pediatricians. Will do so in partnership with health networks and/or primary care providers.	Concern

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50	Quality of Clinical Care		Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) FUM and FUA for complex case management.	Non Clinical PIP: Improve the percentage of members enrolled into care management, CalOptima Health community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed with SMH/SUD.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/14/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration/ Quality Analytics	Baseline Measurement: 01/01/2023 - 12/31/2023 -1.08% Remeasurment 1: 01/01/2024 - 12/31/2024 -2.32%	Percentage has increased by 1.24% during Remeasurment Period 1	1) Continued to receive daily ED report from vendor which contains Real-Time ED data for CCN and COD members. 2) Continue collaboration with telehealth vendor. Vendor to continue ED member outreach and to provide information regarding case managment including ECM and referrals. 3) Collaboration with OC HCA and CalOptima IT regarding 837 data exchange. 4) Completed 2nd Submission for 2025 Remeasurement on 07/29/2025.	Barriers Include: 1) Coordinating/Engaging internal stakeholder departments due to competing priorities. 2) Given the diagnosis there is difficulty in connecting with this member population. 3) PHI Data Sharing with community partners, for coordination of care and outreach. 4) Lack of data exchang	1) Await findings from DHCS regarding 2025 Remeasurment 2nd submission. 2) Continue collaboration with internal Case Management and Financial Analysis depts to ensure accuracy of internal data and reports. 3) Continue to conduct barrier analysis. 4) Continue Telehealth member outreach.	On Target

QAC 03.19.2026

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													e with the County Mental Health System related to SUD. 5) Limited access to timely and regularly updated data hinders our ability to monitor trends, respond proactiv ely, and support data-driven decision -making		

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51	Quality of Clinical Care		Chronic Care Improvement Projects (CCIPs) OneCare: Diabetes Emerging Risk	By December 31, 2025, 5% of members identified as emerging risk* and who participated in program will lower HbA1c to less than 8.0%. *Emerging risk is defined as members with a result of A1C 8.0% to A1C 9.0% who were previously in good control A1C less than 8.0% in previous 12 months.	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics	Quality Analytics	Glycemic Status Assessment for Patients with Diabetes (GSD): HbA1c Poor Control (>9%) OC Controlled (Glycemic Status <8%):48%	GSD OC (controlled) : A 20 percent point increase compared to May 2024	Diabetes Member Outreach text campaign CareNet Live Call Campaign OC HbA1c Report distribution Health Networks via provider portal (daily refresh); actionable report for networks to conduct outreach	None identified.	Continue Emerging Risk project in collaboration with Elisa Mora's team. Exploration of at-home A1c testing with lab partners such as Quest.	Concern
52	Quality of Service: Access		Improve Network Adequacy: Reducing Gaps In Provider Network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network 2) Conduct outreach and implement	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/14/2025	Director of Provider Operations	Sr. Program Manager, Provider Operations/Program Specialist	Provider Data Operations	1. Gap analysis yielded the following results: a. Plan level met time or distance standards. b. Plan closed PMR gaps in LMFT from Q2	1. Time or Distance gaps trended downward from Q2 to Q3, a direct result of HNs working on closing T or D CAPs issued in January. 2. Top Time	1. PDO creating target list of providers to launch recruitment and provider audit outreach with Contracting and PR to expand Orthopedic Surgery network and close	1. WCM aging out members are going to likely need specialty care that is already experiencing access	1. Review results of outreach against goal of closing orthopedic surgery gaps. 2. Collect and review data on mixed specialty	On Target

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					recruiting efforts to address network gaps to increase access for Members					c. Plan continues to show PMR gaps in Orthopedic Surgery and Urology, with a new gap in Internal Medicine for Q3. 3. CCN remains the same at 3 gaps for Time/Distance in San Clemente - for Orthopedic Surgery and Phys Med & Rehab 4. HNs all had time/distance gaps, 6 HNs still have PMR gaps, 1 HN has a new PMR gap in Hematology/Oncology, 1 HN has closed Urology PMR gap.	or Distance Specialties are Phys Med & Rehab, HIV/Infectious Diseases, OB/GYN, Neurology, and Gastroenterology 3. Top Time or Distance Cities are La Habra (North), Ladera Ranch (South), Mission Viejo (South), Rancho Santa Margarita (South), and San Clemente (South) 4. PMR number of gaps remain the same but 2 gaps are now in different specialties from Q2. Plan level has a new gap in Internal Medicine	deficiencies. 2. Network Adequacy Workgroup moved forward with expanding specialty access to care via Telehealth and partnered with other COH departments also exploring telehealth expansion. Telemed2U contract expansion for other specialties in addition to BH is under way, starting with OneCare under Javier Sanchez. 3. Network Adequacy Workgroup is addressing the WCM Transition to Adult Care challenge by exploring ways to expand access to specialties they will need as adults, overall improving member experience	issues in general.	groups to that can be tapped to accept complex members aging out of the WCM program and determine appropriate next steps 3. Create target list to close Phys Med & Rehab Time or Distance gap in San Clemente. 3. Work with other departments leading the effort to expand Telehealth to specialty care via Telemed2U.	

QAC 03.19.2026

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											and Optum has a new gap in Hematology/Oncology. Plan closed PMR gaps in LMFT and Noble closed PMR gaps in Urology from Q2. 5. The top PMR specialties are Urology, Orthopedic Surgery, and Ophthalmology	during the transition			
53	Quality of Service: Access		Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Goal not met. Continue to assess and report the following activities: 1) Conduct an evaluation of appointment and telephone access 2) Issue corrective action for areas of noncompliance 3) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/14/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics / Project Manager of Quality Analytics	Quality Analytics	1. Issued four Access HN CAPs in Q2, and all responses have been received. 2. Issued 74 individual access provider CAPs in Q2, with a current response rate of 60%. 3. Contract with new Timely Access	1. Challenges with collecting CAP responses from individual providers 2. CAPs to remain open until MY-2025 results are received and reviewed 3. Preliminary access survey findings show a	1.ATTAC will provide CalOptima Health with data on providers with bad contact info. 2. Developing workflow and escalation policy to include disciplinary action for access non-compliance. 3. Submitted policy update for GG.1600 to Office of Compliance,	1. Providers refuse to submit response to CAP because of lack of disciplinary action 2. Provider contact data in Facets is not always accurate 3.	1. Outdated contact info will be shared with PDO for potential updates in Facets. 2. Working to develop policies and processes to include clear disciplicary action for non-complianc	On Target

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					to improve timely access. 4) Continue to educate providers on timely access standards 5) Develop and/or share tools to assist with improving access to services.					vendor, ATTAC Consulting Group eff 7/1/2025 4. Modified access survey process to include 5 phases, including resurveying and an education component 5. Survey Go-Live Start Date: September 2nd 6. In collaboration with SullivanLuallin Group, hosted two trainings on Access and Appointment Scheduling for providers and HNs. 7. Filled (replacement) analyst job opening to support Timely Access and other activities. 8. Modified Access and	65% compliance rate, and a high percentage of providers deemed ineligible or refused to partcipate	pending approval	Providers are not aware that it is a State requirement to participate in the Access survey when contacted.	e and non-participation. 3. In phase 2, vendor will educate MY-2025 non-compliant providers on standards 4. Educate providers and HNs on the new survey process using different modalities: newsletters, trainings, faxblasts, etc.	

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										Availability policy GG.1600 to reflect DHCS recommended Timely Access MPL threshold of 70%					
54	Quality of Service: Access		Network Adequacy Regulatory Submission and Audits	Comply with regulatory requirements • Annual Network Certification (ANC) • Subdelegate Network Certification (SNC) • Network Adequacy Validation (NAV) Audit	1) Annual participation of ANC, SNC and NAV to DHCS with AAS or CAP 2) Implement improvement efforts 3) Monitor for Improvement 4) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2025 2) By end of Q2 2025 3) By end of Q3 2025 Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025	Director of Provider Operations	Sr. Program Manager, Provider Operations/Program Specialist	Provider Data Operations	1. 2024 ANC - still awaiting DHCS approval of 2024 AAS revised request. COH submitted DHCS notice of Providence terminating as a medical provider. 2. 2024 SNC - All HNs have been certified by closing all deficiencies remaining through Telehealth or AAS. This update has been submitted to DHCS. 3. 2025 SNC -	1. 2025 ANC monitoring - Providence terming as a medical group did not impact Plan Level network adequacy compliance. 2. 2024 SNC - CHOC and Optum requested the least amount of AAS, AMVI the most amount, AltaMed, AMVI, FCHS, Regal, Noble, and Prospect requested the use of telehealth to close gaps.	1. 2025 ANC - PDO assessed the impact of Providence terminating and coordinated efforts between departments to provide DHCS with a transition plan which included continuity of care for members affected by this significant change. 2. 2024 SNC - COH reviewed telehealth and AAS requests June to September and was able to approve all requests, thereby closing all CAPs issued. 3. NAV: PDO implemented a Virtual Audit	None identified.	1. Perform the required action regarding 2024 ANC once received from DHCS. 2. Complete 2025 SNC Landscape Analysis submission which was issued end of Q3, due to RAC 10/29/25. 3. Begin the 2025 SNC of Health Networks 4. Review the official NAV Audit report findings	On Target

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										COH submitted DHCS NAAAR reporting adding Providence as a new COH Subcontractor 4. COH completed NAV Audit ISCAT form submission by 7/17/25 and completed the HSAG Virtual NAV Audit on 8/18/25. No follow up questions have been received from HSAG.	3. NAV - the audit proved to be a continuation of the prior year, which was HSAG's first year auditing COH. There was less focus on security and more on network adequacy data indicators, namely the source, integrity and accuracy of the data. The auditor expected COH's answers to be very similar to the prior year, since no significant changes were reported.	schedule that divided the audit to different sections, in order to minimize disruption to all departments while ensuring participation from needed departments at designated time slots.		and recommendations once issued by DHCS	

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55	Quality of Service: Access	PHM	Increase Primary Care Utilization - Initial Health Appointment	Increase the IHA completion rate for all new Medi-Cal members from 33% to 50% by December 31, 2025.	Assess and report the following activities: 1) Enhance methods of informing members of the importance of IHA and preventive screenings. 2) Collaborate with delegation oversight to improve IHA compliance by Health Network. 3) Provider and HN education to support new member screening for SDOH screening within 120 days.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director Case Management	Program Manager Case Management	Case Management	1) Member communication: - New member text message campaign went live in December 2024 and is sent monthly. In Q3 2025, text messages reached 9,403 new members with a response rate of 10.1%. - Interactive Voice Response (IVR) campaign goes out to new members twice monthly. 2) Delegation Oversight (DO) Collaboration for HN Compliance Improvement: - Working with DO,	1) N/A; In progress. 2) N/A; In progress. 3) N/A; In progress.	Presentations/ Trainings: - CME: 8/6/25 - PHMC:8/21/25 - CHCN Virtual Meeting:9/25/25 -JOMs: 7/17/25, 7/31/25, 8/14/25, 9/11/25, 9/16/25, 9/23/25 -Quality Update Meetings: 7/1/25, 7/2/25, 7/3/25, 7/23/25, 7/24/25 (2), 9/2/25, 9/3/25, 9/4/25, 9/18/25, 9/25/25 (2), 9/30/25 - CLCHC CalOptima Health Quality Meeting: 8/19/25, 9/16/25 - DOC Meetings: 8/27/25, 9/24/25 -Delegate Health Network Dashboard Monitoring BU Workgroup: 7/8/25, 8/5/25, 9/9/25 - HN	Ongoing barriers to IHA improvement include: •Claims/ encounter-only IHA logic •Auto-assignment delay •Member barriers •Unreliable member contact information •No HNs meeting the KPI benchmark aside from CHOC	1) Member communication: -Continue with existing member outreach efforts 2) DO Collaboration for HN compliance improvement -Steven Chin, Sr. Director, Provider Relations, to review the current auto-assignment process to reduce the amount of time it takes for members to be assigned to HNs -KPI benchmark reevaluation (in collaboration with	On Target

QAC 03.19.2026

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TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
										participation in Internal Stakeholder Collaborative Meetings: Provider Relations and Customer Service to reassess auto-assignment policies to possibly reduce the timeframe for members to be assigned to HN - Participation in the monthly Delegation Oversight Committee (DOC) meetings and Delegate Health Network Dashboard Monitoring Workgroup - Participation in DO's monthly Delegate		Delegation Oversight Meeting: 9/5/25 (2), 9/8/25 (2), 9/11/25 (2), 9/25/25 -Ad Hoc Meeting: 7/3/25, 8/8/25, 8/15/25,9/2/25		DO, HNPR, Medical Directors) 3) Provider/ HN education -Continue educating and supporting HNs and Providers with IHA requirements through various presentations.	

QAC 03.19.2026

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										Health Network Dashboard Monitoring -Business Unit Workgroup -ECH provides an IHA data monitoring slide and update on actions taken to DO monthly for the DOC 3) Provider/HN Education: Presented IHA updates at 40 meetings in Q3, listed in Column Q					

QAC 03.19.2026

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56	Quality of Service: Member Experience		Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal OC: One Star Improvement MC: One Star Improvement	Assess and report on the following activities: 1) Conduct outreach to members in advance of 2025 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively. 3) Launch 8 Listening Post campaigns via two-way Ushur SMS and provide year-round service recovery in collaboration with multiple departments. 4) Launch a recurring meeting series with Health Network partners dedicated to member experience improvement strategy. 5) Propose mapping of member responses to	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Project Manager of Quality Analytics / Manage of Quality Analytics	Quality Analytics	1. Closed 2. Closed 3. 1 of 8 listening posts currently active: post office visit 4. 8 Health Network meetings held to review Medi-Cal CAHPs performance 5. Mapping of CAHPS categories in process 6. Training previously provided to Case Management and ECH teams	Health Networks vary in infrastructure to improve member experence	3. Listening posts updates: YTD 7,977 members have been outreached to that have had an office visit with 306 responding and 106 member required follow up. 4. Patient experience HN meetings were held with Prospect, UCMG, AMVI, Noble, Regal, Optum and Altamed, Family Choice. Customer Service survey completed with the HN's regarding call resolution 5. Mapping of GARS data continues	Members are challenged by access issues.	Continue with plan as listed.	At Risk

QAC 03.19.2026

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					CAHPS categories in support of the organization adopting a Voice of Member reporting system. 6) Train member-facing roles to the Decision Point Insights platform to review and address CAHPS risk during member discussions.										

QAC 03.19.2026

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57	Quality of Service: Member Experience		Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process and report key findings and/or activities, analyze barriers, and improvement efforts. Maintain the grievance and appeals and resolution process while meeting all regulatory requirements for timely processing of appeals and grievances at a target goal of 95%.	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs. Improve process of handling member and provider grievance and appeals Identify trends in grievances quarterly to address member needs and systemic issues within the Plan. Utilize feedback provided in our quarterly GARS Committee Meetings to improve overall member experience and plan operations.	Report progress to GARS Q1 03/11/2025 Q2: 05/13/2025 Q3 08/12/2025 Q4: 11/13/2025 Q1: 02/10/2026	Director of Grievance and Appeals	Manager of Grievance and Appeals	GARS	1) MC and OC grievances resolved timely 2) MC and OC appeals resolved timely	Grievances: Provider/Staff Attitude related to access for appointments, transportation issues (delays, scheduling, service) and telephone accesibility. Appeals: Acess to specialty care.	1) Tracking and trending of specific providers and identifed trends quarter over quarter.	No specific barriers identifie d.	1) Continue to track and trend identified issues and providers quarter over quarter and work with internal departme nts as needed.	On Target

QAC 03.19.2026

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58	Quality of Service: Member Experience		Customer Service Call Center	Implement customer service process and monitor against the following standards: OC Call Center Abandonment Rate 5% or lower OC Call Center Average Speed of Answer 2 minutes or lower MC Call Center Average Speed of Answer 10 minutes or lower Report key findings and/or activities, analyze barriers, and improvement efforts.	Track and trend customer service call center data Comply with regulatory standards Improve process for handling customer service calls	Report progress to QIHEC Q1: 01/14/2025 Report to MemX Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/14/2025	Director of Customer Services	Manager of Customer Service	Customer Service	OneCare Call Center Abandonment Rate: 2.9% OneCare Call Center Average Speed of Answer: 30 seconds Medi-Cal Call Center Average Speed of Answer: 38 seconds	No findings to report.	Hired additional staff, collaborate with various departments to stagger their member engagement campaigns, leveraging call back capabilities for inbound calling members opting in.	None noted.	Continue with plan as listed	On Target
59	Safety of Clinical Care		Plan All Cause Readmission	Plan All-Cause Readmissions 18-64 (PCR) MC: Decrease from 0.8983 to 0.8937 by 12/31/2025. OC: Decrease from 10.00% to 8.00% by 12/31/2025.	1.Provider education for E/M's post discharge appt's within 7 days: 99495 and 99496 at Facility JOM's. Transitional Care Management (TCM) Services 2. Reivew data for usage of 99495 and 99496 at facility JOM's-Transitional Care Management Services 3. Review of ambulatory Follow up within 7 days of DC for HN and discharging facilities. 3. Collaborate	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Medical Management	None	Case Management	MC: Current O/E Rate: 0.0933 OC: Current Rate: 11.72% ** The Jan-Dec is the Prospective Reporting period for HEDISMY2025. Batch run date 10/15/2025. Usually, the data is pulled for the month for the claims paid through a month ago- may have claim lag.	Downward trend for both MC and OC. 3rd qtr findings: MC PCR trending down from Jan-July 1.183 to 0.0933%. OC is trending down from Jan-July of 12.1%-decrease of .38%	1.Provider education for E/M's post discharge appt's within 7 days: 99495 and 99496 at Facility JOM's. Transitional Care Management (TCM) Services 2. Reivew data for usage of 99495 and 99496 at facility JOM's-Transitional Care Management Services 3. Review of ambulatory Follow up within 7 days of DC for HN and discharging	1.Member engagement 2.Member outreach can be limied due to disconnected phone lines, lack of return calls, 3.Decline TCS/ECM services. 4. Limited visibility into readmission details -	Continue Planned activities: 1. Provider education on Readmission rates at Provider JOM's 2. Provider education /usage for Transitional Care Management services (99495 & 99496) at Facility JOM's. 3. Provider education of	Concern

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Back to Agenda Back to Item

QAC 03.19.2026

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					with other departments (UM/CM/TCS) for targeted outreach for TCM services- Dr. Sinha shared TCM tip sheet with provider visit, shared TCM at Community Clinic forum and Lunch and Learn.							facilities. 4. Collaborate with other departments (UM/CM/TCS) for targeted outreach for TCM services- Dr. Sinha shared TCM tip sheet with provider visit, shared TCM at Community Clinic forum and Lunch and Learn. 5. Readmission data presented at Facility JOM's	manual readmission audits	ambulatory Follow up rates within 7 days of DC for HN and facility JOM's. 4. Readmission best practices shared at HN/Facility JOM's and SNF qtrly meetings. Next Steps: 1. Implementation of evidence based TCS post discharge assesment (Project Red) designed to decrease readmissions. 2.Multiple Payor TCS workflows	

QAC 03.19.2026

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60	Safety of Clinical Care		Emergency Department Member Support	Launch the Emergency Department (ED) Program in 2025 and track utilization of services and report key findings and/or activities, analyze barriers, and improvement efforts.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Supports Referrals 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Report to UMC Q1: 02/20/2025 Q2: 05/22/2025 Q3: 08/21/2025 Q4: 11/20/2025	Sr. Director of Utilization Management	Sr. Director of Utilization Management	Utilization Management	3rd Qtr program data: Member engagement volume increased to 378 this qtr. May and June had total volume of 80 members.	Increased Member engagement qtr over qtr since Program inception earlier this year. Member engagement is in person/telephonic.	1)Onsite activities 2) Weekly workgroup identify trends/opportunities/barriers-Added BH to workgroup 3) Program enhancements supporting increased member engagement-self refer to seen members in ED 4) Warm Handoff to delegated HN/CM/TCS/ECM providers 5) Member resources and referrals (CalAim, housing, TCS, CM)	Decreased engagement from Facility staff-increasing slowly. Members decline resources	Continue planned activities 1. Onsite activities 2. Evaluate Assessement in Jiva as reporting enhancement and workflow enhancement 3. Continue refining workflows and processes 4. Expand into additional ED for support to mitigate barriers from ED discharge	On Target

QAC 03.19.2026

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61	Safety of Clinical Care		Transitional Care Services (TCS)	UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% by end of December 31,2025. [New goal will be established Q1 2025]	1) Use of Ushur platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High-Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting.	Report to UMC Q2:05/22/2025 Q3: 08/21/2025 Q4: 11/20/2025	Sr. Director of Utilization Management	Project Manager, Medical Management	Utilization Management	Internal audit results of total volume of cases and successful outreach w/in 7 days: 3rd Qtr audit: 3rd qtr we have average successful interaction at 73% within 7 days 2nd Qtr audit with 68.27% successful outreach within 7 days. 1st Qtr audit with 60.69% successful outreach within 7 days.	Results of random sample audit completed monthly showed a 12.31% improvement from first quarter.	1.DHCS TCS report restarted again (July 2025- pending final tech/specs. 2. Moved to three staff covering MH TCS activities (end of July). 3.Moved to member outreach daily for first 7days post discharge Mid-August.	1.Member outreach efforts can be challenging due to disconnected phone lines, inability to leave voicemails, and a lack of returned calls. 2. Decline TCS services	1. Obtain the most current member information to improve outreach efforts. 2. Updating the TCS reports. 3. Implementation of evidence based TCS post discharge assesment (Project Red) designed to decrease readmissions. 4. Multiple Payor TCS workflows 5. TCS best practices and TCS flyers at HN and Facility JOM's-increasing awarenes s. 6. Udpating TCS flyer with	On Target

QAC 03.19.2026

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														Providence as HN. 7. Continue daily outreach first 7 days post Discharge 8. Call recordings for quality and training purposes.	
62	Cultural and Linguistic Appropriate Services	CLAS	Language Services: Cultural and Linguistics and Language Accessibility	Implement interpreter and translation services and report key findings and/or activities, analyze barriers, and improvement. For translation services, by August 1st, 2025, CalOptima Health will expand the threshold languages to include Russian to meet requirements established by the California Department of Health Care Services (DHCS).	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards, including Member Material requirements Launch Russian as new threshold language.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/14/2025	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	• Cultural and Linguistic Services continually track and identifies trends for interpreter and translation services utilization. During the QIHEC meeting on October 14, 2025, the data and analysis of language services for the 1st, 2nd and 3rd quarters were presented	• Translations continue to have a steady volume with Spanish holding the highest number of translations every quarter. • Russian our newly added threshold language is also maintaining a steady volume of translations throughout all three quarters.	• Track and identifies trends for interpreter and translation services utilization. • Include the translation and interpreting usability for the Russian language.	No specific barriers identified.	• Continue to track and identifies trends for interpreter and translation services utilization, and include the translation and interpreting usability for the Russian language.	On Target

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										to the QIHEC committee members. • Cultural and Linguistic Services continues to comply with regulatory standards, including Member Material requirements. • On August 11, 2025, CalOptima Health's Cultural and Linguistic Services department implemented Russian as a new threshold language. • The update during the QIHEC meeting on October 14, 2025, included the translation					

QAC 03.19.2026

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										and interpreting usability for the Russian language.					
63	Cultural and Linguistic Appropriate Services	CLAS	Network Cultural Responsiveness: Data Collection on Member Demographic Information	By Dec. 31st, 2025, CalOptima Health will increase the collection of sexual orientation gender identify (SOGI) data by 10% through focused outreach and education, ensuring better representation and inclusion of members.	1) Field a survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age). 2) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks. 3) Develop and implement a survey via the Member Portal, mail to new members and other methods. 4) Share member demographic information with practitioners.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/14/2025	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	Survey's offered: 22,853 Surveys completed: 1,384 Collection Rate: 6% Based on the current collection rate, the target of a 10% collection rate won't be met, as the current rate is only at 3% through September 2025.	• The month over monthly collection rate has been steady at 6%. • The large mailing to existing members that was conducted in May 2025 to about 192,000 members resulted in low response rate and dropped our average to 3%.	• It has been difficult to implement interventions due to the reluctancy	• Reluctancy from members to provide SOGI information	• Continue to monitor and track the SOGI data collection. • Review the 2026 Health Equity Standards Changes. • Begin the implementation process for the 2026 requirements as outlined. This involves policy & desktop procedure updates, system configuration, and member survey updates.	At Risk

QAC 03.19.2026

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64	Cultural and Linguistic Appropriate Services	CLAS	Network Cultural Responsiveness: Data Collection on Practitioner Demographic Information	By Dec. 31st, 2025, CalOptima Health will increase the collection of race/ethnicity/languages (REL) data by 10% through focused outreach and education, ensuring better representation and inclusion of providers.	1) Add REL questions to routine forms, including credentialing, provider relations LOI, and provider demographic forms. 2) Enter REL data into the provider data system to ensure it can be retrieved and used for CLAS improvement. 3) Share data on the provider network's capacity to meet the language needs of CalOptima Health members. 4) Assess the provider network's ability to meet CalOptima Health's culturally diverse member needs. 5) Collaborate with other CalOptima Health departments to share SOGI data with Health Networks.	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Director of Provider Operations	Program Manger Provider Data Operations	Provider Data Management Services	REL collection increased to 3.12% overall (Race/Ethnicity 2.83%, Language 3.40%), showing a strong 20× increase from Q2 (0.155%).	Growth reflects consistent outreach and provider engagement. Data remains below the 10% goal. Continued reinforcement and streamlined collection needed.	• Direct outreach: Email and phone reminders to provider offices • PR Lunch & Learn: REL presentations began in Sept, continuing monthly through Dec. • Form-based collection: ACT, LOI, and credentialing packets integrated into workflows	• Provider participation remains voluntary. • Inconsistent completion of REL fields across forms.	• Continue provider and health network reminders to encourage submission. • Request data directly from medical groups. • Monitor quarterly trends to track progress toward the 10% goal. • Maintain monthly PR Lunch & Learn sessions.	Concern

QAC 03.19.2026

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65	Cultural and Linguistic Appropriate Services	CLAS	Experience with Language Services	Evaluate language services experience from member and staff by implementing at language services survey to member and staff by March 31, 2025. By Dec. 31st, 2025, CalOptima Health will evaluate language services experience by collecting feedback from at least 10% of members and 80% of staff using surveys and will analyze the results to identify improvements to language services.	CalOptima Health provides language services to its members and staff, ensuring that they can effectively communicate and receive the necessary support. These services are assessed to gauge satisfaction in both organizational functions and healthcare encounters. • In March 2025, Cultural and Linguistics conducted a staff and member survey to assess the language services satisfaction level of CalOptima staff and Members.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/14/2025	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	The CalOptima Health Staff survey analysis and results. • 46% of Customer Service staff have used the Language Access Program for translating documents, with the highest usage in the "Other Depts.," at 41%. • High satisfaction, with 89% of Customer Service staff and 100% of staff from several other departments being satisfied. • High satisfaction, with 100% of Customer Service staff and	The staff survey results indicate that the Customer Service department is the primary user of language services. Additionally, there is a high overall satisfaction rate with the interpreting and translation services provided at CalOptima Health. The member survey was mailed to 32,480 members who extensively utilized language services between October 2024 and March 2025. CalOptima Health received	• Engage leadership to consistently promote the importance of the survey, to help emphasize the importance of the survey. • Educate staff on the importance of their participation in the survey, which can be done through workshops, meetings, or internal communications. • Ensure that the survey is concise and focused on pinpointing areas for improvement. Making it easier for respondents to complete the survey without feeling overwhelmed. • Send text message reminders to members that have not responded to	Both staff and member surveys yielded a low response rate, which allows an opportunity to increase the response rate.	The survey of both staff and members yielded a low response rate so there is an opportunity to increase the response rate, through planned strategies, such as engage leadership to consistently promote the importance of the survey. Educate staff on the importance of their participation in the survey. Update the surveys to ensure the surveys are	On Target

QAC 03.19.2026

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										100% of staff from several other departments being satisfied. The CalOptima Health member survey results show that a significant number of members utilized language Non-Clinical Encounters: • 610 members (36%) used language services. • 562 members (92%) found it very easy or easy to use the language assistance services. • 573 members (94%) thought the language services	1,883 responses from members, which resulted in a 6% response rate. Regardless of where members utilized the services, survey results show there was a high level of satisfaction, where over 90% of members of all categories were satisfied with the language services provided and found them both accessible and beneficial.	the survey. • Cultural and Linguistic staff will continue, through the existing process, monitoring utilization, issuing notifications, and addressing complaints to ensure timely language services.		concise and focused and pinpoint areas for improvement.	

QAC 03.19.2026

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										received were very helpful. Health Encounters : • 694 members (41%) used language services. • 653 members (94%) found it very easy or easy to use the language assistance services. • 661 members (95%) thought the language services received were very helpful.					

QAC 03.19.2026

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66	Cultural and Linguistic Appropriate Services	CLAS	Network Cultural Responsiveness: Diversity, Equity and Inclusion Training	By Dec. 31st, 2025, CalOptima Health will implement and train 90% of staff, health networks, and providers on Diversity, Equity and Inclusion (DEI) training, ensuring compliance with DHCS All Plan Letter (APL) 24-016.	1. Develop a DEI Training and launch training by July 31, 2025	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/14/2025	Chief Health Equity Officer	Manager Human Resources and Provider Relations	Equity and Community Health/ HR and Provider Relations	N/A	N/A	N/A	Per the CalOptima Health legal team – CalOptima Health is a Federal Contractor. We are reviewing our requirements under state and federal law.	Per the CalOptima Health legal team – CalOptima Health is a Federal Contractor. We are reviewing our requirements under state and federal law.	Concern

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QAC 03.19.2026

TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
1	Program Oversight	2025 Quality Improvement Health Equity and Transformation Program (QIHETP) Description and Annual Work Plan	Obtain Board Approval of 2025 QIHETP Description and Workplan by April 30, 2025	QIHETP Description and Annual Work Plan will be adopted on an annual basis; QIHEC-QAC-BOD Development of the QIHETP Work Plan will include a review of the following: 1. Comprehensive Quality Strategy Report 2. Technical Report 3. Health Disparities Report 4. Preventive Services Report 5. Focus Studies 6. Encounter Data Validation Report	QIHEC: 01/14/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Quality Improvement	N/A	N/A	N/A	N/A	N/A	On Target
2	Program Oversight	2024 QIHETP Description and Work Plan Evaluation	Complete Evaluation of the 2024 QIHETP Description and Work Plan by April 30, 2025	2024 QIHETP Description and Work Plan will be evaluated for effectiveness on an annual basis; QIHEC-QAC-BOD. 2025 QIHETP Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	QIHEC: 02/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Quality Improvement	N/A	N/A	N/A	N/A	N/A	On Target

QAC 03.19.2026

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Back to Agenda

Back to Item

TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
3	Program Oversight	2025 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2025 Integrated UM and CM Program Description by April 30, 2025	Integrated UM and CM Program will be adopted on an annual basis; UMC-QIHEC-QAC-BOD	UMC: 01/23/2025 QIHEC: 2/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Executive Director of Clinical Operations	N/A	N/A	None	N/A	N/A	On Target
4	Program Oversight	2024 Integrated UM CM Program Evaluation	Complete Evaluation of 2024 Integrated UM CM Program Description by April 30, 2025	Integrated UM CM Program Description will be evaluated for effectiveness on an annual basis; UMC-QIHEC-QAC-BOD 2025 UM CM Program Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	UMC: 01/23/2025 QIHEC: 2/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Executive Director of Clinical Operations/Director Case Management	N/A	N/A	None	N/A	N/A	On Target
5	Program Oversight	2025 Population Health Management (PHM) Strategy and PHM Work Plan	Obtain Board Approval of 2025 PHM Strategy and PHM Work Plan by April 30, 2025	PHM Strategy will be adopted on an annual basis; PHMC-QIHEC-QAC-BOD	QIHEC: 01/14/2025 PHMC: 02/20/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director Case Management	N/A	N/A	N/A	N/A	N/A	On Target

QAC 05.19.2026

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
6	Program Oversight	2024 PHM Strategy Evaluation	Complete the Evaluation of the 2024 PHM Strategy by April 30, 2025	PHM Strategy will be evaluated for effectiveness on an annual basis (PHMC-QIHEC-QAC-BOD) and will include the following: 1. Develop collaborative evaluation process 2. Facilitate development of the evaluation process 3. Produce evaluation 4. Present evaluation to the appropriate governing committees 2025 PHM Strategy Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	QIHEC: 02/11/2025 PHMC: 02/20/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director Case Management	N/A	N/A	N/A	N/A	N/A	On Target
7	Program Oversight	2025 Cultural and Linguistic Accessibility Services (CLAS) Program	Obtain Board Approval of 2025 CLAS Program by April 30, 2025	CLAS Program will be adopted on an annual basis; QIHEC-QAC-BOD	QIHEC: 01/14/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Customer Service	N/A	N/A	N/A	N/A	N/A	On Target

QAC 03.19.2026

TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
8	Program Oversight	2024 CLAS Program Evaluation	Complete the Evaluation of the 2024 CLAS Program by April 30, 2025	The CLAS Program will be evaluated for effectiveness on an annual basis; QIHEC-QAC-BOD 2025 CLAS Program Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	QIHEC: 02/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Customer Service	N/A	N/A	N/A	N/A	N/A	On Target
9	Program Oversight	**Population Health Management Committee (PHMC) -** Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Workplan progress and outcomes. 2. Provide overall direction for the continuous improvement process and oversee that activities are consistent with CalOptima Health's PHM strategic goals and priorities. 3. Facilitate quarterly meetings 4. Report on PHMC activities to the QIHEC quarterly.	PHMC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/9/2025	Director Case Management	N/A	N/A	N/A	N/A	N/A	N/A

QAC 03.19.2026

TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
10	Program Oversight	**Credentialing Peer Review Committee (CPRC) Oversight** - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review to ensure quality of care delivered to members	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. 2. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Manager of Quality Improvement	The CPRC met on 10/23/2025, 11/20/2025 and 12/18/2025. Activities were reported for Q3 2025 to QIHEC on 12/09/2025. One Ob/Gyn and one PM physician continued in the Fair Hearing process. Four PQI cases were presented for leveling and actions. Three practitioners were identified for on-going monitoring. Four practitioners were presented for initial credentialing: one for recredentialing for the CCN network. Three practitioners were presented as CMO exceptions for initial credentialing. Two policies were approved. PQI, Credentialing and FSR quarterly reports were presented. Delegation Oversight presented its audit	Met the planned activities.	PQI continues to reduce its backlog. There remain 54 cases that opened prior to 2025. Credentialing completed its backlog.	1)A new Ob/Gyn physician needs to be added to CPRC since one was removed due to his retirement in 2024. 2) Medical Directors are pulled to cover for their colleagues so PQI case reviews are delayed.	Continue to present PQI, credentialing, FSR individual practitioner or group/facility issues, policies and other quality issues identified organizationally.	On Target

QAC 03.19.2026

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
							findings for delegated groups and health networks.					
11	Program Oversight	**Grievance and Appeals Resolution Services (GARS) Committee** - Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health networks. 2. Trends and results are presented by product time to the committee quarterly. 3. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	GARS Committee Report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Associate Director of Grievance and Appeals	1) MC and OC grievances resolved timely 2) MC and OC appeals resolved timely 2025 GARS Committee Meeting Dates: Q1: 05/23/2025 Q2: 08/12/2025 Q3: 11/13/2025 Q4: 03/12/2026	Grievances: Provider/Staff Attitude related to access for appointments, transportation issues (delays, scheduling, service) and telephone accessibility. Appeals: Access to specialty care.	1) Tracking and trending of specific providers and identified trends quarter over quarter.	No specific barriers identified.	1) Continue to track and trend identified issues and providers quarter over quarter and work with internal departments as needed.	On Target

QAO 03.19.2026

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12	Program Oversight	**Member Experience (MEMX) Committee Oversight -** Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. The MEMX Committee reviews the annual results of CalOptima Health's CAHPS surveys, monitors the provider network including access and availability (CCN and the HNs), reviews customer service metrics and evaluates complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	MemX Committee report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Committee met on 10/7/25. Meeting minutes from the 7/15/2025 meeting were approved. Updates presented include network certification, subcontracted network certification, network adequacy, timely access, UM, Customer Service and GARS. Medicare focus group findings were also presented. MemX update was provided to QIHEC on 12/9/2025.	QIHEC accepted the MemX update without further questions or feedback.	Continue as planned.	Member access	Continue with plan as listed.	On Target

QAC 03/19/2026

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13	Program Oversight	**Utilization Management Committee (UMC) Oversight -** Conduct internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. UMC reviews medical necessity, cost-effectiveness of care and services, reviews utilization patterns, monitors over/under-utilization, and reviews inter-rater reliability results. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	UMC Committee report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Executive Director of Clinical Operations/Director Case Management	N/A	N/A	N/A	N/A	N/A	On Target

QAC 03.19.2026

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
14	Program Oversight	**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for eligible children with California Children Services (CCS) are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee key findings/updates, activities, and recommendations to QIHEC.3	Conduct and report on the following activities: 1. WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. 3. Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	WCM CAC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Medical Director of Whole Child Model / Director of Case Management	• WCM Clinical Advisory Committee (CAC) met on November 18, 2025. • Approved August 19, 2025 meeting minutes. • Reviewed Charter updates with minor revisions. • Discussed California legislative changes impacting pharmacy scope of practice: • Presented year-to-date pediatric quality metrics, behavioral health screening data, and operational performance updates. • Reviewed All Plan Letter (APL) 24-008 on immunization requirements and other departmental reports	• Pediatricians noted missed well-child visits when vaccines are administered outside PCP offices. • Limited availability in subspecialty clinics; barriers include VFC eligibility and reimbursement. • Depression screening rates for adolescents declined by 0.8%; provider data submission gaps hinder accurate tracking. • Members flagged with CPT code G9919 (ACE score ≥4) require targeted interventions. • UM retrospective referral process improved; turnaround time was reduced to 3 days. • Enhanced pediatric risk stratification and timely outreach processes;	• Flu Vaccine Initiative: Exploring administration in subspecialty clinics. . • Depression Screening: Planned follow-up meeting to improve screening rates and integrate best practices. • Risk Stratification: Improved processes for timely outreach and assessment completion. • Operational Enhancements: Extended UM retrospective referral lookback to 60 days; streamlined turnaround times. • ACE Screening: Initiated analysis of outcomes and interventions for high-risk members	• Providers often fail to submit depression screening data. • UM turnaround reporting across all Health Networks delayed due to competing priorities. • Vaccine administration outside PCP offices reduces well-child visit adherence. • VFC eligibility and reimbursement issues for flu vaccine in subspecialty clinics.	• Pharmacy staff to research AB 144 implications and Medical RX coverage for pediatric vaccines; report back next meeting. • Schedule focused session on improving adolescent depression screening rates and provider data submission. • ACE Screening - Analyze longitudinal outcomes for high-risk members flagged with CPT G9919. • Develop UM reporting for turnaround times across all Health Networks. • Continue monitoring immunization compliance per APL 24-008 and address gaps in subspecialty vaccine access.	On Target

QAC 03.19.2026

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								committee requested foster care subset analysis				
15	Program Oversight	Care Management (CM) Program	Report on key activities of CM program, analyze CM data compared to goal, and improvement efforts.	Report on the following activities: 1. Basic PHM/CM 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: Report to UMC 11/20/25 for item 1; WCM CAC	Director of Medical Management (Case Management)/Director of Case Management	Interventions and activities were completed for the quarter.	Goal to report on activities is met.	1. Basic PHM/CM a. Ongoing Health Risk Assessments are shared with Primary Care Physician 2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM2. Early and Periodic Screening, Diagnostic	None identified.	Basic/PHM: Measure does not carry over to 2026. EPSDT 3. i) Annual audit of 10 files from each HN by CalOptima Health medical director of HN	On Target

QAC 03.19.2026

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					11/18/25 for item 2				and Treatment (EPSDT) CM: a. Continued to meet in workgroup and review necessary oversight of PSDT services. b. Discussed expanding texting campaign to members overdue for vision, dental, and hearing screening. c. Discussed future monitoring of EPSDT Utilization Management with each Health Network. d. EPSDT and PDN training for both Providers and Health Networks in Q4 on 12/8/2025 e. Ongoing Behavioral Health Integration review of depression and developmental screening codes for oversight needs. f. Ongoing Behavioral Health and Enterprise Analytics working to develop automated dashboards to track screening codes.		UM decisions. 3. ii). Annual EPSDT training for providers and HNs. 3. iii). Annual training for care coordination with regional center for providers and HNs. 3. iv). Continue meeting in workgroup at minimum quarterly to review collected data to address potential gaps in delivery of EPSDT services.	

QAC 03.19.2026

TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
16	Program Oversight	Complex Case Management Program	Implement Complex Case Management Program and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: (1) Ensure provision of CCM services resulting in optimal care coordination as evidenced through monthly auditing of 5 files or 5% of files for each health network resulting in a minimum score of 90% through December 31, 2025. (2) Obtain 85% member satisfaction in CCM program	Conduct and report on the following activities: 1. Continue training and educational opportunities to staff on the 2025 PHM5 Element D and E and complex conditions/situations (Goal 1) 2. Member Satisfaction scores will be shared with the CCN and the delegates to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, member outcomes, and improve the member experience of CM programs (Goal 2) 3. Ongoing training and support for new and existing staff. (Goal 2) 4. Continue to gather member feedback to improve outcomes. (Goal 3) 5. Training and Education on member centric care plans. (Goal 3)	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: Reports to UMC 11/20/25	Director of Medical Management (Case Management)	(1) 9 out of the 10 Health Networks achieved a score of 90% or higher (Goal 1). (2) A total of 49 members were surveyed. All questions from the member satisfaction survey met the 85% benchmark (Goal 2). (3) 49 of the members surveyed found the case management process helped them meet their care plan goals (Goal 3).	Goal 1: Not Met, CCN did not achieve a score of 90% or higher Goal 2: Met Goal 3: Met	1) Continue training and educational opportunities for all CCM staff on 2025 PHM Element D/E and complex conditions/situations. (Goal 1) a. Mock audits with consultants conducted for all health networks in November 2025. b. Individual meetings were conducted with CCN staff on the following dates: i. 11/18/2025 ii. 11/24/2025 iii. 12/30/2025 – 2 meetings iv. 12/31/2025 – 2 meetings 2) Member Satisfactions Survey (MSS) scores shared with CCN and the health networks to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, member outcomes, and improve the member experience of the CM programs. (Goal 2) a. MSS score shared during the Clinical Ops meeting with the	Goal 1: Staff training needed for Elements D and E. CCM assessment in JIVA has been a barrier for CCN	1. Continue training and educational opportunities to staff on the 2026 PHM5 Element D and E and complex conditions/situations (Goal 1). a. Planned training in in Q1 b. Develop new training materials using recommendations from mock audit. c. Provide prompt follow-up and support for any staff with marked-down items, offering coaching and resources. 2. Ongoing training and support for new and existing staff (Goals 1-3). 3. Member Satisfaction scores will be shared with all health networks to provide valuable insight to help identify strengths and areas for	At Risk

QAC 03.19.2026

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			by December 31st, 2025. (3) 85% of members surveyed who participated in CCM between January 1, 2024-December 31, 2025, will report that the case management process helped them meet their care plan goals.						Health Networks on 11/13/2025 and in the CCN CM department meeting on 12/17/2025. 3) Ongoing training and support for new and existing staff. (Goal 2) 4) Continue to gather feedback from MSS to improve outcomes. (Goal 2) a. Meeting held with QI Nurse and leadership on 10/20/2025 to discuss Q3 MSS results 5) Training and education on member centric care plans. (Goal 3) a. Care plan training for Health Networks i. 10.22.2025 Care Planning: Building a SMART Goal (AltaMed/FCMG & Regal) ii. 10.28.2025 Care Planning: Building a SMART Goal (CHOC & Noble) iii. 10.30.2025 Care Planning: Building a SMART Goal (AMVI/Prospect/UCMG		improvement to enhance the quality of care and improve the member experience in the CCM programs (Goal 2). 4. Continue to gather feedback from MSS to improve outcomes. Plan quarterly meetings with leadership to review MSS score, member feedback, and collaborate on strategies to improve the outcome (Goal 2). 5. Training and education on member centric care plans (Goal 3).	

QAC 03.19.2026

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17	Program Oversight	Population Health Management (PHM) Strategy and Program	Implement initiatives for the 2025 PHM program starting January 1, 2025.	Conduct and report the following activities: 1. Population Needs Assessment (PNA) 2. Develop and implement a PHM Work Plan and includes the following: a. Risk stratification b. Screening and Assessment c. Wellness and prevention3. Collect quarterly progress reports from PHM Work Plan implementation owners	Report to PHMCQ1: 02/20/25Q2: 05/15/25Q3: 08/21/25Q4: Reports to UMC 11/20/25/MemX 10/7/25 for Element 1;UMC 11/20/25 for Element 2&3	Director Case Management	1. 2025 PNA Approved in Q2 2025. Planning currently underway for development of 2026 PNA. 2a. Medi-Cal Connect project team refreshed analysis on risk stratification, met with DHCS to share findings, and is developing the strategy for outreach/assessment to all high-risk members identified by Medi-Cal Connect. 2a. Risk stratification: Q4 with 10,382 members (1.7%) risk stratified as high; 74.5% of members identified with an intervention; 25% of members identified without an intervention2b. Screening and assessment: Q3 results for newly enrolled members who completed a HIF/MET and/or HRA within 90 days of enrollment 6.5% and is	Goal 2a and b: Met	a. Risk stratificationOngoing tracking of risk stratification b. Screening and Assessment: Ongoing tracking of HIF/MET and HRA completion within 90 days of enrollment. Prevention	None identified.	1. 2026 PNA to be drafted in Q1. 2a. Develop strategy to outreach/assess all high-risk members identified by Medi-Cal Connect risk stratification. 2ai. Ongoing focus for high-risk members without an identified intervention for outreach.2b. Quarterly track and trend collection rate of HIF/MET2b i). Ongoing Quarterly tracking of HRA collection rates for newly enrolled SPD members. 2b ii). Barrier analysis for non-collected SPD HRA from 2025 data 2b iii). Identify and implement two strategies to address identified barriers2c. Promote HealthHub wellness and	On Target

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
							same average as prior quarter.2c. WebMD HealthHub went live in December to provide members with self-management education and wellness tools, including a library of clinically reviewed health content (articles, videos, images), interactive tools like risk calculators and quizzes. 3. Quarterly PHM Work Plan is in progress.				education to members via CalOptima Health website, social media, member newsletter. Develop process to monitor utilization. 3. Develop 2026 PHM Work plan and obtain QIHEC approval.	
18	Program Oversight	Disease Management Program	Implement 2025 Disease Management Program and report key findings and/or activities, analyze barriers, and improvement efforts and meet the following goal: 1. By December 31, 2025, 85% of members who	Conduct and report on the following activities: 1. Evaluation of current utilization of disease management services 2. Enhance identification of gaps in care to better promote quality care across all Disease Management interventions. 3. Use multimodal methods of outreach to identify members in need of Disease Management services and reduce cold calls.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: QIHEC 12/9/25	Director Case Management	1. Two-Way Text Outreach: Monthly two-way text messages continue to be sent to members identified as high-risk for asthma and diabetes. Since resolving workflow issues, we have observed an increase in the number of members opting in to participate. 2. Disease Management	1. Increase in Callback Requests After Workflow Fix: Since resolving issues with the two-way text messaging workflow, the number of members requesting a callback has significantly increased. For example, during the summer, we identified an	1. Condition-Specific Assessments: Leadership approved new condition-specific assessments to replace the JIVA Adult Integrated Assessment. These assessments include open-ended questions, enabling staff to identify the highest clinical needs more efficiently. Until full integration into JIVA, staff have been using a workaround by copying and	1. System Integration Delays: Integrating new assessments, workflows, and dashboards into the JIVA system is a lengthy process. 2. Technology Limitations: Current system capabilities do not fully support streamlined processes (e.g., pre-call	1. Complete JIVA integration for assessments and letters. 2. Roll out pre-call text campaign across all DM conditions. 3. Provide ongoing staff training on new workflows and tools. 4. Continue monitoring engagement and satisfaction	On Target

QAC 03.19.2026

TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
			participate in Disease Management program from January 1 – December 31, 2025 will report satisfaction	4. Integrate new methods to measure and improve member satisfaction.			Program Revamp: The Disease Management (DM) Leadership team meets monthly with Mr. Hunn to redesign the program. Key enhancements include: - Improved stratification to better target high-risk members - Introduction of new assessments - Updated workflows enabling DM to support members with existing episodes - Drafting a playbook for Health Networks on how to implement the DM program 3. Disease Management Satisfaction Survey: A text-based satisfaction survey is sent to members following their follow-up session to gather feedback on the DM experience.	average of 125 members across both conditions. By November, this number rose to 277 members. 2. Improved Assessment Process: When piloting the new condition-specific assessment, which includes shorter calls and more frequent follow-ups based on members' urgent needs—staff significantly increased the number of assessments completed. This improvement allowed outreach to a greater number of members. 3. High Satisfaction Maintained: Ongoing monitoring of the health coach satisfaction survey continues to show consistently high member satisfaction.	pasting assessment information into JIVA. 2. Updated Provider Communication Letters: Provider communication letters were revised to include condition-specific clinical guidelines for each disease management condition, ensuring more targeted and relevant information. 3. Pre-Call Dashboard Pilot: A pre-call dashboard was piloted to consolidate member information in one place, reducing the time staff spend reviewing data before making calls. 4. Finalization of Stratification Criteria: Collaborated with leadership and the medical director to finalize stratification criteria for each disease management condition, improving the accuracy of member targeting. 5. Pilot of Pre-Call Text Campaign: Based on the substantial increase in engagement with two-way texting, we piloted a new text	dashboard integration), which impacts efficiency while the issue is being addressed. 3. Adapting to new workflows and tools requires ongoing staff training and support, which can slow adoption. 4. Data Accuracy and Stratification: Finalizing and validating stratification criteria for multiple conditions is complex and requires collaboration across teams, which can extend timelines.	metrics. 5. Refine stratification criteria based on performance data. 6. Monitor the use of the Standing Order for Glucose Meter.	

QAC 03.10.2026

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
									message campaign that allows staff to send a message before calling members, providing a courtesy heads-up. In 2026, messages will be customized to align with monthly health observances. 6. Standing Order Process for Glucose Meters: Implemented a process allowing DM staff to order home monitoring glucose meters for high-risk diabetes members without one.			
19	Program Oversight	Health Education	Implement interventions for the 2025 Health Education program and report key findings and/or activities, analyze barriers, and improvement efforts. 2025 Health Education program focuses on promoting early detection,	Conduct and report on the following activities: 1. Evaluation of current utilization of health education services 2. Enhance methods for outreaching, promoting, and enrolling members in Health Education services and classes (e.g. text message outreach, member self-referral, etc.) 3. Expand health education offerings in various community classes and events (e.g. clinic days, virtual and in-person classes, etc.) and tech-based	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: QIHEC 12/9/25	Director Case Management	Q4 2025 referrals for Health Education services totaled 1,198. For comparison purposes, this total was 15% lower than Q4 2024 (1,418). Telephonic coaching, mailing, email and virtual classes continued to be offered as a referral outcome and advertised with community partners and agencies. Decrease in lower	1. Nutrition was again the highest requested topic, followed by weight management and diabetes. Health educators were assigned 435, accounting for 36.3%. 112 were assigned to health coaches (9.3%), 461 assigned to registered dietitians (38.4%) and 117 to the maternity program (9.7%) based on pre-	1.Conducted call campaigns in Q4 to 2,554 OneCare members to support HEDIS performance measures for diabetes and/or hypertension. Staff encouraged members to see their provider and get caught up on screenings or labs, and shared information with providers as needed. 2. Two text campaigns were launched in Q4. -Campaign 1 was launched on 12/3 to 658 OC members.	To reduce compliance risks during call campaigns, ensure PHI authorized representative information is accurately documented and easily accessible in Jiva. Additionally, contact numbers are often to the member's child who is not listed as an authorized representative.	A call campaign to inform members with diagnosed hypertension that they are overdue for labs or screenings will be created and sent in the next quarter.	On Target

QRC 03.19.2026

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
			fostering healthy habits, and empowering members to be proactive with preventive care.	modalities (app/web-based services).			outreach and engagement due to scheduling challenges.	established triage criteria. a. Nutrition - 39% b. Weight management - 21% c. Diabetes - 14% 2. Adult virtual classes continued to be offered in Q4. There were 32 SYL and adult classes provided.	This campaign reached 464 users with an open (click rate) of 1.94% and 4 opt-outs as of 12/10. -Campaign 2 launched on 12/19 to 1,880 OC members. This campaign reached 1,370 users with an open (click rate) of 2.63% and no opt-outs as of 12/24.			
20	Program Oversight	CalAIM Community Supports and Enhance Care Management (ECM)	Implement CalAIM and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: 1. By December 31, 2025, enhance community support services (e.g., housing	Community Supports Activities: 1. Conduct housing transition navigation services audits. 2. Conduct housing deposits audits. 3. Conduct housing tenancy and sustaining services audits. ECM Activity: Track ECM outreach, authorizations and services.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25 Q4: QIHEC 12/9/25	Director of Medi-Cal and CalAIM	1) The Housing Trio audit templates, structure and education to providers was completed as of 12/31/2025. The audit process launched 1/1/2026 for all 60 HousingTrio providers. 2) As of 12/31/2025 there are 6,191 open authorizations for ECM services.	1) There are no current findings for the Housing Trio audit.	1) Meet with each of the 60 contracted Housing providers to review/provide audit results. 2) Based on audit results develop trainings focused on improved quality.	N/A	1) Report results of Housing Trio audits in mid-2026	On Target

QAC 03.19.2026

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
			transition navigation services, housing deposits, and housing tenancy and sustaining services) to achieve optimal care coordination, as demonstrated by auditing the performance of 10 providers. 2. Increase number of members authorized for ECM services by 10%, from 2,500 to 2,842 by December 31, 2025.									

QAC 03.19.2026

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21	Program Oversight	Street Medicine Program	Implement Street Medicine Program and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: (1) By December 31, 2025, connect 80% of unhoused participating members to an active Primary Care Physician (PCP). (2) By December 31, 2025, connect 90% of unhoused participating members with CalAIM ECM and Housing Navigation. (3) By December 31,	Conduct and report on the following activities: Goal 1: ▪ Offer all members the opportunity to utilize the Street Medicine Provider as their PCP. ▪ Utilize Releases of Information when members have active PCP to increase collaboration and communication. ▪ Support member with PCP change, as needed. ▪ Care scheduling and delivery. Goal 2: ▪ Make attempts to engage with members weekly. ▪ Provide ECM and/or Housing Navigation appointments face to face at least every other week. ▪ Care scheduling and delivery. ▪ Document all encounters. Goal 3: ▪ Outreach to and engage unsheltered individuals ▪ Provide ECM and/or Housing Navigation ▪ Enter members in to the Coordinated Entry System ▪ Connect individuals to	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: QIHEC 12/9/25	Director, CalAIM Community Outreach	By December 2025, 98% of unhoused members were enrolled in CalAIM Services. By December 2025, 95% of unhoused members were connected to a Primary Care Physician (PCP). By December 2025, 12% of unhoused members were permanently housed or matched into another housing option.	Goals 1 and 2 were met. Goal 3 is below target; however, this is expected as there is not enough affordable housing in Orange County. There was improvement since last quarter in terms of permanent housing placements, which is worth recognizing. The teams will continue to work towards this goal.	Offer all members the opportunity to utilize the Street Medicine Provider as their PCP. ▪ Utilize Releases of Information when members have active PCP to increase collaboration and communication. ▪ Support members with PCP change, as needed. ▪ Care scheduling and delivery. Goal 2: ▪ Make attempts to engage with members weekly. ▪ Provide ECM and/or Housing Navigation appointments face to face at least every other week. ▪ Care scheduling and delivery. ▪ Document all encounters. Goal 3: ▪ Outreach to and engage unsheltered individuals ▪ Provide ECM and/or Housing Navigation ▪ Enter members in to the Coordinated Entry System ▪ Connect individuals to local shelters ▪ Work with members on completing	While Goal 1 & 2 were met, affordable, permanent housing opportunities continue to be scarce.	Continue to offer street medicine services in the three identified service areas. Launch 4th Street Medicine Program in the city of Santa Ana in early 2026.	On Target

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			2025, connect 20% of unhoused participating members to a shelter or other housing option.	local shelters ▪ Work with members on completing housing documentation					housing documentation			

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
22	Program Oversight	Long-Term Support Services (LTSS)	Implement LTSS Program and meet the 95% compliance with the following TATs: (1) CalAIM Turnaround Time (TAT): Determination completed within 5 business days (2) CBAS Inquiry to Determination (TAT): Determination completed within 30 calendar days (3) CBAS Turnaround Time (TAT): Determination completed within 5 business days (4) LTC Turnaround Time (TAT): Determination completed within 5 business days	Assess and report the following activities: 1. Evaluation of current utilization of LTSS 2. Maintain business for current programs and support for community 3. Improve process of handling member and provider requests 4. Meet goal/TATs	Report to UMC Q1: 02/20/2025 Q2: 05/22/2025 Q3: 08/22/2025 Q4:11/20/2025	Director of Long-Term Support Services	LTC TAT: 99.6% CalAIM Routine TAT: 99.4% CBAS 30-day: 100% CBAS Routine: 100% MSSP Census: 571	All LTSS programs met TAT	Continue to monitor compliance and staffing on a daily basis.	None	Daily stand-up meeting to assess productivity, barriers and staffing needs.	On Target

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
23	Program Oversight	Delegation Oversight	Implement annual oversight and performance monitoring for delegated activities and report key findings and/or activities, analyze barriers, and improvement efforts.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accreditation standard compliance that, at minimum, include comprehensive annual audits and corrective actions.	Report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/9/2025 Q4 12/9/2025	Director of Delegation Oversight	2025 Delegation Oversight Annual Audit (DOAA) completed for the following Health Networks in Q4: Optum AltaMed/Altrua MSO Family Choice/Altura MSO	Corrective Action Plan(s) Issued: Optum - UM (MC & OC) – open (9 findings) AltaMed /Altura MSO - UM (MC & OC) – open (11 findings) Family Choice /Altura MSO - UM (MC & OC) – open (8 findings)	Monitoring progress of CAPs issued for identified areas of non-compliance until closure	None	For all CAPs issued, Delegation Oversight conducts Focused Monitoring to document demonstrated compliance with the applicable identified issue(s) for three consecutive months until CAP is closed.	On Target

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24	Program Oversight	National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan (HP) Accreditation and NCQA Health Equity (HE) Accreditation by January 1, 2026	1. Implement activities for NCQA Standards compliance for HP and HP Renewal Submission by April 6, 2027. 2. Implement activities for NCQA Standards compliance for Initial HE Accreditation Survey and submit requirement documents to NCQA by October 7, 2025.	1) By December 31, 2025 2) By October 7, 2025 Report program update to QIHEC Q1:01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director Quality Improvement	1) Health Equity Accreditation (HEA): CalOptima Health achieved Health Equity Accreditation from NCQA on December 16, 2025, meeting all required deadlines and demonstrating full compliance with DHCS requirements. This accreditation is effective through December 16, 2028. The accreditation process included an initial survey submission on October 7, 2025. 2) Health Plan Accreditation (HPA): CalOptima Health's Health Plan Accreditation encompasses six core domains, evaluated over a 24-month look-back period from April 6, 2025, to April 6, 2027. Year-one document collection began in January 2025	1) Health Equity Accreditation: Earned 100% of the allowable points. There were Initial issues identified that will need improvement (HE2 Element E (Factors 1 & 2) HE4 Element A (Factors 3 & 6) HE4 Element B (Factors 2 & 4) HE5 Element B (Factors 2 & 3).	**1) Health Plan Accreditation:** - Continue collecting documents due to meet year one. Start collection of Year two deliverables due - Consultants: Conducted UM Denials, Complex Case Management, Credentialing, Appeals File reviews on CCN and Delegated networks 2) **Health Equity Accreditation:** - Ordered and shared 2026 Health Outcomes Standards - Work with Consultants to set up training on 2026 HO Standards - Conduct a gap assessment on 2026 HO Standards.	During the File review audits there were identified areas of opportunity for UM Medical Denials, Complex Case Management and some credentialing files on both CCN and Delegate files. Will need to conduct trainings and develop remediation plans for HNs.	1) HPA: Complete Year-One document collection and initiate Year-Two deliverables review to ensure timely submission. 2) Continue internal and external file reviews to ensure compliance with NCQA standards across UM Medical, Behavioral, Non-Behavioral, Pharmacy Denials, Appeals, Credentialing, Recredentialing, and Complex Case Management. 3) Collaborate with stakeholders to collect and review Year-Two documentation for the 2027 HP renewal. 4)Review and update contracts to ensure delegated activities are	On Target

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							and is on track for completion by April 2026. Each domain is actively reviewed and documented in alignment with NCQA's 2026 standards.				clearly defined and appropriately documented. 5) Continue training for delegated entities on file preparation, documentation standards, and universe submission protocols.	

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25	Program Oversight	Quality Performance Improvement: Managed Care Accountability Set (MCAS) OneCare STAR measures DHCS Quality Withhold Health Plan Accreditation (QI3) Health Plan Rating	Track and report quality performance measures required by regulators against the following goals: (1) Achieve 50th percentile MPL or above (2) Achieve 4 Stars or above (3) Achieve 100% of withhold (4) Achieve 3 or higher (5) Achieve 5.0	1. Track rates monthly 2. Share final results with QIHEC annually 3. Review and identify measures for focused improvement efforts after each monthly refresh	By December 2025 Report program update to QIHEC Q1: 01/14/2025 Q2: 05/13/2025 Q3: 07/08/2025 Q4: 11/04/2025	Director of Quality Analytics/Director of Medicare Stars and Quality Initiatives	MCAS MY2025 Prospective rates presented to QIHEC in Dec	9 measures already met the MPL, 6 measures are at the risk	Shared findings with the Quality Initiative team to work on those measures	see measure owner's responses	continue monitoring	On Target

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26	Program Oversight	Value Based Payment Program	Implement a value-based payment program and report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants - HN P4V - Hospital Quality	Assess and report the following activities: 1. Share HN performance on all P4V HEDIS measures via prospective rates report each month. 2. Share hospital quality program performance 3. Develop monthly P4V report to show HNs the estimated amount of P4V dollars based on current performance	Report program update to QIHEC Q1: 01/14/2025 Q2: ~~04/08/2025~~ 05/13/2025 Q3: 07/08/2025 Q4: ~~10/07/2024~~ 11/04/2025	Executive Director of Quality Improvement	MY2024 HN P4V results were calculated and incentives were distributed. MY2024 Hospital Quality results were calculated.	MY2024 HN P4V resulted in about 30% of the available incentive earned based on performance.	Developed NOFO for unearned P4V.	HNs failed to achieve benchmarks to earn full incentive payments.	Corrective actions will be required of HN that scored below the 25th percentile or 3-stars.	On Target
27	Quality of Clinical Care	Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	Monitor PCP, High Volume Specialist and ancillary sites utilizing the DHCS audit tool and methodology and report any findings, barriers and improvement efforts.	Review and report initial and periodic reviews conducted for PCP, high volume specialists and ancillary sites and ensure periodic reviews are conducted every three years. Tracking and trending of reports are reported quarterly.	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director of Quality Improvement	Site Review, PARS, Community-based Adult Services (CBAS), and Nursing Facilities (NF) Oversight: A.FSR: Initials FSRs=16; Periodic FSRs=38; On-site Interims=29; Failed FSRs=0 B.MRR: Initial MRRs=4; Periodic MRRs=36; Failed MRRs=4 C.CAPs: Critical Element (CE)=29; FSR=34; MRR=30	FSR/MRR: The number of Initial FSRs, and On-site Interims completed increased in Q4 2025. The number of Initial MRRs, Periodic FSRs, and Periodic MRRs decreased in Q4 2025. The number of failed FSRs and failed MRRs decreased in Q4 2025. CAPs: The number of CE and FSR CAPs	Extensive educational support and technical assistance provided to sites. This includes but is not limited to review of DHCS FSR and MRR Tools and Standards, U.S. Preventive Services Task Force (USPSTF) A & B recommendations, the American Academy of Pediatrics (AAP) periodicity schedule, most current adult and childhood vaccinations from Advisory Committee on Immunization Practices (ACIP).	None identified.	Continue with work plan as defined for 2026.	On Target

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							D.PARS: Completed PARS=148; Basic Access=52 (35%); Limited Access=96 (65%) E.CBAS Oversight: Critical Incidents=3 (0 COVID); Non-Critical Incidents=22; Falls=16; Audits Completed=16; CAPs Issued=14; Unannounced Visits=0 F. NF Oversight: Critical Incidents=10; On-Site Visits=13; Unannounced Visits=0	issued increased in Q4 2025. The number of MRR CAPs issued decreased in Q4 2025. PARS: The number of PARS completed decreased in Q4 2025. The percentage of PARS with BASIC access decreased to 35% in Q4 2025. CBAS Oversight: The number of Critical Incidents reported decreased significantly from 22 in Q3 2025 to 3 in Q4 2025. The number of Non-Critical Incidents reported increased from 16 in Q3 2025 to 29 in Q4 2025. The number of Falls reported doubled from 8 in Q3 2025 to 16 in Q4 2025.. The number of audits completed increased from 11 in Q3 2025 to 16 in Q4 2025.	Additionally, a hard copy provider audit packet is sent out to sites before every periodic audit and upon request. The packet includes resources to assist sites in providing safe and effective primary care services, to ensure and support the quality of care and documentation of appropriate clinical services, and to improve overall member health.			

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								The number of CAPs issued increased from 9 in Q3 2025 to 14 in Q4 2025. NF Oversight: The number of Critical Incidents reports received decreased from 11 in Q3 2025 to 10 in Q4 2025. The number of on-site visits completed decreased to 13 in Q4 2025.				
28	Quality of Clinical Care	Potential Quality Issues Review	PQIs are reviewed timely to ensure care and services provided fall within the range of professionally recognized standards of health care.	Review and report quality-of-care cases for peer review (CPRC), determine appropriate severity level and make recommendations for actions based on findings.	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Quality Improvement	62 PQIs were opened; 79 were closed. We currently have 326 cases opened. The Medical Directors completed IRR testing for PQI cases.	Less PQI cases were presented to CPRC than previous quarters of 2025. More cases were opened than avg for 2025 (166) and less cases were closed than avg for 2025 (238)	We are collaborating with the medical director to prioritize and close the remaining cases from 2024.	We continue to have performance issues with Jiva causing significant delays for the users.	Continue to work with IT and ZeOmega to identify and fix the performance issues.	Concern

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29	Quality of Clinical Care	Provider Credentialing and Recredentialing	All providers are credentialed and recredentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements: • No more than 180 days between verification and approval • Providers are recredentialed within 36 months	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Quality Improvement	Initial BH Credentialing Q4 = 528 Initial CCN Credentialing Q4 = 33 BH Recredentialing Q4 = 111 CCN Recredentialing Q4 = 121 For QI we did not have any recredentialing files out of compliance	Initial/Recredentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliness of the initial and recredentialing files.	1) Hired a new Director of Credentialing in August 2025 2) Hired 3 temporary positions to help with credentialing volume	1)We still have a large volume of initial credentialing file requests 2) Need resources	Hiring additional temporary positions in process	Concern
30	Quality of Clinical Care	Special Needs Plan (SNP) Model of Care (MOC)	Increase the number of members completing an HRA, and ICP and ICT to meet the following goal: Percent of Members with Completed HRA: Goal 100% Percent of Members with ICP: Goal 100% Percent of Members with ICT: Goal 100%	Assess and report the following activities: 1. Monthly communication process with Networks on ICP development 2. DHCS HRA1 and ICP1 Quarterly reporting 3. HRA Star status 4. MOC Updates 5. Face to Face interactions	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Medical Management	2a. Percent of members with completed HRA through 12/31/2025: 2b. Percent of members with ICP*through 12/31/2025 2bi. Initial 87.80% 2bii. Annual 94.70% 3. HRA Star Status: 4 Stars 5. Face-to-Face Interactions in past 12 months – as of 12/31/2025: 84% *ICP look back is 12 months For Initial ICP:	2a. Performance for HRA stable 2b. Performance for ICP Initial improving and for annual stable. 3. Projected 4 stars for MY 2025 4. Face to Face interactions with slight decrease.	Assess and report the following activities: 1. Network communications: a. Continued monthly communication to health networks. 2. DHCS Reporting: a. DHCS HRA1--This DHCS reporting has been sunset and no longer reported in 2025. b. DHCS ICP1-Q3 2025 1) Q3 results communicated with Health Networks 12/11/2025 during CalOptima Health Clinical Ops meeting. 3. HRA Star Status:	Members who decline or are UTC	1a. Quarterly tracking of reset HRA rate 1b. HRA initial and annual HRA outreach 1c. HRA reminders through texting and postcards 1d. Targeted outreach to members in need of reset or catch-up HRA 1e. QR Codes on HRA cover letters 2a. Quarterly tracking of initial ICP completion rate 2b. Monthly	On Target

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Back to Agenda Back to Item

QAC 03.19.2026

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							Completed within 30 days of HRA, or within 120 days of enrollment if no HRA is collected. For Annual ICP: Completed within 12 months of the prior ICP.		a. Continue HRA reminders through texting and postcards b. Continue targeting outreach to members needing reset or catch-up HRA. c. Continue initial and annual outreach. 4. MOC Updates: The D-SNP Model of Care (MOC) 2026 Matrix was submitted and approved by DHCS and CMS in Q4 2025. 5. Face to Face Interactions with PCP or specialist: Ongoing outreach to members requiring face-to-face visit. Continue sharing with Health Networks their members who are more than 12 months from face-to-face visit.		Communication to Health Networks on ICP Development 3. Monthly tracking of ICT to Health Network 4. Quarterly tracking and trending HRA Star Status and annual face-to-face 5. CalOptima Health D SNP 2027 MOC revision submission 1-3: Barrier analysis with strategies identified to address. 1-3: Implement two strategies to address identified barriers and monitor response.	

QAC 03.19.2026

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31	Quality of Clinical Care	Pediatric and Adolescent Wellness: EPSDT/Children's Preventive and Screening Services	Childhood Immunization Status (CIS) MC Combo 10: 42.34% Increase from 36.50% to 42.34% by 12/31/2025. Immunizations for Adolescents (IMA) MC Combo 2: Increase from 47.45% to 48.66% by 12/31/2025. Well-Child Visits in the First 30 Months of Life (W30) MC First 15 Months: Increase from 58.92% to 63.38% by 12/31/2025. MC 15 to 30 Months: Increase from 72.44% to 73.09% by 12/31/2025. Child and Adolescent Well-Care Visits (WCV) MC Total: Increase from 53.03% to 55.29% by	Goal not met - W30. Continue to assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored and age-appropriate messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs (e.g. provide insight into CIS Combo 10 status for each vaccine) 4. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone) 5. For CIS Combo 10, identify members missing only the first Hep B vaccine and complete chart chase efforts year-round 6. Begin prospective outreach to members that will age into the measure for the following year (i.e. message 1 year old members to ensure compliance with recommended vaccine schedule thus far) 7. Create educational	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/14/2025 Q3: 08/12/2025 Q3: 11/04/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Preliminary results; data through December 2025 CIS-10: 30.83% IMA: 48.34% W30 (0-15 months; 6 or more visits): 61.96% W30 (15-30 months; 2 or more visits): 75.31% WCV: 54.17% LSC: 73.21%	CIS already achieved the 50th (23.89%) percentile during Q3. IMA already achieved 76th percentile (40%) during Q3. The following measures have not met the MPL: W30 (0-15) 63.38%, W30 (15-30) 72.32%, WCV (55.41%), LSC (69.96%). These rates are not final and projected to increase with Cozeva bridge data solution to support gap closure.	Ongoing outreach to parents/guardians/members via Carenet (telephonic) and Ushur (SMS). Creation of personalized pediatric mailer. Launch first pediatric email campaign. Implementation of Cozeva bridge which will support HN and provider partners with detailed data for CIS, W30 and other pediatric measures.	Transition to new requisition system caused delays in the processing of the pediatric mailer. The mailer was cancelled as the mailing date would not lead to measure impact.	Continue Cologuard Campaign monitoring CareNet live calls. Develop and launch culturally appropriate multimodal messages in support of this recommended care. Explore initiatives that target the primary drivers to noncompliance. For example, messaging around HPV vaccination to support IMA, messaging for pediatric flu vaccines in support of CIS. Address vaccine hesitancy in members. Provider education efforts centered around vaccination recommendations and other best practices.	At Risk

QAC 03192026

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			12/31/2025. Lead Screening in Children (LSC) MC LSC: Increase from 63.75% to 63.84% by 12/31/2025.	materials for addressing vaccine hesitancy and distribute to providers and members 8. Drive provider participation in the Standing Orders Program to place lab orders for blood lead testing 9. Provide point-of-care lead testing equipment and supplies to providers via the Quality Improvement Grant Program 10. Early Identification and Data Gap Bridging Remediation for early intervention								

QAC 03.19.2026

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32	Quality of Clinical Care	Adult Wellness: Preventive and Screening Services	Cervical Cancer Screening (CCS) MC: Increase from 58.31% to 60.10% by 12/31/2025. Colorectal Cancer Screening (COL) OC: Increase from 66.84% to 70.33% by 12/31/2025. Breast Cancer Screening (BCS-E) MC: Increase from 58.39% to 59.51 % by 12/31/2025. OC: Increase from 66.88% to 75.00 % by 12/31/2025. Immunization Status - Flu, Pneu, Tdap, Zoster MC Flu Total: Increase from 22.19% to 26.40% by 12/31/2025. OC Flu Total: Increase from 47.17% to 49.12% by 12/31/2025. MC Pneumococca	Assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs 4. Provide facility listings for services completed outside the PCP office setting, such as diagnostic sites for mammography 5.Provide mobile mammography services in collaboration with other departments, Health Network partners, and CHCN providers 6. Provide at-home Cologuard testing for Colorectal Cancer Screening 7. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone)	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Cervical Cancer Screening (CCS) MC: 48.72% Colorectal Cancer Screening (COL) OC: 66% Breast Cancer Screening (BCS) MC: 50.13% OC: 66% Immunization Status - Flu, Pneu, Tdap, Zoster (AIS-E) [data through Nov 2025] AIS: Adult Imms (Influenza) [Medi-Cal]: 18.04 AIS: Adult Imms (Pneumo) [Medi-Cal]: 54.96 AIS: Adult Imms (Td/Tdap) [Medi-Cal]: 45.31 AIS: Adult Imms (Zoster) [Medi-Cal]: 20.61 OC Flu Total: 44.26 OC Pneumococcal 66+: 68.14 OC Tdap Total: 50.07 OC Zoster Total: 25.42	CCS MC: A 5.56 percent point increase compared to Sept 2024 COL OC: A 8 percent point increase compared to Sept 2024 BCS MC: A 1.06 percent point decrease compared to Sept 2024 BCS OC: A 4 percent point increase compared to Sept 2024 AIS: Adult Imms (Influenza) [MC]: 2.08 percentage point increase compared to Sep 2024 AIS: Adult Imms (Pneumo) [MC]: 6.94 percentage point increase compared to Sep 2024 AIS: Adult Imms (Td/Tdap) [MC]: 6.55 percentage point increase compared to Sep 2024 AIS: Adult Imms (Zoster) [MC]: 4.28 percentage point increase compared to Sep	CareNet Live Call Campaign for CCS, MC and OC BCS, OC COL Cologuard Campaign for OC Cologuard Text Campaign Flu Postcard Q4 Care gap member outreach Q4	None identified.	Continue Cologuard Campaign monitoring CareNet live calls for MC CCS, MC/OC BCS, and MC COL Continue Flu Postcard for members Q4 Relaunch Flu Shot IVR robocall campaign Q4 Relaunch Flu Shot Texting Campaign Q4 Launch Flu Shot Email Campaign Q4	On Target

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QAC 03 Q2 2026

Back to Agenda

Back to Item

			l 66+: Increase from 38.18% to 38.73% by 12/31/2025. OC Pneumococcal 66+: Increase from 44.96% to 56.76% by 12/31/2025. MC Tdap Total: Increase from 25.43% to 33.40% by 12/31/2025. OC Tdap Total: Increase from 24.57% to 31.56% by 12/31/2025. MC Zoster Total: Increase from 17.52% to 20.56% by 12/31/2025. OC Zoster Total: Increase from 23.62% to 40.94% by 12/31/2025.					2024 AIS: Adult Imms (Influenza) [OC]: 0.74 percentage point increase compared to Sep 2024 AIS: Adult Imms (Pneumo) [OC]: 22.97 percentage point increase compared to Sep 2024 AIS: Adult Imms (Td/Tdap) [OC]: 8.59 percentage point increase compared to Sep 2024 AIS: Adult Imms (Zoster) [OC]: 0.94 percentage point increase compared to Sep 2024				

QAC 03.19.2026

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33	Quality of Clinical Care	CalOptima Health Comprehensive Community Cancer Screening Program (CCCSP)	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer report key findings and/or activities, analyze barriers, and improvement efforts.	Assess and report the following: 1. Establish the Comprehensive Community Cancer Screening and Support Grants program and monitor Grantees' progress to measure impact 2. Develop and implement a comprehensive plan for other initiatives under CCCSP.	Report Program update to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Chief Medical Officer	Breast Cancer Screening (BCS) MY2024: 59.13% MY2025: 57.73% Cervical Cancer Screening (CCS) MY2024: 49.92% MY2025: 52.68% Colorectal Cancer Screening (COL) MY2024: 47.6% MY2025: 48.78% FQHC Cancer Grant Prospective Rates for November were shared to each grantee to track for their progress report #4	Prospective rates for November show that 3 FQHC Cancer Grants have met their proposed goals for COL and BCS measures; meanwhile, other grantees continue to show improvement and are on track to meet their proposed goals by the end of the grant period.	1. Launched Lung Cancer Screening and Cancer Treatment campaign with mPulse 2. Coordinated four Alinea Mobile Mammography events with various health clinics; 102 total completed screenings 3. Held in-person grantee meeting for Member Success Story sharing 4. Met 1:1 with grantees to discuss the documentation and tracking of early-stage cancer discovery	1.Cancer Treatment Campaign: Due to the eligibility criteria and logic error, the program had to stop the launch of this campaign immediately. 2. Lung Cancer Screening: Lack of resources to ensure timely outreach to members who indicated needing help with scheduling an appointment. 3. Cancer grantees did not report impactful member success stories that highlighted how the grant funds supported effective screening efforts and cancer findings.	1. Revise the Cancer Treatment campaign to appeal in a more general tone and revisit the parameters used for the eligibility file to ensure accuracy. 2. Identify and develop a process to support members who are requesting scheduling or general help. In the interim, leverage an LDCT standing order to close care gaps for the current lung cancer screening campaign launch.	On Target

QAC 03.19.2026

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34	Quality of Clinical Care	Maternal and Child Health: Prenatal and Postpartum Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). MC Prenatal: Increase from 88.08% to 88.58% by 12/31/2025. MC Postpartum: Increase from 80.00% to 80.23% by 12/31/2025.	Assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Implement a comprehensive outreach strategy utilizing multiple modalities timed with the member meeting denominator-qualifying criteria 4. Launch an interdepartmental maternal health workgroup focused on improving outcomes and addressing disparities 5. Provide bundled code education to high volume providers 6.Create a comprehensive dashboard / report that refreshes weekly to ensure timely member identification and intervention 7. Collaborate with OBGYN specialty groups to perform member outreach and schedule services 8. Expand on	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Medicare Stars and Quality Initiatives	Data through December 2025 (continuous enrollment applied): PPC Prenatal Care: 81.77% PPC Postpartum Care: 82.48% Rates shown are administrative. Both measures are hybrid; thus, final rates will vary.	Prenatal Care has not met the 50th percentile (86.37%). Postpartum Care has not met the 50th percentile (77.22%). Final rates are projected to be higher.	1. Quality led telephonic outreach targeting members that were not compliant for postpartum. 2. Maternal Health Team sought report development to support the identification of pregnant members 3. Development of postpartum text message campaign. 4. Interdepartmental maternal health workgroup led by Maternal Health team. 5. Continued maternal health program outreach to members through the entire perinatal timeframe to provide education and support reduction in care gaps. 6. Participate in community collaborative that target the perinatal population.	Resource constraints. Quality partnership with Finance was put on hold to avoid duplication of initiatives as CalOptima Health's maternal team is developing report to support early identification of prenatal/postpartum members.	1. Identify primary drivers to noncompliance and targeted interventions for at risk populations. 2. Develop culturally tailored messaging to improve member engagement. 3. Identification of top Ob/Gyn providers 4. Collaboration with top Ob/Gyn providers (best practices, member outreach and scheduling). 5. Increase postpartum care member health reward from $25 to $50 to help drive members to complete care and implement a broader promotion strategy. 6. Continue maternal health workgroup. 7. Multimodal member communication	At Risk

QAC 03.19.2026

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				collaborative efforts with community-based organizations, providers, and health networks.							(SMS/text/email) .	

QAC 03.19.2026

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35	Quality of Clinical Care	Maternal and Child Health: Prenatal and Postpartum Depression Screening	Prenatal Depression Screening and Follow-Up (PND-E) MC Screening: Increase from 14.52% to 16.03% by 12/31/2025. MC Follow-up: Increase from 52.80% to 53.33% by 12/31/2025. Postpartum Depression Screening and Follow-Up (PDS-E) MC Screening: Increase from 17.33% to 29.84% by 12/31/2025. MC Follow-up: Increase from 56.84% to 61.70% by 12/31/2025.	PND-E & PDS-E Activities: 1. Provider maternal mental health training 2. Enhance CalOptima Health Maternal Depression Program and support referral to Behavior Health Integration when screened at risk. 3. Conduct or promote depression screening at community events.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: QIHEC 11/4/25	Director Medical Management	Data through December 2025 (continuous enrollment applied): Prenatal Depression Screening (PND-E): 4.8% Prenatal Depression Screening Follow-Up (PND-E): 77.78% Postpartum Depression Screening (PDS-E): 3.21% Postpartum Depression Screening Follow-Up (PND-E): 89.29%	Prenatal depression screening and follow-up have both met the 50th percentile; 9.54% and 57.23% respectively. Postpartum depression screening and follow-up have both met the 50th percentile; 5.46% and 69.1% respectively.	1. Continued to screen pregnant and postpartum members for depression during telephonic outreach. 2. Transfer at risk members to BH for additional services 3. Provided TeleMed2U flyer in mailed materials. 4. Implemented a multi-departmental internal maternal health workgroup	ECH Community Impact Team was discontinued so screenings at event also discontinued	Continue to develop strategies to improve rates including better identification of pregnant members.	On Target

QAC 03.19.2026

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36	Cultural and Linguistic Appropriate Services	Maternity Care for Black Members	Medi-Cal 1. Increase timeliness of prenatal care (TOPC) for CalOptima's Black members from 75.71% to 84.55% by December 31, 2025. 2. Increase postpartum care (PPC) for CalOptima's Black members from 71.43% to 80.23% by December 31, 2025.	Assess and report the following activities: 1. Connect members to doula, Enhanced Care Management (ECM) services, and Black Infant Health (BIH) programs. 2. Implement community and clinic events that focus on improving prenatal and postpartum appointments. 3. Explore digital methods of providing perinatal assessments, education, and resource navigation for pregnant and postpartum members.	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Director Medical Management	PPC Postpartum Care: 64.79% compliance rate for Black members compared to 69.43% compliance rate for the entire PPC population (data through August 2025) PPC Prenatal Care: 78.87% compliance rate for Black members compared to 81.54% compliance rate for the entire PPC population (data through August 2025)	Based on August 2025 data, the Black or African American population is trending lower in compliance for prenatal and postpartum care as compared to the entire population and White members.	OC HCA has received the ECM report for Black perinatal members through their MOU with CalOptima Health. They are attempting outreach to these members to offer ECM, doula, and Black Infant Health (BIH) program (4 ECM referrals received in Q4)	1. Limited doula outreach 2. Additional calls to the members due to partner support	Evaluate results of the OC HCA/ CalOptima Health project and determine next steps for outreach to targeted members	On Target

QAC 03.19.2026

37	Quality of Clinical Care	Chronic Conditions: Members with Diabetes	Eye Exam for Patients with Diabetes (EED) MC EED 64.06% Increase from 63.52% to 64.06% by 12/31/2025. OC: EED 77.00%; Increase from 75.14% to 77.00% by 12/31/2025. HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates Percentage of members with poor A1C control-lower rate is better) (>9.0%) MC HBD: Decrease from 29.34% to 27.01% by 12/31/2025. OC HBD: 10.00% decrease from 15.30% to 10.00% by 12/31/2025.	Assess and report the following activities (Quality Analytics): 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs 4. Explore at-home testing for HBD via lab vendor 5. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone) 6. Drive provider participation in the Standing Orders program to place A1c lab orders on behalf of physicians 7. Collaborate with OPH and OPT providers on member outreach and scheduling of services for EED 8 Regularly review members with evidence of A1c testing but no result and address via supplemental data capture 9. Partner with VSP to	By December 2025 Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: QIHEC 11/4/25	Director of Quality Analytics (Medicare Stars and Quality Initiatives)/Director Case Management	Eye Exam for Patients with Diabetes (EED) MC: 52.69% OC: 71% Glycemic Status Assessment for Patients with Diabetes (GSD): HbA1c Poor Control (>9%) MC Poorly Controlled (Glycemic Status >9%): 38.58% OC Controlled (Glycemic Status <8%): 73%	EED MC: A 11.99 percent point increase compared to Sept 2024 EED OC: A 12 percent point increase compared to Sept 2024 GSD MC (poor control): A 20.22 percent point decrease compared to July Sept (lower is better) GSD OC (controlled): A 26 percent point increase compared to Sept 2024	MC and OC Quest Home Test Kit for A1c Quest Home Test Kit Text Campaign CareNet Live Call Campaign for MC and OC HbA1c VSP Eye Exam mailing reminder OC Diabetes Management Mailing Piloted new Disease Management Program model with focused assessments, prioritizing member outreach by A1c, leveling criteria based on clinical needs.	None identified.	Identify member segments for the development of tailored messaging. Continue CareNet Live Call Campaign and other multimodal outreach efforts such as SMS/email. Continue to monitor Quest Home Test Kit Continue VSP mailing Continue EED and GSD member health rewards. Finalize Disease Management program design and share with Health Networks for feedback.	On Target

QAC 05/19/2026

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				educate providers on EED CPT II code submission to capture testing results 10. Explore offering EED testing at community-based events Assess and report the following activities: 1. Enhance Diabetes Education: Launch virtual and group education classes to improve member engagement by FY 2025. 2. Leverage Technology: Use digital apps and web-based tools to support diabetes prevention, management, and interactive engagement. 3. Strengthen Support Services: Link members to medically tailored meals, health coaching nutrition services, community/clinic events.							

QAC 03.19.2026

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38	Quality of Clinical Care	Chronic Conditions: Members with Heart Health (Hypertension)	Controlling High Blood Pressure (CBP) MC CBP: Maintain the 90th percentile (72.75%) or higher by December 31, 2025. OC CBP: Increase from 74.87% to 80.00% by 12/31/2025. Controlling High Blood Pressure (CBP) - CLAS and Health Disparity for Medi-Cal 1. Increase CBP rate among Black and African American Medi-Cal members from 39.21% to 64.48% by 12/31/2025. 2. Increase CBP rate among Black and African American Medicare	Assess and report the following activities: 1. Expand Hypertension Program to offer both virtual and in-person Hypertension Education.	Report to PHMC: Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: QIHEC 11/4/25	Director Case Management	CBP Rate: OC 48% MC 44.78%	Trending upward for both LOB from Q3: OC: 6% increase MC:8.62% increase	1. Telephonic Outreach Continuation and Impact: Continued telephonic outreach to OneCare members with elevated BP readings or no readings on file to provide education on BP management, and reinforced PCP visit importance continued until 12/31/2025. Standing orders for BP monitors were initiated as needed. 2. The standing order program remained a critical strategy, resulting in 730 BP monitors distributed in 2025 to support member self-monitoring. 3. Data Collection and Provider Collaboration: Continued collecting home BP readings from OC members and faxing results to providers for documentation. In Q4, 306 readings were successfully obtained through member self-report.	1. Difficulty reaching members with no BP readings on file or those who are less responsive to telephonic outreach and text campaigns. 2. A workflow integration is needed to automate data extraction and streamline reporting. BP readings must currently be manually pulled from JIVA to share with the QA team, creating inefficiencies. 3. Consistent training is needed to ensure staff understand and follow the specific process for obtaining and reporting BP readings. Without ongoing education, variability in data collection and reporting may occur.	1.Continue to enhance outreach for hypertension and connect members to their PCP for medication review as needed. Provide telephonic education, collect BP readings, monitor distribution of BP monitors, and assess impact on member engagement and clinical outcomes. 2. Provide consistent, ongoing training on BP data collection, reporting processes, and use of standing orders to ensure accuracy and compliance. 3. Develop and implement a JIVA integration to streamline BP data extraction and reporting for QA, reducing	On Target

QAC 03.19.2026

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			members from 47.24% to 77% by 12/31/2025. 3. Increase CBP rate among Korean speaking Medi-Cal members from 24.87% to 64.48% by 12/31/2025. 4. Increase CBP rate among Vietnamese speaking Medicare members from 50.56% to 77% by12/31/2025.								manual workload.	

QAC 03.19.2026

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
39	Quality of Clinical Care	Chronic Conditions: Osteoporosis	Osteoporosis Management in Women Who Had a Fracture (OMW) OC Total: Increase from 34.67% to 39.00% by 12/31/2025.	1.Case management to collaborate with Quality to identify members who need follow-up. 2.Quality to outreach to noncompliant members via SMS, mail, and/or telephone. 3.Quality to pursue at-home DEXA testing via vendor. 4.Quality to provide timely notifications to the member's PCP via fax. 5.Quality to explore collaboration with the Pharmacy team to provide education on the importance of taking a medication to treat osteoporosis (e.g. bisphosphonate). 6.Quality and Case Management coordinate to provide more timely data and insight to the member's compliance deadline date to Health Network partners.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: UMC 11/20/25	Sr. Director Medical Management /Manager of Quality Analytics	The OMW measure is demonstrating stable performance when compared to the same point in time last year (MY2025 performance: 53.42% vs. MY2024 performance: 54.17%).	The OMW measure demonstrates stable performance when compared year over year using Citius administrative data. While the 2025 rate reflects a slight decline from the prior year, overall performance remains consistent. Collaboration between Case Management and Quality supported care coordination of members. The measure is performing at 3 stars through Q4 2025 which represents significant improvement compared to previous year's performance.	All planned activities are ongoing. 1. Case management and Quality team collaboration to identify members who need coordination of care (DEXA, prescription). a. Continued using Point Click Care hospital data source to identify members with fracture. 2. Member outreach to noncompliant members via SMS, mail, and/or telephone. 3. Quality led timely notifications to the member's PCP via fax. 4. Quality and Case Management coordinate to provide more timely data and insight to the member's compliance deadline date to Health Network partner. Ongoing communication with Health Networks.	N/A	Continue with the planned activities and coordination with Case Management and vendor partners to sustain improvement. 1. Case management to collaborate with Quality to identify members who need follow-up. Continue to work with IT to incorporate Point Click Care data for Members identified as OMW to incorporate into Key Event reporting. 2. Member outreach to noncompliant members via SMS, mail, and/or telephone. 3. Utilization of at-home visit providers to complete bone density testing in the home. 4. Ongoing	On Target

QAC 03.19.2026

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
											timely notifications to the member's PCP via fax. 5. Utilize the Cozeva platform to support timely, automatic data sharing with Health Network partners.	
40	Quality of Clinical Care	Chronic Conditions: Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) OC Total: Increase from 51.27% to 53.00% by 12/31/2025.	1. Review and update the Key Events for Emergency Visits 2. Continue to share Emergency Visits with Health Networks through Key Event reporting.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q4: UMC 11/20/25	Director Medical Management	Preliminary results per Citius show stable performance with FMC January 2025 to November at 50.6%.	1. FMC to date for 2025 through November is 50.6% and is similar to 2024 rate of 50.8% for same point in time. 2. Preliminary results for 2025 per Hyperlyft project FMC to be 56% which exceeds targeted goal.	1. Key Event outbound reporting for Emergency Visits updated to reflect members who are identified for FMC. 2. Continued to share Emergency Visits with Health Networks through Key Event reporting.	None identified.	FMC is moving to PHM/Care Management 1. Continue to share FMC information through Key Event reporting. 2. Continue to track quarterly results of FMC when available	On Target

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
41	Quality of Clinical Care	Behavioral Health Services: Child and Adolescent Health on Antipsychotics	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) MC Glucose and Cholesterol Combined-All Ages: Increase from 36.76% to 41.41% by December 31, 2025.	Goal not met. Continue to assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primary Care Providers (PCP) for members in need of metabolic monitoring. 2) Work collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in need of screening. 3) Monthly mailing to prescribing providers to remind of best practices for members in need of screening. 4) Send monthly reminder text message to members (approx. 600 mbrs). 5) Information sharing via provider portal to PCP on best practices.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	APM HEDIS Rates Q4 (November) MC: 33.43%	APM increased from Q3 (September) to Q4 (November) by 6.14%	1) PCP Provider Mailout: a. 9/23/2025 - 123 letters b. 10/16/2025 - 160 letters c. 11/25/2025 - 126 letters d. 12/15/2025 - 121 letters 2) Text Campaign sent out: a. 9/11/2025 b. 10/09/2025 c. 11/13/2025 d. 12/12/2025 3) HEDIS Provider Tool Tip Sheet Edited to add codes 4) Provider Education 11/17/25 - Weekly HN Communication sent out to HNs re: New BH reports in Provider portal 11/19/25 – Live with “BH Measures Report” and “FUM/FUA Daily ED” report in the Provider portal 12/3/25 - Provider Update Newsletter sent out to Providers re: New BH reports in Provider portal 12/8/25 - Reminder on Weekly HN Communication sent out to HNs re:	Barriers include: 1) Unable to do prescribing provider outreach due to lack of data. 2) Edit was needed to Tip Tool Sheet	1) Continue Text message campaign. 2) Continue Provider mailout of Best Practices Letter and Tip tool sheet. 2) Continue mailings of Prescribing Providers materials (Best Practices letter and Provider tip tool sheet) to providers on a monthly basis. 3) Schedule listening sessions with Providers to educate/train on how to obtain BH data upon BH report availability. 4) Resume Coordination for Provider Outreach with Provider Relations a. Coordinate in-person visits with Provider Relations- Draft an outline on what BH can discuss with providers during	Concern

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
									New BH reports in Provider portal		in-person visits. b. Conduct in-person provider outreach with top 10 providers on a monthly basis.	

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
42	Quality of Clinical Care	Behavioral Health Services: Depression	Depression Screening and Follow-up for Adolescents and Adults (DSF-E) MC Screening Total: Increase from 6.57% to 16.22% by December 31, 2025. OC Screening Total: Maintain the 90th percentile (54.28%) or higher by December 31, 2025.	DSF-E Goal not met. Continue to assess and report the following activities: 1) Educate providers on the importance of screenings and follow-up care after positive screenings. 2) Educate members on the importance of screenings through newsletters/outreach and increase follow-up appointments after positive screenings.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	DSF-E HEDIS Rates Q4 (November) MC: 5.89% OC: 5.12%	DSF-E Increased from Q3 (September) to Q4 (November) MC: by 2.19% OC: by 0.62%	1) Provider letter: a. Presented Provider letter to BHQI Workgroup on 08/14/2025. b. BHQI finalized on 8/26/2025 2) PCP Provider Mailout: a. 9/21/2025 - 621 letters b.10/16/2025 - 528 letters c. 11/25/2025 - 477 letters d. 12/18/2025 - 552 letters 3) HEDIS Provider Tool Tip Sheet edited for needed correction 4) Provider Education 11/17/25 - Weekly HN Communication sent out to HNs re: New BH reports in Provider portal 11/19/25 – Live with “BH Measures Report” and “FUM/FUA Daily ED” report in the Provider portal 12/3/25 - Provider Update Newsletter sent out to Providers re: New BH reports in Provider portal 12/8/25 - Reminder on Weekly HN Communication sent out to HNs re:	Barriers include: 1) Unable to do prescribing provider mail out due to lack of data. 2) Data Capture. 3) Lack of interface with Provider EMR to capture Loin Codes.	DSF-E: 1) Continue Provider Mailout of Provider materials: Best Practices letter and Provider tip tool sheet to providers on a monthly basis. 2) Schedule listening sessions with Providers to educate/train on how to obtain BH data upon BH report availability. 3) Commence next steps to send out a text message campaign. 4) Coordinate for Provider Outreach with Provider Relations a. Coordinate in-person visits with Provider Relations- Draft an outline on what BH can discuss with providers during in-person visits. b. Conduct in-person provider outreach with top	At Risk

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
									New BH reports in Provider portal		10 providers on a monthly basis.	

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
43	Quality of Clinical Care	Behavioral Health Services: Schizophrenia	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) MC SSD: Increase from 74.96% to 79.51% by 12/31/2025. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) MC: Increase from 70.19% to 74.83% by 12/31/2025. OC: Increase from 77.37% to 77.93% by 12/31/2025.	SSD Goal not met. Continue to assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collaboratively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx. 1100 mbrs) 5) Member Health Reward Program. SAA Assess and report the following activities: 1) Educate providers on the importance of medication adherence through outreach. 2) Educate members on the importance of	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	SSD Q4 (November) PR: MC 74.45% SAA Q4 (November) PR: MC 66.39% OC 78.72%	SSD PR increased from Q3 (September) to Q4 (November) by 5.01% SAA PR increased from Q3 (September) to Q4 (November) for: MC by 27.88% OC by 5.96%	SSD: 1) Launched a mailing campaign featuring the SSD Best Practice PCP Letter, Tool Tip Sheet and Member Reward Flyer on the following dates: - October 30th to 117 PCP's - November 21st to 112 PCP's - December 16th to 37 PCP's 2) Launched a mailing of the SSD reward flyer on the following dates: - October 30th to 90 members - November 21st to1 member - December 16th to 49 members 3) Text messaging campaign launched to 1,100 members on the following dates: - October 16th - November 20th - December 18th. 4) SSD report added to our Provider Portal November 19th 5) Weekly HN Communication sent out to HNs re: New BH reports in Provider portal sent out on the following dates: - November 17th	SSD Barriers include: 1) Member compliance is a challenge with this population due to diagnosis. 2) Inability to conduct prescribing provider outreach due to missing data. 3) Limited access to timely and regularly updated data hinders our ability to monitor trends, respond proactively, and support data-driven decision-making. SAA Barriers Include: 1) Inability to conduct prescribing provider outreach due to missing data. 2) Limited access to timely and regularly updated data hinders our ability to monitor trends, respond	SSD: 1) Continue tracking members in need of glucose screening test. 2) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 3) Continue to follow up on data pull for text messaging campaign. 4) Monthly mail of the SSD health rewards flyer to eligible members. 5) Continue to mail out to all PCP offices the following: a. Best Practice PCP Letter b. Provider Tool Tip Sheet c. Member Reward Flyer 6) Schedule listening sessions with Providers to educate/train on how to obtain BH data.	SDD -Concern SAA - On Target

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
				medication adherence through newsletters/outreach.					- December 8th 6) Provider Update Newsletter sent out to Providers re: New BH reports in Provider portal on November 19th 7) Submission of SAA/SSD Combo for Medi-Cal text message campaign via MMA process on December 4th (Sent to RAC on 12/11/25) SAA: 1) Launched a mailing campaign featuring the SAA Provider Letter and Tool Tip Sheet on the following dates: - October 30th to Medi-Cal 227 PCP's and 124 Medicare PCP's - November 21st to 112 PCP's - December 16th to 37 PCP's 3) SSD report added to our Provider Portal on November 19th 4) Weekly HN Communication sent out to HNs re: New BH reports in Provider portal sent out on the following dates: - November 17th - December 8th	proactively, and support data-driven decision-making.	7) Coordinate in-person visits with Provider Relations- Drafted an outline on what BH can discuss with providers during in-person visits. SAA: 1) Will use provider portal to communicate best practices and guidelines for medication adherence and member follow-up. 2) Discussion of implementing a text messaging campaign. 3) Continue mail out to all prescribing provider offices the following: a. Best Practice PCP letter b. Provider Tool Tip Sheet 4) Schedule listening sessions with providers to educate/train on how to obtain BH	

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									5) Provider Update Newsletter sent out to Providers re: New BH reports in Provider portal on November 19th 6) Submission of SAA/SSD Combo for Medi-Cal text message campaign via MMA process on December 4th (Sent to RAC on 12/11/25) 7) Submission of SAA Medicare text message campaign via MMA process on December 4tth, RAC completed on 12/10/25, In Translation 12/22/25.		data. 5) Coordinate in-person visits with Provider Relations- Drafted an outline on what BH can discuss with providers during in-person visits.	

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44	Quality of Clinical Care	Behavioral Health Services: Care Coordination and Follow-up Care	Follow-Up After Emergency Department Visit for Mental Illness (FUM) MC 30-Day: Increase from 35.76% to 53.82% by 12/31/2025. MC 7-day: Increase from 21.38% to 33.01% by 12/31/2025. Follow-Up After Emergency Department Visit for Substance Use (FUA) MC 30-Day: Increase from 21.12% to 36.18% by 12/31/2025. MC 7-Day: Increase from 11.23% to 18.76% by 12/31/2025. Follow-up After High-Intensity Care for Substance Use Disorder (FUI) MC 30-Day: Increase from 20.25% to	FUM Goal not met. Continue to assess and report the following activities: 1. Share real-time ED data with our health networks on a secured FTP site. 2. Participate in provider educational events related to follow-up visits. 3. Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4. Bi-Weekly Member Text Messaging (approx. 500 mbrs) 5. IVR calls to members who fall under the FUM measure FUA Goal not met. Continue to assess and report the following activities: 1. IVR calls to members who fall under the FUA measure 2. Continue weekly member text messaging 3. Share FUA data with providers through the Provider Portal. 4. Sharing FUA data with Health Networks via sFTP. FUI: This measure was added for monitoring	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	FUM PR HEDIS Rates Q4 (November): 30 day- 53.02%, 7 day- 33.99% FUA PR HEDIS RATES Q4 (November): 30-day: 30.66% 7-day: 18.02% FUI PR HEDIS Rates Q4 (November): 30-day: 37.84% 7-day: 17.22%	FUM PR increased 13.69% from Q3 (September) Q4 (November) for 30-day and by 10.47% for the 7-day rate. FUA PR increased from Q3 (September) to Q4 (November) for 30-day by 4.77% and for the 7-day the rate increased by 4.13%. FUI PR increased from Q3 (September) to Q4 (November) for 30-day by 11.78% and for the 7-day the rate increased by 8.81%	FUM/FUA Interventions 1) Member text messages sent weekly. 2) Member outreach via BH Telehealth vendor to assist with scheduling Follow up appointments. Outreach based on daily ED data feed. 3) Reminders regarding importance of FUM/FUA sent in monthly HN Communication. 4) Continued sharing FUM/FUA data with HN Networks via sFTP. 6) BH Measures Report and FUM/FUA Daily ED reports went live on Provider Portal 11/19/25 7) Continued Participation in DHCS / OCHCA BH Collaboration Project which is focusing on improving the rates for FUA/FUM measures. 8) Provider Update Newsletter was sent to providers announcing the availability of new Behavioral Health (BH) reports in the Provider Portal sent on 12/3/25 9) Reminder in the Weekly HN Communication sent	1) Member engagement continues to be a challenge with this population due to diagnosis. 2) Limited access to timely and regularly updated data hinders our ability to monitor trends, respond proactively, and support data-driven decision-making.	FUM/FUA 1) Assessing the implementation of IVR calls to remind members who meet FUM/FUA criteria to schedule a follow-up appointment after an ED visit. 2) Continue Daily Text Campaign. 3) Continue to meet with High volume ED's to ensure members are connected to services before they leave the hospital by introducing Telemed2U/NAMI By Your Side. 4) Continue to share BH Measures Report and FUM/FUA Daily ED reports via Provider portal. 5) Continue participation in DHCS/OCHCA BH Collaboration Project.with the goal of improving FUA/FUM HEDIS outcomes 6) Continue to attend HN Quality Meetings.	On Target

QAC 03.19.2026

			44.53% by 12/31/2025. MC 7-Day: Increase from 7.99% to 26.90% by 12/31/2025.	purposes. Opportunities for improvement and/or interventions will be considered upon the ability to obtain data from the Orange County Health Care Agency.					to HNs to remind them that New BH reports are available in the Provider Portal sent on 12/8/25. 10) Collaboration with OCHCA to receive 837 files FUI: 1) Measure is currently being monitored to ensure progress aligns with established targets.		7) Coordinate in-person visits with Provider Relations- Drafted an outline on what BH can discuss with providers during in-person visits. 8) Share BH Medi-Cal Member Journey magnets with QA team to distribute to Transtreme, At-Home Visit Provider, magnets outline key steps in the member care journey to reinforce engagement and follow-up. FUI: 1) Continue to monitor measure on a monthly basis. 2) Continue collaborative meetings between teams to identify best practices to implement strategic interventions. 3) Coordinate in-person visits with Provider Relations- Drafted an	

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											outline on what BH can discuss with providers during in-person visits	

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45	Quality of Clinical Care	Behavioral Health Services: Medication Management	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) MC Total: Increase from 28.95% to 54.55% by 12/31/2025. Pharmacotherapy for Opioid Use Disorder (POD) MC Total: 21.36% Increase from 7.79% to 21.36% by 12/31/2025.	Assess and report on the following activities: 1) Educate providers on measure and best practice guidelines.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	APP: PR HEDIS Rate Q4 (November): MC: 57.69% POD HEDIS RATES Q4 (November): MC: 7.43%	APP has increased by 20.33% from Q3 (September) to Q4(November). POD PR increased from Q3 (September) to Q4 (November) by 1.42%	APP: 1) Sent out 20 Provider Letters and Tip Tool Sheets on 09/11/25 and sent 16 provider letters and tip tool sheets on 10/21/25. 2) APP text message campaign was approved in BHQI Workgroup and submitted to MMA/DHCS. It has been approved and translated; it should be ready to send out to members in 2026. 3) 11/17/25 - Weekly HN Communication sent out to HNs re: New BH reports in Provider portal. 4) 12/3/25 - Provider Update Newsletter sent out to Providers re: New BH reports in Provider portal. 5) 12/8/25 - Reminder on Weekly HN Communication sent out to HNs re: New BH reports in Provider portal. POD: 1) HEDIS Provider Tool Tip Sheet sent to providers in the CalOptima Health, Health Network	APP: 1) There was an error on the APP Provider Tip Tool sheet that was corrected. POD: 1) The barrier with POD is that pharmacy claims data for Medi-Cal members comes through the state; the state pays for those prescriptions. Sometime the claims are not being billed through the state, so if the member is getting their prescription at county, CalOptima Health does not know the process for members to get their prescription outside of the state's coverage. 2) Limited access to timely and regularly updated data hinders our ability to monitor	APP: 1) Provider mailouts will continue to be sent out. POD: 1) Continue to discuss with county the POD data gap issue during county collaboration meetings. 2) Coordinate in-person visits with Provider Relations- Drafted an outline on what BH can discuss with providers during in-person visits	APP-On Target POD- At Risk

QAC 03.19.2026

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									Weekly Communication. 2) Created a Quick Reference Guide (QRG) & Power Point Presentation for providers and staff on how to use the Provider Portal.	trends, respond proactively, and support data-driven decision-making		
46	Quality of Clinical Care	Behavioral Health Services: School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report the following Student Behavioral Health Incentive Program (SBHIP) activities/school base mental health services 1. SBHIP Program Outcome Reporting 2. DHCS CYBHI multi-Payer Fee Schedule	Report program update to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	N/A	N/A	N/A	N/A	N/A	N/A

QAC 03.19.2026

TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
47	Quality of Clinical Care	Medication Management	Appropriate Testing for Pharyngitis (CWP) MC Total: Increase from 43.66% to 76.71% by 12/31/2025. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) MC Total: Increase from 47.55% to 56.73% by 12/31/2025.	1) Identify top 5-10 providers that prescribed antibiotics to members and provide targeted provider education via provider updates/provider newsletter. 2) Provide members with general education on antibiotic avoidance.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Medicare Stars and Quality Initiatives	Appropriate Testing for Pharyngitis (CWP) MC Total: 51.59% OC Total: 15.56% Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) MC Total: 62.59% OC Total: 72.25%	CWP MC: A 0.79 percent point decrease compared to Sep 2024 CWP OC: A 5.88 percent point increase compared to Sep 2024 AAB MC: A 22.89 percent point increase compared to Sep 2024 AAB OC: A 1.73 percent point decrease compared to Sep 2024	Created provider material on antibiotic avoidance. Identified top 10 lower performing providers.	N/A	Send providers measure info in PR provider updates / Provider newsletters in Q1 2026	On Target
48	Quality of Clinical Care	Medication Adherence	Improve medication adherence for Cholesterol (Statins), Hypertension (RAS Antagonists) and Diabetes	1) Member IVR, member education, provider education, PDC report to Health Networks.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Pharmacy Management	4Q25 Overview: -Count of Member adherence IVRs: 5,683 -Adherence intervention calls to providers, members and pharmacies (ongoing) from January 2025 to date: 13,136 calls made to refill actionable prescriptions for 3,435 unique members.success	CY2025 Star Measure reports from November 2025 data show: MAD=89.8%, MAH=89.6%, MAC=87.6% (all outperforming last year's November results).	1) Adherence IVRs 2) Adherence outreach calls to members, pharmacies and providers 3) Health network coaching 4) PDC report enhancements 5) Continue work to promote mail order in 2026 6) Implement Clarest Health software solution for enhanced adherence reporting	1) Members picking up their medications	Continue all interventions outlined.	Concern

QAC 03.19.2026

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							rate was ~40%. -Report distribution Health Networks via provider portal (daily refresh); actionable report for networks to conduct outreach Distribution of best practices document to health networks to assist in intervention design -Implemented mailing services with 2026 mail order pharmacy for OneCare.		and outreach documentation.			
49	Cultural and Linguistic Appropriate Services	Performance Improvement Projects (PIPs) Medi-Cal	Increase well-child visit appointments for Black/African American members (0-15 months) from (final rate TBD) to 55.78% by 12/31/2025.	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP – Increasing W30 6+ measure rate among Black/African American Population	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Data through December 2025 (non-continuous enrollment applied): W30 (0-15 months): 45%	A significant difference in compliance still exists among African American children when compared to other groups and the MPL rate (61.96%). Final rate when factoring in continuous enrollment is projected to increase, however disparities are	Telephonic outreach to parents/guardians to coordinate well-child visit appointments. Text message campaigns to encourage well-child visits.	Contact information: Bad or disconnected phone numbers continued to be a challenge in successfully contacting members and coordinating care.	Explore targeted partnerships with Health Networks and pediatric providers. Develop and launch culturally appropriate messages for groups such as African American members that are performing lower than MPL. To complement the tailored, messages,	At Risk

QAC 03.19.2026

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								projected to be evident.			deploy multimodal outreach campaigns to improve compliance.	
50	Quality of Clinical Care	Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) FUM and FUA for complex case management.	Non-Clinical PIP: Improve the percentage of members enrolled into care management, CalOptima Health community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed with SMH/SUD.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Baseline Measurement: 01/01/2023-12/31/2023-1.08% Remeasurement 1: 01/01/2024-12/31/2024-2.32%	Percentage has increased by 1.24% during Remeasurement Period 1	1) Continued to receive daily ED report from vendor which contains Real-Time ED data for CCN and COD members. 2) Continue collaboration with telehealth vendor. Vendor to continue ED member outreach and to provide information regarding case management including ECM and referrals. 3) Collaboration with OC HCA and CalOptima IT regarding 837 data exchange to enhance visibility into Orange County's FUM and FUA rate trends. 4) Completed 2nd Submission for 2025	1) Coordinating / Engaging internal stakeholder departments due to competing priorities. 2) Given the diagnosis, there is difficulty in connecting with this member population. 3) PHI Data Sharing with community partners, for coordination of care and outreach. 4) Lack of data exchange with the County Mental Health System related to SUD. 5) Limited	1) Meet with internal Case Management and Financial Analysis depts to share 2nd submission results. 2) Continue collaboration with internal Case Management and Financial Analysis depts ensure accuracy of internal data and reports. 3) Continue to conduct barrier analysis. 4) Continue Telehealth member outreach.	Concern

QAC 03.19.2026

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									Remeasurement on 07/29/2025.	access to timely and regularly updated data hinders our ability to monitor trends, respond proactively, and support data-driven decision-making		

QAC 03.19.2026

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51	Quality of Clinical Care	Chronic Care Improvement Projects (CCIPs) OneCare: Diabetes Emerging Risk	By December 31, 2025, 5% of members identified as emerging risk* and who participated in program will lower HbA1c to less than 8.0%. *Emerging risk is defined as members with a result of A1C 8.0% to A1C 9.0% who were previously in good control A1C less than 8.0% in previous 12 months.	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in Persons with Diabetes	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Glycemic Status Assessment for Patients with Diabetes (GSD): OC Controlled (Glycemic Status <8%):73%	GSD OC (controlled): A 26 percent point increase compared to Sept 2024	OC Diabetes Management mailing CareNet Live Call Campaign for MC and OC HbA1c Quest Home test kit for A1c Quest Home test kit Text Campaign	None identified.	CCIP completed in 2025. New CCIP cycle to begin in MY2026. Continue collaboration with Medical Management.	On Target
52	Quality of Service: Access	Improve Network Adequacy: Reducing Gaps In Provider Network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network 2) Conduct outreach and implement recruiting efforts to address network gaps	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025	Director of Provider Operations	1. Gap analysis yielded the following results a. Plan level met time or distance standards. 2. Plan closed PMR gap in Internal Medicine and Orthopedic Surgery from Q3 but continues to show gap in	1. Plan PMR gap has gone down to 1 from Q3. AltaMed has a new PMR gap in OB/GYN. 2. HN Time or Distance gaps continues the downward trend through Q4, a direct result of HNs working on	1. Contracting was able to contract with a new Urology provider to help improve our Urology Provider-to-Member ratio, lessening the gap. 2. PDO continues to support efforts to get TeleMed2U contracted to provide telehealth specialty	1. Urology recruitment takes time due to the general nature of the contracting process, but also due to lack of providers in the specialty that are available to contract.	1. Continue contracting efforts 2. Continue to work with HNs on closing their gaps, which overlaps with Plan level PMR gap	On Target

QAC 03.19.2026

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				to increase access for Members			Urology 3. CCN remains the same at 3 Time/Distance gaps in San Clemente - for Orthopedic Surgery and Phys Med & Rehab 4. HNs all had time/distance gaps, 6 HNs still have PMR gaps,1 HN has a new PMR gap in OB/GYN	closing Time or Distance gaps. 3. HN Top Time or Distance Specialties are Phys Med & Rehab, OB/GYN, Neurology, Gastroenterology, and HIV/Infectious Diseases 4. HN Top Time or Distance Cities are all south county - San Clemente, Mission Viejo, Ladera Ranch, Rancho Santa Margarita, Laguna Niguel unlike Q3 which included La Habra in north county. 5. The top HN PMR gap specialties are Urology, Ophthalmology, OB/GYN, Gastroenterology, Hematology/Oncology, and Orthopedic Surgery	services which will help with Urology gap			

QAC 03.19.2026

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53	Quality of Service: Access	Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Goal not met. Continue to assess and report the following activities: 1) Conduct an evaluation of appointment and telephone access 2) Issue corrective action for areas of noncompliance 3) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely access. 4) Continue to educate providers on timely access standards 5) Develop and/or share tools to assist with improving access to services.	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	•Completed phases 1-3 for the Timely Access Survey - MY2025 •Completed records for phase 1 and 3 combined include a 90% Compliance Rate •Overall results for Phase 1 and 3 combined shows: 1158 Non-Responding Providers and 1041 Ineligibles	•Educating and resurveying provider offices improved overall compliance rate by 30% •Specialists did not meet the appointment standards for both urgent and non-urgent •Family Medicine and Cardiology had the highest number of non-compliant providers between phase 1 and 3 • Largest categories contributing to ineligibles were: providers no longer practices at their locations and invalid phone numbers	•Vendor outreach calls in phase 2 to educate provider offices •Non-compliance notices issued in phase 2 via mail, email, and fax •Resurveyed 344 non-compliant providers in phase 3	•Providers may not be aware that participation is a state requirement •Contact info on file is not accurate •Monitoring process is manual and time consuming	•Notify non-responding providers that survey participation is mandatory when contacted •Resurvey both non-responding and non-compliant providers in phase 4 •Explore the use of the provider portal for surveys for MY2026 •MY2026 Access Survey target date: 7/1/2026	On Target
54	Quality of Service: Access	Network Adequacy Regulatory Submission and Audits	Comply with regulatory requirements • Annual Network Certification (ANC) • Subdelegate Network Certification	1) Annual participation of ANC, SNC and NAV to DHCS with AAS or CAP 2) Implement improvement efforts 3) Monitor for Improvement 4) Communicate	Submission: 1) By end of January 15, 2025 2) By end of Q2 2025 3) By end of Q3 2025 Report to	Director of Provider Operations	1. 2024 ANC - DHCS has approved COH 2024 AAS revised request. 2. 2025 ANC - COH has no gaps in Time or Distance. 3. 2025 SNC -	1. COH showing no time or distance gaps at the plan level. 2. COH found the HNs non-compliant with SNC requirements for RY 2025 in Time	1. Worked on getting 2024 AAS posted on COH Website to meet regulatory requirements	We did not find any barriers this past quarter.	1. Connect with COH departments to ensure that services affected by approved AAS are properly administered according to AAS	On Target

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QAC 03.19.2026

Back to Agenda Back to Item

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			(SNC) • Network Adequacy Validation (NAV) Audit	results and remediation process to HN	MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025		Completed Landscape Analysis submission to DHCS 4. COH received confirmation from HSAG that NAV Virtual Audit is fully closed 5. Completed 2025 SNC Analysis of all HNs.	or Distance and Provider-to-Member Ratio. The HNs passed all other SNC elements.			requirements 2. Issue CAPs to HNs that showed SNC deficiency for RY 2025 3. Increase HN leadership awareness of network adequacy regulatory requirements	
55	Quality of Service: Access	Increase Primary Care Utilization - Initial Health Appointment	Increase the IHA completion rate for all new Medi-Cal members from 33% to 50% by December 31, 2025.	Assess and report the following activities: 1) Enhance methods of informing members of the importance of IHA and preventive screenings. 2) Collaborate with delegation oversight to improve IHA compliance by Health Network. 3) Provider and HN education to support new member screening for SDOH screening within 120 days.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: QIHEC 12/9/25	Director Case Management	1) Member communication: - New member text message campaign went live in December 2024 and is sent monthly. - Interactive Voice Response (IVR) campaign goes out to new members twice monthly. 2) Delegation Oversight (DO) Collaboration for HN Compliance Improvement: - Working with DO, participation in Internal Stakeholder Collaborative Meetings:	1) N/A; In progress. 2) N/A; In progress. 3) N/A; In progress.	Presentations/Trainings: -JOMs: 11/18/25, 12/2/25, 12/11/25 -Quality Update Meetings: 11/4/25, 11/5/25, 11/6/25, 11/20/25 (2), 12/4/25 - Health Network Collaborative Quality Forum 11/12/25 -CLCHC CalOptima Health Quality Meeting: 10/21/25, 11/18/25, 12/16/25 - DOC Meetings: 10/29/25, 12/3/25 - Dashboard Collaboration Workgroup: 10/22/25, 11/19/25	Ongoing barriers to IHA improvement include •Claims/encounter-only IHA logic •Auto-assignment delay •Member barriers •Unreliable member contact information •No HNs meeting the KPI benchmark aside from CHOC	1) Member communication: -Continue with existing member outreach efforts 2) DO Collaboration for HN compliance improvement -Steven Chin, Sr. Director, Provider Relations, to review the current auto-assignment process to reduce the amount of time it takes for members to be assigned to HNs -KPI benchmark reevaluation (in collaboration	On Target

QAC 03.19.2026

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							Provider Relations and Customer Service to reassess auto-assignment policies to possibly reduce the timeframe for members to be assigned to HN - Participation in the monthly Delegation Oversight Committee (DOC) meetings and Delegate Health Network Dashboard Monitoring Workgroup -Participation in DO's monthly Delegate Health Network Dashboard Monitoring - Business Unit Workgroup -ECH provides an IHA data monitoring slide and update on actions taken to DO monthly for the DOC 3) Provider/HN Education: Presented IHA updates at 17				with Enterprise Analytics, DO, HNPR, Medical Directors) 3) Provider/HN education -Continue educating and supporting HNs and Providers with IHA requirements through various presentations.	

QAC 03.19.2026

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							meetings in Q4, listed in Column Q					

QAC 03.19.2026

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56	Quality of Service: Member Experience	Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal OC: One Star Improvement MC: One Star Improvement	Assess and report on the following activities: 1) Conduct outreach to members in advance of 2025 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively. 3) Launch 8 Listening Post campaigns via two-way Ushur SMS and provide year-round service recovery in collaboration with multiple departments. 4) Launch a recurring meeting series with Health Network partners dedicated to member experience improvement strategy. 5) Propose mapping of member responses to CAHPS categories in support of the organization adopting a Voice of Member reporting system. 6) Train member-facing roles to the Decision Point Insights platform to review and address CAHPS risk during member discussions.	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	1. Closed 2. Closed 3. Post office visit Listening Post is live and is launched monthly 4. 9 Health Network Patient Experience meetings were held 5. Mapping of CAHPS categories continues 6. Previously completed with ECH and CM.	Health Networks are engaged in strategies to collectively improve member experience.	3. Listening Post campaign post office visit was sent to 1,526 members in October, 1,328 in November and 1,137 in December. 4. Patient experience meetings were held with Prospect, AMVI, UCMG, CHOC, Family Choice, Heritage Regal, Altamed, Noble and Optum. CAHPS improvement opportunities were reviewed. 5. Mapping of GARS data in process.	Member access and a cohesive approval to member experience by the Health Networks.	Continue with plan as listed.	At Risk

QAC 03.19.2026

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57	Quality of Service: Member Experience	Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process and report key findings and/or activities, analyze barriers, and improvement efforts. Maintain the grievance and appeals and resolution process while meeting all regulatory requirements for timely processing of appeals and grievances at a target goal of 95%.	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs. Improve process of handling member and provider grievance and appeals Identify trends in grievances quarterly to address member needs and systemic issues within the Plan. Utilize feedback provided in our quarterly GARS Committee Meetings to improve overall member experience and plan operations.	Report progress to GARS Q1 03/11/2025 Q2: 05/13/2025 Q3 08/12/2025 Q4 11/13/2025 Q1: 02/10/2026	Director of Grievance and Appeals	1) MC and OC grievances resolved timely 2) MC and OC appeals resolved timely	Grievances: Provider/Staff Attitude related to access for appointments, transportation issues (delays, scheduling, service) and telephone accessibility. Appeals: Access to specialty care.	1) Tracking and trending of specific providers and identified trends quarter over quarter.	No specific barriers identified.	1) Continue to track and trend identified issues and providers quarter over quarter and work with internal departments as needed.	On Target

QAC 03.19.2026

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58	Quality of Service: Member Experience	Customer Service Call Center	Implement customer service process and monitor against the following standards: OC Call Center Abandonment Rate 5% or lower OC Call Center Average Speed of Answer 2 minutes or lower MC Call Center Average Speed of Answer 10 minutes or lower Report key findings and/or activities, analyze barriers, and improvement efforts.	Track and trend customer service call center data Comply with regulatory standards Improve process for handling customer service calls	Report progress to QIHEC Q1: 01/14/2025 Report to MemX Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/07/2025	Director of Customer Services	OneCare Call Center Abandonment Rate: 2.7% OneCare Call Center Average Speed of Answer: 33 seconds Medi-Cal Call Center Average Speed of Answer: 4:35 seconds	The emergency food program increased the amount of calls into our call center, resulting in a higher average speed of answer, however, the regulatory standard was still achieved.	Hired additional staff, collaborate with various departments to stagger their member engagement campaigns, leveraging callback capabilities for inbound calling members opting in.	The emergency food program vendor was not contracted to support inbound calls.	Continue with plan as listed	On Target

QAC 03.19.2026

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59	Safety of Clinical Care	Plan All Cause Readmission	Plan All-Cause Readmissions 18-64 (PCR) MC: Decrease from 0.8983 to 0.8937 by 12/31/2025. OC: Decrease from 10.00% to 8.00% by 12/31/2025.	1. Collaborate with Quality /Data analytics to identify top 5-10 readmission DX – consider adding in top 5-10 member readmission data for targeted education and outreach for member/provider. 2. review of ambulatory Follow up within 7 days of DC for HN and discharging facilities. 3. Provider education for E/M's post discharge appt's within 7 days: 99495 and 99496. 3. Collaborate with other departments (UM/CM/TCS) for targeted outreach for member outreach for	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Medical Management	Results: MC PCR: Trending lower, Jan–Dec average 1.0243 OC: Trending lower, Jan–Dec average 10.26%	Findings: Both MC and OC show a downward trend. Q4 Performance: End-of-year goal not met Continued improvement efforts planned for 2026	Provider Education at JOMs: Review readmission rates and trends. Educate on Transitional Care Management (TCM) services (CPT codes 99495 & 99496) and proper data usage. Share post-discharge ambulatory follow-up rates within 7 days for Health Network (HN) and facility JOMs. Present readmission best practices during HN/Facility JOMs and quarterly SNF meetings. Member Transition Support: Distribute TCS and OneCare support flyers to providers and members. Implement multi-payer TCS workflow to streamline transitions. Conduct daily TCS outreach for the first 7 days post-discharge. Assist with PCP follow-up appointments as needed. Staff Training & Process Enhancements: ECM provider follow-up: Ensure ECM is	Limited visibility into readmission details due to manual audit processes. Post-Transition Support Challenges: Member outreach limitations caused by: Disconnected phone numbers. Lack of returned calls. Member Engagement: Low participation or declination of TCS/ECM services. Limited interaction during TCS support, reducing effectiveness of interventions.	Continue: Provider Education at JOMs: Share readmission rates and trends. Review post-discharge ambulatory follow-up rates within 7 days for HN and facility JOMs. Present readmission best practices during HN/Facility JOMs and quarterly SNF meetings. Member Transition Support: Continue distribution of TCS and OneCare support flyers. Maintain multi-payer TCS workflow for streamlined transitions. Conduct daily TCS outreach for the first 7 days post-discharge. Assist with PCP follow-up appointments as	Concern

QAC 03.19.2026

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									aware of admissions and follow-up needs. Member education: Signs and symptoms to monitor post-discharge. Referral process: Connect members to CM/ECM for ongoing needs after TCS. Additional Outreach: OneCare member outreach following ED discharge. Support scheduling of PCP follow-up appointments post-discharge.		needed. Share TCS success interactions within 7 days at HN JOM's Ongoing Staff Development Additional Outreach: Sustain OneCare member outreach following ED discharge. Support scheduling of PCP follow-up appointments post-discharge.	
60	Safety of Clinical Care	Emergency Department Member Support	Launch the Emergency Department (ED) Program in 2025 and track utilization of services and report key findings and/or activities, analyze barriers, and improvement efforts.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Supports Referrals 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Report to UMC Q1: 02/20/2025 Q2: 05/22/2025 Q3: 08/21/2025 Q4: 11/20/2025	Director of Long Term Support Services	4th qtr. results: 15.6 % increase in member outreach, Member volume 4th qtr. 416 up from 378 from 3rd qtr.	Increased member engagement qtr. over qtr. since inception this year. Member engagement is in person/telephonic. Some members are engaged for follow-up outreach post ED discharge. Referrals for ECM/TCS/CM/Community supports with	Onsite Activities: Provide member resources and referrals as identified. Weekly Workgroup: Review trends and opportunities; follow up with members on recommendations. Care Coordination: Facilitate warm handoffs to HN; collaborate with TCS, ECM, and CM teams. Referral Tracking: Implemented tracking system to gain better insight into program outcomes.	Members often decline resources. Facility with decreased engagement.	Onsite Engagement: Continue providing member resources and referrals as identified. • Weekly Workgroup: Maintain review of trends and opportunities; follow up with members on recommendations. • Care Coordination:	On Target

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QAC 03.19.2026

Back to Agenda Back to Item

TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
								member engagement.	OneCare Outreach: Initiated member outreach in December for follow-up appointments post-ED discharge. Recuperative Care Support: Assist with identification of bed days to support facilities and members.		Sustain warm handoffs to HN; collaborate with TCS, ECM, and CM teams. • Referral Tracking: Continue monitoring referral data for deeper insight into program outcomes. • OneCare Outreach: Track ongoing outreach efforts for follow-up appointments post-ED discharge. • Workflow Optimization: Continue refining workflows and processes to improve efficiency and member experience. • ED Expansion: Extend support into additional Emergency Departments to mitigate barriers and enhance member care. • Recuperative Care Support: Continue	

QAC 03.19.2026

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											assisting with identification of bed days to support facilities and members.	
61	Safety of Clinical Care	Transitional Care Services (TCS)	UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% by end of December 31,2025. [New goal will be established Q1 2025]	1) Use of Ushur platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High-Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting.	Report to UMC Q2: 05/22/2025 Q3: 08/21/2025 Q4: 11/20/2025	Sr. Director of Utilization Management	Internal audit results of total volume of cases and successful outreach w/in 7 days: **4th Qtr. audit:65%** 3rd qtr. we have average successful interaction at 73% within 7 days 2nd Qtr. audit with 68.27% successful outreach within 7 days. 1st Qtr. audit with 60.69% successful	Results of random sample audit completed monthly showed a 7.10% improvement from first quarter. Overall average percent improvement is 13.29%.	Operationalized Multiple Payor TCS workflows TCS best practices and TCS flyers at HN and Facility JOM's-increasing awareness. Updated TCS flyer with Providence as HN. Continue daily outreach first 7 days post discharge Call recordings for Quality and training purposes. Staff training	Challenges in Member Outreach Disconnected phone lines, inability to leave voicemails, and lack of returned calls hinder effective communication. Some members opt out of participating in TCS, limiting engagement opportunities. Variability in TCS Outreach Practices	Maintain operationalized TCS workflows to ensure consistency and efficiency. Continue sharing TCS best practices and updated flyers during Health Network (HN) and Facility JOMs to reinforce awareness. Sustain daily outreach for the first 7 days post-discharge to support smooth transitions and reduce readmissions. Utilize call	On Target

QAC 03.19.2026

Domain abbreviations: PHM = Population Health Management Strategy; CoC = Continuity of Care; HE = Health Equity; CLAS = Cultural and Linguistically Appropriate Services

TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
							outreach within 7 days.				recordings for quality assurance and staff development. Conduct ongoing staff training to strengthen TCS competencies. Collaborative Workgroups: TCS Workgroup and Maternal TCS Workgroup to drive alignment and continuous improvement. Share TCS successful interactions with KPI at HN JOM's. Automate ECM successful interactions - currently manual process for KPI reporting. Update pre-call and post DC all assessments: aligning consistent workflows.	

QAC 03.19.2026

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
62	Cultural and Linguistic Appropriate Services	Language Services: Cultural and Linguistics and Language Accessibility	Implement interpreter and translation services and report key findings and/or activities, analyze barriers, and improvement. For translation services, by August 1st, 2025, CalOptima Health will expand the threshold languages to include Russian to meet requirements established by the California Department of Health Care Services (DHCS).	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards, including Member Material requirements Launch Russian as new threshold language.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Customer Service	Translations continued the steady volume in quarter 4, averaging 3,965 Spanish and 792 Vietnamese and the Russian language which was added as a threshold language in Q3 also maintained a steady volume of translations in Quarter 4. Interpreter service usage also remained consistent in 2025, with an average of 1,207 Spanish and 625 Vietnamese face-to-face interpreter bookings in Quarter 4. Russian was introduced as a new CalOptima Health threshold language to meet DHCS requirements and better serve the growing number of Russian-speaking members in	Translations and interpreting services continued a steady volume in all quarters of 2025. Russian was introduced as a new CalOptima Health threshold language to meet DHCS requirements. A full-time Russian translator was hired to support in-house Russian translation.	Translations continued steadily throughout 2025. Spanish and Vietnamese translations each quarter accounted for the highest volume, averaging 3,965 Spanish and 792 Vietnamese translations. Russian was added as a threshold language and maintained a steady translation volume over the last two quarters of 2025, averaging 368 Russian translations per quarter since its introduction. Interpreter service usage also remained consistent, with an average of 1,207 Spanish and 625 Vietnamese face-to-face interpreter bookings each quarter. Cultural and Linguistic Services continues to monitor and identify trends in the use of interpreter and translation services, including their usability. Russian was added as a new CalOptima	Care Coordination: Sustain warm handoffs to HN; collaborate with TCS, ECM, and CM teams.	N/A	On Target

QAC 03.19.2026

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
							Orange County. A full-time Russian translator was hired to support in-house Russian translation.		Health threshold language in August 2025 to meet DHCS requirements and better serve the growing number of Russian-speaking members in Orange County. During the third quarter, a full-time Russian translator was hired to support in-house Russian translation.			
63	Cultural and Linguistic Appropriate Services	Network Cultural Responsiveness: Data Collection on Member Demographic Information	By Dec. 31st, 2025, CalOptima Health will increase the collection of sexual orientation gender identify (SOGI) data by 10% through focused outreach and education, ensuring better representation	1) Field a survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age). 2) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks. 3) Develop and implement a survey via the Member Portal, mail to new members and other methods. 4) Share member demographic	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Customer Service	2025 Results: Surveys offered: 286,334 Surveys Completed: 8,690 Completion Rate: 3%	The target goal collection rate of 10% was not met. Potential reasons for the low response rate: >Members' reluctance to provide personal information. >Survey fatigue, as CalOptima Health sends multiple surveys to members. >The 10% goal was possibly too aggressive.	The target goal collection rate of 10% of Sexual Orientation Gender Identity (SOGI) surveys was not met. Potential reasons for the low response rate included Members' reluctance to provide personal information, survey fatigue (since CalOptima Health sends a multitude of surveys to members), and the 10% goal being too aggressive. The Sexual Orientation Gender	Members were reluctant to provide SOGI information	Review the 2026 Health Equity Standards Requirements Health Outcomes requirement changes: >Eliminate the requirement to collect Gender Identity, Pronouns and Sex at Birth (Sexual Orientation to remain) >Collection of disability function and identity,	On Target

QAC 03.19.2026

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			and inclusion of members.	information with practitioners.					Identity (SOGI) data from the Members surveys received for Members aged 18+ was as follows: Surveys offered: 286,334; Completed Surveys: 8,690; Completion Rate: 3%. Next Steps and Expected changes: Eliminate the requirement to collect Gender Identity, Pronouns and Sex at Birth (Sexual Orientation to remain); Collection of disability function and identity, physical accommodations, auxiliary aids or services, geographic classification, age, and veteran/military status; Assess/update system capabilities and implement new processes to support the new requirements.		physical accommodations , auxiliary aids or services, geographic classification, age, and veteran/military status >Assess/update system capabilities and implement new processes to support the new requirements.	

QAC 03.19.2026

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TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
64	Cultural and Linguistic Appropriate Services	Network Cultural Responsiveness: Data Collection on Practitioner Demographic Information	By Dec. 31st, 2025, CalOptima Health will increase the collection of race/ethnicity/languages (REL) data by 10% through focused outreach and education, ensuring better representation and inclusion of providers.	1) Add REL questions to routine forms, including credentialing, provider relations LOI, and provider demographic forms. 2) Enter REL data into the provider data system to ensure it can be retrieved and used for CLAS improvement. 3) Share data on the provider network's capacity to meet the language needs of CalOptima Health members. 4) Assess the provider network's ability to meet CalOptima Health's culturally diverse member needs. 5) Collaborate with other CalOptima Health departments to share SOGI data with Health Networks.	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Director of Provider Operations	1. REL data collection continued to increase in Q4 following sustained direct outreach and expanded data collection pathways. 2. Race/Ethnicity submission surpassed the 10% goal by year end. 3. Language Fluency submissions continued steady growth but remained below the Race/Ethnicity collection rate. 4. Health Network onboarding and roster-based submissions contributed to cumulative gains in REL data collection.	1. Direct outreach to CHCN contracted medical groups remained the most effective strategy for increasing REL submissions. 2. Integration of REL fields into onboarding workflows supported consistent data capture in Q4. 3. Language Fluency collection requires continued reinforcement and provider education to accelerate growth.	Russian was implemented as a new CalOptima Health threshold language in August 2025 to meet DHCS requirements and better serve the growing Russian-speaking membership in Orange County. During the 3rd Quarter of 2025, a full-time Russian translator was hired to assist with in-house Russian translations.	1. REL data submission remains voluntary, limiting full provider participation. 2. Language Fluency data is less consistently reported than Race/Ethnicity data. 3. Provider administrative burden and competing priorities impact completion of optional demographic fields.	1. Reinforce REL data submission expectations during provider onboarding and roster update. 2. Engage Health Networks currently in the system to assist with provider education and REL data collection efforts. 3. Monitor quarterly progress and apply lessons learned to planned 2026 interventions.	Concern

QAC 03.19.2026

TOC	Evaluation Category	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
65	Cultural and Linguistic Appropriate Services	Experience with Language Services	Evaluate language services experience from member and staff by implementing at language services survey to member and staff by March 31, 2025. By Dec. 31st, 2025, CalOptima Health will evaluate language services experience by collecting feedback from at least 10% of members and 80% of staff using surveys and will analyze the results to identify improvements to language services.	Goal not met. Continue to assess and report the following activities: 1) Develop and implement a survey to evaluate the effectiveness related to cultural and linguistic services. 2) Analyze data and identify opportunities for improvement.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Customer Service	Neither the staff nor member surveys met the 10% response rate target and yielded low response rates, providing an opportunity to increase them. The Member survey was mailed to 32,480 members, yielding a 6% response rate. The Staff Survey was an in-house online survey conducted via SurveyMonkey, yielding a 4% response rate.	Consistently promote the Staff Survey through Leadership. Engage leadership to consistently promote the importance of the survey. Educate staff on the importance of their participation in the survey through workshops, meetings, or internal communications. Redesign the member survey to be concise, send text message reminders to members who have not responded to the survey.	CalOptima Health offers language services to its members and staff to promote effective communication and access to support. These services are evaluated to measure satisfaction in both organizational functions and healthcare interactions. The process of assessing language services at CalOptima Health includes surveys from staff and members. The Member survey was mailed to 32,480 members who frequently used language services between October 2024 and March 2025. CalOptima Health received 1,883 responses, resulting in a 6% response rate. The Staff Survey was conducted online via SurveyMonkey and distributed through The Week-Ahead and e-News to staff who	Workflow Optimization: Continue refining workflows and processes to improve efficiency and member experience.	Planned Strategies and Interventions Staff Survey – Regularly promote the Staff Survey through leadership. Encourage leaders to consistently emphasize the importance of participation to motivate more responses. Educate staff on the value of their input through workshops, meetings, or internal communications. Member Survey – Keep the member survey concise and focused on identifying areas for improvement. This approach makes it easier for members to complete without feeling overwhelmed. Send text message	On Target

QAC 03.19.2026

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									used language services for members, with a 4% response rate. Both surveys had low response rates, indicating opportunities for improvement.		reminders to members who have not responded to the survey.	
66	Cultural and Linguistic Appropriate Services	Network Cultural Responsiveness: Diversity, Equity and Inclusion Training	By Dec. 31st, 2025, CalOptima Health will implement and train 90% of staff, health networks, and providers on Diversity, Equity and Inclusion (DEI) training, ensuring compliance with DHCS All Plan Letter (APL) 24-016.	1. Develop a DEI Training and launch training by July 31, 2025	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Chief Health Equity Officer	1. Launched the DHCS-required DEI training to CalOptima Health staff and providers in November 2025 with three core modules: • Cultural Competency: The foundation of Equitable Health Care • Diversity, Equity, Inclusion and Belonging • Health Equity Fundamentals	1. The standardized DEI training was effective in achieving full staff compliance, exceeding the original 90% completion goal. 2. DHCS extended DEI Provider Training compliance reporting until 12/31/2026.	1. Implemented mandatory DEI training program aligned with DHCS All Plan Letter (APL) 24-016. • Established a structured curriculum focused on health equity fundamentals and cultural competence. • Coordinated system-wide rollout for staff and providers to ensure timely compliance	Changing federal and state requirements for DEI training.	1. Pending proposed DHCS's update for DEI All Plan letter: Ensure Alignment with • Internal staff training and reporting • Provider training and reporting • Policies and procedures 2. DHCS attestation submission in	On Target

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Back to Agenda Back to Item

QAC 03.19.2026

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							98.22% staff completed the DEI training. 2. Provider DEI Training is ongoing through 2026.				December 2026 for providers.	

Domain abbreviations:
PHM = Population Health Management Strategy
CoC = Continuity of Care
HE = Health Equity
CLAS = Cultural and Linguistically Appropriate Services

QAC 03.19.2026

2025 CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) PROGRAM EVALUATION

QAC 03.19.2026

Back to Agenda Back to Item

Section 1: CalOptima Health Overview
1.1 Our Mission
1.2 Our Values
1.3 Who We Serve
1.4 Our Commitment to Culturally and Linguistically Appropriate Services (CLAS)

Section 2: Executive Summary
2.1 Review of 2025 CLAS Goals
2.2 Recommended Priority Areas and Goals for 2026

Section 3: Program Structure
3.1 CLAS Program Documents
3.2 CLAS Reporting Structure and Community and Member Engagement
3.3 CLAS Monitoring Progress
3.4 Assessment of CLAS Staff and Resources
3.5 Review of System Resources
3.6 Overall Assessment of CLAS Program Structure

Section 4: Language Services
4.1 Cultural and Linguistic and Language Accessibility – Russian
4.2 Cultural and Linguistic and Language Accessibility – Translation Services
4.3 Cultural and Linguistic and Language Accessibility – Interpreter Services
4.4 Experience with Language Services Survey

Section 5: Data Collection and Analysis
5.1 Cultural Responsiveness: Data Collection on Member Demographic Information
5.2 Network Cultural Responsiveness: Data Collection on Practitioner Demographic Information
5.3 Availability of Practitioners: Cultural Needs and Preferences

Section 6: Promotion of Diversity
6.1 Staff, Leadership and Committee Hiring and Recruiting Practices

Section 7: Training
7.1 Cultural Competency Training
7.2 Network Cultural Responsiveness: Diversity, Equity and Inclusion Training

QAC 03.19.2026

Section 1: CalOptima Health Overview

1.1 Our Mission

To serve member health with excellence and dignity, respecting the values and needs of each person.

1.2 Our Values

CalOptima Health C-A-R-E-S: To best serve our members and Orange County, we will lead with Collaboration, Accountability, Respect, Excellence and Stewardship.

1.3 Who We Serve

As a public agency and Orange County's single largest health insurer, CalOptima Health offers health insurance coverage through three major programs:

- Medi-Cal – California's Medicaid Program for low-income children, adults, seniors, and people with disabilities, offering comprehensive health care coverage.
- OneCare (HMO D-SNP) – Medicare Advantage Dual Eligible Special Needs Plan for seniors and people with disabilities who qualify for both Medicare and Medi-Cal.
- Program of All-Inclusive Care for the Elderly (PACE) – PACE for frail older adults, providing a full range of health and social services so seniors can remain living in the community.

1.4 Our Commitment to Culturally and Linguistically Appropriate Services (CLAS)

As a health care organization serving the diverse community of Orange County, CalOptima Health strongly believes in providing culturally and linguistically appropriate services to our members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has developed a Cultural and Linguistic Services Program, a component of the Quality Improvement Health Equity Transformation Program (QIHETP), which integrates culturally and linguistically appropriate services at all levels of operation.

Section 2: Executive Summary

2.1 Review of 2025 CLAS Goals

1. Expanded the threshold languages to include Russian to meet requirements established by the California Department of Health Care Services (DHCS).
    - Translated member-facing documents into Russian.
    - Ensured vendors had sufficient coverage to assist with Russian translations.
    - Updated Cultural and Linguistics (C&L) translation request intake system (K2) to allow staff to select Russian when submitting translation requests.
    - Informed CalOptima Health staff and health networks of the availability of the new threshold language.

OAC 03.19.2026

2. Launched a language services experience survey for members and staff with the aim of collecting feedback from at least 10% of members and 80% of staff using surveys and analyzing the results to identify improvements to language services.

    - Survey mailed to members via U.S. mail.
    - Staff survey distributed to staff via SurveyMonkey.
    - The goal was not met. Response rate results: Member 6%, Staff 4%

3. By December 31, 2025, CalOptima Health will increase the collection of practitioner race/ethnicity/language (REL) by 10% through focused outreach and education, ensuring better representation and inclusion of providers.

    - Added REL questions to routine forms, including credentialing and provider demographic forms.
    - Entered REL data into provider data systems.
    - The goal was not met for language. Response rate results: 4.5%
    - The goal was met for race/ethnicity. Response rate results: 16%

4. Increase the collection of sexual orientation and gender identity (SOGI) data by 10% through focused outreach and education, ensuring better representation and inclusion of members.
    - Surveyed new members ages 18+ via U.S mail and New Member Orientations.
    - Surveyed 186,000 existing members ages 18+ via U.S mail and community events.
    - Surveyed all members via the Member Portal.
    - The goal was not met. Response rate results: 3%

5. Implemented and trained 90% of staff, health networks and providers on Diversity, Equity and Inclusion (DEI) training, ensuring compliance with DHCS All Plan Letter (APL) 24-016.

    - Developed DEI training.
    - Launched DEI Training to staff in November 2025.
    - The goal was met. Staff completion rate: 100%, Provider completion rate: Data not yet available

2.2 Recommended Priority Areas and Goals for 2026

The recommended high-priority areas will focus on the 2026 National Committee for Quality Assurance (NCQA) Health Equity standards, which encompass both changes to existing elements and the introduction of new ones.

HE2: Collection of Member or Patient Level Data: New Elements

- Collection of Data on Disability Status
- Collection of Data on Disability-Related Accommodations
- Classification of Geographic Data
- Access and Availability of Disability Accommodations
- Accessible Digital Content

QAC 03.19.26

Back to Agenda Back to Item

- Support for Disability Accommodations

1. Language Services: Cultural and Linguistic and Language Accessibility: Provide interpreter and translation services and report key findings and/or activities, analyze barriers, and identify improvements.
   - By December 31, 2026, CalOptima Health will increase the collection of language services experience from 6% to 10% of members and from 4% to 80% of staff using surveys and will analyze the results to identify improvements to language services.
   - Member experience with language services will maintain a satisfaction rate of 90% or above by December 31, 2026.
   - Staff experience with language services will maintain a satisfaction rate of 90% satisfaction or above by December 31, 2026.

2. Data Collection of Member Demographic Information
   - By September 30, 2026, CalOptima Health will update the current data system to receive, store and retrieve the following: disability function and identity, physical accommodations, auxiliary aids or services, geographic classification, age, and veteran/military status.
   - By December 31, 2026, CalOptima Health will increase the collection of member disability function data from 0 to 5% through focused outreach and education, ensuring better representation and inclusion of members.

3. Data Collection on Practitioner Demographic Information.
   - By December 31, 2026, CalOptima Health will increase the collection of provider race/ethnicity/languages (REL) from 2% to 5% through focused outreach and education, ensuring better representation and inclusion of providers.

4. Network Cultural Responsiveness: Provider Trainings to Improve Care or Service Delivery.
   - By December 31, 2026, CalOptima Health will implement and train 90% of health networks and providers on how to improve care or service delivery on at least one: racial, ethnic or cultural subgroups; gender or sexual orientation subgroups or patients with disabilities; use of physical accommodations; and use of auxiliary aids or services.
   - By December 31, 2026, conduct a CME on unique health or health care needs of at least one: racial, ethnic or cultural subgroup; gender or sexual orientation subgroup or patients with disabilities; use of physical accommodation; and use of auxiliary aids or services.

5. Network Cultural Responsiveness: Building and Maintaining a Responsive Work Force
   - By December 31, 2026, CalOptima Health will implement and train 90% of staff on how to improve care or service delivery on at least one: racial, ethnic or cultural subgroups; gender or sexual orientation subgroups or patients with disabilities; use of physical accommodation; and use of auxiliary aids or services.

Section 3: Program Structure

Back to Agenda Back to Item

06.19.2026

3.1 CLAS Program Documents	
Author: Carlos Soto/Albert Cardenas	Department(s): Cultural and Linguistic Services
Responsible Party(ies): Albert Cardenas and Carlos Soto	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Obtain Board approval of 2025 CLAS Program Description and Work Plan by April 30, 2025	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background

To ensure effective communication regarding treatment, diagnosis, medical history, and health education, CalOptima Health implemented a Culturally and Linguistically Appropriate Services (CLAS) Program, which is part of the Quality Improvement Health Equity Transformation Program (QIHETP). This program integrates culturally and linguistically appropriate services at all levels of the organization's operation. Objectives for culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of need as appropriate.

II. Data Sources and Methodology

The CLAS Program Description guides the development and implementation of an annual CLAS Work Plan, using a written program description for improving CLAS that includes the following:

- Language services
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues

III. Program Results

Overall, the CLAS Program, which is part of the 2025 QIHETP and Annual Work Plan, was approved and successfully implemented.

IV. Actions/Interventions Implemented in 2025

QAC 03.19.2026

Interventions	Product	Quarter	Type	Status
1. Staff worked with other departments to draft the CLAS Program Description and identified CLAS Work Plan items to be included in the overall QIHETP Work Plan.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
2. The revised 2025 CalOptima Health QIHETP Program and Work Plan, which includes CLAS, was approved by Board of Directors on 4/3/2025, and a copy was posted on CalOptima Health's public website.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☒ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
3. Monitored the status of the CLAS Work Plan and provided updates to the Member Advisory Committee (MAC)/Provider Advisory Committee (PAC) and Quality Improvement Health Equity Committee (QIHEC).	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☒ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
4. Staff began developing a draft of the 2025 CLAS Evaluation and the 2026 CLAS Program Description and Work Plan, with the goal of approval by Q1 2026.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete

V. Effectiveness of Actions/Interventions

Overall, the work plan was effective as it helped staff stay on track by providing timely quarterly updates to the QIHEC.

VI. Qualitative Analysis

C&L staff analyzed the CLAS Program documents. While it was generally successful, several opportunities for improvement were identified to ensure that the CLAS Program description, evaluation and work plan are completed in a timely manner for executive review and approval.

Causal/Barrier Analysis:

- Some reports needed for the CLAS evaluation are completed after the new year, so there is a delay in completing the evaluation.
- Meeting sessions to complete the CLAS Evaluation, Program Description and Work Plan began in late November, so there was insufficient time to complete on time.
- C&L staff did not conduct a regular review of the work plan items to make the necessary adjustments to ensure goals were met.

VII. Opportunities for Improvement

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will address high-priority issues first.

OAC 03.19.2026

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Align CLAS reports with the annual CLAS Evaluation.	Conduct a review of reports needed for the CLAS Evaluation and align the completion timeline and analysis to ensure they are completed and available to report results in the CLAS Evaluation.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L
2. Begin the draft of the CLAS Evaluation earlier in the year.	1. C&L staff begin drafting the 2026 CLAS Evaluation as soon as the Board approves the 2025 CLAS Evaluation and Work Plan. 2. C&L staff will conduct a monthly review of the draft CLAS Evaluation and update items/goals that are completed or achieved. 3. C&L staff will also monitor the CLAS goals work plan items monthly to improve the tracking of indicators and activities. With each review, determine if adjustments are needed for each goal.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ H ☐ M ☐ L
3. Begin CLAS Evaluation collaboration with QI staff in early Q4.	• Schedule the CLAS Evaluation meeting sessions with the QI team at the beginning of Q4 to ensure sufficient time to review goals and priorities for the upcoming year.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ H ☒ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion:

The CLAS Program documents were approved by the QIHEC and CalOptima Health Board of Directors.

3.2 CLAS Reporting Structure and Community and Member Engagement	
Author: Carlos Soto/Albert Cardenas	Department(s): Cultural and Linguistic Services
Responsible Party(ies): Albert Cardenas and Carlos Soto	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background

CalOptima Health is committed to providing member-focused care through active engagement with members and their communities. C&L seeks guidance from the MAC, PAC and the QIHEC.

CalOptima Health engages members through MAC to seek input, advice and guidance related to cultural and linguistic, as well as health equity, goals. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services to ensure that the CLAS Program meets the needs of the population.

The PAC provides advice and recommendations to the Board regarding CalOptima Health programs and services, serving as a liaison on items of interest to the provider community. The PAC meets with the

QAC 03.19.2026

MAC bimonthly and reports directly to the CalOptima Health Board of Directors. MAC/PAC meetings are open to the public.

In addition to the MAC and PAC, CalOptima Health also seeks input, advice and guidance related to cultural and linguistic health equity goals from the QIHEC. The QIHEC provides advice and recommendations regarding CalOptima Health programs and services. The QIHEC reports annually directly to CalOptima Health's Board of Directors.

II. Actions/Interventions Implemented in 2025

Interventions	Product	Quarter	Type	Status
1. CLAS activities and status updates were reported to the QIHEC on a quarterly basis.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
2. The language services satisfaction survey was distributed to both CalOptima Health staff and members.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
3. CalOptima Health staff presented updates on the CLAS Program at the August 2025 MAC/PAC meeting.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
4. Staff began developing a draft of the 2025 CLAS Evaluation and the 2026 CLAS Program Description and Work Plan, with the goal of approval by Q1 2026.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete

III. Program Results and Analysis

CalOptima Health is committed to providing member-focused care through active engagement with members and their communities. CalOptima Health engages members through the MAC and seeks input and advice related to cultural and linguistic, as well as health equity, goals. The MAC has 20 voting members, with each seat representing a constituency served by CalOptima Health. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services to ensure that the CLAS Program meets the needs of the population. The MAC meets on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

CalOptima Health staff presented updates on the CLAS Program at the August MAC/PAC meeting. Staff noted that CalOptima Health strongly believes in the importance of providing culturally and linguistically appropriate services to members to ensure effective communication regarding treatment, diagnosis, medical history and health education. Staff informed the committees of the 2025 CLAS Program and

OAC 03.19.26

Work Plan Goals and provided an update on each goal and the challenges faced with each goal, with the most common challenge being a low member/provider response rate on surveys and outreach efforts.

The CLAS Program was reported to, reviewed and approved by the QIHEC, QAC and CalOptima Health Board of Directors (BOD) on the following dates of 2025:

- QIHEC – 2/11/2025
- QAC – 3/12/2025
- CalOptima Health Board of Directors – 4/3/2025, Annual BOD adoption by the end of April 2025.
- Presented the updates to QIHEC regarding CLAS Work Plan – 7/8/2025

IV. Effectiveness of Interventions

The reporting structure was successful. Staff reported to QIHEC quarterly on all CLAS activities and received feedback and guidance from QIHEC. The QIHEC was able to provide feedback on the following activities:

- Member and CalOptima Health staff language service experience survey
- Collection of SOGI data survey
- Implementation of Russian as a threshold language
- DEI training for CalOptima Health and health network staff

V. Qualitative Analysis

CalOptima Health Staff informed the committees about the 2025 CLAS Program and Work Plan Goals and provided an update on each goal, highlighting the challenges faced, with the most common challenge being a low member/provider response rate to surveys and outreach efforts.

Causal/Barrier Analysis: MAC and PAC meetings have a full agenda. It is challenging to secure dedicated time on the agenda for in-depth discussions and solicit feedback at these meetings.

VI. Opportunities for Improvement

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will address high-priority issues first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1 Identify different methods of presenting to ensure time is secured for discussion and feedback.	• Reassess the presentation to ensure the focus is strictly on the CLAS goals and solicit feedback after each goal is presented. • Observe other presenters to identify different styles of presenting that engage the committee members.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L

QAC 03.19.2026

MC = Medi-Cal; OC = OneCare

VII. Conclusion

CalOptima Health staff presented updates on the CLAS Program and Work Plan at the August 2025 MAC/PAC meeting. Staff informed the committees of the 2024 CLAS Program and Work Plan Goals and provided an update on each goal.

The MAC/PAC committee had no feedback or recommendations to provide.

3.3 CLAS Monitoring Progress	
Author: Carlos Soto/Albert Cardenas	Department(s): Cultural and Linguistic Services
Responsible Party(ies): Carlos Soto and Albert Cardenas	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background

To ensure that the CLAS Program meets the needs of our diverse member population, CalOptima Health conducts ongoing assessments of CLAS-related activities and integrates CLAS-related measures into measurement and continuous quality improvement activities. The QIHEC continuously monitors progress against CLAS goals. At least quarterly, staff from the Cultural & Linguistic Services (C&L) department, in collaboration with multidisciplinary work teams throughout the organization, collect and track indicators and activities specific to CLAS goals, outcomes and outputs. C&L staff prepare quarterly findings and identify potential risks to share with CalOptima Health leadership at QIHEC meetings. CalOptima Health's QIHEC reviews, offers feedback and approves quarterly CLAS monitoring reports. QIHEC summarizes the CLAS monitoring reports and shares them with CalOptima Health's Board of Directors' Quality Assurance Committee (QAC).

II. Program Results and Analysis

CalOptima Health staff followed DHCS regulations and NCQA Health Equity Standards and Guidelines when implementing the CLAS Program goals and monitoring progress against CLAS goals. Quarterly, dedicated C&L staff, in collaboration with multidisciplinary work teams throughout the organization, collect and track indicators and activities specific to CLAS goals, outcomes and outputs.

CalOptima Health C&L staff continued to monitor progress against CLAS goals. Quarterly, C&L staff, in collaboration with multidisciplinary work teams throughout the organization, collected and tracked indicators and activities specific to CLAS goals, outcomes and outputs.

III. Actions/Interventions Implemented in 2025

Interventions	Product	Quarter	Type	Status

1. Developed and finalized the CLAS Program and Work Plan.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
2. Formed the Russian threshold language implementation workgroup.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
3. Monitored the following CLAS workplan goals: ▪ Collection of sexual orientation, gender identity (SOGI) data from members ages 18+. ▪ Monitored the mailing of member experience with language services surveys. ▪ Monitored the distribution of the language services experience survey to CalOptima Health staff. ▪ Reported CLAS progress to QIHEC.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
4. Monitored the successful implementation of Russian as a threshold language.	☒ MC ☐ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☒ Ongoing ☐ Incomplete
5. Monitored the development of the 2025 CLAS Program Evaluation and 2026 CLAS Program Description.	☒ MC ☐ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☒ Ongoing ☐ Incomplete

IV. Effectiveness of Interventions

CalOptima Health continues to monitor and track the CLAS Program. In 2026, changes will be implemented to improve staff and member responses regarding language services.

V. Qualitative Analysis

CalOptima Health staff conducted a qualitative analysis and, while we determined that the overall monitoring of the CLAS Program was effective, staff identified no barriers related to the CLAS monitoring.

VI. Conclusion

Overall, the monitoring of CLAS was successful.

3.4 Assessment of CLAS Staff and Resources	
Author: Carlos Soto/Albert Cardenas	Department(s): Cultural and Linguistic Services
Responsible Party(ies): Albert Cardenas and Carlos Soto	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background

Back to Agenda Back to Item

OAC 03.19.2026

CalOptima Health has dedicated resources and staffing to meet the needs of the CLAS Program throughout the organization, including C&L staff and contracted vendors that support translation, interpreter and alternative format services. Throughout 2025, CalOptima Health's Human Resources department collaborated with the business areas to fill vacant positions and positions needed to support the CLAS Program.

II. Program Results and Analysis

In addition to supporting CLAS, CalOptima Health ensures members are informed of the availability of and their right to linguistic and translation services through:

CalOptima Health's Human Resources department collaborated with the business areas to identify and fill vacant and newly created positions that support the CLAS Program, ensuring adequate staffing to effectively communicate with and assist Limited English Proficiency (LEP) members.

CalOptima Health added several positions that support CLAS, providing adequate staffing and resources to meet members' needs.

The positions identified and filled in to support the CLAS Program included:

- Customer service hired bilingual staff throughout the year to support LEP members seeking telephonic assistance.
- A Russian translator was hired to support the addition of Russian as a CalOptima Health threshold language.
- An interpreting coordinator who was hired to support the coordination and bookings of interpreting requests.

Additionally, to support Customer Service and C&L projects, temporary positions were approved and made available as needed. The interventions were effective; CalOptima Health ensured that sufficient CLAS staff and resources were available to provide culturally and linguistically appropriate services to members effectively.

III. Qualitative Analysis

CalOptima Health C&L staff conducted a Qualitative analysis in Q1and determined the additional staffing resources needed to support the CLAS Program.

IV. Opportunities for Improvement

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will address high-priority issues first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Evaluate staffing resources	• CalOptima Health will continue to ensure adequate staffing is provided to effectively communicate with LEP members.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L

Back to Agenda Back to Item

OAC 03.19.2026

	• Ensure CalOptima Health continues to provide culturally and linguistically appropriate services to members, with effective communication regarding treatment, medical history and health education. • Continue to evaluate staffing resources to ensure there is adequate support for the CLAS Program.			

V. Conclusion

This goal was met, as the appropriate resources were identified and necessary positions were filled, ensuring that resources were available to provide CLAS to members effectively.

3.5 Review of System Resources	
Author: Carlos Soto/Albert Cardenas	Department(s): Cultural and Linguistic Services
Responsible Party(ies): Albert Cardenas and Carlos Soto	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background

To ensure effective communication regarding treatment and to avoid language barriers, CalOptima Health has resources in place to support the CLAS Program. While most of CalOptima Health systems support CLAS, systems that directly support CLAS are:

- Customer Services core system (Facets) houses member eligibility, demographic, claims and member call records/logs.
- K2 Smart Forms support the intake and processing of member translations and interpreter services requests.
- Trados translation memory aids C&L translators in the translation of member-facing documents.
- Jiva Healthcare Enterprise Platform is a comprehensive set of AI-powered solutions that integrate data, apply advanced analytics, automate workflows, and optimize team efficiency and effectiveness with clinical content-driven care pathways. Jiva also developed a module to support potential quality issues (PQIs).

II. Data Sources

These systems play a crucial role in enabling staff to provide CLAS to CalOptima Health members. Contracted providers include Facets, K2 Smart Forms, Trados translation memory system and Jiva.

III. Program Results and Analysis

QAC 03.19.26

With the system updates completed in 2025 and updates scheduled for 2026, CalOptima Health has the necessary system resources to support the CLAS Program.

- Continue to collaborate with vendors and IT to enhance the existing process.
- Updated Trados from GroupShare to Trados Studio.

Indicator/Goal(s): Ensure the systems used by Customer Services and C&L are operational. Systems such as:

- Facets
- K2 Smart Forms
- Trados Studio
- Jiva Healthcare Enterprise Platform

IV. Actions/Interventions Implemented in 2025

Interventions	Product	Quarter	Type	Status
1. Discussed with IT the creation of the term base/translation memory without files for the vendors in Trados for the Russian language.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
2. The Trados Studio (Translation memory software system) was updated from GroupShare to Trados Studio. The C&L team was trained on new segments and features	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete

V. Effectiveness of Interventions

The transition from Trados GroupShare to Trados Studio provides the translation team with improved functionalities, including an updated glossary that stores specific terms used by the organization, thereby maintaining consistency in translations. Also, Trados Studio has a more robust translation memory, resulting in an estimated 30% to 40% increase in productivity.

VI. Qualitative Analysis

The GroupShare version of Trados reached limitations with the translation, formatting and review processes, which required the upgrade to Trados Studio and consequently Trados Studio-2**.**

VII. Opportunities for Improvement

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will address high-priority issues first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority

QAC 03.19.2026

1. Continue to monitor existing systems and make the necessary updates/implementations to ensure CalOptima Health has resources in place to support the CLAS Program.	• Q1: Implement Salesforce as the Customer Service intake system. • Q3: Implement the MuleSoft platform to replace K2 as the interpreter/translations service request intake system.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ H ☐ M ☐ L

VIII. Conclusion

CalOptima Health has the necessary system resources to support the CLAS Program.

3.6 Overall Assessment of CLAS Program Structure	
Author: Carlos Soto/Albert Cardenas	Department(s): Cultural and Linguistic Services
Responsible Party(ies): Albert Cardenas and Carlos Soto	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

CalOptima Health's CLAS Program, part of the QIHETP, integrates culturally and linguistically appropriate services at all levels of operation. CalOptima Health emphasizes the importance of these services for its diverse membership. The objectives include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of need as appropriate.

In 2025, staff successfully implemented the CLAS Work Plan, continually monitoring progress and providing status updates to the QIHEC on a quarterly basis. In August 2025, staff presented updates to the MAC/PAC, which included the introduction of Russian as a threshold language, the collection of member demographic information, and experiences with language services. Feedback and recommendations were sought from MAC/PAC regarding cultural and linguistic needs, as well as the results of the member survey.

The C&L department consists of the Director of Customer Service, the Manager of Cultural and Linguistic Services, a department Supervisor, 10 Translation Specialists, and two Program Specialists/Coordinators, who are responsible for processing and translating member-facing documents and coordinating overflow of translations with contracted vendors. The C&L department is supported by CalOptima Health departments, including but not limited to:

- Communications
- Contracting

- Customer Service
- Equity and Community Health
- Human Resources
- Network Management
- Provider Relations
- Information Technology (IT)
- Quality Improvement

In 2026, C&L staff will continue to provide CLAS to members, with effective communication. We will continue to evaluate member satisfaction with language services resources to ensure there is adequate support for the CLAS Program.

Section 4: Language Services

4.1 Language Services: Cultural and Linguistic and Language Accessibility – Russian	
Author: Carlos Soto/Albert Cardenas	Department(s): Cultural & Linguistic Services
Responsible Party(ies): Albert Cardenas – Director, Customer Service Carlos Soto - Manager, Cultural & Linguistic Services	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: By August 1, 2025, CalOptima Health will expand the threshold languages to include Russian, in order to meet the requirements established by DHCS.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☒ Completed ☐ Ongoing

I. Purpose or Background

Expand to include Russian as a new CalOptima Health threshold language by August 2025, to meet requirements established by DHCS and better serve the growing Russian-speaking member population in Orange County.

In Q3, CalOptima Health implemented Russian as a new CalOptima Health threshold language. All available member-facing materials were translated into Russian. A full-time Russian translator was hired to assist with Russian translations.

II. Data Sources and Methodology

On August 11, 2025, CalOptima Health's C&L department implemented Russian as a new threshold language. C&L continually tracks and identifies trends in the utilization of Russian interpreter and translation services. During the QIHEC meeting on October 14, 2025, the data and analysis of language services for the first, second and third quarters were presented to the QIHEC committee members.

QAC 03.19.2026

III. Program Results and Quantitative Analysis

CalOptima Health's Cultural and Linguistic Services Program's overall translation and interpreter services satisfaction results from Q1 to Q3 2025, for all threshold languages, were the following:

Translations continue at a steady volume of Spanish and Vietnamese translations each quarter. The highest number of translations per quarter in 2025 was an average of 3,965 Spanish translations and 792 Vietnamese translations.

The Russian language was newly added as a threshold language and maintained a steady volume of translations throughout all three quarters, with an average of 368 Russian translations each quarter, since its inception.

We plan to continue to track and identify trends in the utilization of interpreter and translation services, including the usability of translation and interpreting services for the Russian language.

IV. Actions/Interventions Implemented in 2025

CalOptima Health implemented Russian as a new threshold language and began tracking and trending data on member-facing materials translated into Russian. Continue to review interpreter requests as needed.

Interventions	Product	Quarter	Type	Status
1. Began the creation of a Russian Term-Base for Trados translation memory.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
2. Began the translation of member-facing documents into Russian (new threshold language).	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
3. Completed the implementation of Russian as a threshold language, meeting the DHCS regulatory requirement.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
4. Hired a full-time Russian translator.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete
5. By Q4 2025, C&L successfully processed: ▪ 1,288 Russian translations ▪ 570 face-to-face interpreter requests ▪ 1,819 telephonic interpreting requests	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete

V. Effectiveness of Interventions

QAC 03.19.2026

Translated all available member-facing documents into Russian; hired a full-time Russian translator; and ensured interpreting vendors had adequate interpreting staff to support Russian interpreting needs for members. Implemented Russian as a new CalOptima Health threshold language.

VI. Qualitative Analysis

The Customer Service Director conducted a qualitative analysis of the implementation of Russian as a threshold language and concluded that no barriers were identified, the implementation was successful, and it met the DHCS implementation timeline.

VII. Opportunities for Improvement

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Continue to ensure CalOptima Health can meet the requested translation deadlines for all translations, including Russian translations.	• Track and trend Russian language utilization and take the necessary action to resolve issues as they arise.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☐ M ☒ L

VIII. Conclusion

The Russian threshold was successfully implemented and met the regulatory requirement.

4.2 Language Services: Cultural and Linguistic and Language Accessibility - Translation Services	
Author: Carlos Soto/Albert Cardenas	Department(s): Cultural & Linguistic Services
Responsible Party(ies): Carlos Soto/Albert Cardenas	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Enhance translation services and report key findings and/or activities, analyze barriers, and identify improvements.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background

As a health care organization serving the diverse community of Orange County, CalOptima Health recognizes that language misunderstandings and a lack of cultural awareness can sometimes impede clear communication during care delivery. CalOptima Health's C&L department ensures that all members have access to translation services in the threshold languages of CalOptima Health.

II. Data Sources and Methodology

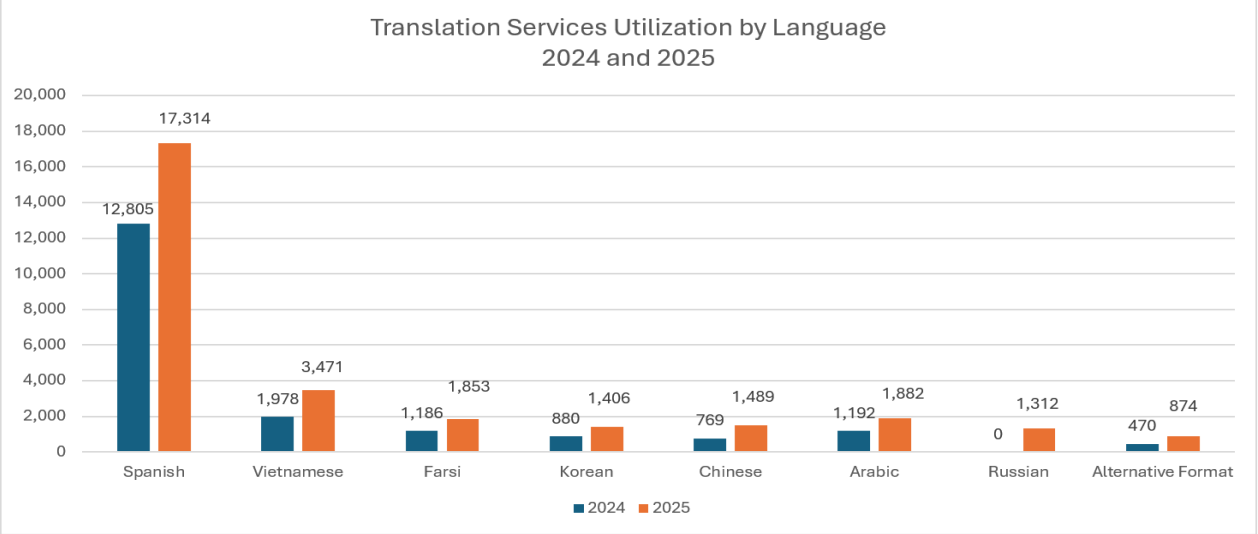
CalOptima Health's C&L department receives translation requests from members via CalOptima Health staff through an internal intake system named K2. C&L staff process requests and translate member-facing materials into CalOptima Health's threshold languages, which include Arabic, Chinese, Farsi, Korean, Spanish, Russian and Vietnamese.

III. Program Results with Data Stratification and Quantitative Analysis

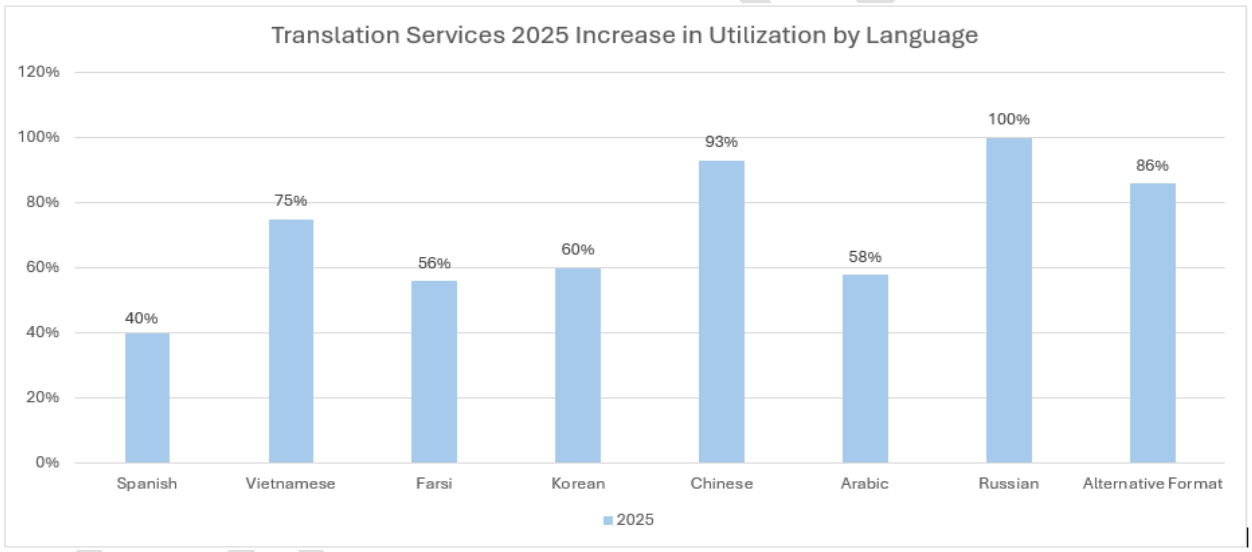
OAC 6.19.26

Back to Agenda Back to Item

The chart below shows an increase in translation requests from 2024 to 2025. This increase was due to a rise in translation requests from CalOptima Health departments, including Utilization Management and GARS. CalOptima Health's C&L department will continue to ensure that all members have access to health care translation services in CalOptima Health's threshold languages.



All languages experienced an increase from 2024 to 2025. Spanish continues to have the highest volume increase in utilization. The chart below shows the increase for each language.



The percentage of increase varies by language with the largest in Russian. However, Russian is a new language, so a 100% increase is expected. Chinese, alternative formats and Vietnamese have seen a significant increase in utilization.

IV. Actions/Interventions Implemented in 2025

Interventions	Product	Quarter	Type	Status
1. Established a transcreation process with contracted vendors to ensure quality translation of marketing materials	☐ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ On-going ☐ Incomplete
2. Established a same-day expedited turnaround time for regulatory letters (NOAs). Shortened turnaround time for alternative format NOAs from 4 days to 1 day TAT to ensure regulatory timeframes are met.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ On-going ☐ Incomplete
3. Successfully translated all 2026 member materials and met all regulatory timeline requirements. The materials included: ▪ OneCare Annual Notice of Change ▪ Summary of Benefits ▪ Provider Directory ▪ Medi-Cal Member Handbook ▪ OneCare Member Handbook	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ On-going ☐ Incomplete
4. Finalized a department translation style guide to ensure consistency across all languages.	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ On-going ☐ Incomplete

V. Qualitative Analysis

The Customer Service Director conducted a qualitative analysis of translation services and concluded that no barriers were identified.

VI. Conclusion

CalOptima Health's translation services were overall successful in providing LEP members with access to translation services in the required threshold languages.

4.3 Language Services: Cultural and Linguistic and Language Accessibility - Interpreter Services	
Author: Carlos Soto/Albert Cardenas	Department(s): Cultural & Linguistic Services
Responsible Party(ies): Carlos Soto/Albert Cardenas	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Implement interpreter services and report key findings and/or activities, analyze barriers, and identify improvements.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background

CalOptima Health recognizes that language misunderstandings and a lack of cultural awareness can sometimes negatively affect communication during a health encounter. CalOptima Health's C&L services ensure that members can communicate clearly with CalOptima Health and health care providers in their preferred language. CalOptima Health's C&L department ensures all members have

Back to Agenda Back to Item

DRAFT 03.19.2026

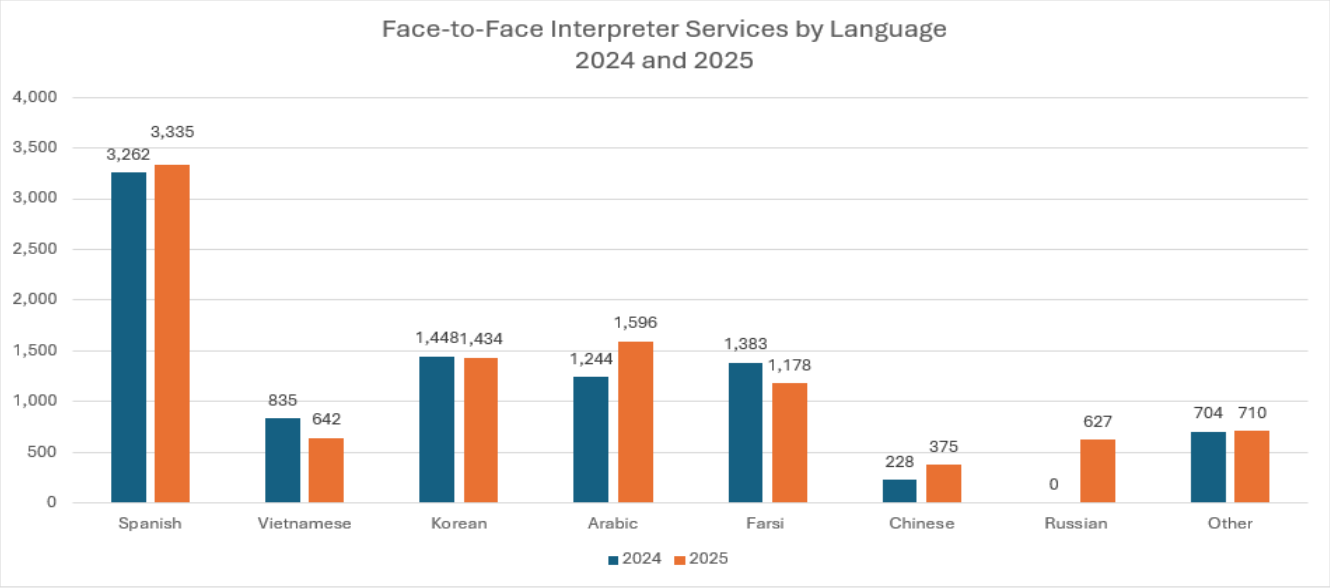
access to interpretation services for receiving health care in any language, including American Sign Language.

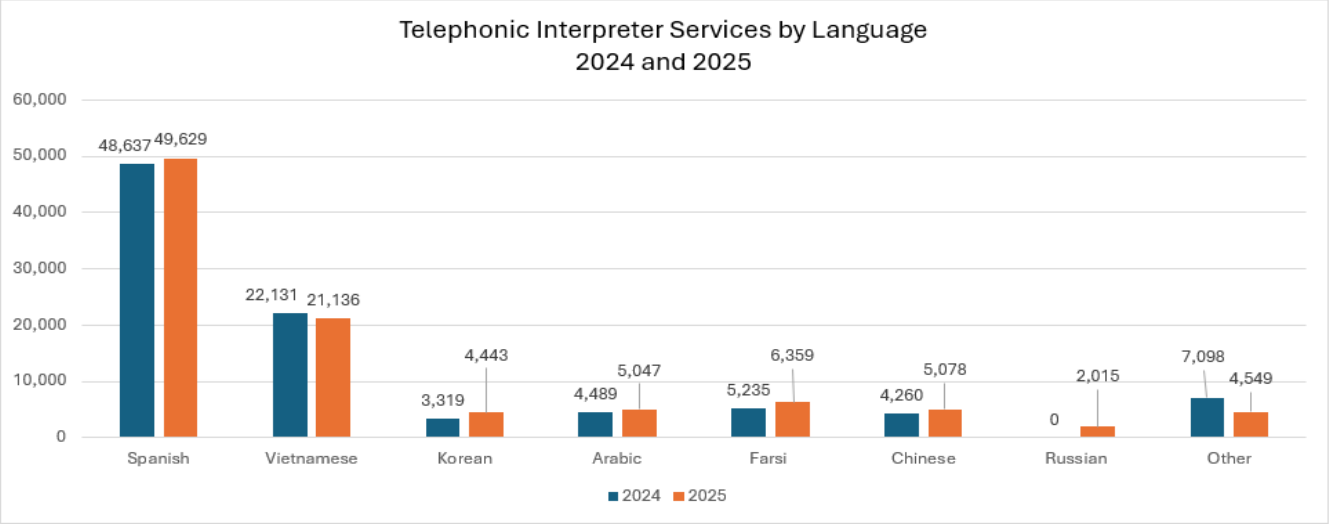
II. Data Sources and Methodology

To ensure members communicate clearly with CalOptima Health and health care providers in their preferred language, CalOptima Health's C&L staff assists members in obtaining an interpreter in their preferred language for health care-related appointments. Interpreter requests from members are submitted through internal intake systems, K2 and Facets, by CalOptima Health staff. CalOptima Health's C&L staff book interpreters for members in any language, including American Sign Language.

III. Program Results with Data Stratification and Quantitative Analysis

The chart below shows that utilization remained steady for both face-to-face and telephonic interpreter services.





Back to Agenda Back to Item

Data analysis shows that for face-to-face interpreter services, utilization remained the same or exceed that of last year, with the except of Farsi and Vietnamese, which had decreased from the previous year. For telephonic interpreter services utilization, there was a slight increase in the use of Spanish, Arabic, Farsi and Korean, and a decrease in Vietnamese and other languages. CalOptima Health's C&L department will continue to ensure that all members have access to interpreter services for health care in any language.

IV. Actions/Interventions Implemented in 2025

Interventions	Product	Quarter	Type	Status
1. C&L staff collaborated with contracted vendors to expand the pool of Russian interpreters. This effort aimed to ensure there were enough interpreters available to meet members' language service needs.	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
2. By monitoring and analyzing provider interpreter service requests, the C&L team identified providers who frequently utilize interpreter scheduling on behalf of members. These high-utilization providers were granted direct access to contracted vendors to schedule appointments, by-passing the need to go through Customer Service.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☐ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

V. Qualitative Analysis

The Customer Service Director conducted a qualitative analysis of translation services and concluded that no barriers were identified.

VI. Conclusion

We will continue to ensure contracted interpreting vendors have interpreter coverage to assist members with their telephonic (over-the-phone), video and face-to-face interpreting needs in any language.

4.4 Experience With Language Services	
Author: Carlos Soto/Albert Cardenas	Department(s): Cultural & Linguistic Services
Responsible Party(ies): Albert Cardenas – Director, Customer Service Carlos Soto - Manager, Cultural & Linguistic Services	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☐ No
Workplan Goal/Objective: Evaluate members' and staff's language services experience by implementing a language services survey by March 31, 2025. By December 31, 2025, CalOptima Health will evaluate language services experience by collecting feedback from at least 10% of members and 80% of staff using surveys and will analyze the results to identify improvements to language services.	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background

Back to Agenda Back to Item

CalOptima Health offers language services to members and staff, ensuring they can communicate effectively and receive the support they need. These services are assessed to gauge satisfaction in both organizational functions and health care encounters.

II. Data Sources and Methodology

The data for utilization of language services and telephonic interpreting were obtained from the following CalOptima Health contracted vendors: Big Language, Language Line and Voiance. The data collected was aggregated, reviewed, and analyzed for this report.

CalOptima Health conducted a member and staff survey to assess the effectiveness and satisfaction of language services provided to CalOptima Health members. This survey was mailed via U.S. Mail to members who used language services. The survey was administered to staff who requested language services on behalf of members. The staff survey was administered via Survey Monkey, and the link to the survey was distributed through electronic internal communications vehicles, including The Week Ahead and eNews.

In March 2025, a member survey was mailed to 32,480 members who had extensively used language services between October 2024 and March 2025. CalOptima Health received 1,883 responses from members, resulting in a 6% response rate.

Item	2025 Volume
Total Mailed	32,480
Total Survey Responses	1,883
Response Rate	6%

In March 2025, an internal online survey was administered via SurveyMonkey, and the survey link was distributed through electronic internal communications vehicles. Notifications were sent to CalOptima Health staff. Additionally, notifications were emailed to department directors in Customer Service, Claims, Utilization Management, Population Health Management, Case Management, Behavioral Health, GARS, as well as other departments identified as high utilizers of language services. A total of 73 survey responses were received from CalOptima Health staff.

Item	2025 Volume
CalOptima Health Staff	1,645
Total Survey Responses	73
Response Rate	4%

For both the member and provider surveys, responses from both staff and member surveys were logged onto a spreadsheet to tally the surveys received and the responses from staff and members.

III. Program Results and Quantitative Analysis

Staff Survey Analysis

1. Interpreter Services

Staff Survey Questions & Responses - Interpreting Services	Total Resp. per question	Staff Survey Results															
		Customer Service		Claims*		UM*		Population Health*		Case Management *		Behavioral Health*		Complaints, Grievances, Appeals*		Other Depts.*	
		#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Number/percentage of staff who have accessed oral interpretation	54	30	62%	0	0%	3	6%	0	0%	1	2%	6	11%	5	9%	9	17%
Number/percentage of staff who were very satisfied or satisfied with the accuracy of interpretation.	54	27	90%	0	0%	3	100%	0	0%	1	100%	6	100%	5	100%	9	100%
Number/percentage of staff who were very satisfied or satisfied with the interpreter's punctuality and professionalism?	54	26	87%	0	0%	3	100%	0	0%	1	100%	6	100%	5	100%	9	100%

* N is less than 10, and the data is not statistically significant.

- **Usage:** 62% of Customer Service staff have used the Access Program for oral interpretation, while other departments have significantly lower usage rates.
- **Satisfaction with Accuracy:** High satisfaction across the board, with 90% of Customer Service staff and 100% of staff from other departments expressing satisfaction.
- **Satisfaction with Punctuality and Professionalism:** Similarly high satisfaction, with 87% of Customer Service staff and 100% of staff from other departments being satisfied.
- CalOptima Health met the goal of 85%.

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2. Translation Services

Staff Survey Questions & Responses – Translation Services	Total Resp. per question	Staff Survey Results															
		Customer Service*		Claims*		UM*		Population Health*		Case Management *		Behavioral Health*		Complaints, Grievances, Appeals*		Other Depts.	
		#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Number/percentage of staff who accessed written material or document translation	32	9	46%	0	0%	2	6%	0	0%	0	0%	3	9%	5	17%	13	41%
Number/percentage of staff who were very satisfied or satisfied with the accuracy of the written translation.	32	8	89%	0	0%	2	100%	0	0%	0	0%	2	75%	5	100%	12	92%
Number/percentage of staff who were very satisfied or satisfied with the amount of time it took to translate their document.	32	9	100%	0	0%	2	100%	0	0%	0	0%	1	33%	5	100%	12	92%

- **Usage:** 46% of Customer Service staff have used the Language Access Program for translating documents, with the highest usage in the Other Departments, at 41%.
- **Satisfaction with Accuracy:** High satisfaction, with 89% of Customer Service staff and 100% of staff from several other departments being satisfied.
- **Satisfaction with Timeliness:** High satisfaction, with 100% of Customer Service staff and 100% of staff from several other departments being satisfied.
- CalOptima Health met the goal of 85%.

Member Survey Analysis

1. Utilization of Language Services

Language Services Utilization ~~by~~ Functional Area													
Total Utilization	Customer Service	%	Claims	%	Utilization Management	%	Population Health	%	Case Management	%	Grievance and Appeals	%	Other	%
59,561	40,921	69%	0	0%	291	0.5%	277	0.5%	10,900	18%	1,579	3%	5,593	9%

This data indicates that Customer Service is the primary user of language services, accounting for 69% of the total population, followed by Case Management, other departments, GARS, Utilization Management and Population Health. The Claims department does not directly interact with members, which explains the lack of utilization in that area. All member issues related to claims are managed by the Customer Service team.

2. Member Experience

Member Survey Questions	Member Survey Results					
	Only Organizational Functions		Only Health Care Encounters		Both Organizational Functions and Health Care Encounters	
	Members	%	Members	%	Members	%
Number/percentage of Members who used Language Services	610	36%	694	41%	404	24%
Number/percentage of Members who thought it was Very Easy/Easy to use the language assistance services.	562	92%	653	94%	378	94%
Members who thought the language services received was very helpful.	573	94%	661	95%	374	93%

The survey results indicate that a substantial number of members used language services and found them both easy to use and highly helpful.

Organizational Functions Encounters:

- 610 members (36%) used language services.
- 562 members (92%) found it very easy or easy to use the language assistance services.
- 573 members (94%) thought the language services received were very helpful.

Health Encounters:

- 694 members (41%) used language services.
- 653 members (94%) found it very easy or easy to use the language assistance services.
- 661 members (95%) thought the language services received were very helpful.

Both Organizational Functions and Health Encounters:

- 404 members (24%) used language services.
- 378 members (94%) found it very easy or easy to use the language assistance services.
- 374 members (93%) thought the language services received were very helpful.

IV. Qualitative Analysis

A qualitative analysis conducted in Q3 2025 to identify barriers found that satisfaction levels are high among both members and staff. While CalOptima Health has met the goals set for satisfaction, the following additional barriers were identified.

Causal/Barrier Analysis:

- Some members experienced several minutes of wait time to connect with a telephonic interpreter.
- The survey of both staff and members yielded a low response.

V. Opportunities for Improvement

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will address high-priority issues first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Track interpreter service Key Performance Indicators (KPIs).	• C&L staff will continue to monitor through monthly reporting the contracted vendors' KPIs, including telephone answer time and address/correct issues as they arise. • C&L staff will monitor member grievances related to language services and track, trend and address issues as they arise.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L
2. Improve CalOptima Health staff engagement.	• Engage leadership to consistently promote the importance of the survey, to help emphasize the importance of the survey. • Educate staff on the importance of their participation in the survey, which can be done through workshops, meetings or internal communications.	☐ MC ☒ OC	☒ Q1 ☒ Q3 Q2 ☒ Q4	☐ H ☒ M ☐ L
3. Improve member engagement.	• Send text message reminders to members who have not responded to the mailed survey.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L
4. Review and revamp the staff and member survey.	• Ensure that the survey is concise and focused on pinpointing areas for improvement to make it easier for respondents to complete the survey without feeling overwhelmed.	☒ MC ☐ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ H ☒ M ☐ L

VI. Conclusion

Overall, with 2025 being the implementation year of the Experience with Language Services survey, it was successful and yielded valuable data results. While the survey showed general satisfaction with language services, the response rates were low and did not meet goal. As a result, this item will remain on the work plan for 2026.

Section 5: Data Collection and Analysis

5.1 Cultural Responsiveness: Data Collection on Member Demographic Information	
Author: Carlos Soto/Albert Cardenas	Department(s): Cultural & Linguistic Services
Responsible Party(ies): Albert Cardenas – Director, Customer Service Carlos Soto - Manager, Cultural & Linguistic Services	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☐ No
Workplan Goal/Objective: By December 31, 2025, CalOptima Health will increase the collection of sexual orientation and gender identity (SOGI) data by 10% through focused outreach and education, ensuring better representation and inclusion of members.	
Goal Met: ☐ Yes ☒ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background

CalOptima Health will gather individuals' race/ethnicity, language, gender identity and sexual orientation data using standardized methods.

II. Data Sources and Methodology

CalOptima Health staff follow the DHCS and NCQA Health Equity Standards and Guidelines when implementing processes for collecting demographic data. The primary sources for collecting information include member surveys, as well as the DHCS eligibility file, the Member Portal, New Member Orientation and community events.

III. Program Results and Quantitative Analysis

CalOptima Health mailed a survey to CalOptima Health members 18 years of age and older to request their race/ethnicity, language, gender identity, and sexual orientation. The survey results were following:

- Survey was offered to 286,334 members ages 18+
- Surveys completed: 8,690
- Completion Rate: 3%

Pronouns

	Medi-Cal	OneCare	Grand Total
She, Her	4,298	109	4,407
He, Him	3,859	68	3,927
They, Them	62		62
Other	75	8	83
Chose not to share	99	5	104
Information unavailable	118	1	119
Grand Total	8,496	191	8,687

Sex at Birth

	Medi-Cal	OneCare	PACE	Grand Total
Female	4,382	119	36	4,537
Male	3,933	72	13	4,018
Intersex or X	2			2
Choose not to share	40	1		41
Information unavailable	89	1		90
Unknown	3			3
Grand Total	8,448	193	49	8,690

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Sexual Orientation

	Medi-Cal	OneCare	PACE	Grand Total
Straight or heterosexual	6,533	140	48	6,721
Lesbian, gay or homosexual	151			151
Bisexual	158	3		161
Pansexual	58			58
Queer	42			42
Questioning	16	1		17
Other	158	4		162
Don't know / Unsure	86	2		88
Chose not to share	501	27	1	529
Information unavailable	362	12		374
Grand Total	8,063	189	49	8,301

Gender Identity

	Medi-Cal	OneCare	PACE	Grand Total
Female	3,991	207	60	4,258
Male	3,610	160	34	3,804
Transgender Male	40			40
Transgender Female	61	1		62
Gender Non-Conforming	13			13
Genderqueer	18			18
Non-Binary	17			17
Unknown	9			9
Other	4			4
Choose not to disclose	45	17		62
Form left blank	3			3
I choose not to answer	1			1
Man	1			1
Grand Total	7,813	385	94	8,292

While strong efforts were made to collect SOGI data from members, only 3% of members responded and the target goal collection rate of 10% was not met.

IV. Qualitative Analysis

CalOptima Health staff conducted a qualitative analysis on the data collection of member demographic information and identified possible barriers related to the low response rate.

Causal/Barrier Analysis:

- The 10% goal was possibly too aggressive.
- Survey fatigue, as CalOptima Health sends a multitude of surveys to members.
- Members' reluctance to provide personal information.

V. Opportunities for Improvement

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will address high-priority issues first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Expand the methods of survey distribution to members.	• Create a texting campaign for members who do not respond to the mailed survey. • Explore the possibility of the Customer Service Call Center assisting with the collection of surveys through member interaction.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L
2. Review the new Health Equity requirements to include the collection of disability function and identity, physical accommodations, auxiliary aids or services, geographic classification, age, and veteran /military status.	• Assess and update system capabilities for collecting, storing and retrieving new data requirements. • Update existing or create new surveys to support new requirements.	☒ MC ☐ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L

VI. Conclusion

Although the 10% goal was not achieved, the implementation of this process has been overall a success. CalOptima Health continues to survey members and gather responses. Moving forward, CalOptima Health will seek ways to improve this process and implement additional new requirements. These will include data collection on disability function and identity, physical accommodations, auxiliary aids or services, geographic classification, age, and veteran/military status.

5.2 Network Cultural Responsiveness: Data Collection on Practitioner Demographic Information	
Author: Linda Huynh	Department(s): Provider Data Operations
Responsible Party(ies): Quynh Nguyen – Director, Provider Data Operations Linda Huynh – Program Specialist Int, Provider Data Operations	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: By December 31, 2025, CalOptima Health will increase the collection of race/ethnicity/language (REL) data by 10% through focused outreach and education, ensuring better representation and inclusion of providers.	
Goal Met: ☐ Yes ☐ No ☒ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background

The purpose of the Data Collection on Provider Demographic initiative is to improve CalOptima Health's collection of provider Race, Ethnicity and Language (REL) data. This information helps us better meet the cultural and language needs of our members and supports CLAS reporting.

II. Data Sources and Methodology

The time period for this initiative was January 1, 2025, through December 31, 2025. The following methodology was used to collect and analyze REL data:

A. REL Provider Data is collected from the following sources:
   1. Addition/Change/Termination (ACT) forms
   2. Letters of Intent (LOIs)
   3. Credentialing packets
   4. Provider rosters
   5. Direct provider outreach (email and phone)

B. The data sources listed in (A) are submitted to Provider Data Management Services (PDMS), which is responsible for entering the provider REL data into Facets.

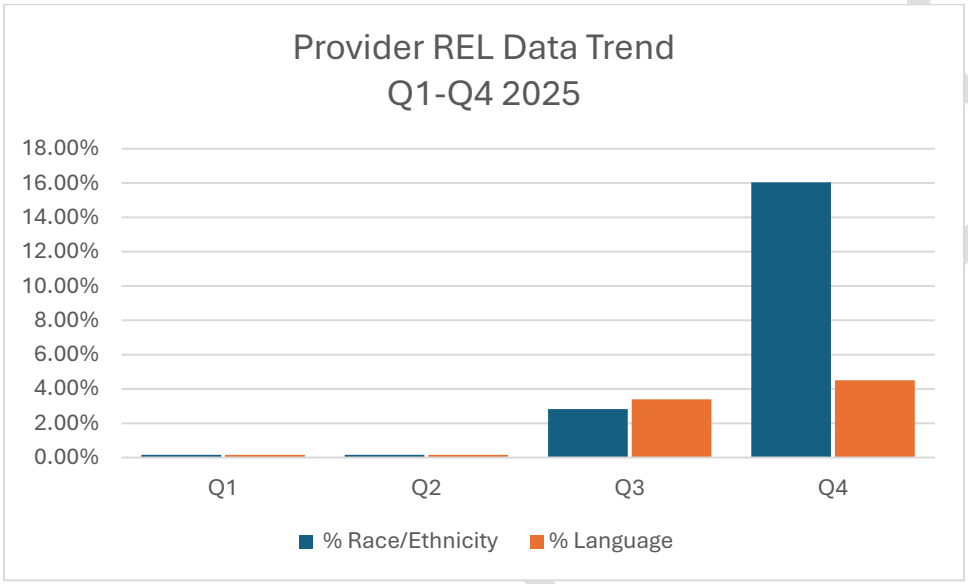
C. CalOptima Health uses the total count of contracted providers in Q1 as the common denominator for all quarterly calculations to ensure consistency across reporting periods. The total count of contracted providers in Q1 2025 is 12,899.

OAC 03.19.26

D. CalOptima Health runs a quarterly report of total provider count with REL data and divides it by the common denominator to arrive at the % REL data collected by quarter. The results are trended quarter over quarter.

III. Program Results and Quantitative Analysis

Indicator/Goal(s): Indicator/Goal(s): 10% of 12,899 contracted Providers by December 31, 2025.



Quarter	Race/Ethnicity	Language Fluency	% Race/Ethnicity	%Language Fluency
Q1	20	20	0.15%	0.15%
Q2	20	20	0.15%	0.15%
Q3	365	438	2.66%	3.19%
Q4	2069	581	16.04%	4.50%

- In Q1, the REL data started with 20 providers (0.15%) out of 12,899 who disclosed the information from the 2024 survey initiative.
- In Q2, the REL submission remained low at 0.15%, no new response. The trend in Q2 results showed that additional interventions were needed in Q3.
- In Q3, REL submission reached 2.66% for Race/Ethnicity and 3.19% for Language Fluency following inclusion in the Provider Relations (PR) monthly newsletter, and targeted outreach to the medical groups via administrative email and phone. This marked a meaningful improvement over the prior quarter.
- In Q4, REL submission increased significantly to 16.04% for Race/Ethnicity and 4.50% for Language Fluency, reflecting the impact of expanded data collection efforts, inclusion of newly onboarded health network providers, and sustained direct outreach activities.

IV. Actions/Interventions Implemented in 2025

Interventions	Product	Quarter	Type	Status
1. Integration of REL fields into ACT forms, LOIs, credentialing applications, and medical groups' rosters.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☒ Q2 ☐ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
2. PR Lunch & Learn and Community Clinic Forum sessions to highlight REL's importance and encourage submission in September and October.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☒ HN ☒ Comm ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
3. Conduct direct outreach to CalOptima Health Community Network (CHCN) contracted medical groups, starting with the largest groups, via email and phone to request REL data.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions

1. Adding REL fields to ACT forms, LOIs and credentialing packets was completed in April and created a consistent option for providers to voluntarily provide REL data to CalOptima Health. However, this did not translate immediately into Q2 results.

2. PR Lunch and Learn sessions and Community Clinic forums raised awareness but had little impact and will not continue.

3. Direct outreach in Q3 was the most effective strategy, leading to the first measurable increase in REL submissions, about 20 times higher than the previous quarter. This demonstrated the value of direct engagement with medical groups by requesting that they collect REL data from their providers.

4. Q4 results reflected the effectiveness of sustained direct outreach and expanded data collection pathways. Race/Ethnicity submissions exceeded the 10% collection goal, while Language Fluency submissions continued to increase steadily, indicating positive impact from ongoing provider engagement and inclusion of newly onboarded health network providers through roster-based processes.

VI. Qualitative Analysis

The qualitative analysis was conducted by Provider Data Operations (PDO) Director, Senior Manager of Provider Data Operations, Analytics Senior Data Analyst, and the Program Specialist. A focused review of REL data collection efforts identified the following barriers:

- **Voluntary Provider Participation**
  The voluntary nature of provider submission of REL data is a reason for the low submission rates. Since it was not required, most opted not to submit the data, significantly hindering progress toward the 10% collection goal. While outreach has been helpful in increasing participation, changing practitioners' mindset to voluntarily provide their REL data will take far longer than a year.

- **REL Data Entry Not Included in Forms Submitted**

OAC 03.19.2026

Back to Agenda Back to Item

Although REL fields were added to the ACT, LOI and credentialing packets by April, they were frequently left blank. This was evident in Q2, where all submitted forms lacked REL data. The absence of complete entries limited PDO's ability to collect REL information during onboarding and provider updates.

- **Forms Saturations**
  REL fields were added to existing forms such as the ACT, LOI, and credentialing packets, which already request extensive information. It is possible that providers overlooked or deprioritized REL questions due to "form fatigue," contributing to low REL data submissions.

VII. Opportunities for Improvement

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will address high-priority items first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Work and communicate directly with CHCN medical groups to submit REL demographics.	Continue targeted outreach to medical groups to collect the REL data from their providers.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
2. Increase health network participation in collecting the REL data.	Develop a one-page REL expectations guide for health networks with examples for simplified execution.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion

REL data collection showed meaningful improvement in 2025, driven by targeted outreach and expanded pathways. Submissions rose sharply from Q2 to Q3, Race/Ethnicity increased from 0.15% to 2.66%, and Language Fluency reached 3.19%, reflecting the impact of direct outreach to medical groups, the most effective strategy for provider participation.

By Q4, Race/Ethnicity collection surpassed the 10% annual goal, supported by workflow integration and onboarding of health network providers. Language Fluency continued to grow steadily but remains a priority and will remain on the work plan for 2026. While voluntary submission remains a challenge, results confirm that outreach and health network engagement work. Sustained application of these strategies and deeper collaboration will be key to meeting future goals.

5.3 Availability of Practitioners: Cultural Needs and Preferences	
Author: Carlos Soto/Albert Cardenas	Department(s): Cultural & Linguistic Services
Responsible Party(ies): Carlos Soto/Albert Cardenas	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective: Monitor language services utilization, grievances related to language services, and member satisfaction of language services.	

OAC 03.19.2026

Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background

CalOptima Health monitors members' ability to access health care services by ensuring an adequate network of practitioners and by analyzing the network's effectiveness in meeting the cultural needs and preferences of its membership. To ensure member needs are met, CalOptima Health analyzes gender, race/ethnicity, language, and member needs/preference data of CalOptima Health members and compares the data against practitioners by health network to determine if there is adequate practitioner coverage to meet members' needs.

- Gender Ratios: Male Member/Male Practitioner, Female Member/Female Practitioner
- Language Ratios: Member/Practitioner ratio for the following languages:
    - Medi-Cal: Arabic, Chinese, Farsi, Korean, Spanish and Vietnamese
- Member Race/Ethnicity: CalOptima Health reviews data received via DHCS 834 eligibility files.
- Provider Race/Ethnicity: Review data from the California Department of Access and Information.
- Religion analysis: Review data from the Pew Research Group to identify the religious composition of California's population.

II. Data Sources and Methodology

The member data collected for this report is extracted from CalOptima Health's core system (Facets). This system contains member data for gender, language and ethnicity, and is updated monthly from DHCS eligibility files and through daily member interactions with Customer Service Call Center staff. The practitioner data for this report are also extracted from Facets and summarized annually as a total, as well as by health network, for gender and language.

Language: For this study, CalOptima Health uses DHCS-established requirements to determine the threshold and concentration of languages as defined below.

DHCS threshold and concentration language requirements are:

- Eligible beneficiaries residing in CalOptima Health's service area who indicate their primary language as a language other than English, and who meet a numeric threshold of 3,000 or 5% of the eligible beneficiary population, whichever is lower (Threshold Standard Language); and
- Eligible beneficiaries residing in CalOptima Health's service area who indicate their primary language as a language other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes (Concentration Standard Language).
- DHCS updates the threshold and concentration language requirements once every three fiscal years.

Race/Ethnicity Data: CalOptima Health collects race/ethnicity data at the state level and receives it through the DHCS 834 eligibility files. The data is stored in CalOptima Health's Core eligibility system.

OAC 03.19.2026

Back to Agenda Back to Item

CalOptima Health currently does not collect practitioner race/ethnicity data and instead uses the California Department of Health Care Access and Information's Health Workforce License Renewal Survey.

Religion: CalOptima Health does not collect member or provider religion and uses the California Department of Health Care Access and Information Health Workforce License Renewal Survey.

III. Program Results and Quantitative Analysis

1. Assessing Gender Data

Gender is a social and cultural variable that encompasses several domains that influence health: gender identity and expression, gender roles and norms, gender relations, power, and equality and equity. Gender socialization tends to influence decisions related to health-seeking behaviors. Several clinical studies have shown that health decisions are influenced by gender preferences and cultural factors.

The study looks at the following criteria for gender:

a) The number of female practitioners with female members
b) The number of male practitioners with male members

This gender study examines the ratio of female members to female practitioners and male members to male practitioners to identify areas that require attention. The standard practitioner-to-member ratio goal is 1:500.

Overall, CalOptima Health had an average of 1:64 female practitioners to female members and 1:66 for male practitioners to male members. When reviewing ratios by health networks, all health networks meet the standard.

Medi-Cal Gender Data			
Male			
Date	12/31/2024		
Health Networks	Ratio	Provider	Member
Health Networks Combined	1:66	5,362	355,420
Alta Med Health Services	1:102	349	35,847
AMVI Healthcare	1:75	189	14,307
CalOptima Community Network	1:13	4,846	64,999
CHOC Health Alliance	1:54	1,347	73,906
Family Choice Health Network	1:72	306	22,239
Noble Mid-Orange County	1:63	200	12,632
Optum Care Network	1:120	685	82,304
Prospect Medical Group	1:51	419	21,776
Heritage - Regal	1:14	401	5,888
United Care Medical Group	1:67	318	21,522

Medi-Cal Gender Data			
Female			
Date	12/31/2024		
Health Networks	Ratio	Provider	Member
Health Networks Combined	1:64	6,093	393,065
AltaMed Health Services	1:189	193	36,575
AMVI Healthcare	1:149	85	12,676
CalOptima Community Network	1:16	5,663	95,130
CHOC Health Alliance	1:49	1,400	68,848
Family Choice Health Network	1:197	119	23,548
Noble Mid-Orange County	1:124	93	11,624
Optum Care Network	1:210	454	95,648
Prospect Medical Group	1:97	225	21,997
Heritage - Regal	1:36	162	5,979
United Care Medical Group	1:131	160	21,040

2. Assessing Language Data

The study assesses the linguistic needs of members and collects language data from CalOptima Health members and practitioners to determine if there is adequate practitioner coverage by language and whether there are sufficient language services for members. CalOptima Health uses this study to

determine whether members lack access to a practitioner who speaks their language or to language services.

The language study examines the ratio and percentage of members who speak a non-English language to practitioners who speak the same non-English language, identifying areas where the practitioner-to-member ratio for a threshold language is too high and requires attention.

Overall, CalOptima Health met the language standard ratio of 1:500 of practitioners who speak the same non-English language to members who speak the same non-English language.

Medi-Cal Language Data			
Farsi			
Date	12/31/2024		
Health Networks	Ratios	Provider	Member
Combined Medi-Cal	1:25	296	7,415
AltaMed Health Services	1:7	32	247
AMVI Healthcare	1:6	15	93
CalOptima Community Network	1:6	228	1,581
CHOC Health Alliance	1:8	85	732
Family Choice Health Network	1:10	16	170
Heritage - Regal	1:5	37	190
Noble Mid-Orange County	1:3	21	75
Optum Care Network	1:40	91	3,684
Prospect Medical Group	1:8	46	381
United Care Medical Group	1:9	29	262

Medi-Cal Language Data			
Chinese			
Date	12/31/2024		
Health Networks	Ratios	Provider	Member
Combined Medi-Cal	1:7	181	1,424
AltaMed Health Services	1:1	31	61
AMVI Healthcare	1:1	14	25
CalOptima Community Network	1:2	148	351
CHOC Health Alliance	1:3	60	225
Family Choice Health Network	1:2	27	76
Heritage - Regal	1:3	23	80
Noble Mid-Orange County	1:1	16	24
Optum Care Network	1:9	52	469
Prospect Medical Group	1:1	34	57
United Care Medical Group	1:2	25	56

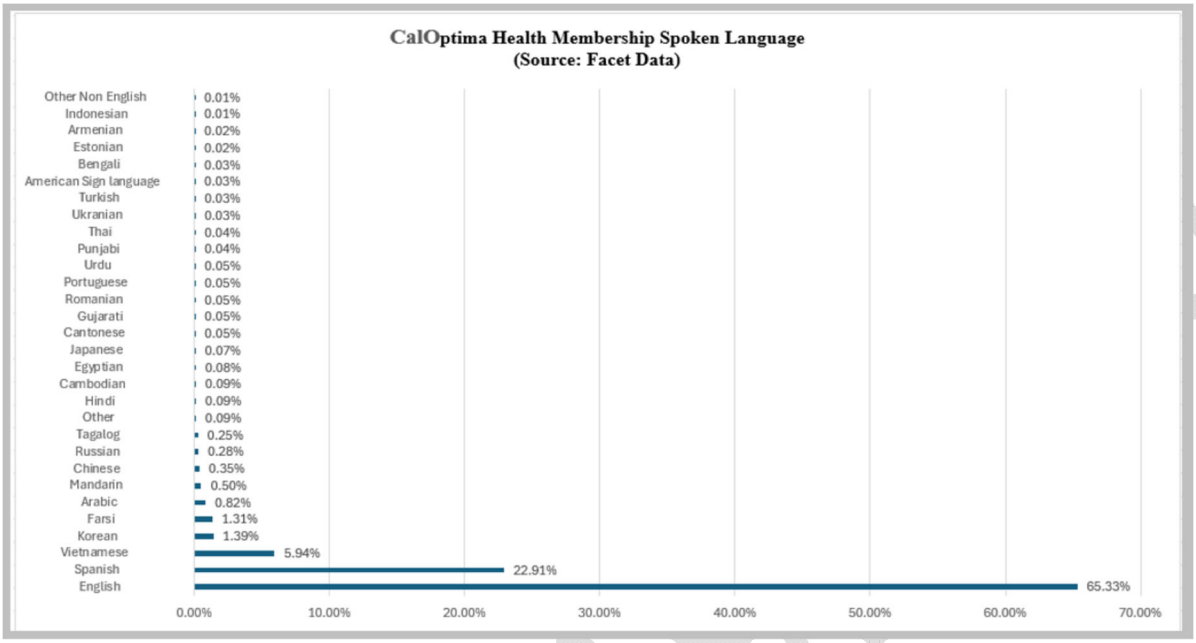
Medi-Cal Language Data			
Spanish			
Date	12/31/2024		
Health Networks	Ratios	Provider	Member
Combined Medi-Cal	1:152	1,614	245,602
AltaMed Health Services	1:140	224	31,540
AMVI Healthcare	1:39	117	4,657
CalOptima Community Network	1:44	1,294	57,132
CHOC Health Alliance	1:97	613	59,709
Family Choice Health Network	1:65	173	11,317
Heritage - Regal	1:14	256	3,696
Noble Mid-Orange County	1:70	148	10,401
Optum Care Network	1:111	428	47,807
Prospect Medical Group	1:37	324	12,046
United Care Medical Group	1:39	186	7,297

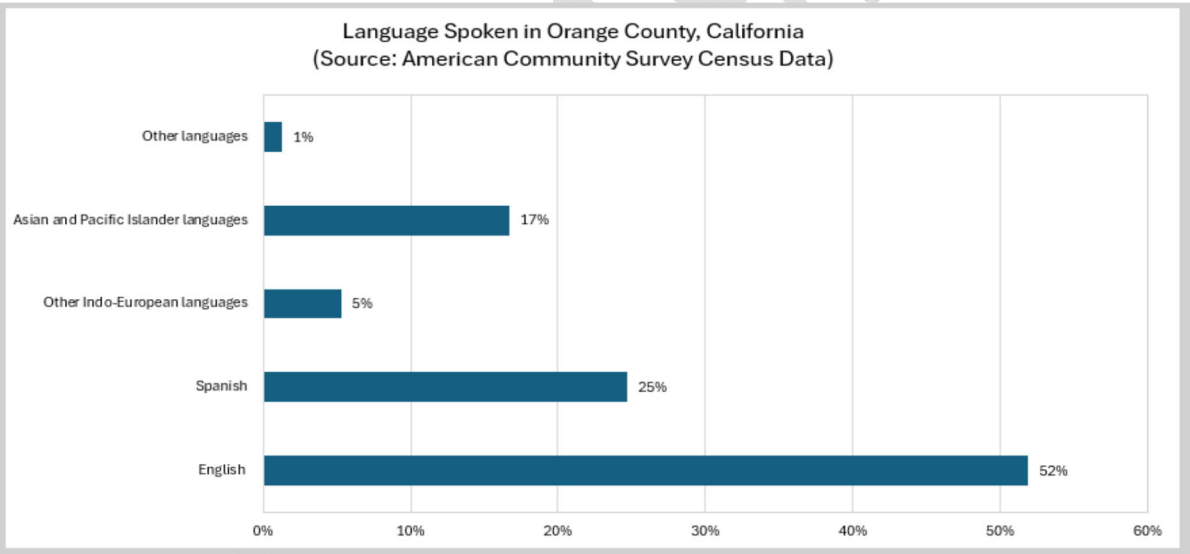
Medi-Cal Language Data			
Vietnamese			
Date	12/31/2024		
Health Networks	Ratios	Provider	Member
Combined Medi-Cal	1:98	544	53,612
AltaMed Health Services	1:9	75	720
AMVI Healthcare	1:76	122	9,279
CalOptima Community Network	1:8	419	3,631
CHOC Health Alliance	1:20	116	2,415
Family Choice Health Network	1:84	179	15,067
Heritage - Regal	1:2	172	514
Noble Mid-Orange County	1:8	67	552
Optum Care Network	1:21	149	3,262
Prospect Medical Group	1:54	123	6,655
United Care Medical Group	1:71	161	11,517

Medi-Cal Language Data			
Korean			
Date	12/31/2024		
Health Networks	Ratios	Provider	Member
Combined Medi-Cal	1:32	215	6,970
AltaMed Health Services	1:12	20	255
AMVI Healthcare	1:4	14	57
CalOptima Community Network	1:13	174	2,298
CHOC Health Alliance	1:16	77	1,282
Family Choice Health Network	1:7	11	85
Heritage - Regal	1:7	24	168
Noble Mid-Orange County	1:5	19	110
Optum Care Network	1:53	41	2,197
Prospect Medical Group	1:16	27	442
United Care Medical Group	1:7	10	76

Medi-Cal Language Data			
Arabic			
Date	12/31/2024		
Health Networks	Ratios	Provider	Member
Combined Medi-Cal	1:34	161	5,481
AltaMed Health Services	1:7	28	209
AMVI Healthcare	1:5	12	70
CalOptima Community Network	1:19	129	2,504
CHOC Health Alliance	1:15	47	748
Family Choice Health Network	1:7	23	163
Heritage - Regal	1:2	41	98
Noble Mid-Orange County	1:3	21	74
Optum Care Network	1:24	50	1,205
Prospect Medical Group	1:6	37	223
United Care Medical Group	1:6	27	187

This trend has been consistent, as demonstrated by data from CalOptima Health's Membership by Spoken Language report and the American Community Survey (ACS). CalOptima Health provides adequate language services for its members.



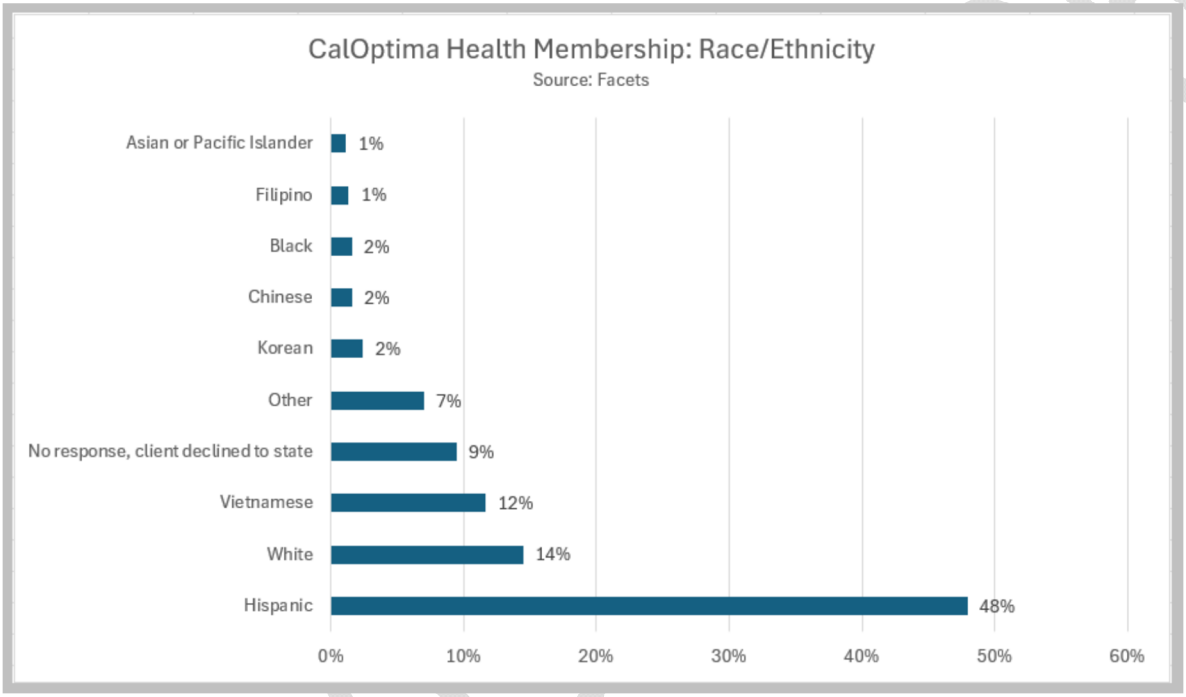


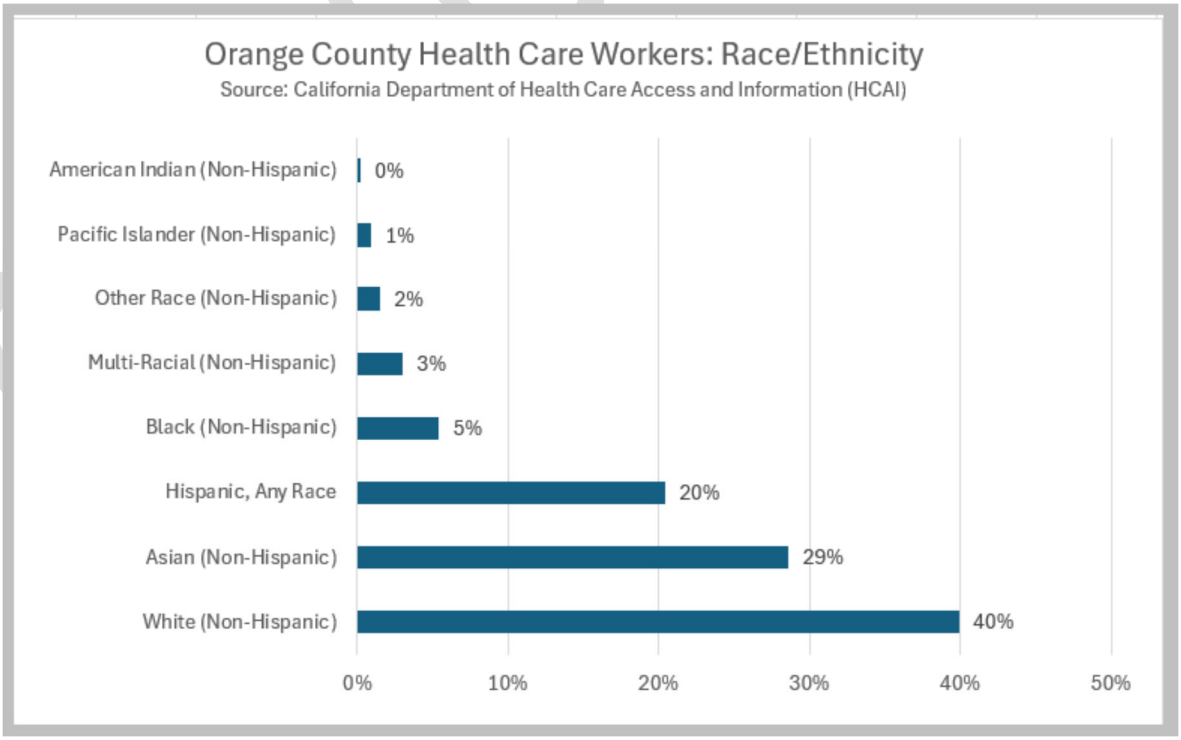
3. Race/Ethnicity Analysis

Due to the low response rate from the CalOptima Health Provider Satisfaction Survey, CalOptima Health used provider race/ethnicity data from the California Department of Health Care Access and Information (HCAI) to compare with the race/ethnicity of CalOptima Health members.

The tables below show the race/ethnicity comparison between CalOptima Health members and health care workers in Orange County.

- Hispanics represent 47% of CalOptima Health's membership, but only 20% of healthcare workers are Hispanic.
- Asians represent 19% of CalOptima Health's membership and are well represented with 29% of Asian health care workers.
- Hispanics are the most underrepresented group in the health workforce, at nearly 30% below the CalOptima Health membership.
- Asians are represented at nearly twice the membership average.
- Other races are well represented at nearly twice the population average.





- The data shows a 28% gap in race/ethnicity between Hispanic members and health care providers. This gap suggests a likelihood that practitioners may not have a good understanding of Hispanic patients' cultural preferences and, therefore, may not appropriately manage Hispanic members' health care needs.

IV. Actions/Interventions Implemented in 2025

Interventions	Product	Quarter	Type	Status
1. Ensure CalOptima Health staff and practitioners continue taking the annual Culture Competency training course to ensure staff are aware of how to address members' cultural differences and needs.	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☒ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
2. Improve the collection of provider race/ethnicity data by integrating key questions into routine forms to streamline data collection.	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☒ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
3. Provide language services to LEP members, including face-to-face during provider office visits.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
4. Monitor member grievances related to cultural and linguistic services.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
5. Evaluate language services experience by collecting feedback from CalOptima Health members and staff using surveys. Analyze the results to identify potential improvements to language services.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

V. Effectiveness of Interventions

Overall, the interventions were effective:

- CalOptima Health staff and practitioners completed the cultural competency training.
- Collection of provider race ethnicity improved from 0.15% to 16%.
- CalOptima Health provided LEP members with interpreter services at all points of contact related to health care services.
- Both staff and members were surveyed regarding their satisfaction with language services. The results indicate a satisfaction rate of over 90%.

VI. Qualitative Analysis

The Director of Customer Service conducted a qualitative analysis to identify barriers related to the availability of practitioners, specifically cultural needs and preferences, and determined that there were no significant gaps in gender and language.

OAC 03.19.25

Causal/Barrier Analysis:

- 28% gap in race/ethnicity between Hispanic members and healthcare providers.

VII. Opportunities for Improvement

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Continue to improve the collection of provider race/ethnicity data by integrating key questions into routine forms to streamline data collection.	Continue targeted outreach to medical groups to collect the REL data from their providers.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
2. Increase health network participation in collecting the REL data.	Develop a one-page REL expectations guide for health networks with examples for simplified execution.	☐ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L
3. Monitor interventions noted in section IV.	Monitor cultural competency training courses, language service utilization, and grievances related to language services and cultural competency.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☒ H ☐ M ☐ L

VIII. Conclusion

Overall, the Availability of Practitioners: Cultural Needs and Preferences results met the needs of CalOptima Health members.

Section 6: Promotion of Diversity

6.1 Staff, Leadership and Committee Hiring and Recruiting Practices	
Author: Michael Coringrato	Department(s): Human Resources/Quality Improvement
Responsible Party(ies): Ravi Hayashida	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: To assess staff and committee experience with DEI at CalOptima Health and utilize the data to identify areas of opportunity for DEI improvement	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☒ Completed ☐ Ongoing

I. Purpose or Background

CalOptima Health analyzed the results of its employee engagement data from the early 2024 Great Places to Work Survey and its own Diversity, Equity and Inclusion surveys for employees and governing bodies completed in early 2025. The DEI survey was in accordance with the organization's AA.1252 Diversity, Equity and Inclusion policy, which states that CalOptima Health will regularly evaluate how our workforce reflects the diversity of the population served and address inadequate representation through interventions to address such opportunities for improvement. The HE1 workgroup collected and analyzed the DEI survey in January 2025 to identify areas for improvement and develop action plans for the 2025 implementation.

OAC 3.19.2026

II. Data Sources and Methodology

a. The Survey period was between Monday, December 16, 2024, and Friday, January 10, 2025. Holidays were taken into consideration when setting this response period.
b. The survey was split into two sections: Perceptions of DEI in the work environment and demographics.
c. Demographics criteria were designed to align with the then-current Office of Management and Budget (OMB) criteria.
d. The anonymous surveys were hosted by HR on SurveyMonkey, and the team is using SurveyMonkey analytics to collect data and reports.
e. Communication plan included Chief-level review, announcements via all-staff meeting, email and internal meeting announcements.
f. Staff/Leadership survey was sent to about 1,600 employees while the Committee survey was sent to 149 participants.
g. Target participation was 15% for both surveys. The actual staff/leadership survey response reached a 38% response rate, and the committee survey obtained a 34% response rate, exceeding expectations for both surveys.

The demographics of the respondents are representative of the employee population and member population served.

Question 4	Employees of diverse backgrounds are encouraged to apply for higher-level positions.						
	Staff & Leadership Responses			Committee Responses		Staff Population	
Race/Ethnicity	Num	% of Responses	Met Goal?	Num	% of Responses	Num	% of Staff
American Indian or Alaska Native	6	0.92%		n/a	n/a	5	0.30%
Asian or Asian American	174	26.77%		n/a	n/a	463	28.06%
Black / African American	33	5.08%		n/a	n/a	83	5.03%
Hispanic or Latin	198	30.46%		n/a	n/a	697	42.24%
Middle Eastern or North African	13	2.00%		n/a	n/a	n/a	n/a
Native Hawaiian or Pacific Islander	6	0.92%		n/a	n/a	19	1.15%
White	141	21.69%		n/a	n/a	345	20.91%
Choose not to share	72	11.08%		n/a	n/a	n/a	n/a
Other	7	1.08%		n/a	n/a	39	2.36%
Totals	**650**	**100%**		**n/a**	**n/a**	**1,651**	**100%**

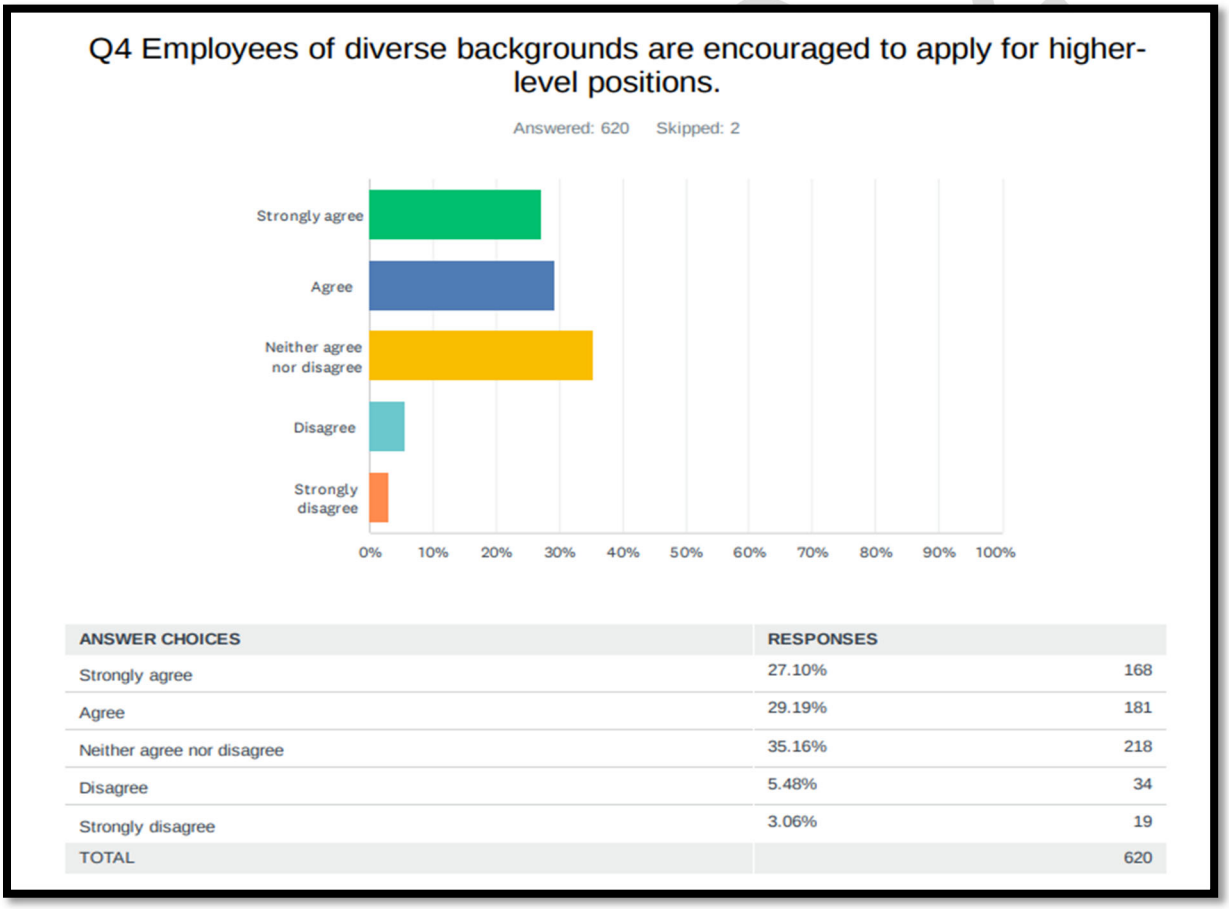
Question 8 of the committee DEI survey was completed by 49 of 50 survey respondents. Due to the small survey population, the demographics of responses were not reported for all groups to protect anonymity.

QA 10.19.2026

Question 8	I am aware of and understand the procedures for reporting incidents of discrimination and/or bias in the committee.						
	Staff & Leadership		Committee Responses			Staff Population	
Race/Ethnicity	Num	%	Num	% of Responses	Met Goal?	Num	% of Staff
American Indian or Alaska Native	n/a	n/a	*	n/a		5	0.30%
Asian or Asian American	n/a	n/a	13	26.00%		463	28.06%
Black / African American	n/a	n/a	*	n/a		83	5.03%
Hispanic or Latino	n/a	n/a	11	22.00%		697	42.24%
Middle Eastern or North African	n/a	n/a	*	n/a		n/a	n/a
Native Hawaiian or Pacific Islander	n/a	n/a	*	n/a		19	1.15%
White	n/a	n/a	12	24.00%		345	20.91%
Choose not to share	n/a	n/a	7	14.00%		n/a	n/a
Other	n/a	n/a	*	n/a		39	2.36%
Total Invitations sent			**149**			n/a	
Total			**50**			**1,651**	

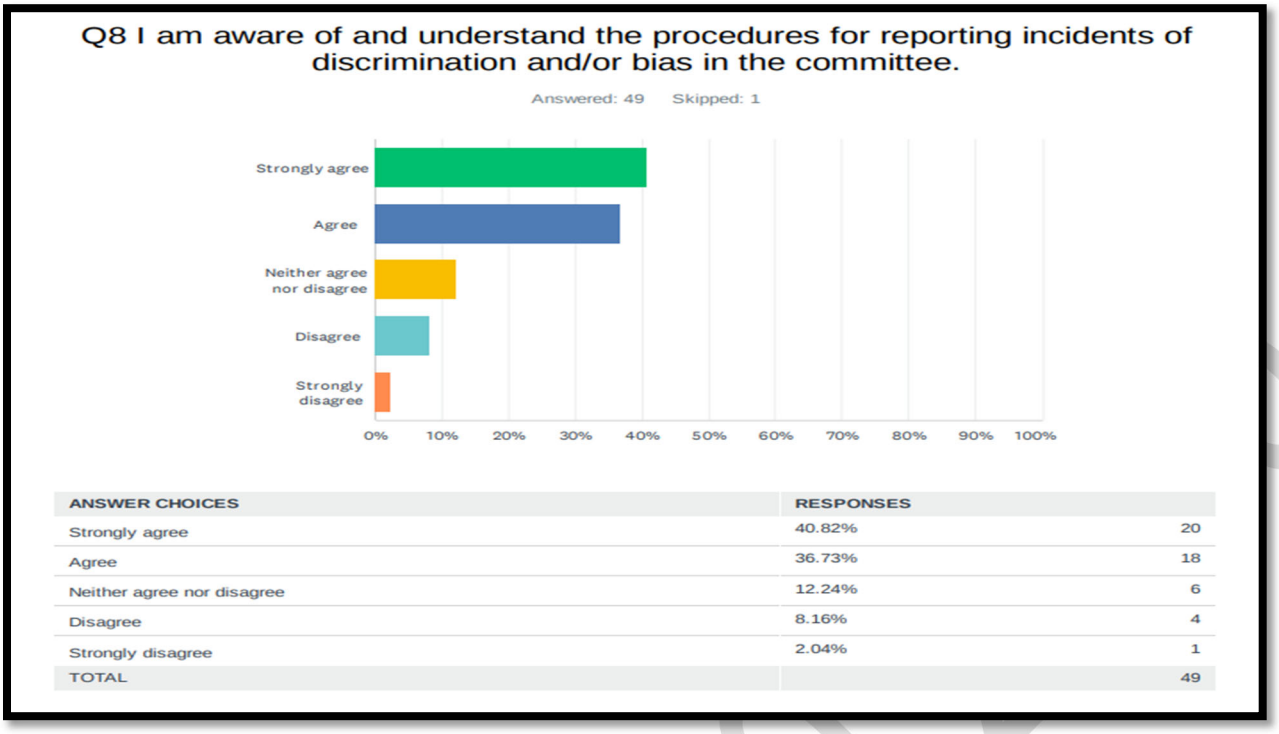
III. Program Results and Quantitative Analysis

Staff identified the following questions on the survey to focus on the analysis.



ANSWER CHOICES	RESPONSES	
Strongly agree	27.10%	168
Agree	29.19%	181
Neither agree nor disagree	35.16%	218
Disagree	5.48%	34
Strongly disagree	3.06%	19
TOTAL		620

For the employee survey, staff focused on whether employees of diverse backgrounds are encouraged to apply for higher-level positions. Most respondents, a total of 56.29% of respondents, either “strongly agreed” or “agreed” with this statement.



ANSWER CHOICES	RESPONSES	
Strongly agree	40.82%	20
Agree	36.73%	18
Neither agree nor disagree	12.24%	6
Disagree	8.16%	4
Strongly disagree	2.04%	1
TOTAL		49

For the committee survey, we identified one opportunity based on the responses to Question 8, "I am aware of and understand the procedure for reporting incidents of discrimination and/or bias in the committee."

The question was answered by 49 respondents, with an aggregate response of 22.45% who did not Agree or Strongly Agree with that statement representing an opportunity to close the perceived procedural gap in reporting incidents of discrimination and/or bias on committees.

IV. Actions/Interventions Implemented in 2025

Interventions	Product	Quarter	Type	Status
1. Promote growth opportunities by: • Enhance existing job opportunity announcements in HR Announcements emails to all employees. • Rewrite Hot Jobs to spot a lot of promotional opportunities in The Week Ahead and the biweekly HR Announcements to encourage views and applications. • Promote Hot Jobs on the HR InfoNet page accessible to all employees.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete
2. Based on the Committee Survey results: Add Nondiscrimination Process Language to Policy GG.1656, Attachment A – Conflict of Interest and Non-Discrimination Attestation	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☒ Completed ☐ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions

The CalOptima Health DEI surveys for employees (staff and leaders) and the committee will be relaunched in Q1 2026 to both evaluate the effectiveness of the interventions and serve as an opportunity to identify additional opportunities for workforce development.

VI. Qualitative Analysis

After the data was collected, the survey results were presented to the workgroup for review. Analysis was completed by the workgroup by focusing on tabulated data versus the overall percentage of responses. Additional attention was given to any indication of trends in responses based on demographic data as well as overall response rates.

The workgroup then discussed and addressed specific action items, including improving internal communication for job opportunities and exploring ways to encourage a broad pool of internal applicants. For the committee survey results, the workgroup identified gaps in the process for committee participants to report issues. The workgroup identified the need to incorporate new language into an existing policy to address that gap.

VII. Opportunities for Improvement

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. For survey participation, there is an opportunity for improvement in 2026 to increase the participation rate in the surveys to obtain data that is comprehensive and reflective of the entirety of the workforce and committee membership. Additional communication, marketing and survey reminders will be implemented in 2026 to encourage participation. Furthermore, it is not anticipated that the Best Places to Work survey will be launched in 2026. This is a potential opportunity for the 2026 DEI survey, as employees are less likely to experience survey fatigue from multiple survey invitations.	For interventions, there is an opportunity in 2026 to engage additional thought leaders in discussions about the survey data, CalOptima Health's policy, and our mission and values, to gain new perspectives from outside the HE1 workgroup and identify solutions and implementation strategies.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion

The CalOptima Health 2025 Diversity, Equity and Inclusion surveys for employees and committees responded in overwhelming agreement (both 89%) that the organization is committed to advancing health equity and removing disparities within the health care system, which strongly align with the mission, vision and values of the organization. The agreement rate was comparable for employees and committees who believe the organization is committed to building a diverse and inclusive workplace.

The 2024–2025 DEI surveys used a data-driven approach to identify areas of improvement. The workgroup implemented interventions specifically designed to address those opportunities. The

QHC 1.9.2026

marketing and communication of promotional opportunities to current employees to generate interest, invite participation and open doors to career growth was implemented through a comprehensive Hot Jobs initiative. With the committee, the governing documents were updated to address a perceived gap in reporting discrimination or bias on committees, thereby further enhancing the committees as safe and professional work environments. The immediate efficacy of those interventions will be measured in the coming 2026 DEI surveys.

CalOptima Health's commitment to AA.1252 Diversity, Equity and Inclusion policy necessitates a 2026 relaunch of the DEI surveys and a new evaluation of the data collected to again evaluate how our workforce reflects the diversity of the population served and, through a data-driven approach, identify any opportunities for future interventions.

Section 7: Training

7.1 Cultural Competency Training	
Author: Carlos Soto/Albert Cardenas	Department(s): Cultural & Linguistic Services
Responsible Party(ies): Carlos Soto	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Workplan Goal/Objective:	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background

The Cultural Competency aims to assess and ensure compliance with cultural competence among CalOptima Health staff, providers and their staff. CalOptima Health ensures that staff and practitioners who have successfully completed the Cultural Competency training can understand, communicate with and interact effectively with people from diverse cultural backgrounds.

II. Data Sources and Methodology

CalOptima Health monitors the cultural competency of CalOptima Health staff, providers and their staff. CalOptima Health identified CalOptima Health staff and practitioners who have successfully completed the annual Cultural Competency training, along with identified findings and a plan of action to address the findings. Cultural competency training is conducted annually and during the onboarding of new employees by CalOptima Health's Human Resources department and provider office staff by CalOptima Health's Provider Relations department. Additionally, CalOptima Health C&L staff conduct monthly trainings for new CalOptima Health staff and provide in-service training as needed. The training includes an overview of the Cultural and Linguistic department, cultural competency and cultural disparities.

III. Program Results and Quantitative Analysis

OAC 03.19.2026

Monthly Bootcamp training courses and in-service training courses for CalOptima Health Customer Service staff were completed in 2025. Cultural Competency training was provided throughout the year to both new and existing CalOptima Health staff and provider office staff.

IV. Actions/Interventions Implemented in 2025

Interventions	Product	Quarter	Type	Status
1. Monthly bootcamp presentations were conducted for all new employees and existing employees as needed.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete
2. Cultural Competency training for CalOptima Health staff through CalOptima Health University and provider office staff annually, and during the onboarding of new staff.	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☐ HN ☐ Comm ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
3. C&L overview in-service provided to Customer Service and Behavioral Health staff.	☒ MC ☒ OC	☐ Q1 ☒ Q3 ☒ Q2 ☐ Q4	☐ Mem ☐ Prov ☐ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete

CalOptima Health staff and provider and office staff who successfully completed the Cultural Competency and the Boot Camp training course in 2025 are as follows:

Cultural Competency Training	
CalOptima Health Employees	1,680
Practitioner Staff	9,890

Boot Camp Training	
CalOptima New Health Employees	169

V. Effectiveness of Interventions

The Cultural Competency training is conducted throughout the year for staff. The intent of the training is for CalOptima Health staff and providers and office staff to gain the necessary knowledge to meet members' needs regarding race, ethnicity, language, and cultural preferences .

VI. Qualitative Analysis

The Director of Customer Service conducted a qualitative analysis to identify barriers and concluded that the overall objective of completing the training was met. However, several barriers have been identified.

Causal/Barrier Analysis:

Back to Agenda Back to Item

- Customer Service conducts quarterly meetings and has a full agenda, so it's challenging to get on their agenda.
- Bootcamp and in-service presentations may contain unneeded or outdated content.

VII. Opportunities for Improvement

The following opportunities were identified and prioritized as high (H), medium (M) or low (L) based on their level of impact on members. CalOptima Health will address high-priority issues first.

Opportunities for Improvement	Planned Intervention for 2026	Product	Quarter 2026	Priority
1. Explore other avenues to provide C&L training to CalOptima Health departments.	• Coordinate with Customer Service and other member-facing department leaders to identify their needs and tailor presentation content for each department.	☒ MC ☒ OC	☒ Q1 ☒ Q3 ☒ Q2 ☒ Q4	☐ H ☒ M ☐ L
2. Enhance training materials/presentations content.	• Review and revamp C&L Bootcamp and in-service presentations.	☒ MC ☒ OC	☒ Q1 ☐ Q3 ☐ Q2 ☐ Q4	☐ H ☐ M ☒ L

MC = Medi-Cal; OC = OneCare

VIII. Conclusion

Overall, the goals of educating CalOptima Health staff and providers on cultural competency were met and achieved effectively.

7.2 Network Cultural Responsiveness: Diversity, Equity and Inclusion Training	
Author: Greta Rice and Adriana Ramos	Department(s): Human Resources/ Provider Relations
Responsible Party(ies): Michaell Rose (Chief Health Equity Officer); Greta Rice (Sr. Manager, Human Resources); Adriana Ramos (Sr. Manager, Provider Relations)	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☒ Yes ☐ No
Workplan Goal/Objective: By Dec. 31st, 2025, CalOptima Health will implement and train 90% of staff, health networks, and providers on Diversity, Equity and Inclusion (DEI) training, ensuring compliance with DHCS All Plan Letter (APL) 24-016.	
Goal Met: ☒ Yes ☐ No ☐ Partial	Status: ☐ Completed ☒ Ongoing

I. Purpose or Background:

In alignment with DHCS vision to advance health equity for all Medi-Cal members, the Medicare Plan DEI Training Program is designed to strengthen the cultural responsiveness, empathy and effectiveness of those who serve diverse member populations. Medi-Cal members represent communities that have historically experienced barriers to care and disproportionate impacts from systemic inequities.

The purpose of this training program is to deepen understanding of these disparities and equip MCP staff with the competencies needed to foster meaningful connection, trust and engagement across all member groups — particularly those disadvantaged by the health care system.

By expanding awareness of cultural differences, social drivers of health, communication practices, and inclusive care behaviors, the program aims to create a more respectful, affirming and equitable experience for every member. This includes improving relationships and connectivity between MCP staff and the communities they serve, as well as reinforcing an inclusive environment both internally and externally among network providers, delegated entities and community-based partners.

Ultimately, the Medi-Cal Plan DEI Training Program supports DHCS's health equity commitments by:

- Enhancing access to care
- Reducing preventable disparities
- Strengthening member trust and engagement
- Improving overall quality, outcomes, and member experience

Through intentional training, shared learning and culturally responsive practice, the program advances a more equitable, just and person-centered delivery system for Medi-Cal members across California.

II. Data Sources and Methodology

The organization's Learning Management System (LMS) serves as the central repository for all training activities and generates the following data points:

- Enrollment records (who was assigned training)
- Completion status (completed, in progress, noncompletion)
- Time spent in the course
- Assessment scores and knowledge checks
- Training dates and timestamps
- Automated assignment to required staff
- Notifications and reminders
- Time-based compliance tracking
- Audit-ready reports
- User role, department and job classification metadata

This data supports audit readiness, reporting accuracy and compliance with DEI training requirements.

- Documentation of both completions and noncompletions

The LMS acts as the **system of record**, supporting:

- DHCS audits
- Compliance review
- Annual reporting requirements

DAC 03.19.2026

Back to Agenda Back to Item

The LMS tracks engagement within the e-learning modules, including:

- Slide-level navigation
- Completion of interactive elements
- Responses to scenario-based questions
- Knowledge check performance

These analytics help measure whether learners gained understanding and can apply DEI concepts.

Optional integration with the Human Resources Information System (HRIS) and workforce data can inform:

- Staff populations requiring training
- Role-based compliance gaps
- Completion disparities across departments or job roles
  (this supports focused interventions aligned with equity goals)

III. Program Results and Quantitative Analysis:

Participation and Completion Metrics

As of December 15, 2025, the organization achieved a **strong participation rate**, with:

- 1,646+ employees and temporary staff have completed the Medicare Plan DEI Training. Three employees require follow-up from their leader and has completed the training, and 36 require follow-up once they return from a leave of absence.

Training Completion Summary

Metric	Value
Employees Completed Training	1,654
Employees on Leave	28
Total Employees Need to Complete Training	1,682
Completion Percentage	98.22%

This indicates a **high level of engagement and compliance** across departments, job classifications and functional areas. Completion rates are on track to meet or exceed organizational and DHCS expectations.

Providers

The DEI training was released in two phases:

- Cultural Competency and Disability Awareness Training
- Diversity, Equity, Inclusion, Belonging Training (released November 17, 2025)

QAC 03.19.2026

The new completion deadline for all provider training is December 31, 2026. CalOptima Health continues to promote the importance of provider training to our providers, and we anticipate 100% completion by the due date.

Completion Rate Analysis

Based on total eligible employees assigned the training, the data reflects:

- A **significant upward trend** in completions during the final two weeks
- High responsiveness to automated LMS reminders and leadership communications
- Strong cross-departmental participation, with most units exceeding 90% completion

These metrics suggest that the training rollout strategy — particularly LMS automation, manager reminders and targeted communications — effectively supported completion and compliance.

IV. Actions/Interventions Implemented in 2025:

Interventions	Product	Quarter	Type	Status
1. Launch of DEI Training	☒ MC ☒ OC	☐ Q1 ☐ Q3 ☐ Q2 ☒ Q4	☐ Mem ☒ Prov ☒ HN ☐ Comm ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal; OC = OneCare; Mem = Member; Prov = Provider; HN = Health Network; Comm = Community

V. Effectiveness of Interventions:

Knowledge Acquisition and Learning Outcomes

Embedded knowledge checks within the e-learning modules demonstrated measurable learning gains:

- The majority of employees **improved their scores** from initial attempts to final mastery
- Learners demonstrated understanding of core concepts, including:
    - Health equity principles
    - Cultural competence
    - Member-centered communication
    - Social drivers of health
    - Practices that reduce disparities in care

Knowledge retention indicators show that employees not only engaged with the training but also **internalized key DEI and health equity concepts**, supporting the program's overall effectiveness.

Indicators of Training Effectiveness

Early analysis of program metrics supports strong training impact:

High Engagement

The high volume of completions before the deadline reflects:

Back to Agenda Back to Item

QAC 03.19.26

- Effective LMS assignment structure
- Clear communication
- Strong organizational commitment to health equity initiatives

Knowledge Gains

Knowledge checks and scenario-based responses show that employees:

- Demonstrated **increased awareness** of equity disparities
- Correctly identified **best practices** for interacting with diverse Medi-Cal populations
- Showed capacity to apply inclusive communication skills

Compliance Confidence

With completions projected to continue through December 12, the organization is positioned to meet or exceed compliance thresholds.

VI. Qualitative Analysis

Causal/Barrier Analysis:

- There was a delay in the full DEI training launch, given the additional review needed to update training components to reflect evolving regulatory requirements.

VII. Opportunities for Improvement:

CalOptima Health will continue to improve the DEI training in accordance with evolving best DEI education and training practices using the following strategies:

- Identifying opportunities based on analysis of health outcomes impacted by cultural and linguistic factors
- Addressing training deficiencies in the health care delivery system with educational solutions
- Instituting methods to partner with and collaborate with community-based organizations that can review education efforts for effectiveness
- Engaging CalOptima Health's Member Advisory Committee and Provider Advisory Committee for continued DEI Training Program recommendations and feedback

VIII. Conclusion:

Final qualitative data analysis and conclusions are pending completion of DEI training by all staff and providers.

QAC 03.19.2026

Medicaid MY2024 HEDIS Goals and Rates

Abbrev	Medicaid HEDIS Measures	Method	HEDIS MY2022 Rpt Rate	HEDIS MY2024 Goal	HEDIS MY2024 Rate	Met? Not Met?	Long Term Goal (90th)	Medicaid 10th percentile	Medicaid 25th percentile	Medicaid 33rd percentile	Medicaid 50th percentile	Medicaid 66th percentile	Medicaid 75th percentile	Medicaid 90th percentile
WCC	Weight Assessment and Counseling for Children/Adolescents (BMI)	H	85.83%	89.72%	90.83%	Met	89.72%	62.77%	71.68%	74.70%	79.56%	83.21%	85.02%	89.72%
	Nutrition	H	85.42%	83.46%	83.84%	Met	83.46%	52.07%	61.60%	65.21%	70.56%	76.04%	77.37%	83.46%
	Physical Activity	H	83.75%	81.54%	83.41%	Met	81.54%	45.50%	58.35%	61.07%	67.76%	72.51%	75.18%	81.54%
ADV	Annual Dental Visit	A	54.18%	54.60%	N/A	N/A	61.86%	27.81%	41.32%	43.13%	49.92%	54.60%	56.36%	61.86%
CIS	Childhood Immunization Status (comb10)	H	39.42%	45.26%	38.69%	Not Met	45.26%	20.68%	24.57%	26.76%	30.90%	35.04%	37.64%	45.26%
IMA	Immunization for Adolescents (comb2)	H	51.82%	48.80%	45.50%	Not Met	48.80%	24.82%	29.44%	30.66%	34.31%	38.93%	40.88%	48.80%
LSC	Lead Screening in Children	H	63.02%	67.12%	70.80%	Met	79.26%	35.28%	49.61%	54.26%	62.79%	67.12%	70.07%	79.26%
CCS	Cervical Cancer Screening	H	57.73%	59.85%	57.86%	Not Met	66.48%	43.50%	50.85%	53.37%	57.11%	59.85%	61.80%	66.48%
CHL	Chlamydia Screening in Women	A	72.11%	67.39%	76.66%	Met	67.39%	42.61%	49.65%	51.39%	56.04%	61.07%	62.90%	67.39%
CWP	Appropriate Testing for Pharyngitis	A	35.21%	68.76%	52.38%	Not Met	82.40%	57.41%	66.25%	68.76%	73.55%	77.56%	79.37%	82.40%
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	A	19.70%	20.14%	N/A	N/A	30.83%	16.35%	19.12%	20.14%	22.27%	24.46%	25.67%	30.83%
PCE	Pharmacotherapy management of COPD exacerbations (Corticosteroid)	A	64.06%	68.39%	72.37%	Met	82.43%	56.05%	65.62%	68.39%	72.46%	75.79%	77.66%	82.43%
	Bronchodilator		85.63%	86.96%	88.92%	Met	90.53%	72.88%	80.46%	82.35%	85.15%	86.96%	87.70%	90.53%
AMR	Asthma Medication Ratio (5-64 years)	A	74.16%	75.92%	66.08%	Not Met	75.92%	55.09%	58.94%	61.81%	65.61%	69.41%	70.82%	75.92%
CBP	Controlling High-Blood Pressure	H	65.85%	67.27%	67.54%	Met	72.22%	50.36%	55.47%	57.66%	61.31%	65.45%	67.27%	72.22%
PBH	Persistence of Beta Blocker Treatment after a Heart Attack	A	76.11%	77.78%	62.57%	Not Met	89.83%	66.67%	75.14%	77.78%	80.58%	83.69%	86.05%	89.83%
SPC	Statin Therapy for Patients with Cardiovascular Disease - Therapy		81.14%	81.64%	81.13%	Not Met	85.04%	70.02%	77.69%	78.80%	80.36%	81.64%	82.58%	85.04%
	Statin Therapy for Patients with Cardiovascular Disease - Adherence	A	77.84%	80.95%	77.89%	Not Met	80.95%	56.67%	64.57%	66.48%	71.05%	73.63%	76.15%	80.95%
CRE	Cardiac Rehabilitation - initiation (MY2020)	A	0.69%	1.51%	0.62%	Not Met	11.76%	0.00%	0.72%	1.51%	2.98%	4.19%	4.93%	11.76%
	Engagement 1	A	2.34%	4.00%	2.69%	Not Met	10.67%	0.00%	1.44%	2.31%	4.00%	5.37%	6.52%	10.67%
	Engagement 2	A	3.03%	3.27%	3.31%	Met	8.24%	0.29%	1.51%	2.17%	3.27%	4.62%	5.26%	8.24%
	Achievement	A	2.34%	2.53%	1.45%	Not Met	3.82%	0.00%	0.35%	0.78%	1.32%	2.13%	2.53%	3.82%
HBD	HbA1c Control for Patients with Diabetes - Poor Control (>9.0%)	H	30.41%	29.44%	30.92%	Met	29.44%	54.01%	44.77%	41.61%	37.96%	34.79%	33.45%	29.44%
	HbA1c Control (<8.0%)	H	61.60%	60.34%	61.60%	Met	60.34%	38.93%	46.96%	49.39%	52.31%	55.72%	57.18%	60.34%
EED	Eye Exam for patient with Diabetes	H	62.63%	63.33%	64.34%	Met	63.33%	36.74%	45.26%	46.96%	52.31%	56.20%	59.37%	63.33%
BPD	Blood Pressure Controlled for Patients with Diabetes	H	67.01%	68.61%	70.07%	Met	74.56%	52.07%	58.15%	59.85%	63.99%	68.61%	70.07%	74.56%
KED	Kidney Health Evaluation for Patients with Diabetes		47.55%	47.55%	51.02%	Met	47.55%	22.73%	27.32%	29.42%	33.52%	38.80%	41.49%	47.55%
SPD	Statin Therapy for Patients with Diabetes - therapy	A	72.68%	72.15%	73.15%	Met	72.15%	54.15%	60.41%	62.58%	65.11%	67.07%	68.39%	72.15%
	Statin Therapy for Patients with Diabetes - adherence		72.76%	77.97%	73.20%	Not Met	77.97%	52.67%	60.19%	62.50%	66.33%	70.37%	72.30%	77.97%
AMM	Antidepressant Medications Management (Acute Phase Treatment)	A	67.00%	74.16%	67.21%	Not Met	74.16%	49.20%	55.79%	57.41%	60.79%	64.17%	66.13%	74.16%
	Continuation Phase Treatment		48.62%	58.06%	50.64%	Not Met	58.06%	31.59%	38.04%	40.01%	43.28%	46.74%	48.50%	58.06%
ADD	Follow-up Care for Children Prescribed ADHD Medication (Initiation Phase)	A	42.37%	44.21%	50.35%	Met	54.25%	33.30%	39.51%	41.46%	44.21%	46.71%	48.11%	54.25%
	Continuation Phase		46.77%	50.98%	58.69%	Met	63.92%	40.38%	48.78%	50.98%	54.40%	57.90%	59.75%	63.92%
DMH	Diagnosed Mental Health Disorders	A	18.55%	21.86%	18.98%	Not Met	36.17%	16.43%	20.03%	21.86%	25.95%	29.46%	32.13%	36.17%
DSU	Diagnosed Substance Use Disorders (any)	A	3.21%	5.08%	3.43%	Not Met	10.72%	2.14%	4.31%	5.08%	6.28%	7.60%	8.54%	10.72%
FUI	Follow-up After High-Intensity Care for Substance Use Disorder (30-day) - (MY2019)	A	22.33%	41.03%	30.69%	Not Met	68.71%	30.93%	38.26%	41.03%	50.83%	57.87%	61.23%	68.71%
	Follow-up After High-Intensity Care for SUD (7-day)		8.07%	23.12%	13.65%	Not Met	49.55%	15.16%	20.83%	23.12%	30.02%	37.31%	40.44%	49.55%
FUM	Follow-up After ED visit for Mental Illness (30-day)	A	58.83%	60.08%	52.33%	Not Met	73.26%	38.18%	47.01%	49.12%	54.87%	60.08%	64.29%	73.26%
	Follow-up After ED visit for Mental Illness (7-day)	A	38.78%	40.59%	32.96%	Not Met	61.68%	23.74%	30.75%	33.61%	40.59%	46.35%	51.29%	61.68%
FUA	Follow-up After ED visit for Alcohol and Other Drug Dependence 30-day		24.05%	36.34%	28.63%	Not Met	53.44%	22.69%	27.75%	30.94%	36.34%	40.53%	42.67%	53.44%
	Follow-up After ED visit for Alcohol and Other Drug Dependence 7-day	A	12.98%	20.00%	16.81%	Not Met	38.15%	13.83%	17.38%	20.00%	24.51%	27.73%	29.98%	38.15%
POD	Pharmacotherapy for Opioid Use Disorder (MY2019)	A	20.77%	28.49%	4.93%	Not Met	40.34%	14.94%	20.73%	23.38%	28.49%	31.93%	33.85%	40.34%
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic medications	A	75.97%	77.40%	76.86%	Not Met	85.52%	72.83%	76.29%	77.40%	79.05%	80.86%	82.27%	85.52%
SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia	A	75.50%	76.66%	76.33%	Not Met	76.66%	58.18%	62.99%	64.87%	69.14%	72.16%	74.07%	76.66%
SMC	Cardiovascular Monitoring for People with Cardiovascular and Schizophrenia	A	62.90%	73.42%	80.82%	Met	85.44%	65.00%	71.17%	73.42%	77.11%	79.35%	80.77%	85.44%
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	A	71.27%	72.61%	69.86%	Not Met	72.61%	41.24%	55.02%	57.79%	61.39%	64.90%	66.94%	72.61%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Glucose	A	57.31%	58.43%	55.57%	Not Met	67.57%	45.50%	49.52%	51.71%	55.91%	58.43%	60.00%	67.57%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics - cholesterol		39.90%	40.50%	35.76%	Not Met	53.58%	26.36%	30.36%	31.97%	36.18%	40.50%	43.18%	53.58%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Total		37.41%	39.01%	34.58%	Not Met	50.95%	24.27%	28.47%	30.43%	34.38%	39.01%	42.01%	50.95%
NCS	Non-Recommended CCS in Adolescent Females	A	0.27%	0.23%	N/A	N/A	0.08%	0.94%	0.61%	0.50%	0.37%	0.23%	0.19%	0.08%
URI	Appropriate Treatment for URI	A	91.77%	93.08%	86.38%	Not Met	95.47%	81.64%	88.15%	89.16%	90.97%	93.08%	93.90%	95.47%
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis*	A	43.91%	57.16%	39.70%	Not Met	77.11%	50.05%	55.31%	57.16%	61.42%	66.19%	68.87%	77.11%

QA 03.19.2025

LBP	Use of Imaging Studies for Low Back Pain*	A	74.10%	75.44%	72.21%	Not Met	79.96%	67.72%	69.98%	71.32%	73.15%	75.44%	76.23%	79.96%
HDO	Use of Opioids at High Dosage	A	2.19%	2.19%	2.08%	Met	0.74%	13.43%	7.37%	6.14%	4.27%	2.19%	1.71%	0.74%
UOP	Use of Opioids From Multiple Providers - multiple Prescribers	A	19.15%	18.76%	20.47%	Not Met	12.97%	26.72%	22.14%	20.60%	18.76%	17.04%	15.14%	12.97%
	Multiple Pharmacies		2.51%	1.80%	1.88%	Not Met	0.85%	6.02%	3.60%	2.78%	1.80%	1.46%	1.23%	0.85%
	Multiple Prescribers and Pharmacies		1.68%	1.16%	1.39%	Not Met	0.40%	3.73%	2.31%	1.79%	1.16%	0.87%	0.72%	0.40%
COU	Risk of Continued Opioid Use (MY2018) - 15 days	A	6.42%	5.70%	6.18%	Not Met	2.09%	10.14%	7.75%	7.13%	5.70%	4.21%	3.61%	2.09%
	Risk of Continued Opioid Use - 31 days	A	2.89%	2.45%	2.77%	Not Met	1.18%	6.19%	4.50%	3.97%	3.36%	2.45%	2.12%	1.18%
FVA	Flu Vaccinations for Adults Ages 18-64		52.15%	52.11%	N/A	N/A	52.11%	30.48%	34.92%	37.05%	39.01%	42.50%	46.11%	52.11%
AAP	Adults' Access to Preventive/Ambulatory Health Services (20-44)	A	56.87%	65.71%	N/A	N/A	79.43%	56.19%	64.22%	65.71%	69.69%	73.31%	74.69%	79.43%
	Adults' Access to Preventive/Ambulatory Health Services (45-64)	A	73.98%	77.32%	N/A	N/A	86.66%	70.23%	75.32%	77.32%	80.18%	82.83%	84.08%	86.66%
	Adults' Access to Preventive/Ambulatory Health Services (65+)	A	80.59%	84.81%	N/A	N/A	92.19%	65.98%	72.80%	75.56%	80.22%	84.81%	88.40%	92.19%
	Adults' Access to Preventive/Ambulatory Health Services (Total)	A	64.05%	69.59%	62.94%	Not Met	82.17%	62.27%	67.68%	69.59%	72.91%	76.57%	78.08%	82.17%
PPC	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	H	88.08%	88.33%	88.15%	Not Met	91.07%	73.48%	79.63%	81.75%	84.23%	86.86%	88.33%	91.07%
	Prenatal and Postpartum Care (Postpartum Care)	H	81.15%	82.00%	81.11%	Not Met	84.59%	67.31%	73.97%	75.18%	78.10%	80.78%	82.00%	84.59%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	A	25.00%	55.19%	53.10%	Not Met	73.87%	36.65%	49.09%	55.19%	60.22%	63.89%	66.27%	73.87%
W30	Well-Child Visits in the First 30 Months of Life (MY2020) 0-15 months	A	55.78%	58.38%	70.28%	Met	68.09%	44.02%	52.84%	55.21%	58.38%	61.64%	63.34%	68.09%
	Well-Child Visits in the First 30 Months of Life - 15-30 months	A	71.20%	71.35%	74.40%	Met	77.78%	57.27%	62.07%	63.73%	66.76%	69.39%	71.35%	77.78%
WCV	Child and Adolescent Well-Care Visits (MY2020) 3-11 years	A	59.89%	60.03%	N/A	N/A	67.94%	45.95%	50.98%	52.40%	55.66%	60.03%	62.89%	67.94%
	Child and Adolescent Well-Care Visits (MY2020) 12-17 years	A	55.58%	56.32%	N/A	N/A	62.57%	38.40%	43.83%	45.57%	49.20%	53.49%	56.32%	62.57%
	Child and Adolescent Well-Care Visits (MY2020) 18-21 years	A	27.65%	29.23%	N/A	N/A	39.00%	16.38%	20.33%	21.72%	24.02%	26.97%	29.23%	39.00%
	Child and Adolescent Well-Care Visits (MY2020) Total	A	51.49%	51.78%	55.46%	Met	61.15%	38.61%	42.99%	44.55%	48.07%	51.78%	55.08%	61.15%
PCR	Plan All-Cause Readmissions 18-64 (new in 2018)	A	93.41%	0.927	N/A	N/A	0.831	1.1874	1.0604	1.0305	0.9853	0.9272	0.8982	0.8314
AIS-E	Adult Immunization Status - influenza Total	E	22.28%	21.05%	17.98%	Not Met	21.05%	6.50%	9.46%	10.82%	13.57%	16.32%	17.80%	21.05%
AIS-E	Adult Immunization Status - Tdap Total		25.26%	29.84%	38.36%	Met	56.53%	18.67%	27.63%	29.84%	34.39%	41.54%	47.11%	56.53%
AIS-E	Adult Immunization Status - Zoster Total		14.96%	14.54%	18.49%	Met	14.54%	1.72%	3.38%	4.42%	7.10%	10.27%	11.17%	14.54%
PRS-E	Prenatal Immunization Status - Influenza	E	26.20%	29.96%	21.75%	Not Met	41.49%	11.58%	17.64%	19.25%	23.78%	29.96%	32.01%	41.49%
	Prenatal Immunization Status - Tdap	E	48.44%	53.86%	45.82%	Not Met	75.03%	29.46%	42.43%	46.93%	53.86%	62.87%	67.45%	75.03%
	Prenatal Immunization Status - Comb	E	21.34%	25.81%	18.03%	Not Met	37.75%	7.94%	13.25%	15.17%	19.49%	25.81%	28.28%	37.75%
BCS-E	Breast Cancer Screening	E	57.67%	62.67%	59.13%	Not Met	62.67%	42.98%	47.09%	48.33%	52.60%	54.94%	57.48%	62.67%
COL-E	Colorectal Cancer Screening	E			47.60%	N/A								
DSF-E	Depression Screening and Follow-up for Adolescents and Adults -Screening Total	E			8.65%	N/A								
	- Follow up Total	E			82.12%	N/A								
PND-E	Prenatal Depression Screening and Follow-up - Screening	E	8.73%	8.81%	13.98%	Met	36.78%	0.00%	0.00%	0.00%	0.23%	2.32%	8.81%	36.78%
	Follow-up	E	45.16%	54.84%	77.53%	Met	69.01%	37.50%	45.61%	49.21%	54.84%	58.97%	60.71%	69.01%
PDS-E	Postpartum Depression Screening and Follow-up - screening	E	8.08%	27.77%	9.24%	Not Met	27.77%	0.00%	0.00%	0.00%	0.10%	1.33%	4.27%	27.77%
PDS-E	Postpartum Depression Screening and Follow-up - follow-up	E	62.96%	63.40%	87.14%	Met	82.78%	44.10%	53.33%	54.17%	63.40%	68.18%	71.43%	82.78%
RDM	Race/Ethnicity Diversity of Membership - Race Direct Total	A	99.99%	100.00%	N/A	N/A	100.00%	63.20%	87.09%	95.91%	100.00%	100.00%	100.00%	100.00%
	Race/Ethnicity Diversity of Membership - Ethinicity Direct Total	A			N/A	N/A		0.03%	18.17%	56.73%	98.21%	100.00%	100.00%	100.00%
DEV-CH	Developmental Screening in the First Three Years of Life	A	26.11%	34.70%	N/A	N/A					34.70%			
TFL-CH	Dental Fluoride Varnish for Children	A	17.74%	19.30%	N/A	N/A					19.30%			

* Measure w/ MPL
Proosed MPL adding for MY2024

PAC 03-19-2026

Medicare MY2024 HEDIS Goals and Rates

Abbrev	Medicare HEDIS Measures	Method	MY2022 HEDIS Reported Rate	MY2024 HEDIS Goals	MY2024 HEDIS Rate	Met? Not Met?	Long Term Goal (90th)	Medicare 33rd percentile	Medicare 50th percentile	Medicare 66th percentile	Medicare 75th percentile	Medicare 90th percentile	3-Star	4-Star	5-Star
BCS	Breast Cancer Screening (C01)	A	65.69%	71%	68.52%	Not Met	79%	66.40%	71.26%	74.62%	77.08%	82.52%	63%	71%	79%
COL	Colorectal Cancer Screening - aged 50-75 (C02)	H	65.24%	71%	66.94%	Not Met	80%	63.99%	69.83%	74.32%	76.77%	81.75%	61%	71%	80%
	Care for Older Adults (SNP) - Medication Review (C09)	H	83.70%	84%	N/A	N/A	98%						84%	93%	98%
	Care for Older Adults (SNP) - Functional status assessment (C10)	H	53.28%	71%	N/A	N/A	93%						71%	85%	93%
COA	Care for Older Adults (SNP) - Pain assessment (C11)	H	85.40%	91%	N/A	N/A	96%						83%	91%	96%
CWP	Appropriate Testing for Pharyngitis	A	NA	NA	N/A	N/A	60.81%	32.62%	38.98%	46.15%	50.60%	60.81%			
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	A	NA	NA	N/A	N/A	34.07%	22.00%	24.55%	27.56%	29.39%	34.07%			
	Pharmacotherapy management of COPD exacerbations (Corticosteroid)		NA	NA	73.88%	N/A	83.08%	70.54%	73.72%	76.74%	78.27%	83.08%			
PCE	Bronchodilator	A	NA	NA	93.28%	N/A	91.85%	82.99%	85.09%	87.93%	88.89%	91.85%			
CBP	Controlling High-Blood Pressure	H	67.82%	68%	77.26%	Met	82.00%	69.57%	72.99%	76.30%	78.25%	82.98%	68%	74%	82%
PBH	Persistence of Beta Blocker Treatment after a Heart Attack	A	NA	NA	72.73%	N/A	95.92%	87.10%	89.16%	91.53%	92.91%	95.92%			
	Statin Therapy for Patients with Cardiovascular Disease - Therapy	A	82.00%	84%	86.13%	Met	90.00%	83.90%	85.54%	87.14%	88.09%	90.40%	84%	86%	90%
SPC	Statin Therapy for Patients with Cardiovascular Disease - Adherence	A	79.27%	82.64%	81.95%	Not Met	91.49%	82.64%	85.10%	87.35%	88.46%	91.49%			
	Cardiac Rehabilitation - initiation (MY2020)	A	NA	NA	1.25%	N/A	11.90%	1.82%	3.13%	5.26%	6.67%	11.90%			
	Engagement 1	A	NA	NA	5.00%	N/A	18.24%	3.08%	5.63%	8.66%	10.32%	18.24%			
	Engagement 2	A	NA	NA	6.25%	N/A	17.20%	3.09%	5.26%	7.91%	9.43%	17.20%			
CRE	Achievement	A	NA	NA	3.75%	N/A	8.74%	0.72%	1.89%	3.79%	5.22%	8.74%			
	HbA1c Control for Patients with Diabetes - Poor Control (>9.0%) (C15)	H	21.67%	20%	15.52%	Met	13%	24.09%	19.22%	15.87%	14.34%	11.78%	28%	20%	13%
HBD	HbA1c Control for Patients with Diabetes - Control (<8.0%)	H	67.50%	70.28%	72.84%	Met	78.83%	65.69%	70.28%	73.97%	75.50%	78.83%			
EED	Eye Exam for Patients with Diabetes(C13)	H	73.33%	81%	77.61%	Not Met	81%	67.88%	73.48%	77.86%	79.81%	84.23%	65%	73%	81%
BPD	Blood Pressure Control for patients with Diabetes (C16)	H	67.78%	71.12%	75.22%	Met	82.73%	66.42%	71.12%	74.94%	77.30%	82.73%			
KED	Kidney Health Evaluation for Patients with Diabetes (MY2020)	A	53.51%	55.13%	59.30%	Met	68.02%	41.31%	48.03%	55.13%	58.73%	68.02%			
	Statin Therapy for Patients with Diabetes - Therapy	A	82.97%	85.72%	83.01%	Not Met	85.72%	77.55%	79.35%	81.44%	82.68%	85.72%			
SPD	Statin Therapy for Patients with Diabetes - Adherence	A	77.11%	80.85%	79.64%	Not Met	90.64%	80.85%	83.72%	86.17%	87.50%	90.64%			
OMW	Osteoporosis Management in Women Who Had a Fracture (C12)	A	NA	NA	43.64%	N/A	71.00%	36.69%	44.59%	52.46%	56.25%	70.27%	42%	55%	71%
OSW	Osteoporosis Screening in Older Women (MY2020)	A	34.70%	42.23%	49.33%	Met	66.24%	42.23%	47.57%	54.55%	57.97%	66.24%			
	Antidepressant Medications Management (Acute Phase Treatment)		75.51%	77.93%	73.71%	Not Met	87.81%	77.93%	80.58%	82.98%	84.39%	87.81%			
AMM	Continuation Phase Treatment	A	55.10%	61.33%	58.22%	Not Met	74.89%	61.33%	64.42%	68.09%	70.21%	74.89%			
	Follow-up After Hospitalization for Mental Illness (30-day)		NA	NA	61.61%	N/A	71.62%	40.32%	47.60%	55.10%	60.54%	71.62%			
FUH	Follow-up After Hospitalization for Mental Illness (7-day)	A	NA	NA	38.39%	N/A	52.94%	21.78%	26.38%	34.00%	36.75%	52.94%			
	Follow-up After High-Intensity Care for Substance Use Disorder (30-day) - (MY2019)		NQ	NA	N/A	N/A	58.02%	32.65%	38.85%	44.44%	46.34%	58.02%			
FUI	Follow-up After High-Intensity Care for SUD (7-day)	A	NQ	NA	N/A	N/A	34.11%	15.85%	20.19%	24.03%	26.09%	34.11%			
	Follow-up After ED visit for Mental Illness (30-day)		NA	NA	51.16%	N/A	72.41%	44.76%	50.00%	56.76%	61.88%	72.41%			
FUM	Follow-up After ED visit for Mental Illness (7-day)	A	NA	NA	25.58%	N/A	56.16%	28.35%	32.68%	38.21%	44.00%	56.16%			
	Follow-up After ED visit for Alcohol and Othe Drug Dependence (new 2017) - 30-day		NA	NA	43.75%	N/A	53.65%	34.69%	37.80%	42.34%	44.44%	53.65%			
FUA	Follow-up After ED visit for Alcohol and Othe Drug Dependence (new 2017) - 7-day	A	NA	NA	18.75%	N/A	35.56%	21.74%	25.00%	28.57%	30.61%	35.56%			
POD	Pharmacotherapy for Opiod Use Disorder	A	NQ	NA	41.27%	N/A	50.00%	32.43%	35.99%	40.44%	44.90%	50.00%			
SAA	Adherence to Antipsychotic medications for Individuals with Schizophrenia	A	79.63%	80.00%	79.47%	Not Met	87.43%	73.40%	76.88%	80.00%	81.82%	87.43%			

CAC 03.19.2025

Back to Agenda

Back to Item

ACP	Advance Care Planning (MY2022)	A	42.86%	NA	N/A	N/A	NA								
	Transitions of Care (new 2018) - Notification Admission	H	17.96%	21.90%	23.60%	Met	73.71%	12.90%	21.90%	42.34%	50.21%	73.71%			
	Receipt Discharge Info	H	6.94%	9.73%	14.84%	Met	55.99%	9.73%	15.82%	26.76%	35.04%	55.99%			
	Engmt after discharge	H	77.96%	79.88%	82.24%	Met	92.23%	79.88%	83.70%	87.59%	89.54%	92.23%			
	Med Reconciliation	H	62.45%	68%	57.42%	Not Met	84%	54.26%	65.69%	75.67%	82.18%	89.29%	52%	68%	82%
TRC	Average		41.33%	52%	N/A	N/A	78%						52%	64%	78%
FMC	Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	A	47.40%	53%	55.62%	Met	68%	51.82%	55.08%	58.70%	60.00%	67.73%	53%	60%	68%
PSA	Non-Recommended PSA-Based Screening in Older Men	A	NA	NA	40.33%	N/A	11.81%	34.51%	28.14%	22.95%	19.47%	11.81%			
URI	Appropriate Treatment for URI (MY2019)	A	75.81%	76.87%	N/A	N/A	84.92%	60.67%	67.45%	73.59%	76.87%	84.92%			
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis (MY2019)	A	NQ	NA	N/A	N/A	49.07%	28.38%	31.53%	35.05%	38.43%	49.07%			
DDE	Potentially Harmful Drug-Disease Interactions in Old Adults	A	NA	NA	35.27%	N/A	24.37%	33.33%	30.84%	28.67%	27.52%	24.37%			
DAE	Use of high-risk medications in Old Adults		19.11%	19.06%	15.46%	N/A	9.89%	19.06%	16.26%	13.70%	12.79%	9.89%			
HDO	Use of Opioids at High Dosage	A	4.23%	3.43%	2.19%	Met	1.38%	6.43%	4.56%	3.43%	2.72%	1.38%			
	Use of Opioids From Multiple Providers - multiple Prescribers	A	15.93%	1.33%	17.80%	Not Met	0.00%	1.33%	0.94%	0.62%	0.48%	0.00%			
	Multiple Pharmacies	A	1.65%	7.15%	1.09%	Met	7.15%	15.92%	13.68%	11.49%	10.37%	7.15%			
UOP	Multiple Prescribers and Pharmacies	A	0.55%	0.48%	0.47%	Met	0.00%	0.74%	0.48%	0.27%	0.14%	0.00%			
	Risk of Continued Opioid Use (MY2018) >= 15 days	A	11.98%	11.95%	N/A	N/A	9.18%	14.88%	13.38%	11.95%	11.17%	9.18%			
COU	Risk of Continued Opioid Use >= 31 days	A	7.29%	6.60%	N/A	N/A	4.57%	9.15%	7.69%	6.60%	6.03%	4.57%			
	Adults' Access to Preventive/Ambulatory Health Services (age 20-44)		92.44%	93.24%	N/A	N/A	95.95%	88.66%	90.55%	92.23%	93.24%	95.95%			
	Adults' Access to Preventive/Ambulatory Health Services (age 45-64)		94.85%	95.71%	N/A	N/A	99.17%	94.26%	95.71%	96.69%	97.14%	99.17%			
	Adults' Access to Preventive/Ambulatory Health Services (age 65+)		90.53%	93.51%	N/A	N/A	99.44%	93.51%	95.06%	96.36%	96.99%	99.44%			
AAP	Adults' Access to Preventive/Ambulatory Health Services (Total)	A	91.74%	93.34%	92.24%	N/A	99.45%	93.34%	95.08%	96.25%	96.89%	99.45%			
	Initiation of Alcohol and Other Drug Dependence Treatment		31.17%	36.59%	29.38%	Not Met	53.18%	30.85%	36.59%	42.60%	44.70%	53.18%			
IET	Engagement of Alcohol and Other Drug Dependence Treatment	A	7.79%	9.82%	4.84%	Not Met	9.82%	2.92%	4.65%	5.93%	7.34%	9.82%			
PCR	Plan All-Cause readmissions - 65+	A	8.57%	8%	N/A	N/A	8%	1.1012	1.037	0.9798	0.9574	0.8392	11%	10%	8%
	Hospitalization following discharge From a Skilled Nursing Facility - 30 rehospitalization 65+	A	NA	NA	N/A	N/A	0.7850	1.1146	1.0474	0.9222	0.8841	0.785			
HFS	Hospitalization following discharge From a Skilled Nursing Facility - 60 rehospitalization 65+	A	NA	NA	N/A	N/A	0.8399	1.1429	1.0509	0.9627	0.9314	0.8399			
	Adult Immunization Status - influenza 66+	E	45.37%	49.02%	44.10%	Not Met	60.29%	25.02%	32.27%	43.96%	49.02%	60.29%			
	Adult Immunization Status - Tdap 66+	E	28.24%	29.49%	41.24%	Met	47.31%	12.53%	18.21%	24.50%	29.49%	47.31%			
	Adult Immunization Status - Zoster 66+	E	21.76%	22.15%	24.43%	Met	38.33%	1.45%	4.79%	13.62%	22.15%	38.33%			
AIS-E	Adult Immunization Status - Pneumococcal 66+	E	26.85%	33.37%	45.08%	Met	60.67%	17.30%	25.91%	33.37%	38.66%	60.67%			
BCS-E	Breast Cancer Screening	E	65.49%	66.51%	68.52%	Met	82.56%	66.51%	71.79%	75.47%	77.48%	82.56%			
HPC	Hospitalization for Potentially Preventable Complications - DMC15	A	0.3873	0.3309	N/A	N/A	0.3309	0.6128	0.5184	0.4432	0.3932	0.3309			

QAC 03.19.2020



2026 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

QAC 3.19.2026

Back to Agenda Back to Item

Table of Contents

1.CalOptima Health Overview 7
1.1.Our Strategic Plan 7
1.1.1.Centers for Medicare & Medicaid Services (CMS) National Quality Strategy 8
1.1.2.Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS) 8
1.1.3.Health Equity Framework 9
1.2.Program Structure 10
1.2.1. Medi-Cal 10
1.2.1.1.Medi-Cal Scope of Services 11
1.2.1.2.Members With Special Health Care Needs 11
1.2.1.3.Medi-Cal Managed Long-Term Services and Supports 12
1.2.2.OneCare (HMO D-SNP) 13
1.2.2.1.OneCare Scope of Services 13
1.2.3.Program of All-Inclusive Care for the Elderly (PACE) 14
1.2.4.Covered California 14
1.3.Provider Partners 15
1.3.1 CalOptima Health Direct (COD) 15
1.3.1.1.CalOptima Health Direct-Administrative (COD-A) 15
1.3.1.2.CalOptima Health Community Network (CHCN) 15
1.3.2.CalOptima Health Contracted Health Networks 15
1.4.Membership Demographics 16
2.1. Quality Improvement and Health Equity Transformation Program Overview 17
2.2. Quality Improvement and Health Equity Transformation Program Purpose, Scope, and Goals 18
2.3.National Committee for Quality Assurance Accreditation 20
2.Conflict of Interest 21
2.5.Non-Discrimination 21
2.6.Confidentiality 22
3. Authority and Accountability 22
3.1. CalOptima Health Board of Directors 22
3.2. Board of Directors' Quality Assurance Committee 23
3.3. Member Advisory Committee 23
3.4. Provider Advisory Committee 23
3.5. Whole-Child Model Advisory Committee 24
3.6. Role of the Chief Executive Officer 24
3.7. Role of the Chief Executive Officer 25
3.8. Role of the Chief Medical Officer 25
3.9. Role of the Chief Operating Officer 25
3.10. Role of the Chief Compliance Officer 26
3.11. Role of the Chief Information Officer 26
3.12. Role of the Chief Financial Officer 26
3.13. Role of the Chief Health Equity Officer 26
3.14. Role of the Chief Human Resources Officer 27
3.15. Role of the Deputy Chief Medical Officer 27
3.14. Quality Improvement and Health Equity Transformation Program Committee Structure 28
3.15. Quality Improvement Health Equity Committee 28

QAC 3.19.2026

Back to Agenda Back to Item

3.17. Credentialing and Peer Review Committee (CPRC) 30
3.17. Utilization Management Committee (UMC) 31
3.17.1. Pharmacy & Therapeutics (P&T) Committee 31
3.17.2. Benefit Management Subcommittee (BMSC) 32
3.18. Whole-Child Model Clinical Advisory Committee (WCM) 32
3.19. Member Experience Committee (MEMX) 32
3.20. Grievance and Appeals Resolution Services (GARS) Committee 33
3.21. Delegation Oversight Committee (DOC) 33
3.22. Compliance Committee 33
4. CalOptima Health Organizational Structure 34
4.1. Organizational Chart — Diagram 34
4.2. Organizational Structure 34
4.3. Organizational Resources 34
4.4. Staff Orientation, Training and Education 35
5.5. Key Business Processes, Functions, Important Aspects of Care and Service 35
5.5.1. Quality Improvement (QI) Department 37
5.5.2 Quality Analytics 37
5.5.3. Equity and Community Health 38
5.5.4. Office of Compliance 38
5.5.5. Population Health Management 39
5.5.6. Care Coordination and Care Management 40
5.5.6.1. Health Risk Assessment (HRA) and Health Needs Assessment (HNA) 41
5.5.6.2 Interdisciplinary Care Team (ICT) 41
5.5.6.3 Individualized Care Plan (ICP) 41
5.5.6.4 Whole-Child Model (WCM) 42
5.5.7. Utilization Management 42
5.5.8. Behavioral Health (BH) 43
5.5.8.1 Medi-Cal Behavioral Health (BH) 44
5.5.8.2 OneCare Behavioral Health 45
5.5.9. OneCare Dual Eligible Special Needs Plan (D-SNP) Model of Care (MOC) 46
6. Program Documents 46
6.1. Quality Improvement and Health Equity Transformation Program Work Plan 46
6.2. Quality Improvement and Health Equity Program Evaluation 47
6.3. Review and Approval of Program Documents 48
7. Quality Improvement and Health Equity Processes 48
7.1. QIHE Project Selection and Focus Areas 48
7.2. QIHE Project Measurement Methodology 49
7.3. Types of QIHE Projects 50
7.4. Improvement Standards 51
7.5. Documentation of QIHE Projects 51
7.6. Communication of QIHE Activities 52
8. Quality Improvement Initiatives 52
8.1. Quality of Care 52
8.1.1. Quality Analytics 52
8.1.1.1. Encounter Data Validation 53

QAC 3.19.2026

Back to Agenda Back to Item

8.1.2. Comprehensive Credentialing Program 53
8.1.3. Facility Site, Medical Record and Physical Accessibility Reviews 54
8.1.4. Medical Record Documentation 55
8.1.5. Corrective Action Plan(s) to Improve Quality of Care and Services and Implementation and Evaluation of Interventions to Reduce Health Disparities 56
8.1.6. Quality Performance Measures 56
8.1.6.1. HEDIS® Measures 56
8.1.6.1.1. OneCare Stars 56
8.1.6.1.2. Medi-Cal Managed Care Accountability Set (MCAS) 57
8.1.6.2. Disparities Reduction Program, Including Collection of Member Demographic Data 57
8.1.6.3. Value-Based Payment Program 57
8.1.6.4 Hospital Quality Program 2023–2027 58
8.2. Access to Care 58
8.2.1. Availability of Primary Care Providers (PCPs) by Language 58
8.2.2. Availability of Practitioners 58
8.2.3. Appointment Access 59
8.2.4. After-Hours Access to Care 59
8.2.5. Telephone Access to CalOptima Health Staff 59
8.3. Member and Provider Satisfaction 59
8.3.1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®) 59
8.3.2. Member Satisfaction Studies 60
8.3.3. Grievances and Appeals 60
8.3.4. Provider Satisfaction 60
8.4. Patient Safety Program 61
8.4.1. Health Education and Wellness 62
8.4.2. Managing Members with Emerging Risk 63
8.4.2.1 Disease Management Program 63
8.4.4. Continuity of Care Studies and Evaluations 64
8.4.5. Appropriate Medication Utilization 64
8.4.6. Peer Review Process for Potential Quality Issues 65
8.5. Cultural and Linguistic Services Program 65
Appendix: 67
A. CalOptima Health's QIHETP Support Positions and Job Descriptions 67
B. 2026 QIHETP Work Plan 67
a. HEDIS MY2025 Medicaid Goals 67
b. HEDIS MY 2025 Medicare Goals 67
C. 2026 Population Health Management Strategy 67
D. 2026 Culturally and Linguistically Appropriate Services (CLAS) Program Description 67
E. CalOptima Health Measurement Year (MY) 2026 Medi-Cal and OneCare Pay for Value Programs 67
F. CalOptima Health Measurement Year (MY) 2026 Behavioral Health Integration Pay for Value Program 67

QAC 3.19.2026

Back to Agenda Back to Item

2026 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM SIGNATURE PAGE

Quality Improvement Health Equity Committee Chair:

_____ _____

Richard Pitts, D.O., Ph.D. **Date**
CalOptima Health Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

_____ _____

Jose Mayorga, M.D. **Date**

Board of Directors Chair:

_____ _____

Supervisor Vicente Sarmiento **Date**

QAC 3.19.2026

1. CalOptima Health Overview

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. CalOptima Health offers health insurance plans for low-income children, adults, seniors and people with disabilities in Orange County. Local leaders launched CalOptima Health in 1995 as a county organized health system to better serve vulnerable residents and provide access to quality health care. CalOptima Health operates independently, under the leadership of a Board of Directors comprising members, providers, business leaders and local government representatives. Through collaboration with our providers, community partners and local stakeholders, we are working to remove barriers, enhance care coordination and support our members in leading healthier lives. Together, we are building a stronger, more equitable health system.

1.1. Our Strategic Plan

CalOptima Health's Board of Directors and executive team worked together to develop our 2025–2027 Strategic Plan. After engaging a wide variety of internal and external stakeholders and collecting feedback, the strategic plan, our strategic roadmap for CalOptima Health activities and investments through fiscal year 2027, was approved in February 2025. Our core strategy is the "inter-agency" co-creation of services and programs, in collaboration with our delegated networks, providers and community partners, to support our mission and vision.

Achieving our Mission, Vision and Values: Through this Strategic Plan, CalOptima Health continues to strive toward our ***mission to serve member health with excellence and dignity, respecting the value and needs of each person.*** This continues to be our mission and what drives our strategic priorities. The new Strategic Plan includes a new Vision Statement to better reflect our aspirational vision for CalOptima Health:

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Finally, we have codified our organizational values — CalOptima Health **C-A-R-E-S**: We believe that to best serve the people of Orange County, we will lead with ***Collaboration, Accountability, Respect, Excellence and Stewardship.***

The four Strategic Priorities are:

- Equity and Population Health
- Quality and Value
- Community Partnerships and Investment
- Operations, Finance and People

CalOptima Health aligns our strategic plan with the priorities of our federal and state regulators.

OAC 3.19.2026

1.1.1. Centers for Medicare & Medicaid Services (CMS) National Quality Strategy

The CMS national quality strategy aims to set and raise the bar for a resilient, high-value health care system that promotes quality outcomes, safety, equity and accessibility for all individuals, especially for people in historically underserved and under-resourced communities. The strategy focuses on a person-centric approach from birth to the end of life as individuals journey across the continuum of care, from home- or community-based settings to hospital to post-acute care, and across payer types, including Traditional Medicare, Medicare Advantage, Medicaid, Children's Health Insurance Program (CHIP) and Marketplace coverage.

Quality Mission: To achieve optimal health and well-being for all individuals.

Quality Vision: As a trusted partner, shape a resilient, high-value American health care system to achieve high-quality, safe, equitable and accessible care for all.

CMS National Quality Strategy has four priority areas, each with two goals.

1. Outcomes and Alignment
    a. Outcomes: Improve quality and health outcomes across the care journey.
    b. Alignment: Align and coordinate across programs and settings.
2. Equity and Engagement
    a. Advance health equity and whole-person care.
    b. Engage individuals and communities to become partners in their care.
3. Safety and Resiliency
    a. Safety: Achieve zero preventable harm.
    b. Resiliency: Enable a responsive and resilient health care system to improve quality.
4. Interoperability and Scientific Advancement
    a. Interoperability: Accelerate and support the transition to a digital and data-driven health care system.
    b. Scientific Advancement: Transform health care using science, analytics and technology.

1.1.2. Department of Health Care Services (DHCS) Comprehensive Quality Strategy (CQS)

The 2025 CQS outlines DHCS' comprehensive approach to developing, implementing, and maintaining a quality strategy that encompasses all Medi-Cal delivery systems—managed care, fee-for-service, behavioral health, dental, and other departmental programs. The strategy defines measurable goals, emphasizes the use of CMS Core Set measures, and tracks improvement while adhering to federal and state requirements. It reinforces DHCS' commitment to reducing health disparities and advancing health equity in every aspect of program design and delivery.

The report describes DHCS' quality improvement infrastructure, the development and review process for the CQS, managed care standards and evaluation requirements, continuous program quality improvement, and the state's plan to identify, evaluate, and reduce health disparities. It

QAC 5.19.2026

also defines “significant change" and highlights additional quality improvement efforts in programs outside managed care.

The 2025 CQS highlights DHCS' ongoing delivery system reform efforts, including California Advancing and Innovating Medi-Cal (CalAIM), Behavioral Health Transformation, and new initiatives such as BH-CONNECT. These efforts focus on reducing variation and complexity, managing member risk through population health strategies, and improving quality outcomes through value-based initiatives and payment reform.

Quality Strategy Goals

1. Engaging members as owners of their own care
2. Keeping families and communities healthy via prevention
3. Providing early interventions for rising risk and member-centered chronic disease management
4. Providing whole-person care for high-risk populations, addressing drivers of health

Quality Strategy Guiding Principles

1. Eliminating health disparities through anti-racism and community-based partnerships
2. Data-driven improvements that address the whole person
3. Transparency, accountability and member involvement

1.1.3. Health Equity Framework

CalOptima Health is committed to advancing health equity and serving members with the excellence, dignity and care they deserve. This commitment extends into the heart of the communities our members call home.

Our vision for health equity remains ambitious, centered on all our operational and strategic priorities. To advance health outcomes and drive meaningful impact, our health equity strategic framework is anchored in five focus areas:

- **Reduce Health Disparities:** Mitigate racial, ethnic, gender and socioeconomic disparities in health outcomes.
- **Leadership and Advocacy for Equity:** Drive health equity initiatives through advocacy, partnership and continuous quality improvement.
- **Member-Centered Care:** Provide equitable, culturally responsive and linguistically accessible care that focuses on prevention and aligns with member needs and preferences.
- **Community Engagement and Partnership:** Empower and collaborate with community stakeholders to co-create equitable health solutions that include prevention.
- **Empowering Change Through Data-Driven Strategies:** Leverage data to discover gaps, strengths and assets to co-design strategies that improve health outcomes with the community.

QAC 3.19.2026



1.2. Program Structure

"Better. Together." is CalOptima Health's motto, and it means that by working together, we can make things better — for our members and community. As Orange County's single largest health insurer, we provide coverage through three major programs:

1.2.1. Medi-Cal

Medi-Cal — known nationally as Medicaid — is a public health insurance program for low-income people administered by the state in partnership with the federal government. It covers those with incomes below 138% of the Federal Poverty Level, which includes families with children, seniors, people with disabilities, foster care children, pregnant women and people with specific diseases. CalOptima Health provides health care coverage for Orange County residents who are eligible for full Medi-Cal.

1.2.1.1. Medi-Cal Scope of Services

Under our Medi-Cal program, CalOptima Health provides a comprehensive scope of acute, specialty, mental health and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima Health through the Whole-Child Model (WCM) program that began in 2019. CalOptima Health also offers medical equipment and supplies, vision care, transportation and long-term care for our members.

CalOptima Health provides Enhanced Care Management (ECM) and all 14 Community Supports to address social drivers of health and assist members with finding stable or safe housing, accessing healthy food, transitioning back home or getting support in the home. As of January 2026, CalOptima Health will provide the 15th Community Support service, Transitional Rent, for members eligible under the Behavioral Health Population of Focus as required by DHCS.

Certain services are not covered by CalOptima Health but may be provided by a different agency, including those indicated below:

- Pharmacy benefits and services when billed by a pharmacy on a pharmacy claim are provided by the DHCS through a pharmacy benefit manager
    - Covered outpatient drugs, eligible under the pharmacy benefit;
    - Enteral nutrition products; and
    - Specific Medical supplies including diabetic supplies (testing supplies, Continuous Glucose Monitoring devices, disposable insulin delivery devices, insulin syringes, and pen needles), miscellaneous medical supplies, and certain contraceptive devices
- Specialty mental health services are administered by the Orange County Health Care Agency (OCHCA)
- Substance use disorder services are administered by OCHCA
- Dental services are provided through the Medi-Cal Dental Program

1.2.1.2. Members With Special Health Care Needs

CalOptima Health is committed to ensuring that members with special health care needs — including seniors, individuals with disabilities, children and youth with special health care needs (CYSHCN), and those with chronic or complex conditions — receive coordinated, accessible and high-quality care. Our approach is grounded in equity, member-centeredness and collaboration with community partners.

To ensure that clinical services as described above are accessible and available to members with special health care needs, such as seniors, people with disabilities and people with chronic conditions, CalOptima Health offers specialized care management (CM) and Complex Case Management (CCM) services to support members with high-risk or medically complex conditions. These services are designed to:

QAC 5.19.2026

- Promote continuity of care across providers and settings
- Address both clinical and social determinants of health
- Develop and monitor Individualized Care Plans (ICPs) tailored to each member's goals, needs, and preferences

CCM is provided in collaboration with the member's health network, primary care provider and specialists.

Services for members with special needs are embedded within CalOptima Health's Utilization Management (UM)/Case Management (CM) Integrated Program and Population Health Management (PHM) Strategy. These frameworks ensure:

- Proactive identification of high-risk members
- Timely outreach and engagement
- Alignment with National Committee for Quality Assurance (NCQA) and DHCS standards for quality and access

Additionally, CalOptima Health works with community programs to ensure that members with special health care needs (or with high-risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established as special services through specific Memoranda of Understanding (MOU) with certain community agencies, including OCHCA and the Regional Center of Orange County (RCOC).

OAC 3.19.2026

1.2.1.3. Medi-Cal Managed Long-Term Services and Supports

Long-Term Services and Supports (LTSS) benefits have been integrated into CalOptima Health since July 1, 2015, for Medi-Cal members. CalOptima Health ensures LTSS are available to members with health care needs that meet program eligibility criteria and guidelines. LTSS includes both institutional and community-based services. The LTSS department monitors and reviews the quality and outcomes of services provided to members in both settings.

These integrated LTSS benefits include the following programs:

- In-Home Supportive Services (IHSS): IHSS provides in-home assistance to eligible aged, blind and disabled individuals as an alternative to out-of-home care and enables members to remain safely in their own homes. CalOptima Health LTSS is responsible for the IHSS referral process to the County of Orange Social Service Agency, which manages the program.
- Nursing Facility Services for Long-Term Care: CalOptima Health LTSS is responsible for the clinical review and medical necessity determination for members receiving long-term Nursing Facility Level A, Nursing Facility Level B and Subacute levels of care.

CalOptima Health LTSS monitors the levels of overall program utilization as well as care setting transitions for members in the program.

- Community-Based Adult Services (CBAS): CBAS offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization. CalOptima Health LTSS monitors the levels of member access to, utilization of and satisfaction with CBAS.
- Multipurpose Senior Services Program (MSSP): Intensive home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid institutionalization. CalOptima Health LTSS monitors the level of member access to MSSP as well as its role in diverting members from institutionalization.
- CalAIM Community Supports: CalOptima Health LTSS is responsible for the clinical review and medical necessity determination for members referred to CalAIM. LTSS collaborates with CalOptima Health CalAIM operations to monitor overall program utilization.

1.2.2. OneCare (HMO D-SNP)

Since 2005, CalOptima Health has offered OneCare, our Medicare Advantage Dual Eligible Special Needs Plan, to low-income seniors and individuals with disabilities who qualify for both Medicare and Medi-Cal. Our OneCare members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for them to get the health care they need. OneCare has extensive experience serving the complex needs of frail, disabled, dual-eligible members in Orange County.

To be a member of OneCare, a person must be 21 years of age or older, reside in Orange County, and be eligible for both Medicare and Medi-Cal. Enrollment in OneCare is voluntary and made by the member's choice.

1.2.2.1. OneCare Scope of Services

OneCare offers comprehensive services to dual-eligible members enrolled in Medi-Cal and Medicare Parts A and B. OneCare features an innovative Model of Care, which serves as the framework for delivering consistent, high-quality care. Each member has a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, the PCCs work with our members and their doctors to create individualized health care plans that fit each member’s needs. Addressing individual needs results in a better, more efficient and higher quality health care experience for the member. CalOptima Health monitors quality for OneCare through regulatory measures, including Part C, Part D and CMS Star measures.

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, OneCare members are eligible for supplemental benefits, such as allowances for over-the-counter items, food and produce for qualifying

OAC 3.19.2026

members, vision, access to no-cost gym memberships, comprehensive dental and companion care.

1.2.3. Program of All-Inclusive Care for the Elderly (PACE)

CalOptima Health PACE is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all necessary preventive, primary, acute, and long-term care services, enabling seniors to continue living in their community.

PACE combines health care and adult day care for people with multiple chronic conditions. These can be offered in the member's home, in the community or at the CalOptima Health PACE Center:

1. Routine medical care, including specialist care
2. Prescribed drugs and lab tests
3. Personal care for things like bathing, dressing and light chores
4. Recreation and social activities
5. Nutritious meals
6. Social services
7. Rides to health-related appointments, and to and from the program
8. Hospital care and emergency services

PACE maintains a separate PACE Quality Improvement Program, work plan and evaluation.

1.2.4. Covered California

CalOptima Health is preparing to launch a new Covered California product line, effective January 1, 2027, which will expand its commercial offerings under the Knox-Keene Act license. This strategic initiative aligns with CalOptima Health's mission to serve member health with excellence and dignity.

CalOptima Health submitted an initial filing to DMHC on June 16, 2025, along with a second filing with provider network rosters on October 31, 2025. Engagement with Covered California's Plan Management Advisory Group is ongoing to align with policy and regulatory changes and internal leadership check-ins and contract amendments are being tracked to ensure timely execution and compliance.

To ensure compliance with Covered California's Qualified Health Plan (QHP) standards, CalOptima Health is initiating a multi-phase approach focused on operational readiness and quality improvement in 2026.

Quality focus areas for 2026 include:

- Alignment with Covered California Quality Transformation Initiative (QTI) measures and implement the HEQMS Benchmark

QAC 3.19.2026

- Preparation for NCQA Health Plan Accreditation for Covered California product

1.3. Provider Partners

CalOptima Health Providers can choose from several options to participate in CalOptima Health's programs and deliver health care services to members. Providers can contract directly with CalOptima Health through CalOptima Health Direct, which consists of CalOptima Health Direct-Administrative and CalOptima Health Community Network (CHCN). Providers also have the option to contract directly with one of our delegated health networks. CalOptima Health members can choose between CHCN or one of 10 health networks, which represent more than 9,000 providers.

1.3.1. CalOptima Health Direct (COD)

CalOptima Health Direct has two elements: CalOptima Health Direct-Administrative and CHCN.

1.3.1.1. CalOptima Health Direct-Administrative (COD-A)

COD-A is a self-directed program administered by CalOptima Health to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in OneCare), share-of-cost members, newly eligible members transitioning to a health network and members residing outside of Orange County.

1.3.1.2. CalOptima Health Community Network (CHCN)

CHCN doctors have an alternate path to contract directly with CalOptima Health to serve our members. CHCN is administered directly by CalOptima Health and available for health network-eligible members to select, supplementing the existing delivery model and creating additional capacity for access.

1.3.2. CalOptima Health Contracted Health Networks

CalOptima Health has contracts with delegated health networks through various risk models to provide care to our members. The following contract risk models are currently in place:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortium (PHC)
- Shared-Risk Group (SRG)

Through our delegated health networks, CalOptima Health members have access to more than 1,200 Primary Care Providers (PCPs), more than 7,500 specialists, 42 acute and rehabilitative hospitals, 70 community health centers and 234 long-term care facilities.

CalOptima Health contracts with the following:

QAC 3.19.2026

Back to Agenda Back to Item

Health Network	Medi-Cal	OneCare
AltaMed Health Services	HMO	SRG
AMVI Care Medical Group	PHC	PHC
CHOC Health Alliance	PHC	not participating
Family Choice Medical Group	HMO	SRG
HPN-Regal Medical Group	HMO	HMO
Noble Mid-Orange County	SRG	SRG
Optum Care Network	HMO	HMO
Prospect Medical Group	HMO	HMO
Providence Health	SRG	Not participating
United Care Medical Group	SRG	SRG

CalOptima Health contracts with vendors that provide benefits for our members. These vendors are responsible for maintaining a contracted network of providers, coordinating services and providing direct services. They may also be delegated for plan functions.

Vendor	Medi-Cal	OneCare
Vision Service Plan	VS	VS
Liberty Dental Plan	—	Dental
MedImpact	—	PBM

HMO=Health Maintenance Organization; PHC=Physician/Hospital Consortium; SRG=Shared-Risk Group; VS=Vision Service; PBM=Pharmacy Benefit Manager

Upon successful completion of readiness reviews and audits, contracted entities may be delegated for clinical and administrative functions, which may include:

- Utilization management
- Basic and complex care management
- Claims
- Credentialing

1.4. Membership Demographics

Membership Data* (as of November 30, 2025)

Total CalOptima Health Membership

877,271

Prior month: 877,802

Program	Members
Medi-Cal	**858,441**
OneCare (HMO D-SNP)	**18,287**
Program of All-Inclusive Care for the Elderly (PACE)	**543**

*Based on unaudited financial report and includes prior period adjustments.

Member Demographics (as of November 30, 2025)

Member Age

0 to 5	8%
6 to 18	22%
19 to 44	34%
45 to 64	20%
65 +	16%

Language Preference

English	56%
Spanish	29%
Vietnamese	9%
Korean	2%
Other	2%
Farsi	1%
Chinese	<1%
Arabic	<1%
Russian	<1%

Medi-Cal Aid Category

Expansion	38%
Temporary Assistance for Needy Families	36%
Seniors	13%
Optional Targeted Low-Income Children	7%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

2.1. Quality Improvement and Health Equity Transformation Program Overview

CalOptima Health's Quality Improvement and Health Equity Transformation Program (QIHETP) encompasses all clinical care, health and wellness services, and quality of service provided to our members, aligning with our vision to deliver an integrated and well-coordinated system of care that ensures optimal health outcomes for all members. This program integrates health equity into quality improvement initiatives by leveraging data-driven insights, evidence-based practices and community engagement strategies.

CalOptima Health develops programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from primary care, urgent care, acute and subacute care to long-term care and end-of-life care. Our comprehensive person-centered approach integrates physical and behavioral health (BH), leveraging care delivery systems and community partners for our members with vulnerabilities, disabilities, special health care needs and chronic illnesses.

CalOptima Health's QIHETP includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All services are provided in a culturally and linguistically appropriate manner.

CalOptima Health is committed to promoting diversity, equity and inclusion in practices throughout the organization, including Human Resources best practices for recruiting and hiring, to ensure the CalOptima Health workforce has the experience, knowledge or expertise relevant to meet the needs of our members. Additionally, as part of the new hire process and annual compliance, employees receive training on cultural competency, bias, diversity, equity and inclusion.

OAC 3.19.24

2.2. Quality Improvement and Health Equity Transformation Program Purpose, Scope, and Goals

The **purpose** of the CalOptima Health QIHETP is to establish objective methods for systematically evaluating and improving the quality of care provided to members. Through QIHETP, and in collaboration with providers and community partners, CalOptima Health strives to continuously improve the structure, processes and outcomes of the health care delivery system to serve members. We aim to identify health inequities and develop structures and processes to reduce disparities, ensuring that all members receive equitable and timely access to care.

CalOptima Health applies the principles of continuous quality improvement (CQI) to all aspects of the service delivery system through analysis, evaluation and systematic enhancements of the following:

- Quantitative and qualitative data collection and data-driven decision-making.
- Up-to-date evidence-based practice guidelines.
- Feedback provided by members and providers in the design, planning and implementation of CQI activities.
- And other issues identified by CalOptima Health or its regulators.

The **scope** of CalOptima Health QIHETP focuses on the specific needs of CalOptima Health's members and stakeholders (health care providers, community-based organizations and government agencies), incorporating CQI methodologies such as Plan-Do-Study-Act (PDSA). The QIHETP implements a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima Health's strategic mission, goals and objectives.
- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.
- Focus on quality improvement and health equity activities carried out on an ongoing basis to support early identification and timely correction of quality-of-care issues to ensure safe care and experiences.
- Maintain organization-wide practices that support health plan and health equity accreditation by the NCQA and meet CMS quality and measurement reporting requirements.

The QIHETP's ongoing responsibilities include the following:

- Developing plans to measure, assess and improve the quality of the organization's governance, management, delivery system and support processes.
- Supporting the provision of a consistent level of high-quality care and service for members throughout the contracted provider networks, as well as monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers.

QAC 3.19.2026

- Recommending delivery system reform to ensure high-quality and equitable health care.
- Monitoring quality of care and services from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.
- Ensuring contracted facilities, as required by federal and state laws, report to OCHCA communicable and non-communicable disease/conditions using specific methods and timeframes, as listed on the OCHCA website. Key reportable categories include vaccine-preventable diseases, foodborne and enteric diseases, healthcare-associated infections (HAIs), vector-borne diseases, emerging and other infections, neurological and systemic diseases, diseases related to environmental exposures or injuries, and outbreaks.
- Promoting member safety and minimizing risk through the implementation of safety programs and early identification of issues that require intervention and/or education, and working with appropriate committees, departments, staff, practitioners, provider medical groups and other related organizational providers to ensure that steps are taken to resolve and prevent recurrences.
- Educating the workforce and promoting a continuous quality improvement and health equity culture at CalOptima Health.
- Ensuring the annual review and acceptance of the Utilization Management (UM)/Case Management (CM) Integrated Program Description, and the Culturally and Linguistically Appropriate Services (CLAS) Program, including the work plans and the annual evaluations of these programs/strategies.

In collaboration with the Compliance Audit & Oversight departments, the QIHETP ensures the following standards or outcomes are carried out and achieved by CalOptima Health's contracted health networks:

- Support the organization's strategic quality and business goals by using resources appropriately, effectively and efficiently.
- Continuously improve clinical care and service quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
- Identify in a timely manner the important clinical and service issues facing members relevant to their demographics, risks, disease profiles for both acute and chronic illnesses and preventive care.
- Ensure continuity and coordination of care between specialists and primary care providers, and between medical and BH practitioners by annually evaluating and acting on identified opportunities.
- Ensure accessibility and availability of appropriate clinical care and a network of providers with experience in providing care for the population.
- Monitor the qualifications and practice patterns of all individual providers in the network to deliver quality care and service.
- Promote the continuous improvement of members and provider satisfaction, including the timely resolution of complaints and grievances.
- Ensure the reliability of risk prevention and risk management processes.
- Ensure compliance with regulatory agencies and accreditation standards.
- Promote the effectiveness and efficiency of internal operations.

QAC 3.19.2026

- Ensure the effectiveness and efficiency of operations associated with functions delegated to the contracted health networks.
- Ensure the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima Health's strategic direction in support of its mission, vision and values.
- Ensure compliance with up-to-date Clinical Practice Guidelines and evidence-based practice.

CalOptima Health's Quality Improvement Health Equity Transformation Program (QIHETP) Goals are aligned with CalOptima Health's mission, vision and values.

Medi-Cal QIHETP Goals

- Meet and exceed the minimum performance levels (MPLs) for the Medi-Cal Accountability Set (MCAS).
- Maintain NCQA Health Plan and Health Outcomes Accreditation (formerly known as Health Equity Accreditation).
- Attain a 4.5 NCQA Health Plan Rating.

OneCare QIHETP Goals

- Attain a Four-Star Rating for Medicare.

Covered California QIHETP Goals

- Attain operational readiness to launch the Covered California product on January 1, 2027.

2.3. National Committee for Quality Assurance Accreditation

CalOptima Health is a NCQA accredited health plan and achieved its initial commendable Health Plan Accreditation for the Medi-Cal product in August 2012. Most recently, in July 2024, CalOptima Health completed a triennial renewal survey for NCQA Health Plan Accreditation. triannual renewal survey for NCQA Health Plan Accreditation and received 135.50 out of 140 allowable points through the document submission and file review process. From this renewal survey, CalOptima Health was awarded Accredited Status, effective through July 10, 2027.

In alignment with CalOptima Health's commitment to advancing health equity, CalOptima Health pursued and successfully attained initial Health Outcomes Accreditation, formerly known as Health Equity Accreditation, for the Medi-Cal product. This recognition took place on December 16, 2025, and will remain valid until December 16, 2028. CalOptima Health received full points and achieved a score of 100% , as an extension of the existing Health Plan Accreditation.

QAC 3.19.2026





QAC 3.19.202

2. Conflict of Interest

CalOptima Health maintains a Conflict of Interest Policy that addresses the process for identifying, disclosing and evaluating potential social, economic and professional conflicts of interest, and taking appropriate actions to ensure they do not compromise or bias professional judgment and objectivity in quality, credentialing and peer review matters. This policy prohibits using proprietary or confidential CalOptima Health information for personal gain or the benefit of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers or members, except when it is determined that the financial interest does not create a conflict. The policy includes an annual attestation completed by all individuals serving in appointed, volunteer or employed positions on the Quality Improvement Health Equity Committee (QIHEC) and its subcommittees. Additionally, all employees who make or participate in making decisions that may foreseeably have a material effect on economic interests must file a Statement of Economic Interests form on an annual basis.

2.5. Non-Discrimination

CalOptima Health is dedicated to creating a professional work environment free from discrimination and harassment. It has policies and procedures that describe how to identify, report and handle discrimination both in the workplace and within the Quality Improvement Health Equity Committee (QIHEC) and its subcommittees. The policy for the QIHEC requires all individuals serving in appointed, volunteer or staff roles to complete an annual attestation. Participants must not discriminate against or harass any other participant, member or provider based on protected categories such as age, disability, ethnicity, gender, marital status, national origin, race, religion or sexual orientation.

2.6. Confidentiality

CalOptima Health has policies and procedures in place to protect and promote the proper handling of confidential and privileged QIHEC medical record information. Upon employment, all CalOptima Health employees, including contracted professionals with access to confidential or member information, sign a written statement outlining their responsibility for maintaining confidentiality. In addition, all committee members of each entity are required to sign a confidentiality agreement on an annual basis. Invited guests must sign a confidentiality agreement at the time of committee attendance.

All records and proceedings of the QIHEC and the subcommittees related to member- or practitioner-specific information are confidential and are subject to applicable laws regarding confidentiality of medical and peer review information, including Welfare and Institutions Code Section 14087.58, which exempts the records of QI proceedings from the California Public Records Act. All information is maintained in confidential files. The delegated networks hold all information in the strictest confidence. Members of the QIHEC and the subcommittees sign a confidentiality agreement. This agreement requires committee members to maintain the confidentiality of any and all information discussed during the meeting. The CEO, in accordance with applicable laws regarding confidentiality, issues any QIHE reports required by law or by the state contract.

3. Authority and Accountability

3.1. CalOptima Health Board of Directors

The CalOptima Health Board of Directors (Board) has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee, which oversees the functions of the Quality Improvement Health Equity Committee (QIHEC) described in CalOptima Health's state and federal contracts, and to CalOptima Health's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions are not unduly influenced by financial considerations. The Board approves and evaluates the QIHETP on an annual basis.

The QIHETP is based on the ongoing systematic collection, integration and analysis of clinical and administrative data to identify member needs, risk levels and appropriate interventions. CalOptima Health uses this information to ensure that the program meets the specific needs of our members, promotes health equity among targeted population segments, and improves overall

QAC 3.19.2026

population health and member experience. The CMO is responsible for identifying suitable interventions and allocating the necessary resources to implement the QIHETP in accordance with federal and state regulations, contractual obligations, and fiscal constraints.

CalOptima Health is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima Health Board meetings are open to the public.

3.2. Board of Directors' Quality Assurance Committee

The Board of Directors' Quality Assurance Committee (QAC) is a Board committee comprising a subset of the Board of Directors' members. The QAC conducts annual evaluations, provides strategic direction, and makes recommendations regarding the overall QIHETP and directs any necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity contractual and regulatory standards. QAC receives quarterly progress reports from the QIHEC, which describe the improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC makes recommendations to the full Board of Directors for annual approval, with modifications and appropriate resource allocations, for the QIHETP and the Work Plan of the QIHETP. The full Board of Directors receives QAC meeting materials.

3.3. Member Advisory Committee

CalOptima Health is committed to providing member-focused care through active engagement with members and their communities. The Member Advisory Committee (MAC) has 20 voting members, with each seat representing a constituency served by CalOptima Health. The MAC ensures that members' values and needs are integrated into the design, implementation, operations and evaluation of the overall QIHETP. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

3.4. Provider Advisory Committee

The Provider Advisory Committee (PAC) was established by the CalOptima Health Board of Directors to advise the Board on issues impacting the CalOptima Health provider community. The PAC members represent the broad provider community that serves CalOptima Health members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of OCHCA, which maintains a standing seat. PAC meetings are open to the public. The 15 seats include:

- Health networks
- Hospitals

QAC 3.19.2026

Back to Agenda Back to Item

- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- Orange County Health Care Agency (standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Safety net
- Behavioral/mental health
- Pharmacy

3.5. Whole-Child Model Advisory Committee

The Whole-Child Model Family Advisory Committee (WCM FAC) has been required by the state as part of California Children's Services (CCS) since it became a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues regarding CalOptima Health's WCM program. The committee can initiate recommendations on issues for study and facilitate community outreach

The WCM FAC includes the following 11 voting seats:

- Family representatives (nine seats)
    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima Health member who is a current recipient of CCS services; or
    - CalOptima Health members ages 18–21 who are current recipients of CCS services; or
    - Current CalOptima Health members over the age of 21 who transitioned from CCS services
- Interests of children representatives (two seats)
    - Community-based organizations; or
    - Consumer advocates

Members of the committee serve staggered two-year terms. WCM FAC quarterly meetings are open to the public.

3.6. Role of the Chief Executive Officer

Chief Administrative Officer (CAO) has overall responsibility and accountability for the activities of the Clerk of the Board, Communications & Marketing, Government Affairs, Strategic Development, and Enterprise Project Management. The CAO creates a shared sense of purpose to achieve an aligned mission and vision executed through CalOptima Health's strategic

QAC 3.19.2026

plan and Chief Executive Officer (CEO) initiatives. The CAO is expected to lead by example and influence others by exhibiting the highest professional and ethical behaviors.

The CAO works closely with and makes presentations to the leadership team, CalOptima Health Board of Directors, elected officials, regulatory agencies, associations, contractors and key stakeholders

3.7. Role of the Chief Executive Officer

Chief Executive Officer (CEO) develops and directs the successful implementation of short and long-term strategic goals and plans for CalOptima Health. The CEO establishes and implements the mission, vision, policies and practices of CalOptima Health, as directed by the Board of Directors, and in the best interests of the members served through the CalOptima Health initiatives. The CEO allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Operating Officer (COO), Chief Medical Officer (CMO) and the Chief Financial Officer (CFO). The CEO ensures that the QIHEC satisfies all remaining requirements of the QIHETP, as specified in the state and federal contracts.

3.8. Role of the Chief Medical Officer

Chief Medical Officer* (CMO) oversees the agency's medical care delivery system, including the development and implementation of strategies and procedures for all medical services, clinical operations and quality programs. This position establishes standards for evaluating providers for inclusion in CalOptima Health's program and for the ongoing performance of participating providers. The CMO ensures that the care provided by the delegated networks meets all quality and regulatory requirements. The CMO is responsible for determining the medical necessity and appropriateness of medical services. The CMO has overall responsibility for the QIHETP and supports efforts to ensure that the QIHETP objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QIHE activities to the Board of Directors' QAC.

3.9. Role of the Chief Operating Officer

The Chief Operating Officer (COO) serves as a key leader within the health plan and holds the authority and accountability to lead areas assigned to next-level capabilities and operational efficiencies consistent with the strategic plan, goals and objectives for CalOptima Health. The COO manages organizational projects, ensuring that operations perform effectively and provides updates to the Board. The COO provides leadership and oversight to the day-to-day operations of several departments and senior leaders, including Customer Service, Information Technology, Enterprise Project Management Office, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, and Coding Initiatives.

QAC 3.19.2026

3.10. Role of the Chief Compliance Officer

Chief Compliance Officer (CCO) oversees all agency compliance programs, policies and practices to ensure CalOptima Health complies with federal, state, and local regulatory requirements and accreditation standards. The CCO is responsible for monitoring and driving interventions to ensure that CalOptima Health, our health networks, and other First Tier, Downstream, and Related Entities (FDRs) meet the requirements set forth by CMS and the Department of Managed Health Care (DMHC). The Compliance staff works in collaboration with the Audit & Oversight department to refer any potential noncompliance issues or trends encountered during audits of health networks and other functional areas. The CCO serves as the State Liaison and is responsible for legislative advocacy. Also, the CCO oversees CalOptima Health's regulatory and compliance functions, including the development and amendment of CalOptima Health's policies and procedures to ensure adherence to state and federal requirements.

3.11. Role of the Chief Information Officer

Chief Information Officer (CIO) is responsible for establishing a technology vision and roadmap that aligns with CalOptima Health's business strategy and the delivery of capabilities required to achieve business success, and for executing that roadmap. Under the leadership of the Chief Operating Officer (COO), the incumbent will participate in and contribute to overall CalOptima Health operations and strategy development, bringing a current knowledge and future vision to leverage information and technology in business model design, business processes, operational improvements and support for the CalOptima Health mission. The incumbent will launch new programs, implement new systems, integrate new vendor solutions and provide direction to cross-functional teams. The incumbent will work across all departments on major initiatives and lead through influence and communication. The incumbent will also be responsible for clearly communicating the organization's technology strategy, status and progress to executives, the board of directors and the advisory committees.

3.12. Role of the Chief Financial Officer

Chief Financial Officer (CFO) manages CalOptima Health's financial strategy, ensuring fiscal responsibility and resource allocation to support organizational priorities, including quality improvement and health equity initiatives.

3.13. Role of the Chief Health Equity Officer

Chief Health Equity Officer (CHEO) co-chairs the QIHEC and is responsible for establishing CalOptima Health's health equity and population health framework, as well as short- and long-range goals, procedures and practices that are in alignment with and support the organization's mission and vision, while developing policies and practices to eliminate and prevent health inequities and address structural and SDOH issues impacting the organization's members. The

QAC 3.19.2025

CHEO works to create health equity-focused resources, training programs, communications, and innovations to promote integration of health equity within member-facing products.

3.14. Role of the Chief Human Resources Officer

Chief Human Resources Officer (CHRO) is responsible for the overall talent strategy and administration of the human resources department, functions, policies and procedures and employee compensation, benefits and retirement, recruitment, employee relations, HRIS, leave and accommodation, and training and education programs for CalOptima Health. The CHRO leads and enhances the overall service delivery, coordination, and evaluation of all HR activities in accordance with CalOptima Health policies and procedures, as well as those identified in the Employee Handbook. The CHRO works in consultation with the Office of the CEO, the other Executive Offices, the Executive Directors, Directors and staff, and helps develop efficient processes that align with CalOptima Health's mission and vision as well as the organizational goals and priorities established by the Board of Directors.

3.15. Role of the Deputy Chief Medical Officer

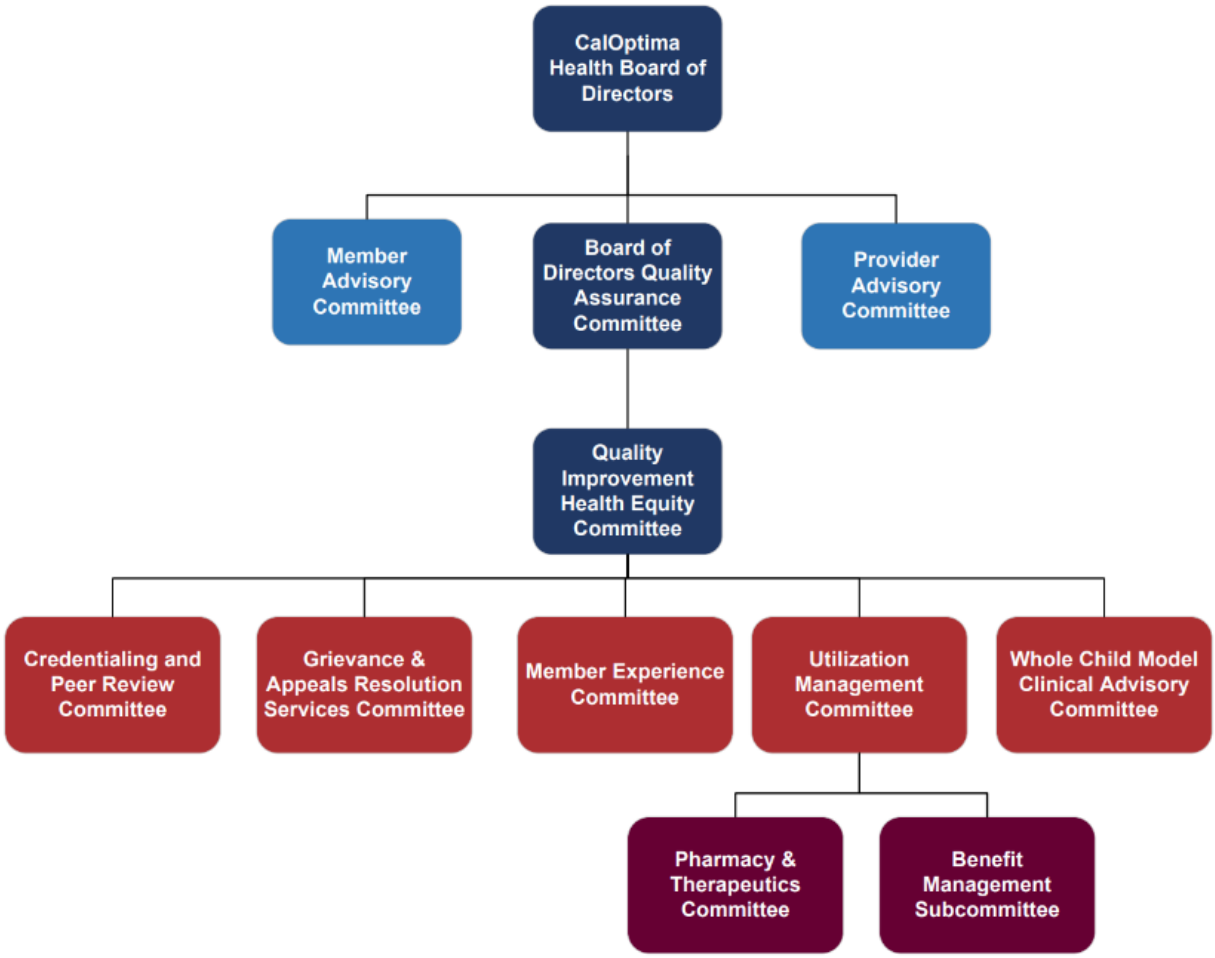
Deputy Chief Medical Officer* (DCMO), along with the CMO, oversees strategies, programs, policies and procedures related to CalOptima Health's medical care delivery system. The DCMO collaborates with Directors and Medical Directors in the operational oversight of the medical division, including Quality Improvement, Quality Analytics, Utilization Management, Care Management, ECH, Pharmacy Management, and other medical management programs.

*Upon employment engagement, and every three years thereafter, the Medical Directors are credentialed. In that process, their medical license is checked to ensure that it is an unrestricted license pursuant to the ***California Knox Keene Act Section 1367.01*** I. Ongoing monitoring is performed to ensure that no Medical Director is listed on state or federal exclusion or preclusion lists.

QAC 3.19.2026

3.14. Quality Improvement and Health Equity Transformation Program Committee Structure

QIHETP Committee Structure — Diagram



3.15. Quality Improvement Health Equity Committee

The Quality Improvement Health Equity Committee (QIHEC) is the foundation of the QIHETP and is accountable to the QAC. The QIHEC is chaired by the CMO and the CHEO. Together, they develop and oversee the QIHETP, QIHETP Work Plan and QIHETP Evaluation activities.

The purpose of the QIHEC is to provide overall direction for the continuous health equity-centered quality improvement process, develop and oversee the QIHETP activities that are consistent with CalOptima Health's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program. It monitors compliance with regulatory, licensing and accrediting body standards relating to QIHETP projects and activities. In addition, and most importantly, it

ensures that members receive optimal quality of care. Performance measurements, improvement activities, and interventions are reviewed, approved, processed, monitored and reported through the QIHEC.

The composition of the QIHEC includes a broad range of CalOptima Health network providers, including, but not limited to, hospitals, clinics, county partners, physicians, subcontractors, downstream subcontractors, community health workers, other non-clinical providers, and members. The QIHEC members are representative of the composition of CalOptima Health's network providers and community and include, at a minimum, network providers who provide health care services to members affected by health disparities, Limited English Proficiency (LEP) members, children and youth with special health care needs, Seniors and Persons with Disabilities (SPDs), and people with chronic conditions. QIHEC members includes practitioners who are external to CalOptima Health, including a BH practitioner to specifically address the integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, care review as needed, and identification of opportunities to improve care.

The QIHEC ensures that all QIHETP activities are performed, integrated and communicated internally and to the contracted delegated health networks to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIHEC oversees the performance of delegated functions by monitoring delegated health networks and their contracted provider and practitioner partners.

Responsibilities of the QIHEC include:

- Review, contribute to and approve the QIHETP, UM/CM Integrated Program, CLAS Program, and Population Health Management (PHM) Strategy annually.
- Analyze and evaluate the results of QIHE activities, including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other quality committees.
- Recommend policy decisions and priority alignment of the QIHETP subcommittees for effective operation and achievement of objectives.
- Oversee the analysis and evaluation of QIHETP activities.
- Ensure practitioner participation through attendance and discussion in the planning, design, implementation and review of QIHETP activities.
- Identify, prioritize, and institute needed actions and interventions to improve quality.
- Ensure appropriate follow-up of quality activities to determine the effectiveness of quality improvement-related actions and remediation of identified performance deficiencies.
- Monitor overall quality compliance for the organization to quickly resolve deficiencies that affect members.
- Evaluate practice patterns of providers, practitioners and delegated health networks, including over-/under-utilization of physical and BH care services.

QAC 3.19.2026

- Recommend practices so that all members receive medical and BH care that meets CalOptima Health standards.
- Review and assess compliance of the Cultural Competency and Diversity, Equity and Inclusion (DEI) training program.
- Provide a written summary of the QIHEC activities to the QAC and make the summary publicly available on CalOptima Health's website.

The QIHEC oversees and coordinates member outcome-related QIHE actions. Member outcome-related QIHE actions consist of well-defined, planned QIHE projects that address and achieve improvement in major focus areas of clinical and non-clinical services. The QIHEC also recommends strategies for disseminating all study results to CalOptima Health contracted providers and practitioners, as well as delegated health networks.

3.16.1 Quality Improvement Health Equity Committee Physician Participation

The QIHEC is chaired by the CMO designee, the Quality Medical Director, and the Chief Health Equity Officer (CHEO). The medical director is a physician who holds a current and unrestricted license in California. The QIHEC has participation from a broad range of network providers, including physicians, and they are also required to have a current and unrestricted California license. Changes to participating physicians are communicated to the QIHEC Program Specialist and QIHEC Chairperson. Changes include but are not limited to a change in health network affiliation or closing a physician panel.

On a monthly basis, the CalOptima Health Human Resources department requests a list of QIHEC members to monitor for provider exclusion or preclusion in accordance with CalOptima Health Policy HH.2021 Exclusion and Preclusion Monitoring.

3.17. Credentialing and Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima Health provider selection process and determines corrective actions, as necessary, to ensure that all providers who serve CalOptima Health members meet generally accepted standards for their profession or industry.

The CPRC reviews, investigates and evaluates the credentials of all CalOptima Health providers, in partnership with health networks and other delegated entities. CPRC maintains a continuous review of the qualifications and/or performance of providers every three years. In addition, the CPRC reviews and monitors quality of care issues, identifying trends across the continuum of CalOptima Health's contracted providers, delegated health networks and organizational providers to ensure a commitment to member safety and delivering error-free outcomes. The CPRC, chaired by the CalOptima Health CMO or physician designee, consists of CalOptima Health Medical Directors and physician representatives from contracted health networks. Participants represent a range of practitioners and specialties from CalOptima Health's provider network. CPRC meets a minimum of six times per year and reports through the QIHEC

QAC 3.19.2026

quarterly. The voting member composition and quorum requirements of the CPRC are defined in its charter.

3.17. Utilization Management Committee (UMC)

The UMC promotes the optimal utilization of health care services while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in managing resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost-effectiveness of the care and services provided to members.

The UMC monitors the utilization of medical services and delegated health networks to identify areas of underutilization or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to ensure consistency in the application of nationally recognized criteria for medical necessity determinations. The committee also participates in the development of evidence-based clinical practice guidelines and completes an annual review, updating the guidelines to ensure they are in accordance with recognized clinical organizations, evidence-based, and comply with regulatory and other organizational standards. These clinical practice guidelines and nationally recognized evidence-based guidelines are approved annually, at a minimum, at the UMC. The UMC meets quarterly and reports to the QIHEC. The composition of UMC voting members (including a BH practitioner*) and the quorum requirements are defined in its charter.

* BH practitioner is defined as the Medical Director, clinical director or participating practitioner from the organization.

3.17.1. Pharmacy & Therapeutics (P&T) Committee

The P&T Committee is a forum for an evidence-based formulary review process. The committee promotes clinically sound and cost-effective pharmaceutical care for all CalOptima Health members. It reviews anticipated and actual drug utilization trends, parameters and results based on specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the committee reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving an interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima Health members. The P&T Committee includes practicing physicians (including both CalOptima Health employee physicians and participating provider physicians), and the membership represents a cross-section of clinical specialties and clinical pharmacists to adequately represent the needs and interests of all members. The P&T Committee provides written decisions regarding all formulary development decisions and revisions. The P&T Committee meets at least quarterly and reports to the UMC. The voting member composition and quorum requirements of the P&T Committee are defined in its charter.

OAC 3.19.2026

3.17.2. Benefit Management Subcommittee (BMSC)

The BMSC is a subcommittee of the Utilization Management Committee (UMC). The purpose of the BMSC is to oversee, coordinate and maintain a consistent set of benefits and benefit interpretations as it relates to CalOptima Health's responsibilities for administration of member benefits, prior authorization and financial responsibility requirements. The BMSC makes recommendations regarding revisions and updates to CalOptima Health's authorization rules based on benefit updates and makes recommendations regarding the need for prior authorization for specific services. The BMSC reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima Health staff, and are provided to contracted participating provider physicians. The Regulatory Affairs and Compliance department provides technical support to the subcommittee, which includes analyzing regulations and guidance that impact the benefit sets and CalOptima Health's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

3.18. Whole-Child Model Clinical Advisory Committee (WCM)

The WCM CAC advises on clinical and behavioral issues related to CCS-eligible conditions, including matters such as treatment authorization guidelines, and ensures that these guidelines are integrated into the design, implementation, operation and evaluation of the CalOptima Health WCM program. The WCM CAC works in collaboration with county CCS, CCS-paneled providers, RCOC, and the County of Orange Social Services Agency. The WCM CAC meets four times a year and reports to the QIHEC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

3.19. Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima Health. The MEMX committee was formed to ensure a strategic focus on the issues and factors that influence members' experience with the health care system. The MEMX committee assesses information and data directly from members, which includes the annual results of CalOptima Health's Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, member complaints, grievances and appeals. MEMX identifies opportunities to implement initiatives to improve our members' overall experience. The Network Adequacy and Timely Access Workgroups, which report to the MEMX committee, monitor a member's ability to get needed care and get care quickly, by monitoring the provider network, reviewing customer service metrics, and evaluating authorizations and referrals for "pain points" in health care that impact our members at the plan and health network level, where appropriate. The MEMX committee, which includes the Network Adequacy and Timely Access Workgroups, meets at least quarterly and is accountable for meeting regulatory requirements related to access and implementing targeted initiatives to

QAC 3.19.2026

improve the member experience and demonstrate significant improvement in subsequent CAHPS survey results.

3.20. Grievance and Appeals Resolution Services (GARS) Committee

The GARS Committee serves to protect the rights of members, promote the provision of quality health care services and ensure that the policies of CalOptima Health are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS Committee also serves to provide a mechanism to resolve provider complaints and appeals expeditiously for all CalOptima Health providers. It protects the rights of practitioners and providers by providing a fair and progressive multilevel process, leading to the resolution of provider complaints. The GARS Committee meets at least quarterly and reports to the QIHEC. The voting member composition and quorum requirements of the GARS Committee are defined in its charter.

3.21. Delegation Oversight Committee (DOC)

The Delegation Oversight Committee (DOC) is responsible for overseeing the delegated functions carried out by CalOptima Health's First Tier, Downstream, and Related Entities (FDRs), including health networks. The DOC monitors delegated FDR adherence to federal and state regulations, contractual requirements, and accreditation standards through regular audits, performance reviews, and risk assessments. It identifies compliance gaps, recommends appropriate corrective actions or sanctions, provides recommendations on the scope, frequency, and nature of delegate reporting, oversight, and auditing activities, and supports the development and implementation of corrective action plans. The DOC meets at least quarterly and communicates its findings and recommendations to the Compliance Committee. The voting member composition and quorum requirements of the DOC are defined in Policy HH.4001.

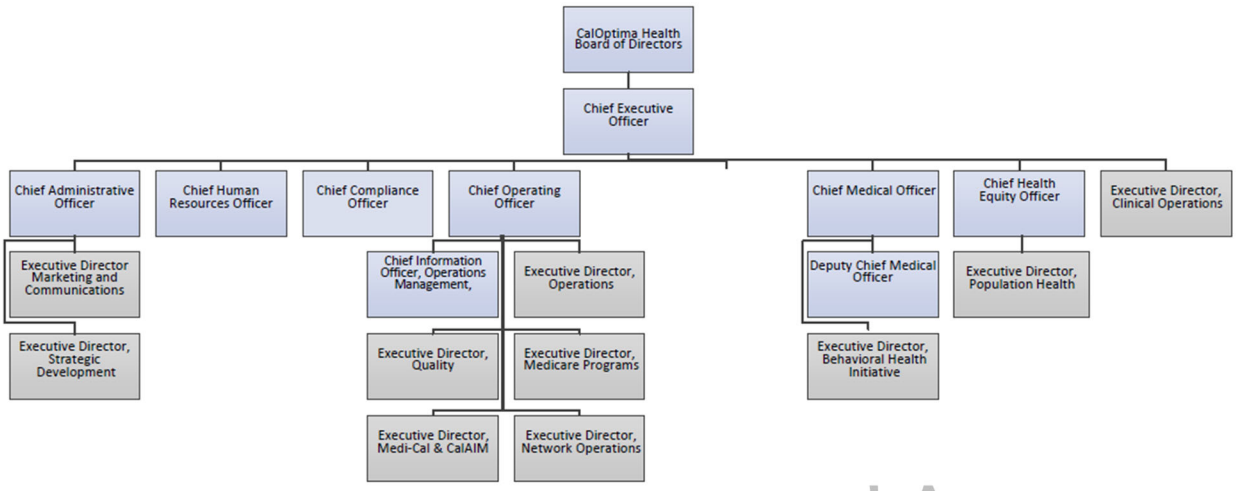
3.22. Compliance Committee

The Compliance Committee, chaired by the CCO, is composed of CalOptima Health's executive staff, including but not limited to the CEO, COO, CIO, CMO and CFO. The role of the Compliance Committee is to oversee and ensure the implementation of the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The Compliance Committee meets at least quarterly, or more frequently as necessary, to ensure reasonable oversight of the Compliance Program.

QAC 5.19.2026

4. CalOptima Health Organizational Structure

4.1. Organizational Chart — Diagram



CalOptima Health's QIHETP Support Positions and Job Descriptions (See Appendix A)

4.2. Organizational Structure

The Quality and Clinical Operations departments, along with CalOptima Health Medical Directors and multiple CalOptima Health departments, support the organization's mission and strategic goals. These areas oversee the processes to monitor, evaluate and implement the QIHETP, ensuring that members receive high-quality care and services. Below are the QIHETP's functional areas and responsibilities.

4.3. Organizational Resources

CalOptima Health's budgeting process includes personnel, information technology services resources, and other clinical and administrative costs projected for the QIHETP. These resources are regularly revisited to ensure adequate support for CalOptima Health's QIHETP.

The QIHE staff directly impacts and influences the QIHEC and related committees through monitoring, evaluation and interventions, and provides various committees with the outcomes and effectiveness of corrective actions. In addition to CalOptima Health's CEO, CMO, COO, CHEO and CHRO, Appendix B includes a list of CalOptima Health's staff positions that provide direct support for organizational and operational QIHETP functions and activities. In addition, CalOptima Health maintains enough administrative and clinical staff with the necessary knowledge and experience to assist and support the staff roles listed in Appendix B in carrying out their QIHETP responsibilities.

QAC 3.19.4

4.4. Staff Orientation, Training and Education

CalOptima Health seeks to recruit highly qualified individuals with extensive experience and expertise in the health services field. Qualifications and educational requirements are delineated in the respective position descriptions. Each new employee receives intensive orientation and job-specific training with a designated staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job descriptions:

- CalOptima Health New Employee Orientation and Boot Camp (CalOptima Health programs)
- HIPAA Rules and Compliance
- Fraud, Waste and Abuse
- Compliance and Code of Conduct Training
- Cybersecurity Awareness
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, fax machines, etc.)
- Applicable department program training, policies and procedures
- Diversity, Equity and Inclusion Training Program
    - Cultural Competency: The Foundation of Equitable Health Care
    - Diversity, Equity, Inclusion and Belonging
    - Health Equity Fundamentals
- Transgender, Gender Diverse, Intersex (TGI) Cultural Competency Training Program

Employees are required to complete annual compliance training courses on the topics listed above. The frequency of the training varies by topic and depends on the employee's job position. CalOptima Health encourages and supports continuing education and training for employees, which enhances their competency in their current roles and/or prepares them for career advancement within CalOptima Health. Each year, a specific budget is set for education reimbursement for employees.

5.5. Key Business Processes, Functions, Important Aspects of Care and Service

CalOptima Health provides comprehensive physical and BH care services based on the philosophy of a medical home for each member. The primary care provider serves as the medical home for members who previously found it challenging to access services within their community.

The important functional areas of care and service around which key business processes are designed include:

- Clinical care and service
- Credentialing and peer review

QAC 3.19.2026

- Cultural and Linguistic services
- Cultural Responsiveness
- BH care
- Access and availability
- Continuity and coordination of care
- Health Risk Assessment/Health Needs Assessment
- Special Needs Program Model of Care
- Transitions of care
- Value-Based Payment Programs
- Pediatric and Adult Wellness
- PIPs and CCIPs
- Prenatal and postpartum care
- Preventive care, including:
    - Initial Health Appointment
    - Behavioral Assessment
    - Immunizations
    - Blood Lead Screenings
- Diagnosis, care and treatment of acute and chronic conditions
- Care management, including complex care management
- Prescription drug services
- Hospice care
- Palliative care
- Major organ transplants
- Health education and promotion
- Disease management
- Member experience and satisfaction
- Patient safety

Administrative oversight:

- Delegation oversight
- Member rights and responsibilities
- Provider training
- Organizational ethics
- Effective utilization of resources, including monitoring of over- and under-utilization
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Fraud and abuse related to quality of care

CalOptima Health has a zero-tolerance policy for fraud and abuse, as required by applicable laws and regulatory contracts. Detecting fraud and abuse is a key function of the CalOptima Health program.

QAC 3.19.2026

5.5.1. Quality Improvement (QI) Department

The QI department fully aligns with departments throughout the organization to support the organizational mission, strategic goals and processes that monitor and drive improvements in quality of care and services. The QI department is responsible for coordinating the development and implementation of the QIHETP, which outlines the QIHE goals, objectives, and methods for evaluating and improving quality. It supports the QIHEC and subcommittees to ensure that all QIHETP activities are performed, integrated and communicated internally and to the contracted delegated health networks, thereby achieving the goal of improved care and services for members. The QI department plays a central role in ensuring that members receive high-quality, safe and effective care. It monitors quality care and service by ensuring that credentialing standards, policies, and procedures are implemented to provide a qualified provider network for our members, by conducting site reviews and by overseeing a systematic process that includes a review of potential quality issues (PQIs), or a suspected deviation from the standard of care, that involves CalOptima Health's Credentialing and Peer Review Committee. The QI department is also responsible for ensuring compliance with federal and state regulations and leads the effort in the timely submission of the NCQA Health Plan and Health Equity Accreditation Surveys.

5.5.2 Quality Analytics

The Quality Analytics (QA) department fully aligns with the QI and Equity and Community Health (ECH) teams to support the organizational mission, strategic goals, regulatory quality metrics, programs and processes. It monitors and drives improvements in the quality of care and services, ensuring that care and services are rendered appropriately and safely to all CalOptima Health members.

The QA department activities include the design, implementation, and evaluation of processes and programs to:

- Report, monitor and trend outcomes
- Conduct measurement analysis to evaluate goals, establish trends and identify root causes
- Establish measurement benchmarks and goals
- Support efforts to improve internal and external customer satisfaction
- Improve organizational quality improvement functions and processes for both internal and external customers
- Collect clear, accurate and appropriate data used to analyze the performance of specific quality metrics and measure improvement
- Coordinate and communicate organizational, health network and provider-specific performance on quality metrics, as required
- Participate in various reviews through the QIHETP, including but not limited to network adequacy, access to care and availability of practitioners
- Facilitate satisfaction surveys for members
- Incentivize health networks and providers to meet quality performance targets and deliver quality care

QAC 3.19.2026

- Design and develop member, provider and organization-wide initiatives to improve - quality of care

Data sources available for identifying, monitoring and evaluating opportunities for improvement and intervention effectiveness include but are not limited to:

- Claims data
- Encounter data
- Utilization data
- Care management reports
- Pharmacy data
- Immunization registry
- Lab data
- EMR supplemental data
- Population Needs Assessment
- HEDIS results
- Member and provider satisfaction surveys
- Timely Access Survey
- Provider demographic information

5.5.3. Equity and Community Health

The Equity and Community Health department is committed to advancing health equity by ensuring all members have a fair and just opportunity to achieve their highest level of health. Our approach embeds health equity into organizational structures and practices, is co-created with the community, and continuously refined through data and feedback. The department is dedicated to integrating health equity, member-centered care, meaningful community engagement, and data-driven decision-making throughout the organization.

5.5.4. Office of Compliance

The Office of Compliance is responsible for monitoring and driving interventions to ensure that CalOptima Health's QIHETP and quality-related activities align with applicable laws, regulations and internal policies and that providers and health networks meet state, federal and contract requirements. The Office of Compliance provides oversight of CalOptima Health's regulatory and compliance functions, including the development and amendment of CalOptima Health's policies and procedures to ensure adherence to regulatory and contract requirements. The Compliance staff monitors changes in regulatory requirements that impact quality measures and care delivery, and ensures timely updates to policies and procedures. The Compliance staff works in collaboration with the Audit & Oversight Department to conduct audits and monitor the implementation of quality activities, detecting noncompliance and risk. The Office of Compliance refers any potential noncompliance issues or trends encountered during audits of health providers, networks and other functional areas for investigation.

QAC 3.19.2026

5.5.5. Population Health Management

The Population Health Management (PHM) Program at CalOptima Health aims to deliver whole-person, safe, timely, efficient and equitable care across the member health care continuum and life span. To achieve this, PHM care coordination includes basic population health management, complex care management, ECM and transitional care services. PHM's streamlined care coordination interactions are designed to optimize member care, meeting their unique and comprehensive health needs.

The PHM Program and related services are developed by a multidisciplinary team of health professionals, community partners and stakeholders. Together, we ensure that our PHM Program is committed to health equity, member involvement and accountability by:

- Building trust and meaningful engagement with members
- Using data-driven risk stratification and predictive analytics to address gaps in care
- Revising and standardizing assessment processes
- Providing care management services for high-risk members
- Creating robust transitional care services to promote continuity of care and limit service disruptions
- Developing effective strategies to address health disparities, SDOH and upstream drivers of health
- Implementing interventions to support health and wellness for all members

CalOptima Health uses the PHM Framework to plan, implement and evaluate the PHM Program and our delivery of care. The information below outlines the key components used to operate the PHM Program, which include:

- Population needs assessment and PHM Strategy that are used to measure health disparities and identify the health priorities and social needs of our member population, including cultural and linguistic, access and health education needs
- Member information on preferences, strengths and needs to connect every member to services at the individual level, and to allocate resources
- Risk data to identify opportunities for more efficient and effective interventions
- Services and supports to address members' needs across a continuum of care

In 2026, the PHM Work Plan will continue to focus on meeting member needs through high-quality care delivery and service coordination. CalOptima Health identified opportunities to expand outreach and initiate new initiatives focused on improving health outcomes as follows:

- Improve access to preventive screenings and services for all CalOptima Health members, with a particular focus on pregnant/postpartum members and children.
- Enhance Disease Management programs to assist members with diabetes and other chronic conditions.
- Expand CalAIM Community Supports and the Street Medicine Program to connect members with whole-person care approaches and address social drivers of health.

QAC 3.19.2026

- Enhance follow-up care after Emergency Department visits related to mental health and alcohol and other drug abuse or dependence.
- Improve member experience for members who participate in PHM services like complex case management and disease management.

Further details of the PHM Program, activities and measurements can be found in the 2026 PHM Strategy (Appendix B).

5.5.6. Care Coordination and Care Management

CalOptima Health is committed to serving the needs of all members, placing additional emphasis on the management and coordination of care for the most vulnerable populations and members with complex health needs. Our goal is the delivery of effective, quality health care to members with special health care needs across settings and at all levels of care, including but not limited to physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification using data, including Health Risk Assessment (HRA) for OneCare and SPD members and Health Needs Assessment (HNA) for WCM members
- Multiple avenues for referral to care management and disease management programs or management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability for member to opt out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g., diabetes, asthma, etc.) through health education and member incentive programs
- Use of evidence-based guidelines distributed to providers who address chronic conditions prevalent in the member population (e.g., COPD, asthma, diabetes, etc.)
- Comprehensive initial assessment and evaluation of health status, clinical history, medications, functional ability, barriers to care, and adequacy of benefits and resources
- Development of ICPs for enrolled case management members that include input from the member, caregiver, PCP, specialists, social worker and providers involved in care management, as necessary
- Coordination of services for members for appropriate levels of care and resources
- Identification and follow-up for transitions
- Documentation of all findings
- Monitoring, reassessing and updating the plan of care to drive appropriate service quality, timeliness and effectiveness
- Facilitate consistent provider-patient relationships

CalOptima Health's Care Management (CM) program includes three care management levels that reflect the acuity of needs: complex case management, care coordination and basic case management. Members within defined models of care (WCM and OneCare) are risk-stratified upon enrollment using a plan-developed tool. This risk stratification informs the HRA/HNA

QAC 3.19.2026

Back to Agenda Back to Item

outreach process. The tool utilizes information from various data sources, including acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy records.

Qualifying members may be referred to ECM as appropriate.

5.5.6.1. Health Risk Assessment (HRA) and Health Needs Assessment (HNA)

The comprehensive risk assessment facilitates care planning and offers actionable items for the interdisciplinary care team (ICT). Risk assessments may be completed face-to-face, virtually, telephonically or in a paper-based format, accommodating threshold language preferences. Risk assessments for WCM and OneCare are completed initially and then annually.

5.5.6.2 Interdisciplinary Care Team (ICT)

The Interdisciplinary Care Team (ICT) facilitates the formal and informal collaborative process of developing, implementing and refining an Individualized Care Plan (ICP) that facilitates integrated, informed and synchronized communication to address the evolving needs and goals of each member. An ICT is linked to members to assist in care coordination and services to achieve the individual's health goals. If a meeting is required of the care team, the following individuals are always invited to the ICT meeting: the member (and caregivers or an authorized representative with the member's approval or appropriate authorization to act on the member's behalf) and the PCP. Other disciplines are included as needed, such as a Medical Director, specialist(s), care manager, BH specialist, pharmacist, social worker, palliative ICT, dementia care specialist, dietitian and/or long-term care manager. The ICT is designed to ensure that members' needs are identified and managed by an appropriately composed team.

- ICT meetings are facilitated by the health network case manager.
- The team is composed of the member, caregiver or authorized representative, health network Medical Director, PCP and/or specialist, care manager, BH specialist and social worker.
- The ICT coordinates and facilitates communication between members, PCP and specialists, as appropriate.
- An ICT meeting can be requested by a member or the member's PCP.

5.5.6.3 Individualized Care Plan (ICP)

The ICP is developed based on the needs of the member. The ICP is a member-centric plan of care that prioritizes goals and target dates. The ICP focuses on the needs identified in the risk assessment (HRA/HNA) and by the ICT. Barriers to meeting treatment goals are addressed. Interventions reflect the care manager's or member's activities required to meet the stated goals. The ICP has an established plan for monitoring outcomes and ongoing follow-up. The ICP is updated based on the member's clinical needs.

OAC 3.19.2026

5.5.6.4 Whole-Child Model (WCM)

The goal of care management for WCM is a single integrated system of care that provides coordination for CCS-eligible and non-CCS-eligible conditions. CalOptima Health WCM Case Management is a member and family-centered care approach to ensure needed clinical and non-clinical services for the CCS-eligible condition are made available to each WCM member through comprehensive, interdisciplinary, and person-centered care management and Care Coordination to provide case finding, authorizations for services and Care Coordination to ensure that WCM members have access to CCS-paneled providers, equipment and medically necessary services. The model uses risk stratification to identify members who have more complex health care needs to outreach for an HNA. A collected HNA informs the ICP development and the ICT.

Further details of the WCM care coordination program, activities and measurements can be found in the UM/CM Integrated Program Description.

5.5.7. Utilization Management

Utilization Management (UM) oversees coverage of health care services, treatments and supplies for all lines of business based on the terms of the plan and member eligibility at the time of service. Services, treatments and supplies are available and accessible to all members, including those with LEP or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. Decisions are made based on medical necessity. Medically necessary services are those that are provided to a member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the member's condition, disease, illness or injury; (iii) not primarily for the convenience of the member or health care provider; and (iv) not more costly than an alternative service, or suite of services, and at least as likely to produce equivalent results.

The use of evidence-based, peer-reviewed and industry-recognized criteria ensures that medical decisions are not influenced by fiscal and administrative management considerations. As described in the UM/CM Integrated Program Description, all review staff are trained and audited in these principles. Licensed clinical staff review and approve requested services based on medical necessity, utilizing evidence-based review criteria. Requests that do not meet the medical necessity criteria are reviewed by a Medical Director or another qualified reviewer, such as a licensed psychologist or clinical pharmacist.

Further details of the UM Program, activities and measurements can be found in the UM/CM Integrated Program Description.

QAC 3.19.2026

5.5.8. Behavioral Health (BH)

CalOptima Health is responsible for providing quality BH across the continuum of care, including mental health, substance use services and BH treatment, including applied behavioral analysis. BH Integration (BHI) focuses on prevention, recovery, resiliency and rehabilitation. As part of the QIHETP, with direction and guidance from the QIHEC, BHI and other supporting departments, continue to monitor the BH care that CalOptima Health provides our members and continue to seek ways to improve BH care.

CalOptima Health's BH Medical Director provides clinical and administrative leadership for all behavioral health services while ensuring regulatory compliance with state and federal requirements like Medi-Cal and the CalAIM initiative. Key responsibilities include overseeing utilization management (UM) and quality improvement (QI) programs, making clinical coverage determinations for treatment requests and appeals, and engaging in peer-to-peer consultations with network providers. A crucial part of the position involves leading the integration of BH and physical health by collaborating with medical directors and other departments to develop and implement whole-person care strategies, manage co-occurring conditions, and ensure seamless coordination of care across primary care and specialty settings. This leader also develops clinical policies, educates staff and providers on best practices, and uses data analysis to enhance program effectiveness and achieve quality outcomes for members.

BHI quality team functions and coordinates with the broader Quality Department. The BHI quality team plays a central role in identifying behavioral health (BH) care gaps and driving targeted interventions.

Sr. Manager II of Quality and Programs, Behavioral Health Integration, is directly involved in:

- Leading BHI quality team meetings
- Coordinating with the Director and the Executive Director of BHI on strategic decisions
- Overseeing policy development and compliance processes with the Office of Compliance

The work is grounded in continuous data monitoring through tools such as HEDIS, Stars metrics, internal dashboards, and root cause analysis to uncover systemic barriers to care.

BHI has clinical auditor positions that support both BHI and other departments as subject matter experts for the BHT/ABA benefit and program. They are both internal and external facing. Some key functions include reviewing treatment plans to identify areas that drive best practices, developing training materials, facilitating training sessions to improve quality upstream, and developing audit tools to ensure consistency in decision-making for BH UM.

The BHI UM department staff participate in the yearly IRR along with other departments that are responsible for UM to support consistency of application in nationally recognized criteria for making medical necessity determinations, as well as development of evidence-based clinical practice guidelines, and complete an annual review and update the clinical practice guidelines to

QAC 3.19.2026

make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other organization standards.

BHI has a BHQI workgroup that meets monthly and consists of the BH medical director, other medical directors, the Executive Director, the Director of BH, the quality leadership team, and other member- and provider-facing departments. The overall purpose is to review BHI quality opportunities and interventions. Goals include analyzing the effectiveness of existing interventions for quality improvement and reporting, as well as collaboration in the development of new interventions when necessary.

The BHQI (Behavioral Health Quality Improvement) workgroup is a monthly convening that includes:

- The BH Medical Director and other internal medical directors
- Executive Director and Director of Behavioral Health Integration
- Quality leadership team
- Leadership from member- and provider-facing departments

This multidisciplinary composition ensures that both clinical and operational perspectives are integrated into quality improvement efforts.

The workgroup's stated mission is to:

- Review BHI quality opportunities and interventions
- Analyze the effectiveness of existing interventions
- Work collaboratively to develop innovative strategies that enhance member engagement, address care gaps, and support comprehensive whole-person health

This is consistently reflected in meeting agendas, coaching documentation, and internal communications within the organization.

5.5.8.1 Medi-Cal Behavioral Health (BH)

CalOptima Health provides outpatient mental health services to members with mild to moderate impairment in mental, emotional, or behavioral functioning. These services include:

- Individual, group, and family psychotherapy
- Psychological testing to evaluate mental health conditions
- Psychiatric consultation
- Medication management
- Behavioral Health Treatment (BHT) for children under 21
- Transcranial Magnetic Stimulation (TMS) when clinically indicated

Members with severe BH impairment needs are referred to the Orange County Behavioral Health Plan (BHP) for specialty mental health services.

QAC 3.19.2026

In addition, CalOptima Health covers behavioral health treatment (BHT)/applied behavior analysis (ABA) for members 20 years of age and younger who meet medical necessity criteria. BHT/ABA services are provided under a specific behavioral treatment plan that has measurable goals over a specific time frame. CalOptima Health provides direct oversight, review and authorization of BHT/ABA services.

CalOptima Health offers Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment (SABIRT) services at the PCP setting to members 11 years and older, including pregnant women. When a screening is positive, providers conduct a brief assessment. Brief counseling on misuse is offered when unhealthy alcohol or substance use is detected. Appropriate referral for additional evaluation and treatment, including medications for addiction treatment, is offered to members whose brief assessment demonstrates probable alcohol use disorder (AUD) or substance use disorder (SUD).

CalOptima Health members can access mental health services directly, without a physician referral. A CalOptima Health representative will conduct a brief mental health telephonic screening to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to BH practitioners within the CalOptima Health provider network. If the member has moderate to severe impairments, the member will be referred to specialty mental health services through the BHP.

CalOptima Health's approach to care coordination emphasizes the framework below:

- Integrated care management for members with complex needs, including those with co-occurring physical and behavioral health conditions.
- Standardized member identification using Health Risk Assessments (HRAs) and claims data.
- Multidisciplinary care planning involves PCPs, specialists, social workers, and behavioral health providers.

CalOptima Health directly manages all administrative functions of the Medi-Cal mental health benefits, including UM, claims, credentialing the provider network, member services and quality improvement.

5.5.8.2 OneCare Behavioral Health

OneCare covers inpatient and outpatient behavioral health services through a directly contracted behavioral health network. OneCare BH continues to be fully integrated within CalOptima Health internal operations. Services include psychotherapy, medication management, psychological testing, intensive outpatient program, partial hospitalization program, opioid treatment program, electroconvulsive therapy and transcranial magnetic stimulation.

OAC 3.19.2026

5.5.9. OneCare Dual Eligible Special Needs Plan (D-SNP) Model of Care (MOC)

The MOC is a document required by CMS for a D-SNP. The MOC defines the care management policies, procedures and operational systems for OneCare. It is "member-centric" with the ongoing focus on the member and the member's family/caregiver.

The MOC goals are:

- Improve coordination of care
- Appropriate utilization of services for preventive health and chronic conditions
- Improving member experience
- Enhanced care transitions across all health care settings and providers

CalOptima Health's D-SNP care management program includes but is not limited to:

- Initial Health Risk Assessment and annual reassessment for each enrollee
- Individualized Care Plan
- Interdisciplinary Care Team
- Transition of Care Protocols

6. Program Documents

6.1. Quality Improvement and Health Equity Transformation Program Work Plan

The QIHETP Work Plan outlines key activities for the year. It is reviewed and approved by the QIHEC and the Board of Directors' QAC. The QIHETP Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QIHETP Work Plan is monitored by CalOptima Health throughout the year. A QIHETP Work Plan addendum may be established to address the unique needs of members, newly identified problems or trends, actions taken to improve care where deficiencies are identified, and follow-up as indicated.

The QIHETP Work Plan is the operational and functional component of the QIHETP and is based on CalOptima Health priorities, the most recent and trended HEDIS, CAHPS, Health Equity and Quality Data (HEQMS), Quality Rating System (QRS) data, physician quality measures and other measures identified for attention, including any specific requirements mandated by contracts, regulatory agencies or accreditation standards. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

The QIHETP guides the development and implementation of an annual QIHETP Work Plan, which includes but is not limited to:

- Quality of clinical care

QAC 3.19.2026

- Safety of clinical care
- Quality of service
- Member experience
- Health equity
- Culturally and linguistically appropriate services
- QIHETP oversight
- Yearly objectives with goals
- Population of focus
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QIHETP

Priorities for QIHE activities based on CalOptima Health's organizational needs and specific needs of CalOptima Health's populations, for key areas or issues, are identified as opportunities for improvement. In addition, ongoing review and evaluation of the quality of individual care aids in the development of QI studies based on quality-of-care trends identified. These activities are included in the Quality Improvement Project (QIP), Performance Improvement Project (PIP), Plan-Do-Study-Act (PDSA) cycle, and Chronic Care Improvement Projects (CCIP). They are reflected in the QIHETP Work Plan.

The QIHETP Work Plan supports the comprehensive annual evaluation and planning process, which includes reviewing and revising the QIHETP and applicable policies and procedures. The QIHETP Work Plan encompasses all quality improvement focus areas, goals, improvement activities, progress toward these goals, and associated timeframes. Planned activities include strategies to improve access to care, service delivery, quality of care, and over- and under-utilization, as well as member population health management. All goals will be measured and monitored in the QIHETP Work Plan, reported to QIHEC on a quarterly basis, and evaluated annually. A copy of the current QIHETP Work Plan is publicly available on the CalOptima Health website.

For the annual QIHETP Work Plan, see Appendix A.

6.2. Quality Improvement and Health Equity Program Evaluation

The objectives, scope, organization and effectiveness of CalOptima Health's QIHETP are reviewed and evaluated annually by the QIHEC and QAC, and approved by the Board of Directors, as reflected in the QIHETP Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and are incorporated into the QIHETP Work Plan and reported on an annual basis. In the evaluation, the following are reviewed:

- A description of completed and ongoing QIHE activities that address the quality and safety of clinical care and quality of services, including the achievement or progress

QAC 3.19.2026

toward goals, as outlined in the QIHETP Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance, including aggregate data on utilization.
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of the effectiveness of QIHE activities, including QIPs, PIPs, PDSAs and CCIPs.
- An evaluation of the effectiveness of member satisfaction surveys and initiatives.
- A report to the QIHEC and QAC summarizing all quality measures and identifying significant trends.
- A critical review of the organizational resources involved in the QIHETP through the CalOptima Health strategic planning process.
- Recommended changes included in the revised QIHETP Description for the subsequent year for QIHEC, QAC and the Board of Directors' review and approval.

A copy of the most recent QIHETP Evaluation is publicly available on the CalOptima Health website.

6.3. Review and Approval of Program Documents

On an annual basis, the QIHETP Description, QIHETP Work Plan, and QIHETP Evaluation are presented to the CalOptima Health Board of Directors and the Board of Directors' QAC for review and approval. The QAC is a Board committee that comprises a subset of the members of the Board of Directors and is responsible for the direction of the program and actively evaluates the annual plan to determine areas for improvement. Board of Directors comments, actions and responsible parties assigned to implement changes are documented in the Board of Directors meeting minutes.

7. Quality Improvement and Health Equity Processes

7.1. QIHE Project Selection and Focus Areas

Performance and outcome improvement projects identified through continuous internal monitoring activities will be selected from the following areas:

- Potential quality issue (PQI) review processes
- Provider and facility reviews
- Preventive care audits
- Access to care studies
- Member experience surveys
- HEDIS results
- NCQA Health Plan and Health Outcomes Standards
- NCQA Health Plan Rating measures

QAC 3.19.2026

- Other opportunities for improvement as identified by QIHEC and/or the subcommittee's data analysis

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, behavioral health (mental health/substance abuse disorder), emergency services, inpatient services, ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Continuity of care for members
- Provisions of chronic care services
- Access to and provision of preventive services

Improvements in work processes, quality of care and service are derived from all levels of the organization. For example:

- Staff, administration and physicians provide vital information necessary to support continuous performance improvement and occur at all levels of the organization.
- Individuals and administrators initiate improvement projects within their area of authority that support the strategic goals of the organization.
- Other prioritization criteria include the expected impact on performance (if the performance gap or potential risk for non-performance is so great as to make it a priority), and items deemed to be high-risk, high-volume or problem-prone processes.
- Project coordination occurs through the various leadership structures: Board of Directors, management, QIHEC, UMC, etc., depending on the scope of work and impact of the effort.

CalOptima Health collaborates with delegated business partners to coordinate QI activities for all lines of business through the following:

- Monthly Health Network Forums
- Quarterly Health Network Collaborative Quality Forums
- Biannual Joint Operation Meetings (JOM) with health networks.

These improvement efforts are often cross-functional and require dedicated resources to assist in data collection, analysis and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

QAC 3.19.2026

7.2. QIHE Project Measurement Methodology

Methods for the identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be used. QI Projects shall include the following:

- Measurement of performance using objective quality indicators
- Implementation of equity-focused interventions to achieve improvement in the access to and quality of care
- Evaluation of the effectiveness of the intervention based on the performance measures
- Planning and initiation of activities for increasing or sustaining improvement

For outcomes studies or measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5%–10% oversampling) to conduct statistically significant tests on any changes. Exceptions apply to studies for which the target population total is less than 411 and to certain HEDIS studies whose sample size is reduced from 411 based on CalOptima Health's previous year's score. Also, a smaller sample size may be appropriate for QI pilot projects that are designed as small-scale tests of change using the rapid improvement cycle methodology. For example, a pilot sample of 30% or 100% of the sample size when the target population is less than 30 can be statistically significant for QI pilot projects.

The PDSA model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement.

2) Define baseline.

3) Describe root cause(s) including barrier analysis.

4) Develop an action plan.

Do 5) Communicate the change plan.

6) Implement the change plan.

Study 7) Review and evaluate the result of the change.

8) Communicate progress.

Act 9) Reflect and act on learning.

10) Standardize the process and celebrate success.

11) As needed, initiate corrective action plan(s), which may include enhanced monitoring and/or re-measurement activities.

7.3. Types of QIHE Projects

CalOptima Health implements several types of improvement projects, including QIPs, PIPs, CCIPs and PDSAs, to improve processes and member outcomes. For each QI Project, specific interventions are developed and implemented to achieve the stated goals and objectives. Interventions for each project must:

QAC 3.19.2026

- Be clearly defined and outlined;
- Have specific objectives and timelines;
- Specify responsible departments and individuals.
- Be evaluated for effectiveness; and
- Be tracked by QIHEC;

For each project, there are specific system interventions that have a reasonable expectation of affecting long-term or permanent performance improvement. System interventions include education efforts, policy changes, development of practice guidelines (with appropriate dissemination and monitoring) and other plan initiatives. Additionally, provider- and member-specific interventions, such as reminder notices and informational communications, are developed and implemented.

7.4. Improvement Standards

Demonstrated Improvement: Each project is expected to demonstrate improvement over baseline measurement on the specific quality measures selected. In subsequent measurements, evidence of significant improvement over the initial performance of the measure(s) must be sustained over time.

Sustained Improvement: Sustained improvement is documented through the continued remeasurement of quality measures for at least one year after the improved performance has been achieved.

Once the requirement for both demonstrated and sustained improvement on a given project has been met, there are no other regulatory reporting requirements related to that project. CalOptima Health may choose to continue the project or pursue another topic.

7.5. Documentation of QIHE Projects

Documentation of all aspects of each QIHE Project is required. Documentation includes but is not limited to:

- Project description, including relevance, literature review (as appropriate), source and overall project goal
- Description of the target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality measures). Where data elements are process measures, there must be documentation that the process indication is a valid proxy for the desired clinical outcomes
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater-to-standard validation review results

QAC 3.19.2026

- Measurable objectives for each quality measure
- Description of all interventions, including timelines and responsibility
- Description of benchmarks
- Remeasurement sampling, data sources, data collection and analysis timelines
- Evaluation of remeasurement performance on each quality measure

7.6. Communication of QIHE Activities

Results of performance improvement and collaborative activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups and will be reflected on the QIHETP Work Plan or calendar. The QIHE subcommittees will report their summarized information to the QIHEC at least quarterly to facilitate communication along the continuum of care. The QIHEC reports activities to the Board of Directors' QAC, through the CMO or designee, on a quarterly basis. Communication of QIHE trends to CalOptima Health's contracted entities, practitioners and providers is through the following:

- Practitioner participation in the QIHEC and its subcommittees
- Health Network Forums, Medical Directors' Meetings, Health Network Collaborative Quality Forums, Joint Operations Meetings (JOMs)
- MAC and PAC
- Other ongoing ad hoc meetings

8. Quality Improvement Initiatives

8.1. Quality of Care

8.1.1. Quality Analytics

By analyzing data that CalOptima Health currently receives (e.g., claims data, pharmacy data and encounter data) in the data warehouse, Quality Analytics staff identify members for quality improvement and access to care interventions, to support improved health care as well as HEDIS scores and CAHPS results. This information will guide CalOptima Health and our delegated health networks in identifying gaps in care and metrics requiring improvement. Examples of quality care analyses include:

- Pediatric and Adolescent Wellness: Children's Preventive and Screening Services
- Evaluation of Maternal and Child Health: Prenatal and Postpartum Services
- Adult Wellness: Preventive and Screening Services
- Medication Management
- BH: Care Coordination and Follow-up
- Performance Improvement Projects (PIPs)
- Chronic Care Improvement Projects (CCIPs)
- Improve Timely Access: Appointment Availability/Telephone Access

QAC 3.19.2026

8.1.1.1. Encounter Data Validation

Accurate and complete encounter data are crucial for assessing quality, monitoring program integrity, and making informed financial decisions. CalOptima Health's health networks must submit complete, timely, reasonable and accurate encounter data that adheres to the guidelines specified in the companion guides for facility and professional claim types, as well as the data format specifications. A health network submits encounter data through the CalOptima Health File Transfer Protocol (FTP) site.

As directed by DHCS, CalOptima Health participates in the External Quality Review Organization's (EQRO) validation of encounter data from the previous 12 months. DHCS releases the results of the validation study annually in DHCS's yearly Encounter Data Validation Study Report. CalOptima Health reviews the report and extracts key findings from medical record reviews on encounter data completeness and accuracy to identify opportunities for improvement.

8.1.2. Comprehensive Credentialing Program

The comprehensive credentialing process is designed to provide primary source verification (PSV) of a practitioner's qualifications, experience and competencies, to ensure the individual meets established standards for credentialing and recredentialing. PSV includes but is not limited to licensure, education, training, board certification, work history and professional background, to validate elements of competency of practitioners working within the CalOptima Health contracted delivery system. CalOptima Health contracts with an NCQA-certified Credentialing Verification Organization to assist with the credentialing process, which involves vetting practitioners and organizational providers.

Practitioners are credentialed and recredentialed according to regulatory and accreditation standards (CMS, DMHC and NCQA) and are verified to be in good standing in Medicare and Medi-Cal programs. The scope of the credentialing program includes, but is not limited to, licensed Medical Doctors (MDs), Doctors of Osteopathy (DOs), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic (DC), Doctor of Dental Surgery (DDS), Doctor of Medical Dentistry (DMD), Advance Practice Professional (APP), Certified Nurse Midwife (CNM), Clinical Nurse/Specialist, Nurse Practitioner, Physician Assistant, including Optometrist, Physical Therapist, Occupational Therapist, Speech and Language Therapist, Audiologist, and behavioral health practitioners, including Psychiatrists, Addiction Medicine Specialists, Psychologists, Clinical Social Workers (master's level), and Psychiatric Nurse Practitioners as well as medical group entity, where applicable, both in the delegated and CalOptima Health direct contract environments. Credentialing and recredentialing activities are performed at CalOptima Health and/or are delegated to health networks and other delegates.

CalOptima Health performs credentialing and recredentialing of organizational providers, including but not limited to acute care hospitals, home health agencies, skilled nursing facilities,

QAC 3.19.2026

Back to Agenda Back to Item

free-standing surgery centers, and dialysis centers. The intent of this process is to assess that these entities meet regulatory requirements, comply with standards for quality of care and are in good standing with state and federal agencies.

CalOptima Health recredentials providers every 36 months. Between recredentialing cycles, CalOptima Health conducts ongoing monitoring of sanctions, which include but are not limited to state or federal sanctions, exclusions, debarments, or other restrictions on licensure or limitations on the practice of medicine, including Medicare and Medicaid participation and eligibility, quality concerns, and member complaints. At recredentialing, CalOptima Health considers PVS, QI elements and other performance monitoring activities into consideration during the review process.

8.1.3. Facility Site, Medical Record and Physical Accessibility Reviews

CalOptima Health does not delegate facility site, medical record or physical accessibility reviews to other managed care plans. CalOptima Health assumes responsibility for conducting and coordinating facility site reviews (FSRs) and medical record reviews (MRRs) for delegated health providers and networks. CalOptima Health retains coordination, maintenance and oversight of the FSR/MRR process. CalOptima Health collaborates to coordinate the FSR/MRR process, minimizing duplication of site reviews and supporting consistency in site reviews for shared providers.

CalOptima Health completes initial site reviews and subsequent periodic FSR, MRR and Physical Accessibility Review Surveys (PARS), per DHCS requirements for all contracted primary care provider (PCP) sites that participate in the provider network, regardless of the status of a site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% on the FSR Site Review Tool. This requirement is waived for pre-contracted provider sites that have documented proof of another local managed care plan completing a site review with a passing score within the past three years. This is in accordance with the DHCS All Plan Letter (APL) 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review and CalOptima Health policies. An initial medical record review shall be completed within 90 calendar days from the date that members are first assigned to the provider. An additional 90-day extension may be allowed only if the provider does not have enough assigned members to complete a review of the required number of medical records. Subsequent site reviews, consisting of an FSR, MRR and PARS, are conducted at least every three years, beginning no later than three years after the initial FSR and at least every three years thereafter. Minimum passing score for FSR and MRR is 80%.

CalOptima Health may review sites more frequently, as per local collaborative decisions or when deemed necessary based on monitoring, evaluation, or follow-up issues related to a corrective

QAC 3.19.2026

action plan (CAP). If the provider site does not meet compliance with review criteria and CAP requirements within the established CAP timeline and/or fails the FSR or MRR on its third consecutive attempt, no CAP will be issued, and the provider site will be removed from CalOptima Health's provider network. If terminated, a provider site may reapply for participation in the CalOptima Health provider network after three years from the effective date of the termination.

CalOptima Health conducts additional DHCS-required reviews for assessing the level of physical accessibility for PCP sites, high-volume specialty sites, providers of ancillary services, and CBAS centers that serve a high volume of SPDs. Results from the PARS include the level of access met at each provider site and are displayed on the CalOptima Health provider directory. The PARS identifies whether each provider site has or does not have access in the following categories:

- Parking
- Building interior and exterior
- Restroom
- Exam room
- Exam table/scale
- Participant areas
- Patient diagnostic and treatment use
- Medical equipment

8.1.4. Medical Record Documentation

The medical record provides legal proof that the member received care. CalOptima Health requires that contracted and delegated health networks ensure each member's medical record is maintained in an accurate, current, detailed, organized, and easily accessible manner. Medical records are reviewed for format, adherence to legal protocols, and documented evidence of the provision of preventive care, as well as coordination and continuity of care services. All data should be filed in the medical record in a timely manner (i.e., lab, X-ray, consultation notes, etc.).

The medical record should provide appropriate documentation of the member's medical care in a manner that facilitates communication, coordination, and continuity of care, promoting the efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by state and federal laws and regulations, and the requirements of CalOptima Health's contracts.

The medical record should be protected to ensure that medical information is released only in accordance with applicable federal and state laws, and must be maintained by the provider for a minimum of 10 years.

QAC 3.19.2026

8.1.5. Corrective Action Plan(s) to Improve Quality of Care and Services and Implementation and Evaluation of Interventions to Reduce Health Disparities

When monitoring by CalOptima Health's QI department, Audit & Oversight department, or other functional areas identifies an opportunity for improvement, the department or functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Delegation Oversight department, as overseen by the Delegation Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima Health's functional areas are reported to QIHEC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams using continuous improvement tools (i.e., quality improvement plans or PDSA) to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.
- Formal or informal discussion of the data/problem with the involved practitioner/provider, either in the respective committee or by a Medical Director.
- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures when the monitoring and evaluation results may indicate problems that can be corrected by changing policy or procedure.

8.1.6. Quality Performance Measures

CalOptima Health collects, tracks, and reports all quality performance measures on an annual basis. Measure rates are validated by an NCQA-certified auditor and reported to NCQA and other entities as required.

8.1.6.1. HEDIS® Measures

CalOptima Health's Health Care Effectiveness Data and Information Set (HEDIS) are collected from various data sources, including claims and encounters, lab data, pharmacy data, state registry and claims data, medical charts and supplemental data from our plan partners. Surveys are conducted annually, and results are audited by an NCQA-approved external survey organization. Results are used by CalOptima Health to measure progress toward meeting goals and objectives, improve the quality, equity, and value of health care services, and to develop quality improvement strategies, goals, objectives and activities.

8.1.6.1.1. OneCare Stars

CalOptima Health's OneCare program is required to participate in the CMS Star Rating program each year. This program comprises more than 40 quality measures, including HEDIS measures, member survey measures such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Health Outcomes Survey (HOS), administrative measures, and

QAC 3.19.2026

pharmacy measures. To ensure high quality and continued improvement of these measures, CalOptima Health has extensive strategies and initiatives, including a Stars Executive Steering Committee, several working sessions with various departments, member experience improvement work groups, and regular meetings with health network partners and providers.

8.1.6.1.2. Medi-Cal Managed Care Accountability Set (MCAS)

CalOptima Health annually collects, tracks, and reports all MCAS measures as required by DHCS. Through various initiatives, CalOptima Health consistently seeks improvement in measure rate performance and improved member health outcomes. These initiatives include regular meetings with health networks and providers, inclusion of MCAS measures held to the minimum performance levels in the CalOptima Health Pay for Value program, and member health rewards. Performance is tracked at least monthly, and initiatives are launched strategically throughout the year to address performance gaps.

8.1.6.2. Disparities Reduction Program, Including Collection of Member Demographic Data

CalOptima Health fosters a culture of equity within its health plan operations and through its participating providers. CalOptima Health shall maintain a disparities reduction program, including the collection of member demographic data, stratification of quality measures by demographic factors, and implementation and evaluation of interventions to reduce health disparities. CalOptima Health's disparities reduction program shall be subject to review by Covered California annually to evaluate compliance with the requirements set forth in its contract. CalOptima Health shall conduct quality improvement and disparities reduction activities compliant with federally required Quality Improvement Strategy (QIS) requirements.

8.1.6.3. Value-Based Payment Program

CalOptima Health's Value-Based Payment Performance Program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health networks, including CHCN, and delegated health networks' primary care providers are eligible to participate in the Value-Based Payment Programs. CalOptima Health has adopted the Integrated Healthcare Association pay-for-performance methodology to assess performance.

CalOptima Health launched the Behavioral Health Pay-for-Value Programs (July 2024 through December 2027) to improve care for members receiving mental health and BHT services. This initiative reflects our ongoing commitment to improving behavioral health outcomes and value-based care. It uses a performance-driven, prospective pay-for-value model that features incentives for mental health providers and Applied Behavior Analysis (ABA) providers to meet specific quality metrics.

OAC 3-19-2026

8.1.6.4 Hospital Quality Program 2023–2027

CalOptima Health has developed a hospital quality program to enhance the quality of care for members by implementing increased patient safety efforts and performance-driven processes. The hospital quality program utilizes public measures reported by CMS and The Leapfrog Group for quality outcomes, patient experience and patient safety. Hospitals may earn annual incentives based on achieving benchmarks.

8.2. Access to Care

Access to care is a major area of focus for CalOptima Health and the organization has dedicated significant resources to measuring and improving access to care.

CalOptima Health participates in the following to monitor and improve network adequacy and access to our members:

- Annual Network Certification (ANC) with DHCS
- Subcontracted Network Certification (SNC) with DHCS
- Network Adequacy Validation with the External Quality Review Organization (EQRO)
- Network Adequacy Monitoring with CMS
- Annual Timely Access Survey

CalOptima Health monitors the following to ensure that we have robust provider networks for our members to access care and that members have timely access to care from primary and specialty health care providers and services.

8.2.1. Availability of Primary Care Providers (PCPs) by Language

CalOptima Health monitors member and provider demographics, threshold languages, and the availability of PCPs and clinic staff quarterly to oversee the language landscape within the network. CalOptima Health supports the provision of care to members in their preferred language and promotes network development to ensure access and availability of PCPs by language. Providers can share PCP and clinic staff languages through various processes throughout the year. Information is accessible to members on the provider search tool or via requests.

8.2.2. Availability of Practitioners

CalOptima Health monitors the availability of PCPs, specialists and BH practitioners and assesses them against established standards quarterly or when there is a significant change to the network. The performance standards are based on CMS, DHCS and NCQA and industry benchmarks. CalOptima Health has established quantifiable standards for both the number and geographic distribution of its network of practitioners. CalOptima Health utilizes a geographic mapping application to assess its geographic distribution. Data is tracked, trended, and used to inform provider outreach and recruiting efforts.

QAC 3.19.2026

8.2.3. Appointment Access

CalOptima Health monitors appointment access for PCPs (including Federally Qualified Health Centers and Community Clinics), specialists, BH providers and ancillary groups and assesses them against established standards at least annually. To measure performance, CalOptima Health collects appointment access data from practitioner offices using a timely access survey. CalOptima Health also evaluates grievances and appeals data quarterly to identify potential issues with access to care. A combination of both these activities helps CalOptima Health identify and implement opportunities for improvement.

Providers who do not meet timely access standards are re-measured and tracked. Follow-up action may include education, enhanced monitoring and/or issuance of a corrective action, as well as potential sanctions.

8.2.4. After-Hours Access to Care

CalOptima Health monitors PCP after-hours care in accordance with DHCS and NCQA standards to ensure members have proper access to care after hours on an annual basis. CalOptima Health's Access and Availability policies include after-hours phone access. CalOptima Health surveys providers on BH follow-up care, emergency instructions for callers, and the availability of on-call providers. To ensure members know how to access care after hours, CalOptima Health publishes and distributes educational materials for members describing appropriate use of their PCP, minute care, urgent care and the emergency room (ER). A provider directory is available online.

Additionally, CalOptima Health nurse advice line is available 24/7 to assist members with access to care after hours. CalOptima Health monitors access to the nurse advice line in accordance with NCQA standards on a quarterly basis.

8.2.5. Telephone Access to CalOptima Health Staff

CalOptima Health monitors access to its Customer Service department and nurse advice line on a quarterly basis. To ensure that members can access their provider via telephone to obtain care, CalOptima Health monitors access to ensure members have access to their PCP during business hours. Providers not meeting timely access standards are remeasured and tracked, and follow-up action may include education, enhanced monitoring, issuance of a corrective action and potential sanctions.

8.3. Member and Provider Satisfaction

8.3.1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CalOptima Health participates in the CAHPS program to better understand our members' experience and improve the quality of care. Results are used to measure progress, improve quality, reduce disparities, and improve health equity and outcomes. Focus is placed on

QAC 3.19.2026

coordinating efforts intended to improve performance on CAHPS survey items for both the adult and child populations.

8.3.2. Member Satisfaction Studies

Improving member experience is a top priority of CalOptima Health and has a strategic focus on the issues and factors that influence the member's experience with the health care system.

CalOptima Health evaluates and assesses member-reported experiences to determine how well plan providers are meeting members' expectations and goals. Annually, CalOptima Health fields the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Focus is placed on coordinating efforts intended to improve performance on CAHPS survey items for both the adult and child populations.

CalOptima Health conducts comprehensive BH surveys and analyses annually to assess member satisfaction regarding BH services. Two separate surveys are administered: the Behavioral Health Member Satisfaction: Applied Behavior Analysis (ABA) Services Survey and the Behavioral Health Member Satisfaction: Mental Health (MH) Services Survey. The MH version of the survey assesses both psychotherapy and medication services, whereas the ABA version is solely for ABA services. The survey questions focus on telehealth services, access to services, treatment experience and overall experience.

Additionally, CalOptima Health reviews customer service metrics and evaluates complaints, grievances, appeals, authorizations and referrals to identify "pain points" that impact members at both the plan and health network levels.

8.3.3. Grievances and Appeals

CalOptima Health has a process for reviewing member and provider complaints, grievances and appeals. Grievances and appeals are tracked and trended on a quarterly basis to assess the timeliness of acknowledgment and resolution, as well as issue types and provider types. The grievance and appeals process includes a thorough investigation and evaluation to ensure timely access to care and the delivery of quality care and/or services. In this process, potential quality of care issues are identified and referred to an appropriately licensed professional for evaluation and further management of clinical issues, such as the timeliness, access and appropriateness of care, including a review of the clinical judgments involved in the case. The quarterly report is presented and reviewed by the GARS Committee, which reports to the QIHEC on a quarterly basis.

8.3.4. Provider Satisfaction

CalOptima Health monitors performance areas affecting provider satisfaction to assess the satisfaction experienced by CalOptima Health's network of PCPs and BH providers, such as network adequacy, provider call center trends, provider complaints and provider surveys. The information obtained is used to measure how well the health plan meets our providers'

QAC 3.19.2026

expectations and needs. We examine the satisfaction of the provider network in the following areas: overall satisfaction, claims payment issues, authorizations, access standards, quality management, coordination of care, pharmacy, CalOptima Health Customer Service staff and provider relations. Based on the information gathered, findings are reported to the QIHEC. The committee reviews the findings and makes recommendations on potential opportunities for improvements.

8.4. Patient Safety Program

Patient safety is a top priority for CalOptima Health. By encouraging members and their families to play an active role in ensuring their care is safe, medical errors can be reduced. Active, involved and informed members and families are vital members of the health care team.

Patient safety is integrated into all components of enrollment and health care delivery and is a significant part of our quality and risk management functions. This safety program is based on a member-specific needs assessment and includes the following areas:

- Identification and prioritization of member safety-related risks for all CalOptima Health members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on risk assessment
- Health education and health promotion
- Over/under-utilization monitoring
- Medication management
- Population Health Management
- Operational aspects of care and service
- Care provided in various health care settings
- Quality-of-care investigations
- Ongoing monitoring of our provider network
- Disease surveillance and reporting

To ensure member safety, activities for prevention, monitoring and evaluation include:

- Providing education and communication through the Population Needs Assessment to consider the members' language comprehension, culture and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care (such as member brochures that outline member concerns or questions that they should address with their practitioners for their care)

Collaborating with health networks and practitioners in performing the following activities:

- Improving medical record documentation and legibility, establishing timely follow-up for lab results, addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance safety.

QAC 3.19.2026

- Alerting pharmacies to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), which helps ensure the appropriate drug is being delivered.
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to ensure timely and accurate communication.
- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety.

Elements of the safety program address the environment of care and the safety of members, staff and others in various settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting:
    - Adherence to Americans with Disabilities Act standards, including provisions for access and assistance in procuring appropriate equipment, such as electric exam tables
    - Annual blood-borne pathogen and hazardous material training
    - Preventive maintenance contracts to promote keeping equipment in good working order
    - Fire, disaster and evacuation plan testing and annual training

- Institutional settings:
    - Falls and other prevention programs
    - Identification and corrective action implemented to address postoperative complications
    - Quality-of-care issues, critical incident identification, appropriate investigation and remedial action
    - Administration of influenza and pneumonia vaccines
    - COVID-19 infection prevention and protective equipment

- Administrative offices:
    - Fire, disaster and evacuation plan testing and annual training

8.4.1. Health Education and Wellness

CalOptima Health's primary goals are to increase member wellness and autonomy through advocacy, communication, education, identification of services and resources, and service facilitation throughout the continuum of care. Health education materials are written at the sixth-grade reading level and field-tested with members once designed, to confirm that they are clear and appropriate both culturally and linguistically.

The Health Education programs identify, assess, stratify and implement appropriate interventions for all members, focusing on wellness, prevention, and including chronic conditions. Programs and materials employ educational strategies and methods tailored for members, families and caregivers to make informed health decisions and modify health behaviors throughout the lifespan. Moreover, these programs are structured with an "equity lens"

OAC 3.19.2026

to address mental wellness and the social drivers of health that most impact members. The programs are designed to achieve behavioral change over time and are reviewed annually. Covered topics include the management of asthma, diabetes, hyperlipidemia, prenatal health, proper exercise, nutrition and weight management, as well as tobacco cessation, immunizations and well-child visits.

CalOptima Health supports members with customized interventions at no cost, which may include:

- Behavior modification and healthy lifestyle management techniques
- Health education programs and services, including topics on medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Online health educational videos and resources
- Informational booklets about key conditions
- Referrals to community or external resources

Member educational classes are offered in various formats, considering accessibility and adaptability. Members may participate in classes through virtual sessions.

8.4.2. Managing Members with Emerging Risk

CalOptima Health staff provide a comprehensive system of care for members with chronic illnesses. The systemwide, multidisciplinary approach entails forming a partnership between the member, the health care practitioner, and CalOptima Health. The stratification process identifies appropriate interventions based on the needs of each member.

Interventions include coordinating care for members and providing services, resources, and support to help them learn to manage their condition and care for themselves.

8.4.2.1 Disease Management Program

CalOptima Health's Disease Management program supports members with chronic conditions, such as diabetes, asthma and heart failure, through personalized, evidence-based care. The program utilizes data-driven targeting to identify at-risk individuals and provides timely outreach, health coaching, and culturally tailored education in members' preferred languages. Services include symptom management, lifestyle guidance, and navigation to clinical and community resources. By aligning with primary care and case management, the program promotes medication adherence, self-monitoring, and the implementation of prevention strategies. The goal is to empower members to manage their health, reduce disparities, and prevent complications, emergency visits and hospitalizations, ultimately improving quality of life.

QAC 3.19.2026

8.4.4. Continuity of Care Studies and Evaluations

CalOptima Health offers continuity of care to newly enrolled members who transition from other health plans or to existing members whose covered services are transitioned from Medi-Cal or other programs, or due to a provider's termination from the CalOptima Health network of providers. CalOptima Health educates members about continuity of care, access to and availability of services. CalOptima Health's monitoring processes ensure and improve the quality of care, accessibility, and timely access to care.

Continuity of care is a key determinant for overall health outcomes. Comprehensive continuity of care improves patient safety, avoids duplicate assessments and costs, procedures or testing, and results in better treatment outcomes. Continuity of care guidelines include the process for identifying newly enrolled members who transition into CalOptima Health and for existing members whose covered services are transitioned from other programs to CalOptima Health. Guidelines include services provided to a member rendered by an out-of-network provider with whom the member has a pre-existing provider relationship.

Continuity of care is monitored through QI studies and annual evaluations of network adequacy, timely access and access to care. This includes processes for correcting network deficiencies, applying for Alternative Access Standards when necessary, and ensuring that providers comply with access standards and timely access requirements. For example, QI studies can be used to investigate the causes of continuity problems and make recommendations aimed at improving the level of continuity provided at a provider clinic, or to assess the effectiveness of information exchange between medical care providers working in different care settings. The results of QI studies and annual evaluations are presented and discussed by the BMSC, MEMX, and/or GARS committees, as well as QIHEC. Based on the findings, the committee members recommend opportunities for improvement that should be implemented by the department responsible for enhancing continuity of care.

8.4.5. Appropriate Medication Utilization

CalOptima Health continuously monitors pharmaceutical data to identify patient safety issues. Drug Utilization Review (DUR) is a structured, ongoing program that evaluates, analyzes and interprets drug usage against predetermined standards and undertakes actions to obtain improvements. The DUR process is designed to help pharmacists identify potential drug-related problems by analyzing patterns of medication use. The goal of the DUR process is to identify potential drug-to-drug interactions, patterns of overutilization and underutilization, high- and low-dose alerts, medication duplication, and other critical elements that can affect patient safety. The DUR study data is collected via an administrative data extraction of paid pharmaceutical claims. Actual prescribing patterns of PCPs, BH practitioners and specialists are compared with CalOptima Health standards. The results of the quantitative analysis are presented to CalOptima Health's P&T Committee, a subcommittee of the Utilization Management Committee. The UMC reports quarterly to the QIHEC for discussion and action, as necessary.

QAC 3.19.2026

8.4.6. Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical Directors triage potential quality of care issues and conduct reviews of suspected physician and ancillary care quality issues. All potential quality of care cases are reviewed by a Medical Director, who determines a proposed action based on the severity of the case. The Medical Director presents cases, determined to be quality-of-care issues, to CPRC, and upon discussion, CPRC provides the final action(s). As cases are presented to CPRC, the discussion of care includes determining the appropriate action and severity level of the case, resulting in a committee-wide IRR process. The QI department tracks, monitors and trends PQI cases to identify opportunities for improving care and service. Results of quality-of-care reviews and tracking and trending of quality-of-service issues are reported to the CPRC and are also reviewed at the time of recredentialing. Potential quality-of-care case referrals are referred to the QI department from various departments throughout CalOptima Health, including but not limited to Prior Authorization, Concurrent Review, Care Management, Legal, Compliance, Customer Service, Pharmacy and GARS, as well as from providers, health networks and regulatory agencies.

The QI department provides training and guidance for non-clinical staff in Customer Service and GARS to assist staff with identifying potential quality issues. Potential quality-of-care grievances are reviewed by a Medical Director, with clinical feedback provided to the member. Declined grievances captured by the Customer Service department are similarly reviewed by a Medical Director.

8.5. Cultural and Linguistic Services Program

As a health care organization in the diverse community of Orange County, CalOptima Health strongly believes in the importance of providing culturally and linguistically appropriate services to members. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has a Cultural and Linguistic Services Program that integrates culturally and linguistically appropriate services at all levels of the operation. Services include but are not limited to face-to-face interpreter services, including American Sign Language, at key points of contact; 24-hour access to telephonic interpreter services; member information materials translated into CalOptima Health's threshold languages and in alternate formats, such as braille, large-print or audio; and referrals to culturally and linguistically appropriate community services programs.

The most common languages spoken by CalOptima Health members across all programs are English, 57%; Spanish, 29%; Vietnamese, 9%; Farsi, 1%; Korean, 1%; Chinese, less than 1%; Arabic, less than 1%; Russian, less than 1%, and other languages are less than 2%. CalOptima Health provides member materials in the following eight languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese, Arabic and Russian.

OAC 3.19.2026

CalOptima Health's Cultural and Linguistic Services Program is committed to providing member-centric care that recognizes the diverse beliefs, traditions, customs and individual differences of its populations. Beginning with the identification of needs through a Population Needs Assessment, programs are developed to address the specific educational, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the MAC and PAC prior to full implementation.

Objectives for serving a culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve other areas of need as appropriate.

Serving a culturally and linguistically diverse membership includes:

- Analyzing significant health care disparities in clinical areas to ensure health equity.
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved.
- Considering outcomes of member grievances and complaints.
- Conducting member-focused interventions with culturally competent outreach materials that focus on race-, ethnic-, language- or gender-specific risks.
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs.
- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group.
- Implementing and maintaining annual sensitivity, diversity, communication skills, Health Equity, and cultural competency training and related training (e.g., providing gender-affirming care) for CalOptima Health employees and contracted provider staff (clinical and non-clinical).

Further details of the CLAS Program, activities and measurements can be found in the CLAS Program Description.

QAC 3.19.2026

Appendix:

A. CalOptima Health's QIHETP Support Positions and Job Descriptions

B. 2026 QIHETP Work Plan

   a. HEDIS MY2025 Medicaid Goals

   b. HEDIS MY 2025 Medicare Goals

C. 2026 Population Health Management Strategy

D. 2026 Culturally and Linguistically Appropriate Services (CLAS) Program Description

E. CalOptima Health Measurement Year (MY) 2026 Medi-Cal and OneCare Pay for Value Programs

F. CalOptima Health Measurement Year (MY) 2026 Behavioral Health Integration Pay for Value Program

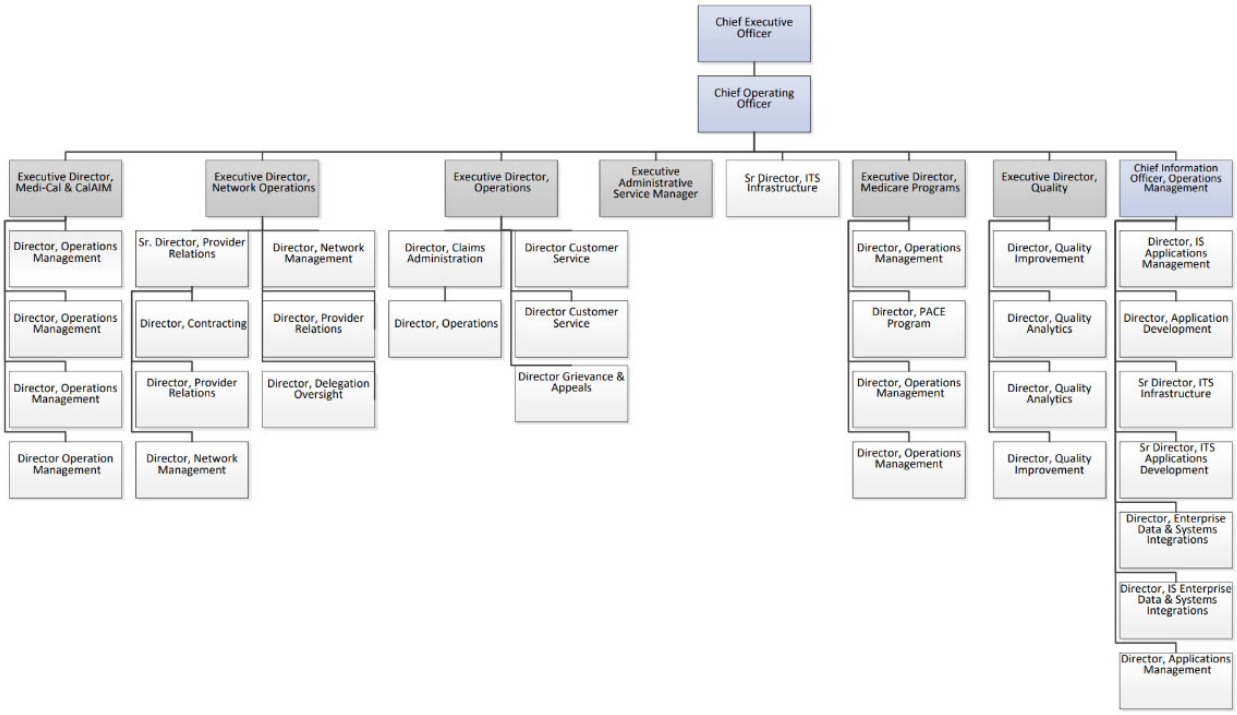
QAC 3.19.2026

Back to Agenda Back to Item

APPENDIX A

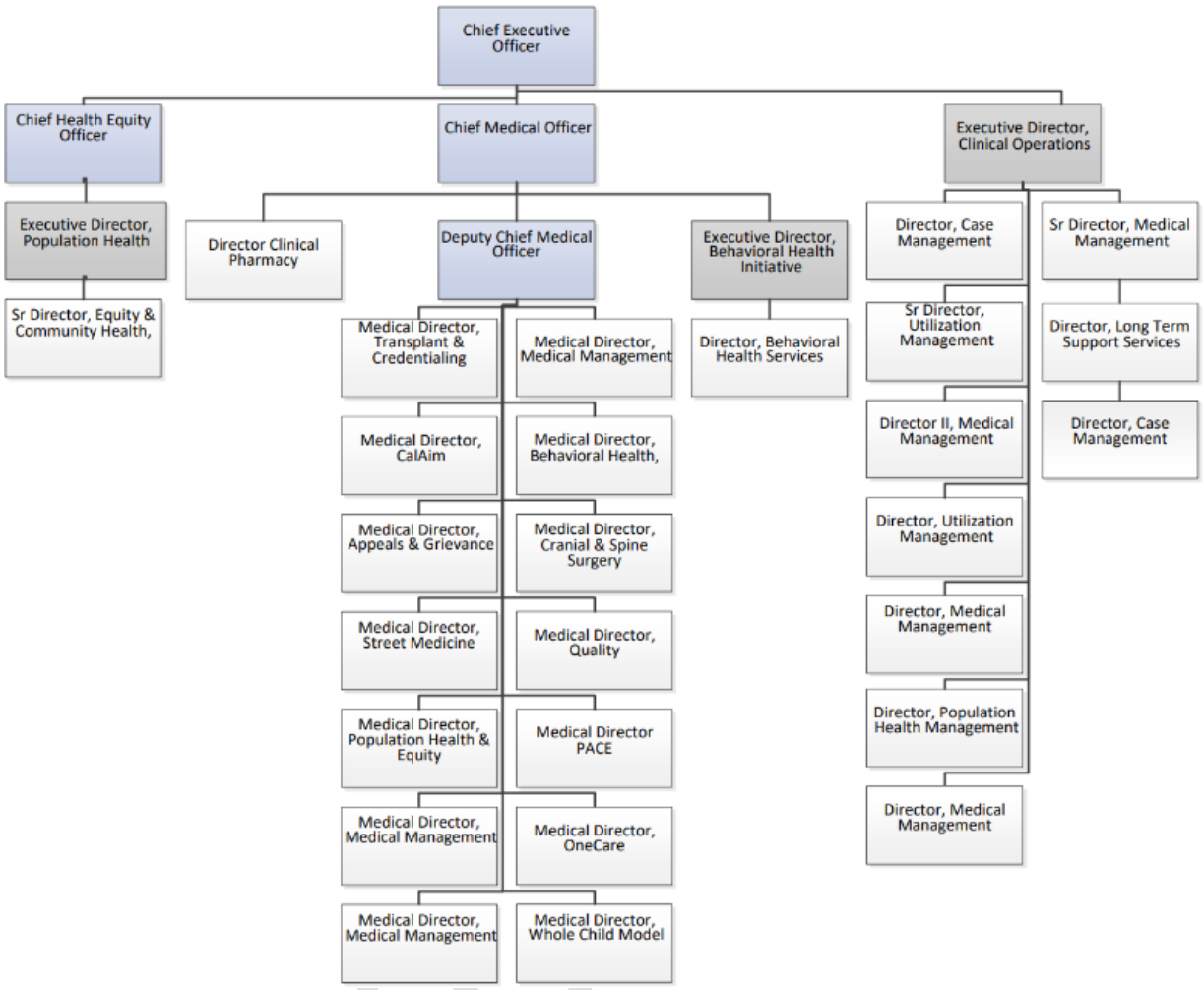
CalOptima Health's QIHETP Support Positions and Job Descriptions

Organizational Chart — Diagram



QAC

Back to Agenda Back to Item



Quality Improvement and Health Equity Transformation Program Organizational Structure

The Quality and Clinical Operations departments and Medical Directors, in conjunction with multiple CalOptima Health departments, support the organization's mission and strategic goals. These areas oversee the processes to monitor, evaluate and implement the QIHETP so that members receive high-quality care and services. Below are QIHETP's functional areas and responsibilities.

Medical Director* (Behavioral Health) The CalOptima Health Medical Director (Behavioral Health) is a key member of the medical management team and will be responsible for providing physician leadership in the Medical Affairs division, serving as a liaison to other CalOptima Health operational and support departments. They will collaborate with the other Medical Directors and clinical, nursing and non-clinical leadership staff across the organization in areas including Quality Management, Utilization and Care Management, Health Education/Disease Management, Long Term Care, Pharmacy, Behavioral Health Integration, Program for All Inclusive Care for the Elderly (PACE) as well as support departments including Compliance, Information Technology Services, Claims, Contracting and Provider Relations.

Back to Agenda Back to Item

Medical Director* (Medical Management) (13) is a key member of the medical management team and will be responsible for providing physician leadership in the Medical Management division, serving as liaison to other CalOptima Health operational and support departments. The Medical Director will collaborate with the other Medical Directors and clinical, nursing and non-clinical leadership staff across the organization in areas including CalAIM, Credentialing, Quality Management, Utilization and Care Management, Health Education/Disease Management, Long Term Care, Pharmacy, Program for All Inclusive Care for the Elderly (PACE), Street Medicine, Transplant, OneCare, Whole-Child Model, Population Health & Equity, Appeals & Grievance as well as support departments including Compliance, Information Technology Services, Claims, Contracting and Provider Relations.

Executive Director (Behavioral Health Integration (BHI)) is responsible for oversight of CalOptima's Behavioral Health (BH) program including utilization of services, quality outcomes, and the coordination and true integration of care between Physical and BH practitioners across all lines of businesses. The Executive Director serves as a member of the executive team and, with the CMO, assures that Medical Management is aligned with CalOptima's strategic and operational priorities. The Executive Director is a key leader within the health plan and is accountable for leading the areas assigned to next-level capabilities and operational efficiencies consistent with the strategic plan, goals, and objectives for CalOptima. The Executive Director will anticipate continuously improving, communicate, and leverage resources and achieving set accountabilities with constraints of limited resources. The Executive Director will be responsible for new program implementation of the implementation of initiatives in the above areas

Executive Director (Clinical Operations) is responsible for the performance of all operational aspects of key functional areas in Medical Management including Case Management, Long Term Services and Support (LTSS), and Utilization Management (UM), along with new clinical program implementation related to initiatives in all areas. The Executive Director serves as a member of the executive team, and with the CMO to ensure that the above aspects of Medical Management are aligned with CalOptima's strategic and operational priorities. The Executive Director is an important leader within the health plan and is accountable for leading the areas assigned to next-level capabilities and operational efficiencies consistent with the strategic plan, goals, and objectives for CalOptima. The Executive Director will be expected to anticipate, continuously improve, communicate, and leverage resources, as well as balance achieving set accountabilities.

Executive Director (Marketing and Communications) will be responsible for leading CalOptima Health's internal and external communications, marketing, community relations and strategic communications. The Executive Director will serve as a member of the executive team and work in collaboration and coordination with the leadership team to support the agency in communicating organizational goals and will plan, develop and implement strategies to effectively communicate the CalOptima Health's mission, vision and strategic priorities with

OAC 03.19.26

internal and external key stakeholders including employees, the public, members, government officials and the media.

Executive Director (Medi-Cal/CalAIM) is responsible for the implementation of CalAIM, a whole-system, person-centered delivery system reform to improve quality and care to members. The Executive Director manages the governance of key decisions to ensure that goals and objectives are accomplished within the constraints of budget, schedule, and customer expectations. The Executive Director is responsible for overall project coordination, including planning and sequencing work, setting milestones and deadlines, assigning responsibilities, facilitating cross-functional workgroups, monitoring progress, and reporting project status. Acting as a subject matter expert for CalAIM and related initiatives, the Executive Director works closely with elected officials, regulatory agencies, contractors, associations and key stakeholders.

Executive Director (Medicare Programs) will be responsible for implementation of products for older adults and individuals eligible for coverage under Medicare and Medi-Cal (Dual eligible). The Executive Director will be responsible for the Medicare Advantage product(s), Program of All Inclusive Care for the Elderly (PACE), and OneCare Sales and Marketing. The Executive Director will manage the governance of key decisions to ensure that membership and financial goals and objectives are accomplished within the constraints of budget, schedule, and customer expectations. The Executive Director will be responsible for overall project coordination, including planning and sequencing work, setting milestones and deadlines, assigning responsibilities, facilitating cross-functional workgroups, monitoring progress and reporting project status. The Executive Director, Medicare Programs, will be the subject matter expert for related initiatives, working closely with elected officials, regulatory agencies, contractors, trade associations and key stakeholders.

Executive Director (Network Operations) is responsible for the development, expansion, and support of the plan's provider delivery system to support the operation of all lines of business or programs. The Executive Director maintains a leadership role for delivery system operations across multiple models including direct contract, delegation, full risk, and accountable care organization. The Executive Director is also responsible for implementing strategies that achieve the established program objectives and to leverage the core competencies of the plan's existing administrative infrastructure to build an effective and efficient operational unit to serve enrollees and contribute to the delivery of accessible, cost effective, quality healthcare services throughout the service delivery network. The Executive Director leads and directs the integrated operations of the provider network contracted under the various programs and coordinates organizational efforts internally as well as externally with members, providers, and other stakeholders.

The Executive Director is responsible for the overall success of network operations for the planning and implementation to fulfill the plan's strategic objectives as related to contracting and operations of the provider delivery system. The Executive Director is responsible for providing

QAC 05.19.2026

relations and support, including provider education and problem resolution. The Executive Director and their staff must have the ability to collaborate with all internal departments to support and assist delegated provider entities and directly contracted providers in their day-to-day interactions and transactions with the plan**.**

Executive Director (Operations) is responsible for overseeing and guiding the following operational departments: Claims Administration, Customer Service, and Grievance & Appeals Resolution Services. The Executive Director works closely with top level leadership to establish policies and implement procedures for the management of departments to accomplish the goals and objectives of CalOptima within budget and within applicable legal requirements. In addition, the Executive Director will oversee the day-to-day operations of the departments, which includes facilitating communication with members, providers, and regulators.

Executive Director (Population Health) will be responsible for oversight of key medical affairs functions including Population Health Management which includes Health Education. The ED of Population Health Management will serve as a member of the executive team and, with the CMO, ensure that medical affairs align with CalOptima Health's strategic and operational priorities. The Executive Director is a key leader and will be responsible for leading the areas assigned to next-level capabilities and operational efficiencies consistent with the strategic plan, goals and objectives for CalOptima Health. The Executive Director will anticipate continuously improving, communicate and leverage resources.

Executive Director, Quality Improvement (ED QI) is responsible for facilitating the companywide QIHETP deployment; driving performance results in HEDIS, DHCS, CMS Star measures and ratings; health equity and quality data standard measures and annual benchmarks for equity and quality in health care delivery and maintaining NCQA accreditation standing as a high-performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement, and Medicare Stars and Quality Initiatives.

Executive Director (Strategic Development) serves as a member of the executive team responsible for the oversight and implementation of CalOptima Health's strategic development programs. Under the general guidance of the Chief Strategy Officer (CSO), the Executive Director works closely with top level leadership to plan, develop, implement strategies and carry out organizational goals and priorities to effectively promote and implement CalOptima Health's mission and vision with internal and external contacts including employees, the public, members, government officials and the media.

QAC 05.19.2026

Director (Behavioral Health Services) provides program development and leadership to the implementation, expansion and/or improvement of processes and services that lead to the integration of physical and behavioral healthcare services for all CalOptima members across all lines of business. The Director of Behavioral Health Services is responsible for the management and strategic direction of the Behavioral Health Integration (BHI) department, clinical operations, program initiatives, and community partnerships. The Director of Behavioral Health Services will ensure the department is compliant with all local, state, and federal regulations and that accreditation standards and all policies and procedures meet current requirements. The Director of Behavioral Health Services will work closely with the Medical Director of Behavioral Health to lead the agency in the development and successful implementation of both short and long-term strategic goals and objectives towards integrated care. The Director of Behavioral Health Services will play an important leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors, executives and departmental directors, plan members, contracted providers, Regulatory Affairs, and Legal Counsel, state and federal officials, and representatives of other agencies. The Director of Behavioral Health Services will be expected to participate with other senior staff within the department in monitoring, analyzing, and reporting to the Executive team on changes in the healthcare delivery environment and program opportunities affecting or available to assist CalOptima in integrating physical and behavioral healthcare services.

Director (Case Management) directs all Case Management programs for CalOptima members to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Community Network and CalOptima Direct. The Director of Case Management is responsible for all departmental compliance with all local, state and federal regulations and ensures that accreditation standards are current and all policies and procedures meet current requirements.

Director (Case Management) (Clinical Operations Administration) will lead the operational components to develop and implement an ongoing comprehensive, outcome-driven clinical strategy to enhance and increase the capacity of Medical Management programs and services for CalOptima Health members. The Director will be responsible for initiating and/or further developing best practice model design and framework that includes visual and technical toolkits for internal and external Health Network Partners to support regulatory and contractual compliance and high caliber medical care. The Director will develop strategies to enhance the programmatic approach to clinical operations that provide strategic efficiencies and economies of scale for increased member outreach and repeatability. The Director will be a thought leader and contributor to organizational alignment, program approach, planning, change management and delivery.

Director (Claims Administration) serves as the leader, decision maker for the development and daily management of the Claims Operations, Coding Initiative, and e-Business departments. The Director of Claims Administration will be responsible for directing claims processing, recovery, reporting and coding processes. Responsibilities also include developing and implementing a strategic plan for CalOptima's claims operations including, planning for growth, developing claims policies and standards, budgeting, quality assurance, and efficiency improvements such as

Back to Agenda Back to Item

streamlining processes and increasing claim automation. Staff development and the ability to build and foster a team environment are essential.

Director (Clinical Pharmacy) will provide strategic leadership and operational oversight for all aspects of pharmacy services within a managed care organization, including Medi-Cal, OneCare (HMO SNP), and Covered California. The Director will be responsible for designing, implementing, and evaluating pharmacy benefit programs that align with clinical goals, financial sustainability, regulatory compliance, and member outcomes. The Director will lead formulary strategy, utilization management, quality initiatives, and vendor performance-including Pharmacy Benefit Manager (PBM) oversight-and serves as the organization's principal pharmacy advisor to executive leadership and the Board of Directors. The Director will ensure compliance with Centers for Medicare & Medicaid Services (CMS), state Medicaid, Covered California, Department of Managed Health Care (DMHC), and National Committee for Quality Assurance (NCQA) standards while advancing initiatives to improve population health, medication adherence, and cost-effective drug use. This Director will require a dynamic, data-driven leader with extensive experience in managed care pharmacy, cross-functional collaboration, and a strong understanding of the regulatory environment governing Medicare, Medicaid, and commercial health plans. The Director will ensure alignment with CalOptima Health's mission to serve member health with excellence and dignity, respecting the value and needs of each person through collaboration with our providers, community partners and local stakeholders.

Director (Contracting) leads the Contracting department and is responsible for the development and implementation of contracting strategies for providers and other business entities, management and monitoring of contractual relationships with existing provider networks and contractors. The Director of Contracting conducts and coordinates financial analysis to determine and design contracting strategies for CalOptima and negotiate provider contracts.

Director (Customer Service) (2) provides leadership, day-to-day management, strategic direction and support to CalOptima Health’s Customer Service operations that include: Medi-Cal, Member Liaison, Behavioral Health, and Utilization Management/Authorization contact centers, CalOptima Health Reception and satellite locations (i.e., Orange County Community Service Center in Westminster), and member portal. The Director of Customer Service will guide staff in the implementation of strategic and tactical directions to improve efficiencies to ensure high quality and responsive services to members, providers, contracted vendors and regulatory agencies. The Director of Customer Service will regularly interact with all levels of internal CalOptima Health staff, as well as external contacts with regulatory agencies, contracted vendors, community-based organizations and medical groups/health networks.

Director (Delegation Oversight) oversees and conducts independent audits of CalOptima Health's contracted partners’ performance of delegated functions. The Director of Delegation Oversight will lead the department in developing audit protocols for all CalOptima Health’s delegates to ensure compliance with contractual, statutory and regulatory requirements, as well as accreditation standards and CalOptima Health’s policies and procedures as it relates to CalOptima Health's programs. The Director of Delegation Oversight will work collaboratively with internal and external partners to promote compliance with requirements. The Director of

Delegation Oversight interacts with CalOptima Health executives, departmental management, delegates and potential delegates, and legal counsel

Director (Enterprise Analytics) will provide leadership to the executive team and key leaders across CalOptima Health in the development of Business Intelligence strategy and roadmap of analytical capabilities. The Director provides management, oversight, and direction of CalOptima Health's Business Intelligence tools to support organizational reporting needs. The Director will work closely with departments that provide data to support the development or extend the data architecture and data definitions. The Director works with key users of data, to develop the platform(s) and capabilities to meet the critical analytical needs of CalOptima staff and external stakeholders. This Director will play a key leadership role, interacting with all levels of CalOptima staff and external stakeholders, including the Board of Directors, executive staff, members, providers, health network management, legal counsel, State and Federal representatives, and representatives of other agencies.

Director (Grievance and Appeals) is responsible for the development and management of the Grievance and Appeals Resolution Services (GARS) department. The Director of Grievance and Appeals ensure service standards and established policies and procedures regarding the appeals and grievance processes adhere to regulatory requirements. The Director of Grievance and Appeals collaborate regularly with all CalOptima Health's staff levels and external contacts with regulatory agencies, health networks, community-based organizations and medical groups. The Director of Grievance and Appeals maintain knowledge of all new regulatory guidelines impacting GARS for all CalOptima Health programs.

Director/Sr. Director (Information Services) Provide management, oversight, and direction of core administrative and clinical systems in support of organizations' day-to-day operational needs. Responsibilities include configuration management and development of such applications, integration of disparate systems and the design of solutions to meet the business requirements. Interacts with Managers and Directors throughout the organization. Assists in systems functions and upgrades and data integrity management.

Director/Dr. Director (Information Technology – Digital and Enterprise Applications, Architecture and Shared Services) The Director will be accountable for the Information Technology (IT) strategy and execution for digital technologies (web applications/portals), enterprise applications (HR, Finance, Compliance, etc.), enterprise architecture, and shared services (QA/testing, release management, and environment management). The Director will work closely with business leadership and the department staff to find solutions and deliver the technology required to support existing and new applications and technology. The Director will be responsible for the effective and efficient management and delivery of all third-party and internal IT resources to implement new systems and enhancements and ensure ongoing support. As a member of the department's leadership team, the Director will contribute to the development and execution of the organizational technology strategy, ensure its alignment with the organization's business strategy, and ensure the delivery of capabilities required to achieve business success. The Director will have extensive health plan technology experience, strong project management acumen, excellent vendor management skills, financial management expertise, and a superior, service-oriented approach to IT.

Back to Agenda Back to Item

Director (Long Term Support Services) is responsible for the overall planning, implementation and evaluation of CalOptima Health's Long Term Support Services (LTSS) programs, which include Long Term Care (LTC), Community Based Adult Services (CBAS), CalAIM authorizations and the Multi-Senior Services Program (MSSP). The Director of Long-Term Support Services will ensure high quality and responsive service for CalOptima Health members residing in LTC facilities or who participate in community based LTSS programs. The Director of Long-Term Support Services will be responsible for the LTSS department's continuous compliance with contractual, regulatory and accreditation standards. The Director of Long-Term Support Services will stay current with industry developments and regulatory changes that may impact CalOptima Health's program.

Director/Sr. Director (Medical Management) (3) will lead the execution and oversight of operational components to support and increase the capacity of Medical Management programs and services for CalOptima Health members. The Director will be responsible for high-level program oversight, design and day-to-day portfolio execution. The Director will be responsible for alignment with organizational goals, regulatory compliance and member-focused outcomes within the clinical teams. The Director will manage cross-functional teams, oversee program implementation when project scale and size is smaller than enterprise formal program support and drive innovation and efficiency within the program.

Director (Network Management) (2) is responsible for providing leadership and direction to ensure proactive development, management, communication, support, and issue resolution for all CalOptima Health contracted providers. CalOptima Health's contracted providers include delegated plans and health networks, multi-specialty physician groups, hospitals, ancillary services providers, community clinics, community support providers, and other partners. The Director of Network Management serves as the strategic, operational and communications lead between CalOptima Health and these critical partners. The Director of Provider Relations develops the overarching provider engagement and partnership strategy to ensure quality of member care, provider satisfaction, provider compliance with contractual and regulatory requirements, and active provider engagement in CalOptima Health's goals and priorities.

Director (Operations) is responsible for providing oversight of operations system contracts, liaison efforts with all parties, and prioritizing and tracking configuration requests. The Director of Operations will lead the development of protocols to track, prioritize and oversee operations system integration. The Director of Operations is to be also responsible for new and change request tracking and completions, defect management and process enhancement recommendations to create continued automation and efficiency. The Director ensures internal and external entities meet operations configuration deadlines and that all defects, system issues and planned outages are researched, planned and communicated to provide minimal impact on delivery of services.

Director of Operations (Network Management) (6) is responsible for all operational aspects of the Network Management department. The Director will oversee the onboarding of all new provider partners, provider data management and analysis, and provider directory production. The Director will be responsible for ensuring CalOptima Health meets and exceeds access and

Back to Agenda Back to Item

availability standards. The Director implements strategies that achieve the established CalOptima Health objectives; meet regulatory requirements and National Committee for Quality Assurance (NCQA) standards, leverage the core competencies of CalOptima Health's existing administrative infrastructure to build an effective and efficient operational unit to serve CalOptima Health's members and ensure the delivery of accessible, cost effective, quality healthcare services throughout CalOptima Health's service delivery network.

Director (PACE) assumes overall leadership and responsibility for PACE. The Director has overall accountability for the program's oversight and administration, which includes effective planning, development and evaluation of the program's operations, quality improvement and marketing and enrollment. The Director ensures that the above aspects of PACE are aligned with CalOptima Health's strategic and operational priorities. The Director is accountable for leading the PACE program in county-wide expansion activities, including next-level capabilities and operational efficiencies consistent with the strategic plan, goals and objectives of CalOptima Health. The Director will identify the needs of seniors in Orange County and strategize initiatives that meet these opportunities.

Sr. Director (Provider Relations) will be responsible for developing and executing opportunities for CalOptima Health to expand its provider network to enhance access to care and quality of care for members across all lines of business. The Sr. Director of Provider Relations will direct and lead the exploration of new opportunities and partnerships, develop innovative contracting models and provide overall leadership in execution of new contracts. The Senior Director will also assist in the oversight and onboarding of new health networks and Management Services Organizations. The Sr. Director of Provider Relations will effectively partner across CalOptima Health's departments and leadership and will cultivate meaningful relationships with the Orange County provider community

Director/Sr. Director (Population Health Management) will advance population-wide health and well-being for CalOptima members by coordinating the development and implementation of a comprehensive population health management plan and health equity framework aligned with the organization's strategic goals. The Director provides oversight and supervision of staff to monitor the implement organization-wide population health initiatives amongst internal departments; contracted providers health networks and external stakeholders aligned with CalOptima's overall mission and strategic goals. The Director ensures that the department meets ongoing regulatory compliance and accreditation standards. The Director plays a key leadership role, interacting with all levels of CalOptima staff and external stakeholders, including the board of directors, executive staff, members, providers, health network management, legal counsel, state and federal representatives, and representatives of other agencies to implement programs and Quality Improvement (QI) processes that improve cost savings, quality outcomes and member/provider satisfaction

Director Provider Relations (Network Management) will be responsible for providing leadership and direction to ensure proactive development, management, communication, support, and issue resolution for all CalOptima Health contracted providers. CalOptima Health's contracted providers include delegated plans and health networks, multi-specialty physician groups, hospitals, ancillary services providers, community clinics, community support providers,

Back to Agenda Back to Item

and other partners. The Director serves as the strategic, operational and communications lead between CalOptima Health and these critical partners. The Director of Provider Relations will develop the overarching provider engagement and partnership strategy to ensure quality member care, provider satisfaction, provider compliance with contractual and regulatory requirements, and active provider engagement in CalOptima Health's goals and priorities.
Day to day responsibilities include, but are not limited to: 1) managing and supervising staff, directing all the day-to-day activities of the Provider Relations department; 2) performing as the entry and exit point for all communications with providers including timely communication of program materials; 3) receiving, tracking, resolving and documenting issues; 4) ensuring outgoing and incoming reporting activities for purposes of oversight; 5) facilitating the communications and collections of regulatory and ad hoc audit deliverables; and 6) providing new provider training and on-going education of all providers.

Director Provider Relations (Network Management) (Health Network Relations) is responsible for providing leadership and direction to ensure proactive development, management, communication, support, and issue resolution for CalOptima's providers who contract with CalOptima under risk-based and delegated arrangements. CalOptima's delegated health networks are comprised of multi-specialty physician groups, hospitals, and restricted Knox-Keene licensed entities. The Direct of Health Network Relations serves as the strategic, operational and communications lead between CalOptima and these critical partners.
The Director responsibilities include, but are not limited to: 1) managing and supervising staff, directing all the day-to-day activities of the Network Management department; 2) performing as the entry and exit point for all communications with delegated entities; 3) documenting, tracking and resolving issues; 4) supporting and facilitating outgoing and incoming reporting activities for purposes of oversight; 5) facilitating the communications and collections of regulatory and ad hoc audit deliverables; and 6) providing new delegated provider training and on-going education of all delegated providers.

Director Provider Network (Operations) will lead the development and implementation of outcome-driven strategies to engage, support and build the capacity of CalOptima Health's provider delivery system. The Director will be responsible for initiating and/or deepening partnerships resulting in CalOptima Health increasing its access to services and the quality of services available to members. In addition, the Director will work across the organization to enhance quality programs and performance outcomes for the provider network. The Director will be a thought leader and contributor to programming approaches, planning, changing management and delivery.

Director (Quality Improvement) oversees the day-to-day operations of the QI department and is responsible for the execution and coordination of all quality assurance and improvement activities. The Director of Quality Improvement plans, develops, organizes, monitors, communicates, and recommends modifications to the QI program and all QI policies and procedures. It is the Director's responsibility to interface with other departments on QI issue.

Director (Quality Improvement) (Credentialing) is responsible for overseeing the process of verifying and maintaining health care provider credentials, ensuring compliance with all relevant regulations and standards, overseeing a contracted credentialing verifications organization

Back to Agenda Back to Item

(CVO), managing a team of credentialing staff, and ensuring ongoing monitoring of the provider network. The Director of Quality Improvement (Credentialing) is responsible for the development and implementation of quality improvement programs and activities related to providers credentialing to ensure compliance with current policies, procedures and regulatory credentialing standards, which is critical to ensure member care and safety at CalOptima Health. The Director of Quality Improvement (Credentialing) develops and implements policies and procedures to streamline the credentialing workflow within CalOptima Health.

Director (Quality Analytics) is responsible for providing leadership to ensure reporting, tracking and trending of quality performance metrics required by regulators or CalOptima Health leadership. The Director of Quality Analytics will oversee the timely delivery of regulatory required Healthcare Effectiveness Data and Information Set (HEDIS) metrics to National Committee for Quality Assurance (NCQA), California Department of Health Care Services (DHCS) and Center for Medicare and Medicaid (CMS) and will provide vision to enhance data collection to improve the organization's quality performance to meet strategic goals. The Director of Quality Analytics will be responsible for the strategic vision of the department to meet future expanded requirements of performance measurement evolution from DHCS, Department of Managed Health Care (DMHC) and NCQA. Director II, (Quality Analytics) is a key thought leader providing frequent feedback to stakeholder organizations including NCQA, DHCS and Association of Community Affiliated Plans (ACAP) regarding proposed, new or changed quality measurement requirements. Additionally, Director of Quality Analytics will provide leadership for the development, implementation and evolution of provider pay for value programs including alternative payment model programs or incentive programs mandated by DHCS and/or DMHC. The Director of Quality Analytics will oversee the development and implementation of all company surveys to measure member and provider satisfaction and will oversee the data analytics team that supports population health management, network adequacy reporting and ad hoc quality measurement performance requests. The Director of Quality Analytics will coordinate communication, keeping senior management and stakeholders informed of health plan and health network quality metrics performance results. The Director of Quality Analytics will work collaboratively with management throughout the organization to promote enhancement of organizational performance and supports the Quality Improvement Committee and sub-committees, as well as other key discussions on strategic and policy-related issues

Director (Quality Analytics) (Medicare Stars and Quality Initiatives) will be responsible for the development and implementation of programs and initiatives to improve quality outcomes across all lines of business consistent with CalOptima Health's mission, vision and values. The Director will manage data analysis to identify and prioritize new opportunities, develop strategies and business cases, develop implementation plans, evaluate impact and provide overall leadership for quality initiatives. The Director will function as a business lead for large-scale, cross-functional quality improvement projects that require interfacing and partnering with CalOptima Health's departments, leadership and provider network. The Director will be responsible for the strategic vision of the department to meet future expanded requirements of performance measurement evolution from the Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC) and National Committee for Quality Assurance (NCQA). The Director will be a key

Back to Agenda Back to Item

thought leader providing frequent feedback to stakeholder organizations, including the NCQA, DHCS and Association of Community Affiliated Plans (ACAP) regarding proposed, new or changed quality measurement requirements

Director/Sr. Director (Utilization Management) is responsible for the oversight, planning, organization, implementation and evaluation of all activities and personnel engaged in Utilization Management (UM) departmental operations. The Director of Utilization Management provides leadership and direction to the Utilization Management department to ensure compliance with all local, state and federal regulations, accreditation standards are current and all policies and procedures meet current requirements. Director of Utilization Management has oversight of CalOptima Health's Utilization Management program for CalOptima Health Community Network, CalOptima Health Direct and the delegated health networks. The Director III is expected to serve as a liaison for various internal and external committees, workgroups, and operational meetings.

*Upon employment engagement, and every three years thereafter, the Medical Directors are credentialed. In that process, their medical license is checked to ensure that it is an unrestricted license pursuant to the ***California Knox Keene Act Section 1367.01*** I. Ongoing monitoring is performed to ensure that no Medical Director is listed on state or federal exclusion or preclusion lists.

QAC 03.19.2026

2026 QI Work Plan

2026 Quality Improvement Health Equity Transformation Program Work Plan **Organization: CalOptima Health**

Purpose: The Quality Improvement (QI) Work Plan outlines the organization's annual priorities for improving clinical quality, member experience, patient safety, access, and health equity. It serves as a roadmap for implementing interventions, monitoring performance, and evaluating outcomes in alignment with NCQA standards and organizational goals.

Monitoring of Previously Identified Issues: CalOptima Health ensures continuous monitoring of issues identified in prior evaluations, regulatory requirements, and member feedback. Each initiative in the work plan includes measurable objectives and goals, accountable owners, planned activities and completion dates, monitoring cadence, and whether the item was carried over from the previous work plan, including the reasons. Performance is reviewed quarterly by the QIHEC and annually evaluated to determine the effectiveness of interventions, need for intervention updates, and whether to retire or add initiatives, as appropriate.

Annual Evaluation: At year-end, CalOptima Health compares performance against targets, evaluates intervention effectiveness, documents lessons learned, and updates the work plan for the next cycle.

I. PROGRAM OVERSIGHT

1	2026 Quality Improvement Health Equity and Transformation Program (QIHETP) Description, the 2026 Annual Work Plan and the 2025 QIHETP Evaluation
2	2026 Integrated Utilization Management (UM) and Case Management (CM) Program Description and the 2025 Integrated UM CM Program Evaluation
3	2026 Population Health Management (PHM) Strategy and the 2025 PHM Strategy Evaluation
4	2026 Cultural and Linguistic Accessibility Services (CLAS) Program and the 2025 CLAS Program Evaluation
5	Quality Improvement Health Equity Committee (QIHEC)
6	Credentialing Peer Review Committee (CPRC)
7	Grievance and Appeals Resolution Services (GARS) Committee
8	Member Experience (MEMX) Committee
9	Utilization Management Committee (UMC)
10	Whole Child Model - Clinical Advisory Committee (WCM CAC)
11	National Committee for Quality Assurance (NCQA) Accreditation
12	External Quality Review Requirements
13	Quality Performance Reporting
14	Quality Performance Improvement
15	Value Based Payment Program: Health Network
16	Value Based Payment Program: Behavioral Health
17	Value Based Payment Program: Hospital

II. QUALITY OF CLINICAL CARE

18	PHM Strategy: Keeping Children Healthy w Performance Improvement Project (PIP)
19	CalOptima Health Comprehensive Community Cancer Screening Program (CCCSP)
20	Maternal Health Program
21	Population Health Management/Care Management
22	Health Education Program
23	Disease Management Program
24	Disease Management Program: Chronic Conditions Improvement Project (CCIP)
25	CalAIM Enhanced Care Management and Community Supports
26	Street Medicine
27	Complex Case Management Program
28	Utilization Management Program
29	Long-Term Support Services (LTSS)
30	Delegation Oversight
31	Special Needs Plan (SNP) Model of Care (MOC)
32	Behavioral Health Services
33	Behavioral Health Services: Care Coordination and Follow-up Care with Performance Improvement Projects (PIPs) Medi-Cal BH
34	Medication Adherence
35	Cozeva PayerOne Software Solution
36	At-Home Visit Program
37	At-Home Lab Testing

Submitted and approved by QIHEC: 01/13/2026
Quality Improvement Health Equity Committee Chairperson:

Richard Pitts, D.O., Ph.D. Date

Submitted and approved by QAC: 03/19/2026
Board of Directors' Quality Assurance Committee Chairperson:

Jose Mayorga, M.D. Date

QAC 03.19.2026

IX. QUALITY OF SERVICE- Access

38 Improve Network Adequacy: Reducing Gaps In Provider Network
39 Improve Timely Access: Appointment Availability/Telephone Access

X. QUALITY OF SERVICE- Member Experience

40 Improve Member Experience/CAHPS
41 Grievance and Appeals Resolution Services
42 Customer Service Call Center

XI. SAFETY OF CLINICAL CARE

43 Emergency Department Program
44 Transitional Care Services (TCS)
45 Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance
46 Potential Quality Issues Review
47 Sentinal Event Monitoring and Disease Surveillance
48 Quality Assurance Performance Improvement (QAPI) for Long-Term Care Services
49 Provider Credentialing and Recredentialing

XII. Cultural and Linguistic Appropriate Services (CLAS)

50 Language Services: Cultural and Linguistics and Language Accessibility
51 Data Collection on Member Demographic Information
52 Data Collection on Practitioner Demographic Information
53 Network Cultural Responsiveness: Provider Trainings to Improve Care or Service Delivery
54 Network Cultural Responsiveness: Building and Maintaining a Responsive Work Force

QAC 03.19.2026

2026 QI Work Plan

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
1	Program Oversight	Quality Documents	2026 Quality Improvement Health Equity and Transformation Program (QIHETP) Description, the 2026 Annual Work Plan and the 2025 QIHETP Evaluation	1. Obtain QIHEC Approval of the 2026 QIHETP Description and Workplan by January 31, 2026, and the Board approval by April 30, 2026 2. Implement initiatives for the 2026 QIHETP Description and Workplan starting January 1, 2026. 3. Complete Evaluation of the 2025 QIHETP Description and Work Plan and obtain QIHEC approval by January 31, 2026, and the Board approval by April 30, 2026	Medi-Cal and OneCare Program	1. Develop the 2026 QIHETP Description and Work Plan and obtain QIHEC and board approval. 2. Collaborate with business owners to ensure the QIHETP Description and Work Plan initiatives are implemented. 3. Develop the 2026 QIHETP Evaluation and obtain QIHEC and board approval.	1. 01/31/2026; 04/30/2026 2. Varies based on intervention; to be completed by 12/31/2026 3. 01/312026; 04/30/2026	QIHEC: 1/13/2026 QAC: 03/19/2026 BOD: 04/02/2026	Marsha Choo	Program Specialist of Quality Improvement	Quality Improvement	Yes - Regulatory / Contractual
2	Program Oversight	Quality Documents	2026 Integrated Utilization Management (UM) and Case Management (CM) Program Description and the 2025 Integrated UM CM Program Evaluation	1. Obtain QIHEC Approval of the 2026 Integrated Utilization Management (UM) and Case Management (CM) Program Description by February 10, 2026, and the Board approval by April 30, 2026 2. Implement initiatives for the 2026 Integrated Utilization Management (UM) and Case Management (CM) Program Description starting January 1, 2026. 3. Complete Evaluation of 2025 Integrated UM CM Program Description and obtain Board approval by April 30, 2026	Medi-Cal and OneCare Program	1. Develop the 2026 Integrated Utilization Management (UM) and Case Management (CM) Program Description and obtain UMC approval. 2. Obtain QIHEC Approval of the 2026 Integrated Utilization Management (UM) and Case Management (CM) Program Description and the Board approval. 3. Implement initiatives for the 2026 Integrated Utilization Management (UM) and Case Management (CM) Program Description starting January 1, 2026. 4. Complete Evaluation of 2025 Integrated UM CM Program Description and obtain QIHEC and board approval.	1. 01/30/2026 2. 02/10/2026; 04/30/2026 3. Varies based on intervention; to be completed by 12/31/2026 4. 02/10/2026; 04/30/2026	UMC: 01/22/2026 QIHEC: 02/10/2026 QAC: 03/19/2026 BOD: 04/02/2026	Kelly Giardina	Director of Utilization Management	Utilization Management	Yes - Regulatory / Contractual
3	Program Oversight	Quality Documents; PHM	2026 Population Health Management (PHM) Strategy and the 2025 PHM Strategy Evaluation	1. Obtain QIHEC Approval of the 2026 Population Health Management (PHM) Strategy by January 31, 2026, and the Board approval by April 30, 2026 2. Implement initiatives for the 2026 Population Health Management (PHM) Strategy starting January 1, 2026. 3. Complete the Evaluation of the 2025 PHM Strategy by April 30, 2026	Medi-Cal	1. Develop the 2026 PHM Strategy and obtain QIHEC and board approval. 2. Collaborate with business owners to ensure the 2026 PHM Strategy initiatives are implemented. 3. Develop the 2026 PHM Strategy Evaluation and obtain QIHEC and board approval.	1. 01/31/2026; 04/30/2026 2. Varies based on intervention; to be completed by 12/31/2026 3. 01/312026; 04/30/2026	QIHEC: 1/13/2026 QAC: 03/19/2026 BOD: 04/02/2026	Katie Balderas	Program Manager Case Management	Case Management	Yes - Regulatory / Contractual
4	Program Oversight	Quality Documents; CLAS	2026 Cultural and Linguistic Accessibility Services (CLAS) Program and the 2025 CLAS Program Evaluation	1. Obtain QIHEC Approval of the 2026 Cultural and Linguistic Accessibility Services (CLAS) Program by January 31, 2026, and the Board approval by April 30, 2026 2. Implement initiatives for the 2026 Cultural and Linguistic Accessibility Services (CLAS) Program starting January 1, 2026. 3. Complete the Evaluation of the 2025 CLAS Program and obtain Board approval by April 30, 2025 4. Presents to and obtains input from the Member Advisory Committee (MAC)	Medi-Cal and OneCare Program	1. Develop the 2026 CLAS Program and obtain QIHEC and board approval. 2. Collaborate with business owners to ensure the 2026 CLAS Program initiatives are implemented. 3. Develop the 2026 CLAS Program Evaluation and obtain QIHEC and board approval. 4. Present CLAS findings and activities to MAC and obtain feedback from the committee.	1. 01/312026; 04/30/2026 2. Varies based on intervention; to be completed by 12/31/2026 3. 01/31/2026; 04/30/2026 4.12/10/2026	QIHEC: 1/13/2026 QAC: 03/19/2026 BOD: 04/02/2026	Albert Cardenas	Manager of Cultural and Linguistics	Customer Service / Cultural and Linguistic Services	Yes - Regulatory / Contractual

OAC 03.19.2026

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
5	Program Oversight	Committee	Quality Improvement Health Equity Committee (QIHEC)	1. Convene at least 8 times a year, maintain and approve minutes, and report committee key findings/updates, activities, and recommendations to QAC quarterly. 2. Conduct oversight of quality Improvement and health equity outcomes and activities in the QIHETP and annual workplan.	Medi-Cal and OneCare Program	1. Convene monthly QIHEC meetings, maintain and approve minutes, and report on all items listed in the 2026 QIHETP Work Plan. 2. Report on QIHEC activities to QAC Quarterly	1. Monthly in 2026 01/13/2026; 02/10/2026; 03/10/2026; 04/14/2026; 05/12/2026; 06/09/2026; 07/14/2026; 08/11/2026; 09/08/2026;10/13/2026; 11/10/2026; 12/08/2026 2. Quarterly 2026	Report to QAC: Q1: 3/19/2026 Q2: 6/18/2026 Q3: 10/22/2026 Q4: 12/17/2026	Marsha Choo	Program Specialist of Quality Improvement	Quality Improvement	New - Program Oversight
6	Program Oversight	Committee	Credentialing Peer Review Committee (CPRC)	1. Convene at least 8 times a year, maintain and approve minutes, and report committee key findings/updates, activities, and recommendations to QIHEC quarterly. 2. Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review to ensure quality of care delivered to members in the timely manner.	Medi-Cal and OneCare Program	Convene at least 8 times a year, maintain and approve minutes, and report on the following activities: 1. Peer review investigations of potential quality issues (PQI), initial and recredentialing of CHCN providers, credentialing oversight and ongoing monitoring of the entire provider network, and initial and periodic site review activity (FSR, MRR, PARS) for Medi-Cal. 2. Trends and results are presented to the committee quarterly and reported to QIHEC quarterly.	Monthly in 2026 01/29/2026; 02/26/2026; 03/26/2026; 04/23/2026; 05/28/2026; 06/25/2026; 07/23/2026; 08/27/2026; 09/24/2026; 10/22/2026; 11/19/2026; 12/17/2026	Report to QIHEC: Q1: 03/10/2026 Q2: 06/09/2026 Q3: 09/08/2026 Q4: 12/08/2026	Laura Guest	Manager of Quality Improvement	Quality Improvement	Yes - Regulatory / Contractual
7	Program Oversight	Committee	Grievance and Appeals Resolution Services (GARS) Committee	1. Convene at least quarterly, maintains and approve minutes, and report committee key findings/updates, activities, and recommendations to QIHEC quarterly. 2. Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.	Medi-Cal and OneCare Program	Convene at least quarterly, maintain and approve minutes, and report on the following activities: 1. Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health networks. 2. Trends and results are presented to the committee by product quarterly and reported to QIHEC quarterly.	Quarterly GARS Committee meeting: Q1: 03/12/2026 Q2: 05/19/2026 Q3: 08/18/2026 Q4: 11/17/2026	Report to QIHEC: Q1: 03/10/2026 Q2: 06/09/2026 Q3: 09/08/2026 Q4: 12/08/2026	Heather Sedillo	Manager of Grievance and Appeals	GARS	Yes - Program Oversight

QAC 02.19.2026

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8	Program Oversight	Committee	Member Experience (MEMX) Committee	1. Convene at least quarterly, maintains and approve minutes, and reports committee key findings/updates, activities, and recommendations to QIHEC quarterly. 2. Conduct oversight of Member Experience activities to improve quality of service, member experience and access to care.	Medi-Cal and OneCare Program	Convene at least quarterly, maintain and approve minutes, and report on the following activities: 1. The MEMX Committee conducts an annual review of CalOptima Health's CAHPS survey results, oversees provider network performance, including access and availability, monitors customer service metrics, and evaluates complaints, grievances, appeals, authorizations, and referrals to identify systemic 'pain points' that affect member experience and quality of care. 2. Trends and results are presented to the committee quarterly and reported to QIHEC quarterly.	Quarterly MEMX Committee meetings: Q1: 01/27/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/06/2026	Report to QIHEC: Q1: 03/10/2026 Q2: 06/09/2026 Q3: 09/08/2026 Q4: 12/08/2026	Kelli Glynn	Manager of Quality Analytics / Project Manager of Quality Analytics	Quality Analytics	Yes - Program Oversight
9	Program Oversight	Committee	Utilization Management Committee (UMC)	1. Convene at least quarterly, maintain and approve minutes, and report committee key findings/updates, activities, and recommendations to QIHEC quarterly. 2. Conduct internal and external oversight of UM activities to ensure over- and under- utilization patterns do not adversely impact member's care.	Medi-Cal and OneCare Program	Convene at least quarterly, maintain and approve minutes, and report on the following activities: Internal Oversight 1. Quarterly Audits to review UM activities including decisions and workflows. 1.a. Monitor adherence to clinical guidelines and regulatory requirements. 2. Discuss utilization trends and outliers. 3. Track quality metrics (readmission rates, ER visits, preventive care compliance). External Oversight 1. Collaborate with delegated entities quarterly to review UMC updates, program evaluation, processes and outcomes. 1.a. Discuss utilization trends and outliers. 1.b. Track quality metrics (readmission rates, ER visits, preventive care compliance). 1.c. Present findings to UMC. 2. Annual DO Program audit to monitor adherence to program. 2.a. Validate compliance with contractual and accreditation standards (e.g., NCQA, DHCS) 3. Review monthly performance dashboards for leadership visibility. 3.a. Escalate patterns that indicate risk to member safety or care quality.	Quarterly UMC meetings: Ad-Hoc - 01/22/2026 Q1: 02/19/2026 Q2: 05/21/2026 Q3: 08/20/2026 Q4: 11/19/2026	Report to QIHEC: Q1: 03/10/2026 Q2: 06/9/2026 Q3: 09/8/2026 Q4: 12/8/2026	Kelly Giardina	Director of Utilization Management	Utilization Management	Yes - Regulatory / Contractual
10	Program Oversight	Committee	Whole Child Model - Clinical Advisory Committee (WCM CAC)	1. Convene at least quarterly, maintain and approve minutes, and report committee key findings/updates, activities, and recommendations to QIHEC quarterly. 2. Ensures that clinical and behavioral health services for children eligible with California Children Services (CCS) are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Medi-Cal Members	Convene at least quarterly, maintain and approve minutes, and report on the following activities: 1. WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations, and Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3) 2. Trends and results are presented to the committee quarterly and reported to QIHEC quarterly.	Quarterly WCM CAC meetings: Q1: 02/17/2026 Q2:.05/19/2026 Q3: 08/18/2026 Q4:11/17/2026	Report to QIHEC: Q1: 03/10/2026 Q2: 06/09/2026 Q3: 09/08/2026 Q4: 12/08/2026	Thanh-Tam Nguyen, MD/Hannah Kim	Program Specialist of Quality Improvement	Medical Management	Yes - Regulatory / Contractual

OAS 02.19.2026

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
11	Program Oversight	Regulatory	National Committee for Quality Assurance (NCQA) Accreditation	1. CalOptima Health must maintain full NCQA Health Plan (HP) Accreditation for Medi-Cal 2. CalOptima Health must maintain full NCQA Health Outcomes Survey (HOS) Accreditation for Medi-Cal. Perform readiness assessment on the newly released 2026 Health Outcomes standards. 3. CalOptima Health must attain operational readiness for NCQA Health Plan (HP) Accreditation for Covered California by December 31, 2026.	Medi-Cal Program	1. Complete Year One deliverables for NCQA Health Plan (HPA) Accreditation 2. Complete Year Two deliverables due except for Delegation oversight for NCQA Health Plan (HPA). 3. Assessment on the new Health Outcomes (HO) standards 4. Engage with NCQA consultants (HMA) to add Covered California as an accreditation.	1. 4/30/2026 2. 12/31/2026 3. 3/31/2026 4. 3/31/2026	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Marsha Choo	Program Manager of Quality Improvement (NCQA)	Quality Improvement	Yes - Regulatory / Contractual
12	Program Oversight	Regulatory	External Quality Review Requirements	Ensure CalOptima Health complies with the following requirements: 1. Quality Performance Measures - Reported under Quality Performance Reporting 2. Performance Improvement Projects (PIPs) - Reported under the area of focus for the PIP 3. Consumer Satisfaction Survey - Reported under the Member Experience and CAHPS 4. Network Adequacy Validation - Reported under Improve Network Adequacy: Reducing Gaps In Provider Network 5. Encounter Data Validation 6. Focused Studies - Reported under the area of focus for the focused study	Medi-Cal Program	1. Participate in any EQRO activities 2. Review all EQRO Reports annually to ensure compliance and report to QIHEC	1. Ongoing 2. 9/30/26	Report to QIHEC 09/24/2026	Marsha Choo	Program Specialist of Quality Improvement	Quality Improvement	Yes - Regulatory / Contractual
13	Program Oversight	Regulatory	Quality Performance Reporting	Track and report quality performance measures required by regulatory bodies against the following goal: 1. Achieve 100% reportable for Managed Care Accountability Set (MCAS) 2. Achieve 100% reportable for OneCare STAR measures	Medi-Cal and OneCare Program	1. Submit MCAS audited IDSS and member-level details to NCQA/DHCS 2. Submit OneCare audited IDSS and member-level details to NCQA/CMS	1. 6/15/2026 2. 6/15/2026	Report to QIHEC 05/12/2026 08/11/2026	Paul Jiang	Manager of Quality Analytics	Quality Analytics	Yes - Regulatory / Contractual

OAC 03.19.2026

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14	Program Oversight	Quality Improvement	Quality Performance Improvement	Achieve performance goals for the following quality programs: 1. Achieve or exceed the 50th percentile (minimum performance level) for Managed Care Accountability Set (MCAS) measures 2. Achieve an overall CMS Star rating of 4 stars 3. Achieve an overall NCQA Health Plan Rating of 4.5 stars 4. Improve from the HEDIS MY2024 final rate to meet the HEDIS MY2025 goal by September 30, 2026 for the following measures: • MC Immunization Status - Pneumonia (MC) • OC Care for Older Adults (COA) • OC Breast Cancer Screening (BCS) • MC Lead Screening in Children (LSC) • MC Appropriate Testing for Pharyngitis (CWP) • MC Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) (Please refer to the attached HEDIS MY2025 Medicare and Medicaid goal sheets for the 2026 HEDIS goals)	Medi-Cal and OneCare Program	1. Implement a comprehensive member outreach strategy across all lines of business using multi-modal engagement (phone, SMS, email, IVR, Member Portal, and mailers). 2. Deploy an at-home visit and care gap closure program with multiple partners (please see these specific activities for details). 3. Forecast end-of-year performance for Medi-Cal MCAS and CMS Stars measures and establish monthly targets for measure owners. 4. Establish reporting to monitor NCQA Health Plan Rating performance throughout the measure year. 5. Deploy the Cozeva PayerOne software solution to achieve automatic bidirectional data exchange with Health Network partners, integrate high-volume provider EMR systems with Cozeva to automatically extract quality data elements for gap closure, onboard providers to the Cozeva user interface, and support year-round collection of supplemental data (please see this specific activity for details). 6. Execute the Quality Improvement Grant Program to provide support to Health Networks with the planning, implementation, and monitoring of quality improvement activities. 7. Establish regular performance review meetings with high-volume providers in partnership with the Provider Relations Department and/or Health Network partners. 8. Distribute provider-facing playbooks for HEDIS and CAHPS improvement. 9. Collaborate with radiology facilities to achieve standing orders, obtain historical data, and complete member outreach to positively impact Breast Cancer Screening and Osteoporosis Screening. 10. Lead several cross-functional workstreams with multiple departments to assess and improve CMS Stars performance.	1. 12/31/2026 2. 4/30/2026 3. Q2 2026 4. Q2 2026 5. 7/31/2026 6. 12/31/2026 7. 4/30/2026 8. 4/30/2026 9. 12/31/2026 10. Q1 2026	Report overall performance to QIHEC 05/12/2026 08/11/2026 Report measure performance to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Kelli Glynn	Manager of Quality Analytics	Quality Analytics	Yes - Prior Year Evaluation (goal not met)
15	Program Oversight	P4V	Value Based Payment Program: Health Network	Complete the MY2025 Medi-Cal and OneCare P4V program quality score calculation and pay out the incentives to health networks and CHCN providers.	Medi-Cal and OneCare Program	Calculate the MY2025 final HEDIS results by Health Networks complete the Health Network quality rating calculation	Medi-Cal 10/31/2026 OneCare 12/31/2026	Report to QIHEC 05/12/2026	Paul Jiang	Manager of Quality Analytics	Quality Analytics	Yes - Regulatory / Contractual
16	Program Oversight	P4V	Value-Based Payment Program: Behavioral Health	Implement a behavioral health value-based payment program and report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants	Medi-Cal and OneCare Program	1. Calculate measurement periods' results for each 6-month measurement period throughout 2026 for planned payouts in 2026. 2. Continue work with IT for provider portal P4V enhancements 3. Present progress and outcomes at QAC in 2026	Ongoing 12/31/2026	Report to QIHEC 05/12/2026	Carmen Katsarov	Director of Behavioral Health Integration	Behavioral Health Integration	New - Program Oversight
17	Program Oversight	P4V	Value-Based Payment Program: Hospital	Complete MY2025 hospital quality score calculations and pay out incentives to qualified hospitals	Contracted hospitals	Solicit hospital stakeholder feedback for program enhancements Revise program for MY2026 Calculate MY2025 program results	12/31/2026	Report to QIHEC 05/12/2026	Linda Lee	Director of Quality Analytics / Program Manager (Quality Incentives)	Quality Improvement / Quality Analytics	Yes - Program Oversight

QAC 05-13-2026

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18	Program Oversight/Quality of Clinical Care	PHM Strategy; HE	PHM Strategy: Keeping Children Healthy with Performance Improvement Project (PIP)	Implement the PHM Strategy for keeping children healthy, report key findings and activities, analyze barriers and improvement efforts, and compare program data against the following goals. Improve from the HEDIS MY2024 final rate to meet the HEDIS MY2025 goal by September 30, 2026 for the following Managed Care Accountability Set (MCAS) measures: 1. Childhood Immunization Status (CIS) Combo 10 2. Immunizations for Adolescents (IMA) Combo 2 3. Well-Child Visits in the First 30 Months of Life (W30) - Well-Child Visits in the First 15 Months - Well-Child Visits for Age 15 Months-30 Months 4. Child and Adolescent Well-Care Visits (WCV) (Please refer to the attached HEDIS MY2025 Medicare and Medicaid goal sheets for the 2026 HEDIS goals) Health Equity Goals: 1. Improve the Childhood Immunization Status (CIS) Combo-10 HEDIS measure, from the stratified rate to the MY 2024 aggregate final rate of 38.69% by September 30, 2026 for the following populations: • Black: 21.88% • White: 21.89% • Native Hawaiian/Other Pacific Islander: 17.65% 2. Improve the Immunizations for Adolescents (IMA) Combo- 2 HEDIS measure, from the stratified rate to the MY 2024 aggregate final rate of 46.21% by September 30, 2026 for the following populations: • Black: 26.92% • White: 20.77% • Native Hawaiian/Other Pacific Islander: 27.03% 3. Improve the Child and Adolescent Well-Care Visits (WCV) HEDIS measure, from the stratified rate to the MY 2024 aggregate final rate of 55.46% by September 30, 2026 for the following populations: • Black: 40.49% • White: 40.04% • Native Hawaiian/Other Pacific Islander: 37.97% 4. Improve the Well-Child Visits in the First 15 Months (W30) Measure rate among Black/African American from 53.06% to the aggregate final rate of 70.28%. (Clinical - PIP)	Pediatric and adolescent Medi-Cal members	Clinical Operations Activities: 1. Provide verbal and written member education on important milestones. Quality Analytics Activities: 1. Deploy multi-modal outreach campaigns to eligible members; utilize text, email, phone, IVR, and/or mailers to encourage well visit and immunization completion. 2. Create member- and provider-facing materials to address vaccine hesitancy. 3. Proactively outreach to members that will age into the HEDIS measures. For example, contact the parents/guardians of 1-year-old members to ensure accordance with W30 and CIS timeframes. 4. Deploy the Cozeva PayerOne software solution to achieve automatic bidirectional data exchange with Health Network partners, integrate high-volume provider EMR systems with Cozeva to automatically extract quality data elements for gap closure, onboard providers to the Cozeva user interface, and support year-round collection of supplemental data (please see this specific activity for details). 5. PIP campaign: improve compliance for Childhood Immunization Status (CIS), Immunizations for Adolescents (IMA), and Child and Adolescent Well-Care Visits (WCV) among Black, White, and Native Hawaiian/Other Pacific Islander populations through the deployment of culturally tailored, multi-modal outreach campaigns in collaboration with multiple departments.	Clinical Operations Activities: 1. 12/31/2026 Quality Analytics Activities: 1. 12/31/2026 2. Q1 2026 3. 12/31/2026 4. 07/31/2026 5.12/31/2026	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Megan Dankmyer / Kelli Glynn	Sr. Manager of Case Management / Manager of Quality Analytics	Quality Analytics	Yes - Program Oversight; CIS and IMA - Prior Year Evaluation (goal not met); W30 and WCV - Maintain and Monitor

OAC 03.19.2026

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19	Program Oversight/Quality of Clinical Care	Program Oversight	CalOptima Health Comprehensive Community Cancer Screening Program (CCCSP)	Implement the CCCSP and report on progress made towards the achievement of goals: 1. Community grants to meet their proposed screening rates for BCS, CCS, COL, and Lung by January 30, 2027. 2. Decrease late-stage cancer diagnosis rates 3. Increase early-stage discovery through improved awareness and access to cancer screening Improve from the HEDIS MY2024 final rate to meet the HEDIS MY2025 goal by September 30, 2026 for the following measures: 1. MC Cervical Cancer Screening (CCS) 2. MC Colorectal Cancer Screening (COL) 3. MC Breast Cancer Screening (BCS-E) (Please refer to the attached HEDIS MY2025 Medicare and Medicaid goal sheets for the 2026 HEDIS goals)	Medi-Cal Members	1. Distribute member-facing [General, BCS, CCS, COL, LUNG] Cancer Screening Direct Mailers 2. Launch updated mPulse Cancer Screening Campaigns for General, BCS, CCS, COL, Lung, and the revised Cancer Treatment campaign. 3. Continue to hold in-person meetings with grantees to review progress reports and share member success stories. 4. Collaborate with Communications to capture impactful member success stories and report to the Board. 5. Collaborate with Kelli Glynn (QI) to identify and engage clinics with high volumes of BCS non-compliance and utilize Alinea mobile mammogram services to improve screening rates and meet STAR measures. 6. Plan for objective evaluation regarding the effectiveness of the Cancer screening program in increasing screening rates and awareness, while identifying opportunities for improvement. 7. Develop a reporting method for Community Grants to capture the total number of cancers found in each category and their stages. 8. Conduct a deeper analysis between the Native Hawaiian population and all ethnic population groups to determine if there is a disparity in cervical cancer screening rates. Once there is a better understanding of the disparity, a more realistic HE goal can be developed.	1. March 31, 2026 2. General by 3/31/2026; BCS by 4/30/2026; CCS by 5/31/2026; COL by 7/31/2026; Lung by 8/31/2026; Cancer Treatment by 9/30/2026 3. Progress Report #4 on 2/17/2026; Member Success Story #2 by 5/18/2026; Progress Report #5 by 8/17/2026; Member Success #3 by 11/16/2026; Final Progress Report by 2/15/2027 4. By each of the "Member Success Story" meeting dates listed above 5. Ongoing 12/31/2026 6. Ongoing 12/31/2026 7. By 5/18/2026 8. By 3/31/2026	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Dr. Richard Pitts	Program Manager of Medical Management	Medical Management	Yes - Program Oversight; MC CCS, MC COL and MC BCS-E - Prior Year Evaluation (goal not met)
20	Program Oversight/Quality of Clinical Care	PHM Strategy	Maternal Health Program	Implement the Maternal Health Program, report key findings and activities, analyze barriers and improvement efforts, and compare program data against the following goals. Improve from the HEDIS MY2024 final rate to meet the HEDIS MY2025 goal by September 30,2026 for the following measures: 1. MC Prenatal (PPC) 2. MC Postpartum (PPC) (Please refer to the attached HEDIS MY2025 Medicare and Medicaid goal sheets for the 2026 HEDIS goals)	Medi-Cal Members with a positive pregnancy	1. Targeted prenatal and postpartum telephonic outreach to educate members on the importance of preventative visits. 2. Assist members with appointment scheduling if barriers or gaps in care are identified during telephonic outreach. 3. Deploy a texting campaign to encourage timely postpartum visits. 4. Improve postpartum visit compliance and enhance member engagement through promotion of postpartum health rewards. 5. Ensure maternal health programmatic alignment with providers and Health Networks. 6. Enhanced reporting to proactively identify and monitor status of perinatal members. 7. Continue internal maternal health workgroup to ensure alignment of initiatives across the organization. 8. Provide targeted interventions for identified at-risk populations.	1. 12/31/26 2. 12/31/26 3. 11/30/26 4. 12/31/26 5. 9/30/26 6. 9/30/26 7. 12/31/26 8. 12/31/26	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Megan Dankmyer	Sr. Manager of Case Management	Case Management	Yes - Program Oversight; MC PPC - Prior Year Evaluation (goal not met)

OAC 03.19.26

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21	Program Oversight/Quality of Clinical Care	Program Oversight	Population Health Management/Care Management	Conduct Population Needs Assessment 1. Complete Population Needs Assessment to inform PHM Strategy and Quality Improvement strategies. Initial Screening and Assessment 1. Increase the IHA completion rate for all new Medi-Cal members from 34.4% to 40% and for new Medi-Cal members ≥18 months from 71.5% to 75%. 2. Track and trend the collection rate of HIF/MET and increase the rate of SPD HRAs completed within 90 days of enrollment from 66% to 70% by 12/31/2026 3. Early and Periodic Screening, Diagnostic and Treatment (EPSDT): Improve ensuring utilization of EPSDT criteria within UM decision from 67% to 70% by 12/31/2026. 4. OC Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)Total Risk Stratification 1. Increase the rate of high-risk members with an intervention by 5% from Q1-Q3 2025 average of 72% by 12/31/2026	Population Needs Assessment: Medi-Cal population Initial Screening and Assessment: 2a. Newly enrolled Medi-Cal members 2b. Newly enrolled SPD members 3. All members under 21 4. Members with multiple high-risk conditions Risk Stratification: 1. High-risk members per CalOptima RSS	Population Needs Assessment: Validate standards, secure data, draft report, finalize and share report. Initial Screening and Assessment 1a. Review/refine IHA logic (including outreach attempts), monitoring benchmarks, and Health Network oversight. 1b. Strengthen SDOH screening and documentation process for new Medi-Cal members via IHA 2a. Quarterly track and trend collection rate of HIF/MET 2b i). Quarterly tracking of HRA collection rates for newly enrolled SPD members. 2b ii). Barrier analysis for non-collected SPD HRA from 2025 data 2b iii). Identify and implement two strategies to address identified barriers EPSDT 3. i) Annual audit of 10 files from each HN by CalOptima Health medical director of HN UM decisions. 3. ii). Annual EPSDT training for providers and HNs. 3. iii). Annual training for care coordination with regional center for providers and HNs. 3. iv). Continue meeting in workgroup at a minimum of quarterly to review collected data to address potential gaps in delivery of EPSDT services. 4. Assisting OneCare members discharged from ED with follow-up appointments within 7 days. a). Case Management will continue to outreach to all members admitted. b). UM notification to PCP of all admissions and discharges c). Implement post discharge program with Papa and share with all health networks d). PointClickCare discharge sharing (implemented 9/18/2025) e) Point clickCare admission notifications (live 12/15/2025) f) Provider Portal enhancement- PCP notification for admissions and discharges (implemented 10/2025) Risk Stratification: track and trend MY rates 1a. Quarterly track and trend High-risk members per CalOptima Health RSS who have an intervention: 1b i). Barrier analysis for high-risk members without intervention for 2025. 1b ii). Identify and implement two strategies to address identified barriers	Complete Population Needs Assessment by end of Q2. Initial Screening and Assessment 2a Q4 2025 by 3/31/2026; Q1 2025 by 6/30/2026; Q2 2026 by 9/30/2026; Q3 by 12/31/2026 2b i) Q4 2025 by 2/8/2026; Q1 by 5/8/2025; Q2 by 8/8/2025; Q3 by 11/8/2026 2b ii) 6/30/2026 2b iii) 12/31/2026 3. i. Q2 and Q4 2026 3. ii. by Q4 2026 3. iii. by Q4 2026 3. iv. Q1, Q2, Q3 and Q4 2026 4. a-f update quarterly x4 by 12/31/2026 Review quarterly. Risk Stratification: 1a Q 2025 by 3/31/2026; Q1 2025 by 6/30/2026; Q2 2026 by 9/30/2026; Q3 by 12/31/2026 1b i) 3/31/2026 1b ii). 6/30/2026 1b iii). 9/30/2026	Report to UMC Q1 - 02/19/2026 Q2 - 05/21/2026 Q3 - 08/20/2026 Q4 - 11/19/2026	Katie Balderas / Hannah Kim	Manager of Case Management	Case Management	Yes - Program Oversight and Prior Year Evaluation (IHA)

OAC 02.19.2026

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
22	Program Oversight	Program Oversight	Health Education Program	Implement the Health Education Program, report key findings quarterly to QIHEC to analyze barriers and improvement efforts, and compare program data against the following goals. 1. By December 31, 2026, 95% timely (up to 14 days) fulfillment of health education materials and referrals. 2. By December 31, 2026, increase the rate of members' participation and access to multimodal health education content by 15%	Medi-Cal Members	1. Develop a standardized Health Education playbook that involves analyzing health data, surveying members, and collaborating with health networks. 2. Develop a communication and evaluation strategy to monitor the Diabetes Prevention Program. 3. Identify priority areas based on prevalent health issues, knowledge gaps, or population needs. Use a multimodal approach for health education, including self-care guides, interactive tools, virtual classes, texts, and mailings. 4. Create a tracking process for capturing member participation and access to health education material.	1. By the end of Q1, 2026. 2. By the end of Q2, 2026. 3. Ongoing- end of Q4 2026 4. By the end of Q1, 2026.	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Aulina Bradley	Manager of Case Management	Case Management	Yes - Program Oversight
23	Program Oversight/Quality of Clinical Care	PHM Strategy	Disease Management Program (Emerging Risk)	Implement the Disease Management Program, report key findings and activities, analyze barriers and improvement efforts, and compare program data against the following goals. 1. By December 31, 2026, 90% of members who participate in the Disease Management program from January 1 to December 31, 2026, will report satisfaction. 2. By December 31, 2026, increase rate of Health Coaching engagement to members with high/mod risk conditions from 7.5%% to 15%. Improve from the HEDIS MY2024 final rate to meet the HEDIS MY2025 goal by September 30, 2026, for the following measures: 1. MC and OC Eye Exam for Patients with Diabetes (EED) 2. MC Kidney Health Evaluation for Patients with Diabetes (KED) 3. MC and OC HBD (GSD) 4. MC and OC Controlling High Blood Pressure (CBP) (Please refer to the attached HEDIS MY2025 Medicare and Medicaid goal sheets for the 2026 HEDIS goals)	CalOptima Health members with chronic conditions, including diabetes, asthma, congestive heart failure, and hypertension.	1. Develop a standardized Disease Management playbook inclusive of member identification/stratification, interventions, and Health Network/provider collaboration strategies. 2. Use multimodal methods of outreach (text, WebMD, mailings) to identify members for Disease Management services and provide evidence-based health education and self-management resources. 3. Integrate new methods to monitor and improve clinical outcomes and satisfaction for members with chronic conditions.	1. By end of Quarter 1, 2026. 2. Ongoing. 3. Ongoing	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Katie Balderas	Manager of Case Management	Case Management	Yes - Program Oversight; MC EED - Prior Year Evaluation (goal not met); OC EED MC KED, MC and OC GSD, and MC and OC CBP - Prior Year Evaluation (continued improvement, maintenance and monitoring)

OAC 03.19.2026

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
24	Program Oversight/Quality of Clinical Care	Improvement Project	Disease Management Program: Chronic Conditions Improvement Project (CCIP)	Chronic Conditions Improvement Project (CCIP): Implement a targeted outreach campaign using multi-modal communication (SMS, email, phone calls, and/or mailers) to engage CalOptima Health Community Network (CHCN) OneCare hypertensive and diabetic members with an HbA1c > 9%. CCIP Goals: 1. Reach at least 50% of identified members by December 2026. 2. Achieve a 10% improvement in compliance for the Glycemic Status Assessment for Patients with Diabetes (GSD) and Controlling Blood Pressure (CBP) HEDIS measures amongst the targeted population by the end of the campaign.	CCIP: CalOptima Health Community Network (CHCN) OneCare hypertensive and diabetic members with an HbA1c > 9%	1. Member identification: use claims, clinical, and HEDIS data to identify 'uncontrolled' diabetic and hypertensive OneCare CHCN members (defined by an HbA1c >9% and eligibility for the Controlling Blood Pressure (CBP) HEDIS measure). 2. Personalized messaging: develop culturally tailored scripts for SMS, email, phone calls, and/or mailers emphasizing the importance of testing and follow-up care. 3. At-home support: provide eligible members with at-home lab testing for HbA1c and a blood pressure cuff for at-home monitoring. 4. Health education: provide members with health coaching and WebMD resources. 5. Tracking and reporting: log all outreach attempts and member responses in a centralized way to monitor engagement, outcomes, and quality care gap closure.	1. By 01/31/2026 2. Ongoing 12/31/2026 3. Ongoing 12/31/2026 4. Ongoing 12/31/2026 5. Ongoing 12/31/2026	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Kelli Glynn	Manager of Quality Analytics	Quality Analytics	Yes - Regulatory / Contractual
25	Program Oversight	PHM Strategy	CalAIM Enhanced Care Management and Community Supports (Patient Safety or Outcomes Across Settings)	Continue to ensure ECM and Community support are accessible to members who qualify for services and ensure services provided meet required quality standard by December 31, 2026. 1) Increase ECM authorization for services by 5%. 2) Complete the annual ECM audit process. 2) Complete the initial audit for the Housing Trio of Community Support services. 3) Develop the audit process for the Personal Care and Homemaker community support service. 4) Require recuperative care providers to complete the NIMRC certification process.	Members who qualify for CalAIM services.	1. Implement an annual CalAIM training schedule to support all CalAIM providers in providing quality services aligned with CalOptima Health's standards of care. 2. Utilize the results of the ECM audit to develop training workshops for contracted ECM providers. 3. Utilize results of the Housing Trio audit to develop training workshops for contracted housing providers. 4. Develop audit templates for Personal Care and Homemaker services audit. 5. Work with NIMRC to ensure the recuperative care certification process is successful.	1. December 31, 2026 2. August 31, 2026 3. August 31, 2026 4 December 31, 2026 5. December 31, 2026	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Mia Arias	Director of Medi-Cal and CalAIM	Medi-Cal and CalAIM	Yes - Program Oversight
26	Program Oversight	PHM Strategy	Street Medicine (Patient Safety or Outcomes Across Settings)	1. Sustain or exceed 80% of unhoused participating members connected to an active PCP throughout 2026. 2. Sustain or exceed 90% of unhoused participating members engaged with CalAIM ECM and Housing Navigation throughout 2026. 3. By December 2026, increase the rate of unhoused participants connected to a shelter or other housing option to 20%.	Members experiencing homelessness, members with serious mental/substance use disorders	Goal 1: (1) Offer all enrolled members the opportunity for the street medicine provider to serve as PCP. (2) Assist all enrolled members who elect to have street medicine serve as their PCP in calling Customer Service for a change. (3) Obtain Release of Information for any enrolled member who wants to keep their assigned PCP to enable communication between both providers. Goal 2: (1) Upon enrollment, submit CalAIM authorizations for ECM and Housing Navigation. (2) As needed, submit re-authorizations. (3) Provide service delivery of both services at routine, bi-monthly intervals at minimum. Goal 3: (1) Offer all enrolled members temporary shelter, if available, at each time of service. (2) Work with each enrolled member at becoming 'document ready'. (3) Enter all enrolled members into the Coordinated Entry System for housing opportunities.	Continue all activities through 2026	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Nicole Garcia	None	Medi-Cal and CalAIM	Yes - Program Oversight

OAC 02/23/2026

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
27	Program Oversight	PHM Strategy	Complex Case Management Program (Managing Multiple Chronic Conditions)	Implement the Complex Case Management Program, report key findings and activities, analyze barriers and improvement efforts, and compare program data against the following goals. 1. Ensure provision of CCM services resulting in optimal care coordination as evidenced through monthly auditing of 5 files or 5% (whichever is larger) of files for each HN, resulting in a minimum score of 90% by 12/31/2026. 2. Members who participated in the CCM program will report 90% overall satisfaction by December 31, 2026. 3. By 12/31/2026, 90% of members who participated in the CCM program and completed a survey in 2026 will report that the program was "helpful" or "very helpful" to meet their care goals.	The population of focus includes members with the most complex health care needs. Most frequently managed conditions, diseases or high-risk groups*	Goal 1: Enhance Staff Competency in PH5 Elements D and E 1a. Training and educational opportunities for all health networks on the 2026 PHM5 Element D and E and complex conditions/situations 1b. Develop new training materials utilizing feedback from HMA consultants during the recent mock audit. 1c. Provide 1:1 and group training as needed and intervene immediately and meet to discuss audit outcomes for all health networks. Goal 2: Enhance Member Experience with Complex Case Management (CCM) Program 2a. Share Member Satisfaction (MSS) scores with all health networks on a quarterly basis. 2b. Conduct quarterly leadership meetings to review MSS scores and member feedback to collaborate on strategies to improve outcomes. Goal 3: Member-Centric Care Planning 3a. Continue training and education on member centric care plans for all health networks as needs arise.	Goal 1a. by 3/31/2026 Goal 1b. by 1/31/2026 Goal1c. through 12/31/2026 Goal 2a. Q1, Q2, Q3, Q4 2026 Goal 2b. Q1, Q2, Q3, Q4 2026 Goal 3a. through 12/31/2026	Report to UMC: Q1: 02/19/2026 Q2: 05/21/2026 Q3: 08/20/2026 Q4: 11/19/2026	Megan Dankmyer / Hannah Kim	Quality Improvement Nurse	Case Management	Yes - Program Oversight

OAC 03.19.2026

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28	Program Oversight	Committee	Utilization Management Program	1. By 12/31/26, all key metrics will demonstrate a 5% reduction from prior year performance based on line of business and aid category 2. Key metrics include; Admit PTMPY, ALOS, Days PTMPY, Readmit Percent, ED PTMPY *Expansion & TANF 18+ Admit PTMPY Goal 114.9 ALOS Goal 4.3 Days PTMPY Goal 515.9 Readmit Goal 16.4% *TANF Under 18 Admit PTMPY Goal 29.1 ALOS Goal 12.2 Days PTMPY Goal 374.7 Readmit Goal 2.2% *SPD Admit PTMPY Goal 241.5 ALOS Goal 5.7 Days PTMPY Goal 1,438.7 Readmit Goal 21.6% *LTC Admit PTMPY Goal 554.0 ALOS Goal 7.4 Days PTMPY Goal 4,276.0 Readmit Goal 22.2% *OneCare Admit PTMPY Goal 261.5 ALOS Goal 5.5 Days PTMPY Goal 1,520.3 Readmit Goal 14.6% *WCM Admits PTMPY Goal 308.2 ALOS Goal 9.1 Days PTMPT Goal 2,926.6 Readmit Goal 3.7%	Utilization Management of OC and Medi-Cal CCN/COD populations	1. Review of quarterly data at UMC meetings 2. Implementation of interventions identified at the various workgroups led by CalOptima Health Medical Directors	1. UMC meetings: Q1 - 02/19/2026 Q2 - 05/21/2026 Q3 - 08/20/2026 Q4 - 11/19/2026 2. Ongoing 12/31/2026	Report to UMC: Q1: 02/19/2026 Q2: 05/21/2026 Q3: 08/20/2026 Q4: 11/19/2026	Stacie Oakley	Director of Case Management	Utilization Management	New - Program Oversight

OAC 03.19.2026

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29	Program Oversight	Program Oversight	Long-Term Support Services (LTSS)	Implement the LTSS program, report key findings and activities, analyze barriers and improvement efforts and compare program data against the 95% compliance with the following TATs: 1. CalAIM Turnaround Time (TAT): Determination completed within 5 business days for routine authorizations and 72 hours for expedited authorizations. 2. CBAS Inquiry to Determination (TAT): Determination completed within 30 calendar days. 3. CBAS Turnaround Time (TAT): Routine determination completed within 5 business days. 4. LTC Turnaround Time (TAT): Determination completed within 5 business days.	1. Long Term Care-Custodial 2. CBAS 3. CalAim Community Supports	1. Evaluation of the current utilization of LTSS. 2. Maintain current business and expand as needed for current and any new LTSS programs. 3. Continuous process improvement in DTPs, and management of member, provider, and CalOptima Health requests. 4. Meet or exceed all regulatory and policy TAT goals.	End of Q1, Q2, Q3 & Q4.	Report to UMC: Q1: 02/19/2026 Q2: 05/21/2026 Q3: 08/20/2026 Q4: 11/19/2026	Scott Robinson	Manager of Long-Term Support Services	Long Term Support Services	Yes - Program Oversight
30	Program Oversight	Program Oversight	Delegation Oversight	Implement annual oversight and performance monitoring for delegated activities and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: 1. By December 31, 2026, conduct an annual audit for each delegate and issue CAPs, as needed. 2. Conduct a pre-delegation assessment for all potential delegates prior to execution of the delegation agreement.	Delegated health networks and FDRs.	Report on Delegation Oversight activities to CPRC or another applicable Committee at least semi-annually	01/31/2026 & 07/31/2026	Report to QIHEC: Q1: 03/10/2026 Q2: 06/09/2026 Q3: 09/08/2026 Q4: 12/08/2026	Stacy Baker	Manager of Delegation Oversight	Delegation Oversight	Yes - Program Oversight

OAC 03.19.2026

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
31	Quality of Clinical Care	Program Oversight	Special Needs Plan (SNP) Model of Care (MOC)	1. Decrease the number of reset HRAs identified on 1/1/2026 5% by 12/31/2026 2. Increase the number of Initial members with an ICP per CMS criteria within 90 days of eligibility from 95% to 98% by 12/31/2026. 3. Increase the number of members with a formal or informal ICT collaboration from 90% to 95% by 12/31/2026. 4. Track and trend HRA Star Status and annual face-to-face visit quarterly. 5. CalOptima Health D SNP 2027 MOC revision submission	1. OneCare Members 2. Newly enrolled Members 3. OneCare members	1a. Quarterly tracking of reset HRA rate 1b. HRA initial and annual HRA outreach 1c. HRA reminders through texting and postcards 1d. Targeted outreach to members in need of a reset or catch-up HRA 1e. QR Codes on HRA cover letters 2a. Quarterly tracking of initial ICP completion rate 2b. Monthly Communication to Health Networks on ICP Development 3. Monthly tracking of ICT to Health Network 4. Quarterly tracking and trending HRA Star Status and annual face-to-face 5. CalOptima Health D SNP 2027 MOC revision submission 1-3: Barrier analysis with strategies identified to address. 1-3: Implement two strategies to address identified barriers and monitor response.	1a-e. Q4 2025 by 3/31/2026; Q1 2026 by 6/30/2026; Q2 2026 by 9/30/2026; Q3 by 12/31/2026 1f. 6/30/2026 1g. 12/31/2026 2a. Q4 2025 by 3/31/2026; Q1 2026 by 6/30/2026; Q2 2026 by 9/30/2026; Q3 by 12/31/2026 2b. Monthly through 2026 2c. 6/31/2026 2d. 12/31/2026 3. Monthly through 2026. 4. Q4 2025 by 3/31/2026; Q1 2026 by 6/30/2026; Q2 2026 by 9/30/2026; Q3 by 12/31/2026 5. 5/29/2026	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Megan Dankmyer	QI Nurse Specialist	Medical Management	Yes - Program Oversight

OAC 03.19.26

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
32	Quality of Clinical Care	Behavioral Health	Behavioral Health Services	Improve from the HEDIS MY2024 final rate to meet the HEDIS MY2025 goal by September 30, 2026, for the following measures: 1. MC Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) 2. MC Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) 3. MC Pharmacotherapy for Opioid Use Disorder (POD) 4. MC and OC Depression Screening and Follow-up for Adolescents and Adults Total (DSF-E) 5. MC Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) 6. MC Prenatal Depression Screening and Follow-Up (PND-E) 7. MC Postpartum Depression Screening and Follow-Up (PDS-E) (Please refer to the attached HEDIS MY2025 Medicare and Medicaid goal sheets for the 2026 HEDIS goals)	Medi-Cal and OneCare	SSD 1. Continue to track members in need of a glucose screening test 2. Use the provider portal to communicate follow-up best practices and guidelines for follow-up visits. 3. Continue to follow up on the data pull for the text messaging campaign. 4. Mail out member health rewards flyers to eligible members. 5. Continue to mail out to all PCP offices the following: - Best Practice PCP Letter - Provider Tool Tip Sheet - Member Reward Flyer 6. Schedule listening sessions with Providers to educate/train on how to obtain BH data. Pending report availability. APP 1. In 2026, we will continue to send out monthly provider mailouts. We also hope to send out an APP text message campaign to members starting in January 2026. POD 1. Educate providers on measures and best practice guidelines. DSF-E 1. Continue distributing HEDIS Tool Tip Sheets, ensuring they are accessible through provider portals and our website. 2. Offer virtual training or review DSF-E requirements and documentation tips. 3. Collaborate office visits with Provider relations for Provider Outreach and education. 4. Targeted Social Media Campaign to members that may need a depression screening. 5. Partner with community-based organizations to amplify importance of depression screenings APM 1. Share aggregate performance data with provider groups to highlight trends and encourage alignment with quality goals. 2. Share provider-level performance reports to increase awareness and accountability. 3. Offer targeted training on the importance of metabolic monitoring. 4. Use stratified data to identify non-compliant members and prioritize outreach based on risk level or historical gaps in care.	SSD by: End of Q4 APP by: End of Q4 POD by: End of Q4 DSF-E by: End of Q4 APM by: End of Q4	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Diane Ramos / Natalie Zavala / Carmen Katsarov	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	Yes - Program Oversight; MC POD, SSD, APM, APP, and PDS-E - Prior Year Evaluation (goal not met);PND-E and PDS-E - Prior Year Evaluation (continued improvement, maintenance and monitoring)

OAC 03.19.2026

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
33	Quality of Clinical Care	Behavioral Health; PHM Strategy	Behavioral Health Services: Care Coordination and Follow-up Care Performance Improvement Projects (PIPs) Medi-Cal BH (Patient Safety or Outcomes Across Settings)	Improve from the HEDIS MY2024 final rate to meet the HEDIS MY2025 goal by September 30, 2026, for the following measures: 1. MC Follow-Up After Emergency Department Visit for Mental Illness (FUM): 30-Day and 7-day 2. MC Follow-Up After Emergency Department Visit for Substance Use (FUA): 30-Day and 7-day 3. MC Follow-up After High-Intensity Care for Substance Use Disorder (FUI):30-Day and 7-day PIP Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) FUM and FUA for complex case management. (Please refer to the attached HEDIS MY2025 Medicare and Medicaid goal sheets for the 2026 HEDIS goals)	Medi-Cal	FUM/FUA 1. Assess IVR Call Implementation - Explore and pilot automated Interactive Voice Response (IVR) calls to remind members who meet FUM/FUA criteria to schedule follow-up appointments after ED visits. 2. Continue Daily Text Campaign - Maintain ongoing text message outreach to encourage timely follow-up care. 3. Engage High-Volume EDs - Continue in-person meetings with high-volume emergency departments to ensure members are connected to services before discharge. - Reinforce partnerships with Telemed2U and NAMI By Your Side for immediate member support. 4. Provider Portal Enhancements - Continue sharing BH Measures Report and FUM/FUA Daily ED reports via the Provider Portal to improve provider visibility and accountability. 5. Collaboration Projects - Maintain active participation in DHCS/OCHCA Behavioral Health Collaboration Project to improve FUA/FUM HEDIS outcomes. 6. Health Network Engagement - Continue attending HN Quality Meetings to provide updates, education, and performance feedback. 7. Provider Relations Coordination - Implement in-person visits with Provider Relations teams using a drafted outline of Behavioral Health discussion points to strengthen provider engagement. 8. Member Journey Magnets Distribution - Share BH Medi-Cal Member Journey magnets with QA team for distribution to Transtreme and At-Home Visit providers. - Magnets will outline key steps in the member care journey to reinforce engagement and follow-up. FUI 1. This measure was added for monitoring purposes. Opportunities for improvement and/or interventions will be considered for 2026. PIP 1. Conduct member outreach through the behavioral health telehealth provider to coordinate follow-up appointments post-ED visit. 2. Facilitate monthly collaboration meetings with key stakeholders to design and refine workflows for member outreach and engagement. 3. Ongoing Partnership with OC HCA and CalOptima Health IT teams to support the exchange of data files.	FUM/FUA/FUI by: End of Q4 PIP: by End of Q4	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Diane Ramos / Natalie Zavala / Carmen Katsarov	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	Yes - Regulatory / Contractual and Prior Year Evaluation (goal not met)

OAC 03/19/2026

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
34	Quality of Clinical Care	Program Oversight	Medication Adherence	Improve from the HEDIS MY2024 final rate to meet the HEDIS MY2025 goal by September 30, 2026 for the following measures: 1. Medication adherence for Cholesterol (Statins) 2. Hypertension (RAS Antagonists) 3. Diabetes (Non-insulin)	OneCare members	1. Member outreach calls 2. Provider outreach calls 3 Pharmacy outreach calls 4 Health Network report support 5. IVRs 6. Mail order sign-up outreach	12/31/2026 (all)	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Dr. Nicki Ghazanfarpour	Clinical Pharmacist	Pharmacy Management	Yes - Program Oversight
35	Quality Data	Initiative	Cozeva PayerOne Software Solution	Deploy the Cozeva PayerOne software solution to advance the completeness and timeliness of quality data exchange. Goals include: 1. Achieve automatic bidirectional data exchange with Health Network partners by February 2026. 2. Onboard 20 high-volume provider offices to the Cozeva user interface by July 2026. 3. Integrate at least 5 high-volume CHCN provider EMR systems with Cozeva to automatically extract quality data by December 2026.	N/A	1. Launch the Cozeva Bridge solution to obtain quality data from Health Network partners. 2. Provide Cozeva with the file set needed to support HEDIS measure computation and weekly refresh (i.e. medical claims, pharmacy claims). 3. Provide Cozeva with the file set needed to support Risk Adjustment activities (i.e. MAO/MMR/MOR files). 4. Complete measure validation. 5. Enable natural language processing (NLP) in support of automated chart review and improved quality care gap closure. 6. Launch computation tenancy. 7. Begin provider onboarding activities. 8. Begin EMR integration activities.	1. By 01/16/2026 2. By 02/09/2026 3. By 02/09/2026 4. By 02/28/2026 5. By 02/28/2026 6. By 03/31/2026 7. By 04/01/2026 8. By 04/01/2026	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Kelli Glynn	Program Manager (Quality Incentives)	Quality Analytics	New - Program Oversight
36	Program Oversight/Quality of Clinical Care	Initiative	At-Home Visit Program	Goal: Implement an at-home visit program and report key findings and activities, analyze barriers and improvement efforts, and compare program data against the following goals: 1. By December 31, 2026, connect 40% of eligible members to an at-home visit provider. 2. By December 31, 2026, complete at least 500 at-home annual wellness visits (AWVs) for eligible members. 3. By December 31, 2026, improve HEDIS measure performance for Care for Older Adults, Controlling Blood Pressure, and Diabetes Care - Blood Sugar Control by at least 5%.	CalOptima Health Community Network (CHCN) members across all lines of business who have not had an Annual Wellness Visit (AWV) within the last 12 months, and/or have multiple open quality care gaps.	1. Complete all contracting-related activities in Q1 2026. 2. Launch multi-modal outreach campaigns to eligible members in Q1 2026; utilize text, email, and phone to encourage AWV scheduling. 3. Implement reporting tools to track AWV completion, member engagement, member satisfaction, and quality care gap closure. 4. Compare program data against target goals quarterly. Highlight trends and barriers in reports to leadership and QIHEC.	1. By 02/20/2026 2. By 02/27/2026 3. By 03/20/2026 4. Ongoing 12/31/2026	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Kelli Glynn	Supervisor, Quality Analytics	Quality Analytics	New - Program Oversight
37	Program Oversight/Quality of Clinical Care	Initiative	At-Home Lab Testing	Goal: Implement an at-home lab testing program and report key findings and activities, analyze barriers and improvement efforts, and compare program data against the following goals: 1. By December 31, 2026, achieve a 20% kit return rate for Colorectal Cancer Screening, Hemoglobin A1c testing, and kidney health testing. 2. By December 31, 2026, improve HEDIS measure performance for Colorectal Cancer Screening, Diabetes Care - Blood Sugar Control, and Kidney Health Evaluation for Patients with Diabetes by at least 5%.	CalOptima Health Community Network (CHCN) members across all lines of business are due for Colorectal Cancer Screening, Diabetes Care - Blood Sugar Control, or	1. Launch multi-modal outreach campaigns to eligible members; utilize text, email, and phone to encourage completion of lab testing. 2. Implement reporting tools to track test completion, member engagement, member satisfaction, and quality care gap closure. 3. Compare program data against target goals quarterly. Highlight trends and barriers in reports to leadership and QIHEC.	1. 12/31/2026 2. By Q2 2026 3. 12/31/2026	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Kelli Glynn	Manager of Quality Analytics	Quality Analytics	New - Program Oversight

OAC 03.19.2026

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
					Kidney Health Evaluation for Patients with Diabetes HEDIS measures.							
38	Quality of Service	Network Adequacy	Improve Network Adequacy: Reducing Gaps In Provider Network	1. For primary care providers: • Meet or exceed the MPL of 1:2000 (practitioner to member) ratio • Meet or exceed the 99% of practitioners being within ten (10) miles or thirty (30) minutes from any Member or anticipated Member's residence 2. For high-volume specialists: • Meet or exceed the MPL practitioner-to-member ratios in GG.1600 and MA.7007. • Meet or exceed the 99% of practitioners being within fifteen (15) miles or thirty (30) minutes from any Member or anticipated Member's residence 3. Participate and comply with regulatory submissions/audits: • Annual Network Certification (ANC) • Subdelegate Network Certification (SNC) • Network Adequacy Validation (NAV) Audit	Medi-Cal and OneCare Provider Network	Assess and report the following activities: 1. Conduct gap analysis of our network to identify opportunities with providers and expand the provider network 2. Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members 3. Annual participation of ANC, SNC and NAV to DHCS with AAS or CAP 4. Communicate monitoring results and the remediation process to HN	1) Quarterly gap analysis 03/31/2026 06/30/2026 09/30/2026 12/31/2026 2) Completion will vary depending on the quarter that results in a gap 3) Submission- ANC by end of Q1 SNC by DHCS designated deadline NAV audit - date TBD by DHCS 4) Quarterly 03/31/2026 06/30/2026 09/30/2026 12/31/2026	Report to MEMx Q1: 01/27/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/06/2026	Quynh Nguyen	Manager, Provider Operations	Provider Data Operations	Yes - Regulatory / Contractual

OAC 03.19.2026

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
39	Quality of Service	Network Adequacy	Improve Timely Access: Appointment Availability/Telephone Access	1. Reach DHCS threshold appointment compliance rate of 70% MPL for all provider types by December 31, 2026. 2. Decrease the survey non-participation rate with individual providers by 10%.	Medi-Cal and OneCare Providers	1. Offer two training sessions per year on appointment and telephone access. 2. Provide Health Networks with a list of their noncompliant (including non-participating) providers for further action. 3. Resurvey non-compliant providers up to three times within a survey period. 4. Include individual provider survey results through multiple communication channels.	1. Q2 2026 2. Q1-Q3 2026 3. Q4 2026 4. Q4 2026	Report to MEMx Q1: 01/27/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/06/2026	Kelli Glynn	Manager of Quality Analytics / Project Manager of Quality Analytics	Quality Analytics	Yes - Regulatory / Contractual and Prior Year Evaluation (focus area = Psychiatrist Urgent and Psychiatrist Follow-up Appointments)
40	Quality of Service	Member Experience	Improve Member Experience/CAHPS	Improve CAHPS performance as follows:For OneCare:1. Annual Flu Vaccine: maintain or exceed 4 Stars2. Getting Needed Care: improve from 1 Star to 3 Stars3. Getting Appointments and Care Quickly: improve from 1 Star to 3 Stars4. Customer Service: improve from 1 Star to 3 Stars5. Rating of Health Care Quality: improve from 2 Stars to 3 Stars6. Rating of Health Plan: improve from 3 Stars to 4 Stars7. Care Coordination: improve from 1 Star to 3 Stars8. Rating of Drug Plan: improve from 3 Stars to 4 Stars9. Getting Needed Prescription Drugs: improve from 1 Star to 3 StarsFor Medi-Cal: Achieve or exceed the 33rd percentile for the following measures:1. Rating of All Health Care2. Rating of Health Plan3. Getting Needed Care4. Getting Care Quickly	All CalOptima Health Members	Assess and report on the following activities: 1. Execute the 'Just in Time' campaign in Q1 2026 to connect with members likely to respond negatively to the CAHPS survey to address unmet needs, as well as encourage survey completion amongst members who are likely to respond positively.2. Launch several Listening Post campaigns via two-way SMS across both lines of business and provide year-round service recovery in collaboration with multiple departments.3. Hold recurring meetings with Health Network Member Experience teams dedicated to MEMX improvement strategy.4. Provide Health Network partners with member-level predictive CAHPS analytics to inform targeted outreach campaigns.5. Partner with multiple departments to complete multi-modal outreach to members upon referral inquiry and post-referral authorization for impacted specialties such as Neurology, Rheumatology, and Urology.6. Distribute CAHPS playbooks and tip sheets to Health Network partners and provider offices.7. Launch member-facing digital educational campaigns regarding accessing care and the specialty referral process.	1. Q1 20262. Ongoing 12/31/20263. Ongoing 12/31/20264. Q2 20265. Ongoing 12/31/20266. Ongoing 12/31/20267. Q2 2026	Report to MEMxQ1: 01/27/2026Q2: 04/14/2026Q3: 07/14/2026Q4: 10/06/2026	Kelli Glynn	Manager of Quality Analytics / Project Manager of Quality Analytics / Quality Improvement Specialist	Quality Analytics	Yes - Program Oversight: CAHPS - Prior Year Evaluation (goal not met)

OAC 02.19.2026

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
41	Quality of Service	Member Experience	Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process, and report key findings and/or activities, analyze barriers, and improvement efforts. Maintain the grievance, appeals, and resolution process while meeting all regulatory requirements for timely processing of appeals and grievances, with a target goal of 95%.	OneCare members Medi-Cal members	1. Track and trend appeals and grievance data and implement process improvements and remediations as needed. 2. Comply with regulatory standards and compliance.	1. Ongoing 12/31/2026 2. Ongoing 12/31/2026	Report to GARS: Q1: 03/12/2026 Q2: 05/19/2026 Q3: 08/18/2026 Q4: 11/17/2026	Heather Sedillo	Manager of Grievance and Appeals	GARS	Yes - Regulatory / Contractual
42	Quality of Service	Member Experience	Customer Service Call Center	Implement customer service process and monitor against the following standards: 1. OC Call Center Abandonment Rate 5% or lower 2. OC Call Center Average Speed of Answer 2 minutes or lower 3. MC Call Center Average Speed of Answer 10 minutes or lower Report key findings and/or activities, analyze barriers, and improvement efforts.	OneCare members Medi-Cal members	Track and trend customer service call center data Comply with regulatory standards Improve the process for handling customer service calls	Report to MEMx Q1: 01/27/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/06/2026	Report to MEMx Q1: 01/27/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/6/2026	Andrew Tse	Managers of Customer Service (Medi-Cal and OneCare)	Customer Service	Yes - Regulatory / Contractual

OAC 03.19.2026

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
43	Safety of Clinical Care	PHM Strategy	Emergency Department Program (Patient Safety or Outcomes Across Settings)	Enhance care coordination and member outcomes by: 1. Maintaining real-time member outreach in ED. 2. Expand to at least 2 additional ED locations by the end of Q4 2026. 3. Assisting OneCare members discharged from ED with follow-up appointments within 7 days. 4. Tracking service utilization, reporting key findings, and analyzing barriers for continuous improvement.	Adults At Risk for Avoidable Hospital or ED Utilization	1. Maintain Real-Time Member Outreach in Emergency Departments (ED) a. Continue proactive engagement with members during ED visits. b. Monitor and adjust outreach strategies as needed. 2. Sustain Weekly Workgroup Meetings and Continuous Improvement a. Hold regular workgroup sessions to review interventions and recommendations. b. Implement ongoing refinements to processes and workflows. 3. Implement ED Post-Discharge Follow-Up for OC Members a. Begin scheduling post-discharge follow-up appointments for OC members. b. Finalize and optimize workflows for member identification and appointment scheduling. c. Continuously refine processes based on feedback and outcomes. 4. Expand Onsite Staff Presence Across Additional Emergency Departments a. Identify new ED locations for program expansion. b. Develop and implement strategies for scaling onsite activities. c. Continue process improvements to support expansion efforts.	Activities 1-3 March 30, 2026; Activities 4a-c Dec 31, 2026	Report to UMC: Q1: 02/19/2026 Q2: 05/21/2026 Q3: 08/20/2026 Q4: 11/19/2026	Michelle Evans		Utilization Management	Yes - Program Oversight
44	Safety of Clinical Care	PHM Strategy	Transitional Care Services (TCS) (Patient Safety or Outcomes Across Settings)	1. UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% by 12/31/2026. 2. Achieve the 2026 Goal for the following measures: a. MC and OC: Plan All-Cause Readmissions 18-64 (PCR). For MC, the goal is to decrease the Observed to Expected Ratio (O/E) from 0.8983 to 0.8937 by 12/31/2026; for OC, the goal is to decrease readmissions from 10% to 8% by 12/31/2026. b. OC: Transitions of Care (TRC)	• Adults At Risk for Avoidable Hospital or ED Utilization • Pregnant and Postpartum Women; • Individuals experiencing homelessness ; • Members experiencing a transition; • High-risk members. OneCare members	1a. TCS: Develop and Implement Reporting Dashboards: Create a dashboard for DHCS reporting requirements in collaboration with IT. b. Implement a real-time dashboard to identify opportunities for member outreach within 7 days of discharge. c. TCS; Continue refining workflows to improve operational efficiency. d. Implement process improvements that support timely interventions. e. TCS:Automate Jiva System Enhancements for TCS activity creation linked to inpatient episode creation. f. Reduce manual processes through system integration and automation. g. Automate ECM Reporting: Transition ECM successful interaction reporting from manual to automated processes. h. Ensure accurate and timely reporting for compliance and performance tracking. 2a-b i). Collaborating on Readmission Strategies: Attend Health Network (HN) Joint Operating Meetings (JOMs). ii). Request and document strategies HNs are using to reduce readmissions. a iii) Identify best practices for integration into workflows. iii). Share Readmission Rates for Transparency: Provide quarterly updates on facility-level and HN readmission rates during JOMs. iv). Use shared data to highlight opportunities for improvement. v). Report Post-Discharge Ambulatory Follow-Up Rates: Share quarterly reports on follow-up rates within 7 days of discharge with HNs and facilities during JOMs.	1a. March 30, 2026; 1b-h Dec 31, 2026 2. Dec 31, 2026; 3. Sept 30, 2026; 4. June 30, 2026;	Report to UMC: Q1: 02/19/2026 Q2: 05/21/2026 Q3: 08/20/2026 Q4: 11/19/2026	Michelle Evans	Project Manager, Medical Management	Utilization Management	Yes - Program Oversight and Prior Year Evaluation (PCR and TRC)

OAC 03.19.2026

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
						vi). Continue TCS activities and program enhancements to support member outreach and engagement. vii). Support Member Engagement and PCP Follow-Up; Maintain TCS activities focused on connecting members with their PCP after discharge. viii). Assisting OneCare members discharged from ED with follow-up appointments within 7 days. ix). Case Management will continue to outreach to all members admitted. x). UM notification to PCP of all admissions and discharges xi). Implement post-discharge program with Papa and share with all health networks xii). PointClickCare discharge sharing (implemented 9/18/2025) xiii). PointClickCare admission notifications (live 12/15/2025) xiv). Provider Portal enhancement- PCP notification for admissions and discharges (implemented 10/2025)						
45	Quality of Clinical Care and Safety of Clinical Care	Program Oversight	Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	Monitor PCPs, High Volume Specialists, and ancillary sites using the DHCS audit tool and methodology, and report any findings, barriers, and improvement efforts. 1. 95% of subsequent site reviews will be conducted at least every three years from the previous FSR/MRR. 2. 95% of Initial FSRs to be completed on relocated PCP sites within 60 days of notification or discovery of the move. 3. 95% of PARS will be conducted at least every three years from the previous PARS	Medi-Cal Providers	Q1-Q4 2026:. 1. Complete periodic site reviews by assigned due dates. 2. Complete annual site reviews on sites with failed scores on previous FSR and/or MRR audits. 3. Monitor and evaluate critical element criteria on all PCP sites between regularly scheduled site reviews. 4. Provide extensive training, education, and technical assistance on all sites with scores less than 80%.	1. Ongoing 2. Ongoing 3. Ongoing 4. 12/31/2026	Report to CPRC: Q1: 02/26/2026 Q2: 05/28/2026 Q3: 08/27/2026 Q4: 11/19/2026	Marsha Choo	Manager of Quality Improvement	Quality Improvement	Yes - Regulatory / Contractual

OAC 03.19.2026

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
46	Quality of Clinical Care and Safety of Clinical Care	Program Oversight	Potential Quality Issues Review	1. Close 80% of PQIs within 90 days. 2. Close 80% of declined grievances within 30 days.	Medi-Cal and OneCare Program	1. Review and report on quality-of-care cases for peer review (CPRC), determine appropriate severity level and make recommendations for actions based on findings. 2. In Q1, collaborate with IT to develop a report to monitor TAT. 3. Monthly, monitor the TAT of PQIs and declined grievances. 4. Develop and implement an IRR process for RNs for QOC grievances. 5. Review the current training in Customer Service and GARS of PQI and update materials as needed.	1. Ongoing - Monthly 2. March 30, 2026 3. Ongoing - Monthly 4. December 31, 2026 5. December 31, 2026	Report to CPRC: Q1: 01/29/2026 Q2: 04/23/2026 Q3: 07/23/2026 Q4: 10/22/2026	Marsha Choo	Manager of Quality Improvement	Quality Improvement	Yes - Program Oversight
47	Quality of Clinical Care and Safety of Clinical Care	Program Oversight	Sentinel Event Monitoring and Disease Surveillance	1. Screen claims and encounter data for Provider Preventable Conditions (PPCs) monthly. 2. Report to DHCS PPCs when identified.	Medi-Cal and OneCare Program	1. Screen claims and encounter data monthly. 2. Present PPC findings quarterly to CPRC.	1. Ongoing - Monthly 2. Ongoing - Quarterly	Report to CPRC: Q1: 03/10/2026 Q2: 06/09/2026 Q3: 09/08/2026 Q4: 12/08/2026	Marsha Choo	Manager of Quality Improvement	Quality Improvement	New - Regulatory / Contractual

OAC 03.19.2026

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
48	Quality of Clinical Care and Safety of Clinical Care	Program Oversight	Quality Assurance Performance Improvement (QAPI) for Long-Term Care Services	1. Develop and implement an LTSS QAPI Program 2. Develop and implement an LTC Performance Improvement Project (PIP) as part of the QAPI	LTC Facilities	1. Develop an annual QAPI Program and submit to DHCS 2. Implement the QAPI and report, at a minimum but not limited to the following: - Potential Quality Issues (PQIs) - Critical Incidents (CIs) - Skilled Nursing Facility (SNF) QAPI Oversight including audits - LTC PIP	1. 01/31/2026 2. Ongoing 12/31/2026	Report to QIHEC: Q1: 03/10/2026 Q2: 06/09/2026 Q3: 09/08/2026 Q4: 12/08/2026	Scott Robinson	Manager of Long-Term Support Services	Long Term Support Services	Yes - Regulatory / Contractual and Program Oversight
49	Quality of Clinical Care and Safety of Clinical Care	Program Oversight	Provider Credentialing and Recredentialing	All providers are credentialed and recredentialed according to regulatory and accreditation timeframe requirements: 1. A credentialing decision will be rendered for 90% of credentialing files within 120 days from receipt of a complete application 2. 90% of providers are recredentialed within 36 months from the last credentialing or recredentialing decision date	Medicaid, Medicare, Exchange	1. Review and report providers are credentialed according to regulatory requirements: 2. CVO and technology RFP release in Q1 2026 3. CVO and technology implementation by Q4 2026 (consistent with vendor availability to go live in 2026)	1. Ongoing 2. 03/31/2026 3. 12/31/2026	Report to CPRC: Q1: 02/26/2026 Q2: 05/28/2026 Q3: 08/27/2026 Q4: 11/19/2026	Sharlee LeBleu	Manager of Quality Improvement	Quality Improvement	Yes - Regulatory / Contractual

OAC 03.19.2026

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
50	Cultural and Linguistic Appropriate Services	CLAS	Language Services: Cultural and Linguistics and Language Accessibility	Provide interpreter and translation services and report key findings and/or activities, analyze barriers, and identify improvements. 1. By December 31, 2026, CalOptima Health will evaluate its language services experience by collecting feedback from 6% to 10% of members and from 4% to 80% of staff using surveys and will analyze the results to identify improvements to language services. 2. Member experience with language services will maintain a satisfaction rate of 90% or above by December 31, 2026. 3. Staff experience with language services will maintain a satisfaction rate of 90% or above by December 31, 2026.	CalOptima Health employees and CalOptima Health LEP members who utilize language services	1. Review and revamp CalOptima Health member and staff survey. 2. Launch surveys to LEP members who utilized language services within the previous 6 months. 3. Distribute surveys to CalOptima Health member-facing staff/departments. 4. Collect and analyze response data and identify gaps/opportunities for improvement 5. Complete the 2026 Experience with Language Services and Utilization Analysis Report	1. 02/16/2026 2. 04/15/2026 3. 04/15/2026 4. 06/30/2026 5. 07/31/2026	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Albert Cardenas	Manager of Cultural and Linguistics	Cultural and Linguistic Services	Yes - Regulatory / Contractual and Program Oversight and Prior Year Evaluation (member and staff low response rate)
51	Cultural and Linguistic Appropriate Services	CLAS	Data Collection on Member Demographic Information	1. By September 30, 2026, CalOptima Health will update the current data system to receive, store and retrieve the following: disability function and identity, physical accommodations, auxiliary aides or services, geographic classification, age, and veteran/military status 2.By Dec. 31st, 2026, CalOptima Health will increase the collection of member disability function data from 0 to 5% through focused outreach and education, ensuring better representation and inclusion of members.	CalOptima Health Members	1. Work with IT to update Facet to accept/store disability function, identity and physical accommodations, auxiliary aides or services, geographic classification, age, and veteran/military status. 2. Develop/modify member surveys to collect disability function, identity and physical accommodations, auxiliary aids or services, geographic classification, age, and veteran/military status. 3. Develop scripting and training for Customer Service staff to capture disability function, identity and physical accommodations, auxiliary aids or services, geographic classification, age, and veteran/military status during phone interaction. Begin the mailing of surveys to collect disability function, identity and physical accommodations, auxiliary aids or services, geographic classification, age, and veteran/military status.	1.09/20/2026 2.03/30/2026 3.06/30/2026	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Albert Cardenas	Manager of Cultural and Linguistics	Cultural and Linguistic Services	New - Program Oversight

OAC 05.19.2026

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
52	Cultural and Linguistic Appropriate Services	CLAS	Data Collection on Practitioner Demographic Information	1. By Dec. 31st, 2026, CalOptima Health will increase the collection of provider race/ethnicity/languages (REL) data through focused outreach and education, ensuring better representation and inclusion of providers as follows: • Race/Ethnicity – 18% • Language – 7%	N/A	1. Outreach to medical groups to collect REL data 2. Load REL data into the provider data system to ensure it can be retrieved and used for CLAS improvement	1. 02/28/2026 2. 12/31/2026	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Quynh Nguyen	Manager, Provider Data Operations	Provider Data Operations	Yes - Program Oversight and Prior Year Evaluation (low response rate)
53	Cultural and Linguistic Appropriate Services	CLAS	Network Cultural Responsiveness: Provider Trainings to Improve Care or Service Delivery	2. By December 31, 2026, CalOptima Health will provide at least one continuing education training to providers on the unique health or health care needs of: 1. At least one racial, ethnic or cultural subgroup that represents CalOptima Health members. 2. At least one gender or sexual orientation subgroup relevant to CalOptima Health members 3. Members with disabilities 4. Members in rural geographies	Healthcare Providers	1. Collaborate with a selected ethnic group to co-develop a presentation. 2. Identity presenter, determine presentation component, design relevant content and schedule training date. 3. Consult with the Dayle McIntosh Center on training opportunities for members with disabilities. 4. Incorporate strategies to improve access to care for members in rural geographies within at least one continuing education training.	1. 06/30/2026 2. 12/31/2026 3. 12/31/2026 4. 12/31/2026	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Jane Flanegan-Brown / Rocio Valencia	Manager of Provider Relations	Provider Relations and Equity and Community Health	New - Program Oversight

OAC 03.19.2026

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
54	Cultural and Linguistic Appropriate Services	CLAS	Network Cultural Responsiveness: Building and Maintaining a Responsive Work Force	1. By Dec. 31st, 2026, CalOptima Health will offer at least one training or education to employees focused on improving the quality of or experience with health care or services or reducing disparities.	CalOptima Health employees	1. Assess whether the Dec 2025 DEI training module, which had 100% active employee participation, has met this goal. 2. Identify SME's for developing or selecting training content to be hosted by CalOptima University LMS.	1. 09/30/2026 2. 12/31/2026	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Michael Coringrato	Lead Training and Education Specialist	Human Resources	Yes - Program Oversight

OAC 03.19.2026

HEDIS MY2025 Medicaid Goals

Abbrev	Medicaid HEDIS Measures	Method	HEDIS MY2024 Rpt Rate	HEDIS MY2025 Goal	Long Term Goal (90th)	Medicaid 10th percentile	Medicaid 25th percentile	Medicaid 33rd percentile	Medicaid 50th percentile	Medicaid 66th percentile	Medicaid 75th percentile	Medicaid 90th percentile
WCC	Weight Assessment and Counseling for Children/Adolescents (BMI)	H	90.83%	**91.24%**	91.24%	66.91%	75.00%	76.89%	82.73%	86.20%	87.59%	91.24%
	Nutrition	H	83.84%	**84.37%**	84.37%	51.70%	63.87%	65.94%	71.78%	76.40%	79.08%	84.37%
	Physical Activity	H	83.41%	**82.16%**	82.16%	46.23%	59.85%	62.29%	68.33%	73.97%	77.13%	82.16%
CIS	Childhood Immunization Status (comb10)	H	38.69%	**42.34%**	42.34%	18.25%	22.87%	24.39%	27.49%	31.32%	34.79%	42.34%
IMA	Immunization for Adolescents (comb2)	H	45.50%	**48.66%**	48.66%	25.41%	29.72%	31.39%	34.30%	38.69%	41.61%	48.66%
LSC	Lead Screening in Children	H	70.80%	**63.84%**	79.51%	36.22%	53.12%	58.30%	63.84%	68.74%	71.11%	79.51%
BCS-E	Breast Cancer Screening	E	59.13%	**59.51%**	0.6348	42.86%	47.93%	49.24%	52.68%	56.66%	59.51%	63.48%
CCS	Cervical Cancer Screening	H	57.86%	**60.10%**	67.46%	43.31%	49.64%	52.07%	57.18%	60.10%	61.56%	67.46%
CHL	Chlamydia Screening in Women	A	76.66%	**67.39%**	67.39%	42.61%	49.65%	51.39%	56.04%	61.07%	62.90%	67.39%
COL-E	Colorectal Cancer Screening	A	47.60%	**49.35%**	49.35%	27.27%	31.58%	34.30%	38.07%	41.59%	43.71%	49.35%
CWP	Appropriate Testing for Pharyngitis	A	52.38%	**76.71%**	89.17%	61.35%	73.85%	76.71%	80.68%	85.11%	86.26%	89.17%
PCE	Pharmacotherapy management of COPD exacerbations (Corticosteroid)	A	72.37%	**71.36%**	82.88%	55.28%	63.48%	66.86%	71.36%	74.78%	77.35%	82.88%
	Bronchodilator		88.92%	**86.54%**	89.96%	67.25%	78.79%	80.19%	83.56%	86.54%	87.93%	89.96%
AMR	Asthma Medication Ratio (5-64 years)	A	66.08%	**70.56%**	76.65%	54.56%	59.47%	62.35%	66.24%	70.56%	72.22%	76.65%
CBP	Controlling High-Blood Pressure	H	67.54%	**72.75%**	72.75%	54.61%	59.73%	61.43%	64.48%	67.40%	69.37%	72.75%
PBH	Persistence of Beta Blocker Treatment after a Heart Attack	A	62.57%	**57.39%**	67.21%	40.74%	50.82%	53.57%	57.39%	61.90%	63.12%	67.21%
SPC	Statin Therapy for Patients with Cardiovascular Disease - Therapy	A	81.13%	**81.42%**	85.89%	66.64%	77.92%	79.82%	81.42%	83.00%	83.86%	85.89%
	Statin Therapy for Patients with Cardiovascular Disease - Adherence		77.89%	**81.79%**	81.79%	59.95%	65.19%	67.42%	70.52%	74.07%	76.48%	81.79%
CRE	Cardiac Rehabilitation - initiation (MY2020)	A	0.62%	**1.72%**	13.60%	0.00%	1.11%	1.72%	2.92%	3.95%	4.91%	13.60%
	Engagement 1	A	2.69%	**4.24%**	11.88%	0.00%	1.20%	2.38%	4.24%	6.01%	7.06%	11.88%
	Engagement 2	A	3.31%	**3.81%**	9.03%	0.11%	1.39%	2.30%	3.81%	4.98%	5.81%	9.03%
	Achievement	A	1.45%	**1.28%**	4.15%	0.00%	0.30%	0.68%	1.28%	1.87%	2.34%	4.15%
GSD	HbA1c Control for Patients with Diabetes - Poor Control (>9.0%)	H	30.92%	**27.01%**	27.01%	47.65%	40.15%	37.47%	33.33%	30.90%	29.93%	27.01%
	HbA1c Control (<8.0%)	H	61.60%	**59.64%**	63.50%	44.25%	51.58%	54.50%	57.42%	59.64%	60.83%	63.50%
EED	Eye Exam for patient with Diabetes	H	64.34%	**64.06%**	64.06%	40.39%	45.74%	49.15%	53.53%	57.09%	59.41%	64.06%
BPD	Blood Pressure Controlled for Patients with Diabetes	H	70.07%	**77.37%**	77.37%	58.15%	62.53%	65.32%	68.75%	71.78%	73.59%	77.37%
KED	Kidney Health Evaluation for Patients with Diabetes		51.02%	**45.11%**	49.72%	26.79%	30.63%	33.00%	36.46%	42.10%	45.11%	49.72%
SPD	Statin Therapy for Patients with Diabetes - therapy	A	73.15%	**71.41%**	71.41%	51.96%	60.83%	62.66%	65.28%	67.01%	68.12%	71.41%
	Statin Therapy for Patients with Diabetes - adherence		73.20%	**73.39%**	79.73%	53.23%	61.38%	64.18%	68.06%	70.91%	73.39%	79.73%
AMM	Antidepressant Medications Management (Acute Phase Treatment)	A	67.21%	**68.35%**	76.76%	49.86%	56.34%	58.37%	62.43%	65.60%	68.35%	76.76%
	Continuation Phase Treatment		50.64%	**48.16%**	61.06%	31.52%	38.63%	41.00%	44.25%	48.16%	50.14%	61.06%
ADD-E	Follow-up Care for Children Prescribed ADHD Medication (Initiation Phase)	A	50.35%	**48.96%**	55.40%	34.62%	41.30%	42.51%	45.72%	47.74%	48.96%	55.40%
	Continuation Phase		58.69%	**53.90%**	63.49%	37.19%	45.78%	48.94%	53.90%	56.83%	59.13%	63.49%
DMH	Diagnosed Mental Health Disorders	A	18.98%	**23.90%**	39.71%	17.78%	21.65%	23.90%	27.69%	31.55%	33.77%	39.71%
DSU	Diagnosed Substance Use Disorders (any)	A	3.43%	**4.97%**	11.47%	2.11%	4.30%	4.97%	6.44%	8.02%	8.90%	11.47%
FUI	Follow-up After High-Intensity Care for Substance Use Disorder (30-day) - (MY2019)	A	30.69%	**44.53%**	69.82%	31.71%	40.07%	44.53%	53.28%	59.90%	63.69%	69.82%
	Follow-up After High-Intensity Care for SUD (7-day)		13.65%	**26.90%**	50.80%	15.91%	23.08%	26.90%	32.34%	37.64%	41.53%	50.80%
FUM	Follow-up After ED visit for Mental Illness (30-day)	A	52.33%	**53.82%**	73.12%	36.32%	46.05%	49.22%	53.82%	59.65%	63.06%	73.12%
	Follow-up After ED visit for Mental Illness (7-day)	A	32.96%	**33.01%**	59.95%	21.19%	29.99%	33.01%	38.62%	44.33%	49.49%	59.95%
FUA	Follow-up After ED visit for Alcohol and Other Drug Dependence 30-day		28.63%	**36.18%**	49.40%	21.41%	26.79%	29.07%	36.18%	39.35%	41.86%	49.40%
	Follow-up After ED visit for Alcohol and Other Drug Dependence 7-day	A	16.81%	**18.76%**	37.47%	12.73%	16.74%	18.76%	24.00%	27.62%	29.09%	37.47%
POD	Pharmacotherapy for Opioid Use Disorder (MY2019)	A	4.93%	**21.36%**	36.71%	12.05%	18.18%	21.36%	25.28%	29.01%	31.78%	36.71%
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic medications	A	76.86%	**79.51%**	87.27%	75.46%	78.06%	79.51%	81.42%	83.51%	84.63%	87.27%
SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia	A	76.33%	**75.47%**	79.49%	60.89%	66.75%	68.75%	71.27%	73.74%	75.47%	79.49%
SMC	Cardiovascular Monitoring for People with Cardiovascular and Schizophrenia	A	80.82%	**79.55%**	87.50%	67.39%	74.30%	76.36%	79.55%	81.40%	83.44%	87.50%
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	A	69.86%	**74.83%**	74.83%	44.65%	56.14%	58.60%	62.56%	66.15%	68.08%	74.83%
APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Glucose	A	55.57%	**58.64%**	68.79%	46.17%	50.74%	52.20%	56.59%	58.64%	61.05%	68.79%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics - cholesterol		35.76%	**43.06%**	54.29%	27.42%	30.97%	32.99%	37.62%	43.06%	44.70%	54.29%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Total		34.58%	**41.41%**	52.57%	25.86%	29.41%	30.92%	35.59%	41.41%	43.58%	52.57%
NCS	Non-Recommended CCS in Adolescent Females	A	N/A	**0.15%**	0.05%	0.83%	0.53%	0.45%	0.31%	0.21%	0.15%	0.05%
URI	Appropriate Treatment for URI	A	86.38%	**89.13%**	94.15%	80.14%	86.50%	87.38%	89.13%	91.27%	92.47%	94.15%
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis*	A	39.70%	**56.76%**	77.66%	49.48%	54.94%	56.76%	62.14%	67.03%	69.28%	77.66%
LBP	Use of Imaging Studies for Low Back Pain*	A	72.21%	**74.09%**	78.72%	64.77%	67.07%	67.84%	70.55%	72.74%	74.09%	78.72%
HDO	Use of Opioids at High Dosage	A	2.08%	**2.14%**	0.75%	13.18%	7.73%	6.15%	3.95%	2.14%	1.51%	0.75%
UOP	Use of Opioids From Multiple Providers - multiple Prescribers	A	20.47%	**18.61%**	12.85%	26.98%	23.01%	21.50%	18.61%	16.67%	15.79%	12.85%
	Multiple Pharmacies		1.88%	**3.14%**	1.44%	6.27%	4.29%	3.74%	3.14%	2.27%	1.95%	1.44%

DAC 03-19-2025

	Multiple Prescribers and Pharmacies		1.39%	**1.83%**	0.63%	4.21%	2.73%	2.44%	1.83%	1.22%	1.02%	0.63%
COU	Risk of Continued Opioid Use (MY2018) - 15 days	A	6.18%	**6.04%**	2.46%	10.37%	7.98%	7.23%	6.04%	4.80%	3.92%	2.46%
	Risk of Continued Opioid Use - 31 days	A	2.77%	**2.79%**	1.17%	6.06%	4.85%	4.14%	3.39%	2.79%	2.29%	1.17%
AAP	Adults' Access to Preventive/Ambulatory Health Services (20-44)	A	N/A	**67.52%**	80.42%	57.20%	65.41%	67.52%	71.68%	75.08%	76.68%	80.42%
	Adults' Access to Preventive/Ambulatory Health Services (45-64)	A	N/A	**77.77%**	87.18%	69.81%	75.97%	77.77%	81.07%	83.79%	84.89%	87.18%
	Adults' Access to Preventive/Ambulatory Health Services (65+)	A	N/A	**80.72%**	93.29%	67.01%	73.46%	75.67%	80.72%	86.11%	89.17%	93.29%
	Adults' Access to Preventive/Ambulatory Health Services (Total)	A	62.94%	**71.01%**	83.25%	62.61%	69.16%	71.01%	74.88%	78.35%	79.54%	83.25%
PPC	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	H	88.15%	**88.58%**	91.85%	73.48%	79.81%	81.94%	84.55%	86.89%	88.58%	91.85%
	Prenatal and Postpartum Care (Postpartum Care)	H	81.11%	**80.23%**	86.62%	68.63%	75.67%	77.37%	80.23%	82.48%	83.33%	86.62%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	A	53.10%	**54.55%**	74.14%	41.57%	48.98%	54.55%	60.22%	64.10%	67.06%	74.14%
W30	Well-Child Visits in the First 30 Months of Life (MY2020) 0-15 months	A	70.28%	**60.38%**	69.67%	46.98%	54.46%	57.15%	60.38%	63.29%	64.99%	69.67%
	Well-Child Visits in the First 30 Months of Life - 15-30 months	A	74.40%	**73.09%**	79.94%	59.69%	65.53%	66.79%	69.43%	71.93%	73.09%	79.94%
WCV	Child and Adolescent Well-Care Visits (MY2020) 3-11 years	A	N/A	**62.76%**	70.95%	49.07%	53.50%	55.27%	59.40%	62.76%	65.39%	70.95%
	Child and Adolescent Well-Care Visits (MY2020) 12-17 years	A	N/A	**58.92%**	65.37%	41.90%	46.77%	48.09%	52.39%	56.22%	58.92%	65.37%
	Child and Adolescent Well-Care Visits (MY2020) 18-21 years	A	N/A	**30.69%**	42.37%	19.73%	23.24%	25.08%	27.90%	30.69%	33.78%	42.37%
	Child and Adolescent Well-Care Visits (MY2020) Total	A	55.46%	**55.29%**	64.74%	41.83%	46.57%	48.15%	51.81%	55.29%	58.07%	64.74%
AXR	Antibiotic Utilization for Respiratory Conditions		N/A	**24.21%**	33.84%	16.70%	21.98%	24.21%	26.62%	29.47%	30.89%	33.84%
PCR	Plan All-Cause Readmissions 18-64 (new in 2018)		N/A	**0.8937**	0.8188	1.1783	1.0652	1.029	0.9619	0.9124	0.8937	0.8188
DSF-E	Depression Screening and Follow-up for Adolescents and Adults - Screening 12-17	E	N/A	**15.28%**	15.28%	0.00%	0.00%	0.03%	0.16%	1.20%	2.69%	15.28%
	Depression Screening and Follow-up for Adolescents and Adults - Screening 18-64	E	N/A	**16.48%**	16.48%	0.00%	0.09%	0.32%	1.39%	3.30%	4.71%	16.48%
	Depression Screening and Follow-up for Adolescents and Adults - Screening 65+	E	N/A	**27.33%**	27.33%	0.00%	0.26%	0.63%	1.83%	4.98%	9.14%	27.33%
	Depression Screening and Follow-up for Adolescents and Adults -Screening Total		8.65%	**16.22%**	16.22%	0.00%	0.09%	0.32%	1.03%	2.67%	4.52%	16.22%
DSF-E	- Follow up 12-17	E	N/A	**93.49%**	93.49%	71.61%	78.32%	80.67%	83.03%	87.37%	89.03%	93.49%
	- Follow up 18-64	E	N/A	**84.14%**	84.14%	47.37%	56.76%	62.50%	70.76%	77.03%	78.32%	84.14%
	- Follow up 65+	E	N/A	**45.85%**	82.24%	32.50%	41.03%	45.85%	52.51%	61.36%	65.85%	82.24%
	- Follow up Total		82.12%	**77.07%**	87.39%	48.28%	58.11%	65.70%	70.91%	77.07%	78.82%	87.39%
DMS-E	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Period 1	E	N/A	**17.60%**	17.60%	0.00%	0.04%	0.33%	1.38%	3.21%	6.12%	17.60%
	Period 2	E	N/A	**17.26%**	17.26%	0.00%	0.00%	0.09%	0.87%	4.55%	6.77%	17.26%
	Period 3	E	N/A	**18.76%**	18.76%	0.00%	0.00%	0.10%	0.79%	2.96%	5.22%	18.76%
	Total	E	N/A	**18.91%**	18.91%	0.00%	0.08%	0.34%	0.93%	3.95%	6.95%	18.91%
DRR-E	Depression Remission or Response for Adolescents and Adults - Follow-up	E	N/A	**50.00%**	50.00%	3.17%	8.29%	14.81%	26.68%	39.71%	43.42%	50.00%
	remission		N/A	**12.55%**	12.55%	0.00%	1.06%	2.23%	4.17%	5.56%	7.02%	12.55%
	Response		N/A	**14.05%**	18.09%	0.00%	2.70%	4.39%	7.89%	11.91%	14.05%	18.09%
AIS-E	Adult Immunization Status - influenza 19-65	E	N/A	**24.63%**	24.63%	7.39%	10.77%	12.40%	14.75%	17.16%	18.34%	24.63%
	Adult Immunization Status - influenza 66+		N/A	**40.88%**	50.10%	16.67%	25.49%	28.57%	35.15%	40.88%	43.21%	50.10%
	Adult Immunization Status - influenza Tota		17.98%	**26.40%**	26.40%	7.39%	10.98%	12.55%	15.53%	17.91%	19.80%	26.40%
	Adult Immunization Status - Tdap 19-65		N/A	**33.84%**	57.96%	22.14%	30.59%	33.84%	38.39%	47.72%	50.74%	57.96%
	Adult Immunization Status - Tdap 66+		N/A	**23.01%**	49.82%	14.73%	20.25%	23.01%	27.90%	35.23%	39.52%	49.82%
	Adult Immunization Status - Tdap Total		38.36%	**33.40%**	57.67%	21.26%	30.35%	33.40%	38.12%	47.30%	50.31%	57.67%
	Adult Immunization Status - Zoster 50-65		N/A	**19.39%**	19.39%	2.20%	4.72%	6.38%	9.75%	13.35%	14.18%	19.39%
	Adult Immunization Status - Zoster 66+		N/A	**19.13%**	31.32%	3.85%	8.45%	10.22%	14.69%	19.13%	21.72%	31.32%
	Adult Immunization Status - Zoster Total		18.49%	**20.56%**	20.56%	2.23%	5.30%	7.15%	10.67%	13.49%	15.79%	20.56%
	Adult Immunization Status - Pneumococcal 66+		N/A	**38.73%**	68.07%	21.04%	35.13%	38.73%	44.41%	55.03%	58.18%	68.07%
PRS-E	Prenatal Immunization Status - Influenza		21.75%	**29.96%**	38.51%	11.45%	17.30%	19.74%	25.10%	29.14%	31.99%	38.51%
	Prenatal Immunization Status - Tdap	E	45.82%	**53.86%**	76.54%	29.65%	43.16%	48.95%	56.53%	63.41%	67.22%	76.54%
	Prenatal Immunization Status - Comb		18.03%	**25.81%**	35.60%	8.42%	13.37%	15.96%	20.85%	24.92%	27.64%	35.60%
PND-E	Prenatal Depression Screening and Follow-up - Screening	E	13.98%	**16.03%**	41.38%	0.00%	0.24%	1.13%	5.62%	12.29%	16.03%	41.38%
	Follow-up	E	77.53%	**53.33%**	66.67%	31.82%	41.90%	45.21%	50.98%	53.33%	57.68%	66.67%
PDS-E	Postpartum Depression Screening and Follow-up - screening		9.24%	**29.84%**	29.84%	0.00%	0.08%	0.25%	1.30%	5.75%	8.80%	29.84%
PDS-E	Postpartum Depression Screening and Follow-up - follow-up	E	87.14%	**61.70%**	84.44%	40.85%	51.30%	54.69%	61.70%	69.68%	71.88%	84.44%
RDM	Race/Ethnicity Diversity of Membership - Race Direct Tota	A	N/A	**70.92%**	99.97%	43.11%	62.41%	70.92%	79.15%	90.44%	93.86%	99.97%
	Race/Ethnicity Diversity of Membership - Ethinicity Direct Tota	A	N/A	**67.53%**	100.00%	4.33%	24.64%	44.96%	67.53%	91.23%	97.32%	100.00%

QAC 03.19.2020

HEDIS MY2025 Medicare Goals

Abbrev	Medicare HEDIS Measures	Method	MY2024 HEDIS Reported Rate	MY2025 HEDIS Goals	Long Term HEDIS Goal (90th)	Medicare 33rd percentile	Medicare 50th percentile	Medicare 66th percentile	Medicare 75th percentile	Medicare 90th percentile	3-Star	4-Star	5-Star
BCS-E	Breast Cancer Screening	E	68.52%	75%	82%	67.84%	71.88%	75.65%	78.57%	82.80%	67%	75%	82%
COL-E	Colorectal Cancer Screening - Total		N/A	70.33%	82.33%	65.21%	70.33%	74.94%	77.86%	82.33%			
	Colorectal Cancer Screening - aged 50-75 (C02)	H	66.94%	75%	83%	66.37%	70.95%	75.56%	78.35%	82.44%	65%	75%	83%
COA	Care for Older Adults (SNP) - Medication Review (C09)	H	N/A	92%	98%						80%	92%	98%
	Care for Older Adults (SNP) - Pain assessment (C11)	H	N/A	92%	96%						81%	92%	96%
CWP	Appropriate Testing for Pharyngitis	A	N/A	72.5%	85.60%	72.51%	75.18%	78.10%	80.65%	85.60%			
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	A	N/A	23.42%	35.92%	23.42%	26.38%	28.96%	31.09%	35.92%			
PCE	Pharmacotherapy management of COPD exacerbations (Corticosteroid)	A	73.88%	71.19%	83.81%	71.19%	74.17%	77.07%	78.44%	83.81%			
	Bronchodilator		93.28%	91.70%	91.70%	82.57%	85.00%	87.18%	88.15%	91.70%			
CBP	Controlling High-Blood Pressure	H	77.26%	80%	85%	72.51%	75.18%	78.10%	80.65%	85.60%	74%	80%	85%
SPC	Disease - Therapy	A	86.13%	88%	92%	84.90%	86.25%	87.50%	88.48%	91.11%	85%	88%	92%
	Statin Therapy for Patients with Cardiovascular Disease - Adherence	A	81.95%	84.18%	92.45%	84.18%	85.93%	87.99%	89.12%	92.45%			
CRE	Cardiac Rehabilitation - initiation (MY2020)	A	1.25%	2.27%	15.95%	2.27%	3.38%	5.63%	6.90%	15.95%			
	Engagement 1	A	5.00%	2.90%	21.37%	2.90%	5.53%	8.61%	11.29%	21.37%			
	Engagement 2	A	6.25%	3.05%	17.77%	3.05%	5.99%	8.99%	10.23%	17.77%			
	Achievement	A	3.75%	2.90%	21.37%	2.90%	5.53%	8.61%	11.29%	21.37%			
GSD	HbA1c Control for Patients with Diabetes - Poor Control (>9.0%) (C15)	H	15.52%	10%	10%	21.17%	17.03%	13.54%	12.24%	9.60%	28%	16%	10%
	HbA1c Control for Patients with Diabetes - Control (<8.0%)	H	72.84%	72.99%	81.02%	69.28%	72.99%	75.86%	77.68%	81.02%			
EED	Eye Exam for Patients with Diabetes(C13)	H	77.61%	77%	83%	69.10%	74.70%	78.59%	81.03%	85.89%	70%	77%	83%
BPD	Blood Pressure Control for patients with Diabetes (C16)	H	75.22%	78.00%	85.96%	71.43%	74.45%	78.00%	80.05%	85.96%			
KED	Kidney Health Evaluation for Patients with Diabetes (MY2020)	A	59.30%	59%	72%	45.73%	52.73%	58.85%	63.04%	72.00%			
SPD	Statin Therapy for Patients with Diabetes - Therapy	A	83.01%	83.05%	85.74%	77.73%	79.65%	81.85%	83.05%	85.74%			
	Statin Therapy for Patients with Diabetes - Adherence	A	79.64%	82.42%	91.72%	82.42%	84.43%	86.52%	87.85%	91.72%			
OMW	Osteoporosis Management in Women Who Had a Fracture (C12)	A	43.64%	39%	71%	34.00%	43.81%	52.72%	57.09%	71.62%	39%	52%	71%
OSW	Osteoporosis Screening in Older Women (MY2020)	A	49.33%	49.08%	68.41%	43.24%	49.08%	57.30%	59.58%	68.41%			
AMM	Antidepressant Medications Management (Acute Phase Treatment)	A	73.71%	78.39%	88.71%	78.39%	81.14%	84.09%	85.65%	88.71%			
	Continuation Phase Treatment		58.22%	62.58%	76.27%	62.58%	65.08%	69.02%	70.53%	76.27%			
FUH	Follow-up After Hospitalization for Mental Illness (30-day)	A	61.61%	56.55%	71.46%	41.27%	48.48%	56.55%	60.38%	71.46%			
	Follow-up After Hospitalization for Mental Illness (7-day)		38.39%	33.52%	50.78%	22.58%	26.67%	33.52%	36.91%	50.78%			
FUI	Follow-up After High-Intensity Care for Substance Use Disorder (30-day)	A	N/A	34.69%	59.38%	34.69%	38.89%	44.12%	47.39%	59.38%			
	Follow-up After High-Intensity Care for SUD (7-day)		N/A	15.79%	37.07%	15.79%	19.60%	24.53%	27.19%	37.07%			
FUM	Follow-up After ED visit for Mental Illness (30-day)		51.16%	49.23%	71.63%	43.17%	49.23%	55.56%	59.06%	71.63%			
	Follow-up After ED visit for Mental Illness (7-day)	A	25.58%	32.57%	57.58%	26.74%	32.57%	39.31%	44.68%	57.58%			
FUA	Follow-up After ED visit for Alcohol and Othe Drug Dependence (new 2017) - 30-day	A	43.75%	38.00%	51.61%	33.54%	38.00%	42.57%	44.71%	51.61%			
	Follow-up After ED visit for Alcohol and Othe Drug Dependence (new 2017) - 7-day	A	18.75%	26.90%	36.67%	20.00%	23.21%	26.90%	29.82%	36.67%			
SAA	Adherence to Antipsychotic medications for Individuals with Schizophrenia	A	79.47%	77.90%	87.32%	75.00%	77.90%	80.91%	82.64%	87.32%			
TRC	Transitions of Care (new 2018) - Notification Admission	H	23.60%	30%	78.87%	29.93%	41.73%	56.69%	65.45%	78.87%			
	Receipt Discharge Info	H	14.84%	15%	61.80%	15.09%	24.33%	33.65%	39.91%	61.80%			
	Engmt after discharge	H	82.24%	86%	93.92%	82.14%	85.54%	89.05%	90.83%	93.92%			
	Med Reconciliation	H	57.42%	73%	87%	63.02%	73.27%	81.57%	84.43%	91.73%	57%	73%	87%
	Average		N/A	52%	77%						52%	63%	77%
FMC	Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions		55.62%	53%	69%	52.96%	56.44%	59.75%	62.19%	72.09%	53%	60%	69%
ACP	Advance Care Planning (MY2022)		N/A	42.62%	85.07%	32.56%	42.62%	53.52%	60.32%	85.07%			
PSA	Non-Recommended PSA-Based Screening in Older Men	A	40.33%	35.10%	11.90%	35.10%	29.32%	24.16%	20.75%	11.90%			
URI	Appropriate Treatment for URI (MY2019)	A	N/A	65.16%	84.00%	59.37%	65.16%	71.72%	74.57%	84.00%			
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis (MY2019)	A	N/A	47.50%	47.50%	27.45%	30.77%	35.07%	37.16%	47.50%			
DDE	Potentially Harmful Drug-Disease Interactions in Old Adults	A	35.27%	25.79%	25.79%	34.80%	32.36%	29.80%	28.68%	25.79%			
DAE	Use of high-risk medications in Old Adults		15.46%	13.75%	9.96%	19.55%	16.19%	13.75%	12.73%	9.96%			
HDO	Use of Opioids at High Dosage	A	2.19%	3.00%	1.19%	5.73%	4.13%	3.00%	2.33%	1.19%			
UOP	Use of Opioids From Multiple Providers - multiple Prescribers	A	17.80%	13.92%	7.41%	16.45%	13.92%	11.48%	10.00%	7.41%			
	Multiple Pharmacies	A	1.09%	1.16%	0.00%	2.13%	1.62%	1.16%	0.85%	0.00%			

OAC 03-19-2026

Back to Agenda Back to Item

	Multiple Prescribers and Pharmacies	A	0.47%	0.96%	0.00%	0.96%	0.61%	0.39%	0.21%	0.00%			
COU	Risk of Continued Opioid Use (MY2018) >= 15 days	A	N/A	13.64%	8.86%	15.30%	13.64%	12.22%	11.38%	8.86%			
	Risk of Continued Opioid Use >= 31 days	A	N/A	6.88%	4.76%	9.16%	7.86%	6.88%	6.17%	4.76%			
AAP	Adults' Access to Preventive/Ambulatory Health Services (age 20-44)	A	N/A	91.03%	96.26%	89.51%	91.03%	92.31%	93.46%	96.26%			
	Adults' Access to Preventive/Ambulatory Health Services (age 45-64)		N/A	95.89%	99.70%	94.60%	95.89%	96.95%	97.44%	99.70%			
	Adults' Access to Preventive/Ambulatory Health Services (age 65+)		N/A	93.77%	99.83%	93.77%	95.48%	96.68%	97.27%	99.83%			
	Adults' Access to Preventive/Ambulatory Health Services (Total)		92.24%	93.67%	99.69%	93.67%	95.44%	96.55%	97.13%	99.69%			
IET	Initiation of Alcohol and Other Drug Dependence Treatment	A	29.38%	30.54%	52.89%	30.54%	36.44%	41.88%	45.00%	52.89%			
	Engagement of Alcohol and Other Drug Dependence Treatment		4.84%	4.24%	10.07%	2.81%	4.24%	5.84%	6.67%	10.07%			
PCR	Plan All-Cause readmissions - 18+	A	N/A	10%	8%	1.0848	1.0244	0.9665	0.9371	0.8357	12%	10%	8%
HFS	Hospitalization following discharge From a Skilled Nursing Facility - 30 rehospitalization 65+		N/A	1.0319	0.7202	1.116	1.0319	0.9275	0.8822	0.7202			
	Hospitalization following discharge From a Skilled Nursing Facility - 60 rehospitalization 65+		N/A	0.9648	0.7994	1.1294	1.0651	0.9648	0.923	0.7994			
HPC	Hospitalization for Potentially Preventable Complications - DMC15		N/A	0.4114	0.338	0.6399	0.5341	0.4631	0.4114	0.338			
DSF-E	Depression Screening and Follow-up for Adolescents and Adults -screening	E	N/A	54.28%	54.28%	0.00%	1.03%	5.34%	9.79%	54.28%			
	follow-up		N/A	52.17%	89.23%	52.17%	64.31%	71.29%	75.00%	89.23%			
DMS-E	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Period 1	E	N/A	5.72%	43.34%	0.00%	1.36%	5.72%	10.49%	43.34%			
AIS-E	Adult Immunization Status - influenza 19-65	E	N/A	55.02%	55.02%	22.42%	28.86%	36.97%	41.54%	55.02%			
	Adult Immunization Status - influenza 66+	E	44.10%	53.11%	66.07%	25.53%	35.72%	46.54%	53.11%	66.07%			
	Adult Immunization Status - influenza Total	E	N/A	49.12%	64.00%	24.16%	33.40%	44.73%	49.12%	64.00%			
	Adult Immunization Status - Tdap 19-65	E	N/A	34.03%	56.03%	15.43%	23.74%	34.03%	39.84%	56.03%			
	Adult Immunization Status - Tdap 66+	E	41.24%	28.79%	49.31%	13.74%	20.13%	28.79%	34.56%	49.31%			
	Adult Immunization Status - Tdap Total	E	N/A	31.56%	51.37%	14.35%	21.25%	31.56%	35.97%	51.37%			
	Adult Immunization Status - Zoster 50-65	E	N/A	33.34%	33.34%	2.03%	6.86%	15.19%	19.55%	33.34%			
	Adult Immunization Status - Zoster 66+	E	24.43%	24.38%	42.39%	1.98%	8.07%	18.49%	24.38%	42.39%			
	Adult Immunization Status - Zoster Total	E	N/A	40.94%	40.94%	2.07%	7.70%	17.78%	23.46%	40.94%			
	Adult Immunization Status - Pneumococcal 66+	E	45.08%	56.76%	75.29%	30.00%	42.29%	56.76%	62.32%	75.29%			

QAC 03.10.2026

2026 Population Health Management (PHM) Strategy & Work Plan

QAC 03.19.2026

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TABLE OF CONTENTS

Introduction, Overview & Purpose	3
Strategic Management	4
Population Identification	4
PHM Strategy and Program	6
PHM Impact Assessment	9
Promoting Health Equity and Addressing Health Disparities	9
Activities and Resources	10
Delivery System Supports	12
PHM Structure	14
PHM Oversight	18

QAC 03.19.2026

Back to Agenda Back to Item

INTRODUCTION

Organization Overview

CalOptima Health believes that our members deserve access to quality care and service throughout the health care continuum. As a county organized health system, CalOptima Health works in collaboration with members, providers, community stakeholders and government agencies to achieve our mission and vision.

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and support to achieve optimal health and well-being through an equitable and high-quality health care system.

CalOptima Health's Strategic Plan

The organization's 2025–2027 Strategic Plan prioritizes population health by leveraging technology and data to strengthen health equity, implementing consistent care models, expanding preventive services for vulnerable groups, and annually assessing member needs to guide targeted interventions. Health equity is integrated throughout all initiatives, ensuring proactive, data-driven approaches to close care gaps and improve outcomes for every member.

Strategy Purpose

The PHM Strategy outlines CalOptima Health's cohesive plan of action to address the needs of our members across the continuum of care. Through the PHM Strategy and our commitment to health equity, CalOptima Health also incorporates an upstream approach to address social determinants of health (SDOH) and close gaps in care that lead to health disparities among our members. For each focus area, CalOptima Health establishes annual measurable goals based on member needs and aligned with Department of Health Care Services (DHCS) and National Committee for Quality Assurance (NCQA) quality priorities.

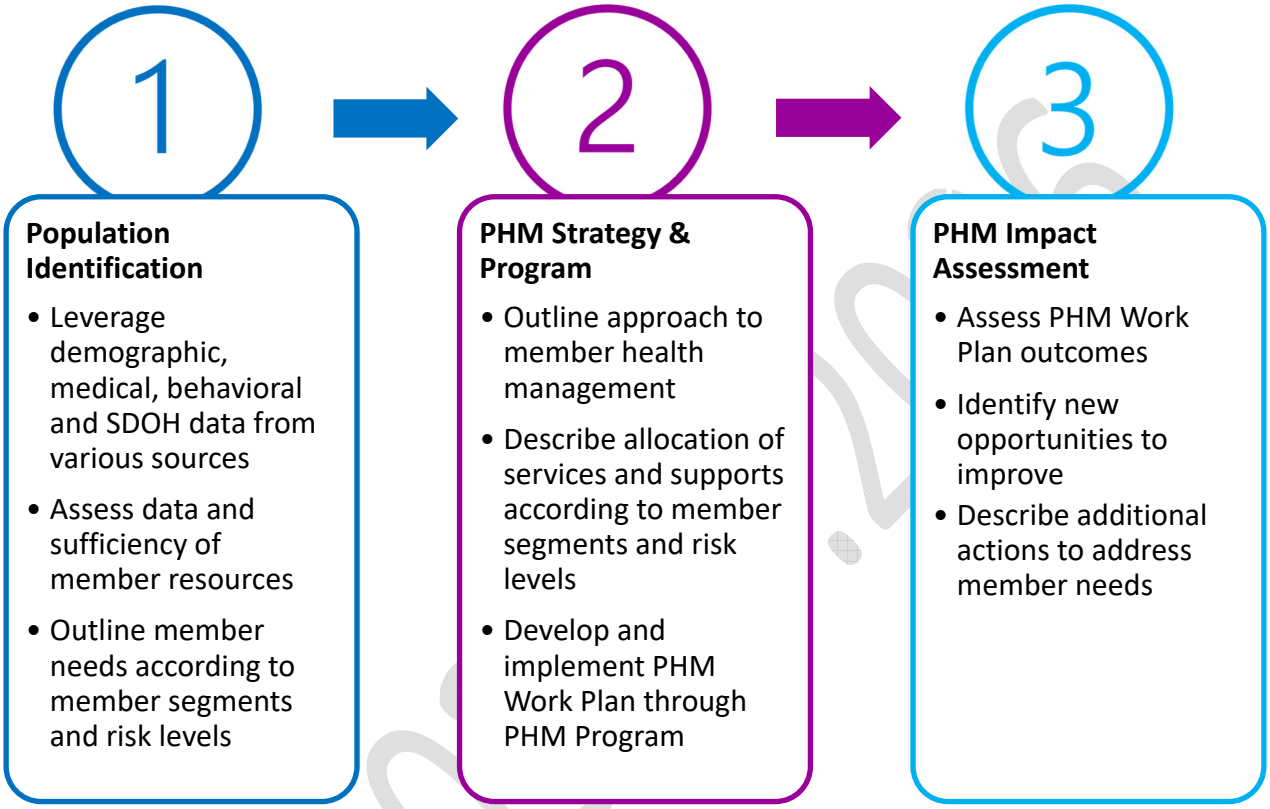
CalOptima Health's PHM Strategy addresses the following areas of focus:

1. Keeping members healthy
2. Managing members with emerging risks
3. Increasing patient safety or outcomes across settings
4. Managing members with multiple chronic conditions

OAC 05.19.2026

Strategic Management

To inform our PHM Strategy and programs, CalOptima Health has several processes in place to review collected data to understand our members' needs, develop strategies to address those needs and evaluate the impact of those strategies through a comprehensive PHM Work Plan. The following diagram illustrates these activities:



Population Identification

Population Needs Assessment

CalOptima Health's Population Needs Assessment (PNA) provides a comprehensive annual summary using a variety of data to describe member characteristics and health needs. Using the PNA to better understand trends in member health overall as well as specific focus populations supports better data-driven planning and decision-making. This report specifically focuses on CalOptima Health's:

- Overall member population, including SDOH
- Children and adolescent members ages 2–19 years old
- Members with disabilities
- Members with serious and persistent mental illness (SPMI)
- Members according to racial and ethnic groups
- Members with limited English proficiency
- Relevant focus populations

CalOptima Health uses PNA key findings to inform the PHM Strategy and Work Plan, which aim to address gaps in member care through intervention strategies and quality initiatives. Report findings also help identify the need for process updates and resource allocation.

Population Segmentation and Care Coordination

CalOptima Health segments and stratifies its entire member population based on potential risk factors, such as health outcomes, utilization and claims data. This process aims to target focused interventions for members who are most likely to benefit. The segmentation and risk stratification methodology informs resource allocation and the development of tailored interventions, including program access and eligibility for specific services.

CalOptima Health divides its member population into meaningful segments using information collected from population assessments and other sources. These segments are defined by shared needs, characteristics, identities, conditions or behaviors, and include the following:

- Low risk
- Medium risk
- High risk
- Highest risk

Based on these risk levels, members may receive a variety of services and interventions, including but not limited to:

Basic Population Health Management is an array of services that include care coordination, comprehensive wellness programs and prevention initiatives, all requiring a strong connection to primary care.

Disease Management programs focus on conditions such as asthma, congestive heart failure and diabetes. These interventions promote self-management skills, enabling members to manage their health daily and actively engage in their care.

Complex Care Management addresses complex medical, behavioral or social needs, including comprehensive assessments, care coordination and advocacy to ensure effective health management and prevention of poor outcomes.

Enhanced Care Management (ECM) offers intensive, person-centered care for individuals with complex health and social needs. "A dedicated "Lead Care Manager" coordinates care across providers and services, addressing unique needs like housing and SDOH.

All Members **Medium Risk** **High Risk** **Highest Risk**

Back to Agenda Back to Item

PHM Strategy and Program

PHM Section of the Quality Improvement (QI) Work Plan

CalOptima Health uses insights from the PNA, population segmentation and care coordination to guide its PHM Strategy and a PHM section in the QI Work Plan. These findings help address care gaps, inform interventions and identify areas for process improvements and resource allocation. In alignment with our commitment to health equity, this strategy also takes an upstream approach to address SDOH and reduce the health disparities that affect our members.

The following outlines CalOptima Health's 2026 PHM section of the QI Work Plan:

Keeping Members Healthy

- Keeping Children Healthy
- Maternal Health Program

Emerging Risk

- Disease Management Program

Patient Safety or Outcomes Across Settings

- CalAIM Enhanced Case Management and Community Supports
- Street Medicine Program
- Behavioral Health Services
- Transitional Care Services
- Emergency Department Pilot Program

Managing Multiple Chronic Conditions

- Complex Case Management Program

QAC 05.19.26

PHM Program

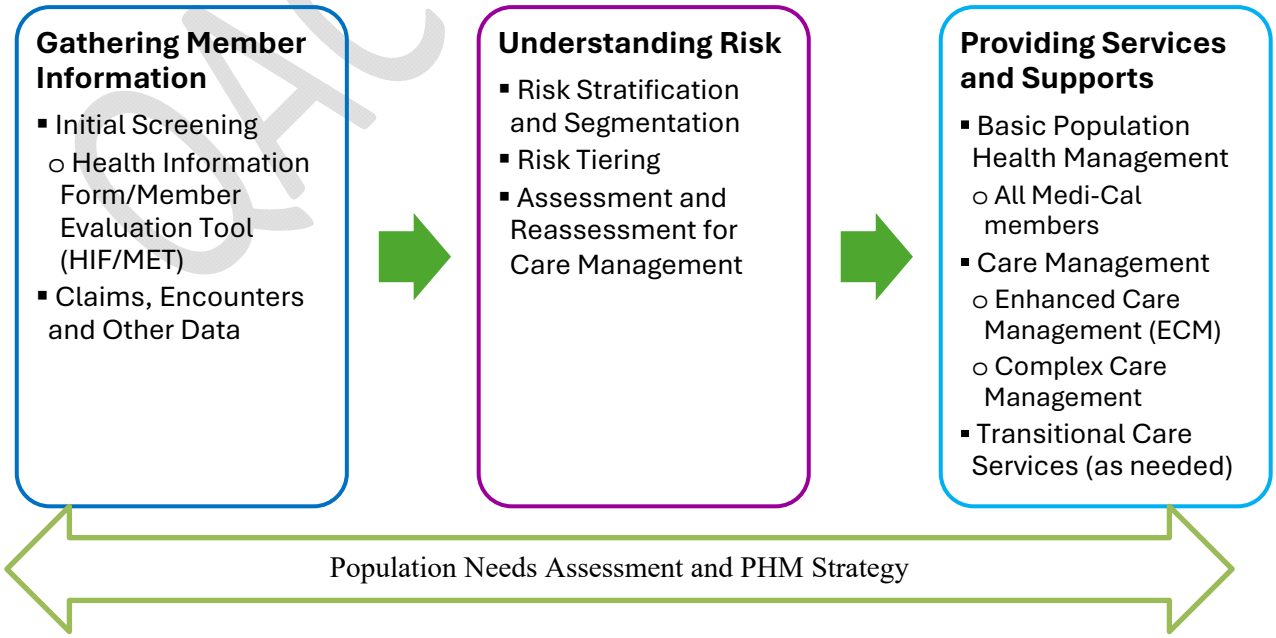
The PHM Strategy guides CalOptima Health's PHM Program. Our PHM Program and related services are developed by a multidisciplinary team of health professionals, community partners and stakeholders. Together, we ensure that our PHM Program is committed to health equity, member involvement and accountability. This is achieved by:

- Building trust and meaningful engagement with members.
- Using data-driven risk stratification and predictive analytics to address gaps in care.
- Revising and standardizing assessment processes.
- Offering care management services for all high-risk members.
- Creating robust transitional care services (TCS) to ensure members are supported from discharge planning to obtain needed services and supports.
- Developing effective strategies to address health disparities, SDOH and upstream drivers of health.
- Implementing interventions to support health and wellness for all members, including health education supports and self-management tools.

PHM Framework

CalOptima Health adopted guiding principles of the PHM Framework to plan, implement and evaluate the PHM Program and our delivery of care. The diagram below outlines the key components used to operationalize the PHM Program:

- ***Population Needs Assessment and PHM Strategy*** to measure health disparities and identify the health priorities and social needs of our member population, including cultural and linguistic, access, and health education needs.
- ***Gathering member information*** on preferences, strengths and needs to connect every member to services at the individual level, and to allocate resources.
- ***Understanding risk*** to identify opportunities for more efficient and effective interventions.
- ***Providing services and supports*** to address members' needs across a continuum of care.



DAC 03.19.2026

Back to Agenda Back to Item

PHM Program Coordination

CalOptima Health's PHM Program spans across several settings, providers and levels of care to meet our members' needs. To streamline PHM Program activities and avoid duplication, CalOptima Health uses a care management system to facilitate the coordination of care and data management for members among several care teams, including:

- Behavioral Health Integration
- Case Management
- Long-Term Support Services (LTSS)
- Program of All-Inclusive Care for the Elderly (PACE)
- Pharmacy
- Utilization Management

Through its care management system, CalOptima Health can determine member eligibility for services, share data to identify and address care gaps, and coordinate care across settings. The system is available to all care team staff responsible for member care and enables them to provide any of the following:

- Create links between all systems that allow appropriate coordination of care and support delivered at the proper time while minimizing duplication of effort between the coordinating teams.
- Access member records to expedite and view all relevant data in one location.
- Identify member needs through established system logics or from providers and member self-referrals to plan an appropriate level of support whereby a staff (e.g., Case Manager or Health Coach) is assigned to help the member with managing their health and social needs.
- Provide members with appropriate assessments and educational materials, derived from evidence-based tools and standardized practices.
- Create an individualized care plan with prioritized goals and facilitate services that minimize or eliminate barriers to care for optimal health outcomes.
- Inform interdisciplinary care team of member care needs, related activities and health goal progress.

Additionally, CalOptima Health uses real-time information on hospital and emergency department admissions and discharges, enabling care teams to act swiftly and effectively to identify high-risk individuals in need of follow-up, prioritizes outreach and supports seamless care transitions. This proactive approach helps reduce readmissions and ensures timely, targeted engagement for members with complex care needs.

Informing Members and Practitioners About PHM Programs

CalOptima Health uses multiple interactive methods to inform both members and practitioners about PHM programs, including program eligibility and how to access services. Practitioners are informed through provider news alerts, the CalOptima Health website, regular meetings and office visits.

Members receive information based on their language preferences through various channels: the Member Welcome Packet, newsletters, program letters, benefit manuals, the member website, text messages, personal phone calls, robocalls and in-person outreach. All PHM programs are voluntary.

QAC 03.19.2026

Key elements include:

- Eligibility: Medi-Cal and OneCare members who meet program criteria are referred to appropriate staff for enrollment support.
- Service Use: Instructions are provided in multiple languages and tailored to appropriate health literacy levels.
- Voluntary Participation: Members may self-refer or opt out at any time. Outreach efforts clearly state that participation is voluntary.

PHM Impact Assessment

CalOptima Health's annual PHM Impact assessment measures the effectiveness of the agency's PHM Strategy and related programs to address member care needs. Through this analysis, CalOptima Health also identifies and addresses opportunities for improvement. Specifically, the assessment focuses on the:

- Clinical impact of programs
- Cost and/or utilization impact of programs
- Member experience with programs

CalOptima Health uses key performance indicators (e.g., primary care, ambulatory care, emergency department visit, inpatient utilization) and quality measures (e.g., Healthcare Effectiveness Data and Information Set [HEDIS®]) to assess the effectiveness of the PHM Program and adjust it to meet the needs of our members. The PHM Impact findings are shared with our care management team, stakeholders and regulatory agencies at least annually.

PROMOTING HEALTH EQUITY AND ADDRESSING HEALTH DISPARITIES

CalOptima Health is committed to advancing health equity and serving members with the excellence, dignity and care they deserve. This commitment extends into the heart of the communities our members call home. To advance health outcomes and drive meaningful impact, our health equity strategic framework is anchored in five focus areas:

- **Reducing Health Disparities:** Mitigate racial, ethnic, gender and socioeconomic disparities in health outcomes.
- **Leadership and Advocacy for Equity:** Drive health equity initiatives through advocacy, partnership and continuous quality improvement.
- **Member-Centered Care:** Provide equitable, culturally responsive and linguistically accessible care that focuses on prevention and aligns with member needs and preferences.
- **Community Engagement and Partnership:** Empower and collaborate with community stakeholders to co-create equitable health solutions that include prevention.
- **Empowering Change Through Data-Driven Strategies:** Leverage data to discover gaps, strengths and assets to co-design strategies that improve health outcomes with the community.

QAC 03.19.2026

CalOptima Health has operationalized our health equity efforts through a broad range of programs and services. Based on health outcomes identified in the 2025 Population Needs Assessment and 2025 PHM Impact Report, the 2026 PHM section of the QI Work Plan will focus on addressing the following health disparities:

- Increasing Childhood Immunizations and Well Child Visits for Black, White, and Native Hawaiian/Other Pacific Islander members through multi-modal outreach, member education, vaccine hesitancy resources, proactive engagement before HEDIS milestones, automated data exchange via Cozeva, and culturally tailored campaigns.
- Increasing Cervical Cancer Screening rates for Native Hawaiian/Other Pacific Islander members through targeted cancer screening mailers, enhanced text messaging campaigns, in-person engagement with Cancer Program grantees, impactful success story sharing, clinic partnerships with mobile mammogram services, program effectiveness evaluation, and robust reporting on cancer detection and stages.
- Increasing access and engagement to primary care, ECM, and housing services for members experiencing homelessness through integrated Street Medicine, coordinated ECM and housing navigation, and streamlined support for continuity of care and housing readiness.

Additional details about these goals and interventions can be found in the 2026 PHM section of the QI Work Plan.

PHM Activities and Resources

CalOptima Health recognizes the importance of mobilizing multiple resources to support our members' health needs. At least annually, CalOptima Health conducts a strategic review of existing structures, programs, activities and resources using its PNA and dashboards. This strategic assessment helps CalOptima Health leaders set new program priorities, recalibrate existing programs, redistribute resources to ensure health equity and proactively mitigate emerging risks. Please see the annual PNA Report for details of this review and a description of the activities and resources supported by CalOptima Health.

In addition, CalOptima Health conducts activities that are designed to support the PHM Strategy, including activities not directed at individual members. Building partnerships with community-based organizations, local health care agencies, hospitals and clinics, universities and others to streamline efforts and leverage resources. Examples of these activities are described below:

Continuous Provider Education, Training and Professional Development

CalOptima Health advances patient care by equipping providers with the knowledge and skills needed to deliver culturally responsive, person-centered care. Our Continuing Medical Education (CME) and Continuing Education (CE) programs offer in-person and virtual training for health networks, providers, community partners, and CalOptima Health staff. These evidence-based sessions not only fulfill regulatory requirements but also promote health equity by addressing disparities and strengthening collaboration between healthcare organizations and community-based agencies—bridging clinical and community efforts to improve outcomes and quality of care.

In addition, CalOptima Health provides a comprehensive suite of services designed to enhance patient experience and engagement. These include interactive workshops for clinicians and staff that build effective care teams, improve patient-provider communication, and support service excellence. Providers

QAC 03.19.2026

Back to Agenda Back to Item

also benefit from our shadow coaching program, which offers personalized feedback and actionable plans based on real-time observation, followed by ongoing reinforcement to ensure lasting skill development.

Performance and Quality Improvement Initiatives

CalOptima Health leverages Performance Improvement Projects (PIPs) and Quality Improvement Projects (QIPs) as strategic tools to enhance member care indirectly by improving system-level processes and outcomes. These initiatives focus on identifying gaps, implementing evidence-based interventions, and fostering collaboration across providers and partners to drive measurable improvements in health quality and access. Recent improvement projects have targeted critical areas of care, including:

- Increasing Well-Child Visit Rates to support early detection and preventive care.
- Improving Blood Sugar Control for members with diabetes to reduce complications and enhance long-term health outcomes.
- Enhancing Follow-Up Care for members who visited the emergency department for severe mental illness or substance use disorder, ensuring continuity of care and reducing readmissions.

Interventions within these projects are multifaceted and designed to remove barriers to care while promoting engagement. Key strategies include direct member outreach, streamlined access to care through telehealth options and scheduling support, data exchange and workflow integration with provider networks and community partners to improve coordination and efficiency. By addressing systemic challenges and optimizing care delivery processes, these improvement projects create a ripple effect that enhances member experience, promotes health equity, and drive better outcomes across populations.

Collaboration to Support Providers and Community Partners

CalOptima Health, in collaboration with Kaiser Permanente and the Orange County Health Care Agency, is committed to protecting children's health by increasing blood lead screenings across Orange County. Through a collaborative, equity-driven approach, the partners co-designed an initiative to address screening gaps in specific neighborhoods with the greatest disparities. The collaborative developed evidence-based resources and training programs that equip Community Health Workers (CHWs) to guide families through blood lead screening and related preventive services. These tools emphasize environmental health education, navigation support, and advocacy, ensuring parents receive culturally responsive, high-quality information. Examples of resources developed include:

- **Data Dashboard**: A Tableau dashboard that overlaid quality data and public health risk factors which identified neighborhoods in Santa Ana, San Juan Capistrano, and Fullerton as priority areas of focused outreach and engagement.
- **Education Toolkit**: A Blood Lead Screening Toolkit enabling CHWs to educate families on the importance of blood lead screenings and assist in accessing these critical services.
- **CHW Training Curriculum**: A CHW training curriculum on Blood Lead that leveraged the Toolkit and used outreach scripts and role-play scenarios to strengthen CHW communication and scheduling support for families in need of blood lead screening.

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DELIVERY SYSTEM SUPPORTS

Providers and practitioners play a vital role in helping CalOptima Health members achieve their highest level of health. Therefore, CalOptima Health works intentionally and collaboratively to support our provider and practitioner community to fulfill PHM goals. CalOptima Health offers ongoing support to providers and practitioners in our health networks, such as sharing patient-specific data, offering evidenced-based or shared decision-making aids, holding continuing education sessions, and providing comparative quality and cost information. These supports are described below:

Information Sharing

CalOptima Health ensures timely and comprehensive sharing of member-level information with providers and practitioners to support care coordination, quality improvement, and population health management. This process spans multiple programs and processes, including Case Management, utilization of services (including new Medi-Cal members due for their Initial Health Appointment), and programs to ensure high quality care.

1. **Case Management:** CalOptima Health has a comprehensive care management framework which gathers member preferences, strengths, and needs through initial screenings, claims, and encounter data. Risk stratification and segmentation guide individualized care plans, which are shared with providers to ensure alignment and continuity of care. Provider letters and individualized care plans are distributed to practitioners, reinforcing collaboration and adherence to evidence-based guidelines.

2. **Utilization of Initial Health Appointment (IHA):** The Initial Health Appointment (IHA) is a requirement for newly enrolled Medi-Cal members that must be completed within 120 days of enrollment. The IHA allows a member and their primary care physician (PCP) to meet, identify, and address current care needs and form a working partnership toward managing the member's health. The CalOptima Health Provider Portal gives primary care providers access to a list of their assigned newly enrolled Medi-Cal members for outreach and IHA scheduling.

3. **Quality Data**: CalOptima Health shares member-level data with providers to support the Pay for Value (P4V) program, improve health outcomes, and enhance compliance with quality measures. Actionable gaps-in-care reports are available through the Provider Portal and are provided monthly to assist with preventive care outreach and engagement. CalOptima Health remains committed to improving information sharing through integrated and actionable data.

Shared Decision-Making Aids

CalOptima Health aligns decision-making aids with our clinical practice guidelines to promote shared decision-making among providers and their members. These are approved by CalOptima Health's Quality Improvement committees, posted to CalOptima Health's provider website and promoted through our provider newsletter. Shared decision-making aid topics include:

- Cardiac Conditions
- Treatment for Opioid Use Disorder
- Diabetes Medication Choice
- Heart Disease

QIC 05.19.2026

Back to Agenda Back to Item

- Hypertension
- Treatment for Kidney Failure

Comprehensive Provider Training and Support

CalOptima Health offers an ongoing program of Continuing Medical Education (CME) and Continuing Education (CE) trainings for medical providers, covering a wide range of clinical and behavioral health topics, such as hypertension, diabetes, trauma-informed care, substance use and asthma management. Trainings are delivered in-person and virtually to enhance clinical knowledge, support best practices, improve patient outcomes and fulfill licensure requirements.

Through its Culture and Health Conversations, CalOptima Health also provides culturally responsive education, enhancing understanding of physical and mental health needs and culturally specific practices for populations of focus. These efforts foster collaboration between health care organizations and community-based agencies, with partner agencies selected for their cultural expertise, alignment with health and wellness goals, community leadership, and service to CalOptima Health members in Orange County.

Additionally, CalOptima Health supports providers with workshops and coaching programs focused on improving patient experience and engagement. These services help build effective care teams, strengthen communication, manage challenging situations and promote service excellence. Providers benefit from personalized feedback and ongoing support to reinforce new skills.

Through these efforts, CalOptima Health equips providers with up-to-date information, practical skills, and continuous support to better serve the health and well-being of our diverse members.

Transformation Support

CalOptima Health's Orange County Population Health and Value-Based Care Initiative (PHVBC) is a five-year, $50 million initiative aimed at helping community health centers transform care delivery and strengthen the local safety net. Through this initiative, participating clinics will implement projects that enhance population health capabilities and prepare for value-based care models. The focus is on improving access, equity and quality — particularly for communities disproportionately impacted by health disparities.

The Institute for High Quality Care (IHCQ) will provide tailored technical assistance, including training, coaching and best practice sharing. The Center for Community Health and Evaluation (CCHE) will lead evaluation efforts. CalOptima Health will also use provider profiles to identify care gaps and align financial incentives with quality improvement goals. These supports will help clinics shift from volume-based to value-based, whole-person care by enabling better care coordination, preventive services and staffing aligned with member needs.

Additionally, in 2025 CalOptima Health launched the Equity and Practice Transformation (EPT) Program, an initiative funded by DHCS to advance health equity and transform primary care for Medi-Cal members. CalOptima Health supports 14 Orange County practices with targeted coaching, training, and data support to help them meet rigorous milestones and earn incentive payments. The program focuses on improving access, reducing disparities and building patient-centered, value-based care models. EPT is closely aligned with CalOptima Health's PHM strategy, reinforcing our commitment to data-driven equity, quality improvement and sustainable transformation across our provider network.

QAC 03.19.2026

Pay for Value (P4V)

CalOptima Health's Pay for Value (P4V) program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health networks and CalOptima Health Community Network (CHCN) primary care providers are eligible to participate in the P4V programs.

The purpose of CalOptima Health's P4V program is to:

1. Recognize and reward health networks and their physicians for demonstrating quality performance.
2. Provide comparative performance information about CalOptima Health to members, providers and the public.
3. Provide industry benchmarks and data-driven feedback to health networks and physicians on their quality improvement efforts.

The Medi-Cal P4V program incentivizes performance on all HEDIS® measures included in the DHCS Managed Care Accountability Sets (MCAS) required to achieve minimum performance levels (MPLs) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures.

PHM Structure

Population Health Management (PHM) operations at CalOptima Health are supported by a multidisciplinary leadership team, allied health professionals and administrative staff. In 2025, oversight of PHM transitioned from the Equity and Community Health (ECH) department to Clinical Operations. This strategic realignment was implemented to better integrate health education and disease management programs within the broader care continuum. Under Clinical Operations, PHM efforts are now more closely aligned with care coordination, case management and utilization management. While ECH previously led strategic initiatives to identify and address member health and wellness needs, Clinical Operations now assumes responsibility for these functions in accordance with DHCS and NCQA requirements. The following describes the current roles and responsibilities for PHM across the organization.

Team Roles and Responsibilities

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the Quality Improvement Health Equity Committee (QIHEC) satisfies all requirements of the PHM Program, as specified in state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Information Technology, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, Medi-Cal/CalAIM and Coding Initiatives.

Chief Medical Officer (CMO) oversees strategies, programs, policies and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members, including PHM. At least quarterly, the CMO presents reports on PHM activities to the Board of Directors' Quality Assurance Committee.

QIC 05.19.2026

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees the strategies, programs, policies and procedures related to CalOptima Health's medical care delivery system. The DCMO and CMO oversee Quality Analytics (QA), Quality Improvement (QI), Utilization Management (UM), Case Management (CM), Pharmacy Management (PM), Behavioral Health Integration (BHI), Long-Term Support Services (LTSS) and Enterprise Analytics (EA).

Chief Health Equity Officer (CHEO) leads the development and implementation of health equity as a core competency through collaboration with leaders across CalOptima Health. The CHEO oversees Equity and Community Health (ECH) and serves as the voice and content expert on health equity for CalOptima Health's members, affiliates and partners, providing strategic direction around clinical interventions, benefit design and engagement strategies, and participating in testing and evaluation initiatives.

Executive Director, Clinical Operations (ED CO) is responsible for overseeing all clinical operations functions, including the Utilization Management, Care Coordination, Complex Case Management, Disease Management, Health Education and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas.

Medical Director, Population Health Management (MD PHM) provides clinical leadership for CalOptima Health's population health strategies. This role oversees PHM programs, including Transitional Care Services, ensuring members are supported from discharge through connection to needed services. The MD also guides staff and provider education, ensures clinical accuracy of interventions, and promotes equitable, evidence-based care across the delivery system.

Executive Director, Behavioral Health Integration (ED BHI) is responsible for the management and oversight of CalOptima Health's BHI department, along with the implementation of new state and county behavioral health initiatives. The ED BHI leads strategies for integrating behavioral health across the health care delivery system and populations served.

Executive Director, Equity and Community Health (ED ECH) is responsible for the management and oversight of CalOptima Health's Equity and Community Health department. The ED ECH oversees development and implementation of organizational strategies to advance health outcomes, strengthen community partnerships, and promote equitable access to care that improves health outcomes for all members. The ED ECH serves as a member of the executive team, reporting to the CHEO, and in partnership with the CMO, DCMO and Executive Director of Clinical Operations, supports efforts to promote adherence to established quality improvement and health equity strategies. The ED ECH also collaborates with leaders across the organization to integrate community health priorities into the delivery system and populations served.

Executive Director, Medi-Cal/CalAIM leads the strategic implementation and oversight of California Advancing and Innovating Medi-Cal (CalAIM), a transformative, person-centered initiative aimed at improving health outcomes and care delivery for vulnerable populations. This role is responsible for aligning operational execution with the broader vision of whole-system reform, integrating medical, behavioral and social services to address the full spectrum of member needs.

Executive Director, Network Operations (ED NO) is responsible for the overall success of network operations to fulfill the plan's strategic objectives as related to contracting and operations of the provider delivery system. The ED NetOps is responsible for provider relations and support, including provider education and problem resolution. The ED NetOps and their staff must have the ability to collaborate with

Back to Agenda Back to Item

OAC 03.19.2026

all internal departments to support and assist delegated provider entities and directly contracted providers in their day-to-day interactions and transactions with the plan.

Executive Director, Operations (ED O) is responsible for overseeing and guiding the following operational departments: Claims Administration, Customer Service and Grievance & Appeals Resolution Services. The ED Ops works closely with top-level leadership to establish policies and implement procedures for the management of departments to accomplish the goals and objectives of CalOptima Health within budget and within applicable legal requirements.

Executive Director, Quality (ED Quality) is responsible for facilitating the organization wide QI Program deployment; driving performance results in HEDIS, DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high-performing health plan. The ED Quality serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and ED CO, supports efforts to promote adherence to established quality improvement strategies across the delivery system.

Executive Director, Strategic Development (ED SD) is responsible for the oversight and implementation of CalOptima Health's strategic development programs. Under the general guidance of the Chief Administrative Officer (CAO), the ED SD works closely with top-level leadership to plan, develop and implement strategies and carry out organizational goals and priorities to effectively promote and implement CalOptima Health's mission and vision with internal and external contacts, including employees, the public, members, government officials and the media.

Sr. Director, Equity and Community Health (Sr. ECH Director) is responsible for leading the development and implementation of strategies designed to address identified health inequities. The Sr. ECH Director is responsible for assisting the ED ECH and CHEO in developing, implementing, analyzing, and refining the CalOptima Health goals and objectives related to health equity. The Sr. ECH Director partners with leaders across the organization to strengthen the organization's commitment and strategy to advance health equity, promote health literacy and reduce health disparities. The Sr. Director also engages with community partners on health equity initiatives that improve health outcomes.

Sr. Director and Directors, Case Management, lead the development and implementation of CalOptima Health's PHM strategies. They oversee departmental operations, ensure regulatory and accreditation compliance, and coordinate cross-functional initiatives with internal teams, health networks, providers and community stakeholders. These leaders are responsible for aligning care management programs with organizational goals to improve quality outcomes, cost efficiency and member experience.

The following staff support the implementation of PHM strategies:

- *Sr. Managers and Managers, Case Management*: The Sr. Managers and Managers develop PHM goals; oversee case, maternal and disease management programs; and ensure compliance and efficiency. Managers support daily operations, staff development and project execution under the Director's guidance. They monitor reports, ensure policy adherence, participate in operational and community meetings, and report key findings to leadership and relevant committees.
- *Supervisors, Case Management* oversee the daily operations of case management activities, ensuring compliance with regulatory requirements and internal policies. These roles provide leadership and guidance to staff, manage complex referrals directly, and support the implementation of new programs. Supervisors are responsible for monitoring team productivity

Back to Agenda Back to Item

QAC 9.19.25

and quality standards, addressing complex member and provider needs, and serving as a key resource for CalOptima Health's providers, health networks and community partners.

- *Program Managers:* Lead cross-organization initiatives and regulatory compliance, develop and evaluate new interventions, and stay informed on health care policy impacts.
- *Health Educators and Coaches:* Deliver member-focused health education, coaching, group classes and self-management support for chronic conditions, sharing progress with care teams.
- *Registered Dietitians:* Provide nutrition counseling, develop education materials and collaborate on member care planning.
- *Personal Care Coordinators:* Conduct assessments and coordinate care to ensure timely services and smooth transitions. They collaborate with members, PCPs, and care teams to address barriers and improve access across all levels of care.
- *Medical Case Managers/Care Managers:* Provide ongoing case management services for CalOptima Health's members. The Medical Case Manager facilitates communication and coordination among all participants of the health care team and the member to ensure the services provided promote quality and cost-effective outcomes. Social Workers provide administrative case management and coordination of benefits for carved-out services. Social Workers serve as a departmental resource regarding benefits and available resources for the aged, behavioral health, foster care and the disabled population. Social Workers also serve as a liaison to Orange County-based community agencies.

QAC 03.19.26

PHM Oversight

CalOptima Health strives to ensure that PHM strategic management processes are co-created, monitored and evaluated with input from members, providers, stakeholders and leadership. This helps ensure that all PHM programs and services are informed by multidisciplinary experts and approved through careful consideration by leadership. The following description provides a high-level summary of our PHM strategic management oversight process.

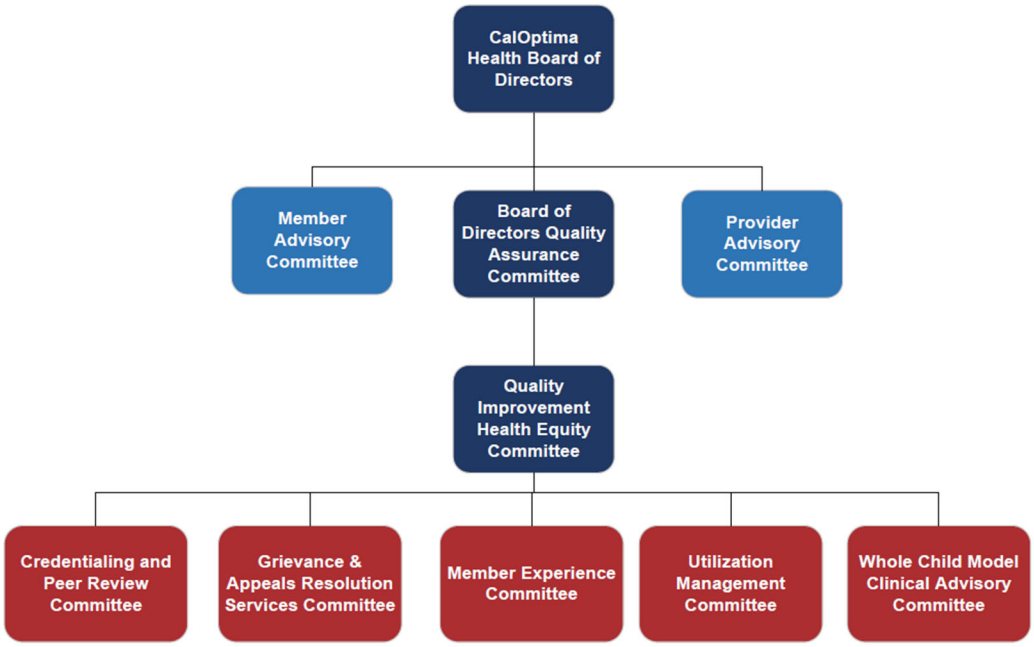
PHM Oversight Responsibilities

Dedicated staff from Clinical Operations, in collaboration with other multidisciplinary work teams throughout the organization and with guidance from CalOptima Health leadership, assess service utilization patterns, disease burden and SDOH factors to identify gaps in member care. This comprehensive assessment is summarized in an annual PNA. Key findings from the PNA are shared with CalOptima Health's Member Advisory Committee, multidisciplinary care teams and stakeholders to propose new interventions that address member care gaps. Proposed interventions are documented as part of the annual PHM Strategy and Work Plan proposals, which are presented to the Quality Improvement Health Equity Committee (QIHEC) or Utilization Management Committee (UMC) for review and approval. CalOptima Health's QIHEC reports summarize approved PHM Strategy and Work Plans to the Board of Directors' Quality Assurance Committee (QAC).

Committee Approval Descriptions

The diagram below illustrates the pathway of approval and oversight of the PHM Strategic Management activities along with committee descriptions.

PHM Oversight Structure



Back to Agenda Back to Item

Quality Improvement Health Equity Committee (QIHEC)

The purpose of the QIHEC is to provide overall direction for continuous, health equity-centered quality improvement processes, oversee activities consistent with CalOptima Health's strategic goals and priorities, and monitor compliance with regulatory and licensing requirements related to QI projects and activities.

Utilization Management Committee (UMC)

The UMC at CalOptima Health is led by a Medical Director and oversees the implementation, supervision and evaluation of the UM Program. It ensures optimal utilization of health care services, protects member rights, and monitors medical necessity and quality. The UMC meets quarterly, coordinates annual reviews, and reports to the Quality Improvement Health Equity Committee and the Board of Directors.

Board of Directors' Quality Assurance Committee (QAC)

The QAC routinely receives progress reports from the QIHEC, describing the improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations.

CalOptima Health Board of Directors (BOD)

The BOD has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the BOD to the Board's QAC — which oversees the functions of the QI Committee described in CalOptima Health's state and federal contracts — and to CalOptima Health's CEO.

QAC 03.19.2026

2026 Culturally and Linguistically Appropriate Services (CLAS) Program Description

QAC 03.19.2026

Table of Contents

CalOptima Health Overview 3
Our Mission and Vision..... 3
Who We Serve 3
Membership Demographics 4
Our Commitment to Culturally and Linguistically Appropriate Services (CLAS) 5
Authority and Accountability 5
CLAS Reporting Structure 8
Community and Member Engagement 8
Goals 10
CLAS Work Plan 10
CLAS Monitoring Progress 11
CLAS Evaluation 11
Cultural & Linguistic Services Organizational Chart Structure 12
Key Business Processes, Functions, Important Aspects of Cultural and Linguistic Services … 16
Language Services 16
Cultural Competency and Training 17
Promotion of Diversity 19
Data Collection and Analysis 19

QAC 03.19.2026

CalOptima Health Overview

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. We believe that our Medi-Cal, Medicare and Program of All-Inclusive Care for the Elderly (PACE) members deserve the highest quality care and service throughout the health care continuum. CalOptima Health collaborates with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and support to achieve optimal health and well-being through an equitable and high-quality health care system.

Who We Serve

As a public agency and Orange County's single largest health insurer, CalOptima Health offers health insurance coverage through three major programs:

- **Medi-Cal** – California's Medicaid program for low-income children, adults, seniors and people with disabilities, offering comprehensive health care coverage.
- **OneCare (HMO D-SNP**) – Medicare Advantage Special Needs Plan for seniors and people with disabilities who qualify for both Medicare and Medi-Cal.
- **Program of All-Inclusive Care for the Elderly (PACE)** – PACE for frail older adults, providing a full range of health and social services so seniors can remain living in the community.

QAC 03.19.2026

Membership Demographics

Membership Data (as of November 30, 2025)

Total CalOptima Health Membership 877,271	Program	Members
	Medi-Cal	858,441
	OneCare (HMO D-SNP)	18,287
	Program of All-Inclusive Care for the Elderly (PACE)	543
	*Based on unaudited financial report and includes prior period adjustment	

Member Demographics (as of November 30, 2025)

Member Age

0 to 5	**8%**
6 to 18	**22%**
19 to 44	**34%**
45 to 64	**20%**
65+	**16%**

Language Preference

English	**56%**
Spanish	**29%**
Vietnamese	**9%**
Korean	**2%**
Other	**2%**
Farsi	**1%**
Chinese	**<1%**
Arabic	**<1%**
Russian	**<1%**

Medi-Cal Aid Category

Expansion	**38%**
Temporary Assistance for Needy Families	**36%**
Seniors	**13%**
Optional Targeted Low-Income Children	**7%**
People With Disabilities	**5%**
Long-Term Care	**<1%**
Other	**<1%**

QAC 03.19.26

Our Commitment to Culturally and Linguistically Appropriate Services (CLAS)

As a health care organization in the diverse community of Orange County, CalOptima Health strongly believes in the importance of providing culturally and linguistically appropriate services

to members. CalOptima Health is committed to providing effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has developed a Culturally and Linguistically Appropriate Services Program (CLAS Program), a component of the Quality Improvement and Health Equity Transformation Program (QIHETP), which integrates culturally and linguistically appropriate services at all levels of planning and operation.

Objectives for culturally and linguistically diverse membership include:

- Reduce health care disparities in clinical areas.
- Improve cultural competency in materials and communications.
- Improve network adequacy to meet the needs of underserved groups.
- Improve access to disability accommodations, auxiliary aids and services.
- Improve other areas of need as appropriate.

Authority and Accountability

Board of Directors (Board)

The CalOptima Health Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima Health members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee, which oversees the functions of the Quality Improvement Health Equity Committee (QIHEC) described in CalOptima Health's state and federal contracts, and to CalOptima Health's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions are not unduly influenced by financial considerations. The Board approves and evaluates the QIHETP annually, which includes the CLAS Program.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to conduct annual evaluations, provide strategic direction, and make recommendations to the Board regarding the overall QIHETP, including the CLAS Program, and to direct any necessary modifications to QIHETP policies and procedures to ensure compliance with the Quality Improvement (QI), health equity and CLAS contractual and regulatory standards and the Department of Health Care Services (DHCS) Comprehensive Quality Strategy. QAC routinely receives progress reports from the QIHEC, which describe the improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval, with modifications and appropriate resource allocations for QIHETP and the QIHETP Work Plan.

Member Advisory Committee

QAC 05.19.2026

CalOptima Health is committed to delivering member-focused care through active engagement with members and the community. The Member Advisory Committee (MAC) has 20 voting members, with each seat representing a constituency served by CalOptima Health. The MAC ensures that the values and needs of CalOptima Health members are integrated into the design, implementation, operations and evaluation of the overall QIHETP. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC membership includes representatives from the following constituencies:

- Behavioral/mental health
- Children
- Dental provider
- Developmental Disabilities
- Family/Caregiver support
- Foster children
- Local Education Agency
- Medi-Cal beneficiaries or authorized family members (four seats)
- Member advocate
- OneCare member or authorized family members (four seats)
- People with disabilities
- Recipients of CalWORKs
- Seniors
- County of Orange Social Services Agency (SSA) (standing seat)

One of the 20 positions, held by SSA, is a standing seat. Each of the remaining 19 appointed members may serve two consecutive three-year terms.

QAC 03.19.2026

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established by the CalOptima Health Board of Directors to advise the Board on issues impacting the CalOptima Health provider community. The PAC members represent the broad provider community that serves CalOptima Health members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of the Orange County Health Care Agency, which maintains a standing seat. PAC meetings are open to the public. The 15 seats include:

- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- Orange County Health Care Agency (standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Safety net
- Behavioral/mental health
- Pharmacy

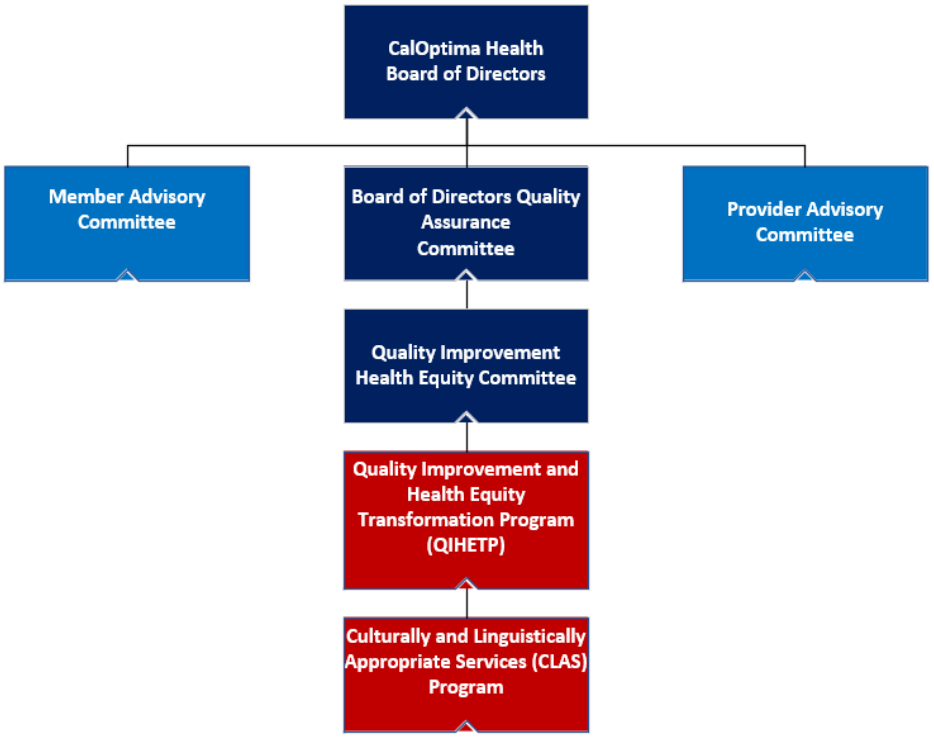
Quality Improvement Health Equity Committee (QIHEC)

The QIHEC is the foundation of the QIHETP, which includes the CLAS Program and is accountable to the QAC. The QIHEC is chaired by the CMO and the Chief Health Equity Officer (CHEO), and they collaboratively develop and oversee the QIHETP and QIHETP Work Plan activities.

The purpose of the QIHEC is to ensure that all QIHETP activities are performed, integrated and communicated internally and to the contracted delegated health networks to achieve the result of improved care and services for members. In collaboration with the Compliance Committee, the QIHEC oversees the performance of delegated functions by monitoring delegated health networks and their contracted provider and practitioner partners.

QAC 03.19.2026

CLAS Reporting Structure



The CLAS Program is a part of the overall QIHETP, and CLAS activities are embedded in the QIHETP Work Plan. CLAS activities are reported to QIHEC for analysis, evaluation and adjustment as needed.

Community and Member Engagement

CalOptima Health is committed to providing member-focused care through active engagement with members and their communities. The organization engages members through the MAC and seeks input and advice related to cultural and linguistic, as well as health equity goals.

By actively seeking feedback and advice from the community, CalOptima Health ensures that its services are tailored to meet the diverse needs of its members. The MAC represents the diversity of its membership, including individuals from ethnic and language groups that represent at least 5% of the population.

Ethnicity	Ethnicity Membership Percentage	Language	Language Membership Percentage	Number of Members	Corresponding Seats
Hispanic	15%	Spanish	15%	3	1 OneCare Member/Family Member 1 Behavioral/Mental Health Representative 1 SSA Representative
White	50%	English	50%	10	1 Children

					1 Family/Caregiver Rep. 1 Foster Children 2 Medi-Cal Beneficiaries/ Family Members 1 Developmental Disabilities 1 Recipient of CalWORKS 1 Senior 2 OneCare Members/ Family Members
Vietnamese	5%	Vietnamese	5%	1	1 Person With Disabilities
Korean	5%	Korean	5%	1	1 Member Advocate

In addition to engaging MAC members, CalOptima Health gathers member input through community events, meetings and/or surveys.

Goals

The following are the 2026 areas of focus for the CLAS Program:

1. Language Services: Cultural and Linguistic and Language Accessibility: Provide interpreter and translation services and report key findings and/or activities, analyze barriers, and identify improvements.
    - By December 31st, 2026, CalOptima Health will evaluate its language services experience by collecting feedback from 6% to 10% of members and from 4% to 80% of staff using surveys and will analyze the results to identify improvements to language services.
    - Maintain a member and CalOptima Health staff satisfaction rate or above by December 31st, 2026
2. Data Collection of Member Demographic Information.
    - By September 30, 2026, CalOptima Health will update the current data system to receive, store and retrieve the following: disability function and identity, physical accommodations, auxiliary aids or services, geographic classification, age, and veteran/military status.
    - By December 31st, 2026, CalOptima Health will increase the collection of member disability function data from 0 to 5% through focused outreach and education, ensuring better representation and inclusion of members.
3. Data Collection on Practitioner Demographic Information.
    - By December 31st, 2026, CalOptima Health will increase the collection of provider race/ethnicity/languages (REL) from 2% to 5% through focused outreach and education, ensuring better representation and inclusion of providers.
4. Provider Trainings to Improve Care or Service Delivery.
    - By December 31st, 2026, CalOptima Health will implement and train 90% of health networks and providers on how to improve care or service delivery on at least one: racial, ethnic or cultural subgroups, gender or sexual orientation subgroups or patients with disabilities, use of physical accommodation and use of auxiliary aids or services.
    - By December 31st, 2026, conduct a CME on unique health or health care needs of at least one: racial, ethnic or cultural subgroup, gender or sexual orientation

ORIG 9.9.2025

subgroup or patients with disabilities, use of physical accommodation and use of auxiliary aids or services.

5. Building and Maintaining a Responsive Work Force
    - By December 31st, 2026, CalOptima Health will implement and train 90% of staff on how to improve care or service delivery on at least one: racial, ethnic or cultural subgroups, gender or sexual orientation subgroups or patients with disabilities, use of physical accommodation and use of auxiliary aids or services.

CLAS Work Plan

The CLAS Work Plan is a subset of and is embedded within the QIHETP Work Plan, outlining key activities for the upcoming year. It is reviewed and approved by the QIHEC and the Board of Directors' QAC. The CLAS Work Plan indicates objectives, scope, timeline, planned monitoring and accountable staff for each activity. Progress against the CLAS Work Plan is monitored throughout the year.

The CLAS Program guides the development and implementation of an annual CLAS Work Plan, which includes but is not limited to:

- Network cultural responsiveness
- Language services
- Program scope
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the CLAS Program

The CLAS Work Plan supports the comprehensive annual evaluation and planning process, which includes reviewing and revising the CLAS Program as well as applicable policies and procedures. The 2026 CLAS Work Plan encompasses all cultural and linguistic focus areas, including goals, improvement activities, progress toward these goals, and associated timeframes. Planned activities include strategies to continue to enhance the collection, storage, retrieval, and sharing of data on race/ethnicity, language and sexual orientation. Additionally, new activities include implementing a process for collecting, storing, retrieving, and sharing data on disability status, disability-related accommodations and accessible digital content. All goals will be measured and monitored in the CLAS Work Plan, reported to QIHEC on a quarterly basis and evaluated annually. A copy of the QIHETP (and CLAS) Work Plans is also available to the public on the CalOptima Health website.

For more details on the 2026 CLAS Work Plan, see Appendix A: 2026 QIHETP Work Plan

CLAS Monitoring Progress

To ensure that the CLAS Program meets the needs of our diverse member population, CalOptima Health conducts ongoing assessments of CLAS-related activities and integrates CLAS-related measures into measurement and continuous quality improvement activities. The QIHEC continuously monitors progress against CLAS goals. At least quarterly, dedicated staff

QAC 03.19.2026

from the Cultural & Linguistic Services (C&L) department, in collaboration with multidisciplinary work teams throughout the organization, collect and track indicators and activities specific to CLAS goals, outcomes and outputs. C&L staff prepare quarterly findings and identify potential risks to share with CalOptima Health leadership at QIHEC meetings. CalOptima Health's QIHEC reviews, offers feedback and approves quarterly CLAS monitoring reports. QIHEC summarizes the CLAS monitoring reports and shares them with CalOptima Health's Board of Directors' QAC.

CLAS Evaluation

The objectives, scope, organization and effectiveness of CalOptima Health's CLAS Program are reviewed and evaluated annually by the QIHEC and QAC, as part of the overall CLAS Program Evaluation and approved by the Board of Directors, as reflected in the CLAS Work Plan. The results of the written annual evaluation to serve as the basis for formulating the next year's initiatives and are incorporated into the CLAS Work Plan and reported to DHCS and the Centers for Medicare & Medicaid Services (CMS) on an annual basis. In the evaluation, the following are reviewed:

- A description of completed and ongoing CLAS activities that address the cultural and linguistic needs of our members, including achievements and progress toward goals, as outlined in the CLAS Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance in the quality, accuracy and utilization of translation and interpreter services.
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of the effectiveness of CLAS activities, including Quality Improvement Projects (QIPs), Performance Improvement Projects (PIPs), Plan-Do-Study-Act cycles (PDSAs).
- An evaluation of the effectiveness of member experience surveys related to cultural and linguistic services.
- A report to the QIHEC and QAC summarizing all CLAS measures and identifying significant trends.
- A critical review of the organizational resources involved in the CLAS Program through CalOptima Health's strategic planning process.
- Recommended changes included in the revised CLAS Program Description for the subsequent year for QIHEC, QAC and the Board of Directors' review and approval.

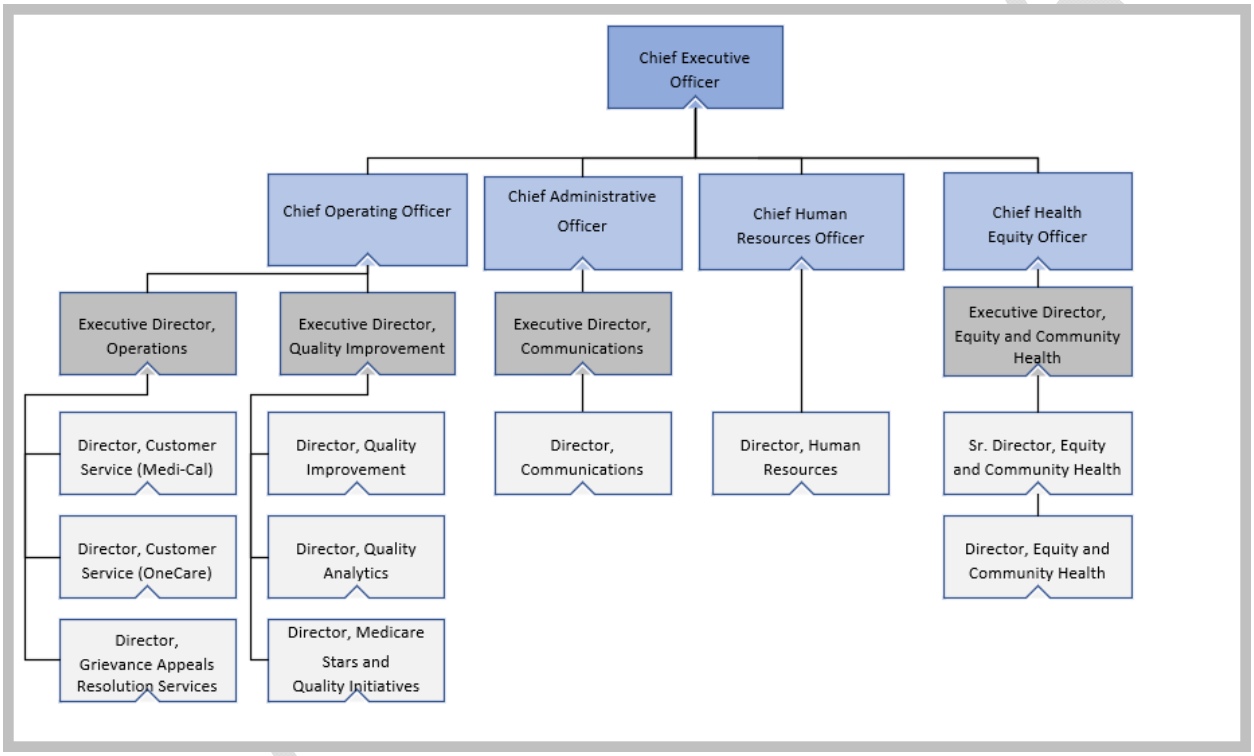
A copy of the CLAS Evaluation is also available to the public on the CalOptima Health website.

The C&L department consists of the Director of Customer Service/Cultural & Linguistics, the Manager of Cultural & Linguistics, a Supervisor, 10 Translation Specialists, and two Program Specialists, who are responsible for translating documents and coordinating cultural and linguistic services with contracted vendors. The C&L department is supported by CalOptima Health departments, including but not limited to:

- Communications
- Utilization Management
- Grievance and Appeals Resolution Services

- Compliance
- Customer Service
- Equity and Community Health
- Human Resources
- Network Operations
- Provider Relations
- Quality Analytics

Cultural & Linguistic Services Organizational Chart Structure



Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO ensures that the QIHEC satisfies all remaining requirements of the QIHETP, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Customer Service, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, and the Executive Directors who have oversight of these areas.

Chief Administrative Officer (CAO) has overall responsibility and accountability for the activities of the Clerk of the Board, Communications & Marketing, Government Affairs, Strategic Development, and Enterprise Project Management. The CAO creates a shared sense of purpose to achieve an aligned mission and vision executed through CalOptima Health's

strategic plan and CEO initiatives. The CAO is expected to lead by example and influence others by exhibiting the highest professional and ethical behaviors.

Chief Human Resources Officer (CHRO) is responsible for the overall administration of CalOptima Health's human resources functions, including policies and procedures, benefits and retirement programs. The CHRO works in consultation with the Office of the CEO, the other Executive Offices, the Executive Directors, Directors and staff, and helps to develop efficient processes for alignment with CalOptima Health's mission and vision, strategic/business/fiscal plans, and the organizational goals and priorities as established by the Board of Directors.

Chief Health Equity Officer (CHEO) co-chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The CHEO provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees strategies, programs, policies and procedures related to CalOptima Health's medical care delivery system. The DCMO collaborates with Directors and Medical Directors in the operational oversight of the medical division, including Quality Improvement, Quality Analytics, Utilization Management, Care Management, ECH, Pharmacy Management, and other medical management programs.

Executive Director, Behavioral Health Integration (ED BHI) is responsible for oversight of CalOptima Health's BH program, including utilization of services, quality outcomes and the coordination and true integration of care between physical and BH practitioners across all lines of businesses.

Executive Director, Clinical Operations (ED CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including UM, Care Coordination, Complex Care Management, along with new program implementation related to initiatives in these areas. The ED CO serves as a member of the executive team and, with the CMO, DCMO, ED BHI and ED ECH makes certain that Medical Affairs is aligned with CalOptima Health's strategic and operational priorities.

Executive Director, Operations (ED O) is responsible for overseeing and guiding Claims Administration, Customer Service, GARS, Coding Initiatives and Electronic Business.

Executive Director, Quality Improvement (ED QI) is responsible for facilitating the company-wide QIHETP deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining National Committee for Quality Assurance (NCQA) accreditation standing as a high-performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement, and Medicare Stars and Quality Initiatives.

Executive Director, Network Operations (ED NO) is responsible for the plan's provider delivery system; leads delivery system operations across multiple models; implements strategies that achieve the established program objectives and leverage the core competencies of the plan's existing administrative infrastructure; directs the integrated operations of the provider network contracted under the various programs and coordinates organizational efforts;

responsible for the overall success of network operations for the planning and implementation to fulfill the plan's strategic objectives as related to contracting and operations of the provider delivery system; and responsible for provider relations and support, including provider education and problem resolution.

Executive Director, Equity and Community Health (ED ECH) is responsible for overseeing comprehensive population strategies to improve the member experience and increase access to care through the promotion of community-based programs. The ED ECH serves as a member of the executive team, and with the CHEO, CMO, DCMO, ED CO and ED BHI, supports efforts to promote optimal health outcomes, ensure efficient care, address mental wellness, address disparities and improve health equity. The Director of Equity and Community Health reports to the ED ECH.

Director, Customer Service (Medi-Cal) is responsible for day-to-day management, strategic direction and support to CalOptima Health Customer Service operations, including Medi-Cal Call Center, Behavioral Health Call Center, Member Liaison, Customer Service Data Analysts, member-facing sections of the CalOptima Health website and the CalOptima Health Member Portal.

Director, Customer Service (OneCare) is responsible for day-to-day management, strategic direction and support to CalOptima Health Customer Service operations, including OneCare Call Center, Cultural & Linguistic Services, Member Communications, Enrollment & Reconciliation, member-facing sections of the CalOptima Health website and the CalOptima Health Member Portal.

Director, Grievance and Appeals Resolution Services is responsible for the day-to-day operations of the Grievance and Appeals Resolution Services (GARS) department, including ensuring that service standards and established policies and procedures regarding the appeals and grievance processes adhere to regulatory requirements.

Director, Quality Improvement is responsible for the day-to-day operations of the Quality Management functions, including credentialing, potential quality issues, facility site reviews (FSRs) and medical record reviews (MRRs), physical accessibility compliance and working with the ED QI to oversee the QIHETP and maintain NCQA accreditation. This position also supports the QIHEC, the committee responsible for oversight and implementation of the QIHETP and QIHETP Work Plan.

Director, Quality Analytics is responsible for leading the collection, tracking and reporting of quality performance measures, including HEDIS and Stars metrics, as required by regulatory entities. This director conducts data analysis to inform root cause analysis, identify opportunities for improvement, and measure the effectiveness of interventions. Provides data analytical direction to support quality measurement activities for the organization-wide QIHETP.

Director, Medicare Stars and Quality Initiatives is responsible for leading the implementation of quality initiatives to improve quality outcomes for Medicare products, including HEDIS, member satisfaction, access and availability, and Medicare Stars. This director provides data analytical direction to support quality measurement activities for the organization-wide QIHETP by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement.

The position provides coordination and support to the QIHEC and other committees to ensure compliance with regulatory and accreditation agencies.

Director, Communications is responsible for coordinating and implementing CalOptima Health's internal and external communications in a manner that promotes and preserves CalOptima Health, its mission, and strategic goals and objectives. This director interacts with CalOptima Health's executive management and legal counsel, as well as members of the media and general public.

Director, Contracting is responsible for the development and implementation of contracting strategies for providers and other business entities, management and monitoring of contractual relationships with existing provider networks and contractors. The Director of Contracting also conducts and coordinates financial analysis to determine and design contracting strategies for CalOptima Health and negotiates provider contracts.

Director, Provider Operations is responsible for all operational aspects of the Provider Network Operations department. The director will oversee the onboarding of all new provider partners, provider data management and analysis, and provider directory production. The Director of Network Management is responsible for ensuring CalOptima Health meets and exceeds access and availability standards; implements strategies that achieve the established CalOptima Health objectives; meets regulatory requirements and NCQA standards; leverages the core competencies of CalOptima Health's existing administrative infrastructure to build an effective and efficient operational unit to serve members and ensure the delivery of health care services throughout CalOptima Health's service delivery network.

Director, Provider Relations is responsible for providing leadership and direction to ensure proactive development, management, communication, support and issue resolution for all CalOptima Health contracted providers. The Director of Provider Relations serves as the strategic, operational and communications lead between CalOptima Health and these critical partners. The Director of Provider Relations develops the overarching provider engagement and partnership strategy to ensure quality member care, provider satisfaction, provider compliance with contractual and regulatory requirements, and active provider engagement in CalOptima Health's goals and priorities.

Director, Human Resources leads, oversees, and manages the administration of Human Resources (HR) services, policies, and programs for CalOptima which may include benefits and wellness programs, classification and compensation, employee engagement, employee relations, human resources information systems (HRIS), leaves programs, performance management, Workers' Compensation as determined by the Chief Human Resources Officer. Provides highly responsible and complex guidance to executives and management.

Sr. Director, Equity and Community Health (ECH) The Sr. Director of Health Equity is responsible for leading the development and implementation of community outreach and member engagement strategies designed to address identified health inequities. This position is responsible for directly assisting the CHEO in developing, implementing, analyzing and refining the CalOptima Health goals and objectives related to health equity (HE). This position will partner with the CHEO, Executive Director of Equity and Community Health and other leaders to strengthen the organization's commitment and strategy to advance health equity and reduce health disparities of our member population, as well as to remain a diverse, equitable and inclusive organization.

Key Business Processes, Functions, and Important Aspects of Cultural and Linguistic Services Language Services

CalOptima Health's CLAS Program ensures that all members have access to health care-related interpreter services in any language and translated member materials in CalOptima Health's threshold languages. CalOptima Health offers language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
Services Included:

- Free access to translations of Member Handbooks/Evidence of Coverage and other important information in English, Spanish, Vietnamese, Arabic, Farsi, Korean, Chinese and Russian.
- Oral translation for other languages upon request or as needed, by a qualified translator at no cost.
- Routine and immediate translation of member notices pertaining to a denial, limitation, termination, delay or modification of benefits, and the right to file a grievance or appeal at no cost.
- Free access to materials in alternative formats such as Braille, large print, data, and audio files.
- Free 24-hour access to telephonic interpreter services for members with limited English proficiency at no cost.
- Free remote video interpreting.
- Free access to face-to-face interpreters at the provider's office at no cost.
- Free access to American Sign Language interpretation assistance for deaf or hard-of-hearing members.
- Tactile signing assistance for deaf-blind members.

CalOptima Health ensures members are informed of the availability of, and their right to, language services through:

- Language Interpreting Services poster in the reception area
- Member Handbook/Evidence of Coverage
- Summary of Benefits
- Quarterly/Annual Newsletters
- New Member Orientations
- Customer Service Call Center
- Health education workshops
- CalOptima Health website
- Member Portal
- Presentations/trainings at community-based organizations and public agencies

CalOptima Health also provides easy-to-understand print and multimedia materials, as well as signage, in the languages commonly used by the populations in its service area. CalOptima Health provides informational materials to members, written at a reading level no higher than sixth grade and translated into CalOptima Health's threshold languages. DHCS threshold and concentration language requirements for Orange County are:

- Eligible beneficiaries residing in CalOptima Health's service area who indicate their primary language as a language other than English and who meet a numeric threshold of 3,000 or 5% of the eligible beneficiary population, whichever is lower (Threshold Standard Language); and

06.19.2026

- Eligible beneficiaries residing in CalOptima Health's service area who indicate their primary language as a language other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes (Concentration Standard Language).

CalOptima Health ensures the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.

Cultural & Linguistic Services Language Competency Testing

Cultural & Linguistic Services staff are tested quarterly to evaluate their language skills, logical thinking and translation competency for U.S. health care materials in each of the seven CalOptima Health threshold languages: Arabic, Chinese, Farsi, Korean, Spanish, Russian and Vietnamese.

The test consists of translating sample documents and replying to several questions. Based on their translation and answers, a trained evaluator will assess their translation competence. A trained evaluator will assess the translator's fluency in the source and target languages, their ability to convey the source meaning in the target language, their familiarity with both source and target cultures, and their research skills.

Cultural Competency and Training

Cultural Competence is the ability to understand, communicate with and effectively interact with people across different cultures, while continuing self-assessment regarding culture, acceptance and respect for differences, ongoing development of cultural knowledge and resources and the dynamic and flexible application of service models to meet the needs of minority populations. Cultural Competence includes awareness of:

- **Race:** Any of the different varieties or populations of human beings distinguished by physical traits such as hair color and texture, eye color, skin color or body shape.
- **Ethnicity:** A group having a common cultural heritage or nationality, as distinguished by customs, language, common history, etc.
- **Culture:** The ideas, customs, skills, arts, etc. of a people or group that are transferred, communicated or passed along to current or succeeding generations.

Some factors influencing culture are age, gender, socioeconomic status, ethnicity, national origin, religion, geographical location, migration, sexual orientation and gender identity.

During the onboarding of new employees, on an annual basis, and as needed, CalOptima Health ensures that staff, providers, health networks and other delegated entities receive Disability Awareness and Sensitivity, and Cultural Competency training as outlined in HR policy AA.1250 and Provider Relations policy EE.1103. Training courses include:

- CalOptima Health staff cultural competency training (Initial and Annual)
- CalOptima Health staff new employee "Boot Camp" C&L Overview (Initial)
- Provider Cultural Competency training (Initial and Annual)
- Provider Disability Training (Initial and Annual)
- Provider Cultural and Linguistic Requirements (Initial and Annual)

For contracted health networks (including their subdelegates) and all staff who are in direct contact with (oral and/or written) members in the delivery of care or member services with individuals who identify as transgender, gender diverse or intersex (TGI), CalOptima Health ensures evidenced-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as TGI, every two years or more often if needed.

Promotion of Diversity, Equity and Inclusion

CalOptima Health is committed to reducing bias and promoting diversity, equity and inclusion (DEI), and supports initiatives that advance health equity for Medi-Cal members.

CalOptima Health is committed to maintaining a workforce that reflects the cultural and linguistic diversity of the communities it serves. This includes the following:

- Inclusive job descriptions and hiring practices.
- Training on the following topics for leaders:
    - Diversity, Inclusion and Unconscious Bias
    - Disability Awareness
    - Cultural Competency
- Mentorship program for career development
- Regular pay equity analysis
- Benefits and perks that support the diverse needs of employees (i.e., flexible work arrangements)

CalOptima Health is also committed to creating and fostering better relationships and connectivity with its diverse community members. The organization supports initiatives to create an inclusive environment within CalOptima Health and with network providers, as well as other community-based contractors and staff with lived experience. CalOptima Health ensures CalOptima Health staff, contracted health networks (including subdelegates), and network providers receive DEI training that includes the following up-to-date and evidence-based DEI training topics:

- Sensitivity
- Diversity
- Cultural Competency
- Cultural Humility
- Health Equity

Data Collection and Analysis

CalOptima Health is committed to collecting information that helps provide better culturally and linguistically appropriate services. Complete, accurate data on race, ethnicity, disability, language, sexual orientation, and/or expression will be collected for Medi-Cal members to illuminate and evaluate the impact of CLAS on health equity and outcomes, informing service delivery and addressing health inequities. Focus is placed on collecting, storing and retrieving member health care data to better address our members' needs. The following data is collected to monitor disparities and inform targeted information.

- Member demographics include but are not limited to race/ethnicity, language, gender identity, disability status and sexual orientation
- Health outcomes
- Language preferences

PAC 05.19.2026

CalOptima Health uses this data to assess the existence of disparities and to focus on quality improvement efforts toward improving the provision of culturally and linguistically appropriate services and decreasing health care disparities. Quality performance, health care data and member experience data are stratified by race, ethnicity, language and other demographic factors to identify disparities. Opportunities for improvement are identified when a disparity is identified and added to the CLAS Work Plan, where the progress of planned activities is tracked toward achieving health equity and CLAS goals. Data is trended to determine whether performance is improving, declining or remaining stable.

CalOptima Health conducts regular assessments of community health assets and needs, using the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area. CalOptima Health conducts an annual Population Needs Assessment (PNA) to review and prioritize the needs of our member population and relevant subpopulation through data-driven planning and decision-making. The PNA considers the unique health needs of children and adults throughout Orange County who are enrolled in Medi-Cal, including:

- Overall member population, including Social Determinants of Health
- Children and adolescent members ages 2–19
- Members with disabilities
- Member clinical and utilization trends, including analysis by racial and ethnic groups
- Members with limited English proficiency
- Relevant focus populations, including members who are pregnant or experiencing homelessness

The PNA's key findings inform the annual CLAS Program, which aims to identify health disparities and address gaps in members' cultural and linguistic needs. Key findings also help identify the need for process updates and resource allocation.

QAC 03.19.2026

Attachment 1

CalOptima Health Measurement Year (MY) 2026
Pay for Value Programs

MY 2026 Medi-Cal Pay for Value (P4V)

The Medi-Cal P4V program incentivizes performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) that are included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL). The Medi-Cal P4V programs also includes incentives for Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. Health networks (HNs) and CalOptima Health primary care providers are eligible to participate in the Medi-Cal P4V program.

MY 2026 Medi-Cal P4V Program Components

1. Include measures held to a DHCS MPL or quality withhold in the MY2026 MCAS measure set.

MY 2026 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness- 30 days	Prenatal and Postpartum Care: Postpartum Care
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Depression Screening and Follow-Up for Adolescents and Adults	Postpartum Depression Screening and Follow Up
Child and Adolescent Well-Care Visits	Prenatal Depression Screening and Follow Up
Childhood Immunization Status- Combination 10	Breast Cancer Screening
Development Screening in the First Three Years of Life*	Cervical Cancer Screening
Immunizations for Adolescents- Combination 2	Colorectal Cancer Screening
Lead Screening in Children	CAHPS- Rating of Health Network: Adult and Child
Topical Fluoride in Children*	CAHPS- Rating of Health Care: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Controlling High Blood Pressure	CAHPS- Getting Needed Care: Adult and Child
Glycemic Status Assessment for Patients with Diabetes (>9%)	CAHPS- Getting Care Quickly: Adult and Child
	CAHPS- Coordination of Care: Adult and Child

- Utilize both Child and Adult CAHPS scores proportional to the age distribution of the assigned member population. For example, if a HN's membership is 30% children ages 0 to 18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN.
   - Attainment and Improvement scores are calculated for each measure. The better of the two scores is used.
   - Scoring
     - Attainment Points
       - Scale of 1-10 points

CAC 03.19.2026

Back to Agenda Back to Item

- Points based on performance between 50th percentile and 95th percentile.
- $1 + \left(\frac{(MY2026\ Rate - 50th\ Percentile)}{((95th\ Percentile - 50th\ Percentile)/9)} \right)$

- Improvement Points
  - Scale of 0-10 points
  - Points reflect performance in the prior year compared to the current year.
  - $\left(\frac{(MY2026\ Rate - MY2025\ Rate)}{((95th\ Percentile - MY2025\ Rate)/10)} \right)$

3. Prior year (MY2025) National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks. *Developmental Screening in the First Three Years of Life and Topical Fluoride are CMS measures where the only benchmark is the 50th percentile. For these two measures, CMS percentiles will be used and HNs will earn 10 points for performance at or above the 50th percentile and 1 point for performance below the 50th percentile.
4. Measure weighting
   - HEDIS measures weighted 1.0
   - CAHPS measures weighted 1.5
5. Maintain program funding at ten percent (10%) of professional capitation (base rate only).
6. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance.
7. HNs that score below the 50th percentile will be required to submit an improvement plan for that measure to CalOptima Health.
8. DHCS quality withhold penalties will be deducted from each HN's earned P4V program payment.

QAC 03.19.2026

Attachment 1

CalOptima Health Measurement Year (MY) 2026
Pay for Value Programs

OneCare Pay for Value Program (P4V)

The OneCare P4V program focuses on select Centers for Medicare and Medicaid Services (CMS) Star Part C and Part D measures. Measures are developed from industry standards including HEDIS, CAHPS member experience, and Pharmacy Quality Alliance. Health networks (HNs) and CalOptima Health primary care physicians (PCPs) are eligible to participate in the OneCare P4V program.

MY 2026 OneCare P4V Program Components

Alignment with the CMS Star program and the following components- CMS Star Part C and Part D measures, measure weights, and Star cut points as benchmarks:

1. Utilize a subset of CMS Star measures

MY 2026 OneCare Pay for Value Program Measurement Set	
Measure Category	**Measure**
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Care for Older Adults- Medication Review
	Care for Older Adults- Functional Status Assessment
	Osteoporosis Management in Women who had a Fracture
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – Blood Sugar Controlled
	Kidney Health Evaluation for Patients with Diabetes
	Controlling Blood Pressure
	Transitions of Care
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
	Statin Therapy for Patients with Cardiovascular Disease
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Network Quality
	Rating of Health Network
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Concurrent Use of Opioids and Benzodiazepines

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.

   - Scoring
     - Attainment Points

QAC 05.19.2026

Back to Agenda Back to Item

- Scale of 1-5 points
- Points based on performance between 3-Star and 5-Star cut points.
- $1 + \left(\frac{(MY2026\ Rate - 3\ Star\ cut\ point)}{((5\ Star\ cut\ point - 3\ Star\ cut\ point)/4)} \right)$

▪ Improvement Points
- Scale of 0-5 points
- Points reflect performance in the prior year compared to the current year.
- $\left(\frac{(MY2026\ Rate - MY2025\ Rate)}{((5\ Star\ cut\ point - MY2025\ Rate)/5)} \right)$

3. MY2026 CMS Star cut points used as benchmarks. These benchmarks will be released by CMS in Q4 2027 in the 2028 Star Rating Technical Notes.
4. Measure weighting
   - HEDIS process measures weighted 1
   - CAHPS measures weighted 2
   - Outcome measures weighted 3
5. Apply a program funding methodology of $20 PMPM
6. Available Incentive Pool: the OneCare incentive pool will be determined by each HN's Stars performance as described in the table below. Actual OneCareP4V incentives will be based on performance as described in this section.

OneCare P4V Performance	MY2026 Incentive Percentage SY2028
Below 3.0 stars	0%
3 Stars	20%
3.5 Stars	40%
4.0 Stars	60%
4.5 Stars	80%
5.0 Stars	100%

Note: MY = measurement year, SY= Star rating display year

7. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance
8. HNs that score below 3.0 Stars will be required to submit an improvement plan for that measure to CalOptima Health.

QAC 03.19.2026

Attachment 1

CalOptima Health Measurement Year (MY) 2026
Pay for Value Programs

Covered California Pay for Value Program (P4V)

The Covered California P4V program focuses on measures included in the Quality Transformation Initiative. Health networks (HNs) are eligible to participate in the Covered CA P4V program.

MY 2027 Covered CA P4V Program Components

Alignment with the Covered CA Quality Transformation Initiative (QTI) and the following components:

1. CalOptima Health will adopt the 2027 QTI measures for the MY2027 P4V Program.

MY 2027 Covered CA Pay for Value Program Measurement Set
Controlling High Blood Pressure
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
Colorectal Cancer Screening
Childhood Immunization Status (Combo 10)
Depression Screening and Follow-Up for Adolescents and Adults

2. Utilize an attainment scoring methodology where rates that meet designated benchmarks qualify for percentages of incentives per measure
3. MY2026 National Committee for Quality Assurance (NCQA) Quality Compass National Exchange percentiles used as benchmarks
4. Measures will be weighted equally
5. Establish program funding at ten percent (10%) of professional capitation (base rate only)
6. Covered CA P4V incentives will be based on performance compared to benchmarks as described below:

NCQA Quality Compass National Exchange Percentile	% of Incentive Earned per Measure
75th	100%
66th	75%
50th	50%
33rd	25%

7. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance

QAC 03.19.2026

Back to Agenda Back to Item

CalOptima Health Measurement Year (MY) 2026
Behavioral Health Integration (BHI) Department Pay for Value Programs

The Behavioral Health Integration Department has implemented two Pay-for-Value programs designed to improve quality of care and incentivize performance among directly contracted providers: one for Applied Behavior Analysis (ABA) and another for non-ABA mental health provider groups.

1) Applied Behavior Analysis Pay-for-Value Program (ABA P4V)

Behavioral Health Integration Department proprietary designed Applied Behavior Analysis (ABA) Pay-for-Value (P4V) Program approved by the Board of Directors and applies to measurement periods from **July 1, 2024, through June 30, 2026.**

- **ABA P4V Program Metrics**

CalOptima Health developed a proprietary ABA Pay-for-Value (P4V) Program using a structured approach that incorporated clinical best practices into the program metric selection.

	Category	Program Metric	Metric Weight %
1	Quality	Client Received Monthly Direct Services	2.0%
2	Quality	Client Received 10% or More Supervision	2.0%
3	Quality	Client Received Monthly In-Person BCBA/BMC Field Visits	2.0%
4	Care Experience	Client Received Timely Treatment	2.0%
5	Care Experience	Client Received Monthly Parent Training Visits	2.0%
		Total Percentage	**10%**

- **ABA P4V Program Methodology**
  - Measurement Period: Every 6 months
  - Data Source: Claims and encounter submissions
  - Review Frequency: Semi-annual performance review
  - Incentive Opportunity: Providers can qualify for up to a 10% incentive applied to adjudicated paid claims during the payout period

Measurement Period	Review Period	Payout Period
Jul – Dec 2024	Jan – Jun 2025	July– Dec 2025
Jan – Jun 2025	Jul – Dec 2025	Jan – Jun 2026
Jul – Dec 2025	Jan – Jun 2026	Jul – Dec 2026
Jan– Jun 2026	Jul – Dec 2026	Jan – Jun 2027

2) Mental Health Provider Pay-for-Value Program (MH P4V)

Behavioral Health Integration's proprietary program incentivizes mental health provider/group contracted directly with CalOptima Health. The program was approved by the Board of Directors and applies to measurement periods from **January 1, 2025, through December 31, 2026.**

- **MH P4V Program Metrics**

This is a proprietary program developed by CalOptima Health. The measures listed in the table align with a combination of standards, including select Healthcare Effectiveness Data and Information Set (HEDIS) quality metrics, Department of Managed Health Care (DMHC) timely access requirements, and clinical best practices.

QAC 08. 19.2026

Back to Agenda Back to Item

	Category	Program Metric	Metric Weight Percentage
1	Quality	Timely Follow-up After BH/SUD ED visit	2.5 %
2	Quality	Follow–up After Initial Visits	2.5%
3	Quality	Effective Ongoing Care	1.0%
4	Capacity/Growth	Capacity/Panel Growth	1.0%
5	Care Effectiveness	Quality Monitoring of Essential Labs and Diagnostics	1.0%
6	Care Effectiveness	Clinical Measurement of Care	1.0%
		Total Percentage:	**10%**

- **MH P4V Program Methodology**
  - Measurement Period: Every 6 months
  - Data Collection: Claims and encounter submissions and provider attestation forms
  - Review Frequency: Semi-annual performance review
  - Incentive Opportunity: Providers can qualify for up to a 10% incentive applied to adjudicated paid claims during the payout period

Measurement Period	Review Period	Payout Period
Jan – Jun 2025	Jul – Dec 2025	Jan – Jun 2026
July – Dec 2025	Jan – Jun 2026	Jul – Dec 2026
Jan – Jun 2026	Jul – Dec 2026	Jan – Jun 2027
July – Dec 2026	Jan – Jun 2027	Jul – Dec 2027

QAC 05.19.2026

Back to Agenda Back to Item

2025 Quality Improvement and Health Equity Transformation Program Evaluation

Quality Assurance Committee Meeting

March 19, 2026

Linda Lee, Executive Director, Quality Improvement

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

2025 Quality Improvement and Health Equity Transformation Program (QIHETP) Evaluation

Linda Lee, Executive Director, Quality Improvement

2025 Program Achievements

- **January 2025:** The Orange County Board of Supervisors approved a revision to the ordinance that will allow participation in Covered California.
- **March 2025:** CalOptima Health Board of Directors approved the expansion of the Street Medicine Program to Santa Ana.
- **August 2025:** CalOptima Health held the second annual Back-to-School Health and Wellness Event, attracting more than 3,500 attendees to the event, held for the first time in Westminster.
- **October 2025:** CalOptima Health Board of Directors approved $19.8 million to expand outreach efforts to ensure Orange County's vulnerable residents understand how to maintain their health coverage.
- **November 2025:** Added a 10th health network by partnering with Providence.
- **December 2025:** Achieved Health Outcomes Accreditation* from the National Committee for Quality Assurance (NCQA).

*Formerly known as Health Equity Accreditation

CalOptima Health

Review of 2025 Priority and Goals

Priority Goals	Evaluation
Close racial/ethnic disparities in well-child visits and immunizations by 50%: Not Met	• Rate for well-child visits (0-15months) for the African American population increased from 45.05% to 53.06% but did not meet the goal of 55.78%. • Adolescent immunization rates for African American and Native Hawaiian and Other Pacific Islander decreased.
Close maternity care disparity for Black and Native American persons by 50%: Met*	• While the rate did meet the goal, due to low denominators, the rates were not statistically significant.
Exceed the 50th percentile for all children's preventive care measures: Met	• Met or exceeded the 50th percentile for all children's preventive measures.

*Low denominator – not statistically valid.

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Review of 2025 Priority and Goals (Cont.)

Priority Goals	Evaluation
Improve maternal and adolescent depression screening by 50%: Not Met	• Maternal depression screening rate decreased. • For adolescent and adult depression screening, while the rate did not increase by 50%, there was a 32% increase from the previous year.
Improve follow-up care for mental health and substance abuse disorder by 50%: Not Met	• While the rates did not increase by 50%, there was a 46.5% and 33.7%, for mental health and substance abuse, respectively, increase from the previous year.
Medi-Cal: Meet or exceed the Minimum Performance Levels (MPLs) for Medi-Cal Managed Care Accountability Set (MCAS): Not Met	• Follow-up After ED Visit for Alcohol and Other Drug Dependence within 30 Days (FUA), Follow-up After ED Visit for Mental Illness within 30 Days (FUM), and Asthma Medication Ratio (AMR) did not meet the MPL[1].
OneCare: Attain a Four-Star Rating for Medicare: Not Met	• CalOptima Health met a 3.0 overall star rating for MY2024

1. MPL – Minimum Performance Level

2025 QI Evaluation Highlights: Program Structure and Oversight

- The Quality Improvement Health Equity Committee (QIHEC) met 12 times in 2025
  - Five (5) subcommittees met at least quarterly
  - Population Health Management Committee sunset
- QIHEC reported to the Quality Assurance Committee (QAC) quarterly
- QIHEC summary posted to the CalOptima Health website quarterly
- Achieved full points (100%) and "accredited" status for the initial NCQA[1] Health Outcomes Accreditation Survey*

1. NCQA - National Committee for Quality Assurance
*Formerly known as Health Equity Accreditation

2025 QIHETP Evaluation Highlights: Quality of Clinical Care and Performance Outcomes (Cont.)

- For Medi-Cal:
  - NCQA[1] Health Plan Rating
    - Prevention and Equity: 4 Stars
    - Treatment: 3 Stars
  - CalOptima Health met 15 of the 18 MCAS[2] measures held to the MPL[3]
    - Measures that did not meet MPL[3]:
      - Follow-up After ED visit for Alcohol and Other Drug Dependence within 30 days (FUA) didn't meet MPL[3]
      - Follow-up After ED visit for Mental Illness within 30 days (FUM) didn't meet MPL[3]

1. NCQA - National Committee for Quality Assurance
2. MCAS – Medi-Cal Managed Care Accountability Set; goal is 50th percentile
3. MPL – Minimum Performance Level

2025 QIHETP Evaluation Highlights: Quality of Clinical Care and Performance Outcomes

- For Medi-Cal:
  - Department of Health Care Services (DHCS) Quality Withhold
    - Earned 100% of the quality withhold dollars for measurement year (MY) 2024

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2025 QIHETP Evaluation Highlights: Quality of Clinical Care and Performance Outcomes

- For OneCare:
  - 9 of the 15 Star measures achieved a 3.0 Star or higher rating
    - Annual Flu Vaccine received a 4.0 Star rating
  - Star measures below the 3-star cut-point
    - Controlling of blood pressure (CBP)
    - Colorectal Cancer Screening (COL-E)
    - Care for Older Adults (COA-Medication Review)
      - COA - Functional status assessment will return from display to Star measure for MY2025
      - COA-Pain assessment will be retired for MY2025
    - Transitions of Care (TRC)
    - Plan All-Cause readmissions (PCR)

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2025 QIHETP Evaluation Highlights: Quality of Service and Member Experience

- Member Experience (CAHPS[1]) Surveys were fielded at both the plan and network level in 2025
  - NCQA[2] Health Plan Rating for Patient Experience at 2.5-Stars (Medi-Cal)
  - Centers for Medicare and Medicaid (CMS) Star Rating (OneCare)
    - Rating of Health Plan at 3-Stars
    - Rating of Health Care Quality 2-Stars

1. CAHPS - Consumer Assessment of Healthcare Providers and Systems
2. NCQA - National Committee for Quality Assurance

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2025 QIHETP Evaluation Highlights: Quality of Service and Member Experience

- CalOptima Health submitted all deliverables to the DHCS[1] for Annual Network Certification (ANC) and Subcontracted Network Certification (SNC).
  - Met all network certification requirements for ANC and SNC.
  - Area of focus: Timely Access (appointment availability) and network adequacy at the health network level.

1. DHCS - Department of Health Care Services

2025 QIHETP Evaluation: New Recommendations for 2026

- Promote at-home health care and services (e.g., at-home visits and at-home labs).
- Expand member and provider demographic data, particularly on disability and veteran/military status, to ensure effective measurement and reduction of health disparities.
- Enhance data exchange and sharing to advance the completeness and timeliness of quality data.
- Attain operational readiness to launch the Covered California product on January 1, 2027.

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2025 Population Health Management Strategy Evaluation

Kelly Giardina, Executive Director, Clinical Operations

2025 Population Health Management (PHM) Strategy Impact Evaluation

PHM Strategy Domain	Program	2025 PHM Goal Met/Not Met
Keeping Members Healthy	Blood Lead Screening	Met
	Prenatal/Postpartum Depression Screening	Met
	Healthy Heart Program	Not Met
Emerging Risk	Chronic Condition Care and Self-Management Program	Met
Patient Safety	CalAIM Community Supports	Not Met
	Street Medicine Program	Partially Met
	Behavioral Health Services	Not Met
Managing Multiple Chronic Conditions	Complex Case Management	Partially Met
Advanced Care Support	Enhanced Care Management	Met

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PHM Program Accomplishments & Highlights

- Care Coordination, Access, and Experience
  - Leveraged standing orders to prescribe 709 blood pressure monitors to members with hypertension;
  - Improved rates for all child health measures (Blood Lead, Well Child)
  - Strong satisfaction among members in Case Management and Disease Management
- Member Risk Stratification, Segmentation, and Tiering (RSST)
  - Proportion of high-risk members receiving interventions or HRA increased from 62% in Q4 2024 to 76% by Q4 2025
  - Analysis of Medi-Cal Connect RSST completed

1. PHM – Population Health Management

PHM Program Accomplishments & Highlights (continued)

- Local Health Department Collaboration with Orange County Health Care Agency
  - Data sharing process established with Orange County Health Care Agency
  - Developed Community Health Workers Toolkit and a training for Blood Lead Screening

1. PHM – Population Health Management

2025 Culturally and Linguistically Appropriate Services Program Evaluation

Albert Cardenas, Director, Customer Service

2025 Culturally and Linguistically Appropriate Services Program (CLAS) Evaluation

CLAS Goals	Met / Not Met/Partial
Expanded the threshold languages to include Russian by August 11, 2025.	Met
Launched a language services experience survey collect feedback from at least 10% of members and 80% of staff using surveys and analyzing the results to identify improvements to language services.	Not Met
By Dec. 31st, 2025, CalOptima Health will increase the collection of practitioner race/ethnicity/language (REL) to 10% through focused outreach and education, ensuring better representation and inclusion of providers	Partial
Increase the collection of sexual orientation and gender identity (SOGI) data to 10% of members	Not Met
Diversity, Equity and Inclusion (DEI) training implementation and train 90% of staff, health networks, and providers.	Partial

CLAS = Culturally and Linguistically Appropriate Services

2025 CLAS Evaluation

- Opportunities for Improvement:
  - Evaluate each CLAS goal and set achievable outcomes
  - Improve interdepartmental collaboration on CLAS Program goals
  - Align CLAS reports with the annual CLAS evaluation
  - Begin drafting the evaluation in early Quarter 4 to ensure timely completion and distribution
  - Ensure all activities outlined in all CLAS-related reports are executed and completed

CLAS = Culturally and Linguistically Appropriate Services

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2026 Quality Improvement Health Equity Transformation Program (QIHETP) Description and Work Plan

Quality Assurance Committee Meeting

March 19, 2026

Linda Lee, Executive Director, Quality Improvement

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

2026 Quality Improvement Health Equity Transformation Program (QIHETP) Description and Work Plan

Linda Lee, Executive Director, Quality Improvement

2026 QIHETP Priority Areas and Goals

Products	Goals
Medi-Cal	• Meet and exceed the minimum performance levels (MPLs) for the Medi-Cal Accountability Set (MCAS) • Maintain National Committee for Quality Assurance (NCQA) Health Plan and Health Outcomes Accreditation* • Attain a 4.5 NCQA Health Plan Rating
OneCare	• Attain a Four-Star Rating for Medicare
Covered California	• Attain operational readiness to launch the Covered California product on January 1, 2027.

*Formerly known as Health Equity Accreditation

2026 QIHETP Description: Revision Highlights

- Updated the priority areas and goals for 2026
  - Align with the newly updated 2025 Comprehensive Quality Strategy Report
- Added Covered California
- Added the Behavioral Health Integration Pay for Value Program
- Updated committee structure organization chart
  - Removed the Population Health Management Committee (PHMC)
  - PHMC items will be reported to the Utilization Management Committee (UMC) or the Quality Improvement Health Equity Committee (QIHEC) directly

2026 QIHETP Description: Revision Highlights (Cont.)

- Updated the staffing and resources to reflect the current organizational structure
  - Added Sr. Director of Provider Network Strategy
  - Added Manager of Quality Improvement (NCQA1)
  - Added Director of Quality Improvement (Credentialing)
  - Added Director of Medical Management
- Removed programs that sunset in 2025
- Updated sections in the QIHETP to reflect current operational processes and workflows

1. NCQA - National Committee for Quality Assurance

2026 Work Plan Revisions: Removed

- Population Health Management Committee (PHMC) sunset
- Student Behavioral Health Incentive Program (SBHIP) concluded
- Goal for increasing timeliness of prenatal care for Black members – denominator is too low to measure
- Removed retired measures (i.e. Asthma Medication Ratio)

2026 Work Plan: High Priority Areas

- Medi-Cal measures not meeting the Medi-Cal Managed Care Accountability Set (MCAS) Minimum Performance Levels (MPLs)
- Medi-Cal measures below 2 for Health Plan Ratings
- Medicare Star measures that significantly declined or performed at or below 2 stars

2026 Work Plan Revisions: Changes

- NCQA[1] Accreditation
  - Added Operational readiness for Covered California
  - Revised Health Equity to Health Outcomes Accreditation
- Separated items: Quality Performance Reporting and Quality Performance Improvement
- Enhancing Member and Provider Demographic Data Collection and Analysis (i.e., disability status, physical accommodations, military status, etc.)
- Emergency Department (ED) Pilot Program graduated to the ED Program

1. NCQA - National Committee for Quality Assurance

2026 Work Plan Revisions: New

- Quality Improvement Health Equity Committee (QIHEC)
- Utilization Management Program
- External Quality Review Requirements
- Behavioral Health Integration Value-Based Payment Program
- Sentinel Event Monitoring and Disease Surveillance
- Cozeva PayerOne Software Solution
- At-Home Visit Program
- At-Home Lab Testing Program

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2026 Population Health Management (PHM) Strategy and Work Plan

Kelly Giardina, Executive Director of Clinical Operations

2026 PHM Work Plan Areas of Focus*

- Description: The organization outlines its PHM strategy for meeting the care needs of its member population
- Intent: The organization has a cohesive plan of action for addressing member needs across the continuum of care
- Areas of focus (while improving outcomes across all settings) includes:
  - Keeping members healthy
  - Managing members with emerging risk
  - Patient safety or outcomes across settings
  - Managing members with multiple chronic conditions

2026 PHM Work Plan Areas of Focus*

Keeping Members Healthy

- Keeping Children Healthy
- Maternal Health Program

Emerging Risk

- Disease Management Program

Patient Safety or Outcomes Across Settings

- CalAIM Enhanced Case Management and Community Supports
- Street Medicine Program
- Behavioral Health Services
- Transitional Care Services
- Emergency Department Pilot Program

Managing Multiple Chronic Conditions

- Complex Case Management Program

Goals for each area of focus are listed in the QIHETP Work Plan

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2026 Culturally and Linguistically Appropriate Services (CLAS) Program

Albert Cardenas, Director of Customer Service

2026 CLAS Goals

Domain	2026 CLAS Goals
Language Services	1. Increase the survey response rate from 6% to 10% for members and 4% to 80% for staff 2. Maintain a satisfaction rate of 90% or above
Data Collection on Member Demographic Information	1. Update the current data system to receive, store and retrieve the following: disability function and identity, physical accommodations, auxiliary aides or services, geographic classification, age, and veteran/military status 2. Increase the collection of member disability function data from 0 to 5% through focused outreach and education, ensuring better representation and inclusion of members.

2026 Culturally and Linguistically Appropriate Services (CLAS) Program Description

- 2026 CLAS Program revisions and updates include:
  - Member demographics
    - Updates to CalOptima Health membership by program, age, language, and Medi-Cal aid codes
  - Member Advisory Committee (MAC)
    - Revisions to the number of voting members, ethnicity and language percentage of voting members and constituency representation.
  - 2026 CLAS Workplan
    - Updates to the areas of focus for the CLAS Program
  - Data Collection and Analysis
    - Revisions to include disability status and accommodations.

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 19, 2026
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

5. Recommend that the Board of Directors Receive and File the 2025 CalOptima Health Utilization Management Program Evaluation and Approve the 2026 CalOptima Health Utilization Management and Case Management Integrated Program Description

Contacts

Michael Hunn, Chief Executive Officer, (714) 246-8570
Kelly Giardina, Executive Director, Clinical Operations, (657) 900-1013

Recommended Actions

Recommend that the Board of Directors:

1. Receive and file the 2025 CalOptima Health Utilization Management Program Evaluation, and
2. Approve the 2026 CalOptima Health Utilization Management and Case Management Integrated Program Description.

Background

CalOptima Health's Utilization Management (UM) and Case Management (CM) Integrated Program explains how medically necessary and quality health care services are provided to members in a coordinated, comprehensive, and culturally competent way. The program ensures that medical decisions are not influenced by financial factors, does not reward practitioners or others for denying coverage, and does not promote decisions that lead to underuse.

CalOptima Health's UM Program is reviewed and approved annually by the Board of Directors. It outlines the structure for UM activities and establishes procedures for systematically coordinating, managing, and monitoring these processes to achieve positive outcomes for members.

CalOptima Health's UM Program accomplishments in 2025 include:

- Clinical Operations Governance: Established leadership forums to design an iterative medical model that meets members' needs.
- Provider portal automation enhancements.
- Enhanced authorization review processes, including refined retrospective authorization process and the enhanced peer-to-peer process.
- UM Process Enhancements: Supported Centers for Medicare & Medicaid Services (CMS) Medicare Star rating improvement, PointClickCare enhancements, initiated process to implement print fulfillment vendor, established a Pediatric Workgroup to review for Early and Periodic Screening Diagnosis Treatment and appropriate referrals to California Children's Services and the Local Educational Agency.
- Enhanced oversight of delegated health networks.
- Transitional Care Services (TCS): Expanded workflows, added complex discharge support staff to facility rounds, continued refinement of admit, discharge, and transfer file for primary care provider notifications, and enhancement of member outreach.

Back to Agenda

- Implemented Emergency Department (ED) Diversion Program: Implemented a weekly workgroup, and deployed ED staff to provide resources.
- Skilled Nursing Facility (SNF) Engagement: Established a SNF workgroup and implemented a quarterly SNF Consortium.
- Hospital Collaboration: Implemented Pediatric Facility Clinical Rounds, member outreach campaigns to support post-hospital admission, and established hospital rounds with Loma Linda to support transplant care and coordination.

Discussion

CalOptima Health's 2026 UM and CM Integrated Program Description includes the following departments: Quality, Pharmacy Management, Health Management/Disease Management, Behavioral Health, Care Management, Utilization Management, and Long-Term Services and Supports. The program description is designed to ensure that all regulatory requirements and National Committee for Quality Assurance (NCQA) accreditation standards are consistently met across all lines of business and are aligned with health network and strategic organizational changes.

The key revisions to the 2026 Annual UM and CM Integrated Program Description include, but are not limited to, the following areas:

- Enhanced ED Diversion Program.
- Addition of Transitional Rent CalAIM Community Support.
- Addition of Providence Medical Foundation as a delegated health network.
- Enhanced health network oversight and monitoring.
- Updated turnaround time standards to align with 2026 regulatory requirements.
- Enhanced TCS program.

The purpose of the 2026 UM and CM Integrated Program Description is to outline the oversight and delivery of CalOptima Health's structure, clinical processes, and programmatic strategy. All health care services address the culturally diverse needs of the CalOptima Health population and are provided at the appropriate level of care, efficiently and promptly, by both delegated and non-delegated providers.

The updates to CalOptima Health's UM and CM Integrated Program Description reflect current clinical operations and are essential to meet the requirements set by the CMS, the California Department of Health Care Services, and NCQA accreditation standards.

Fiscal Impact

The recommended actions do not have a fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2025-26 Operating Budget or separate Board of Directors actions. Staff will include updated expenditures for the period of July 1, 2026, through December 31, 2026, in the FY 2026-27 Operating Budget.

Back to Agenda

Rationale for Recommendation

Staff recommends receiving and filing the 2025 UM Program Evaluation and approving the 2026 UM and CM Integrated Program Description to ensure alignment with NCQA requirements and compliance with regulatory requirements.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. 2025 UM Program Evaluation (Clean version)
2. 2026 UM and CM Integrated Program Description (Redline version)
3. 2026 UM and CM Integrated Program Description (Clean version)
4. 2025 UM Program Evaluation and 2026 UM and CM Integrated Program Description (PowerPoint)
5. 2026 UM Appendix Slides

/s/ Michael Hunn *03/12/2026*
Authorized Signature **Date**

Back to Agenda

2025 CalOptima Health Utilization Management Program Evaluation

Executive Summary

The 2025 Utilization Management (UM) Program description defines, and outlines CalOptima Health's clinical activities to ensure optimal utilization and the delivery of high-quality health care services. These services are delivered compassionately at the right time and in the appropriate setting.

CalOptima Health evaluates the UM Program structure, scope, processes, and information sources used to determine utilization trends, medical necessity, program effectiveness and benefit coverage determinations. This evaluation is reviewed and approved annually by the UM Committee (UMC), the Quality Improvement Health Equity Committee (QIHEC) and the Quality Assurance Committee (QAC). The look back period for the 2025 UM program evaluation is Q4 2024 through the end of Q3 2025.

Program Structure and Process

The UM Program was enhanced throughout 2025 to ensure member needs were addressed, while maintaining compliance with regulatory and accreditation standards. While the core staffing model for UM nursing and non-clinical teams remained stable, a notable leadership shift in responsibilities occurred:

- **Leadership Change**: The UM Manager overseeing prior authorization retired. Oversight responsibilities transitioned to the Senior UM Manager and a Senior Director, Medical Management Hospital/Facility Liaison, who joined the UM Department Manager in supporting the hospital-based team.
- **Role Evolution**: Clinical support teams and administrative staff expanded reach to support process improvements within the UM program. Some examples of the contributions of this programmatic refinement work included but where not limited to the following:
    - **Workflow Optimization:** Prioritized aging inventory through improved workflows and oversight to ensure regulatory turnaround compliance.
    - **Leadership Oversight:** Enhanced UM Leadership daily touchpoint for

effective monitoring of pending inventory.

- **Reporting Improvements:** Upgraded reporting to track authorization standards, including decision and notification compliance.
- **Inpatient Rounds:** Strengthened inpatient facility rounds for real-time solutions and proactive discharge planning; expanded participation to address discharge and clinical concerns; improved early identification of provider-driven referrals for Transitional Care Services (TCS) and complex placement needs.
- **Data Timeliness:** Refined reporting processes to improve timeliness and strengthen UM treatment authorization oversight.
- **Post-Stabilization Authorization (PSA):** Maintained rigorous oversight of PSA protocols to ensure compliance, member access, and hospital support; conducted regular "Secret Shopper" audits with health network partners and internal teams; shared results during Joint Operations Meetings (JOMs).
- Transitional Care Services (TCS) **Program Oversight:** Established additional clinical roles, including a dedicated Medical Director; implemented bi-monthly TCS case reviews with Medical Director involvement.
- **Workflow Refinement:** Improved TCS workflows and adopted evidence-based post-discharge assessments and complex case reviews.
- **Prior Authorization Updates:** Removed prior authorization requirements for preventive care and screenings under OneCare.
- **Staffing Stability:** Deployed temporary staff for clinical and non-clinical roles to mitigate staffing gaps.
- **Gender-Affirming Care Compliance:** Reinforced compliance through enhanced auditing and staff education aligned with APLs and WPATH standards; delivered TGI cultural competency training for clinical staff and contracted providers.
- **Continuity of Care:** Re-trained staff on continuity of care processes, implemented enhanced monitoring, and launched monthly audits to ensure compliance with APL 23-022.
- **Transplant Program Support:** Continued weekly collaboration with UCSD Transplant Center of Excellence and presented program outcomes at CalOptima Health's Health Network Clinical Forum.
- **PA Process Standardization:** Formed a prior authorization (PA) consultant workgroup to standardize and streamline PA processes and develop a codified PA requirements list for internal and delegated Health Networks.
- **Goal Setting:** Analyzed inpatient and ED utilization data to establish 2026 performance goals.
- **Health Network Clinical Oversight:** Continued refinement of education and accountability with Health Network clinical teams in Clinical forum, 1:1 quarterly oversight, ongoing weekly communication and Joint-Operations Meetings (JOM's).

Program Structure

Medical Director Responsibilities:
No additional Medical Directors were appointed in 2025; however, responsibilities for all existing Medical Directors were expanded as appropriate to align with clinical operations priorities. This ensures competency and comprehensive oversight of Care Model program delivery. For example, one Medical Director now has oversight of the Transitional Care Services (TCS) program. The disease management and maternal health case management programs now also have medical director consults and rounds available for complex case discussion and support.

Information sources as well as staff assigned activities used to determine benefit coverage and medical necessity remained current to standards, policies, and regulations and appropriate for the populations served by CalOptima Health. The current UM structure supports CalOptima Health's UM functions. Medical Necessity coverage tools and hierarchical protocols continue to be reviewed and approved annually at the UMC.

Program Scope Impact

Program Scope impact areas also included but were not limited to:

- Continued refinement of CalAIM services.
- Enhanced review of KPI utilization data for over and underutilization including Health Network utilization data.
- Refined EPSDT review and protocols.

PROJECTS, PROGRAMS AND INITIATIVES

Utilization Management

Oversight of prior authorization (PA) inventory remained a core component of the UM Program, focused on improving the average turnaround times and aligning with CalOptima Health's strategic vision for same day treatment authorizations.

Key Initiatives implemented or enhanced to support the UM Program include but are not limited to:

- Clinical Operations Governance: Established progressive leadership forums with physician teams and clinical leaders, including UM/CM workgroups, physician-led subgroups, and Medical Director initiatives to design an iterative medical model that meets member needs.
- Behavioral Health Integration: Continued integration of Behavioral Health team members to strengthen member support.
- Provider Portal Automation: Refined referral intelligence rules to improve PA access and protocols.
- Authorization Review Processes:
    - Refined retrospective authorization review process.
    - Enhanced peer-to-peer process for provider engagement.
    - Refined the retrospective authorization review process.

- UM Process Enhancements:
    - Supported STAR rating improvement through ADT software, PointClickCare enhancements for secure EMR messaging of admission/discharge notifications.
    - Initiated the process to implement print fulfillment vendor implementation to improve notification efficiency.
    - Established a Pediatric Workgroup led pediatric workgroup to review cases for EPSDT criteria including denial auditing to validate compliance with APL 23-005, appropriate referrals to CCS and the Local Educational Authority (LEA).
- Enhanced oversight of delegated Health Networks to include but not limited to; quarterly meetings to review UM Workplans, over/under utilization of data, and Key Performance Improvement (KPI) metrics.
- Transitions of Care Services (TCS)
    - Expanded TCS workflows to include Maternal Health and multi-payor TCS under Population Health Management (PHM).
    - Distributed referral flyers via JOMs and Health Network forums to educate providers on accessing TCS.
    - Added TCS and complex discharge support staff to facility rounds for real-time discharge planning.
    - Continued refinement of Admit, Discharge, and Transfer (ADT) data file transfers for timely PCP notifications.
    - Refinement of enhanced Transitional Care Services (TCS) for member outreach with admission to a facility supporting increased member engagement in TCS services.
    - Implementation of warm handoffs to ensure seamless transitions to community care networks, delegated networks, Transitional Care Services (TCS), Case Management, and Enhanced Care Management (ECM).
- ED Diversion Program and focus:
    - Implemented weekly interdisciplinary workgroup with Medical Director oversight, integrating Case Management, LTSS, TCS, and Behavioral Health.
    - Deployed onsite ED staff to provide resources, facilitate referrals, and address barriers at the point of service.
    - Delivered education to ED staff on available resources and processes.
    - Integrated High-Risk Management Sub-Workgroup to review ED utilization and identify improvement opportunities.
    - Implemented ED Diversion Workgroup with Medical Director oversight. Weekly workgroups use an Interdisciplinary team approach that includes Case Management, LTSS, TCS and Behavioral Health integration. The High-Risk Management workgroup also reviews ED utilization and identify opportunities for improvement and outcomes are integrated into both forums.
    - Deployment of onsite ED staff to provide resources, facilitate referrals, and address barriers to care at the point of service.
    - Implemented texting campaigns for members admitted identifying TCS

support line for assistance.
    - Comprehensive education for ED staff on available resources and processes.
- Skilled Nursing Facility Engagement:
    - Established a Skilled Nursing Facility (SNF) Workgroup led by CalOptima Health Medical Directors to enhance the concurrent review process.
    - Conducted quarterly SNF Consortium focused on sharing resources, best practices in discharge planning, strategies for readmission prevention, and claims overview.
- Hospital Collaboration
    - Continued review and pursuit of EMR access for timely discharge summaries and medication reconciliation to PCPs.
    - Implemented Pediatric Facility Clinical Rounds to focus on long lengths of stay (NICU and PICU) and coordination of CCS eligibility and needs.
    - Member outreach campaigns to provide member support post hospital admission.
    - Enhanced Urgent Care services with development of an access to care flyer for members.
    - Continue to refine and enhance texting campaign to include members seen in the ED as well as those at high risk for readmission.
    - Established hospital rounds with Loma Linda to support transplant care and coordination.

UM Medical Directors

UM Medical Director(s) continued to play a key advisory role and lead critical decision-making processes, while continuing to provide clinical oversight for the administration of the UM Program. This oversight and support included but were not limited to reviewing outcomes in UMC to ensure compliance with regulatory, contractual and accreditation guidelines and clinical evidence-based criteria, review of over and underutilization patterns, evaluating the UM Program's effectiveness against established goals, and leading Committee's and Sub Workgroups that report into the UMC.

Assigned UM Medical Directors (including those with specialties in Gender Affirming Care, Pediatrics, Behavioral Health and Pharmacy when necessary) are responsible for overseeing provider and member satisfaction efforts through the activities of the Benefit Management Subcommittee (BMSC). The purpose of the BMSC is to evaluate new and modified benefits and determine the need for prior authorization. This Subcommittee is led by the chair Medical Director and includes input from peer Medical Directors, Deputy Chief Medical Officer, and Clinical Leaders within Utilization Management. The activities of this Subcommittee continue to gain provider and member satisfaction and allow for access and automation where appropriate.

The assigned UM Medical Director responsible for facilitating the bi-weekly Utilization Management Work Group (UMWG) ensures collective CalOptima Health Clinical leadership, Medical Director leaders, including behavioral health, pharmacy and the Deputy Chief Medical Officer provide input to the development and processes of the UM Program to ensure that

quality care is delivered to CalOptima Health members to meet their physical health, behavioral health and social drivers of health needs. The UMWG activities include but are not limited to, providing input to key UM performance indicators, measures, goals, protocols, provide input to UM Department policies and procedures, and provide updates and input to the quarterly UMC.

The designated UM Medical Director, who facilitates the High-Risk Management Sub Workgroup, provides leadership in reviewing bed day and Emergency Department (ED) data, identifying patterns of under- and overutilization, and guiding the development and implementation of improvement strategies.

The Medical Director team conducted internal weekly hospital facility clinical rounds with the nursing team to support members with complex discharge needs. In addition, during these rounds meetings, hospital discharge staff were educated on Enhanced Case Management (ECM), community supports, and integrated case management available to members in weekly hospital partner rounding. Rounds also provided real-time discharge planning support and opportunities to mitigate barriers. The Medical Director team also attended the bi-weekly Clinical Operations Health Network UM CM forum and provided support that included but was not limited to education of regulatory guidance as outlined by new and/or revised APLs and other regulatory requirements.

Medical Director oversight was added to the TCS Program to strengthen clinical oversight and ensure members receive seamless, coordinated care across the continuum-from admission through discharge. As part of this oversight function, the Medical Director conducted bi-weekly case reviews with TCS staff, offered clinical guidance, supported decision-making with the team and promoted staff education to optimize member outcomes. Additionally, the Medical Director actively participated in workgroups that support or intersect with TCS activities, fostering collaboration and alignment across programs.

Lastly, the Medical Director team provided education and consultation to the CalOptima Health clinical team and external provider. Topics included but were not limited to MRI of the breast clinical criteria review and CCS eligibility criteria.

The designated Behavioral Health Medical Director and the Behavioral Health Integration (BHI) clinical leadership team provided oversight and input on the UM Program throughout the year to ensure that all BH activities were integrated and aligned with the medical program. Their oversight and input ensured compliance with UM regulatory and accreditation requirements and ensured parity in decision-making. The designated BH Medical Director and BH clinical leadership participated in bi-weekly UM work groups, quarterly Utilization Management Committee (UMC) meetings, and Benefit Management Subcommittee (BMSC) meetings to ensure adequate representation of critical BH topics such as coordination with the county to serve our shared members during this period.

Authorization Automation Rule Oversight

Data below reflects authorization received between October 2024 – September 2025. The total authorization volume has fluctuated up and down month-over-month and the percentage of auto-approvals has remained consistent throughout the reporting period. The decrease in total authorizations noted in March and April 2025 were a result of temporary removal of specialty consult

codes from the portal intelligence rules. This removal resulted in a high percentage of manual review for these months.

Month	Total Auths	% Auto-approved	% Manual Review
Oct-24	39,866	35.9%	64.1%
Nov-24	34,476	36.3%	63.7%
Dec-24	34,532	35.7%	64.3%
Jan-25	39,716	41.5%	58.5%
Feb-25	36,538	42.0%	58.0%
Mar-25	25,590	15.4%	84.6%
Apr-25	23,107	13.7%	86.3%
May-25	40,308	43.2%	56.8%
Jun-25	38,565	43.3%	56.7%
Jul-25	40,582	42.1%	57.9%
Aug-25	37,910	42.7%	57.3%
Sep-25	37,070	46.4%	53.6%

Source: Enterprise Analytics ad-hoc pull for data . October 2024 – September 2025. Data pulled 12/5/2025

Behavioral Health Integration

CalOptima Health manages all the administrative functions of Behavioral Health benefits covered under Medi-Cal and OneCare (OC) including mild to moderate mental health benefits and behavioral health treatment (BHT) services for CalOptima Health members. The BHI department continues direct responsibility for BH UM activities including but not limited to prior authorization of routine and urgent outpatient behavioral health services and concurrent review of inpatient psychiatric admission.

UM Data Management

UM data reporting design continued to be led by UM Leadership and generated by CalOptima Health's Enterprise Analytics (EA) and Information Technology Services (ITS) Departments. Together with UM Department subject matter experts, EA and ITS maintained a focused effort to improve the visibility and understanding of key data standards to ensure reliable reporting and trending of metrics for both CalOptima Health and the delegated Health Networks (HNs). Daily pending inventory reports, notification compliance report, failed fax notification reports, and turn-around-time monitoring reports continued be enhanced throughout 2025 to ensure timely processing of treatment authorization requests and provider and member notifications of approvals, denials and modifications.

Inpatient Bed Day Utilization Performance (excludes Health Network data)

The 2025 goals reflect a re-alignment of membership categorization including a roll up of Medi-

Cal Expansion and Temporary Assistance for Needy Families (TANF) members ages 18 and up. The Adult Medi-Cal population excludes members who are 18 and up but qualify for the Whole Child Model program.
TANF members under age 18, Seniors and Persons with Disabilities (SPD), Whole Child Model (WCM) and Long-Term Care (LTC) Medi-Cal Aid categories remain reported separately. Medi-Cal pediatric members under age 18 who are not Whole Child Model members are included in the TANF Under 18 population. Members who are Medi-Cal and qualify for Whole Child Model are categorized separately as Whole Child Model and excluded from other Medi-Cal reports.

Utilization data reported below excludes acute rehabilitation and LTAC data and includes maternal health planned birth admissions.

Adult Medi-Cal (Expansion and TANF 18+)

Metric	Goal	2024 Q4	2025 Q1	2025 Q2	2025 Q3
Admits/1000 PTMPY	107.1	121.0	114.2	105.4	116.8
Days/1000 PTMPY	441.2	537.7	499.3	471.3	501.8
ALOS	3.7	4.4	4.4	4.5	4.3
Readmit %	14.7%	18.6%	16.2%	16.2%	17.8%

Source: Membership and Utilization Trends Tableau report, Data reflecting Medi-Cal CCN/COD for Q4 2024 – Q3 2025.

- **Admit/1000 Per Year (PTMPY):** Admits PTMPY decreased quarter over quarter from Q4 2024 to Q2 2025 and had a slight uptick in Q3 2025. Admits PTMPY remained above goal during the reporting period except for Q2 2025.
- **Bed Days/1000 Per Year (PTMPY):** Bed Days PTMPY decreased in Q1 and Q2 2025 with an uptick in Q3 2025. Bed Days PTMPY remained above goal throughout the reporting period.

- **Average Length of Stay (ALOS):** The ALOS remained stable, however above goal during the reporting period.
  - **Readmission Rate: Readmission Rate decreased in Q1 2025 and had an uptick in Q3 2025. Readmissions are above goal in the reporting period.**

Pediatric Medi-Cal (TANF Under 18, Non WCM)

Metric	Goal	2024 Q4	2025 Q1	2025 Q2	2025 Q3
Admits/1000 PTMPY	13.9	34.7	28.3	27.2	26.8
Days/1000 PTMPY	193.7	489.8	378.5	326.5	331.0
ALOS	13.2	14.1	13.4	12.0	12.4
Readmit %	2.0%	1.1%	0.0%	0.0%	0.0%

Source: Membership and Utilization Trends Tableau report, Data reflecting Medi-Cal CCN/COD for Q4 2024 – Q3 2025.

- **Admits/1000 Per Year (PTMPY):** Admits PTMPY are above goal in the reporting period, with a decrease quarter over quarter.
- **Bed Days/1000 Per Year (PTMPY):** Bed Days PTMPY remained above goal during the reporting period, however decreased in Q1 2025 – Q3 2025.

- **Average Length of Stay (ALOS):** The ALOS decreased in Q1 2025 from Q4 2024 with a slight uptick in Q3 2025. ALOS was above goal for Q4 2024-Q1 2025 but below goal for Q2 2025 – Q3 2025.
- **Readmission Rate:** Readmission Rate was below goal throughout the reporting period. The rate decreased in Q1 2025 to 0% and remained at 0% through Q3 2025.

Seniors and Persons with Disabilities (SPD)

Metric	Goal	2024 Q4	2025 Q1	2025 Q2	2025 Q3
Admits/1000 PTMPY	n/a	262.8	240.6	239.0	234.2
Days/1000 PTMPY	n/a	1,507.6	1,509.2	1,372.7	1,332.8
ALOS	n/a	5.7	6.3	5.7	5.7
Readmit %	n/a	24.7%	22.4%	22.8%	25.4%

Source: Membership and Utilization Trends Tableau report, Data reflecting Medi-Cal CCN/COD for Q4 2024 – Q3 2025.

- **Admits/1000 Per Year (PTMPY):** Admits PTMPY decreased quarter over quarter from Q4 2024 to Q3 2025.
- **Bed Days/1000 Per Year (PTMPY):** Bed Days PTMPY had a slight uptick in Q1 2025 and then continued to decrease in Q2 2025 and Q3 2025.
- **Average Length of Stay (ALOS):** The ALOS remained stable for all quarters reported.
- **Readmission Rate:** Readmission Rate remained stable for decreased in Q1 2025 and remained stable in Q2 2025, with a slight uptick in Q3 2025.

Long-Term Care (LTC)

Metric	Goal	2024 Q4	2025 Q1	2025 Q2	2025 Q3
Admits/1000 PTMPY	n/a	514.3	716.7	519.6	486.7
Days/1000 PTMPY	n/a	3,480.0	5,000.0	3,085.3	3,041.8
ALOS	n/a	6.8	7.0	5.9	6.3
Readmit %	n/a	12.5%	35.1%	17.9%	13.8%

Source: Membership and Utilization Trends Tableau report, Data reflecting Medi-Cal CCN/COD for Q4 2024 – Q3 2025.

- **Admits/1000 Per Year (PTMPY):** Admits PTMPY had an uptick from Q4 2024 to Q1 2025 and then decreased in Q2 2025 and Q3 2025.
- **Bed Days/1000 Per Year (PTMPY):** Bed Days PTMPY had an uptick from Q4 2024 to Q1 2025 and then a decrease in Q2 2025 and Q3 2025.
    - **Average Length of Stay (ALOS):** The ALOS fluctuated in the reporting period but remained within 5.9 to 7 days.
    - **Readmission Rate:** Readmission Rate increased from Q4 2024 to Q1 2025 and then decreased in Q2 2025 and Q3 2025.

Whole Child Model (WCM)

Metric	Goal	2024 Q4	2025 Q1	2025 Q2	2025 Q3
Admits/1000 PTMPY	n/a	316.9	315.1	294.9	289.6
Days/1000 PTMPY	n/a	2,368.3	2,720.1	2,847.1	1,875.9
ALOS	n/a	7.5	8.6	9.7	6.5
Readmit %	n/a	5.1%	4.8%	4.3%	10.1%

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2024 – Q3 2025.

- **Admits/1000 Per Year (PTMPY):** Admits PTMPY decreased quarter over quarter from Q4 2024 to Q3 2025.
- **Bed Days/1000 Per Year (PTMPY):** Bed Days PTMPY increased quarter over quarter from Q4 2024 to Q2 2025 and declined in Q3 2025.
- **Average Length of Stay (ALOS):** The ALOS increased in Q1 2025 and Q2 2025 with a decline in Q3 2025.
- **Readmission Rate:** Readmission Rate remained stable during Q4 2024 to Q2 2025 and had an increase in Q3 2025

Emergency Department Utilization Performance

A re-alignment of membership categorization occurred in 2025. Adult members ages 18 and up in the Medi-Cal Expansion population and the TANF population were combined into a single group titled “Adult Medi-Cal” due to the shared interventions supporting these populations. The Adult Medi-Cal population excludes members who are 18 and up but qualify for the Whole Child Model program.

Medi-Cal pediatric members under 18 who are not Whole Child Model are included in the TANF Under 18 population. Members who are Medi-Cal and qualify for Whole Child Model are categorized separately as Whole Child Model and excluded from other Medi-Cal reports.

Adult Medi-Cal (Expansion and TANF 18+)

Metric	Goal	2024 Q4	2025 Q1	2025 Q2	2025 Q3
ED Visits / 1000 PTMPY	459.4	530.2	507.7	483.7	516.2

Source: Membership and Utilization Trends Tableau report, Data reflecting Medi-Cal Expansion and TANF ages 18+ CCN/COD Q4 2024 – Q3 2025

Adult Medi-Cal ED utilization remained stable quarter over quarter with a decrease in Q2 2025. All reporting quarters are above goal.

Pediatric Medi-Cal (TANF Under 18, Non WCM)

Metric	Goal	2024 Q4	2025 Q1	2025 Q2	2025 Q3
ED Visits / 1000 PTMPY	349.1	421.8	405.7	331.9	330.1

Source: Membership and Utilization Trends Tableau report, Data reflecting Medi-Cal CCN/COD Q4 2024 – Q3 2025.

Pediatric Medi-Cal ED utilization decreased from Q4 2024 through Q3 2025. Both Q2 2025 and Q3 2025 were below goal.

Seniors and Persons with Disabilities (SPD)

Metric	Goal	2024 Q4	2025 Q1	2025 Q2	2025 Q3
ED Visits / 1000 PTMPY	n/a	684.7	660.7	633.3	637.0

Source: Membership and Utilization Trends Tableau report, Data reflecting Medi-Cal CCN/COD Q4 2024 – Q3 2025.

Medi-Cal SPD ED utilization declined from Q4 2024 to Q2 2025 with a slight increase in Q3 2025.

Long Term Care (LTC)

Metric	Goal	2024 Q4	2025 Q1	2025 Q2	2025 Q3
ED Visits / 1000 PTMPY	n/a	308.6	266.7	373.5	365.0

Source: Membership and Utilization Trends Tableau report, Data reflecting Medi-Cal CCN/COD Q4 2024 – Q3 2025.

Med-Cal LTC ED utilization fluctuated month over month during the reporting period. Fluctuations may be attributed to a small volume of members driving increased rates utilization.

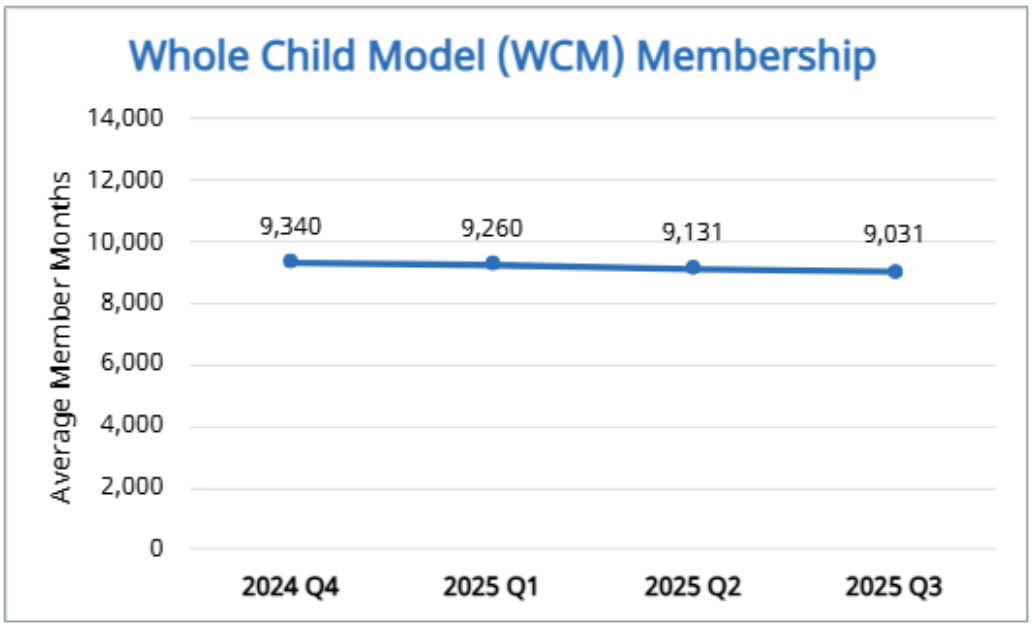
Whole Child Model (WCM)

Metric	Goal	2024 Q4	2025 Q1	2025 Q2	2025 Q3
ED Visits / 1000 PTMPY	717.4	733.8	802.8	620.3	613.0

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2024 – Q3 2025.

WCM ED utilization had an uptick in Q1 2025 and then trended down in Q2 2025 and Q3 2025. Q2 2025 and Q3 2025 were below goal.

Whole Child Model (WCM)



Source: Membership and Utilization Trends Tableau report, WCM Membership reflecting Q4 2024 – Q3 2025. Data pulled 12/9/2025

Whole Child Model membership remained stable with a slight decline throughout the report period.

WCM Health Network Membership Counts

Reporting Period: December 2025

Health Network	# of total WCM Eligible Members as of 1st day of Reporting Period	# of total newly eligible WCM members as of 1st day of Reporting Period	# of aged out WCM members
CHOC Health Alliance	5,995	98	600
CalOptima Community Network	997	56	172
Optum Care Network	802	14	143
AltaMed Health Services	347	9	56
United Care Medical Group	169	1	32
Family Choice Health Network	144	0	18
Noble Mid-Orange County	126	1	24
Providence	114	2	9
Prospect Medical Group, Inc.	106	0	25
AMVI Care Health Network	84	1	11
HPN - Regal	31	3	7
506-Cal Optima-Orange	**8,915**	**185**	**1,097**

WCM counts source: Core Report WCM Member Counts (CC0218). Reporting Period December 2025. Data pulled 12/14/2025

Children's Hospital of Orange County (CHOC) Health Alliance continues to have the majority of the WCM members with 67.2% of the total WCM membership. CalOptima Health's CCN network has the second largest WCM membership with 11.2% of total membership as of

Referral Volume

Referrals Processed Q4 2024 - Q3 2025 (CCN/COD)					
Year	Quarter	LOB	Prospective Routine	Prospective Urgent	Retro/ Post Service
2024	Q4	Medi-Cal	78,192	21,041	4,371
		One Care	4,034	992	192
2025	Q1	Medi-Cal	70,787	20,074	5,529
		One Care	4,070	1,122	206
	Q2	Medi-Cal	72,196	20,476	3,320
		One Care	4,434	1,204	213
	Q3	Medi-Cal	83,704	21,854	3,275
		One Care	5,092	1,349	218
Grand Total			**322,509**	**88,112**	**17,324**

Enterprise Analytics ad-hoc pull for data for October 2024 – September 2025. Data pulled on 12/5/2025.

CalOptima Health direct network prospective routine Medi-Cal referrals increased slightly in Q3 2025. All other Medi-Cal and OneCare referrals for the CalOptima direct network remained stable in the reporting period.

Prior Authorization Turn Around Time – Medi-Cal and OneCare

Prior Authorization Turnaround Time Compliance (TAT) Q4 2024 - Q3 2025						
Year	Goal	Quarter	Month	Prospective Routine	Prospective Urgent	Retro Post Service
2024	95%	Q4	Oct	100.0%	99.8%	100.0%
			Nov	99.8%	99.8%	99.6%
			Dec	99.9%	99.8%	99.8%
2025	95%	Q1	Jan	100.0%	100.0%	100.0%
			Feb	98.9%	98.6%	99.3%
			March	99.8%	99.2%	98.7%
	95%	Q2	April	99.8%	99.6%	95.1%
			May	99.8%	99.6%	97.1%
			June	99.7%	99.5%	99.7%
	95%	Q3	July	99.7%	99.7%	98.7%
			Aug	99.8%	99.7%	99.0%
			Sept	99.9%	99.9%	96.7%

Source: Authorization Inventory Tableau Data Q4 2024-Q3 2025. Data pulled 11/18/2025.

Prior authorization turnaround time compliance for prospective routine, prospective urgent and retrospective cases remained compliant at or above 95% for the reporting period.

Inpatient Review Turn Around Time – Medi-Cal and OneCare

Inpatient Turnaround Time Compliance (TAT) Q4 2024 - Q3 2025 (CCN/COD)					
Year	Goal	Quarter	Month	Concurrent Review	Retro Post Service
2024	95%	Q4	Oct	98.0%	95.2%
			Nov	95.6%	100.0%
			Dec	95.5%	97.1%
2025	95%	Q1	Jan	97.7%	97.2%
			Feb	98.4%	96.9%
			March	98.0%	98.3%
	95%	Q2	April	97.8%	96.8%
			May	97.3%	98.8%
			June	98.2%	100.0%
	95%	Q3	July	97.9%	98.7%
			Aug	99.0%	100.0%
			Sept	98.5%	100.0%

Source: Authorization Inventory Tableau Data Q4 2024-Q3 2025. Data pulled 11/18/2025.

Both inpatient concurrent review and retro post service turnaround time remained compliant at 95% or higher throughout the reporting period.

OVER AND UNDERUTILIZATION

In 2025, CalOptima Health strengthened its processes for identifying and monitoring over- and underutilization, maintaining ongoing oversight of utilization patterns across CalOptima Health and its delegated Health Networks. CalOptima Health continued quarterly Health Network clinical discussions with delegated Health Networks and CalOptima Health staff including but not limited to, Chief Medical Officer, Deputy Chief Medical Officer and Clinical Operations Executive Leadership. Discussions were related to utilization trends against KPIs and Health Network UM Workplans.

Metric benchmarks were defined as indicators for over and underutilization and continued to be monitored in 2025. Metrics are analyzed on a quarterly basis to ensure they are indicative of over and underutilization monitoring. Reports include representation from the following areas including but are not limited to

- Physical, behavioral health (BH) and pharmacy prior authorization
- Physical and BH inpatient
- Appeal volumes to include overturn rates
- Member grievances
- Potential quality issues (PQI)
- Adult and children's access to PCP services
- Appropriate utilization for pharmaceuticals

- Outlier reporting from the Compliance Department regarding fraud, waste and abuse

Over and underutilization data analysis was reported by UM leadership to UMC, QIHEC, the Delegation Oversight Committee (DOC), and the Quality Assurance Committee (QAC).

Operational Performance

Authorization Utilization for Expedited/Urgent, Standard/Routine, and Retrospective Requests — Medi-Cal and OneCare

Referrals Processed	
Routine	322,576
Urgent	88,345
Retro	17,339
Total*	428,260

Referrals Processed	
Faxed	63,835
COLAs (Portal)	356,481
Auto Auth	162,682
Other (E-mail, phone, internal referral)	7,944
Total*	428,260

Turnaround Time Compliance (TAT)	
Routine	99.9%
Urgent	99.9%
Retro	99.7%

**Note: Referrals processed includes all LOB; MC, OneCare, and PACE. Auto-Auth is a subset of Portal authorization volume.*

Source: Enterprise Analytics Report ad-hoc data pull provided 12/5/2025 for Q4 2024-Q3 2025 for Referrals Processed charts. Turnaround Time Compliance (TAT) pulled from Authorization Inventory Jiva Tableau for YTD 2025. Data pulled on 12/14/2025

Referrals continue to increase compared to the same reporting period prior year. Turnaround time compliance remained above goal of 95% across all authorization types throughout the reporting period.

Authorization Utilization for Expedited/Urgent, Routine, and Retro Requests – Pharmacy

Pharmacy Authorization Turnaround Time Compliance (TAT) CY Q4 2024 - Q3 2025 (CCN/COD)						
Year	**Goal**	**Quarter**	**Month**	**Standard**	**Urgent**	**Retro**
2024	**95%**	**Q4**	Oct	99.4%	100.0%	100.0%
			Nov	100.0%	100.0%	100.0%
			Dec	100.0%	100.0%	93.8%
2025	**95%**	**Q1**	Jan	99.7%	100.0%	100.0%
			Feb	99.7%	99.2%	100.0%
			March	100.0%	100.0%	100.0%
	95%	**Q2**	April	100.0%	100.0%	100.0%
			May	100.0%	100.0%	100.0%
			June	99.3%	100.0%	100.0%
	95%	**Q3**	July	100.0%	100.0%	100.0%
			Aug	99.4%	100.0%	100.0%
			Sept	100.0%	100.0%	100.0%

Source: Enterprise Analytics Report ad-hoc data pull provided 12/30/2025

Pharmacy exceeded the goal of 95% for every quarter of the reporting period except for Q4 2024. Retro authorizations in December of 2024 missed the goal threshold due to the impact of one auth missing TAT and the low volume of retro authorizations received that month.

Authorization for Routine Requests — Long-Term Services and Supports (LTSS) programs include Community Based Adult Services (CBAS) and LTC.

LTC Turnaround Time Compliance (TAT) Q4 2024 - Q3 2025			
Year	**Goal**	**Quarter**	**Routine**
2024	**95%**	**Q4**	97.7%
2025	**95%**	**Q1**	98.7%
	95%	**Q2**	99.4%
	95%	**Q3**	99.4%

Source: Jiva UM TAT Detail Report – LTC Turnaround Time Compliance Q4 2024-Q3 2025

LTC met required turnaround times of 95% or greater during the reporting period: Q4 2024 – Q3 2025.

LTC Program Referral Volume

LTC Referrals Processed Q4 2024 - Q3 2025			
Year	**Quarter**	**Month**	**Routine**
2024	**Q4**	Oct	720
		Nov	533
		Dec	754
2025	**Q1**	Jan	839
		Feb	824
		March	803
	Q2	April	981
		May	799
		June	843
	Q3	July	909
		Aug	814
		Sept	867

Source: Jiva UM Decision TAT Detail Report – LTC Referrals Processed Q4 2024-Q3 2025

CBAS TAT Compliance: LTSS Authorization Turnaround Detail

CBAS Turnaround Time Compliance (TAT) Q4 2024 - Q3 2025			
Year	**Goal**	**Quarter**	**TAT Compliance**
2024	**95%**	**Q4**	96.0%
2025	**95%**	**Q1**	99.7%
	95%	**Q2**	100.0%
	95%	**Q3**	100.0%

Source: Jiva UM Decision TAT Detail Report – CBAS Turnaround Time Compliance Q4 2024-Q3 2025

CBAS met required turnaround times of 95% or greater during the reporting period: Q4 2024 – Q3 2025.

CBAS Program Referral Volume

CBAS Referrals Processed Q4 2024 - Q3 2025			
Year	**Quarter**	**Month**	**Routine**
2024	**Q4**	Oct	580
		Nov	220
		Dec	413
2025	**Q1**	Jan	401
		Feb	277
		March	359
	Q2	April	564
		May	316
		June	510
	Q3	July	442
		Aug	589
		Sept	658

Source: Jiva UM Decision TAT Detail Report – CBAS Referrals Processed Q4 2024-Q3 2025

Multipurpose Senior Services Program

MSSP Admissions & Discharges						
Year	**Quarter**	**Admissions**	**Change From Previous Qtr.**		**Discharges**	**Change From Previous Qtr.**
2024	**Qtr. 4**	50	19		19	24
2025	**Qtr. 1**	31	-19		30	11
	Qtr. 2	54	23		14	-16
	Qtr. 3	42	-12		31	17

Source: MSSP Admissions & Discharges Source: MSSP Departmental Spreadsheet

Utilization Performance / Program Outcomes

LTC and CBAS Utilization

Members Residing in LTC / Potential Nursing Home Eligible					
Year	**Quarter**	**LOB**	**Residing in LTC / Potentially Nursing Home Eligible**	**% Residing in LTC**	**Change From Previous Qtr.**
2024	**Qtr 4**	Medi-Cal	4,911 / 146,655	3.4%	0.06%
		One Care	147 / 17,042	0.9%	0.10%
2025	**Qtr 1**	Medi-Cal	4,840 / 148,135	3.3%	0.10%
		One Care	149 / 17,367	0.9%	0%
	Qtr 2	Medi-Cal	5,916 / 150,751	3.9%	-0.60%
		One Care	147 / 17,786	0.8%	0.03%
	Qtr 3	Medi-Cal	4,813 / 153,236	3.1%	0.80%
		One Care	152 / 18,124	0.8%	-0.01%

Source: Jiva Inpatient Census Report and Tableau Membership Report

The ratio of members residing in a nursing home versus those that are eligible for LTC, in both the Medi-Cal and OC populations, has remained stable with minimal change for the last 4 quarters.

Pharmacy Utilization

Pharmacy Utilization			
	Medication Adherence for Diabetes Medications (ADH-Diabetes)	**Medication Adherence for Hypertension (RAS antagonists)**	**Medication Adherence Cholesterol (Statins)**
Goal	89.0%	89.0%	88.0%
OneCare Rate	89.8%	89.6%	88.0%

Source: CMS Acumen Jan-November 2025

Goals were met for all three adherence measures through November 2025. Interventions included but were not limited to provider faxes, distribution of educational materials to member, comprehensive medication reviews, member telephonic outreach, pharmacy outreach, member IVR campaigns and member text campaigns.

INTER-RATER RELIABILITY (IRR)

IRR is administered annually to evaluate the consistency with which Medical Directors and clinical staff apply UM criteria decision making in compliance with the UM Program. IRR metric targets were achieved for 2025.

All clinical reviewers within the Medical Management Department passed IRR testing with a score of 90% or greater.

Department	IRR Score
UM Clinical Staff: Prior Authorization	94.4%
UM Clinical Staff: Inpatient services	91.7%
Utilization Management	95.8%
UM Physical Therapist	100.0%
Medical Directors (UM)	96.3%
Pharmacy: RPh	98.4%
LTSS: LTC	95.0%
LTSS: CBAS	97.0%
LTSS: MSSP	96.7%
CalAIM	100.0%
Behavioral Health	99.5%
Medical Directors (BH)	100.0%

Source: https://learn.mcg.com/local/mcg_reports/index.php?c=report&a=completion

MEMBER SATISFACTION

Satisfaction with the UM Program is evaluated based upon analysis of Grievances and Appeals data, Member and Provider Experience Surveys including the CAHPS survey related to the UM Program. Opportunities pertaining to the UM Program demonstrated some trends in the following categories:

- Member feedback obtained through Grievances and Appeals included but was

not limited to:
  - Approval of referrals/authorizations to providers who are no longer contracted with CalOptima Health. Approval of referrals/authorizations to providers who are not seeing new patients.
  - Approval of authorizations to providers who are unable to treat the member due to the type of care the member required or the members age was not in the scope of their specialty practice.
  - Approval of authorizations to providers with limited panels, as there are some providers who only see members already affiliated with their organization.

- Member Feedback from the 2025 CAHPS Survey reporting measurement year 2024 data included but is not limited to:
  - 75.6% of adult members reported through survey response they usually or always getting an appointment with a specialist as soon as needed, this is an increase from 67.7% from the previous survey for adult members.
  - 87.2% of adult members reported through survey response that they felt it was usually or always easy to get the care, tests, or treatment needed. This is an increase from 84.8.% of the previous survey period.
  - 66.1% of pediatric members reported through survey response they usually or always get an appointment with a specialist as soon as needed. This is a decrease from the year prior survey of 68.3%
  - 84.1% of pediatric members reported through survey response they felt it was usually or always easy to get the care, tests, or treatment a child needed. This is an increase from 81.7% during the previous survey period.

During 2025 a new process was implemented to monitor timely access to care identified by clinical staff. Collection of data pertaining to delays in care due to circumstances such as timely and appropriate referrals allows CalOptima Health to track and trend barriers to access and creates opportunities for cross-departmental collaboration to close gaps in care. Since its launch in September 2025 the Access to Care initiative resolved 29 of the 51 issues reported.

PROVIDER EXPERIENCE

To evaluate provider experience, CalOptima Health analyzed provider grievances, provider UM appeals, and provider claims disputes. The top reason for provider grievances consisted of providers disputing recoupment notices and disagreeing with CalOptima Health QI and Fraud Waste and Abuse (FWA) audit results.

The top reasons for provider UM appeals were:

- Denials for no medical necessity.
- Denials for no prior authorization obtained prior to services.
- Retroactive authorization denials for non-timely submission.

The majority (95%) of provider UM appeals were upheld.

The top reason for provider claims disputes was level of payment including underpaid claims, contract rates, fee schedule, HCI edits and DRG payments.

Based on provider experience data, CalOptima Health continues to show success in the education of providers on prior authorization requirements and claims payment policies.

POTENTIAL QUALITY ISSUES (PQIS)

Quality-of-care Potential Quality Issues (PQIs) are reviewed by CalOptima Health Medical Directors. PQIs that are leveled as a severe quality-of-care issue are presented individually to the Credential and Peer Review Committee (CPRC). Trend data related to authorization issues is reported quarterly at the Utilization Management Committee (UMC). In 2025 there were a total of 83 PQIs related to treatment authorizations, more than double the rate of 2024. Forty-one (49%) were related to authorizations that were denied or delayed.

Potential Quality Issues (PQIs)					
Issue	**Q1 2025**	**Q2 2025**	**Q3 2025**	**Q4 2025**	**TOTAL**
Authorization denied or delayed	8	21	10	2	**41**
Authorization issues	0	0	0	2	**2**
Delay of service	0	0	2	0	**2**
Failure to notify the member of the referral	2	0	0	1	**3**
Failure to refer	3	6	4	2	**15**
Failure to submit referral timely	4	5	3	0	**12**
Referral submitted to wrong specialist or specialty	0	6	2	0	**8**
Total	**17**	**38**	**21**	**7**	**83**

Source: Quality of Care Issues Against Providers (QI0090)
**Q4 is October and November data only. Source CORE report QI0090.*

CalOptima is continually looking at improving response times to treatment authorizations through interventions such as proactive peer to peer consultations and improved communication to expediate health plans decisions.

SUMMARY

CalOptima Health continued to adjust workflows and configuration in the clinical documentation platform that launched in February 2024.
Efforts are reflected in the UM referral statistics outlined above. Medi-Cal and OneCare prior authorization turnaround time compliance remained above goal of 95% from Q4 2024 – Q3 2025. In addition, pharmacy turnaround time compliance remained above of 95% from Q4 2024 – Q3 2025.

Inpatient bed day goals reflect a re-alignment of membership categorization to include a roll up of Medi-Cal Expansion and TANF 18+ (Medi-Cal Adult 18+) excluding members who are under 18 years of age or qualify for WCM. Additional categories include Medi-Cal Pediatric members who are under the age of 18 and do not qualify for WCM. The OneCare, SPD, WCM, and LTC categories remain unchanged.

Medi-Cal Adult 18+ and Medi-Cal Pediatric remained bed days remained above going during the reporting period. Medi-Cal and OneCare inpatient turnaround time goals were above goal in the entire reporting period.

Process improvements contributing to the 2025 UM Program included but are not limited to improved workflows, enhanced oversight of the continuity of care process, enhancements to the TCS program, continued monitoring and response to over and underutilization patterns, and enhanced UM oversight of CalOptima Health's delegated entities. In addition, the following workgroups were developed to concentrate on specific areas within Medical Management, ED Diversion Workgroup, Pediatric Facility Clinical Rounds, and a Skilled Nursing Facility Workgroup.

Staffing metrics, productivity standards and reports to monitor productivity were enhanced to ensure staff are working to their full capability and to address staffing needs. Leadership strengthened processes to address continued productivity non-compliance.

The UMC, UM Medical Directors and Behavioral Health Medical Director continued to guide and support the CalOptima Health integrated UM/CM Program (medical, behavioral and pharmacy). The UMC, QIHEC and Medical Director's continued to oversee, guide and support process improvement, review and address over and under-utilization trends and enhance the CalOptima Health UM/CM Program through Committee and Workgroup efforts.

20256 Integrated Utilization Management and Case Management Program Description

Back to Agenda Back to Item

20256 Integrated Utilization Management and Case Management Program

Signature Page

Utilization Management Committee Chair:

Zeinab Dabbah, M.D.
Deputy Chief Medical Officer

Date

Board of Directors' Quality Assurance Committee Chairperson:

Jose Mayorga, M.D.

Date

Board of Directors Chair:

Vicente Sarmiento

Date

Back to Agenda Back to Item

TABLE OF CONTENTS

2026~~5~~ Integrated Utilization Management and Case Management Program Description 1
2026~~5~~ Integrated Utilization Management and Case Management Program 2

Signature Page 2

We Are CalOptima Health 5

Our Mission 5
Our Vision 5
We are "Better. Together." 5
Our Strategic Plan 5
Future Growth - What Is CalOptima Health? 6
Our Unique Dual Role 6
What We Offer 6
Quality Program Initiatives ..... 10~~9~~
Whole-Child Model ..... 12~~10~~
California Advancing and Innovating Medi-Cal (CalAIM) ..... 12~~11~~~~11~~
Population Health Management (PHM) Program ..... 14~~12~~
CalOptima Health Direct Network and Health Network Entities ..... 17~~14~~~~14~~

Utilization Management Program ..... 27~~19~~

Utilization Management Purpose ..... 27~~19~~
UM Scope ..... 27~~19~~
UM Process ..... 27~~19~~
UM Program Goals ..... 28~~20~~
UM Program Structure ..... 30~~21~~
Long-Term Services and Supports (LTSS) ..... 31~~22~~
Behavioral Health Services ..... 31~~22~~
Authority, Boards of Directors' Committees, and Responsibilities ..... 33~~24~~~~23~~
Utilization Management Committee (UMC) ..... 48~~37~~
Integration with the QI Program ..... 59~~46~~~~43~~
Review and Authorization of Services ..... 61~~48~~~~45~~

Appropriate Professionals for UM Decision Process 655249
Pharmaceutical Management 665350
Behavioral Health Determinations 675451
UM Hierarchical Criteria 685451
Timeliness of UM Decisions 746057
UM Decision and Notification Timelines 756158
Emergency Services 937067
Admission/Inpatient Review Process 947168
Discharge Planning Review 957269
Denials 967370
Grievance and Appeal Process 977471
Expedited Appeals and Grievances 987572
State Hearing 997673
Independent Medical Review 997673
Provider Preventable Conditions 997673
Long-Term Services and Supports 1007774
Over/Under Utilization 1027976
Program Evaluation 1037976
Satisfaction with the UM Process 1038077

Case Management Process **1048077**
Program Updates and/or Changes 1048178
Team Composition and Roles 1058178
Staff Training/Education 1088481
Coordination of Care 1098582
Coordination of Carved Out Services 1148885
Clinical Protocols 1158886
Types of Case Management Services 1168987
Special Programs 1219391

We Are CalOptima Health

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. Our Medicaid (Medi-Cal) and Medicare members deserve the highest quality of care and service across the health care continuum. CalOptima Health works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision.

Our Mission

To serve members' health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.~~remove barriers to health care access for our members, implement same-day treatment authorizations and real-time claims payments for our providers, and annually assess members social determinants of health.~~

We are "Better. Together."

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan

In 2024, CalOptima Health's Executive Team ~~worked together to~~ developed the 2025 3-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan ~~is currently under final review o~~was approved by the~~f~~ CalOptima Health Board of Directors on February 6, 2025 ~~as of January 2025. The Strategic plan once approved~~. The plan~~and will~~ continues to be reviewed and updated, at a minimum of annually, based on guidance and recommendations from CalOptima Health Board of Directors and the Executive ~~Team input~~Team. The core strategy of the Strategic Plan is an inter-agency co-creation of services and programs, together with our delegated networks, providers, and community partners, to support the mission and vision. Our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima Health.

The Clinical Operations/ Medical Management Priorities and Objectives are to:

1.1 Utilize technology and innovation to strengthen equity and population health management programs.	% compliance with HbA1c Control for Patients with Diabetes (~~HBD~~GSD)~~.~~ ~~Adequate Control <8.0% measure.~~
1.2 Implement a consistent model of care for population health and care management, including delegated networks.	% of members successfully enrolled in CCM program.
1.3 Annually assess members' health and social needs and utilize data to develop targeted interventions.	~~% of new members assessed for social needs within 60 days~~% compliance with the Annual Wellness Visit (AWV) and Initial Health Appointment (IHA) measures.
1.4 Increase access to preventive services for vulnerable populations in pursuit of health equity	% compliance with Prenatal and Postpartum Care (PPC) measures through targeted member outreach.
2.1 Achieve NCQA rating of 4-stars for Medi-Cal. Achieve CMS rating of 3.5-stars for Medicare.	Achieve 4-star rating for Medi-Cal and 3.5-star rating for Medicare annually
2.4 Expand the delivery of behavioral health services, invest in the workforce, and drive quality improvement through innovation.	% Follow-Up After Emergency Department Visit for Mental Illness (FUM) within 30 days
4.1 Improve the turnaround time for treatment authorizations for direct and delegated networks.	Improve Treatment authorizations processing time by 10% for all CalOptima Health Providers by 2027.
4.3 Launch and grow programs that take care of our members and their families across their lifespan.	Membership by Line of Business

Future Growth - What Is CalOptima Health?

Our Unique Dual Role

CalOptima Health operates as both a public agency and a community health plan.
In this dual role, CalOptima Health is responsible for the following programmatic objectives:

- Provide quality health-care to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input.
- Be accountable for the decisions we make.

What We Offer

Medi-Cal

In California, Medicaid is known as Medi-Cal. Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, Affordable Care Act (ACA) expansion members, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Health Medi-Cal subject to ~~. Effective January 1, 2024, California expanded access to adults ages 26 through 49 to qualify for full Medi-Cal regardless of immigration status. Other~~ Medi-Cal eligibility rules~~,~~ and ~~including~~ income limits~~, still apply. This latest expansion of Medi-Cal means that all Californians now have access to coverage.~~

Scope of Services

CalOptima Health provides a comprehensive scope of acute, chronic and preventive care services for Orange County's Medi-Cal and dual eligible population. In addition, since 2019 CalOptima Health has managed a Whole-Child Model (WCM) Program under California Children's Services (CCS) consisting of specialized services for members with qualifying~~, including eligible~~ conditions ~~under California Children's Services (CCS) managed by CalOptima Health through the Whole-Child Model (WCM) Program that began in 2019~~.

Certain services carved out of coverage ~~are not covered~~ by CalOptima Health but may be ~~but may be~~rather provided by a different agency, ~~In~~in these cases, CalOptima Health coordinates with the various agencies to ensure member access . ~~, but and coordinated by CalOptima Health~~Services coordinated by CalOptima Health ~~are indicated below~~These services include:

~~1.~~ Specialty mental health and substance use disorder services ~~are~~ administered by the Orange County Health Care Agency (HCA).

~~•~~

- Dental services ~~are~~ provided through the Medi-Cal Dental Program.

Members with Special Health Care Needs

To ensure that clinical services ~~as described above~~ are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima Health has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

~~Additionally,~~ CalOptima Health works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions)

receive additional services ~~that~~ to enhance their Medi-Cal benefits. ~~These p~~Partnerships with designated service administrators are established as ~~special services~~ through a specific Memoranda of Understanding (MOU) with ~~certain~~ community agencies~~, including~~ such as the Orange County Health Care Agency (HCA)~~. and the Regional Center of Orange County (RCOC).~~

Medi-Cal Managed Long-Term Services and Supports

Since July 1, 2015, the Department of Health Care Services (DHCS) has integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Health Medi-Cal members into the scope of benefits provided by CalOptima Health. CalOptima Health ensures LTSS services are available to members who meet the program eligibility criteria and guidelines and have health care needs that would benefit from the programs~~and meet the program eligibility criteria and guidelines~~.

~~These integrated~~Integrated LTSS benefits include three programs:

1. Community-Based Adult Services (CBAS)
2. Nursing Facility (NF) Services for Long-Term Care (LTC)
3. Multipurpose Senior Services Program (MSSP)

Emergency Department (ED) Diversion Program

~~Purpose:~~

CalOptima Health operates an Emergency Department (ED) Diversion Program to help members access care at the right level and avoid unnecessary ED visits. The program is currently embedded at our highest-volume hospital partner, the University of California Irvine (UCI), one of the largest facilities serving CalOptima Health members.

The primary goal is to provide face-to-face engagement whenever possible with members in the ED to ensure timely coordination of follow-up care with their ambulatory care team. A dedicated CalOptima Health Care Manager (MSW) works onsite to:

- Expedite care coordination across CalOptima Health departments and community-based resources.
- Connect members to appropriate services such as primary care, behavioral health, pharmacy, transportation, and social supports.~~CalOptima Health has implemented an Emergency Department Diversion Program with our largest volume hospital partner to support accessing services in an appropriate care setting. Starting in January 2025~~An e~~, two~~o~~ One embedded CalOptima Health Care Managers (RN & MSW) will engages CalOptima Health members in the Emergency Department to expedite coordinate coordination of care with across CalOptima Health departments (UM, CM, ECH, LTSS, CalAIM and Customer Service) as well asplus community based resources and supports resources in an expeditious manner. Currently theThe program is embedded in University

Back to Agenda Back to Item

of California Irvine (UCI) one of the largest factilitiesfacilities serving our members. Evaluation of the program is taking place including analyzing Future enhancements include expandingexpansion into other Emergency Departments.. This is a program that will have rotating facility participation based on the need to increase communication and support across the county, starting with UCI, one of the largest facilities to serve our members in the county.

Goals of the Emergency Department Diversion program include:

- Coordinate the member'smembers' plan of care with the facility ED team, CalOptima Health and community resources.
- Coordinate appointments with the member's providers including but not limited to Primary Care Physician (PCP)/ or specialist appointments, pharmacy, transportation, durable medical equipment (DME), Home Health, Hospice, Palliative Care, CalAIM, Behavioral Health, CalOptima Health CM and Enhanced Case Management ECM.
- Educate member about accessing care in alternative settings such as through their PCP or Urgent Care facilities.

Support community resource access post ED visit without a hospital admission.

- Prevent future ED visits by assisting with connection and access to ambulatory care and resources.
  - Ensure access to resources and social determinates of health are addressed based on member needs and preferences.
  - Warm handoff transitions to CalOptima HealthsHealth's' delegated Health Networks, CM, ECM or TCS referrals.

OneCare (HMO D-SNP)

CalOptima Health's OneCare program serves dual-eligible members—those enrolled in both Medi-Cal and Medicare Parts A and B—who live in Orange County. By combining benefits into a single plan, OneCare simplifies access to care and ensures members receive the services they need.

Since 2005, OneCare has supported low-income seniors and individuals with disabilities, offering coordinated medical, behavioral, and supportive services. Enrollment is voluntary, and each member is assigned a Case Manager or Personal Care Coordinator (PCC) as a single point of contact. This role helps members navigate the health care system and develop an individualized care plan in collaboration with providers, ensuring a seamless, high-quality experience.

OneCare provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B who reside in Orange County. Our OneCare (OC) members have dual enrollment in Medicare and Medi-Cal benefits that are covered in oneby a single plan, making it easier for our members to get the health care they members need. Since 2005, CalOptima Health has been offering OC to low- income seniors and people with disabilities who qualify for both Medicare and Medi-Cal. CalOptima Health's OneCare programC has extensive experience serving the complex needs of the frail, disabled and dual eligible members in Orange County.

OC provides a comprehensive scope of services for dual eligible members enrolled in Medi-Cal and Medicare Parts A and B and reside in Orange County. Enrollment in OC is by member choice and voluntary. OC has an innovative Model of Care, which is thea defined structure for to support ing consistent provision of quality of care. Each Every OC member has a Case Management single point of contact, either a Case Manager or a Personal Care Coordinator (PCC) whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Also, tThe Case Manager collaborates with peers within the Case Management team works to coordinate with our members and their doctors (PCP, . specialists, behavioral health providers) to create an individualized care plan that fitsunique to each member's needs. Addressing individual needs results in a better, more efficient, and higher quality health care experience for the member.

Quality Program Initiatives

CalOptima Health's Health has a Quality Improvement and Health Equity Transformation Program with Priority Areas and Goals align that align with CalOptima Health's Strategic Goals and California Department of Health Care Services (DHCS) Bold Goals. The aligned quality initiatives include:

- Maternal Health
  - Close racial/ethnic disparities in well-child visits and immunizations by 50%
  - Close maternity care disparity for Black and Native American persons by 50%
- Children's Preventive Care
  - Exceed the 50th percentile for all children's preventive care measures
- Behavioral Health Care
  - Improve maternal and adolescent depression screening by 50%
  - Improve follow-up for mental health substance disorder by 50%
- Program Goals
  - Medi-Cal: Exceed the minimum performance levels (MPLs) for the Medi-Cal
- Accountability Set (MCAS)
  - OneCare: Attain a Four-Star Rating for Medicare

Comprehensive Community Cancer Screening and Support Program

The Comprehensive Community Cancer Screening and Support Program ~~was approved~~launched in December 2022 through approval by the CalOptima Health Board of Directors ~~in December 2022~~. The program aims to create a health ethos with respect to breast cancer, cervical cancer, colorectal cancer and lung cancer. CalOptima Health strives to be the health care exemplar for all Orange County residents.

The goal of the program is to create a culture of cancer prevention, early detection and collaboration with partners such as physicians, Cancer Centers and the community. Collectively, the program ~~to~~ work~~s~~ toward~~s~~ dramatically decreasing late-stage cancer incidence and ensuring CalOptima Health Medi-Cal members have equitable access to high quality care. Increasing cancer screening rates is crucial for the early diagnosis and treatment of cancer, ultimately increasing life expectancy, quality of life and reducing health care costs.

The Comprehensive Community Cancer Screening and Support Program aims to increase early detection through improved awareness and access to cancer screening, decrease late-stage cancer diagnoses rates and mortality, and improve quality and member experience during cancer screening and treatment procedures among Medi-Cal members.

The program uses a phased-in approach over a four-year period to invest ~~over the next four years~~ in the following three pillars:

1. Community and member awareness and engagement
2. Access to cancer screening
3. Improved member experience throughout cancer treatment

~~The measurement of this program will evaluate the comparison of newly diagnosed cancer rates to baseline rates. As of October 2, 2023, 3,718 CalOptima Health members were newly diagnosed with cancer this year.~~ To support these pillars, CalOptima Health award~~ed~~ s grants to community-based organizations and a Digital Health communication vendor ~~in September 2024~~. ~~The organization~~CalOptima Health oversees the grant administration, partners closely with grantees to support programmatic outcomes, and holds quarterly meetings to review ~~data~~progress toward goals and share best practices.

Five-Year Hospital Quality Program 2023-2027

~~Five-Year Hospital Quality Program 2023-2027.~~ CalOptima Health has developed a hospital quality program to improve quality of care to members through increased patient safety efforts and

performance-driven processes. The hospital quality program utilizes public measures reported by CMS and The Leapfrog Group for quality outcomes, patient experience, and patient safety. Hospitals may earn annual incentives based on the achievement of benchmarks.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain eligible serious medical conditions. CCS provides medical care, case management, physical/occupational therapy, and financial assistance to qualifying members. Since July 1, 2019, through Through the passing of SB 586 on July 1, 2019, the state integrated CCS services into CalOptima Health's Medi-Cal managed care plan benefit, now called Whole Child Model (WCM). The goal of this transition and integration was to improve health care coordination by providing all needed care (CCS and non-CCS services including utilization management, transportation, care coordination, case management and complex case management) into a managed care plan (MCP), rather than providing CCS services separately. The HCA in Orange County continues to have the CCS program to operate the medical eligibility determination processes, the Medical Therapy Unit and Program and CCS service authorizations for non- CalOptima Health enrollees. CalOptima Health works closely with the county CCS office to align protocols and ensure continuity of care for CCS-eligible members.

California Advancing and Innovating Medi-Cal (CalAIM)

California Advancing and Innovating Medi-Cal (CalAIM) is a multiyear initiative by DHCS, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of our California's Medicaid population. CalAIM by implementincludes implementation ofing a broad delivery system, program, and payment reforms across Medi-Cal.

CalOptima Health has been operating CalAIM services and supports since 2022 and continues to work on increasingexpanding member access. CalOptima Health's CalAIM program operates based upon three primary goals:

1. Identification and management of member risk and need through whole person care approaches and addressing social determinants of health.
2.
   - Development of a consistent and seamless delivery of care and services through reduction of complexity and increased flexibility.
   - Improved member outcomes, reduction of health disparities, improved health equity and innovation through value-based initiatives, modernization of payment reform.

2.

Enhanced Care Management and Community Supports

CalOptima Health has launched CalAIM at the program's inception by Enhancedimplementing Enhanced Care Management (ECM) as well as alland adopting all 14 Community Supports at it's inception. An additional 15th Community Support, Transitional rent, the 15th community support went live on 1/1/2026. ECM provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Members eligible for ECM are identified either through risk stratification into a DHCS Population of Focus (POF) or by meeting DHCS eligibility criteria and being referred for services.Members are identified to participate in ECM services through either a risk stratification approach that proactively identifies members as falling into one of the 9 DHCS identified Populations of Focus (POF) or members who meet the DHCS eligibility criteria are referred to ECM so that they can receive the services.

CalOptima Health contracts with ECM providers who are responsible for coordinating care with members' existing providers and other agencies to deliver the following seven core service components:

1. • Outreach and Engagement
2. • Comprehensive Assessment and Care Management Plan
3. • Enhanced Coordination of Care
4. • Health Promotion
5. • Comprehensive Transitional Care Services
6. • Member and Family Supports
- • Coordination of and Referral to Community and Social Support Services
  7.

CalOptima Health has partnered with local Community Based Organizations to provide the 14 15 Community Supports tofor our members in a medically appropriate, community-rooted, cost-effective manner. ThThe 14 e Community Supports areinclude:

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
5. Recuperative Care (Medical Respite)

- •
  1. Respite Services
  6.
- •

Day Habilitation Programs

7.

•

1. Assisted Living Facility (ALF) Transitions

8.

•

Nursing Facility Transition/Diversion to Assisted Living Facilities

9. 9. Community or Home Transition Services Community Transition Services/Nursing Facility Transition to a Home

•

5. 10. Personal Care and Homemaker Services

11.6. Environmental Accessibility Adaptations (Home Modifications) includes Personal Emergency Response Systems (PERS)

12.7. Medically Tailored Meals/Medically Supportive Foods

13.8. Sobering Centers

9. Asthma Remediation

14.10. Transitional Rent- Went live on 1-1-2026

Authorizations for CalAIM ECM and Community Supports are coordinated through the CalOptima Health Connect CalAIM Portal.

Population Health Management (PHM) Program Strategy

CalOptima Health's Population Health Management (PHM) Strategy is a foundational effort to deliver whole-person, equitable, and coordinated care across the full continuum of health services and throughout the life span of CalOptima Health members. CalOptima Health's PHM program demonstrates its commitment to improving member outcomes through integrated, person-centered care that spans physical and behavioral health, LTSS, care coordination, utilization management, and complex case management. PHM services include population health management, care management, ECM, transitional care, and complex care management.This approach reflects CalOptima Health's commitment to improving member outcomes through integrated, person-centered care that spans physical health, behavioral health, long-term services and supports (LTSS), care coordination, and complex case management.In 2023, DHCS launched Population Health Management (PHM), a cornerstone of the CalAIM program. CalOptima Health's approach to PHM aims to ensure the care and services provided to our

Back to Agenda Back to Item

~~members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.~~

~~The PHM approach integrates physical health, behavioral health, LTSS, care coordination and complex case management to improve coordination of care between health care departments. PHM services include basic population health management, care management, complex care management, ECM, and transitional care services.~~

The PHM Strategy is guided by five key focus areas:

- Keeping members healthy
- Managing members with emerging risks
- Increasing patient safety and improving outcomes across care settings
- Managing members with multiple chronic conditions
- Providing advance care support

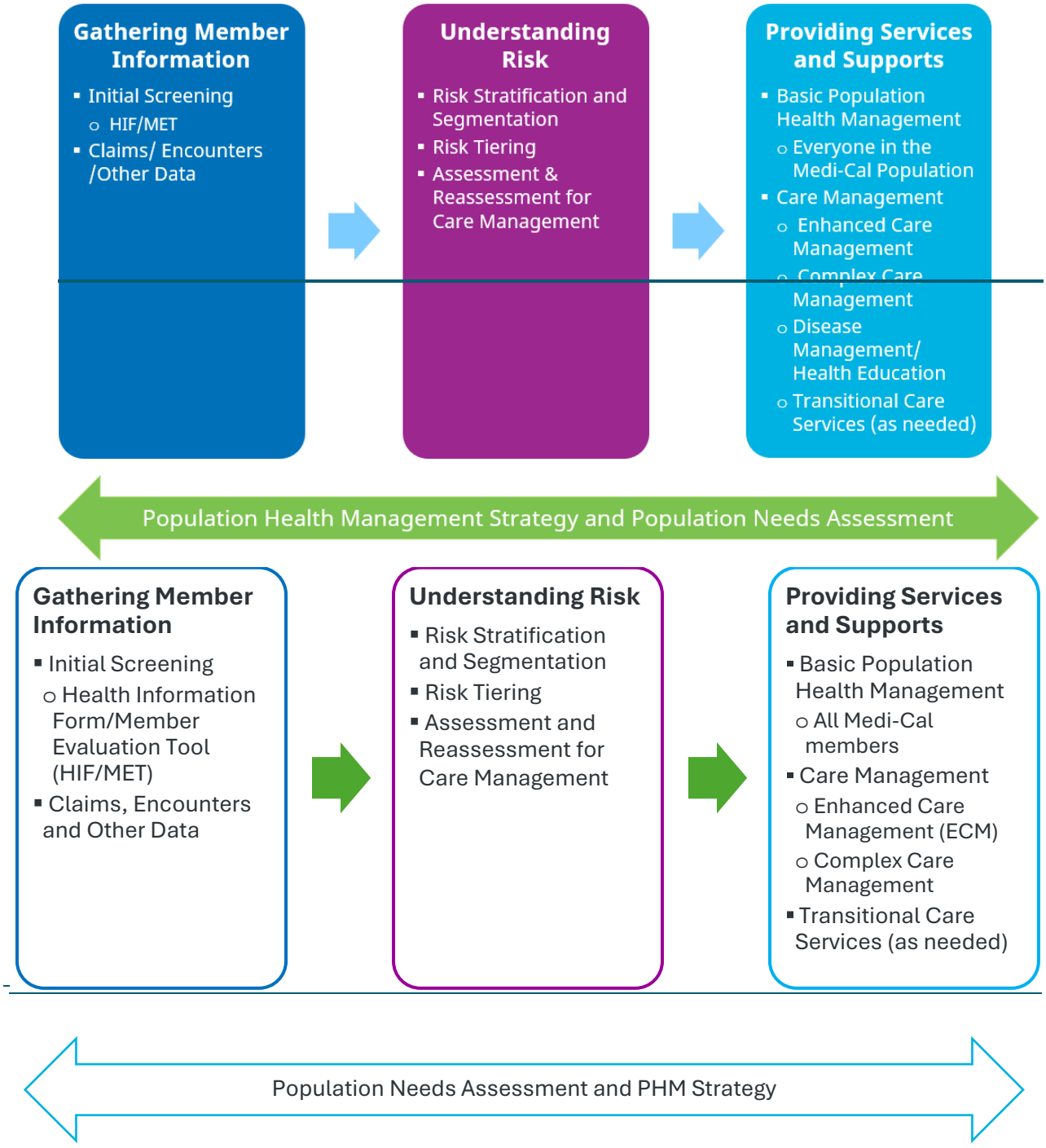
~~CalOptima Health's PHM addresses the following four key strategies:~~

~~1. Keeping members healthy~~
~~2. Managing members with emerging risks~~
~~3. Considering patient safety or outcomes across settings~~
~~4. Managing multiple chronic conditions~~

The PHM Framework outlines four key components for operationalizing the program:

- Population Health Management Strategy and Population Needs Assessment~~;~~
- Gathering member information~~;~~
- Understanding risk~~; and~~
- Providing services~~.~~

Figure 1: PHM Framework



The goals of the PHM program are to establish:

- Trust and meaningful engagement with members

- Data-driven risk stratification and predictive analytics to address gaps in care
- Revisions to standardize assessment processes
- Care management services for all high-risk members
- Robust transitional care services (TCS)
- Effective strategies to address health disparities, Social Determinants of Health (SDOH) and upstream drivers of health
- Interventions to support health and wellness for all members

CalOptima Health analyzes the PHM PHM approach program annually and uses key performance indicators (KPIs) to measure the effectiveness of PHM. KPIs may include but are not limited tosuch as utilization of Primary Care, ambulatory care, ED visits, and and inpatient utilization stays as well asand outcomes for quality measures, such as HEDIS, to measure the effectiveness of PHM.

CalOptima Health Direct Network and Health Network Entities

Direct Network and Contracted Health Networks Entities

Providers have several options for participating in CalOptima Health's programs and providing health care to CalOptima Health members. Providers can participate through the CalOptima Health Direct (COD) network, CalOptima Health Community Network (CCN), or through a Health Network (HN) affiliation. EX

CalOptima Health members can choose a Primary Care Provider (PCP) in CalOptima's Community Network (CCN) or one of 101 HNs, representing more than 10,000 practitioners. CalOptima Health members that do not choose a PCP are provisionally assigned to CalOptima Health's Direct Administrative network for forty-five (45) days until they choose a HN and PCP.

CalOptima Health Direct (COD)

CalOptima Health Direct (COD) network is composed of two elements: CalOptima Health Direct-Administrative (COD-A) and the CalOptima Health Community Network (CCN).

1. *CalOptima Health Direct-Administrative (COD-A)* is a self-directed program administered by CalOptima Health to serve Medi-Cal members in special situations, including:

- Dual-eligible individuals (those with both Medicare and Medi-Cal who choose not to participate in CalOptima Health's OneCare program)
- Share-of-cost members
- Newly eligible members transitioning from CCN to a health network (HN)

Back to Agenda Back to Item

Members residing outside Orange County awaiting benefit transitions.~~CalOptima Health Direct-Administrative (COD-A) is a self-directed program administered by CalOptima Health to serve Medi-Cal members in special situations, including dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima Health's OneCare program), share of cost members, newly eligible members transitioning to a HN from CCN, and members residing outside of Orange County awaiting benefit transitions.~~

2. *CalOptima Health Community Network (CCN)* - provides doctors with an alternate path to contract directly with CalOptima Health to serve our members. CCN is administered directly by CalOptima Health and is available for HN eligible members, supplementing the existing HN delivery model and creating additional capacity for access for certain covered services that are not the financial risk of the HN.

CalOptima Health Contracted Health Networks

CalOptima Health has contracts with HNs that are delegated to perform certain clinical and administrative functions on behalf of CalOptima Health through a variety of risk models to provide care to members. The following contract risk models are currently in place with HNs:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortia (PHC)
- Shared-Risk Group (SRG)

Through our delegated HNs, CalOptima Health members have access to 1,~~236~~306 primary care providers (PCPs), ~~6,969~~7,966 specialists, ~~40~~42 hospitals, ~~57~~71 Community Health Centers clinics and ~~207~~240 long-term care facilities.

Table 1: Provider Network Data (as of ~~November 27, 2024~~December 29,2025)

	Number of Providers
Primary Care Providers	~~1,236~~1,306
Specialists	7,966~~6,969~~
Pharmacists	498~~517~~
Acute and Rehab Hospitals	4~~20~~
Community Health Centers	71~~57~~
Long-Term Care Facilities	240~~07~~

CalOptima Health contracts with the following Health Networks as Shared Risk Group (SRG), Physician-Hospital Consortia (PHC), or Health Maintenance Organization (HMO):

Table 2: CalOptima Health Network

Health Network/Delegate	Medi-Cal	OneCare
AltaMed Health Services	HMO	SRG
AMVI Care Medical Group	PHC	PHC
CHOC Health Alliance	PHC	
Family Choice Medical Group		SRG
Family Choice Health Services	HMO	
HPN – Regal Medical Group	HMO	HMO
Optum	HMO	HMO
Noble Mid-Orange County	SRG	SRG
Prospect Medical Group	HMO	HMO
United Care Medical Group	SRG	SRG
Providence Medical Foundation	SRG	

CalOptima Health delegates ~~UM~~ clinical functions~~activities~~ for a portion of the CalOptima Health membership to Health Network's (HN)~~s~~ that demonstrate the ability to meet CalOptima Health's standards, as outlined in the UM Program Description and CalOptima Health policies and procedures. Delegated clinical functions may include but are not limited to Utilization Management, Basic and Complex Case Management and navigation and referrals to CalAIM community supports, ECM, and community organizations.

CalOptima Health retains accountabilities for all delegated functions and services, and monitors the performance of the delegated HN through the following processes:

- ~~Frequent~~ Routine ~~reporting~~ monitoring of key performance indicators (KPIs) ~~metrics that are~~, contracted data elements ~~required~~ submitted by delegates and/or developed by CalOptima Health's Claims, Credentialing, Customer Service, ~~Equity & Community Health,~~ and Utilization Management Departments in consultation with Delegation Oversight and Information Technology Services. KPIs that fall below goal are addressed through a defined escalation process ~~, result in~~commencing with a Health Network Dashboard Response Form.
- Quarterly and ad hoc meetings with the business unit department to discuss UM ~~UM~~ Work Plan activities and ~~continued~~addressing any KPIs measuring below goal.
- Quarterly ~~R~~reporting of KPIs~~key performance metrics~~ to the Delegation Oversight Committee (DOC) and/or Quality Improvement Health Equity Committee (QIHEC).
- Annual and ad hoc audits of UM activities by CalOptima Health's Delegation Oversight Department to ensure accurate and timely completion of delegated activities.

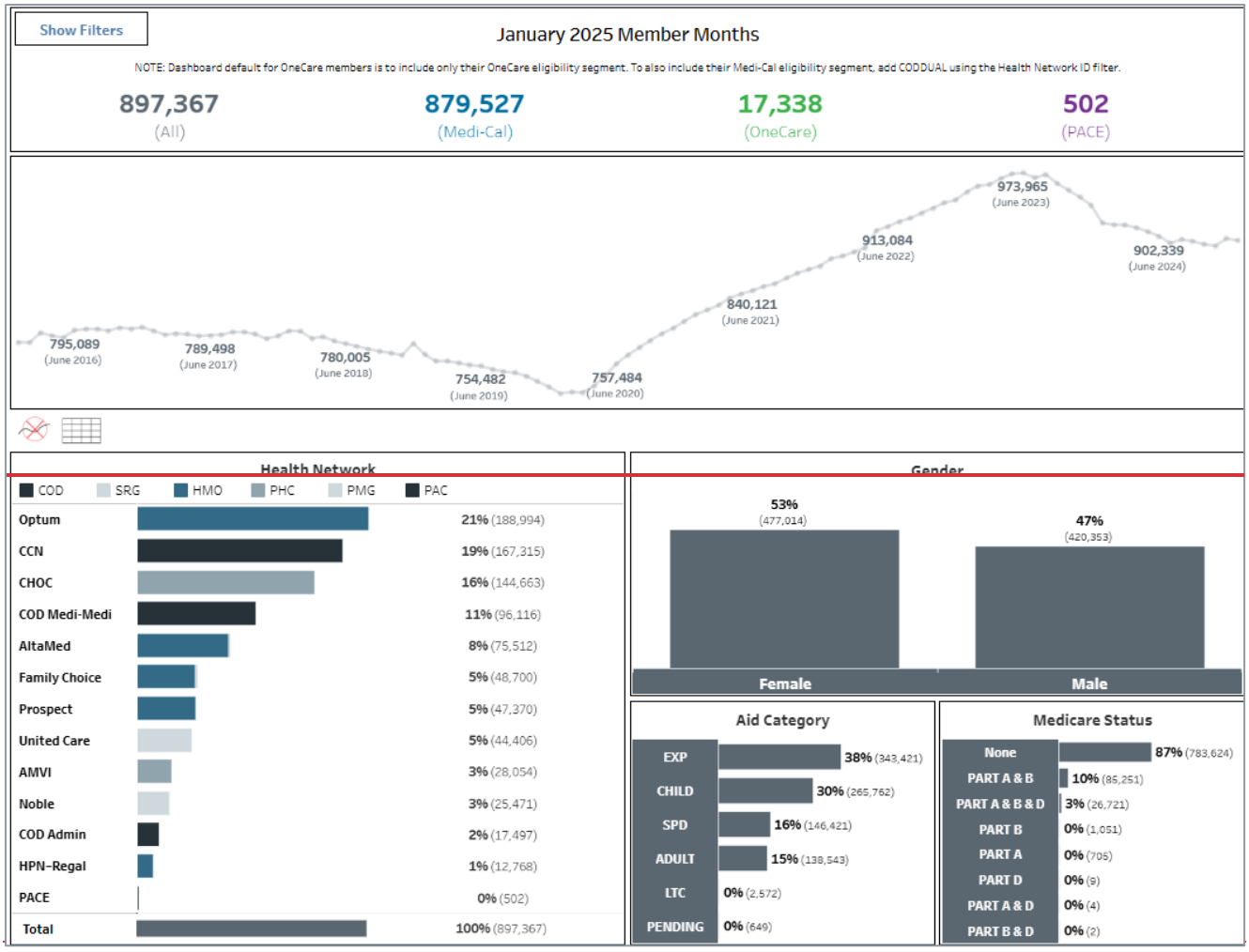
- Annual or more frequent evaluation to determine whether the delegated activities are being carried out ~~according to~~in accordance with DHCS, Centers for Medicare & Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), and CalOptima Health policies, standards and program requirements.
- Annual approval of the HNs UM Program (or portions of the program that are delegated), as well as approval of any significant changes that occur during the contract year.

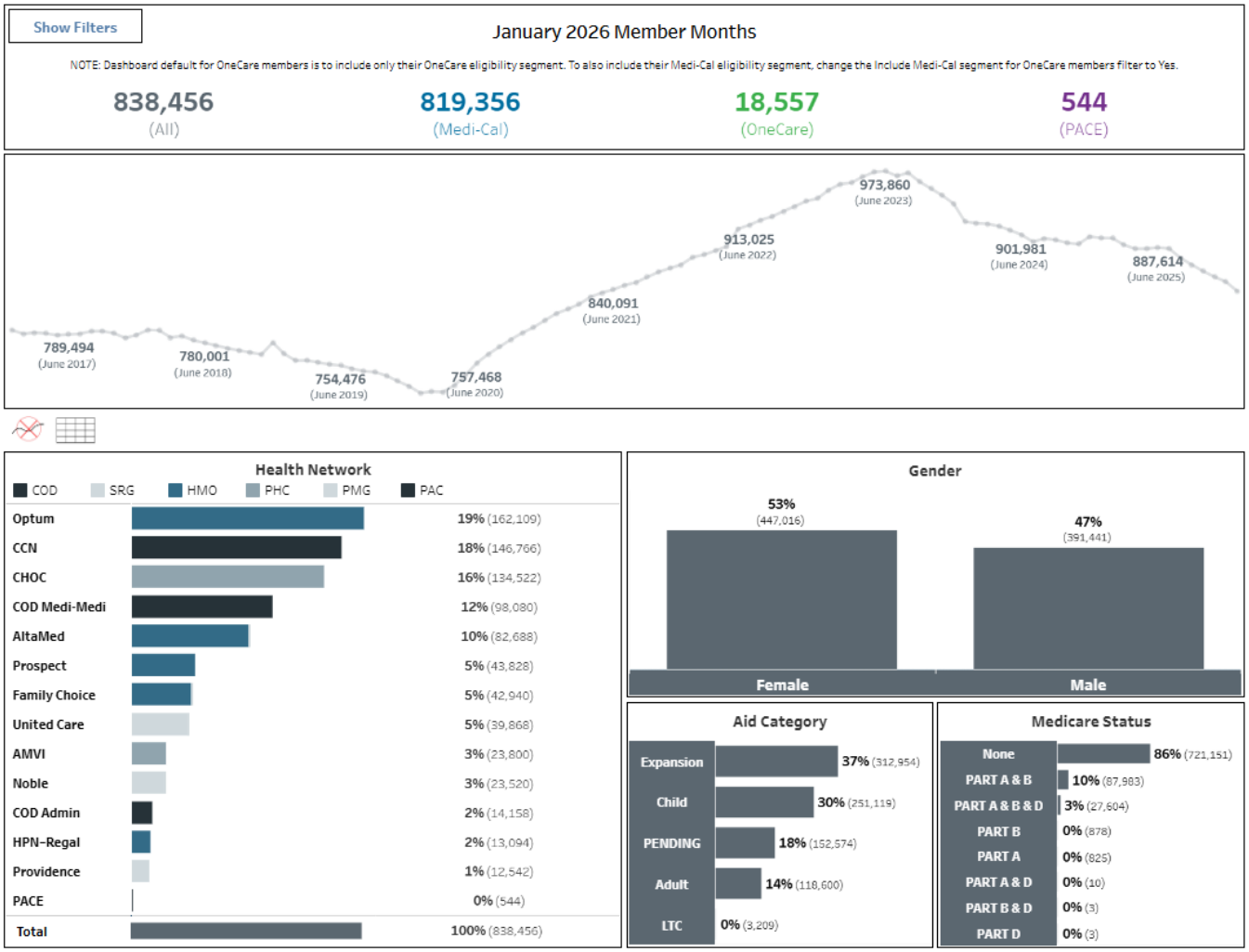
In the event the HN does not adequately perform contractually specified delegated duties, CalOptima Health takes further action, including increasing the frequency or number of focused audits, requiring the HN to implement corrective actions, imposing sanctions, capitation review, or de-delegation.

Health Network Forum

CalOptima Health's monthly Health Network Forum is led by the Executive Director of Network Operations. The forum includes representatives from Health Networks and CalOptima Health who come together to discuss enhancements and changes to the implementation and operation of medical management programs. This forum allows all Health Networks the opportunity to provide feedback and discuss how to improve operations by establishing a cohesive and unified approach to managing CalOptima Health members, regardless of who is managing the care of the member.

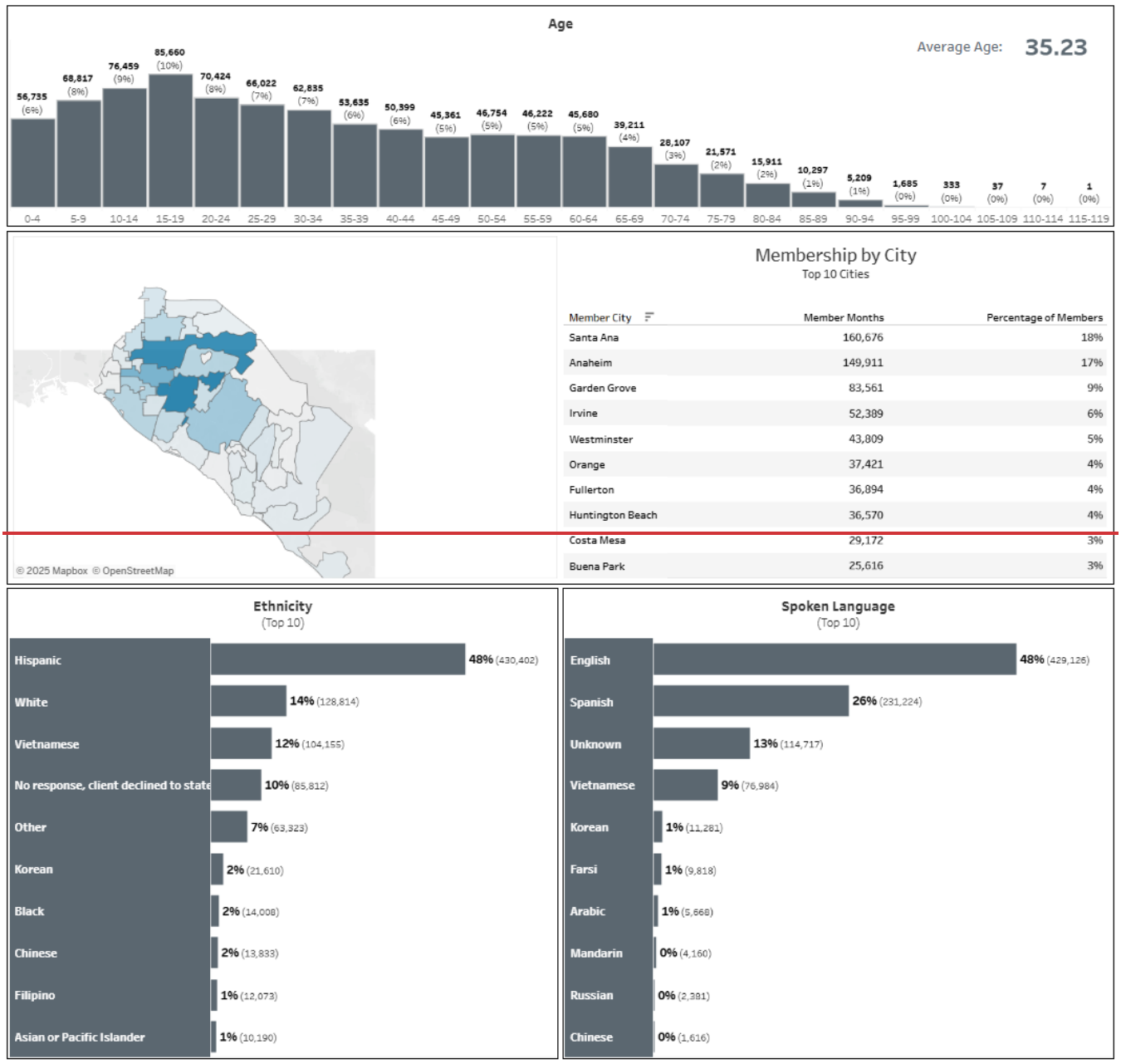
Figure 2. ~~January~~ January Member Overview

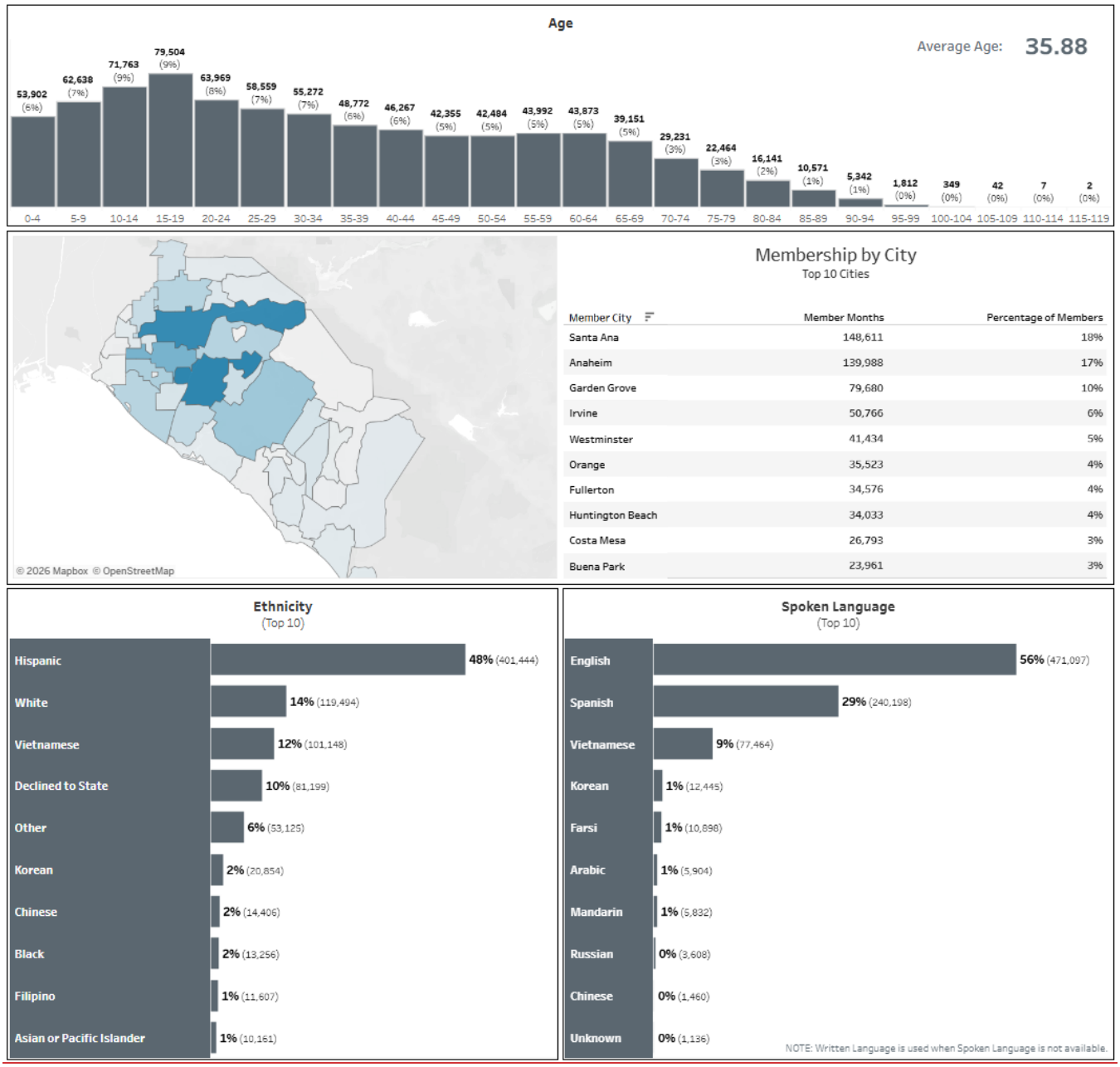

Show Filters
January 2025 Member Months
NOTE: Dashboard default for OneCare members is to include only their OneCare eligibility segment. To also include their Medi-Cal eligibility segment, add CODDUAL using the Health Network ID filter.
897,367
(All)
879,527
(Medi-Cal)
17,338
(OneCare)
502
(PACE)
795,089
(June 2016)
789,498
(June 2017)
780,005
(June 2018)
754,482
(June 2019)
757,484
(June 2020)
840,121
(June 2021)
913,084
(June 2022)
973,965
(June 2023)
902,339
(June 2024)
Health Network
COD
SRG
HMO
PHC
PMG
PAC
Optum 21% (188,994)
CCN 19% (167,315)
CHOC 16% (144,663)
COD Medi-Medi 11% (96,116)
AltaMed 8% (75,512)
Family Choice 5% (48,700)
Prospect 5% (47,370)
United Care 5% (44,406)
AMVI 3% (28,054)
Noble 3% (25,471)
COD Admin 2% (17,497)
HPN-Regal 1% (12,768)
PACE 0% (502)
Total 100% (897,367)
Gender
53%
(477,014)
47%
(420,353)
Female
Male
Aid Category
EXP 38% (343,421)
CHILD 30% (265,762)
SPD 16% (146,421)
ADULT 15% (138,543)
LTC 0% (2,572)
PENDING 0% (649)
Medicare Status
None 87% (783,624)
PART A & B 10% (85,251)
PART A & B & D 3% (26,721)
PART B 0% (1,051)
PART A 0% (705)
PART D 0% (9)
PART A & D 0% (4)
PART B & D 0% (2)



Source: Membership Dashboard tableau, data pulled ~~1/3~~1/16/2026~~/2025~~

Figure 3. ~~January~~ January Member Overview (continued)


Age
Average Age: 35.23
56,735 (6%)
68,817 (8%)
76,459 (9%)
85,660 (10%)
70,424 (8%)
66,022 (7%)
62,835 (7%)
53,635 (6%)
50,399 (6%)
45,361 (5%)
46,754 (5%)
46,222 (5%)
45,680 (5%)
39,211 (4%)
28,107 (3%)
21,571 (2%)
15,911 (2%)
10,297 (1%)
5,209 (1%)
1,685 (0%)
333 (0%)
37 (0%)
7 (0%)
1 (0%)
0-4 5-9 10-14 15-19 20-24 25-29 30-34 35-39 40-44 45-49 50-54 55-59 60-64 65-69 70-74 75-79 80-84 85-89 90-94 95-99 100-104 105-109 110-114 115-119
© 2025 Mapbox © OpenStreetMap
Membership by City
Top 10 Cities
Member City | Member Months | Percentage of Members
Santa Ana 160,676 18%
Anaheim 149,911 17%
Garden Grove 83,561 9%
Irvine 52,389 6%
Westminster 43,809 5%
Orange 37,421 4%
Fullerton 36,894 4%
Huntington Beach 36,570 4%
Costa Mesa 29,172 3%
Buena Park 25,616 3%
Ethnicity
(Top 10)
Hispanic 48% (430,402)
White 14% (128,814)
Vietnamese 12% (104,155)
No response, client declined to state 10% (85,812)
Other 7% (63,323)
Korean 2% (21,610)
Black 2% (14,008)
Chinese 2% (13,833)
Filipino 1% (12,073)
Asian or Pacific Islander 1% (10,190)
Spoken Language
(Top 10)
English 48% (429,126)
Spanish 26% (231,224)
Unknown 13% (114,717)
Vietnamese 9% (76,984)
Korean 1% (11,281)
Farsi 1% (9,818)
Arabic 1% (5,668)
Mandarin 0% (4,160)
Russian 0% (2,381)
Chinese 0% (1,616)



Source: Membership Dashboard tableau, data pulled ~~1/3~~1/16/2026~~/2025~~

Utilization Management Program

Utilization Management Purpose

The purpose of the Utilization Management (UM) Program is to define the oversight and delivery of CalOptima Health's structure, clinical processes, and programmatic approach to review health care services, treatment~~, and supplies,~~ and provide quality, coordinated health care services to CalOptima Health members. The UM Program includes ~~review~~ monitoring and analysis of utilization trends ~~including identification of~~for under and over-utilization to determine whether members are receiving appropriate services. The UM Program ensures a~~A~~ll health care services serve the culturally diverse needs of the CalOptima Health population and are delivered at the appropriate level of care, in an effective, and timely manner by delegated and non-delegated providers.

UM Scope

The comprehensive UM Program ~~is comprehensive with a~~ scope ~~that~~ encompasses all eligible members across all product types, age categories and range of diagnoses within CalOptima Health's membership. In addition, the UM program scope includes oversight of continuity of care and assurances for access to appropriate services, providers, and care settings. The UM Program incorporates physical and behavioral health, pharmacy services, emergency services, Long-term care and long-term services and supports (LTSS). ~~This~~LTSS includes preventive~~, emergency~~, primary, specialty, home and community-based services, as well as acute, subacute, short-term, and long-term facility and ancillary care services.

UM Process

The UM process includes but is not limited to the following program components: referral/prior authorization, inpatient and concurrent review, post-stabilization services, ambulatory care review, retrospective review, discharge planning, continuity of care coordination, transitions of care, and second opinions. All requests are reviewed against hierarchical guideline criteria and services must meet medical necessity criteria to be approved. The clinical decision process commences upon receipt of a treatment authorization request. ~~Request types~~Types of treatment authorization requests may include but are not limited to, authorization of specialty services, second opinions, outpatient services, ancillary services, post-stabilization inpatient services, scheduled inpatient services, and durable medical equipment. The treatment authorization review process is complete when the requesting practitioner, rendering practitioner, and member (when applicable) ~~has~~ have been notified of the determination.

UM policies and processes serve as integral components in preventing, detecting, and responding to utilization trends and opportunities as well as identifying potential fraud, waste and abuse among practitioners and members. The UM Department works closely with the Regulatory Affairs and Compliance Department and the Fraud, Waste and Abuse Unit to resolve any potential issues that may be identified. All UM team members and oversight Committees members sign an annual attestation and are expected to abide by and uphold CalOptima Health's policy for ensuring all medical decisions are made based in alignment within regulatory requirements and are not unduly influenced by financial considerations.

The CalOptima health UM Program may use (clinical, rule-based) algorithmic tools or other software to assist in the utilization review process (e.g. MCG or clinical provider portal rules) . , tThese tools are prohibited from autonomously denying, modifying or delaying healthcare services. Any tool used for UM must bases the its determination on the member's specific medical history, individual clinical circumstances, and relevant clinical records. All adverse (modify, deny) medical necessity determinations are made by a licensed physician or appropriate licensed healthcare provider. Any such tools automation or algorithmic tools are overseen by the UMC to ensure they are up to date, reliable and ensure non-discrimination. In addition, all such tools are open to regulatory audit and compliance review to ensure that they do not supplant human clinical judgement or cause patient harm.

CalOptima Health offers Continuity of Care services for up to 12 months. These services apply to a member's primary care provider, specialists, and certain ancillary providers when the member is a Medi-Cal beneficiary transitioning to CalOptima Health or moving from a Managed Care Plan whose contracts with CalOptima Health or a Health Network are expiring.CalOptima Health provides Continuity of Care services for up to 12 months to a requesting member's primary care provider, specialists and some ancillary providers for Medi-Cal beneficiaries transitioning to CalOptima Health or transitioning from a Managed Care Plan with contracts expiring with CalOptima Health or a Health Network.

UM Program Development and Enhancement Process

CalOptima Health uses a multiprong approach to the development, ongoing review and enhancements to medical necessity criteria. The Medical Director team utilizes workgroups are held to discuss establishing or updating medical necessity criteria. Input from community providers representing various specialties and Health Network clinical leaders is integrated into final decisions.
Decisions made by the workgroups that are reported up throughto the Utilization Management Committee (UMC). Input from community providers representing various specialties and Health Network clinical leaders is integrated into final decisions.

UM Program Goals

The purpose of the UM Program is to manage appropriate utilization of medically necessary covered services and to ensure access to quality and cost-effective health care for members of CalOptima Health. ~~, this is~~UM Program achieves its goals by ~~accomplished through the following goals: Assisting in the coordination~~coordinating ~~of~~ medically necessary services—including physical health, behavioral health, Long-Term Services and Supports (LTSS), Long-Term Care (LTC), and pharmacy—based on benefit and clinical criteria. This coordination follows established hierarchies, state and federal laws, contract requirements, NCQA standards, and other evidence-based guidelines.~~physical health, behavioral health, Long-Term Services and Supports (LTSS), Long-Term Care (LTC) and pharmacy services in accordance with benefit and clinical criteria and hierarchy, state and federal laws, regulations, contract requirements, NCQA standards and other evidence-based clinical criteria.~~

UM Program goals include:

- Enhancing the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Providing a mechanism to address concerns about access, availability, and timeliness of care.
- Clearly ~~define~~ defining staff responsibility for activities regarding decisions based on medical necessity including non-clinical, clinical and Medical Director staff roles and responsibilities.
- Establishing and maintaining processes used to review medical and behavioral health care and pharmacy service requests, including timely notification to members and/or providers of appeal rights when an adverse determination is made based on medical necessity and/or benefit coverage.
- Identifying and referring members to Care Coordination, Case Management, Complex Case Management and Enhanced Care Management programs, LTSS, Transitional Care Services (TCS), Behavioral Health, ~~and/or~~ Population Health Management services and CCS as appropriate.
- Promoting a high level of member, practitioner, and stakeholder satisfaction.
- Protecting the confidentiality of members' health and personal information.
- Identifying and reporting potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) ~~and refer them~~through referral to the Quality Improvement (QI) Department for further action.
- Identifying and addressing over and underutilization of services. Monitoring utilization ~~practice~~ patterns of practitioners to identify variations from the standard practice that may indicate the need for additional education or support.

- Promoting improved member outcomes by coordinating services with appropriate county or ~~/~~state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health.
- Working collaboratively with CalOptima Health's Health Networks~~'s~~ to coordinate care for complex discharge needs and CalAIM services.
- ~~Provide~~ Continuously monitoring~~continuous identification of~~ UM staffing needs including clinical, non-clinical and Medical Directors to ensure appropriate capacity to address the needs of the members we serve.
- ~~Provide~~ Providing ongoing~~continuous~~ training for competency, and ~~as well as~~ ensuring~~e~~ staff are well versed in UM processes, regulatory requirement changes and changes to departmental workflow/process ~~changes within the department~~.

UM Program Structure

The CalOptima Health UM Program ensures members receive appropriate, cost-effective~~icient~~ and quality-based health care. The UM program is designed to support optimal health outcomes and includes collaboration ~~with~~with, but not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community

The UM Program is overseen by the Chief Medical Officer and UM Committee. The UM program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Medical Management and Quality leadership team including but is not limited to the Deputy Chief Medical Officer; Medical Director(s) of UM; Behavioral Health Medical Director; Executive Director of Behavioral Health Integration; Executive Director, Clinical Operations; UMC; and QIHEC.

The UM Program is reviewed, evaluated and revised at least annually and as needed for effectiveness and compliance with the standards of CMS, DHCS, California Department of Aging (CDA), NCQA and established best practice standards/ internal benchmarks. The ~~structure of the~~ UM Program ~~is designed to promote~~promotes organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by CalOptima Health's network. Additionally, the UM program structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and ~~multiple~~ across disciplines within the organization. ~~The organization chart and the UM Program identify the Board of Directors as the governing body, dictate senior management responsibilities, committee reporting structure, and lines of authority.~~ The Board of Directors governs the organizational structure and the UM Program. The Board of Directors specifies the responsibilities of senior management, the committee reporting structure, and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The

composition and functions of the Utilization Management Committee (UMC) and Quality Improvement Health Equity Committee (QIEHC), which serve as the oversight committees for UM functions, are contained and delineated in the committee's charters.

The UM Program is overseen by the Chief Medical Officer and UM Committee. The UM program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Medical Management and Quality leadership team including but is not limited to the Deputy Chief Medical Officer; Medical Director(s) of UM; Behavioral Health Medical Director; Executive Director of Behavioral Health Integration; Executive Director, Clinical Operations; UMC; and QIHEC.

Long-Term Services and Supports (LTSS)

CalOptima Health ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program includes both institutional and community-based nursing and sub-acute facility services for both adults and pediatrics. CalOptima Health's LTSS Department monitors and reviews the quality and outcomes of services provided to members in both settings.

Home and Community-Based Services

CalOptima Health's LTSS Department monitors member utilization, level of access and satisfaction with Community Based Adult Services (CBAS) and Multipurpose Senior Services Programs (MSSP) focusing on diverting members from institutionalization, when appropriate.

Behavioral Health Services

CalOptima Health directly manages all administrative functions of behavioral health benefits including UM, claims, provider network credentialing, member services and Quality Improvement (QI).

CalOptima Health behavioral health services are available to Medi-Cal and One Care members with mild to moderate impairment of mental, emotional, or behavioral functioning.

Most behavioral health services do not require a physician referral. Members may access mental health and or substance use disorder services by calling the CalOptima Health Behavioral Health Line at 855-877-3885. Behavioral Health screenings are conducted by CalOptima Health's Behavioral Health Integration (BHI) licensed clinicians. The BHI screenings is are used to make an

Back to Agenda Back to Item

initial determination of the member's impairment level due to a mental health condition. If the member has mild to moderate impairments the member will be ~~offered~~ recommended to engage behavioral health practitioners within the CalOptima Health provider network. If the member has significant to severe impairments, the member will be referred to specialty mental health services (SMHS) through the Orange County Behavioral ~~Mental~~ Health Plan (~~OC~~B~~M~~HP) managed by the Orange County Health Care Agency (OC HCA).

CalOptima Health also covers alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT). SABIRT services are provided to members 11 years and older, including pregnant women, by providers within their scope of practice. Members who need Drug Medi-Cal Organized Delivery System (DMC-ODS) substance use disorder services—California's county-run programs that provide comprehensive, evidence-based treatment and integrate care with mental health—will be referred to the Orange County Behavioral Health Plan (BHP).~~Members who need Drug Medi-Cal Organized Delivery System (DMC-ODS) substance use disorder services will be referred to the Orange County Behavioral Mental Health Plan (BOCMHP).~~

Medi-Cal Behavioral Health Services include:

- Outpatient individual, family and group psychotherapy
- Psychiatric consultation
- Outpatient medication management
- Psychological testing
- Behavioral Health Treatment (BHT)/Applied Behavior Analysis (ABA) for members 20 years and younger
- Transcranial magnetic stimulation (TMS)

One Care Behavioral Health services include:

- Inpatient psychiatric hospitalization
- Intensive outpatient program (IOP)
- Partial hospitalization program (PHP)
- Outpatient individual and group psychotherapy
- Outpatient medication management
- Psychological testing
- Opioid treatment program (OTP) services
- Electro convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)

~~Alcohol and drug use screening, assessment, brief interventions, and~~

~~referral to treatment (SABIRT)~~

Authority, Boards of Directors' Committees, and Responsibilities

Board of Directors

CalOptima Health's Board of Directors has ultimate accountability and responsibility for overseeing the quality of care and services provided to CalOptima Health members. Oversight of the UM Program rests with the Quality Assurance Committee (QAC), a subsidiary of the Board of Directors. The QAC also oversees the Quality Improvement Health Equity Committee (QIHEC) as outlined in CalOptima Health's state and federal contracts, and to CalOptima Health's Chief Executive Officer (CEO), as described below.~~The responsibility to oversee the UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC) which oversees the functions of the Quality Improvement Health Equity Committee (QIHEC) described in CalOptima Health's state and federal contracts — and to CalOptima Health's Chief Executive Officer (CEO), as described below.~~

The Board holds the CEO and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board ensures the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the UM Program annually.

The responsibility for the direction and management of the UM Program has been delegated to the CMO. Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the UMC, the QIEHC and the QAC on an annual basis.

CalOptima Health is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 et seq., to hold public meetings except under specific circumstances described in the Act. CalOptima Health's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the QAC to conduct an annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QI Program. QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives, and quality performance results. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QI Program.

Member Advisory Committee

The Member Advisory Committee (MAC) ensures that CalOptima Health members' values and needs are integrated into the design, implementation, operation and evaluation of the overall QI program. Each seat of the MAC ~~includes members with each seat~~ is inclusive of members representing a constituency served by CalOptima Health. ~~The MAC ensures that CalOptima Health members' values and needs are integrated into the design, implementation, operation and evaluation of the overall QI program.~~ The MAC provides advice and recommendations on community outreach, cultural and linguistic ~~needs and~~ needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC ~~membership has~~committee includes ~~representatives~~ representation from the following constituencies:

- Adult Beneficiaries
- Children
- Family Support
- Foster Children
- Medi-Cal Beneficiaries or Authorized Family Member (two seats)
- Member Advocate
- OneCare Member or Authorized Family Member (four seats))
- Orange County Social Services Agency (standing seat)
- People with Disabilities
- Behavioral/Mental Health Representative
- People with Special Needs
- Recipients of CalWORKs
- Seniors

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Health Board of Directors to advise the Board on issues impacting the CalOptima Health provider community. PAC members represent ~~a~~ the broad ~~provider~~ community of providers that serve~~s~~ CalOptima Health members. The PAC meets bi-monthly and is open to the public. ~~The m~~Members of the PAC include:

- Health Networks
- Hospitals
- Physicians (three seats)
- Nurse

- Allied Health Services (two seats)
- Community Health Centers
- Health Care Agency (HCA) (standing seat)
- Long Term Services and Supports
- Non-physician Medical Practitioner
- Traditional Safety Net Provider
- Behavioral/Mental Health
- Pharmacy

Whole-Child Model Family Advisory Committee

The Whole-Child Model Family Advisory Committee (WCM FAC) is required by the state as part of California Children's Services (CCS), a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board of Directors and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima Health's WCM program. The committee initiates recommendations on issues for study and facilitates community outreach. The WCM FAC meets on a quarterly ~~basis~~basis, and meetings are open to the public.

Members of WCM FAC include:

- Authorized Family Member Representatives, which include parents, foster parents and caregivers of CalOptima Health members who are current recipients of CCS services (seven seats~~); or~~).
- CalOptima Health members ages 18–21 who are current recipients of CCS services.~~;~~
- Current CalOptima Health members over the age of 21 who transitioned from CCS services.
- Interests of children receiving CCS services representatives.~~;~~
- Community-based organizations (two seats).~~; or~~
- Consumer advocates (two seats).

CalOptima Health Officers

The CalOptima Health Officers are the senior leaders responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral health QI, medical and behavioral health utilization review and authorization, case management, and health education program implementations. CalOptima Health Officers include the Chief Medical Officer (CMO), Chairperson of the Utilization Management Committee (UMC), Executive Director of

Clinical Operations, and/or any designee as assigned by CalOptima Health's Chief Executive Officer (CEO), and the Chief Health Equity Officer.

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the Quality Improvement Health Equity Committee (QIHEC) satisfies all ~~remaining~~ requirements of the QI Program, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO) oversees strategies, programs, policies, and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees the strategies, programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO and CMO oversee Utilization Management (UM), Case Management (CM), Pharmacy Management (PM), Behavioral Health Integration (BHI), and Long-Term Support Services (LTSS).

Chief Health Equity Officer (CHEO) co-chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The CHEO provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met. The CHEO is a voting member for the UMC to ensure that health equity is considered in all committee decisions.

Executive Director, Clinical Operations (ED CO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the UM, Care Coordination, Complex Case Management, Transitional Care Services, Disease Management, Health Education, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The ED CO serves as a member of the executive team, and with the CMO, DCMO and the Executive Director of Behavioral Health Integration.

Executive Director, Quality Improvement (ED QI) is responsible for facilitating the companywide QIHETP deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high performing health plan. The ED QI serves as a member of the

executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement and Medicare Stars and Quality Initiatives.

Executive Director, Behavioral Health Integration (ED ~~of~~ BHI) is responsible for the management and oversight of CalOptima Health's Behavioral Health Integration department, along with new implementation related to state and county behavioral health initiatives. The ED ~~of B~~BHI leads strategies for integrating behavioral health across the health care delivery system and populations served. The ED BHI serves as a member of the executive team, and with the CMO, DCMO and the Executive Director of Clinical Operations.

Executive Director, Equity and Community Health (ED ECH) is responsible for the management and oversight of CalOptima Health's ~~disease management and health education~~ Equity and Community Health department. ~~s.~~ The ED ECH oversees the development and implementation of companywide ~~Population Health Management~~ strateg~~y~~ies to advance health equity, strengthen community partnerships, and promote equitable access to care ~~to~~that improves ~~member experience, promote optimal~~ health outcomes~~, ensure efficient care and improve health equity~~ for all members. The ED ECH serves as a member of the executive team. The ED ECH reports~~, reporting~~ to the CHEO, and in partnership with the CMO, DCMO and~~, and~~ Executive Director of~~,~~ Clinical Operations, supports efforts to promote adherence to established quality improvement and health equity strategies. The ED ECH also collaborates with leaders across the organization in efforts to ~~and~~ integrate ~~behavioral~~ community health across the delivery system and populations served. ~~The Senior Director of Equity and Community Health reports to the ED ECH.~~ ~~The Director of Equity and Community Health reports to the ED ECH.~~

Physical and Behavioral Health Medical Directors *(hereinafter referred to "Medical Directors")* ~~have primary assigned roles but may provide coverage and back up to other specialties as needed. Medical Directors~~ are appointed by the CMO and/or DCMO and are responsible to adhere to and oversee the direction of the UM Program and objectives, as well as evaluation of the UM Program. Medical Directors have primary assigned oversight functions and accountabilities but may provide coverage and back up as needed. Medical Directors serve as committee chairs to ensure decisions are made based on clinical relevance and in the best interest of our members.

- The Medical Director who oversees UM ensures quality medical service delivery to members managed directly by CalOptima Health and is responsible for medical direction and clinical decision making in UM. The Medical Directors serve as the senior-level physicians designated to oversee the implementation of the UM Program. The Medical Directors ensure~~s~~ that an appropriately licensed professional conducts reviews

on cases that do not meet medical necessity and uses evidence-based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO and/or DCMO, the Medical Director also provides supervisory oversight and administration of the UM Program and oversees the UM activities and clinical decisions of staff that work in concurrent, prospective and retrospective medical management activities. The Medical Director , monitors for documentation ~~adequacy, and~~adequacy and works with the clinical staff that support the UM process. The Medical Director provides clinical education and in-service training to staff, presenting key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. The Medical Director of UM ensures physician availability to staff during both normal business hours and ~~on-call~~on call after hours. ~~Also serves A~~as the Chair of the UMC and the Benefit Management Subcommittee, the Medical Director of UM facilitates the biweekly UM Workgroup meetings and participates in the CalOptima Health Medical Directors Forum and QIHEC.

- The Medical Director who oversees the behavioral health program is a double board-certified Psychiatrist specializing in Child and Adolescent Psychiatry and is a participating member of the UMC, QIHEC and CPRC. The Medical Director provides consultation and oversight to the UM Program, including guidance on criteria review and development to ensure parity. The Medical Director supports the behavioral health aspects of the UM Program. The Medical Director also provides leadership and program development in the creation and/or improvement of services and systems ensuring the integration of physical and BH care services for CalOptima Health members. Clinical oversight is also provided for BH benefits and services provided to members. The Medical Director works closely with all departments to ensure appropriate access and coordination of behavioral health care services, improves member and provider satisfaction with services and ensures quality BH outcomes.
- The Medical Director oversees specialty programs and services, as a key member of the medical management team, and is responsible for the Medi-Medi programs, MLTSS programs, and Case Management programs. The Medical Director is also the chair of the Pharmacy & Therapeutics committee (P&T). The Medical Director provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima Health operational and support departments, other health networks in an oversight capacity for UM and CM, including PHM, disease management and health education programs, and clinical quality oversight of the Program of All-Inclusive Care for the Elderly (PACE) Center.

UM Program Leadership

CalOptima Health uses appropriate licensed health care professionals to process and/or supervise UM activities. The UM Program health care professionals:

- Provide day-to-day supervision of assigned UM staff.
- Participate in staff training.
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
- Monitor documentation for adequacy.
- Are available on site or by telephone.

6. In compliance with Department of Health Care Services (DHCS) contract requirements and National Coalition Quality Assurance (NCQA) standards, medical necessity decisions are supervised by;by, Medical Directors, licensed Registered Nurses, licensed Vocational Nurses, other approved licensed staff.

Director, Utilization Management is responsible for the planning, organization, implementation and evaluation of all activities and personnel engaged in UM departmental operations. This position provides leadership and direction to the UM department, ensures compliance with all local, state and federal regulations. The Director, Utilization Management, also ensures that accreditation standards are current, and all policies and procedures meet current requirements. The Director, Utilization Management oversees CalOptima Health's UM Program for CalOptima Health Community Network, CalOptima Health Direct and the delegated HNs. The Director is expected to serveserves as a liaison for various internal and external committees, workgroups, and operational meetings.

Senior Director, Hospital Relations and Inpatient Clinical Support is responsible for leading leads clinical operational effectiveness betweenacross hospitals,, and all CalOptima Health and health network partners. The Senior Director is responsible This role ensures for ensuring patient access through quality outcomes and a system approach to ensurethat supports inpatient care, transitional care services and communication amongst treatmentcare teams. The Senior Director leads through a front-line, coordinated approach workingpartnering direct coordination and partnership with our hospitals, direct providers and health networks partnerships to ensure exceptional enhance exceptional ddirection and communication to and serve CalOptima Health members.

The Director, Clinical System Configuration and Portfolio Management (Medical Management) is responsible for providing oversight of clinical system contracts/ liaising and configuration request prioritization and tracking. The director leads development of protocols to track, prioritize and oversee clinical system integration, new and change request tracking and completions, defect management and process enhancement recommendations to create

continued automation and efficiencies. The director oversees internal and external entities and adherence to clinical configuration deadlines and outcomes for optimal delivery of care.

Director, Behavioral Health Integration is responsible for the planning, organization monitoring, and evaluation of all activities and personnel engaged in the BH UM operations. The director tracks and analyzes changes in the behavioral health care delivery environment and program opportunities affecting CalOptima Health members. The director is ~~or~~ available to assist CalOptima Health in integrating physical and BH care services. This position provides leadership and direction to the BH UM team to ensure compliance with all local, state, and federal regulations, that accreditation standards are current, and all policies and procedures meet current requirements. The d~~D~~irector ~~is expected to~~ serves as a liaison for various internal and external committees, workgroups, and operational meetings.
~~This position plays a key leadership role in coordinating with all levels of CalOptima Health staff, including the Board of Directors, executive staff, members, providers, HN management, state and federal officials, and representatives of other agencies.~~

Director, Credentialing is responsible for initial credentialing and credentialing of providers contracted with CalOptima Health. This position is also responsible for oversight and monitoring of credentialed providers including those providers that are credentialed by delegated entities.

Director, Quality Improvement is responsible for assigned day-to-day operations of the Quality Management operations, including the Quality Improvement and Health Equity Transformation Program (QIHETP) and annual Work Plan. Responsibilities include handling potential quality issues (PQIs), conducting facility site and medical record reviews, ensuring physical accessibility compliance, maintaining NCQA Health Plan and Health Outcomes Accreditation, and working with the ED Quality Improvement and the Quality Improvement Health Equity Committee (QIHEC) to oversee and implement the QIHETP and its Work Plan.

Director, Quality Analytics, is responsible for leading collection, tracking and reporting of quality performance measures, including HEDIS and Stars metrics, as required by regulatory entities. The director c~~C~~onducts data analysis to inform root cause analysis, identify opportunities for improvement, and measure effectiveness of interventions. This role ~~P~~provides data analytical direction to support quality measurement activities for the agencywide QIHETP.

Director, Medicare Stars and Quality Initiative is responsible for leading implementation of quality initiatives to improve quality outcomes for Medi-Cal and Medicare products, including HEDIS, member satisfaction, access and availability, and Medicare Stars. Provides data analytical direction to support quality measurement activities for the organization wide QIHETP by managing, executing and coordinating QI activities and projects., ~~aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides~~

~~coordination and support to the QIHEC and other committees to ensure compliance with regulatory and accreditation agencies.~~

Director, Internal Audit oversees and conducts regulatory compliance audits and monitoring of CalOptima Health's internal operations with an emphasis on transparency, efficiency and effectiveness and in accordance with state/federal requirements, CalOptima Health policies, and industry best practices. The director validates that CalOptima Health's business areas perform consistently with ~~both~~ CMS and ~~state~~ DHCS requirements for all programs. ~~Specifically, the~~The director leads the department in the application of auditing and monitoring to validate adequate performance relative to both quality and timeliness. ~~director leads the department in developing audit protocols for all internal functions to ensure adequate performance relative to both quality and timeliness.~~ Additionally, the director is responsible for the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls. The position interacts with the Board of Directors, CalOptima Health Executives, Compliance Committee, departmental management, and legal counsel.

Sr. Manager, Utilization Management RN/LVN (Prior Authorization (PA)) manages the day-to-day operational activities of the prior authorization department to ensure staff compliance with CalOptima Health policies and procedures, regulatory and accreditation agency requirements. ~~provides UM Department prior authorization compliance oversight of internal and external delegated health networks.~~ The Sr. Manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members. The Sr. Manager leads inventory management process ~~for improvement~~improvements ~~of all clinical operation teams~~ to maximize efficiencies and ensure regulatory compliance. The Sr. Manager also establishes and maintains collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Manager, Utilization Management RN/LVN (Inpatient Services (IP)) manages the day-to-day operational activities of the inpatient ~~D~~department to ensure staff ~~compliance~~ comply with CalOptima Health ~~company~~ policies and procedures, ~~and~~ regulatory and accreditation agency requirements. The Manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Supervisor, Utilization Management RN/LVN(IP) provides day-to-day supervision of assigned UM staff. The supervisor ~~,~~ monitors and oversees daily work ~~assignment~~assignments and activities to ensure that service standards are met and ~~,~~ makes recommendations regarding assignments based on assessment of workload. The Supervisor is a resource to the IP staff regarding CalOptima Health policies and procedures, as well as regulatory and accreditation

agency requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff through training activities. The Supervisor also monitors documentation for adequacy~~, --~~including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours and during weekend/holiday on call schedules.

~~**Manager, Utilization Management RN/LVN (Prior Authorization (PA))** manages the day-to-day operational activities of the department to ensure staff compliance with CalOptima Health policies and procedures, regulatory and accreditation agency requirements. The Manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members. The Manager also establishes and maintains collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.~~

Supervisor, Utilization Management RN/LVN (PA) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met. The Supervisor assigns cases based on assessment of workload and provides ongoing monitoring and development of staff through training activities. This role is a resource to the Prior Authorization staff regarding CalOptima Health policies and procedures as well as regulatory requirements governing prior and retrospective authorization processing. The Supervisor also monitors documentation adequacy, including clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member’s clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours and during weekend/holiday on call schedules.

The following staff positions provide direct support for the UM Department’s organizational/operational functions and activities:

Letter Team ~~Notice of Action~~ Medical Case Managers (RN/LVN) draft and evaluate modification and denial letters for adequate documentation, utilization of appropriate criteria, and assurance that the letter is written in plain language that a layperson understands.

Medical Case Managers (RN/LVN) provide inpatient and outpatient utilization reviews and authorization of services in support of members. Medical Case Managers ~~They~~ are responsible for assessing the medical appropriateness, quality and cost effectiveness of proposed inpatient

hospital and outpatient medical/surgical services, in accordance with established evidence-based criteria. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Medical Authorization Assistants (MAA) are responsible for interacting with practitioners, members, family, and other customers. Medical Authorization Assistants sStaff members who are not qualified health care professionals are under the direct supervision of a licensed clinician. Non-licensed team members process service requests that do not require application of clinical judgement. They perform routine medical administrative tasks specific to the assigned unit and office support functions. They MMAs can administratively authorize services according to departmental guidelines and under the oversight of UM nurse reviewers and Medical Directors.

Quality Improvement (QI) Nurse Specialists Utilization Management (LVN) are responsible for conducting routine oversight, and monitoring and auditing of internal UM activities to ensure compliance with state, federal and accreditation standards. Monitoring activities include reviewing and auditing prior authorizations, continuity of care files, NEMT files, and inpatient records. They also involve addressing Corrective Action Plan (CAP) findings and identifying opportunities for process improvement. Monitoring activities include but are not limited to prior authorization, continuity of care files, NEMT files, and inpatient file reviews, addressing Correction Action Plans (CAPS) findings, and identifying opportunities for process improvement during the monitoring process. The QI Nurse Specialist serves as a Jiva subject matter expert (SME), reviews and responds to Regulatory Affairs and Compliance (RAC) requests and requests for validation (RVD), assists with updates to policies and department desktop procedures. The QI Nurse Specialist assists the Delegation Oversight Department in oversight and monitoring of Health Network Key Performance Indicators (KPIs) and UM letter implementation.

Pharmacy Staffing Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements and administers all aspects of the CalOptima Health pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs, and oversees the day-to- day functions of the contracted pharmacy benefit management vendor (PBM). The director is also responsible for administration of pharmacy services delivery and has frequent interaction with external contacts including local and state agencies, contracted service vendors, pharmacies and pharmacy organizations.

Manager, Clinical Pharmacist supports the Pharmacy Director and staff in developing and implementing strategies for targeted drug utilization and disease state management. These strategies aim to control costs and improve health care quality and outcomes for members enrolled in CalOptima Health delegated health plans and CalOptima Health Direct. Using various approaches—such as provider and plan profiling, member drug profile reviews, updating drug utilization criteria, and case-by-case interventions, the Pharmacy Manager promotes clinically appropriate prescribing practices that align with CalOptima Health and national guidelines. Additionally, the Pharmacy manager continuously researches, develops, and updates drug utilization management strategies and intervention techniques. ~~assists the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in the CalOptima Health delegated health plans and CalOptima Health Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by- case intervention), the Pharmacy manager promotes clinically appropriate prescribing practices that conform to CalOptima Health, as well as national practice guidelines and on an ongoing basis, research, develops, and updates drug UM strategies and intervention techniques.~~ The Pharmacy manager develops and implements methods to measure the results of these programs and assists the Pharmacy director in preparing drug monographs and reports for the Pharmacy & Therapeutics (P&T) Committee. The Manager, Clinical Pharmacist, interacts frequently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interactions with external contacts, including the pharmacy benefit managers' clinical department staff.

Clinical Pharmacists assist the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in CalOptima Health delegated health plans and CalOptima Health Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima Health, as well as national, practice guidelines. On an ongoing basis, they research, develop, and update drug UM strategies and intervention techniques, and develop and implement methods to measure the results of these programs.

The Clinical Pharmacists assist the Pharmacy director in preparing drug monographs and reports for the P&T Committee, interact with other department staff as needed to perform the duties of the position, and have frequent interactions with external contacts, including the pharmacy benefit managers' clinical department.

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

LTSS Staffing Resources

Director, Long-Term Services and Supports develops, manages and implements LTSS programs including Long-Term Care (LTC) ~~facilities~~ facility authorization services for room and board, CBAS and MSSP~~, and~~. The LTSS Director also manages the staff associated with those programs.

Manager, Long-Term Services and Supports (CBAS/LTC/MSSP) develops and manages the LTSS department's ~~work activities~~operations and ~~team~~staff. The manager ensures that service standards are met, and operations are consistent with CalOptima Health's policies and regulatory and accrediting agency requirements to ensure high quality and responsive services for CalOptima Health's members who are eligible for and/or receiving LTSS.

Supervisor, Long-Term Services and Supports (CBAS/LTC/MSSP) is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of LTSS to members in the community and institutionalized setting.

Medical Case Managers, Long-Term Services and Supports (MCM LTSS)~~,~~ are part of an advanced specialty collaborative practice responsible for case management, care coordination and function, providing coordination of care, and ongoing case management services for qualified CalOptima Health members in LTC facilities and members receiving CBAS and MSSP. They provide case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the members' needs. The MCM LTSS acts as liaisons to Orange County community agencies, CBAS centers, skilled nursing facilities, members and providers.

Behavioral Health Integration Staffing Resources

Sr Manager, Behavioral Health CalOptima Health ~~manages the day-to-day operational activities of the BH UM team to ensure staff compliance with CalOptima Health policies and procedures, and regulatory and accreditation agency requirements.~~ manages the day-to-day operational activities of the department to ensure staff compliance with CalOptima Health policies and procedures, regulatory and accreditation agency requirements. The Sr. Manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members. The Sr. Manager leads inventory management ~~process~~processes for improvement to maximize efficiencies and ensure regulatory compliance. The Sr. Manager also establishes and maintains collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Supervisor, Behavioral Health, (BH) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are ~~met,~~ met and makes recommendations regarding assignments based on assessment of workload. The Supervisor is ~~a resource~~provides guidance ~~to the~~to BH staff regarding CalOptima Health policies and procedures, as well as regulatory and accreditation agency requirements governing prior authorization and concurrent review and authorization processing. The BH Supervisor~~, while providing~~ provides ongoing monitoring and development of staff through training activities. The Supervisor also monitors documentation for adequacy, including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition~~.~~

Medical Case Managers (MCM BH-RN/LVN or MCM Licensed BH Clinician) provide inpatient and outpatient utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality and cost effectiveness of proposed inpatient psychiatric hospital and outpatient BH services, in accordance with established evidence-based criteria. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

~~**Care Manager (BH CM) Board Certified Behavior Analyst, BCBA)** provides utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality and cost effectiveness of proposed BHT services, in accordance with established evidence-based criteria. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.~~

Medical Authorization Assistants Behavioral Health (MAA BH) are responsible for interacting with practitioners, members, family, and other customers. Staff members who are not qualified health care professionals are under the direct supervision of a licensed clinician. Non-licensed team members process service requests that do not require application of clinical judgement.

They perform routine medical administrative tasks specific to the assigned unit and office support functions. They can administratively authorize services according to departmental guidelines and under the oversight of UM nurse reviewers and Medical Directors. ~~are responsible for interacting with practitioners or other customers, under the direction of the licensed Medical Case Manager and or Care Manager. They perform routine medical administrative tasks specific to the assigned unit and office support functions.~~

Qualifications and Training

CalOptima Health hires staff who are highly qualified clinical individuals with extensive experience and expertise in UM and CM ~~for staff positions~~. Qualifications and educational requirements are delineated in the position job description of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. ~~The following topics~~Topics included in the new hire ~~are covered during the~~ program vary ~~,~~ as applicable to specific job descriptions. Examples of topics may include but are not limited ~~:~~to:

- ~~1.~~ CalOptima Health New Employee Orientation
- HIPAA and Privacy/Corporate Compliance
- Diversity, Inclusion, and Unconscious Bias
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- UM and CM Program, policies/procedures, etc.
- Medical Management information system data entry
- Application of Review Criteria/Guidelines
- Appeals process
- Seniors and Persons with Disabilities (SPD) awareness training
- OneCare (OC) training

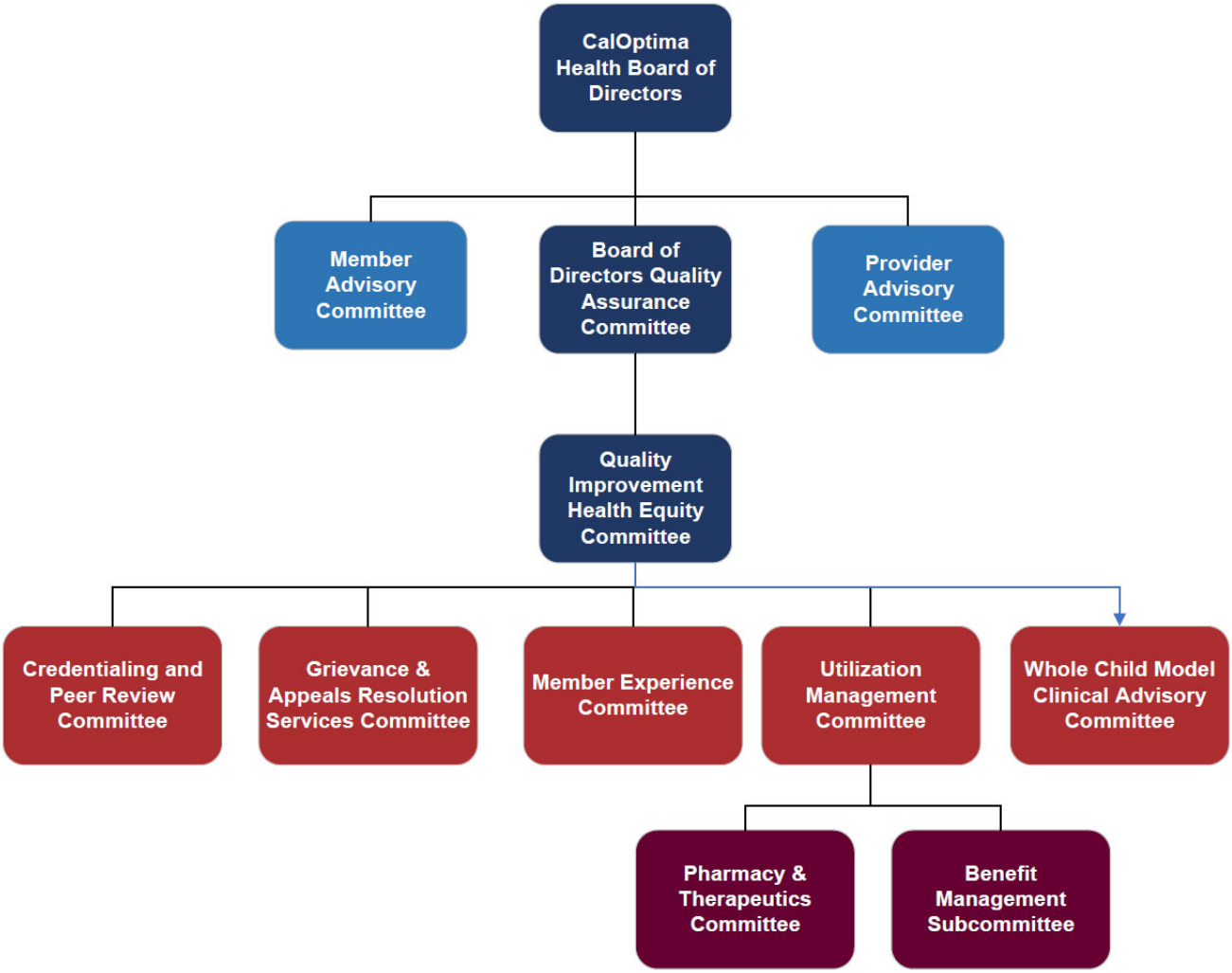
CalOptima Health encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima Health.

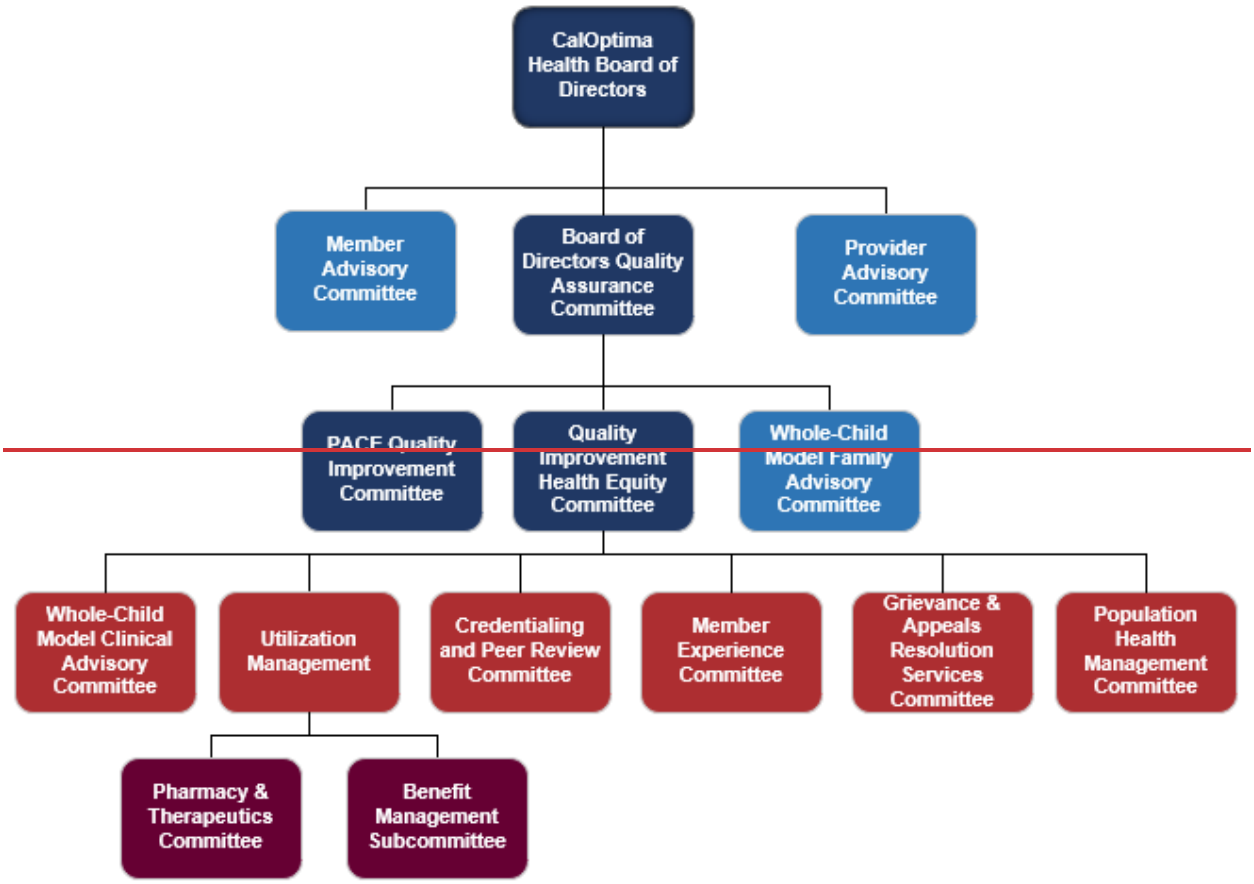
CalOptima Health and its delegated HN UM staff do not permit or provide compensation or anything of value to its employees, agents or contractors based on the percentage or the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which

the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

Utilization Management Committee (UMC)

Figure 44: Diagram representing the committee structure


CalOptima Health Board of Directors
Member Advisory Committee
Board of Directors Quality Assurance Committee
Provider Advisory Committee
Quality Improvement Health Equity Committee
Credentialing and Peer Review Committee
Grievance & Appeals Resolution Services Committee
Member Experience Committee
Utilization Management Committee
Whole Child Model Clinical Advisory Committee
Pharmacy & Therapeutics Committee
Benefit Management Subcommittee



Utilization Management Committee (UMC)

The UMC is led by a CalOptima Health Medical Director. This senior level physician ~~is involved in~~has oversight of UM activities~~,~~ including but not limited to implementation, supervision, program oversight, and evaluation of the UM Program.

The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of health care services by CalOptima Health Direct, CalOptima Health Community Care Network and through the delegated HMOs, PHCs and SRGs, to identify areas of under or over utilization that may adversely impact member care. The UMC is~~I~~

responsible for the annual review and approval of medical necessity criteria and protocols, and the UM policies and procedures. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, ensure coordination of care, ensure appropriate use of services and resources, and improve member and practitioner satisfaction with the UM process.

The UMC meets at least quarterly and coordinates an annual review and revision of the UM Program Description, as well as reviews and approves the Annual UM Program Evaluation.

UMC documents are reviewed and approved by the QIHEC and QAC and ultimately the Board of Directors. UMC meeting minutes and recommendations for UM program improvement activities made are included in the Board of Director updates as appropriate. The UMC routinely submits meeting minutes as well as written reports regarding analyses of the above tracking and monitoring processes and the status of corrective action plans to the QIHEC. Oversight and operating authority of UM activities is delegated to the UMC, ~~are~~ overseen by the CMO and deputy CMO. UMC reports up to QIHEC and ultimately to QAC and the Board of Directors.

Conflict of Interest

CalOptima Health maintains a Conflict-of-Interest policy ~~addressing the process to identify and~~to identify, evaluate, and address ~~evaluate~~ potential social, economic, and professional conflicts of interest ~~and take appropriate actions~~. CalOptima Health requires that all individuals who serve on the UMC or who otherwise make decisions on UM, quality oversight and activities, disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.

All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

Participating Physician

A ~~practicing~~participating physician is a physician that holds a current California license. Changes to participating physicians are communicated to the UMC Program Specialist and UMC Chairperson. Changes include but are not limited to; change in Health Network affiliation or closing a physician panel.

Internal Medical Directors and external physicians are credentialed and go through a recredentialing process every three years. The credentialing process includes annual verification of licensesof licenses, disciplinary actions and work history.

On a monthly basis, the CalOptima Health Human Resources Department requests a list of UMC members to monitor for for provider excludedsion or precludedsion monitoring alignmentin accordance with with CalOptima Health Policy HH.2021 Exclusion and Preclusion Monitoring.

Confidentiality

CalOptima Health has policies and procedures to protect and promote proper handling of confidential and privileged medical record information that are overseen by the Department of Compliance and assigned Privacy Officer. During the onboarding process, all CalOptima Health employees, --including contracted professionals, who have access to confidential or member information sign a written statement for maintaining confidentiality. In addition, all non-employee Committee members are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

UMC Scope and Responsibilities

The scope and responsibilities of the UMC include but are not limited to:

- Provides oversight and overall direction for the continuous improvement of the UM Program, consistent with CalOptima Health's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima Health and its delegated HNs.
- Oversees the UM activities and compliance with federal and state statutes and regulations, as well as contractual and NCQA requirements that govern the UM process.
- Reviews and approves the UM / CM Integrated Program Description, medical necessity criteria, UMC Charter, UM policies, and the UM Program Evaluation on an annual basis.
- Reviews and analyzes UM operational and outcome data; reviews trends and/or utilization patterns presented at committee meetings and makes recommendations for further action.
- Reviews and approves annual UM metric targets and goals.
- Reviews progress toward UM Program goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects.
- Promotes a high level of satisfaction with the UM Program across members, practitioners, stakeholders, and client organizations by examining results of annual

member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identifying areas for performance improvement, and evaluate performance improvement initiatives.

- Reviews~~s~~, assesses~~es~~, and recommends~~s~~ utilization management best practices used for selected diagnoses or disease classes.
- Conducts~~s~~ review of under/over utilization monitoring and makes~~s~~ recommendations in accordance with UM Policy and Procedure GG.1532: Over and Under Utilization Monitoring; makes~~s~~ recommendations for improving performance on identified over/under utilization.
- Reviews~~s~~ and provides~~s~~ recommendations for improvement, as needed, to reports submitted by the following:
    - Benefit Management Subcommittee (BMSC)
    - P&T Committee
    - Reports~~s~~ to the QIHEC on a quarterly basis, communicatinges~~es~~ significant findings and ~~makes~~ making recommendations related to UM issues.

Departments Reporting Relevant Information on UM Issues include:

~~1.~~• Delegation Oversight
- Behavioral Health
- Grievance and Appeals
- LTSS
- Pharmacy

UMC Membership

Voting Members in the UMC Committee include:

- Chief Medical Officer (Specialty: Emergency Medicine)
- Chief Health Equity Officer ~~Deputy~~ who oversees Equity and Community Health (Specialty: Doctor of Public Health and Licensed Social Worker)
- Deputy Chief Medical Officer (Specialty: Internal Medicine)
- Medical Director who oversees Utilization Management, UMC Chairperson (Specialty: Family Practice)
- Medical Director who oversees ~~UM Program~~ UM Delegation Oversight and Health Networks (Specialty: Internal Medicine)
- Medical Director who oversees Behavioral Health Program (Specialty: Psychiatry [Child/Adolescent & Adult])
- Medical Director who oversees Senior Programs (Specialty: Internal Medicine)

- Medical Director who oversees Whole-Child Model Program (Specialty: Medicine/Pediatrics)
- Medical Director who oversees Quality and Analytics (Specialty: Pediatrics)
- Medical Director who oversees California Advanced and Innovating Medi-Cal (CalAIM) (Specialty: Family Medicine and Addition Medicine)
- Executive Director, Clinical Operations (Master of Science in Gerontology, Certified Case Manager)
- Executive Director, Behavioral Health Integration~~,~~ (Licensed Professional Clinical Counselor, Certified Case Manager)
- Outside Practitioner 1 (Specialty: Family Medicine)
- Outside Practitioner 2 (Specialty: Family Medicine~~Pediatrics~~)
- Outside Practitioner 3 (Specialty: Neurology)
- Outside Practitioner 4 (Specialty: ~~Pulmonary~~Internal Medicine/Neurological & Critical Care Medicine)

Participating members of the UMC that don't have voting rights, ~~although~~ but present~~s~~ data, program outcomes and updates to policies ~~consists of~~include:

- Director, Utilization Management
- Director, Behavioral Health Integration
- Director, Quality Improvement
- Director, Pharmacy
- Sr. Manager, Utilization Management
- ~~UM Manager, Prior Authorization~~
- UM Manager, Inpatient Services

[1] Participating practitioners from the community are selected to be representative of the health care delivery system, and include primary care, high volume specialists and administrative practitioners. At least six outside practitioners are assigned to the committee to ensure that at least three are present each meeting as part of the quorum requirements.

~~B~~Benefit Management Subcommittee (BMSC)

The BMSC is a subcommittee of the UMC. The BMSC is chartered by the UMC ~~and directed~~ to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business. ~~,~~ The BMSC establishes a single source for the revisions and updates to CalOptima Health's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Medi-Cal Managed Care Division (MMCD), local and national coverage determinations, All Plan Letters (APLs) and the Medi-Cal Manual.

BMSC Scope

The BMSC is responsible for the following:

- Revising and updating CalOptima Health's authorization rules.~~,~~
- Making recommendations regarding the need for prior authorization for specific services.~~,~~
- Clarifying financial responsibility of the benefit, when needed.~~,~~
- Recommending benefit decisions to the UMC.
- Communicating benefit changes to staff responsible for implementation.

BMSC Voting Membership

The following individuals have voting privileges for BMSC:

- Medical Director who oversees UM services— Chairperson
- Medical Director who oversees Population Health and Equity
- Medical Director who oversees Behavioral Health
- Executive Director, Clinical Operations
- Executive Director, Behavioral Health Integration
- Director, UM (Alternate; Manager, Prior Authorization)
- Director, Behavioral Health Integration (Alternate: Sr Manager Behavioral Health Integration ~~Medical Director who oversees Behavioral Health~~)
- Director, Claims (Alternate: Manager, Claims/Coding Initiatives)
- Director, Pharmacy (Alternate: Manager, Clinical Pharmacist)

The BMSC meets quarterly, at a minimum, and reports recommendations ~~from the BMSC are reported~~ to the UMC on a quarterly basis.

UM Workgroup

The UM Workgroup is a sub-work-group under the UMC. The Workgroup meets bi-monthly and includes staff members from UM, CM, BHI, Medical Directors and Grievance and Appeals Resolution Services (GARS). Roles and responsibilities of this Workgroup include but are not limited to:

- ~~1.~~ Provide input to the development and processes of the UM Program.
- Provide input to key performance metrics, measures, and goals.
- Provide input and recommend criteria and protocols for approving new technology, treatment, and diagnostic procedures.
- Review, assess, and recommend internal utilization management best practices.
- Review outcome data, trend studies, and key performance indicators.
- Provide input on UM Department policies and procedures and desktop procedures.
- Identify opportunities to optimize UM processes.

The UM Workgroup reviews utilization data and analyzes patterns and outliers ~~for determining~~to inform decisions regarding what ~~which~~ item requires prior authorization and when prior authorization is no longer required. Data review includes but is not limited to:

- Review of services to determine medical necessity based on evidence-based guidelines and validation that the service(s) provides the best outcome for the member.
- Review of the frequency and variability of use of the service(s), evaluate if the service(s) are being used appropriately or in excess, and evaluate appropriate use of services to ensure member safety.
- Identification of~~y~~ services that are complex, experimental or require specialized training or to be performed in a specialized facility.
- Assess if prior authorization will ensure delivery of high quality of care and prevent complications or adverse outcomes.
- Consider alternative treatments.
- Ensure adherence to guidelines established by regulatory bodies and align prior authorization with industry standards to~~of like~~ CalOptima Health Managed Care Plans.
- Incorporate stakeholder feedback.
- Establish review frequency.

The goals of the UM Workgroup include~~s~~ but ~~is~~ are not limited to:

- Ensure regulatory and accreditation compliance is met.
- Provide ongoing review and input for current process improvement initiatives.

- Ensure policies and procedures are current and comply with new and modified regulatory initiatives.
- Ensure key performance indicators are met and/or process improvements are initiated when appropriate.

Additional Based on discussions at the UM Workgroup, other Sub Workgroups of the UM Workgroup include:were formed in 2024 and will continue in 2025

1. Bed Day Reduction Workgroup, named changed to High-Risk Management Workgroup
- Over/Under Utilization Workgroup
- Early and Periodic Screening Diagnosis Treatment (EPSDT) Workgroup
- Enhanced Case Management (ECM) Clinical Oversight Workgroup
- Skilled Nursing Facility (SNF) Workgroup

High-Risk Management Workgroup

The High-Risk Management Workgroup was is the(also known as Bed Day Reduction Workgroup) was established in 2023. In 2024 the name changed , and the workgroupit was combined with the UM Authorization Strategy Workgroup. The High-Risk Management Workgroup is a cross-departmental, clinical-leadMedical Director-lead work-group designed to evaluate utilization data. The workgroup is responsible for improving patient outcomes by implementingidentifying interventions to optimize utilization in the Emergency Department (ED), inpatient facilities and long-term care settings and improve patient outcomes. This The focus of the workgroup is to implement involves implementing clinical strategies to reduce unnecessary ED visits/hospitalizations, decrease the length of stay in acute care and long-term acute care facilities, and target high-risk members for preventative interventions.

Over/Underutilization Workgroup

CalOptima Health utilization monitoring is tracked by the Over/Under Utilization Workgroup consisting of representatives from the UM leadership team, enterprise analytics, Medical Directors and Ad-hoc participants who support clinical programs and operations. The workgroup monitors metrics, discusses analyzes performance, addresses identifies trends, contributes to the analysis and, and implements action plans for decreasing impacting over and underutilization. Actions and outcomes from this workgroup are that is reported up through the UMC.

Early and Periodic Screening Diagnosis Treatment (EPSDT) Workgroup

The EPSDT Workgroup brings together ~~representatives~~ representation from the Medical Directors, Case Management, Utilization Management, Behavioral Health Integration, Delegation Oversight, and Quality Analytics to address EPSDT services ~~to~~available to eligible Members under the age of 21. The EPSDT workgroup began in April 2024 and ~~covers all~~collaboratescontinues to monitor and ensure that members receive medically necessary EPSDT services as required by DHCS APL 23-005~~to ensure and monitor that members receive medically necessary EPSDT services as required by DHCS APL 23-005. es on how to enhance meeting requirements under EPSDT medically necessary services for members under age 21.~~

Enhanced Case Management (ECM) Clinical Oversight Workgroup

The purpose of the ECM Clinical Oversight Workgroup is to ~~establish~~ oversee and monitor protocols for clinical assurances for ~~ECM clinical oversight and monitoring process for~~ members enrolled in ECM. The goals of the workgroup are to ensure members are receiving appropriate clinical care and related social services and to support ECM providers serving members.

ECM Workgroup is composed of CalAIM Executive Director, CalAIM Directors, CalAIM Medical Director, Behavioral Health Medical Director, Clinical Operations Executive Director, Sr. Director (Clinical Operations), Behavioral Health Integration Executive Director, and Project Manager.

Skilled Nursing Facility (SNF) Workgroup

The Skilled Nursing Facility (SNF) Workgroup was established in 2025~~. The purpose of the SNF Workgroup is~~ to enhance the concurrent review process--including the appeal process, for skilled nursing facility inpatient stays. The SNF Workgroup ~~including the appeal process and~~ ensures staff ~~cross training~~are cross trained for concurrent review coverage of inpatient cases.

Integration of Utilization Management ~~with the~~ and Quality ~~I Program~~ Management

Programmatic Integration and Cross-Functional Synergy: The Utilization ~~M~~management (UM) and Case Management (CM) Integrated ~~P~~Program operates ~~ed~~ as a unified framework, ensuring seamless continuity across Behavioral Health (BH), Long-Term Services and Supports (LTSS), and Pharmacy and Therapeutics (P&T). This holistic structure is closely linked with Credentialing, Compliance, and Delegation Oversight to maintain a rigorous "Triple Aim" approach to care delivery. By aligning these specialized areas, CalOptima Health ensures that clinical decisions are not ~~siloed~~ made in a ~~but~~silo but are instead informed by a comprehensive view of the member's medical, behavioral, and social needs. The UM CM Integrated Program is annually evaluated and submitted for review and approval ~~annually~~ by the Utilization Management ~~C~~committee (UMC), Quality Improvement Health Equity Committee (QIHEC) and Quality Assurance ~~C~~committee (QAC). A~~, with~~ final review and approval is made by the Board of Directors.

Quality Indicators and Patient Safety Integration: CalOptima Health's UM review process is anchored in evidence-based quality indicators prescribed by the CalOptima Health Patient Safety Plan. As medical case managers conduct UM functions, they actively surveil, identify and document potential safety events or care gaps using ~~standardized~~formalized reporting tools. These findings are forwarded to the Quality Improvement (QI) Department for formal review and resolution, facilitating a **Continuous Quality Improvement (CQI)** loop.

- Bidirectional Data Exchange: CalOptima Health emphasizes the bidirectional flow of information between UM and QI to identify trends in hospital readmissions, medication adherence, and preventive screening opportunities.
- HEDIS Alignment: Quality indicators are specifically selected to align with HEDIS measures, such as Transitions of Care and Follow-Up After Emergency Department Visits.
- Regulatory & Delegation Oversight: CalOptima Health's Delegation Oversight team conducts quarterly audits to ensure that all delegated entities adhere to these integrated standards, maintaining the integrity of clinical data and the safety of members.
- Outcome-Driven Care Delivery: As a result of this integration, the utilization of services is directly correlated with clinical quality and member outcomes. By leveraging data from UM and CM encounters, the QI Department can implement targeted interventions that reduce avoidable complications and improve the overall efficacy of the healthcare delivery system.

Paradigms of the outcome-driven care delivery include:

- The UM Program is evaluated, revised and prepared for approval by the UM and Behavioral Health (BHI) Director in conjunction with the Executive Director of Clinical Services, Executive Director of Behavioral Health Integration, Chief Medical Officer, and Deputy Chief Medical Director prior to submission for committee review and approval.
- Utilization data including, but not limited to, denials, unused authorizations, bed day utilization data, ED utilization data, provider preventable conditions, and trends representing potential over or underutilization, is collected, aggregated and analyzed.
- UM staff may identify potential quality issues and/or provider preventable conditions during utilization of review activities. These issues are referred to the QI staff for evaluation.
- The UMC is a subcommittee of the QIHEC and routinely reports activities to the QIHEC.
- The QIHEC reports to the Board of Directors QAC.

Integration with Other Processes

The UM CM Integrated Program, BH Program, LTSS Program, P&T, QI, Credentialing, ~~Compliance~~ Compliance, ~~-~~and Delegation ~~Audit &~~ Oversight are closely linked in function and process. The UM process uses quality indicators as a part of the review process and provides the results to the QI Department. As case managers perform the functions of UM, quality indicators, prescribed by CalOptima Health as part of the patient safety plan, are identified. The required information is documented in the appropriate form and forwarded to the QI Department for review and resolution. As a result, utilization of services is interrelated with the quality and outcome of the services.

Any adverse information that is gathered through interaction between UM staff and the practitioner or facility staff is ~~also~~ vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of non-covered benefits~~, etc.~~. The information is forwarded to the QI Department in the format prescribed by CalOptima Health for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima Health's Credentialing and Peer Review Committee (CPRC). If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes also serve as integral components in preventing, detecting and responding to Fraud and Abuse among practitioners and members. The UM Department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues

that may be identified. In addition, CalOptima Health coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Health Check
- Services provided by local public health departments

Review and Authorization of Services

Medical Necessity Review

Medical necessity review requires consideration of the members' clinical needs, evaluation of available services within the local delivery system and application of evidenced based guidelines and CalOptima Health policies to provide quality care in the most appropriate setting.

Covered services are those medically necessary health care services provided to members as outlined in CalOptima Health's contract with CMS and the State of California for Medi-Cal and OneCare. Medically necessary means all covered services or supplies are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Medicare, covered services that are reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C section 1395y.

Medical necessity for members receiving MLTSS is determined by using a member's current needs assessment and is consistent with person-centered planning.

CalOptima Health UM processes consist of ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure quality medically necessary services are provided in the most appropriate setting. Appropriate to the situation, physicians, pharmacists or psychologists review and determine all final denial or modification decisions for requested medical and BH care services. The review of the denial of a pharmacy prior authorization is completed by a qualified physician or pharmacist.

Back to Agenda Back to Item

CalOptima Health's UM Department is responsible for the review and authorization of health care services for CalOptima Health Direct Administrative (COD-A) and CCN members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services
- Continuity of care review
- Admission review
- Post-stabilization review
- Concurrent/Continued stay review for selected conditions
- Discharge Planning review
- Retrospective review
- Evaluation for potential transplant services for HN members

The following standards and considerations are applied when reviewing prior authorizations, inpatient concurrent review, and retrospective review requests:

1. Evidence-based clinical criteria or guidelines are applied consistently and regularly reviewed and updated.
- Member circumstances and characteristics are considered when applying criteria to address the individual needs of the member. These characteristics include, but are not limited to: please indent all characteristics below
    - Age
    - Co-morbidities
    - Complications
    - Progress of treatment
    - Psychological/Psychosocial situation
    - Home environment, when applicable
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. If member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action.
- Clinical rationale and reasons for decisions are clearly documented in the medical management system, including the criteria used to make the determination.
- The Medical Director may be contacted by calling their direct dial number listed at the bottom of the provider denial notification or through contacting the UM Department

during the review process. A CalOptima Health Case Manager may also coordinate communication between the CalOptima Health Medical Director and requesting practitioner. All peer-to-peer discussions are documented within the CalOptima Health clinical documentation platform.

- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency timeframes, and members and providers are notified of appeals and grievance procedures.
- Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima Health's Grievance and Appeals Resolution Services (GARS) process, and as the member's condition requires.
- Medical conditions requiring time sensitive services are reviewed in accordance with the appropriate CalOptima Health Policy and Procedure.
- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing.
- Records, including documentation of an oral notification or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law.
- The requesting provider may be notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request.
- Medi-Cal members are notified in writing of any decision to deny, modify, or delay a service.
- OneCare members are notified in writing of ~~any and all~~all determinations.
- All providers are encouraged to request information regarding the criteria used in making ~~a clinical~~clinical determination. Contact can be made directly with the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action or UM Coverage letter. A provider may request a discussion with the Medical Director (Peer-to-Peer), or a copy of the specific criteria utilized.

Supporting documents used to make medical necessity determinations may include, but are not limited to:

- Office and hospital records
- A documented history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history

- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- Evidenced based criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics, circumstances and information
- Information from responsible family members

The data collection process shall not be burdensome to the member and provider.

The UMC and BMSC reviews the Prior Authorization List regularly, in conjunction with CalOptima Health's CMO, Medical Directors and Executive Director of Clinical Operations and UM Management, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management areas are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima Health program requirements, and/or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications are made.

Prior Authorization

Prior Authorization requires the provider or practitioner to submit a formal Authorization Request Form (ARF) medical necessity determination request, and all relevant clinical information related to the request to CalOptima Health prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior Authorization is required for selected services, such as non-emergency inpatient admissions, elective out-of-network services, certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization Required List located in the provider section on the CalOptima Health website at www.caloptima.org. Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process, which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima Health's medical management system is a member-centric system utilizing evidence-based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social, and personal care needs of members supporting the identification of cultural diversity and complex care needs.

The CalOptima Health Provider Portal allows for non-urgent and urgent online authorizations to be submitted by providers and processed electronically. The provider portal functionality includes referral intelligence rules, approved by clinical leadership to auto-adjudicate when criteria are met. The referral intelligence rules, and auto-adjudication trends are reviewed quarterly at a minimum to identify potential misuse or utilization issues that require follow up. Practitioners may also submit referrals and requests to the UM Department by mail, fax and/or telephone.

Second Opinions

A second opinion may be requested when there is a question concerning the diagnosis, options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, member representative, parent and/or guardian. A social worker exercising custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of-network practitioner if there is no in-network practitioner available.

Extended Specialist Services

Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, CalOptima Health provides guidance on how members with life-threatening conditions or diseases that require specialized medical care over a prolonged period can request and obtain access to specialists and specialty care centers.

Out-of-Network Providers

The decision to authorize use of an out-of-network provider is based on ~~a number of~~several factors including, but not limited to, continuity of care, availability and location of an in-network provider of the same specialty and expertise, and lack of an in-network provider with the specialty and expertise.

Appropriate Professionals for UM Decision Process

An ~~A~~appropriately licensed health care professional supervises all medical necessity review decisions. The UM decision process requires that qualified; licensed health professionals assess

the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the UM Nurse Case Managers (NCM) or BH Medical Case Manager ~~-~~forwards the request to the appropriate qualified, licensed health practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial, modification, reduction, or termination of services based on medical necessity. All practitioners or pharmacists rendering decisions must have education, training, and professional experience in medical or clinical practice, and must have a current unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima Health distributes an ~~affirmative~~ affirmation statement about incentives to members in the Member Handbook, annually to all members in the Annual Notices Newsletter, and at least annually to all practitioners and employees who make UM decisions. The affirmation statement~~,~~ ~~affirming~~ affirms that UM decision making is based only on appropriateness of care and services and existence of coverage and that CalOptima Health does not specifically reward practitioners or other individuals for issuing denials of coverage. CalOptima Health ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

Pharmaceutical Management

Pharmac~~y~~eutical Management is overseen by the CMO~~,~~ and ~~CalOptima Health's~~the Director, Clinical Pharmacy Management for CalOptima Health. All policies and procedures utilized by CalOptima Health related to pharmaceutical management include the criteria used to adopt the procedure, as well as a process that uses clinical evidence from appropriate external organizations. The pharmaceutical management program is reviewed at least annually by P&T and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and are made available to practitioners via the provider newsletter and/or CalOptima Health website.

The P&T Committee is responsible for the development of the Medi-Cal physician-administered drug prior authorization list and the OneCare Formulary, which is based on sound clinical evidence, and is reviewed at least annually by practicing practitioners and pharmacists. Updates to the Formulary are communicated to both members and providers.

~~Pharmacy Determinations Medi-Cal Effective~~Since January 1, 2022, pharmacy determinations for the Medi-Cal outpatient pharmacy benefit moved to the Medi-Cal fee-for-service program, Medi-Cal Rx.

Medicare

CalOptima Health does not delegate OneCare Pharmacy UM responsibilities. Pharmacy coverage determinations follow required CMS timeliness guidelines and medical necessity review criteria.

Pharmacy Benefit Manager (PBM)

The PBM is responsible for some pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, pharmacy help desk, clinical services and quality improvement functions. The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity, the PBM is monitored according to the Audit & Oversight department's policies and procedures.

Behavioral Health Determinations

Medi-Cal

CalOptima Health's BHI department performs prior authorization review for Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) services and ~~t~~transcranial ~~m~~magnetic ~~s~~stimulation (TMS). ~~and psychological testing.~~ Prior authorization requests are reviewed by BH ~~UM staff that consist of~~ Medical Case Managers ~~and Care Managers (BCBA)~~. All determinations are based on CalOptima UM hierarchical criteria.

Medicare

CalOptima Health's BHI department performs prior authorization review functions for One-Care covered BH services. Services requiring~~e~~ prior authorization include inpatient psychiatric care, partial hospitalization program, intensive outpatient program, ~~psychological testing,~~ opioid treatment program electro convulsive therapy (ECT), and transcranial magnetic stimulation (TMS). Prior authorization requests are reviewed by BH Medical Case Managers.

- ~~The BH UM staff may approve or defer for additional information, but final determinations of modification, denial, or appeal may be made by a Medical Director or a qualified health care profession with appropriate clinical expertise in treating the behavioral health condition. CalOptima Health's written notification of BH modifications and denials to members and their treating practitioners contains:~~
- ~~A description of appeal rights, including the member's right to submit written comments, documents, or other information relevant to the appeal.~~

- ~~An explanation of the appeal process, including the appeal timeframes and the member's right to representation.~~
- ~~A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.~~
- ~~Notification that expedited external review can occur concurrently with the internal appeal process for urgent care.~~

~~CalOptima Health gives practitioners the opportunity to discuss BH UM denial decisions.~~

UM Hierarchical Criteria

CalOptima Health conducts Utilization Review using UM hierarchical criteria for medical, BH, and pharmacy medical necessity decisions that are objective, nationally recognized, evidence-based standards of care and include input from recognized experts in the development, adoption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Clinical guideline criteria are published on the CalOptima Health website to be accessible and available for members, providers, and the public upon request. Such criteria and guidelines include, but are not limited to:

Medi-Cal

- Medi-Cal Provider Manual and Department of Health Care Services (DHCS) All Plan Letter's (APL)
- ~~a. National Correct Coding Initiative (NCCI) Policy Manual~~
- CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook
-
-
- Milliman Care Guidelines (MCG) ~~Care Guidelines~~
- Drug Compendia Micromedex
- ~~1.~~ DrugDex and American Hospital Formulary Service Drug Information (AHFS-DI)
-
- ~~1.~~ Peer-Reviewed Medical Literature
-
- ~~1.~~ National Comprehensive Cancer Network Guidelines (NCCN)
-
- ~~b.~~ Other: Medical Societies, National Guidelines, and other Authoritative Publications:
- ~~a.~~ Hayes Criteria
- ~~b.~~ World Professional Association for Transgender Health (WPATH)

c. U.S. Food and Drug Administration (FDA)
d. Centers for Disease Control and Prevention (CDC)
e. American Board of Medical Specialties
f. Up To Date
g. Optum 2023 Current Procedural Coding Expert (Encoder Pro)
h. Preventive Health Guidelines (e.gl, U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG) Guidelines
- National Guideline Clearinghouse, and
i. National Correct Coding Initiative (NCCI) Policy Manual

Medicare (OneCare)

1. CMS National Coverage Determinations (NCD), including NCD with Coverage Evidence Development (CED),
a. CMS Local Coverage Determination (LCD) (Noridian Local Contractor for California)
b. CMS Local Coverage Article (LCA)
c. CMS Manuals (Medicare Benefit Policy Manual, Medicare National (NCD) Manual, Medicare Claims Processing Manual, etc.)
d. National Correct Coding Initiative (NCCI) Policy Manual
e. CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook
f. Drug Compendia: Micromedex, DrugDex, American Hospital Formulary Service-Drug Information (AHFS-DI), Clinical Pharmacology
g. National Comprehensive Cancer Network Guidelines (NCCN) Drugs and Biologics Compendium, Lexi Drugs, National Comprehensive Cancer Network® (NCCN) Drugs and Biologics Compendium, Lexi-Drugs;
- Internal criteria, such as:
h. MCG Care Guidelines
- CMS LCD/LCA (Non-California)
1. Department of Health Care Services (DHCS) Treatment Authorization Review (TAR) Requirement
-
-
Medi-Cal Provider Manual, and Department of Health Care Services (DCHS) All Plan Letters (APL), and
1. Other: Medical Societies, National Guidelines, and other Authoritative Publications:
a. Hayes Criteria

b. World Professional Association for Transgender Health (WPATH)
c. U.S. Food and Drug Administration (FDA)
d. Centers for Disease Control and Prevention (CDC)
e. American Board of Medical Specialties
f. Up To Date
g. Optum 2023 Current Procedural Coding Expert (Encoder Pro)
h. Preventive Health Guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG) Guidelines
- National Guideline Clearinghouse
i. National Comprehensive Cancer Network (NCCN) Guidelines

Whole Child Model (WCM)

1. California Children Services (CCS) Numbered Letters and CCS Information Notices
a. Medi-Cal Provider Manual and DHCS APLs
b. National Correct Coding Initiative (NCCI) Policy Manual
2. CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook
c. MCG Care Guidelines
d. Drug Compendia: Micromedex, DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology
e. National Comprehensive Cancer Network Guidelines (NCCN)
f. Other: Medical Societies, National Guidelines, and other Authoritative Publications:
a. Hayes Criteria
b. World Professional Association for Transgender Health (WPATH)
c. U.S. Food and Drug Administration (FDA)
d. Centers for Disease Control and Prevention (CDC)
e. American Board of Medical Specialties
f. Up To Date
g. Optum 2023 Current Procedural Coding Expert (Encoder Pro)
h. Preventive Health Guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG) Guidelines
- National Guideline Clearinghouse
- National Correct Coding Initiative (NCCI) Policy Manual

~~Covered California (Effective 01/01/2027)~~

Due to the dynamic state of medical/health care practices, each medical decision must be case-specific, and based on current medical knowledge and practice, regardless of available practice guidelines, as well as based on the member's individual needs. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

Clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology) are used in conjunction with national guideline criteria in review for medical necessity. Additional guidelines may include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, World Professional Association for Transgender Health (WPATH), Lead Screening, Immunizations, and ADHD/ADD guidelines for both adults and children.

Board Certified Clinical Consultants

In some cases, such as for authorization of a specific procedure or service, BH, or certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty or qualified BH professionals as determined by the Medical Director, for additional or clarifying information when making medical necessity determinations or denial decisions. ~~the Medical Director may consult with a board-certified physician from the appropriate specialty or qualified BH professionals as determined by the Medical Director, for additional or clarifying information when making medical necessity determinations or denial decisions.~~ Clinical experts outside of CalOptima Health may be contacted, when necessary to avoid a conflict of interest~~. CalOptima Health defines conflict of interest to~~, as defined by CalOptima Health to include situations in which the practitioner who would normally advise on an UM decision made the original request for authorization or determination, ~~or is in,~~ or is affiliated with~~,~~ the same practice group as the practitioner who made the original request or determination.

Practitioner and Member Access to Criteria

At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting the UM Department or may discuss the UM decision with CalOptima Health's Medical Director per the peer-to-peer process. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that

contains critical information about how and when to interact with the UM Department. The manual also outlines CalOptima Health's UM policies and procedures. On an annual basis, all contracted hospitals receive an in-service to review all required provider trainings, including operational and clinical information such as UM timeliness of decisions. In addition, Provider Relations also provides any related policies regarding UM timeliness of decisions, as needed. Similar information is found in the Member Handbook and clinical criteria is located on the CalOptima Health website at www.CalOptimaHealth.org.

Inter-Rater Reliability (IRR)

At least annually, the UM Managers evaluate the consistency with which Medical Directors and other clinical staff involved in UM apply UM criteria in decision-making. If an opportunity for improvement is identified through this process, UM and Medical Director leadership take corrective action(s). Newly hired UM staff are required to successfully complete IRR testing prior to being released from training oversight. IRR results are reported to the UMC and QIHEC on an annual basis and any actions taken for performance below the established benchmark of 90% are discussed and recommendations taken from UMC.

Provider and Member Communication

Members and practitioners can access UM staff at least eight hours a day during normal business hours for inbound collect or toll-free calls at (888) 587-8088 or outbound calls regarding UM issues or questions about the UM process. TTY services for deaf, hard of hearing or speech impaired members are available toll free at 711. These phone numbers are included in the Member Handbook, on the CalOptima Health website, and in all member letters and materials. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services. Except as otherwise provided below, communications received after normal business hours are returned the next business day and communications received after midnight on Monday–Friday are responded to on the same business day. CalOptima Health has Medical Director and UM coverage 24 hours a day, 7 days a week through after-hours answering services.

Inbound and outbound communications include directly speaking with practitioners and members, fax correspondence, electronic or telephonic communications (e.g., sending email messages or leaving voicemail messages). Staff identify themselves by name, title, and CalOptima Health UM ~~A~~ Department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM Department are automatically routed to an ~~on-call~~on call contracted vendor. The vendor is not a delegated UM entity and therefore does not make authorization decisions. Vendor staff take authorization information and share the information with CalOptima Health staff for follow-up and response ~~for~~ the next business day ~~response by CalOptima Health~~. In cases requiring immediate response, vendor staff

~~notifies~~ contact the CalOptima Health on-call nurse. CalOptima Health will review and process authorizations outside business hours, as necessary, including decisions to approve, deny or modify authorization requests which are made by CalOptima Health on-call UM Medical Director. A log is shared daily identifying activity and follow-up needed the following day.

Access to Physician Reviewer

The CalOptima Health Medical Director or appropriate practitioner reviewer (BH and clinical pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation, and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Health Medical Director who made a denied determination may be contacted by calling their direct number listed at the bottom of the provider denial notification or through contacting the UM Department. A CalOptima Health Case Manager may also coordinate communication between the Medical Director and requesting practitioner. All peer-to-peer discussions are documented within the clinical documentation platform

UM Staff Access to Clinical Expertise

The CMO and Medical Directors have the authority, accountability, and responsibility for denial determinations and follow sound clinical and professional judgment. Contracted HNs that are delegated for UM responsibilities utilize a Medical Director, or designee, as the sole authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

Requesting Copies of Medical Records

During prospective, retrospective, inpatient and concurrent review requests, copies of medical records are required to validate medical necessity for the requested service. In those cases, only the necessary or pertinent sections of the record are required to determine medical necessity and appropriateness of the services requested. Medical records may also be requested to complete an investigation of a member grievance, appeal, or when a potential quality of care issue is identified through the UM process Confidentiality of information necessary to conduct UM activities is maintained at all times.

Sharing Information

CalOptima Health's UM staff share all clinical and demographic information on individual patients among various areas of the agency (e.g., discharge planning, case management, ECH, health education, etc.) to avoid duplicate requests for information from members or practitioners. Pertinent medical records are stored in a single system which services as the source of truth for decision making.

Provider Communication to Member

CalOptima Health's UM Program does not prohibit or restrict health care professionals from acting within the lawful scope of practice or advising or advocating on behalf of a member including but not limited to the following:

- The member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs ~~in order to~~to decide among all relevant treatment options.
- The risks, benefits and consequences of treatment or absence of treatment.
- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Timeliness of UM Decisions

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for providers to notify CalOptima Health of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner. These turnaround time requirements are dictated by regulatory bodies such as DHCS, CMS, and NCQA.

UM Decision and Notification Timelines

~~UM Decision and Notification Timelines~~

Back to Agenda Back to Item

Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification (May be Electronic or Written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Routine (Non-urgent) Pre-Service Prospective or outpatient service requests. All necessary information is received at time of initial request.	Approve, Modify, or Deny as expeditiously as the member's health condition requires not to exceed 5 business days from receipt of the information reasonably necessary to render a decision, and no longer than 7 calendar days from date of receipt of the request.	**Practitioner: Electronic/Written** Within 24 hours of making the Decision, not to exceed 7 calendar days from date of receipt of the request.	**Practitioner: Electronic /Written** Within 24 hours of making the decision, not to exceed 7 calendar days from date of receipt of the request. **Member: Written** Within 2 business days of the decision not to exceed 7calendar days from date of receipt of the request.
Routine (Non-urgent) Pre-Service – Extension Needed • Additional clinical information required. • Require consultation by an Expert Reviewer. • Additional examination or tests to be performed.	Approve, Modify, or Deny within 5 business days from receipt of the information reasonably necessary to render a decision, and no longer than 14 calendar days from the receipt of the request. • The decision may be delayed /deferred, and the time limit extended an additional 14 calendar days from the Medical Director pend request, only where the member or member's provider requests an extension, or CalOptima Health can provide justification upon request by the State for the need for additional information and how it is in the member's interest. **Additional Clinical Information required:** The decision may be deferred, and the time limit extended an additional 7 calendar days when a member or provider requests the extension, or CalOptima Health justifies a need for additional information and can demonstrate how the extension is in the member's best interest. There is reasonable likelihood that receipt of such information would lead to approval of the request.	**Practitioner: Electronic/Written** Written notice of "Delay" must be sent within 24 hours of making the decision to delay, not to exceed 7 calendar days from the date of receipt of initial request for services. **Member: Written** Written notice of "Delay" must be sent within 2 business days of making the decision to delay, not to exceed 14 calendar days from receipt the date of the initial request for services. **Letters Must Include:** • The additional information needed to render the decision, • The type of expert reviewer and/or the additional examinations or tests required, • The anticipated date on which a decision will be rendered.	**Practitioner: Electronic/Written** Written notice of "Delay" must be sent within 24 hours of making the decision to delay, not to exceed 7 calendar days from the date of receipt of the initial request for services. **Member: Written** Written notice of "Delay" must be sent within 2 business days of making the decision to delay, not to exceed 14 calendar days from the date of receipt of the initial request for services. **Letters Must Include:** • The additional information needed to render the decision, • The type of expert reviewer and/or the additional examinations or tests required, • The anticipated date on which a decision will be rendered.
	Additional information received If requested information is received, the decision must be made within 5 business days of date of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service. **Additional information incomplete or not received** If the Provider does not comply with the request for additional information the decision must be made no later than 28 calendar days from the date of receipt of the initial request with the information that is available.	**Practitioner:** Within 24 hours of making the Decision, not to exceed 28 calendar days from the date of receipt of the request.	**Practitioner: Electronic/Written** Within 24 hours of making the decision, not to exceed 28 calendar days from the date of receipt of the request. **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the date of receipt of the request for service.

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https://www.calhr.ca.gov/employees/pages/state-holidays.aspx

Back to Agenda Back to Item

Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification (May be Electronic or Written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Routine (Non-urgent) **Pre- Service** Prior Authorization / Prospective or outpatient service requests.	Approve, Modify, or Deny within 5 business days from receipt of the information reasonably necessary to render a decision, and no longer than 14 calendar days from receipt of the request.	**Practitioner: Electronic** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Notice must be postmarked within 2 business days of decision not to exceed 14 calendar days from receipt of the request.
Routine (Non-urgent) **Pre- Service – Extension Needed** • Additional clinical information required. • Require consultation by an Expert Reviewer. • Additional examination or tests to be performed.	Approve, Modify, or Deny within 5 business days from receipt of the information reasonably necessary to render a decision, and no longer than 14 calendar days from the receipt of the request. • The decision may be delayed /deferred, and the time limit extended an additional 14 calendar days from the Medical Director pend request, only where the member or member's provider requests an extension, or CalOptima Health can provide justification upon request by the State for the need for additional information and how it is in the member's interest. • CalOptima Health will notify the member and practitioner of the decision to delay / defer, in writing, within 5 14 calendar days from the receipt of initial request. • Notice of delay / deferral should include the additional information needed to render the decision, the type of expert reviewer and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered.	**Practitioner: Electronic** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the receipt of the request for service. **Practitioner/Member: Written** Notice of Action "Delay" notification within 14 calendar days from the receipt of the initial request.
	Additional information received If requested information is received, decision must be made within 5 business days of receipt of information, not to exceed 28 calendar days from the date of initial receipt of the request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from initial receipt of the request.

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Back to Agenda Back to Item

Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification (May be Electronic or Written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Expedited Authorization (Pre-Service) • Provider or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. • All necessary information received at time of initial request.	Approve, Deny, or Modify within 72 hours from receipt of the request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision, not to extend 3 business days from the receipt of the request for service
Expedited Authorization (Pre-Service) - Extension Needed • A request is extended when the member or provider requests the extension, or CalOptima Health justifies a need for additional information and can demonstrate how the extension is in the member's best interest. There is reasonable likelihood that receipt of such information would lead to approval of the request.	Approve, Deny, or Modify within 72 hours from receipt of the request **Additional clinical information required:** Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify the practitioner and member using the "Delay" written notification, and insert specifics about what has not been received,, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered. **Note:** The time limit may be extended by up to 14 calendar days if the member requests an extension, or CalOptima Health can provide justification upon request by the State for the need for additional information and how it is in the member's interest.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision, not to extend 3 business days from the receipt of the request for service
	Additional information received • If requested information is received, decision must be made within 1 business day of receipt of information.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision
	Additional information incomplete or not received •Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.

Back to Agenda Back to Item

Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification (May be Electronic or Written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Expedited Authorization (Pre-Service) Provider or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain maintain or regain maximum function. All necessary information received at time of initial request.	**Approve, Deny, or Modify** as expeditiously as the Member's health condition requires not to exceed 72 hours from the date and time of receipt of the request.	**Practitioner: Electronic/Written** Within 24 hours of making the decision not to exceed 72 hours from the date and time of receipt of request.	**Practitioner: Electronic/Written** Within 24 hours of making the decision not to exceed 72 hours from the date and time of receipt of request. **Member: Written** Within 2 business days of making the decision, not to exceed 72 hours of receipt of request.
Expedited Authorization (Pre-Service) - Extension Needed • Additional clinical information required. • Require consultation by an Expert reviewer. • Additional examination or tests to be performed.	**Additional Clinical Information required:** The decision may be deferred, and the time limit extended an additional 14 calendar days when a Member or Provider requests the extension, or CalOptima Health justifies a need for additional information and can demonstrate how the extension is in the Member's best interest. There is reasonable likelihood that receipt of such information would lead to approval of the request.	**Practitioner: Electronic/Written** Written notice of "Delay" must be sent within 24 hours of the decision to delay not to exceed 72 hours after MCPs receipt of initial request for services. **Member: Written** Written notice of "Delay" must be sent within 2 business days of making the decision to delay, not to exceed 72 hours from receipt of the initial request for services. **Letters Must Include:** • The additional information needed to render the decision, • The type of expert reviewer and/or the additional examinations or tests required, • The anticipated date on which a decision will be rendered.	**Practitioner: Electronic/Written** Written notice of "Delay" must be sent within 24 hours of the decision to delay, not to exceed 72 hours after receipt of the initial request for services. **Member: Written** Written notice of "Delay" must be sent within 2 business days of making the decision to delay not to exceed 72 hours from receipt of the initial request for services. **Letters Must Include:** • The additional information needed to render the decision, • The type of expert reviewer and/or the additional examinations or tests required, • The anticipated date on which a decision will be rendered.
	Additional information received If requested information is received, decision must be made within 1 business day of the date receipt of information not to exceed 17 calendar days from the date of receipt of the request for services. **Additional information incomplete or not received** If the Provider does not comply with the request for additional information, the decision must be made no later than 17 calendar days from the date of receipt of the initial request with the information that is available.	**Practitioner: Electronic/Written** Within 24 hours of making the decision not to exceed 17 calendar days from the date of receipt of request.	**Practitioner: Electronic/Written** Within 24 hours of making the decision not to exceed 17 calendar days from the date of receipt of the request. **Member: Written** Within 2 business days of making the decision, not to exceed 17 calendar days from the date of receipt of the request for service.

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https://www.calhr.ca.gov/employees/pages/state-holidays.aspx

Back to Agenda Back to Item

Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Initial Notification (May be Electronic or Written)	Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member
Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	Approve, Modify, or Deny within 72 hours of receipt of the request. **Extension:** CalOptima Health may extend the time frame, by up to 14 calendar days, under the following conditions: Additional supporting clinical information is needed.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision
Concurrent (Inpatient) Concurrent review of inpatient treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	Approve, Modify, or Deny within 72 hours of last approved day or decision consistent with urgency of member's medical condition. **Extension:** CalOptima Health may extend the timeframe 48 hours or up to 14 calendar days under the following conditions: •Additional supporting clinical information is needed.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic or Oral** Within 24 hours of receipt of the request. **Member: Written** Written notification within 2 business days of decision. **Note:** If oral notification is given within 24 hours of request, then written/electronic notification must be given no later than 2 business days after the oral notification.
Post-Service / Retrospective Review All necessary information received at time of request (decision and notification is required within 30 calendar days from request).	Within 30 calendar days from receipt of request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 30 calendar days of receipt of the request. **Member: Written** Within 30 calendar days of receipt of request.
Hospice - Inpatient Care	Within 24 hours of receipt of request.	**Practitioner:** Within 24 hours of making the decision.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.

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https://www.ftb.ca.gov/aboutftb/holidays.shtml

Back to Agenda Back to Item

Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Initial Notification PRACTITIONER APPROVALS (Notification May Be Electronic/Written)	Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member
Concurrent & Urgent Concurrent (Inpatient) • Provider or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services). Care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the patient. All necessary information is received at the time of the initial request.	Approve, Deny, or Modify the admission as expeditiously as the member's health condition requires, not to exceed 72 hours from receipt of the request.	**Practitioner: Electronic/Written Notification** must be provided to the treating provider within 24 hours of making the final decision, not to exceed 72 hours from the discharge (This is not a regulatory requirement- it is contract based)	**Practitioner: Electronic/Written** Notification must be provided to the treating provider within 24 hours of making the final decision not to exceed 72 hours from the discharge. **Member: Written** For denials and modifications only: Within 2 business days of making the decision not to exceed 72 hours
Concurrent & Urgent Concurrent (Inpatient) - Extension Needed • Additional clinical information required. • Require consultation by an Expert Reviewer. • Additional examination or tests to be performed. Care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	**Additional Clinical Information required:** The decision may be deferred, and the time limit extended an additional 14 calendar days when a member or provider requests the extension, or CalOptima Health justifies a need for additional information and can demonstrate how the extension is in the member's best interest. There is reasonable likelihood that receipt of such information would lead to an approval of the request.	**Practitioner: Electronic/Written** Written notice of "Delay" must be sent within 24 hours of the decision the delay not to exceed 72 hours of receipt of the initial request for services. **Member: Written** Written notice of "Delay" must be sent within 2 business days of making the decision to delay, not to exceed 72 hours from receipt of the initial request for services. **Letters Must Include:** • The additional information needed to render the decision, • The type of expert reviewer and/or the additional examinations or tests required, • The anticipated date on which a decision will be rendered.	**Practitioner: Electronic/Written** Written notice of "Request for Clinical Review" must be sent within 24 hours of the decision to extend, not to exceed 72 hours of receipt of the initial request for services. **Member: Written** (This process does not apply to the member for IP/ concurrent review) **Letters Must Include:** • The additional information needed to render the decision, • The type of expert reviewer and/or the additional examinations or tests required, • The anticipated date on which a decision will be rendered.

Back to Agenda Back to Item

	Additional information received: If requested information is received, decision must be made within 1 business day of receipt of the information not to exceed 17 calendar days from the date of receipt of the request for services. **Additional information incomplete or not received** If the provider does not comply with the request for additional information the decision must be made no later than 17 calendar days from receipt of the initial request with the information that is available.	**Practitioner: Electronic/Written** Notification must be provided to the treating provider within 24 hours of making the decision not to exceed 17 calendar days from receipt of the request.	**Member: Written** For Denials and Modifications only: Within 2 business days of making the decision, not to exceed 17 calendar daysof receipt of the request.

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Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification PRACTITIONER APPROVALS (Notification May Be Electronic/Written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Retrospective Review (Post-Service)	Within 30 calendar days from receipt of the request.	**Practitioner: Electronic/Written** Within 24 hours of making the decision not to exceed 30 calendar days from receipt of the request.	**Practitioner: Electronic/Written** Within 24 hours of making the decision not to exceed 30 calendar days from receipt of the request. **Member: Written** Within 30 calendar days of receipt of request.
Hospice (Inpatient Care)	Within 24 hours of receipt of the request.	**Practitioner: Electronic/Written** Within 24 hours of receipt of the request.	**Practitioner: Electronic/Written** Within 24 hours of receipt of the request. **Member: Written** Within 24 hours of receipt of the request.

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https://www.calhr.ca.gov/employees/pages/state-holidays.aspx

Back to Agenda Back to Item

Attachment B
TIMEFRAMES FOR ONECARE DECISIONS AND NOTIFICATIONS

OneCare Decision and Notification Timelines		
Type of Request	**Decision**	**Notification Timeframe**
Standard Integrated Organization Determinations Prior Authorization / Prospective or outpatient service requests.	Approve, Modify or Deny no later than 14 calendar days from receipt of request. **Extensions: CalOptima Health may not extend deadlines for Integrated Organization Determinations.**	**Practitioner:** Decision: Electronic or Written Within 24 hours of making the decision. **Practitioner/Member: Written** Within 2 business days of decision. **Issue the Coverage Decision Notice for written notification of denial decision.**
Standard Integrated Organization Determinations Prior Authorization / Prospective or outpatient service requests. Expedited Integrated Organization Determinations Prior Authorization / Prospective or outpatient service requests.	Approve, Modify or Deny expeditiously but no later than 72 hours from receipt of the request CalOptima Health must request the necessary information from the noncontracted provider within 24 hours of the receipt request. **Extensions: CalOptima Health may not extend the deadlines for Integrated Organization Determinations.**	**Practitioner:** **Decision: Electronic or Oral Notification** Within 24 hours of making the decision. **Member: Oral** Within 24 hours of determination. **Practitioner/Member: Written** Within 2 business days of making the decision. When oral notification is given, it must be followed by written notification within 3 calendar days of the oral notification.
Expedited Authorization (Pre-Service) **If Expedited Criteria are not met**	If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: • Automatically transfer the request to the standard timeframe. The 14 calendar day period begins with the day the request was received for an expedited determination.	If request is not deemed to be expedited, CalOptima Health must notify member (within 72 hours) oral notification of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notification. **Use the Expedited Criteria Not Met** template to provide written notice. The written notice must include: • Explain that CalOptima Health will automatically transfer and process the request using the 14-day timeframe for standard determinations. • Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination. • Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member. • Provide instructions about the expedited grievance process and its time frames.

Back to Agenda Back to Item

Attachment B
TIMEFRAMES FOR ONECARE DECISIONS AND NOTIFICATIONS

OneCare Decision and Notification Timelines		
Type of Request	**Decision**	**Notification Timeframe**
Standard Integrated Organization Determinations Prior Authorization/Prospective or outpatient service requests.	Approve or Deny no later than 7 calendar days from receipt of the request. **Extensions: CalOptima Health and it's delegated Health Networks may not extend deadlines for Integrated Organization Determinations for the OneCare line of business.**	**Practitioner:** **Decision: Electronic or Written** Within 24 hours of making the decision. not to exceed 7calendar days (includes weekends and holidays) of receipt of the request **Practitioner/Member: Written** Within 2 business days of the decision. not to exceed 7 calendar days (includes weekends and holidays) of receipt of the request **For favorable determinations, issue an approval notification. For partially favorable or adverse determinations, issue the Coverage Decision Notice .**
Expedited Integrated Organization Determinations Prior Authorization/Prospective or outpatient service requests.	Approve, or Deny as expeditiously as possible, but no later than 72 hours from receipt of the request. Must request the necessary information from the provider within 24 hours of receipt of the request. **Extensions: CalOptima Health and it's delegated Health Networks may not extend the deadlines for Integrated Organization Determinations.**	**Practitioner:** **Decision: Electronic or Verbal Notification** Within 24 hours of making the decision, not to exceed 72 hours of receipt of the request **Member: Written or Verbal Notification** Within 24 hours of the determination, not to exceed 72 hours of receipt of the request. **Practitioner/Member: Written** When successful verbal notification is given, it must be followed by written notification within 3 calendar days of the successful verbal notification.
Expedited Authorization (Pre-Service) **If Expedited Criteria are not met**	If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: • Automatically transfer the request to the standard timeframe. The 7 calendar day period begins the day the request was received for an expedited determination.	If the request is not deemed to be expedited, notify the member (within 72 hours) oral notification of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notification. • Use the Expedited Criteria Not Met template to provide written notice. The written notice must include: 1) Explain that CalOptima Health will automatically transfer and process the request using the 7- day timeframe for standard determinations. 2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination. 3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member. 4) Provide instructions about the expedited grievance process and its time frames.

Back to Agenda Back to Item

Attachment B
TIMEFRAMES FOR ONECARE DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Notification Timeframe
Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	**Urgent Concurrent (Inpatient)** Requests where a provider indicates or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Concurrent (Inpatient) Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	Approve, Modify or Deny within 72 hours of last approved day or decision consistent with urgency of member's medical condition. **Extension:** CalOptima Health may extend the time frame 48 hours or up to 14 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner/Member: Electronic or Oral** Within 24 hours of receipt of the request. **Practitioner/Member: Written** Within 3 calendar days of decision.
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days from receipt of request information that is reasonably necessary to make a decision.	**Practitioner: Written** Within 30 calendar days of receipt of the request **Member: Written** Within 30 calendar days of receipt of request.
Hospice - Inpatient Care	Within 24 hours of receipt of request.	**Practitioner: Electronic or Oral** Within 24 hours of making the decision **Practitioner /Member: Written** Within 2 business days of making the decision

Working days = Monday through Friday excluding California State Holidays
https://www.ftb.ca.gov/aboutftb/holidays.shtml

Back to Agenda Back to Item

Attachment B
TIMEFRAMES FOR ONECARE DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Notification Timeframe
Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health/Health Network determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, ma int a in or regain maximum function.	Approve or Deny within 72 hours of the admission notification. **Extension:** May extend the time frame, by up to 7 calendar days from the admission notification, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Concurrent (Inpatient) Concurrent review of inpatient treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's/Health Network's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that	Approve or Deny within 72 hours of the last approved day or decision consistent with the urgency of the member's medical condition. **Extension:** May extend the time frame 48 hours or up to 7 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner/Member: Electronic or Verbal** Within 24 hours of final decision **Practitioner/Member: Written** Within 3 calendar days of final decision.
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from date of receipt of the request)	Decision within 30 calendar days from date of receipt of the request.	**Practitioner: Written** Within 30 calendar days of date of receipt of the request **Member: Written** Within 30 calendar days of date of receipt of request.
Hospice - Inpatient Care	Within 24 hours of receipt of the request.	**Practitioner: Electronic or Verbal** Within 24 hours of making the decision **Practitioner /Member:** Written Within 2 business days of making the decision

Working days = Monday through Friday excluding California State Holidays
https://www.calhr.ca.gov/employees/pages/state-holidays.aspx

Back to Agenda Back to Item

OneCare Decision and Notification Timelines			
Type of Request	**Decision**	**Important Message (IM) from Medicare**	**Important Message (IM) from MedicareDetailed Notice of Discharge (DND)**
Hospital Discharge Appeal Notices (Concurrent)	Hospitals are responsible for delivery of the Important Message from Medicare (IM): • Within 2 calendar days of admission to a hospital inpatient setting. • No more than 2 calendar days prior to discharge from a hospital inpatient setting. • CalOptima Health is responsible for the delivery of the Detailed Notice of Discharge (DND) when members appeal a discharge. • DND must be delivered no later than noon of the day after notification by QIO (Quality Improvement Organization)	Hospitals must issue IM within 2 calendar days of admission. Hospitals must issue IM no more than 2 calendar days prior to discharge from an inpatient stay.	CalOptima Health must issue the DND to both the member and QIO as early as possible but no later than noon of the day after notification by the QIO.

Working days = Monday through Friday excluding California State Holidays
https://www.ftb.ca.gov/aboutftb/holidays.shtml

Type of Request	**Decision**	**Important Message (IM) from Medicare**	**Important Message (IM) from MedicareDetailed Notice of Discharge (DND)**
Hospital Discharge Appeal Notices (Concurrent)	Hospitals are responsible for delivery of the Important Message from Medicare (IM): 1. Within 2 calendar days of admission to a hospital inpatient setting. 2. No more than 2 calendar days prior to discharge from a hospital inpatient setting. 3. CalOptima Health/Health Network is responsible for the delivery of the Detailed Notice of Discharge (DND) when members appeal a discharge. 4. DND must be delivered no later than noon of the day after notification by QIO (Quality Improvement Organization)	Hospitals must issue the IM within 2 calendar days of admission. Hospitals must issue the IM no more than 2 calendar days prior to discharge from an inpatient stay.	CalOptima Health must issue the DND to both the member and QIO as early as possible but no later than noon of the day after notification by the QIO.

Working days = Monday through Friday excluding California State Holidays
https://www.calhr.ca.gov/employees/pages/state-holidays.aspx

Pharmacy Prior Authorization Determination Timelines

Medi-Cal Pharmacy Prior Authorization Determination Timelines*

**Medi-Cal Timelines for determination apply to pharmacy authorization requests managed by CalOptima Health*

Medi-Cal Pharmacy Prior Authorization Determination Timelines		
Type of Request	**Determination Timeline**	**Notification Timeline**
Standard (Non-urgent) Preservice All necessary information received at time of initial request.	A decision to approve, modify, or deny is required within 24 hours of receipt of the request.	**Provider:** Within 24 hours of receipt of the request. **Member (modify or deny only):** Within 24 hours of receipt of the request.
Standard (Non-urgent) Preservice - Information Needed Additional clinical information required.	A deferral response is required within 24 hours of receipt of the request. • A decision to approve, modify, or deny is required within 24 hours of receiving the additional information reasonably necessary to render a decision, but no longer than 14 calendar days from receipt of the original request.	**Provider:** Within 24 hours of receipt of the additional information reasonably necessary to render a decision. **Member (modify or deny only):** Within 24 hours of receipt of the additional information reasonably necessary to render a decision.
Standard (Non-urgent) Preservice- Delay Needed Additional clinical information not received within initial 14 calendar days.	CalOptima Health may delay the timeframe for an additional 14 calendar days if the requested information was not received within 14 calendar days of receipt of the original request, under the following conditions: • The member or the member's provider may request for an extension, or CalOptima Health can provide justification upon request by DHCS for the need for additional information and how it is in the member's interest. • The delay notice shall include the additional information needed to render the decision, the type of expert needed to review and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered.	**Provider:** Delay notice sent within 14 calendar days of receipt of the original request to delay the timeframe for an additional 14 calendar days. **Member:** Delay notice sent within 14 calendar days of receipt of the original request to delay the timeframe for an additional 14 calendar days.

Back to Agenda Back to Item

Attachment C
TIMEFRAMES FOR PHARMACY DECISIONS AND NOTIFICATIONS

Type of Request	Determination Timeline	Notification Timeline
Expedited (Urgent) Preservice/Concurrent All necessary information received at time of initial request.	A decision to approve, modify, or deny is required within 24 hours of receipt of the request.	**Provider:** Within 24 hours of receipt of the request. **Member** (modify or deny only): Within 24 hours of receipt of the request
Expedited (Urgent) Preservice/Concurrent - Information Needed Additional clinical information required.	A deferral response is required within 24 hours of receipt of the request. • A decision to approve, modify, or deny is required within 24 hours of receiving the additional information reasonably necessary to render a decision, but no longer than 72 hours from receipt of the original request.	**Provider:** Within 24 hours of receipt of the additional information reasonably necessary to render a decision. **Member (modify or deny only):** Within 24 hours of receipt of the additional information reasonably necessary to render a decision.
Expedited (Urgent) Preservice/Concurrent - Delay Needed Additional clinical information not received within initial 72 hours.	CalOptima Health may delay the timeframe for an additional 14 calendar days if the requested information was not received within 72 hours of receipt of the original request, under the following conditions: • The member or the member's provider may request for an extension, or CalOptima Health can provide justification upon request by DHCS for the need for additional information and how it is in the member's interest. • The delay notice shall include the additional information needed	**Provider:** Delay notice sent within 72 hours of receipt of the original request to delay the timeframe for up to an additional 14 calendar days. **Member:** Delay notice sent within 72 hours of receipt of the original request to delay the timeframe for up to an additional 14 calendar days.
Post-Service/Retrospective	A decision to approve, modify, or deny is required within 30 calendar days of receipt of the request.	**Provider:** Within 30 calendar days of receipt of the request. **Member:** Within 30 calendar days of receipt of the request.

Medi-Cal Pharmacy Prior Authorization Determination Timelines		
Type of Request	**Determination Timeline**	**Notification Timeline**
Standard (Non-urgent) Preservice All necessary information received at time of initial request.	A decision to approve, modify, or deny is required within 24 hours of receipt of the request.	**Provider:** Within 24 hours of receipt of the request. **Member (modify or deny only):** Within 24 hours of receipt of the request.
Standard (Non-urgent) Preservice - Information Needed Additional clinical information required.	A decision to approve, modify, or deny is required within 24 hours of receipt of the request.	**Provider:** Within 24 hours of receipt of the request. **Member (modify or deny only):** Within 24 hours of receipt of the request.
Expedited (Urgent) Preservice/Concurrent All necessary information received at time of initial request.	A decision to approve, modify, or deny is required within 24 hours of receipt of the request.	**Provider:** Within 24 hours of receipt of the request. **Member** (modify or deny only): Within 24 hours of receipt of the request
Expedited (Urgent) Preservice/Concurrent - Information Needed Additional clinical information required.	A decision to approve, modify, or deny is required within 24 hours of receipt of the request.	**Provider:** Within 24 hours of receipt of the request. **Member** (modify or deny only): Within 24 hours of receipt of the request
Post-Service/Retrospective	A decision to approve, modify, or deny is required within 30 calendar days of receipt of the request.	**Provider:** Within 30 calendar days of receipt of the request. **Member:** Within 30 calendar days of receipt of the request.

Back to Agenda Back to Item

Attachment C
TIMEFRAMES FOR PHARMACY DECISIONS AND NOTIFICATIONS

OneCare Pharmacy Part D Determination Timelines

OneCare Pharmacy Part D Determination Timelines		
Type of Request	**Determination Timeline**	**Notification Timeline (Member and Prescriber)**
Standard (Non-urgent) Preservice/Concurrent	A decision to approve or deny is required within 72 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from when the request was received).	Within 72 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from the date of the original request).
Expedited (Urgent) Preservice/Concurrent	A decision to approve or deny is required within 24 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from when the request was received).	Within 24 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from the date of the original request).
Post-service/Retrospective	A decision to approve or deny is required within 14 calendar days of the initial receipt of the request.	Within 14 calendar days of the initial receipt of the request.

OneCare Pharmacy Part D Determination Timelines		
Type of Request	**Determination Timeline**	**Notification Timeline (Member and Prescriber)**
Standard (Non-urgent) Preservice/Concurrent	A decision to approve or deny is required within 72 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from when the request was received for exception requests submitted by members, without prescriber supporting statement (PSS)).	Within 72 hours of receipt of the request or prescriber supporting statement for member exception request (not to exceed seven calendar days from when the request was received for members exception requests, without prescriber supporting statement (PSS)). If successful verbal notification is made, written notification made within 3 calendar days of verbal notification.
Expedited (Urgent) Preservice/Concurrent	A decision to approve or deny is required within 24 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from when the request was received for exception requests submitted by members, without prescriber supporting statement (PSS)).	Within 24 hours of receipt of the request or prescriber supporting statement for member exception request (not to exceed seven calendar days from when the request was received for members exception requests, without prescriber supporting statement (PSS)). If successful verbal notification is made, written notification made within 3 calendar days of verbal notification.
Post-service/Retrospective	A decision to approve or deny is required within 14 calendar days of the initial receipt of the request.	Within 14 calendar days of the initial receipt of the request.

Back to Agenda Back to Item

Attachment C
TIMEFRAMES FOR PHARMACY DECISIONS AND NOTIFICATIONS

Back to Agenda Back to Item

Emergency Services

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, a person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined ~~on the basis of~~based on lists of diagnoses or symptoms.

Emergency room services are available 24 hours per day, 7 days per week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima Health also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a plan network practitioner, or plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as follows:

Authorization for Post-Stabilization Inpatient Services

Post stabilization services are covered services related to an emergency medical condition provided after a member is stabilized to maintain, improve, or resolve the member's condition.

In accordance with Title 28 CCR 1300.71.4, when a member is stabilized, the Emergency Department (ED) provider believes the member requires additional medically necessary services and may not be discharged safely, CalOptima Health or the HN must approve or deny the request for post-stabilization care within 30 minutes of the request for a Medi-Cal member and within 60 minutes for a OneCare member. This requirement applies to both contracted and non-contracted providers. If CalOptima Health or a HN does not respond within the 30-minute (Medi-Cal) or 60-minute timeframe (OneCare), post-stabilization inpatient services are considered approved.

A hospital is required to notify CalOptima Health of a Post-Stabilization request for services prior to admission.

Retrospective Review

Retrospective review is an initial review of services that require prior authorization for which the services have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima Health notification and/or authorization and when there was no opportunity for pre-service review. Retrospective authorization is only permitted in accordance with CalOptima Health Policy and Procedure GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers which states the following:

1. The request is made within sixty (60) calendar days after the initial date of service and one of the following conditions apply:
~~1.~~2. The Member has Other Health Coverage (OHC); or
3. The Member's medical condition is such that the Provider or Practitioner was unable to verify the Member's eligibility for Medi-Cal, or OneCare, as applicable, at the time of service.

~~a.~~

If supporting documentation satisfies the administrative waiver of notification requirements of the policy, the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is approved. If the supporting documentation is questionable, the UM Nurse Case Manager or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. Medical necessity of post-service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

Admission/Inpatient Review Process

Contracted facilities are required to notify CalOptima Health of all inpatient admissions within 24 hours of admission. The inpatient review process assesses the clinical status of the member and verifies the need for continued hospitalization. Information assessed during the review includes but is not limited to:

- Clinical information to support the appropriateness and level of service being provided
- Validation of the diagnosis

- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care
- Additional days/service/procedures requested
- Reasons for the extension of the treatment or service

Utilizing evidenced based clinical guidelines, inpatient and concurrent review is conducted throughout the member's inpatient stay and with each approved hospital day based on review of the patient's condition and evaluation of medical necessity. Inpatient review can occur on-site or telephonically. The frequency of review is based on the severity/complexity of the member's condition and/or necessary treatment and discharge planning activity.

If, at any time, services cease to meet inpatient clinical criteria and discharge criteria are met and/or alternative care options exist, the Nurse Case Manager refers the case to the Medical Director for review. If the Medical Director determines the case no longer meets medical necessity for inpatient care, a Notice of Action (NOA)/UM Coverage Determination letter is issued immediately by fax and telephone to the hospital and mailed to the member. If the member is ~~an OC~~a OneCare member, verbal notification is also provided.

The need for case management or discharge planning services is assessed during the admission review, ~~and~~ with each inpatient admission, and with consideration for the most appropriate alternative to inpatient care. If at any time UM staff become aware of potential quality of care ~~issue~~issues, the concern is referred to CalOptima Health QI Department for investigation and resolution.

Discharge Planning Review

Discharge planning begins at the time of an inpatient admission and is designed to identify and initiate ~~a safe~~safe, quality-driven treatment intervention for post-hospital care needs. ~~It~~ Discharge planning is a coordinated effort between~~among~~ the facility and CalOptima Health and includes participation from but ~~is~~ not limited ~~to~~to the attending physician, hospital discharge planner, UM staff, complex discharge team, Case Management team, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review ~~are~~include:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention.
- Development of an individual care plan involving an appropriate multidisciplinary team and family members involved in the member's care.

- Communication with the attending physician and member, when appropriate, to suggest alternate health care resources.
- Communication to the attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge planning staff, and UM staff.

UM staff obtain medical record information ~~and~~and based on discharge review criteria/guidelines, identifies the need for discharge to a lower level of care. If the attending physician orders discharge to a lower level of care, UM staff assist~~s~~ the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director as previously noted in the Inpatient Review Process.

Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, denial, or termination of any service based on medical necessity or benefit limitations.

Upon any adverse determination for medical or behavioral health services made by a CalOptima Health Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner.

Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the timeframes as noted in CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. The written notification is ~~written in~~composed using lay language that is easily understandable at a sixth grade reading level and includes member-specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and timeframes for appeal of the decision. All templates for written notifications of decision making are DHCS and CMS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. A CalOptima Health Medical

Director or appropriate practitioner reviewer (BH practitioner, pharmacist, etc.) serves as the point of contact for the peer-to-peer discussion. The ~~denial letter coversheet outlines the~~ process for a practitioner to speak to the Medical ~~Director~~Director is outlined in the denial letter coversheet as well as ~~and this information is~~ provided at the time of verbal notification of the denial.

Grievance and Appeal Process

CalOptima Health has a comprehensive review system to address matters when Medi-Cal and OC members wish to exercise their right to contest the UM decision to deny, delay or modify a request for services, or terminate a previously approved service. This process is initiated by contact from a member, a member's representative or treating practitioner. Requests for members enrolled in COD or one of the contracted HMOs, PHCs and SRGs are submitted to CalOptima Health's Grievance and Appeals Resolution Services (GARS) ~~received~~ by phone, fax, mail, online web submission or in person submission. ~~to Grievances and Appeals for members enrolled in COD or one of the contracted HMOs, PHCs and SRGs are submitted to CalOptima Health's Grievance and Appeals Resolution Services (GARS).~~ The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution.

The grievance process is in accordance with CalOptima Health Member Complaint Policy. HH.1102: Member Grievance for our Medi-Cal line of business and Policy MA.9002 Member Grievance Process for our OneCare line of business. The appeal process is in accordance with CalOptima Health Appeal Policy GG.1510: Member Appeal Process for our Medi-Cal line of business and MA.9015: Standard Integrated Appeals for our OneCare line of business. These policies define processes including but not limited to:

- Collection of information and/or medical records related to the grievance or appeal.
- Communication with the member and provider.
- Thorough evaluation of the substance of the grievance or appeal.
- Review of the investigation for a grievance or medical records for an appeal.
- Resolution of operational or systems issues and of medical review decision.
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case.

The grievance and appeal process for ~~all of~~all CalOptima Health Networks ~~are~~ is handled by CalOptima Health GARS department. CalOptima Health collaborates with the community provider or delegated entity to gather the necessary information and ~~supporting~~support documentation. If a member is not satisfied with the appeal decision, he/she may file for a State Hearing with the

California Department of Social Services. This process is in accordance with CalOptima Health Policy, HH.1108: State Hearing Process and Procedure. Grievances and appeals may be initiated by a member, a member's representative, or a practitioner. An Appeal may be processed as expedited or standard and will be handled as expeditiously as the member's health requires.

All medical necessity decisions are made by a licensed physician reviewer. Grievances and appeals are reviewed by an objective reviewer separate from the reviewer who made the initial denial determination.

The Medical Director or designee evaluates grievances regarding the denial, delay, termination, or modification of care or service. The Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An "Expert Panel" roster is maintained from which, either via Letter of Agreement or Contract, a Board-Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is under appeal.

CalOptima Health sends written notification to the member and/or practitioner of the outcome of the review ~~within the~~in accordance with regulatory defined time limits. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues are identified during the investigation process, the ~~identified issue~~issue identified in the review is directed to Quality Improvement for further review and a Potential Quality Issue (PQI) investigation is opened. PQI investigations are confidential and peer protected and are a separate process from the grievance and appeal review.

All members have a right to access copies of all documents relevant to the member's appeal. Documentation requests may be submitted by calling the CalOptima Health Customer Service department.

Expedited Appeals and Grievances

Expedited appeals and grievances are managed in an accelerated fashion to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum functionality. A member, member's authorized representative or provider may request the grievance or appeal process to be expedited if there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, risk for adverse health outcome

if not decisioned quickly, or potential loss of life, limb, or major bodily function. All expedited grievance or appeal requests that meet the expedited criteria shall be reviewed and resolved in an expeditious manner as the matter requires, but no later than 72 hours after receipt, with the exception ofexcept for OCOneCare expedited grievances which are reviewed and resolved no later than 24 hours after receipt. At the time of the request, the information is reviewed, and a decision is made regarding the expedited appeal criteria.

State Hearing

CalOptima Health Medi-Cal members have the right to request a State Hearing from the California Department of Social Services once the appeal process has been exhausted. A member may file a request for a State Hearing within 120 days from the Notice of Appeal Resolution. CalOptima Health and delegated HNs comply with State Aid Paid Pending requirements, as applicable. Information and education on filing a State Hearing are included annually in the member newsletter, in the member's evidence of coverage, and with each adverse Notice of Appeal Resolution sent to the member or the member's representative.

Independent Medical Review

OC OneCare members have a right to request an independent review if they disagree with the termination of services from a Skilled Nursing FFacility (SNF), home health agency or a comprehensive outpatient rehabilitation facility. CMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. CalOptima Health is notified when a request is made by a member or member representative. CalOptima Health supports the process by providing the medicalmedical records for the QIO's review. The QIO notifies the member or member representative and CalOptima Health of the outcome of their review. If the decision is overturned, CalOptima Health complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

Provider Preventable Conditions

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs:

1. Health care acquired conditions (HCAC) occurring in inpatient acute care hospitals.

~~a.~~2. Other provider preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified, the PPC is reported to CalOptima Health's QI department for further research and reporting to government and/or regulatory agencies, and to claims for possible overpayment recovery.

Long-Term Services and Supports

Long Term Care (LTC)

The LTC case management program includes authorizations for the following facilities:

- Nursing Facility Level A (NF-A) Custodial Intermediate LOC.
- Intermediate Care Level of Care (CCR Title 22 Section 51334(/)) In order to qualify for intermediate care services, a patient shall have a medical condition which needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. Intermediate care services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual patient independence to the extent of his ability.
- Nursing Facility Level B (NF-B).
- Skilled Level of Care.
- Skilled Nursing Level of Care (CCR Title 22 Section 51335 (j)) In order to qualify for skilled nursing facility services, a member shall have a medical condition which needs visits by a physician at least every 60 days, one or more physical disabilities, and constantly available skilled nursing services.
- Subacute care.
- Adult subacute care is a level of care that is defined as a level of care needed by a patient who does not require hospital acute ~~care~~care, but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a skilled nursing facility.
- Pediatric subacute care is a level of care needed by a person less than 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.
- Subacute patients require special medical equipment, supplies, and treatments such as ventilators, tracheostomies, total parenteral nutrition, tube feeding and complex wound management care.

Facilities are required to notify CalOptima Health of admissions within 24 hours and submit authorization requests within 21 days. Nurse Case Managers assess a member's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to MSSP, IHSS, CalAIM or CBAS. Referrals to case management can also be made upon discharge when a member's needs indicate a referral is appropriate. In addition, the LTC staff provide education to facilities and their staff at the request of the facility and when new programs are implemented.

Community-Based Adult Services (CBAS)

CBAS is an outpatient, facility-based program offering day-time care and health and social services to frail seniors and adults with disabilities. CBAS ~~which~~ enables participants to remain living at home instead of in a nursing facility. Services offered through CBAS centers may include but are not limited to health care coordination; meal service (at least one per day at center); medication management; mental health services; nursing services; personal care and social services; physical, occupational and speech therapy; recreational activities; training and support for family and caregivers; and transportation to and from the center. In addition to the facility-based benefit, the CBAS benefit has allowance for members to receive Emergency Remote Services (ERS) in lieu of attending the center when they are experiencing an event that precludes them from attending the center in person. By allowing for ongoing support while the member is experiencing a public or personal emergency, the CBAS can continue to coordinate care and services on the member's behalf.

Multipurpose Senior Services Program (MSSP) ~~MSSP~~

CalOptima Health is an approved MSSP site through California Department of Aging (CDA). The Multipurpose Senior Services Program (MSSP) provides social and health care services for people 60~~5~~ or older who may have a disability or could be at risk for going into a nursing home. MSSP care managers work with the member, their family and others who may help support the member. The goal is to give members a chance to stay in their homes and enjoy a higher quality of life. To ~~get~~ qualify for MSSP~~these~~ services, CalOptima Health members must: Be 60~~5~~ years of age or older, have a possible need for nursing home care and be receiving Medi-Cal with an MSSP qualifying aid code.

Registered nurses (RNs) and social workers review the member's and family's needs and create a care plan with the member to meet his or her needs. MSSP buys some services or items that cannot be found through other resources, connects the member to services that meet the care

plan goals, regularly review the member's needs to track the progress of services, and help the member keep services and find new ones.

MSSP care managers ~~arrange~~ coordinate a wide ~~choice~~ range of services based on the members' needs, such as:

- Community-Based Adult Services (formerly Adult Day Health Care)
- Medical equipment such as walkers, canes, grab bars, wheelchairs, hospital beds, bath chairs, etc.
- Non-medical equipment such as medical alert systems, ramps, heaters, fans, etc.
- Personal care, homemaker chore services and caregiver relief
- Transportation
- Minor housing repairs

Counseling for mental illness or medical issues

Over/Under Utilization

Over/under utilization monitoring is ~~tracked~~ tracked and monitored by the UM leadership team, the UM Workgroup, identified stakeholders, the Medical Director Team and reported to UMC. Over/under utilization data ~~The UMC~~is reviewed by the UMC ~~reviews over/under utilization data~~ on a quarterly basis to ~~and approves and~~ monitors metrics, discusses performance, address identifiedy trends, ~~contributes to the~~enhance the analysis, and ~~identifies action plan~~identify interventions for decreasing over ~~and~~/-under utilization.

Over/under utilization monitoring and performance are reported to the QIHEC on a quarterly basis.

The UMC may track and monitor ~~over and~~over/-under utilization data in the following areas to include but not limited to:

- ED utilization
- Bed day utilization
- Readmission rates
- Pharmacy utilization measures
- Member and grievance data
- Identified Trends from Fraud, Waste and Abuse investigations
- Select HEDIS rates for selected measures
- PCP and specialist referral pattern analysis

- Member utilization patterns
- Trends in UM-related complaints
- Potential quality issues

Behavioral health measures

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otOther areas as identified

Program Evaluation

The UM Program is evaluated at least annually, and modifications are made as necessary based on outcomes and opportunities. The Deputy Chief Medical Director, Executive of Clinical Operations and UM Director evaluate the impact of the UM Program by using:

- Member complaint, grievance, and appeal data
- Results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction survey results~~s~~
- Relevant UM data
- Practitioner profiles
- DUR profiles (where applicable)

The evaluation encompasses all aspects of the UM Program. Problems and/or concerns are identified through the evaluation process, and recommendations for ~~removing barriers~~improvements or barrier removal ~~to improvement~~ are provided. The evaluation and recommendations are submitted to the UMC for review, action and follow-up. The final document is then submitted to the Board of Directors through the QIHEC and QAC for approval.

Satisfaction with the UM Process

CalOptima Health provides an explanation of the GARS process, State Fair Hearing, and Independent Medical Review (IMR) processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers and postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima Health QI Department for investigation and resolution.

Annually, CalOptima Health evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include but are not limited to member

satisfaction survey results such as Consumer Assessment of Healthcare Providers and Systems (CAHPS); member/provider complaints and appeals that relate specifically to UM; provider satisfaction surveys with specific questions about the UM process; and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the collective information ~~gathered~~ indicates areas of dissatisfaction, CalOptima Health develops an action plan and interventions to improve the areas of concern. Actions~~, which~~ may include but are not limited to staff retraining and member/provider education.

Case Management Process

The Case Manager is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitating communication between the member's PCP, the member, family members (at the member's discretion), other practitioners, facility personnel, other health care delivery organizations and community resources, as applicable.

Program Updates and/or Changes

Each year, based upon the evaluation and review of member satisfaction and effectiveness data, CalOptima Health updates the Case Management~~)~~ process to better address member needs. Evaluation results are shared with staff and training is provided to ensure understanding of any programmatic changes to the current process for the upcoming year. Updates and/or changes to the Case Management program and process include but are not limited to the following:

- Ongoing development of the clinical documentation platform to enhance functionality of assessments, care plans, and outputs and provide continued training in clinical standards of care, NCQA PHM 5: Complex Case Management Standards, and techniques for effective case management to both CalOptima Health and Health Network staff.
- Creation of additional tools to assist CalOptima Health and Health Network staff to ensure all elements of NCQA PHM 5 are addressed.
- ~~Provide~~ Provision of targeted outreach and case management to support members who are risk stratified as high risk. ~~Some~~ Develop best practices for outreaching and improving overall care of high-risk members ~~may primarily be~~who primarily utiliz~~inge~~ the emergency department for care ~~and develop best practices for outreaching to these members and improving their overall care~~.
2. Continuation of ~~e~~ development of specialized outreach and management for special populations, such as members struggling with pain, behavioral health issues, or who may

Back to Agenda Back to Item

be experiencing homelessness. Enhance training in resources and engagement to care management staff, with the goal of increasing member engagement in case management.

~~Transitioned to new clinical documentation platform in February 2024.~~

~~CalAIM~~

Team Composition and Roles

The Case Management Department consists of functional teams that focus on specific program activities. The ~~teams are~~ multidisciplinary teams are composed of Case Managers, Social Workers, and Personal Care Coordinators to meet the needs of the member ~~and are composed of Case Managers, Social Workers, Medical Assistants,~~ and Personal Care Coordinators, ~~and, as appropriate, to meet the needs of the member~~. Case Managers are assigned a variable size ~~caseloads that are variable in volume depending~~caseload with consideration for ~~on~~ the complexity of the cases they manage~~d~~. The Case Management ~~Teams~~ teams include ~~a Triage Team,~~ Health Risk Assessment and Health Needs Assessment ~~Team~~, Health Network Liaison ~~Team~~, an Oversight Clinical Team and a Direct Clinical Team.

The following staff positions provide support for organizational/operational CM Department's functions and activities:

Sr. Director, Clinical Operations oversees the Case Management and Long-Term Services and Supports (LTSS) programs within CalOptima Health. The Sr. Director ~~to~~ ensures that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Health Community Network and CalOptima Health Direct Network. The ~~incumbent~~ Sr. Director is responsible for programmatic oversight, strategic planning and ongoing compliance with all local, state and federal regulations and accreditation standards according to the CalOptima Health mission and vision.

Director of Care Management directs all Case Management programs for CalOptima Health members to ensure that case management functions are properly and consistently implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Health Community Network and CalOptima Health Direct. The ~~incumbent~~ Director is responsible for all departmental compliance with all local, state, and federal regulations, ~~and~~ ensures that accreditation standards are current, and all policies and procedures meet current requirements.

Manager of Case Management provides shared responsibility for the daily operations, activities, and projects for the Case Management department. The ~~incumbent~~ Manager works under the

general direction of the Director of Case Management and in partnership with the other department managers to provide performance management and development of the case management staff and departmental projects ~~associated with the department~~. ~~The incumbent~~This position ensures compliance with department policies and procedures and supports the implementation of departmental projects. The ~~incumbent~~ Manager may be required to attend joint operational and community meetings and is~~. The incumbent is~~ responsible for monitoring case management reports and reporting to management or committees.

Case Management Supervisor is responsible for the daily operation of case management activities, the implementation of new programs and compliance with regulations. The ~~incumbent~~ Supervisor provides guidance to staff and directly handles complex case management referrals. This role ~~e incumbent~~ is accountable for establishing quality and productivity standards for the team and ensuring compliance with department policies and procedures in collaboration with the manager. The ~~incumbent~~ Supervisor serves as a resource for CalOptima Health's providers, health networks and community partners.

Medical Case Manager (Ambulatory) / Care Manager is responsible for providing ongoing case management services for CalOptima Health's members. The Medical Case Manager facilitates communication and coordination among all participants of the health care team and the member to ensure the services provided promote quality and cost-effective outcomes.

Health Network Liaison is a liaison between the delegated Health Networks (HN) and CalOptima Health, assisting members assigned to the delegated HN with coordination of care and service-related issues. Additionally, the ~~incumbent~~Health Network Liaison provides~~ will provide~~ consultation to the health networks and groups to improve overall compliance with regulations and standards. The ~~incumbent~~liaison is a resource for members, HN Case Managers, Personal Care Coordinators (PCCs), and community partners to address medical, behavioral and psychosocial concerns.~~responsible for ensuring case management services for CalOptima Health members. The Health Network Liaison completes intensive investigation of cases that are referred to the Case Management Team. The position serves as a resource for members, delegated plan case managers, Personal Care Coordinators (PCCs) and community partners to ensure medical, behavior, and psychosocial concerns are addressed. In conjunction with other team members, the incumbent may make recommendations for a comprehensive individualized care plan at all levels of care.~~

~~**Medical Assistants** are responsible for performing medical and administrative routine tasks specific to the assigned unit, and office support functions.~~

Social Worker provides administrative case management and coordination of benefits for community resources and services~~carved-out services~~. The Social Worker serves as a

departmental resource regarding benefits and available resources for the aged, behavioral health, foster care and the disabled population. The Social Worker also serves as a liaison to Orange County based community agencies.

Personal Care Coordinators (PCC) support CalOptima Health members in completing a Health Risk Assessment (HRA) and ensure communication of the HRA and care plan with the member, Primary Care Provider (PCP) and health care team. The PCCs also identify barriers to members' care and assist in improving these barriers for all levels of care. The ~~incumbent~~ PCC role works closely with the PCP and health care team to ensure members have access to timely services and coordination of care.

Program Assistant provides support to staff, including but not limited to preparing meeting materials, maintaining minutes, routing documents, conducting data entry and handling of incoming and outgoing correspondence per administrative policy. Provides administrative support for specific and/or ongoing projects, such as generating reports, logs, calendars, and mailings, applying general business practices, as well as CalOptima Health policies and procedures under the direction of the Director.

Data Analyst performs analysis and reports data related to Case Management projects ~~and~~ to ~~ensures~~ ensure that case management goals and objectives are accomplished within specified time frames, through the judicious and efficient use of CalOptima Health resources.

QI Nurse Specialist is responsible for overseeing regulatory reports and audits for the entire Case Management department to ensure regulatory compliance, implementing and monitoring policy changes to case management reporting, and providing quality review of submitted health network data to meet Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), and National Committee for Quality Assurance (NCQA) requirements. In addition, the ~~incumbent~~ QI Nurse Specialist performs analysis and reports data related to the Case Management projects and ensures that Case Management goals and objectives are accomplished within specified time frames. The ~~incumbent~~ QI Nurse Specialist interacts with other internal CalOptima Health departments, health networks, and external agencies.

While CalOptima Health enjoys a robust array of internal case management resources, case management activities are also performed by the Health Networks. The Health Networks utilize their own case management staff to manage CalOptima Health's members who are assigned to them. Case management departments at the Health Networks are staffed with ~~Licensed~~ Case Managers, Social Workers, Pharmacists, and unlicensed support staff. While these staff are supervised by the Health Networks, they participate in CalOptima Health specific training and are overseen by CalOptima Health.

Staff Training/Education

CalOptima Health ~~seeks to recruit~~recruits highly qualified individuals with extensive experience and expertise in Case Management for staff positions. Required qualifications and educational criteria are specified within the respective position descriptions~~Qualifications and educational requirements are delineated in the position descriptions of the respective position~~.

Each new employee is provided with orientation and job specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job description:

- CalOptima Health New Employee Orientation and Boot Camp (CalOptima Health programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Use of technical equipment (phones, computers, printers, facsimile ~~machines~~process, etc.)
- Workplace Harassment Prevention training
- Cultural Competency, Bias or Inclusion and Trauma-Informed Care training

~~Seniors and Persons with Disabilities Awareness Training~~

- OneCare Model of Care Training
- Dementia Care Specialists
- ~~•~~ Case Management Program: policies/procedures and desk top processes, etc.

~~•~~

~~1.~~ Medical Information System data entry

~~Appeals Process~~

~~•~~

QI Referral Process

•

3. Other training offered as appropriate

~~Dementia Care Specialists~~

~~Motivational Interviewing.~~

~~Licensed nursing~~Case/Care Managers ~~staff~~ are monitored for appropriate application of NCQA requirements and case management documentation. Training opportunities are identified through regular administration of proficiency evaluations and addressed ~~as immediately as they are identified~~upon identification. Any employee who fails the evaluation is provided with additional training and provided with a work improvement process. Formal training, including

seminars and workshops, is provided to all Case Management staff on an annual basis. Delegated Health Network staff participate annually in CalOptima Health model of care training.

CalOptima Health encourages and supports continuing education and training for employees, ~~which increases~~increasing employee competency in their present jobs and/or prepar~~ing~~es ~~them~~ for career advancement within CalOptima Health. Each year, a specific budget is set for continuing education for ~~each~~ licensed and certified CM employees.

Coordination of Care

Coordination of services and benefits is a key function of Case Management, both during inpatient acute episodes of care as well as for complex or special needs cases that are referred to the Case Management department for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services, and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. I~~i~~n order to maintain access to appropriate services and~~.B~~ because Medi-Cal is always the payer of last resort, CalOptima Health must coordinate benefits with other payers the member may utilize including but not limited to Medicare, Worker's Compensation, and commercial insurance~~, etc.. in order to maintain access to appropriate services.~~

Other attempts to promote continuity and coordination of care include ~~member~~ notifications to members~~those~~ affected by a PCP or practice group termination from CalOptima Health. CalOptima Health assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. In certain situations, if the provider ~~is not termed~~termination is due to a reason other than a quality issue, continuity of care may also be explored to continue treatment with the provider~~ in certain situations~~. CalOptima Health also coordinates continuity of care with other Managed Care Plans when a new member comes into CalOptima Health, or a member terminates from CalOptima Health to enroll in a new health plan.

CalOptima Health ~~may~~ uses multiple ~~s the following~~ data sources to identify a member for case management. Data sources may include ~~if available~~ but are not limited to:

- Pharmacy data
- Health Risk/Needs Assessment
- Claims or encounter data

- Hospital Discharge data
- Utilization Management data
- ~~Laboratory results~~
- Data supplied by purchasers
- Data ~~supplied~~ provided by member or caregiver
- Data supplied by practitioners
- Risk Stratification and Segmentation (RSS)
- Health Information Form (HIF) ~~if available~~

Members enter the case management program through multiple avenues. Referrals to case management may be made through but not limited to:
~~The avenues for referring a member for case management are:~~

- Member self-referral
- Member's authorized representative/family referral
- Practitioner/Provider referral
- Customer Service referral
- Discharge Planner referral
- Disease Management program referral
- Community Agency referral
- HN referral
- Utilization Management referral
- Long-term Services and Supports referral

The case management program is built on evidence-based guidelines and includes a documented process to assess the needs of the member population. It establishes clear program goals and uses standardized mechanisms, such as data analysis, to identify members who may benefit from case management. Referrals can come through multiple avenues, and members are followed across the continuum of care—from outpatient or ambulatory settings to inpatient care. Eligible members are informed about case management services and have the option to accept or decline participation.

As the case manager documents activities, care plan goals, and interventions. the case management system automatically records essential details, including the case manager's name, date, time of actions, and prompts for required follow-up. Clinical practice guidelines and algorithms guide initial assessments and ongoing management.

As part of the case management process, individualized care plans are developed, implemented, and modified through an interdisciplinary, collaborative process involving providers, members, and their families or caregivers. These plans prioritize goals that reflect the member's preferences and include self-management strategies.

Case managers coordinate services to ensure appropriate levels of care and resources, document all findings, and continuously monitor, reassess, and adjust care plans to maintain quality, timeliness, and effectiveness. Data and member feedback are analyzed to identify opportunities for improvement, and any quality-of-care issues are referred to the Quality Improvement Department.
The program also coordinates carved-out services such as Medi-Cal Dental, addresses mental health needs through Behavioral Health referrals, and connects members to Population Health/Disease Management programs, LTSS, and other resources. Finally, continuity of care needs are assessed in collaboration with the Utilization Management department.
~~The case management program includes:~~
~~Development of the program through the use of evidence-based guidelines.~~
~~Documented process to assess the needs of the member population.~~
~~Development of the program through the use of evidence-based guidelines.~~
~~Defined program goals.~~
~~Standardized mechanisms for member identification through use of data.~~
~~Multiple avenues for referrals to case management.~~
~~Following members across the continuum of health care from outpatient or ambulatory to inpatient settings.~~
~~Process to inform eligible members of case management services, and the ability to elect or decline services.~~
~~Documentation in a case management system that supports automatic documentation of case manager's name, date, time of action and prompts for required follow up.~~
~~Use of evidenced-based clinical practice guidelines or algorithms.~~
~~Initial assessment and ongoing management process.~~
~~Developing, implementing and modifying an individualized care plan through an interdisciplinary and collaborative team process, in conjunction with the provider, member and/or their family/caregiver.~~
~~Developing prioritized goals that consider the member or caregiver's goals and preferences.~~
~~Developing member self-management plans.~~
~~Coordinating services for members for appropriate levels of care and resources.~~
~~Documenting all findings.~~
~~Monitoring, reassessing, and modifying an individualized care plan the plan of care to ensure quality, timeliness, and effectiveness of services.~~
~~Analyzing data and member feedback to identify opportunities for improvement.~~

~~Mechanism for identification and referral of quality-of-care issues to QI Department.~~
~~Coordination of carved out services, such as Denti-Cal~~Medi-Cal Dental
~~Identification of mental health needs and referral to Behavioral Health~~
~~Identification of educational needs and referral to Population Health~~Disease ~~Management~~
~~Referral to LTSS~~
~~Assess and identify continuity of care needs and work collaboratively with UM department~~

The i~~I~~nitial assessment of the member is used to assign the member to a programmatic level aligned to the programmatic needs identified through the assessment. The initial assessment includes the following:

- Member health status, including condition-specific issues~~of members' health care status and needs, including condition-specific issues:~~
-
-
- ~~Member's right to accept or decline case management services~~
- ~~Review of past medical history and co-morbidities~~
- Documentation of clinical history, including medications. ~~Medication reconciliation and compliance~~
-
-
- Initial assessment of the activities of daily living (ADL).~~Assessment of functional status - activities of daily living (ADLs) and instrumental activities of daily living (iADLs)~~
-
- Assessment of behavioral health status
- Assessment of social drivers of health (SDOH)
- Evaluation of cultural and linguistic needs~~, preferences, or limitations~~
- Evaluation of visual and hearing needs
- Evaluation of caregiver resources
- Evaluation of available benefits
- Evaluation of community resources
- Assessment of life-planning activities

- ~~Assessing member's support systems/caregiver resources and involvement~~
- ~~Evaluation of behavioral health, cognitive function, and substance use disorder~~

- ~~Evaluation of cultural and linguistic needs, preferences, or limitations~~
- ~~Member's motivational status or readiness to learn~~
- ~~Assessment of visual and hearing needs, preferences, or limitations~~
- ~~Assessment of life-planning activities~~
- ~~Assessment of functional status - activities of daily living (ADLs) and instrumental activities of daily living (iADLs)~~
- ~~Assessment of social drivers of health (SDOH)~~
- ~~Review status and treatment plan~~
- ~~Identifies barriers to quality, cost-effective care and fulfilling the treatment plan~~
- ~~Determines implications of resources, and availability and limitations of benefit coverage~~
- ~~Assessment of need for referrals to community resources~~
- ~~Evidence-based clinical guidelines or algorithms to conduct assessment and management~~

Upon acceptance of a member into the CM Program, the Case Manager will develop a Case Management Plan based on the outcomes of the initial assessment, member-feedback, and member's clinical history. The Case Management Plan ~~that~~ identifies the interventions required to provide appropriate care to the member.

A Case Management Plan includes Development of prioritized SMART goals with consideration for:

- Member or caregiver's goals or preferences
- ~~•~~ Member or caregiver's desired level of involvement in case management plan
- ~~•~~
- ~~1.~~ Identification of ~~B~~barriers to meeting goals and complying with ~~self-management plan~~the case management plan
- ~~•~~
- Development of schedules for follow-up and communication with member ~~Scheduled time frame for follow-up and communication with members~~
- Development and communication of member self-management plans
- ~~•~~
- ~~•~~ Assessment of progress against case management plans and goals, and modification as needed
- ~~Assessment of progress towards goal, with modifications as needed~~
- ~~Resources to be utilized, including the appropriate level of care~~
- ~~Planning for continuity of care, including transition of care and transfer~~
- ~~Collaborative approaches to be used, including family/caregiver participation~~
- ~~~~

Coordination of Carved Out Services

CalOptima Health provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap-around services that enhance their medical benefits.

Memorandum of Understanding (MOU) with other community agencies and programs, such as the HCA/California Children's Services and ~~,~~ Orange County Behavioral Health Plan (BHP)~~Department of Mental Health, and the Regional Center of Orange County~~. The CM staff and delegated entity practitioners are responsible for identification of such cases and coordination of referrals to appropriate State agencies and specialist care according to the member's benefit coverage~~when the benefit coverage of the member dictates~~. The Case Management Department assists members with the transition to other care, if necessary, when benefits end. ~~This~~ Support may include informing members about ways to obtain continued care through other sources, such as community resources or waiver services.

Case Management Programs include identification and referral of a member eligible for community and/or Federal Medicaid Waiver programs, including, but not limited to:

- Specialty Mental Health Services (SMHS)
- Drug Medi-Cal Organized Delivery System (DMC-ODS) for substance use services
- California Children's Services (CCS) (for intercounty transfers)
- Regional Center of Orange County (RCOC)
- Local Education Agency (LEA)
- Genetically Handicapped Persons Program (GHPP)
- AIDS Waiver Program
- 1915 (c) Home and Community Based Services
- Assisted Living Waiver (ALW)
- Home and Community-Based Alternative (HCBA) Waiver ~~(formerly NF/AH Waiver)~~
- Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD) Waiver
- Multipurpose Senior Services Program (MSSP)
- Tuberculosis Program (Direct Observation Therapy)
- Targeted Case Management (TCM)

~~Collaboration with the HCA/PDS TB Control Officer~~

Clinical ~~Protocols~~Practice

CalOptima Health is committed to serving the needs of all members ~~assigned~~ and places additional emphasis on the coordination of care for ~~the~~ vulnerable populations. Approved clinical practice guidelines and nationally recognized protocols are used to guide treatment and care provided to the members. ~~The use of~~Following clinical practice guidelines or nationally recognized protocols is challenging for the CalOptima Health membership as many of their needs are socioeconomic in nature and not a consideration for recognized guidelines or protocols. ~~These guidelines~~Evidence-based clinical guidelines do not address many of the supplemental benefits or community-based resources that may be critical to a comprehensive care plan for these individuals. Lack of transportation may create obstacles to care, yet the member may not meet criteria for non-emergency medical transportation. Members who are at the end of life may be inappropriate for certain preventive care screenings.

When use of a clinical practice guideline or nationally recognized protocol is challenging or inappropriate for an individual member the following steps may be taken:

1. ICT is convened with the member, the member's PCP, and specialists (if appropriate).
2. Participants of the ICT review the case and mutually develop an Individualized Care Plan (ICP), prioritized per member's preferences.
3. PCP or Case Manager facilitates referrals and linkages to identified supplemental benefits, community referrals and resources.

When a member's specific clinical requirements indicate the need for an alternative approach, decisions to modify clinical practice guidelines or nationally recognized protocols are made by the member, PCP or specialists, in consultation with other members of the health care team. The care team members review the member's current health status, limitations, social support, barriers, and treatment approach, which include any modifications needed in the clinical practice guidelines that support the ICP. Timeframes are established for each of the action items of the ICP to ensure successful completion of these tasks, identification of barriers, and attainment of goals. Updated ICP is shared with the care team members including but not limited to the members, caregivers, and PCP.

To address the unique needs of our members, CalOptima Health offers supplemental benefits, which can be accessed either through self-referral or via referral by a treating practitioner. These benefits are intended to aid members in maintaining optimal health status, either by providing health care services not covered by Medicare or Medi-Cal (e.g., vision care), by addressing barriers to access to care (e.g., Non-Medical Transportation), or by promoting regular physical activity (gym benefit).

Types of Case Management Services

The Case Management program supports members through individualized programs that meet each member's unique needs and preferences. Members are leveled into programmatic levels that include tailored interventions designed to support the members' needs at that level of care. Programmatic levels include Basic Case Management, Care Coordination, and Complex Case Management.

Members may also qualify for specialty programs such as Children and Youth with Special Health Care needs, Whole Child Model, Transitional Care Services, Transplant, and Palliative Care.

Basic Case Management

Basic case management activities by the primary care practitioner ~~may include, but are not limited to~~~~is~~include:

1. A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a ~~Member's~~member's health and functional needs.
2. Services are provided by the Primary Care Physician (PCP) or by a PCP supervised Physician Assistant (PA), Nurse Practitioner (NP), or Certified Nurse Midwife, as the Medical Home.
3. Coordination of services outside the health plan, such as community social services or specialty mental health or Drug Medi-Cal services, are considered basic case management services.

~~A health assessment of member's current acute, chronic and preventive health needs~~

~~Development of the members' treatment plan~~

~~Communication between the practitioner and member/authorized representative to ensure compliance with established treatment plan~~

~~Identification of the need for medical, specialty or ancillary referrals~~

~~Referrals to case management and/or disease management~~

Care Coordination

Care coordination consists of ~~CalOptima Health or a Health Network may provide a Member with Care Coordination Case Management, to include an assessment and creation of a care plan, if the Member does not qualify for Complex Case Management but would benefit from case management support. Care Coordination Case Management shall include:~~

~~C~~case management provided to Members who are at stratified at moderate ~~risk, but~~risk but ~~still~~ have an acute or chronic medical condition that requires coordinated support. Care coordination includes assessment, ICP, and coordination of resources in order to maintain the Members in the

Back to Agenda Back to Item

least restrictive setting. ~~It~~Care Coordination is provided by the Member's Health Network~~,~~ in collaboration with their PCP and specialists, as appropriate.

- ~~Assistance with access to care issues;~~
- ~~Health and disease-specific education;~~
- ~~Referral to resources; and~~
- ~~Coordination of care with all Providers.~~

Complex Case Management (CCM)

Complex Case ~~m~~Management is provided to Members who are stratified at high risk. Complex Case management ~~that~~ requires assessment, ICP, and coordination of resources in order to maintain the Members in the least restrictive setting. It is provided by the Member's Health Network, in collaboration with their PCP and specialists, as appropriate.

~~Complex Case Management Services are provided by CalOptima Health, in collaboration with the Primary Care Provider, and includes, at minimum:~~

- ~~Basic Case Management Services~~
- ~~Management of acute or chronic illness, including emotional and social support issues by a multidisciplinary case management team~~
- ~~Intense coordination of resources to ensure member regains optima health or improved functionality~~
- ~~With member and PCP input, development of care plans specific to individual needs, and updating of the care plans at least annually~~

Complex Case Management is ~~provided~~available to CalOptima Health ~~the following M~~members who include but are not limited to:

- A Member who is stratified as high-risk, defined as:
- A Member who has a medically complex condition, including the most frequently managed conditions; or

4. High risk groups, that may include, but are not limited to:
5. Spinal Injuries;
6. Transplants;
7. Cancer;
8. Serious Trauma;
9. AIDS;
10. Multiple chronic illnesses; and

- Chronic illnesses that result in high utilization
- A Member who has a complex social situation that affects the medical management of the Member's care;

Back to Agenda Back to Item

- A Member who requires an extensive use of resources; or
- A Member who has an illness or condition that is severe, and the level of management necessary is very intensive.

~~Complex Case Management is the coordination of care and services provided to a member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.~~
~~The members in Complex Case Management usually:~~
~~Are at high risk; or~~
~~Have medically complex or frequently managed conditions or diseases, including, but are not limited to, the following:~~
~~Spinal Injuries~~
~~Transplants~~
~~Cancer~~
~~Serious Trauma~~
~~AIDS~~
~~Multiple chronic illnesses~~
~~Chronic illnesses that result in high utilization~~
~~Have a complex social situation that affects the medical management of their care;~~
~~Require extensive use of resources; or~~
~~Have an illness or condition that is severe, and the level of management necessary is very intensive.~~

CalOptima Health uses this criterion when data mining and as a guideline for internal and external referral sources to identify members who would benefit from ~~appropriate~~ CCM ~~cases~~.

Children and Youth with Special Health Care Needs Case Management
Children and Youth with Special Health Care Needs (CYSHCN) ~~are~~ include infants, children, and youth from birth to age 21 who have one or more chronic physical, developmental, behavioral, or emotional conditions, and require special health and support services~~those who have, or are at increased risk for, a chronic physical, developmental, behavioral, or emotional condition~~. ~~They may have a disability or chronic medical condition due to complications of prematurity, metabolic disorder, chromosomal abnormalities, or congenital abnormalities. They require health and related services of a type or amount beyond that required by children generally.~~

Back to Agenda Back to Item

Case Management staff ensure coordination of care with other entities that provide services for Children and Youth with Special Health Care Needs (e.g., mental health, substance abuse, Regional Center, CCS, local education agency, child welfare agency).

~~The goals of CSHCN Case Management are to:~~

- ~~Collaborate with family and providers to develop an Individualized Care Plan~~
- ~~Facilitate member access to needed services and resources~~
- ~~Preventing duplication of services~~
- ~~Optimize members' physical and emotional health and well-being~~
- ~~Improve member's quality of life~~

Whole Child Model (WCM)Case Management

Children and youth who meet condition-specific eligibility are supported through Whole Child Model Case Management. ~~The Whole-Child Model is a program that aims to help California Children's Services (CCS) children, and their families get better care coordination, access to care, and health results. The WCM program combines a qualified member's Medi-Cal and CCS benefits under CalOptima Health. CCS is a statewide program that arranges and pays for medical care, equipment and other services for children and young adults under 21 years of age who have certain serious medical conditions.~~

~~Provides access for families so that families know where to go for ongoing information, education, and support in order that they understand the goals, treatment plan, and course of care for their child or youth and their role in the process, what it means to have primary or specialty care for their child or youth, when it is time to call a specialist, primary, urgent care, or emergency room, what an Interdisciplinary Care Team (ICT) is, and what the community resources are.~~

~~The~~ Whole Child Model ~~program~~ Case Management includes:

- ~~Assigning Personal Care Coordinator (PCC) will be assigned to each CCS-eligible Member.~~
- Case Management staff such as a (PCC) or a licensed care manager to each CCS-eligible Member.
- Case Management staff shall serve as the Member's assigned primary point of contact with CalOptima Health or a Health Network.
- Performing initial and periodic outreach to assist the Member with Care Coordination.
- Providinge information, education and ~~support continuously~~ongoing support, as appropriate.
- ~~Assisting~~ the Member and the Member's family in understanding the CCS-eligible Member's health, ~~other~~ availability of eligible~~le~~ services, and how to access those services.

Back to Agenda Back to Item

-
- Assisting as point of contact for other care managers and service Providers that serve WCM members, including ECM and Community Supports providers.
  Improve coordination of services to meet the needs of the child and family

  Maintain existing patient-provider relationships when possible
  Retain CCS program standards
  Improve overall health results

Transitional Care Services (TCS)

In January 1, 2023 DHCS outlined a phased approach in the Population Health Management (PHM) Policy Guide to provide Transitions of Care Services that started January 1, 2023. Transitional Care Services are provided to members transitioning from between levels of care. Transitions may include, including between and out of hospitals, institutions, other acute care facilities and skilled nursing facilities, post-acute care facilities or long termlong-term care settings. Members meeting the definition of identified as TCS High Risk, per DHCS definition, receive outreach from designated TCS staff.

The goal of outreach is to address all member needs after hospitalization, including scheduling follow-up visits with the PCP, reviewing medications, coordinating transportation, and resolving discharge-related items such as home health services and durable medical equipment. The goal of outreach is to ensure all member needs are metaddressed following post hospitalization, including scheduling follow up visits with PCP, medication review, coordinating transportation needs, and resolution ving of discharge-related items such as summary follow up items such as home health services, and durable medical equipment. An additional area Additional focus areas include connecting members to resources that promote indepenenceindependence, such as of focus is referrals to resources and services that support independence such as IHSS, CBAS and MSSP. Additional services that support transitions such as as well as and services that support transition such as CalAIM Community supports. The TCS program continues to strengthen outreach efforts to support transitions of care such as through text messaging, AtTexting campaign initiatedlaunchedinitiated in October 2024 to outreach to members post-dischargeenahnces post-discharge outreach. The TCS program Continuecontinues to strengthen improving outreach efforts to supporting transitions of care.

The TCS program responsibilities include:

- Coordination ensuringEnsuring assigned members recevierecevie all appropriate TCS services, regardless of care setting- including inpatient facilities, discharging facilities and community based organizations.

- ~~Facilitate collaboration~~Collaborating and communica~~tion~~ting ~~among~~with members, family members, ~~families,~~ guardians and support persons to promote safe and effective transitions.
- Facilitati~~nge~~ collaboration, communication and coordination with hospitals, emergency departments, LTSS, and providers including PCP, ~~physicians, nurses~~physicians, nurses, social workers, discharge planners and service providers.

While not required to perform all tasks directly, TCS staff are accountable for ensuring the completion of all transitional care management activities, including:

- ~~Dishargе~~Discharge risk assessments.
- Discharge planning documentation.
- Coordination of post-discharge services.

11. Promot~~e~~ion of continuity of care and reduc~~e~~tion of avoidable readmission by ensuring all needed services and supports are in place post hospitalization and clear communication across care teams.

~~The TCS dedicated staff are responsible for coordinating and verifying that assigned members receive all appropriate TCS, regardless of setting and including, but not limited to, inpatient facilities, discharging facilities, and community-based organizations. The TCS staff are also responsible for ensuring collaboration, communication, and coordination with members and their families/support persons/guardians, hospitals, EDs, LTSS, physicians (including the member's PCP), nurses, social workers, discharge planners, and service providers to facilitate safe and successful transitions. While the TCS staff do not need to perform all activities directly, they must ensure all transitional care management activities occur, including the discharge risk assessment, discharge planning documentation, and necessary post-discharge services.~~

For members enrolled with Case Management or ECM, the assigned Case Manager ~~will~~ ~~provide~~provides TCS ~~and support~~for recently discharged members. The CM point of contact provides tools and support to promote and maintain the member's self-management skills, helping reduce the risk of readmission and improve the member's quality of life. ~~with tools and support to encourage and sustain self-management skills to help minimize the potential of a readmission and optimize the member's quality of life.~~ TCS is provided to ensure members are supported from discharge planning until they have been successfully connected to all needed services and supports.

Special Programs

Transplant Program

~~The CalOptima Health Transplant Program is coordinated by the Medical Director, UM Department and CM Department staff.~~

The CalOptima Health Transplant Program provides the resources and tools needed to proactively manage members identified as potential transplant candidates. The CalOptima Health Transplant Program is coordinated by the Medical Director, UM Department and CM Department staff who ~~The CalOptima Health Utilization Management and Case Management Department~~ work~~s~~ in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence or CMS certified Centers for OneCare.

CalOptima Health Utilization Management will notify Case Management ~~for~~about members who have been referred for transplant evaluation. Case Management follows ~~the~~ all identified member~~s~~ and assists members as needed with transplant related issues. Coordination and support occur throughout the transplant continuum~~--through~~ during the transplant evaluation process, while the member is waiting to procure an organ, and post-transplant for one year.

Members are monitored on an inpatient and outpatient basis and followed through the transplant continuum. ~~The~~ Coordination occurs between the member, physician and facilities ~~are assisted in order~~ to assure timely, efficient and coordinated access to the appropriate level of care and services within the member's benefit structure. ~~In this manner,~~This structure allows the Transplant Program to benefit~~s~~ the member~~s~~, the community of transplant staff and the facilities. CalOptima Health monitors and maintains oversight of the Transplant Program and reports to the UM Committee regarding oversight of~~to oversee the~~ accessibility, timeliness, and quality of the transplant protocols.

Transplants for Medi-Cal members are not delegated to the HMOs, PHCs or SRGs.

Palliative Care Services

The CalOptima Health Case Management and Utilization Management teams work collaboratively to ensure access to Palliative Care services. Palliative care consists of patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. ~~Palliative care is specialized medical care for people living with a serious illness.~~ Palliative care may be provided concurrently with curative care and does not require the member to have a life expectancy of six months or less~~, and palliative care may be provided concurrently with curative care~~.

~~This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve the quality of life for both the members and their family.~~

Palliative care is provided by a trained team of doctors, nurses and other specialists who work together with the member's ~~s other~~ practitioner team~~doctors~~ to provide an extra layer of support. Eligibility for p~~P~~alliative care, as ~~is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment~~~~eligibility~~ defined ~~in~~by DHCS APL ~~All Plan Letter~~ 18-020 must be met.

Back to Agenda Back to Item

2026 Integrated Utilization Management and Case Management Program Description

Back to Agenda Back to Item

2026 Integrated Utilization Management and Case Management Program

Signature Page

Utilization Management Committee Chair:

Zeinab Dabbah, M.D.	***Date***
Deputy Chief Medical Officer	

Board of Directors' Quality Assurance Committee Chairperson:

Jose Mayorga, M.D.	***Date***

Board of Directors Chairperson:

Vicente Sarmiento	***Date***

Table of Contents

2026 Integrated Utilization Management and Case Management Program Description 1

2026 Integrated Utilization Management and Case Management Program 2

Signature Page 2

We Are CalOptima Health 6

Our Mission 6

Our Vision 6

We are "Better. Together." 6

Our Strategic Plan 6

Future Growth - What Is CalOptima Health? 7
Our Unique Dual Role 7

What We Offer 8
Medi-Cal 8
Members with Special Health Care Needs 8
Medi-Cal Managed Long-Term Services and Supports 9
Emergency Department (ED) Diversion Program 9
OneCare (HMO D-SNP) 10

Quality Program Initiatives 10
Comprehensive Community Cancer Screening and Support Program 11
Five-Year Hospital Quality Program 2023-2027 11

Whole-Child Model 11

California Advancing and Innovating Medi-Cal (CalAIM) 12
Enhanced Care Management and Community Supports 12

Population Health Management (PHM) Program Strategy 13

CalOptima Health Direct Network and Health Network Entities 15
Direct Network and Contracted Health Networks Entities 15

Utilization Management Program 21

Utilization Management Purpose 21

UM Scope 21

UM Process 21

UM Program Development and Enhancement Process 22

Back to Agenda Back to Item

UM Program Goals 22
UM Program Structure 24
Long-Term Services and Supports (LTSS) 24
Home and Community-Based Services 25
Behavioral Health Services 25
Authority, Boards of Directors' Committees, and Responsibilities 26
Board of Directors 26
CalOptima Health Officers 29
UM Program Leadership 32
Pharmacy Staffing Resources 36
LTSS Staffing Resources 37
Behavioral Health Integration Staffing Resources 38
Qualifications and Training 39
Utilization Management Committee (UMC) 39
Utilization Management Committee (UMC) 40
Conflict of Interest 41
Participating Physician 41
Confidentiality 42
UMC Scope and Responsibilities 42
Benefit Management Subcommittee (BMSC) 44
UM Workgroup 45
High-Risk Management Workgroup 47
Over/Underutilization Workgroup 47
Early and Periodic Screening Diagnosis Treatment (EPSDT) Workgroup 47
Enhanced Case Management (ECM) Clinical Oversight Workgroup 47
Skilled Nursing Facility (SNF) Workgroup 48
Integration of Utilization Management and Quality Management 48
Integration with Other Processes 49
Review and Authorization of Services 50
Medical Necessity Review 50
Prior Authorization 53
Appropriate Professionals for UM Decision Process 54
Pharmaceutical Management 55
Medicare 56
Pharmacy Benefit Manager (PBM) 56
Behavioral Health Determinations 56
Medi-Cal 56
Medicare 56
UM Hierarchical Criteria 56

Medi-Cal 57
Medicare (OneCare) 57
Whole Child Model (WCM) 58
Board Certified Clinical Consultants 59
Practitioner and Member Access to Criteria 59
Inter-Rater Reliability (IRR) 60
Provider and Member Communication 60
Access to Physician Reviewer 61
UM Staff Access to Clinical Expertise 61
Requesting Copies of Medical Records 61
Sharing Information 62
Provider Communication to Member 62
Timeliness of UM Decisions 62
UM Decision and Notification Timelines 62
Pharmacy Prior Authorization Determination Timelines 70
Emergency Services 72
Authorization for Post-Stabilization Inpatient Services 72
Retrospective Review 73
Admission/Inpatient Review Process 73
Discharge Planning Review 74
Denials 75
Grievance and Appeal Process 76
Expedited Appeals and Grievances 77
State Hearing 78
Independent Medical Review 78
Provider Preventable Conditions 78
Long-Term Services and Supports 79
Long Term Care (LTC) 79
Community-Based Adult Services (CBAS) 80
Multipurpose Senior Services Program (MSSP) 80
Over/Under Utilization 81
Program Evaluation 81
Satisfaction with the UM Process 82
Case Management Process **82**
Program Updates and/or Changes 83
Team Composition and Roles 83

Staff Training/Education 86
Coordination of Care 87
Coordination of Carved Out Services 89
Clinical Practice 90
Types of Case Management Services 91
Special Programs 94

We Are CalOptima Health

Caring for the people of Orange County has been CalOptima Health's privilege since 1995. Our Medicaid (Medi-Cal) and Medicare members deserve the highest quality of care and service across the health care continuum. CalOptima Health works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision.

Our Mission

To serve members' health with excellence and dignity, respecting the value and needs of each person.

Our Vision

By 2027, provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

We are "Better. Together."

We cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, state and federal agencies, and other community stakeholders. Together, we develop innovative solutions and meet our diverse members' health care needs. We are "Better. Together."

Our Strategic Plan

In 2024, CalOptima Health's Executive Team developed the 2025 3-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan was approved by the CalOptima Health Board of Directors on February 6, 2025 . The plan continues to be reviewed and updated, at a minimum of annually, based on guidance and recommendations

from CalOptima Health Board of Directors and the Executive Team. The core strategy of the Strategic Plan is an inter-agency co-creation of services and programs, together with our delegated networks, providers, and community partners, to support the mission and vision. Our Priorities and Objectives are designed to enhance the programs and services provided to members by CalOptima Health.

The Clinical Operations/ Medical Management Priorities and Objectives are to:

1.1 Utilize technology and innovation to strengthen equity and population health management programs.	% compliance with HbA1c Control for Patients with Diabetes (GSD).
1.2 Implement a consistent model of care for population health and care management, including delegated networks.	% of members successfully enrolled in CCM program.
1.3 Annually assess members' health and social needs and utilize data to develop targeted interventions.	% compliance with the Annual Wellness Visit (AWV) and Initial Health Appointment (IHA) measures.
1.4 Increase access to preventive services for vulnerable populations in pursuit of health equity	% compliance with Prenatal and Postpartum Care (PPC) measures through targeted member outreach.
2.1 Achieve NCQA rating of 4-stars for Medi-Cal. Achieve CMS rating of 3.5-stars for Medicare.	Achieve 4-star rating for Medi-Cal and 3.5-star rating for Medicare annually
2.4 Expand the delivery of behavioral health services, invest in the workforce, and drive quality improvement through innovation.	% Follow-Up After Emergency Department Visit for Mental Illness (FUM) within 30 days
4.1 Improve the turnaround time for treatment authorizations for direct and delegated networks.	Improve Treatment authorizations processing time by 10% for all CalOptima Health Providers by 2027.
4.3 Launch and grow programs that take care of our members and their families across their lifespan.	Membership by Line of Business

Future Growth - What Is CalOptima Health?

Our Unique Dual Role

CalOptima Health operates as both a public agency and a community health plan.
In this dual role, CalOptima Health is responsible for the following programmatic objectives:

- Provide quality healthcare to ensure optimal health outcomes for our members.
- Support member and provider engagement and satisfaction.
- Be good stewards of public funds by making the best use of our resources and expertise.
- Ensure transparency in our governance procedures, including providing opportunities for stakeholder input.
- Be accountable for the decisions we make.

What We Offer

Medi-Cal

In California, Medicaid is known as Medi-Cal. Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, Affordable Care Act (ACA) expansion members, children in foster care (as well as former foster youth up to age 26), pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A Medi-Cal member must reside in Orange County to be enrolled in CalOptima Health Medi-Cal subject to Medi-Cal eligibility rules and income limits

Scope of Services

CalOptima Health provides a comprehensive scope of acute, chronic and preventive care services for Orange County's Medi-Cal and dual eligible population. In addition, since 2019 CalOptima Health has managed a Whole-Child Model (WCM) Program under California Children's Services (CCS) consisting of specialized services for members with qualifying conditions.

Certain services carved out of coverage by CalOptima Health but may be provided by a different agency, in these cases, CalOptima Health coordinates with the various agencies to ensure member access . These services include:

- Specialty mental health and substance use disorder services administered by the Orange County Health Care Agency (HCA).
    - Dental services provided through the Medi-Cal Dental Program.

Members with Special Health Care Needs

To ensure that clinical services are accessible and available to members with special health care needs — such as seniors, people with disabilities and people with chronic conditions — CalOptima Health has developed specialized case management services. These case management services are designed to ensure coordination and continuity of care and are described in the Utilization Management (UM) Program and the Population Health Management (PHM) Strategy.

CalOptima Health works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services to enhance their Medi-Cal benefits. Partnerships with designated service administrators are established as through a specific Memoranda of Understanding (MOU) with community agencies such as the Orange County Health Care Agency (HCA).

Medi-Cal Managed Long-Term Services and Supports

Since July 1, 2015, the Department of Health Care Services (DHCS) has integrated Long-Term Services and Supports (LTSS) benefits for CalOptima Health Medi-Cal members into the scope of benefits provided by CalOptima Health. CalOptima Health ensures LTSS services are available to members who meet the program eligibility criteria and guidelines and have health care needs that would benefit from the programs.

Integrated LTSS benefits include three programs:

1. Community-Based Adult Services (CBAS)
2. Nursing Facility (NF) Services for Long-Term Care (LTC)
3. Multipurpose Senior Services Program (MSSP)

Emergency Department (ED) Diversion Program

CalOptima Health operates an Emergency Department (ED) Diversion Program to help members access care at the right level and avoid unnecessary ED visits. The program is currently embedded at our highest-volume hospital partner, the University of California Irvine (UCI), one of the largest facilities serving CalOptima Health members.

The primary goal is to provide face-to-face engagement whenever possible with members in the ED to ensure timely coordination of follow-up care with their ambulatory care team. A dedicated CalOptima Health Care Manager (MSW) works onsite to:

- Expedite care coordination across CalOptima Health departments and community-based resources.
- Connect members to appropriate services such as primary care, behavioral health, pharmacy, transportation, and social supports.

Goals of the Emergency Department Diversion program include:

  - Coordinate the members' plan of care with the facility ED team, CalOptima Health and community resources.
  - Coordinate appointments with the member's providers including but not limited to Primary Care Physician (PCP) or specialist, pharmacy, transportation, durable medical equipment (DME), Home Health, Hospice, Palliative Care, CalAIM, Behavioral Health, CalOptima Health CM and Enhanced Case Management ECM.
  - Educate member about accessing care in alternative settings such as through their PCP or Urgent Care facilities.
- Prevent future ED visits by assisting with connection and access to ambulatory care and resources.

- Ensure access to resources and social determinates of health are addressed based on member needs and preferences.
- Warm handoff transitions to CalOptima Health's' delegated Health Networks, CM, ECM or TCS referrals.

OneCare (HMO D-SNP)

CalOptima Health's OneCare program serves dual-eligible members—those enrolled in both Medi-Cal and Medicare Parts A and B—who live in Orange County. By combining benefits into a single plan, OneCare simplifies access to care and ensures members receive the services they need.

Since 2005, OneCare has supported low-income seniors and individuals with disabilities, offering coordinated medical, behavioral, and supportive services. Enrollment is voluntary, and each member is assigned a Case Manager or Personal Care Coordinator (PCC) as a single point of contact. This role helps members navigate the health care system and develop an individualized care plan in collaboration with providers, ensuring a seamless, high-quality experience.

Quality Program Initiatives

CalOptima Health has a Quality Improvement and Health Equity Transformation Program with Priority Areas and Goals that align with CalOptima Health's Strategic Goals and California Department of Health Care Services (DHCS) Bold Goals. The aligned quality initiatives include:

- Maternal Health
  - Close racial/ethnic disparities in well-child visits and immunizations by 50%
  - Close maternity care disparity for Black and Native American persons by 50%
- Children's Preventive Care
  - Exceed the 50th percentile for all children's preventive care measures
- Behavioral Health Care
  - Improve maternal and adolescent depression screening by 50%
  - Improve follow-up for mental health substance disorder by 50%
- Program Goals
  - Medi-Cal: Exceed the minimum performance levels (MPLs) for the Medi-Cal
- Accountability Set (MCAS)
  - OneCare: Attain a Four-Star Rating for Medicare

Comprehensive Community Cancer Screening and Support Program

The Comprehensive Community Cancer Screening and Support Program launched in December 2022 through approval by the CalOptima Health Board of Directors. The program aims to create a health ethos with respect to breast cancer, cervical cancer, colorectal cancer and lung cancer. CalOptima Health strives to be the health care exemplar for all Orange County residents.

The goal of the program is to create a culture of cancer prevention, early detection and collaboration with partners such as physicians, Cancer Centers and the community. Collectively, the program works toward dramatically decreasing late-stage cancer incidence and ensuring CalOptima Health Medi-Cal members have equitable access to high quality care. Increasing cancer screening rates is crucial for the early diagnosis and treatment of cancer, ultimately increasing life expectancy, quality of life and reducing health care costs.

The Comprehensive Community Cancer Screening and Support Program aims to increase early detection through improved awareness and access to cancer screening, decrease late-stage cancer diagnoses rates and mortality, and improve quality and member experience during cancer screening and treatment procedures among Medi-Cal members.

The program uses a phased-in approach over a four-year period to invest in the following three pillars:

1. Community and member awareness and engagement
2. Access to cancer screening
3. Improved member experience throughout cancer treatment

To support these pillars, CalOptima Health awards grants to community-based organizations and a Digital Health communication vendor. CalOptima Health oversees the grant administration, partners closely with grantees to support programmatic outcomes, and holds quarterly meetings to review progress toward goals and share best practices.

Five-Year Hospital Quality Program 2023-2027

CalOptima Health has developed a hospital quality program to improve quality of care to members through increased patient safety efforts and performance-driven processes. The hospital quality program utilizes public measures reported by CMS and The Leapfrog Group for quality outcomes, patient experience, and patient safety. Hospitals may earn annual incentives based on the achievement of benchmarks.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with eligible serious medical conditions. CCS provides medical care, case management, physical/occupational therapy, and financial assistance to qualifying members. Through the passing of SB 586 on July 1, 2019, the state integrated CCS services into CalOptima Health's Medi-Cal managed care plan benefit, now called Whole Child Model (WCM). The goal of this integration was to improve health care coordination by providing all needed care (CCS and non-CCS services including utilization management, transportation, care coordination, case management and complex case management) into a managed care plan (MCP), rather than providing CCS services separately. The HCA in Orange County continues to have the CCS program to operate the medical eligibility determination processes, the Medical Therapy Unit and Program and CCS service authorizations for non- CalOptima Health enrollees. CalOptima Health works closely with the county CCS office to align protocols and ensure continuity of care for CCS-eligible members.

California Advancing and Innovating Medi-Cal (CalAIM)

California Advancing and Innovating Medi-Cal (CalAIM) is a multiyear initiative by DHCS, spanning from 2022 to 2027, to improve the quality of life and health outcomes of California's Medicaid population. CalAIM includes implementation of a broad delivery system, program, and payment reforms across Medi-Cal.

CalOptima Health has been operating CalAIM services and supports since 2022 and continues to work on increasing member access. CalOptima Health's CalAIM program operates based upon three primary goals:

- Identification and management of member risk and need through whole person care approaches and addressing social determinants of health.
    - Development of a consistent and seamless delivery of care and services through reduction of complexity and increased flexibility.
    - Improved member outcomes, reduction of health disparities, improved health equity and innovation through value-based initiatives, modernization of payment reform.

Enhanced Care Management and Community Supports

CalOptima Health launched CalAIM at the program's inception by implementing Enhanced Care Management (ECM) and adopting all 14 Community Supports. An additional 15th Community Support, Transitional rent, went live on 1/1/2026. ECM provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Members eligible for ECM are identified either through risk stratification into a DHCS Population of Focus (POF) or by meeting DHCS eligibility criteria and being referred for services.

CalOptima Health contracts with ECM providers who are responsible for coordinating care with members' existing providers and other agencies to deliver the following seven core service components:

- Outreach and Engagement
- Comprehensive Assessment and Care Management Plan
- Enhanced Coordination of Care
- Health Promotion
- Transitional Care Services
- Member and Family Supports
- Coordination of and Referral to Community and Social Support Services

CalOptima Health has partnered with local Community Based Organizations to provide the 15 Community Supports for our members in a medically appropriate, community-rooted, cost-effective manner. The Community Supports include:

1. Housing Transition Navigation Services
2. Housing Deposits
3. Housing Tenancy and Sustaining Services
4. Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Assisted Living Facility (ALF) Transitions
- Community or Home Transition Services
5. Personal Care and Homemaker Services
6. Environmental Accessibility Adaptations (Home Modifications) includes Personal Emergency Response Systems (PERS)
7. Medically Tailored Meals/Medically Supportive Foods
8. Sobering Centers
9. Asthma Remediation
10. Transitional Rent- Went live on 1-1-2026

Authorizations for CalAIM ECM and Community Supports are coordinated through the CalOptima Health Connect Portal.

Population Health Management (PHM) Program Strategy

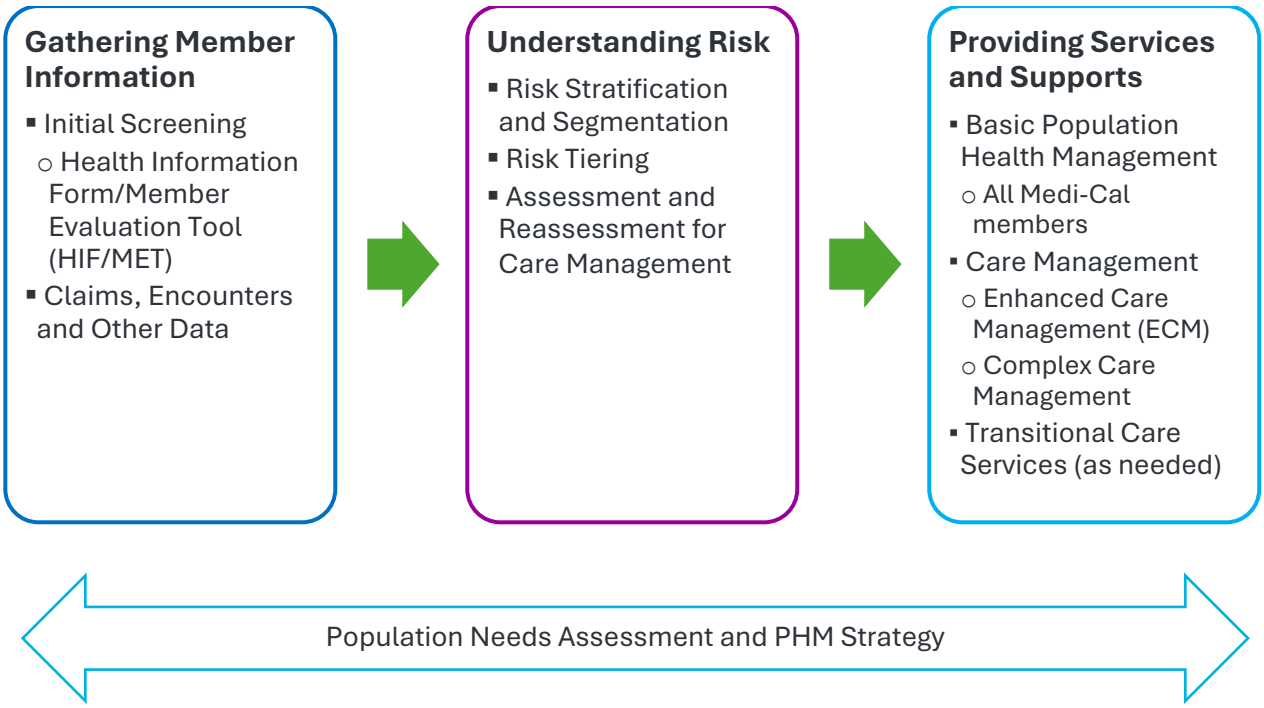
CalOptima Health's Population Health Management (PHM) Strategy is a foundational effort to deliver whole-person, equitable, and coordinated care across the full continuum of health services and throughout the life span of CalOptima Health members. CalOptima Health's PHM program demonstrates its commitment to improving member outcomes through integrated, person-centered care that spans physical and behavioral health, LTSS, care coordination, utilization management, and complex case management. PHM services include population health management, care management, ECM, transitional care, and complex care management.
The PHM Strategy is guided by five key focus areas:

- Keeping members healthy
- Managing members with emerging risks
- Increasing patient safety and improving outcomes across care settings
- Managing members with multiple chronic conditions
- Providing advance care support

The PHM Framework outlines four key components for operationalizing the program:

- Population Health Management Strategy and Population Needs Assessment
- Gathering member information
- Understanding risk
- Providing services

Figure 1: PHM Framework



The goals of the PHM program are to establish:

- Trust and meaningful engagement with members
- Data-driven risk stratification and predictive analytics to address gaps in care
- Revisions to standardize assessment processes
- Care management services for all high-risk members
- Robust transitional care services (TCS)
- Effective strategies to address health disparities, Social Determinants of Health (SDOH) and upstream drivers of health
- Interventions to support health and wellness for all members

CalOptima Health analyzes the PHM program annually and uses key performance indicators (KPIs) to measure the effectiveness of PHM. KPIs may include but are not limited to utilization of Primary Care, ambulatory care, ED visits, and inpatient stays as well as outcomes for quality measures, such as HEDIS.

CalOptima Health Direct Network and Health Network Entities

Direct Network and Contracted Health Networks Entities

Providers have several options for participating in CalOptima Health's programs and providing health care to CalOptima Health members. Providers can participate through the CalOptima Health Direct (COD) network, CalOptima Health Community Network (CCN), or through a Health Network (HN) affiliation.

CalOptima Health members can choose a Primary Care Provider (PCP) in CalOptima's Community Network (CCN) or one of 11 HNs, representing more than 10,000 practitioners. CalOptima Health members that do not choose a PCP are provisionally assigned to CalOptima Health's Direct Administrative network for forty-five (45) days until they choose a HN and PCP.

CalOptima Health Direct (COD)

CalOptima Health Direct (COD) network is composed of two elements: CalOptima Health Direct-Administrative (COD-A) and the CalOptima Health Community Network (CCN).

1. *CalOptima Health Direct-Administrative (COD-A)* is a self-directed program administered by CalOptima Health to serve Medi-Cal members in special situations, including:

- Dual-eligible individuals (those with both Medicare and Medi-Cal who choose not to participate in CalOptima Health's OneCare program)
- Share-of-cost members

- Newly eligible members transitioning from CCN to a health network (HN) Members residing outside Orange County awaiting benefit transitions.

2. *CalOptima Health Community Network (CCN)* - provides doctors with an alternate path to contract directly with CalOptima Health to serve our members. CCN is administered directly by CalOptima Health and is available for HN eligible members, supplementing the existing HN delivery model and creating additional capacity for access for certain covered services that are not the financial risk of the HN.

CalOptima Health Contracted Health Networks

CalOptima Health has contracts with HNs that are delegated to perform certain clinical and administrative functions on behalf of CalOptima Health through a variety of risk models to provide care to members. The following contract risk models are currently in place with HNs:

- Health Maintenance Organization (HMO)
- Physician/Hospital Consortia (PHC)
- Shared-Risk Group (SRG)

Through our delegated HNs, CalOptima Health members have access to 1,306 primary care providers (PCPs), 7,966 specialists, 42 hospitals, 71 Community Health Centers clinics and 240 long-term care facilities.

Table 1: Provider Network Data (as of December 29,2025)

	Number of Providers
Primary Care Providers	1,306
Specialists	7,966
Pharmacists	498
Acute and Rehab Hospitals	42
Community Health Centers	71
Long-Term Care Facilities	240

CalOptima Health contracts with the following Health Networks as Shared Risk Group (SRG), Physician-Hospital Consortia (PHC), or Health Maintenance Organization (HMO):

Table 2: CalOptima Health Network

Health Network/Delegate	Medi-Cal	OneCare
AltaMed Health Services	HMO	SRG
AMVI Care Medical Group	PHC	PHC

CHOC Health Alliance	PHC	
Family Choice Medical Group		SRG
Family Choice Health Services	HMO	
HPN – Regal Medical Group	HMO	HMO
Optum	HMO	HMO
Noble Mid-Orange County	SRG	SRG
Prospect Medical Group	HMO	HMO
United Care Medical Group	SRG	SRG
Providence Medical Foundation	SRG	

CalOptima Health delegates clinical functions for a portion of the CalOptima Health membership to Health Network's (HN) that demonstrate the ability to meet CalOptima Health's standards, as outlined in the UM Program Description and CalOptima Health policies and procedures. Delegated clinical functions may include but are not limited to Utilization Management, Basic and Complex Case Management and navigation and referrals to CalAIM community supports, ECM, and community organizations.

CalOptima Health retains accountabilities for all delegated functions and services, and monitors the performance of the delegated HN through the following processes:

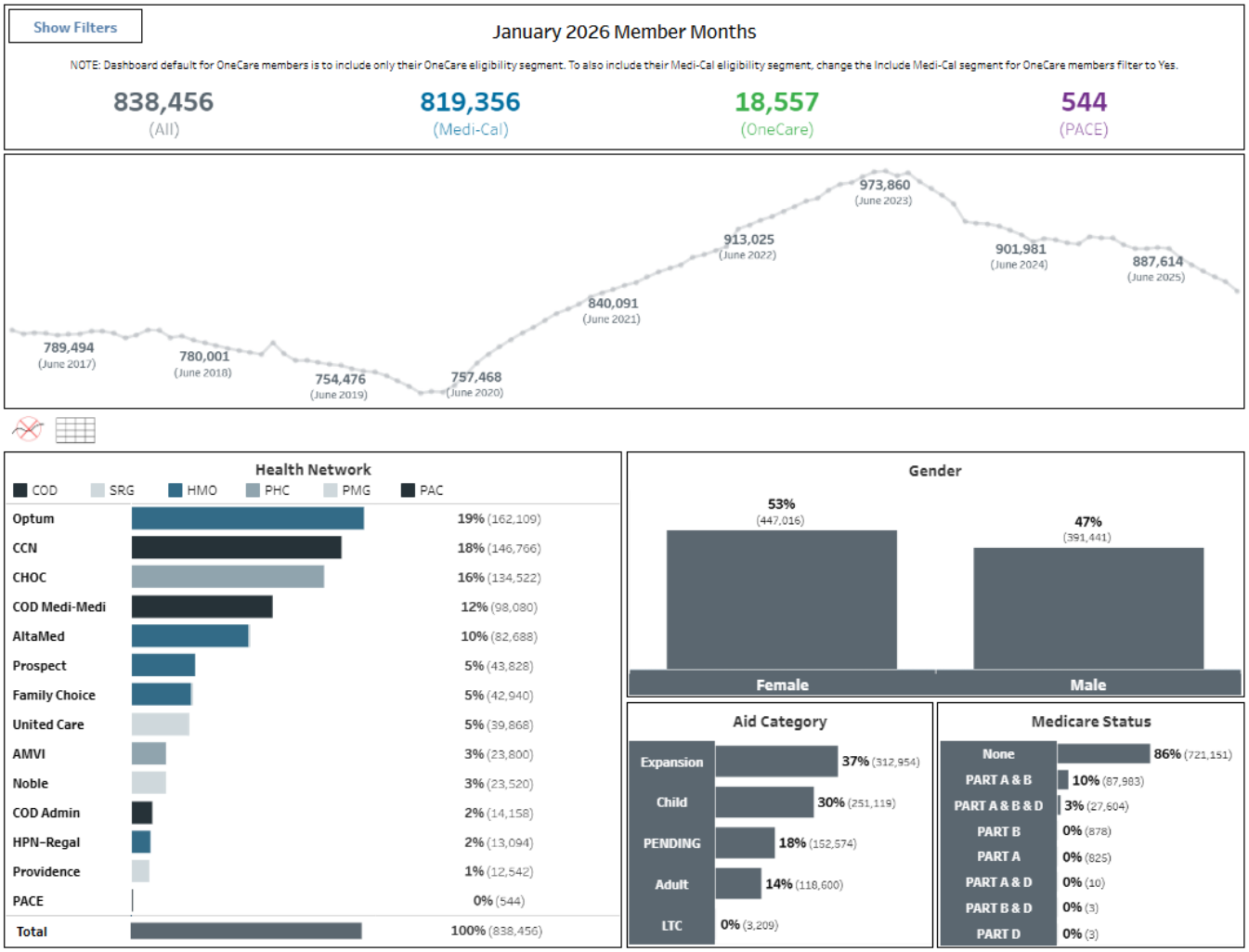
- Routine monitoring of key performance indicators (KPIs) , contracted data elements submitted by delegates and/or developed by CalOptima Health's Claims, Credentialing, Customer Service, and Utilization Management Departments in consultation with Delegation Oversight and Information Technology Services. KPIs that fall below goal are addressed through a defined escalation process commencing with a Health Network Dashboard Response Form.
- Quarterly and ad hoc meetings with the business unit department to discuss UM Work Plan activities and addressing any KPIs measuring below goal.
- Quarterly reporting of KPIs to the Delegation Oversight Committee (DOC) and/or Quality Improvement Health Equity Committee (QIHEC).
- Annual and ad hoc audits of UM activities by CalOptima Health's Delegation Oversight Department to ensure accurate and timely completion of delegated activities.
- Annual or more frequent evaluation to determine whether the delegated activities are being carried out in accordance with DHCS, Centers for Medicare & Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), and CalOptima Health policies, standards and program requirements.
- Annual approval of the HNs UM Program (or portions of the program that are delegated), as well as approval of any significant changes that occur during the contract year.

In the event the HN does not adequately perform contractually specified delegated duties, CalOptima Health takes further action, including increasing the frequency or number of focused audits, requiring the HN to implement corrective actions, imposing sanctions, capitation review, or de-delegation.

Health Network Forum

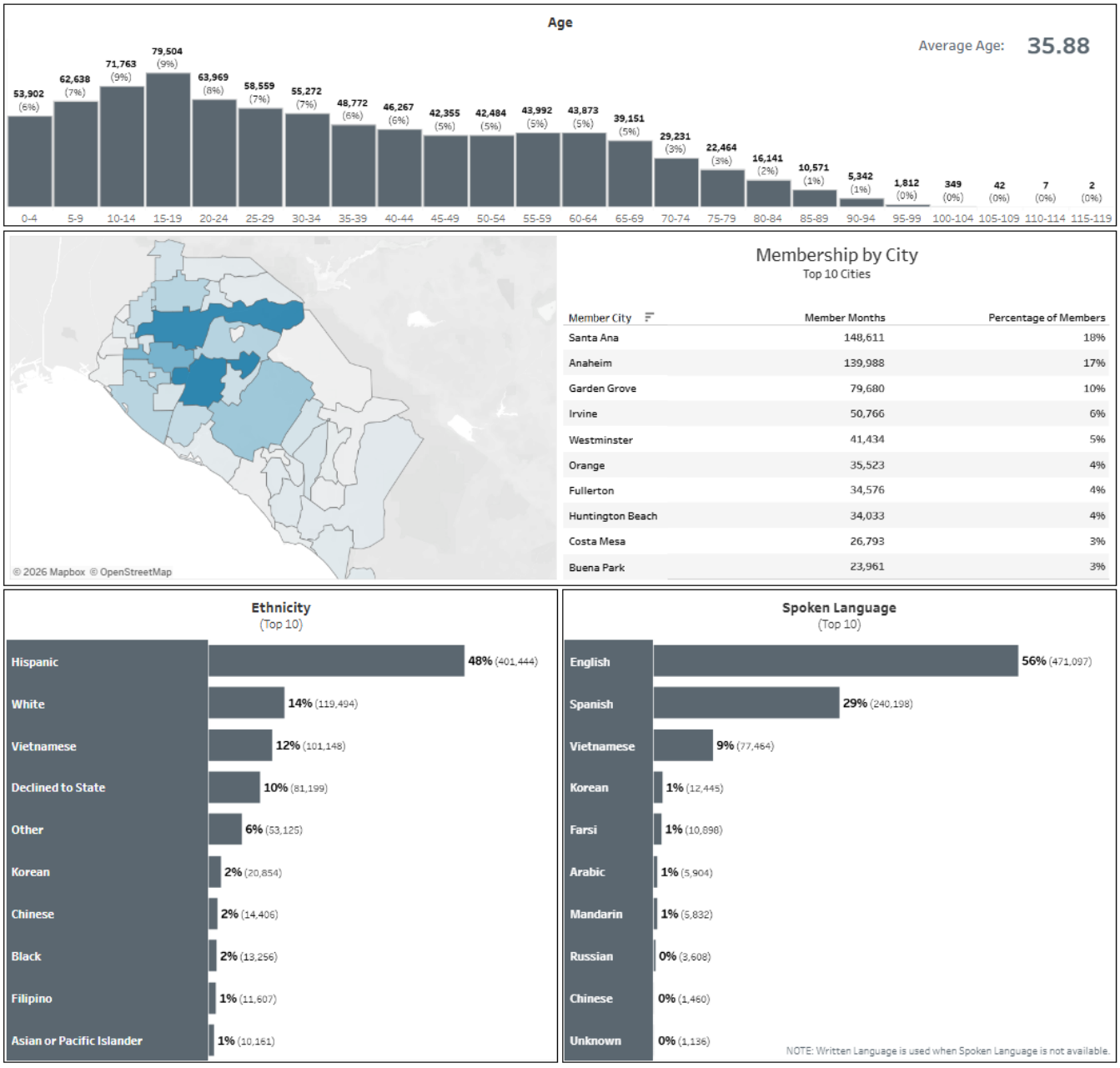
CalOptima Health's monthly Health Network Forum is led by the Executive Director of Network Operations. The forum includes representatives from Health Networks and CalOptima Health who come together to discuss enhancements and changes to the implementation and operation of medical management programs. This forum allows all Health Networks the opportunity to provide feedback and discuss how to improve operations by establishing a cohesive and unified approach to managing CalOptima Health members, regardless of who is managing the care of the member.

Figure 2. January Member Overview



Source: Membership Dashboard tableau, data pulled 1/16/2026

Figure 3. January Member Overview (continued)



Source: Membership Dashboard tableau, data pulled 1/16/2026

Utilization Management Program

Utilization Management Purpose

The purpose of the Utilization Management (UM) Program is to define the oversight and delivery of CalOptima Health's structure, clinical processes, and programmatic approach to review health care services, treatment, and provide quality, coordinated health care services to CalOptima Health members. The UM Program includes monitoring and analysis of utilization trends for under and over-utilization to determine whether members are receiving appropriate services. The UM Program ensures all health care services serve the culturally diverse needs of the CalOptima Health population and are delivered at the appropriate level of care, in an effective, and timely manner by delegated and non-delegated providers.

UM Scope

The comprehensive UM Program scope encompasses all eligible members across all product types, age categories and range of diagnoses within CalOptima Health's membership. In addition, the UM program scope includes oversight of continuity of care and assurances for access to appropriate services, providers, and care settings. The UM Program incorporates physical and behavioral health, pharmacy services, emergency services, Long-term care and long-term services and supports (LTSS). LTSS includes preventive, primary, specialty, home and community-based services, as well as acute, subacute, short-term, and long-term facility and ancillary care services.

UM Process

The UM process includes but is not limited to the following program components: referral/prior authorization, inpatient and concurrent review, post-stabilization services, ambulatory care review, retrospective review, discharge planning, continuity of care coordination, transitions of care, and second opinions. All requests are reviewed against hierarchical guideline criteria and services must meet medical necessity criteria to be approved. The clinical decision process commences upon receipt of a treatment authorization request. Types of treatment authorization requests may include but are not limited to, authorization of specialty services, second opinions, outpatient services, ancillary services, post-stabilization inpatient services, scheduled inpatient services, and durable medical equipment. The treatment authorization review process is complete when the requesting practitioner, rendering practitioner, and member (when applicable) have been notified of the determination.

UM policies and processes serve as integral components in preventing, detecting, and responding to utilization trends and opportunities as well as identifying potential fraud, waste and abuse among practitioners and members. The UM Department works closely with the Regulatory Affairs and Compliance Department and the Fraud, Waste and Abuse Unit to resolve any potential issues that may be identified. All UM team members and oversight Committee members sign an annual attestation and are expected to abide by and uphold CalOptima Health's policy for ensuring all medical decisions are made in alignment within regulatory requirements and are not unduly influenced by financial considerations.

The CalOptima health UM Program may use (clinical, rule-based) algorithmic tools or other software to assist in the utilization review process (e.g. MCG or clinical provider portal rules) . These tools are prohibited from autonomously denying, modifying or delaying healthcare services. Any tool used for UM bases the determination on the member's specific medical history, individual clinical circumstances, and relevant clinical records. All adverse (modify, deny) medical necessity determinations are made by a licensed physician or appropriate licensed healthcare provider. Any automation or algorithmic tools are overseen by the UMC to ensure they are up to date, reliable and ensure non-discrimination. In addition, all such tools are open to regulatory audit and compliance review to ensure that they do not supplant human clinical judgement or cause patient harm.

CalOptima Health offers Continuity of Care services for up to 12 months. These services apply to a member's primary care provider, specialists, and certain ancillary providers when the member is a Medi-Cal beneficiary transitioning to CalOptima Health or moving from a Managed Care Plan whose contracts with CalOptima Health or a Health Network are expiring.

UM Program Development and Enhancement Process

CalOptima Health uses a multiprong approach to the development, ongoing review and enhancements to medical necessity criteria. Medical Director workgroups are held to discuss establishing or updating medical necessity criteria. Input from community providers representing various specialties and Health Network clinical leaders is integrated into final decisions. Decisions made by the workgroups are reported to the Utilization Management Committee (UMC).

UM Program Goals

The purpose of the UM Program is to manage appropriate utilization of medically necessary covered services and to ensure access to quality and cost-effective health care for members of CalOptima Health. UM Program achieves its goals by coordinating medically necessary services—including physical health, behavioral health, Long-Term Services and Supports (LTSS), Long-Term

Care (LTC), and pharmacy—based on benefit and clinical criteria. This coordination follows established hierarchies, state and federal laws, contract requirements, NCQA standards, and other evidence-based guidelines.

UM Program goals include:

- Enhancing the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Providing a mechanism to address concerns about access, availability, and timeliness of care.
- Clearly defining staff responsibility for activities regarding decisions based on medical necessity including non-clinical, clinical and Medical Director staff roles and responsibilities.
- Establishing and maintaining processes used to review medical and behavioral health care and pharmacy service requests, including timely notification to members and/or providers of appeal rights when an adverse determination is made based on medical necessity and/or benefit coverage.
- Identifying and referring members to Care Coordination, Case Management, Complex Case Management and Enhanced Care Management programs, LTSS, Transitional Care Services (TCS), Behavioral Health, Population Health Management services and CCS as appropriate.
- Promoting a high level of member, practitioner, and stakeholder satisfaction.
- Protecting the confidentiality of members' health and personal information.
- Identifying and reporting potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) through referral to the Quality Improvement (QI) Department for further action.
- Identifying and addressing over and underutilization of services. Monitoring utilization patterns of practitioners to identify variations from the standard practice that may indicate the need for additional education or support.
- Promoting improved member outcomes by coordinating services with appropriate county or state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health.
- Working collaboratively with CalOptima Health's Health Networks to coordinate care for complex discharge needs and CalAIM services.
- Continuously monitoring UM staffing needs including clinical, non-clinical and Medical Directors to ensure appropriate capacity to address the needs of the members we serve.
- Providing ongoing training for competency, and ensuring staff are well versed in UM processes, regulatory requirement changes and changes to departmental workflow/process.

UM Program Structure

The CalOptima Health UM Program ensures members receive appropriate, cost-effective and quality-based health care. The UM program is designed to support optimal health outcomes and includes collaboration with, but not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community

The UM Program is overseen by the Chief Medical Officer and UM Committee. The UM program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Medical Management and Quality leadership team including but is not limited to the Deputy Chief Medical Officer; Medical Director(s) of UM; Behavioral Health Medical Director; Executive Director of Behavioral Health Integration; Executive Director, Clinical Operations; UMC; and QIHEC.

The UM Program is reviewed, evaluated and revised at least annually and as needed for effectiveness and compliance with the standards of CMS, DHCS, California Department of Aging (CDA), NCQA and established best practice standards/ internal benchmarks. The UM Program promotes organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by CalOptima Health's network. Additionally, the UM program structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and across disciplines within the organization. The Board of Directors governs the organizational structure and the UM Program. The Board of Directors specifies the responsibilities of senior management, the committee reporting structure, and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the Utilization Management Committee (UMC) and Quality Improvement Health Equity Committee (QIEHC), which serve as the oversight committees for UM functions, are contained and delineated in the committee's charters.

Long-Term Services and Supports (LTSS)

CalOptima Health ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program includes institutional and community-based nursing and sub-acute facility services for both adults and pediatrics. CalOptima Health's LTSS Department monitors and reviews the quality and outcomes of services provided to members in both settings.

Home and Community-Based Services

CalOptima Health's LTSS Department monitors member utilization, level of access and satisfaction with Community Based Adult Services (CBAS) and Multipurpose Senior Services Programs (MSSP) focusing on diverting members from institutionalization, when appropriate.

Behavioral Health Services

CalOptima Health directly manages all administrative functions of behavioral health benefits including UM, claims, provider network credentialing, member services and Quality Improvement (QI).

CalOptima Health behavioral health services are available to Medi-Cal and OneCare members with mild to moderate impairment of mental, emotional, or behavioral functioning.

Most behavioral health services do not require a physician referral. Members may access mental health and or substance use disorder services by calling the CalOptima Health Behavioral Health Line. Behavioral Health screenings are conducted by CalOptima Health's Behavioral Health Integration (BHI) licensed clinicians. BHI screenings are used to make an initial determination of the member's impairment level due to a mental health condition. If the member has mild to moderate impairments the member will be recommended to engage behavioral health practitioners within the CalOptima Health provider network. If the member has significant to severe impairments, the member will be referred to specialty mental health services (SMHS) through the Orange County Behavioral Health Plan (BHP) managed by the Orange County Health Care Agency (OC HCA).

CalOptima Health also covers alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT). SABIRT services are provided to members 11 years and older, including pregnant women, by providers within their scope of practice. Members who need Drug Medi-Cal Organized Delivery System (DMC-ODS) substance use disorder services—California's county-run programs that provide comprehensive, evidence-based treatment and integrate care with mental health—will be referred to the Orange County Behavioral Health Plan (BHP).

Medi-Cal Behavioral Health Services include:

- Outpatient individual, family and group psychotherapy
- Psychiatric consultation
- Outpatient medication management
- Psychological testing
- Behavioral Health Treatment (BHT)/Applied Behavior Analysis (ABA) for members 20 years and younger

- Transcranial magnetic stimulation (TMS)

One Care Behavioral Health services include:

- Inpatient psychiatric hospitalization
- Intensive outpatient program (IOP)
- Partial hospitalization program (PHP)
- Outpatient individual and group psychotherapy
- Outpatient medication management
- Psychological testing
- Opioid treatment program (OTP) services
- Electro convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)

Authority, Boards of Directors' Committees, and Responsibilities

Board of Directors

CalOptima Health's Board of Directors has ultimate accountability and responsibility for overseeing the quality of care and services provided to CalOptima Health members. Oversight of the UM Program rests with the Quality Assurance Committee (QAC), a subsidiary of the Board of Directors. The QAC also oversees the Quality Improvement Health Equity Committee (QIHEC) as outlined in CalOptima Health's state and federal contracts, and to CalOptima Health's Chief Executive Officer (CEO), as described below.

The Board holds the CEO and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board ensures the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the UM Program annually.

The responsibility for the direction and management of the UM Program has been delegated to the CMO. Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the UMC, the QIEHC and the QAC on an annual basis.

CalOptima Health is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 et seq., to hold public meetings except under specific circumstances described in the Act. CalOptima Health's Board meetings are open to the public.

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the QAC to conduct an annual evaluation, provide strategic direction, and make recommendations to the Board regarding the overall QI Program. QAC routinely receives progress reports from the QIHEC describing improvement actions taken, progress in meeting objectives, and quality performance results. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QI Program.

Member Advisory Committee

The Member Advisory Committee (MAC) ensures that CalOptima Health members' values and needs are integrated into the design, implementation, operation and evaluation of the overall QI program. Each seat of the MAC is inclusive of members representing a constituency served by CalOptima Health. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC committee includes representation from the following constituencies:

- Adult Beneficiaries
- Children
- Family Support
- Foster Children
- Medi-Cal Beneficiaries or Authorized Family Member (two seats)
- Member Advocate
- OneCare Member or Authorized Family Member (four seats))
- Orange County Social Services Agency (standing seat)
- People with Disabilities
- Behavioral/Mental Health Representative
- People with Special Needs
- Recipients of CalWORKs
- Seniors

Provider Advisory Committee

The Provider Advisory Committee (PAC) was established in 1995 by the CalOptima Health Board of Directors to advise the Board on issues impacting the CalOptima Health provider community. PAC members represent the broad community of providers that serve CalOptima Health members. The PAC meets bi-monthly and is open to the public. Members of the PAC include:

- Health Networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied Health Services (two seats)
- Community Health Centers
- Health Care Agency (HCA) (standing seat)
- Long Term Services and Supports
- Non-physician Medical Practitioner
- Traditional Safety Net Provider
- Behavioral/Mental Health
- Pharmacy

Whole-Child Model Family Advisory Committee

The Whole-Child Model Family Advisory Committee (WCM FAC) is required by the state as part of California Children's Services (CCS), a Medi-Cal managed care plan benefit. The WCM FAC provides advice and recommendations to the Board of Directors and staff on issues concerning the WCM program, serves as a liaison between interested parties and the Board, and assists the Board and staff in obtaining public opinion on issues relating to CalOptima Health's WCM program. The committee initiates recommendations on issues for study and facilitates community outreach. The WCM FAC meets on a quarterly basis, and meetings are open to the public.

Members of WCM FAC include:

- Authorized Family Member Representatives, which include parents, foster parents and caregivers of CalOptima Health members who are current recipients of CCS services (seven seats).
- CalOptima Health members ages 18–21 who are current recipients of CCS services.
- Current CalOptima Health members over the age of 21 who transitioned from CCS services.
- Interests of children receiving CCS services representatives.
- Community-based organizations (two seats).
- Consumer advocates (two seats).

CalOptima Health Officers

The CalOptima Health Officers are the senior leaders responsible for implementing the UM Program, including appropriate use of health care resources, medical and behavioral health QI, medical and behavioral health utilization review and authorization, case management, and health education program implementations. CalOptima Health Officers include the Chief Medical Officer (CMO), Chairperson of the Utilization Management Committee (UMC), Executive Director of Clinical Operations, and/or any designee as assigned by CalOptima Health's Chief Executive Officer (CEO), and the Chief Health Equity Officer.

Chief Executive Officer (CEO) allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Medical Officer (CMO), the Chief Financial Officer (CFO) and the Chief Operating Officer (COO). The CEO makes certain that the Quality Improvement Health Equity Committee (QIHEC) satisfies all requirements of the QI Program, as specified in the state and federal contracts.

Chief Operating Officer (COO) is responsible for oversight and day-to-day operations of several departments, including Operations, Network Management, Information Services, Claims Administration, Customer Service, Grievance and Appeals Resolution Services (GARS), Coding Initiatives, Electronic Business and Human Resources.

Chief Medical Officer (CMO) oversees strategies, programs, policies, and procedures as they relate to CalOptima Health's quality and safety of clinical care delivered to members. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO), along with the CMO, oversees the strategies, programs, policies and procedures as they relate to CalOptima Health's medical care delivery system. The DCMO and CMO oversee Utilization Management (UM), Case Management (CM), Pharmacy Management (PM), Behavioral Health Integration (BHI), and Long-Term Support Services (LTSS).

Chief Health Equity Officer (CHEO) co-chairs the QIHEC and is responsible for overseeing QIHETP activities and quality management functions. The CHEO provides direction and support to CalOptima Health's Quality teams to ensure QIHETP objectives are met. The CHEO is a voting member for the UMC to ensure that health equity is considered in all committee decisions.

Executive Director, Clinical Operations (ED CO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the UM, Care Coordination, Complex Case Management, Transitional Care Services, Disease Management, Health Education, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in

these areas. The ED CO serves as a member of the executive team, and with the CMO, DCMO and the Executive Director of Behavioral Health Integration.

Executive Director, Quality Improvement (ED QI) is responsible for facilitating the companywide QIHETP deployment; driving performance results in Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS Star measures and ratings; and maintaining NCQA accreditation standing as a high performing health plan. The ED QI serves as a member of the executive team, reporting to the COO, and with the CMO, DCMO and Executive Director, Clinical Operations, supports efforts to promote adherence to established quality improvement strategies and integrate behavioral health across the delivery system and populations served. Reporting to the ED QI are the Directors of Quality Analytics, Quality Improvement and Medicare Stars and Quality Initiatives.

Executive Director, Behavioral Health Integration (ED BHI) is responsible for the management and oversight of CalOptima Health's Behavioral Health Integration department, along with new implementation related to state and county behavioral health initiatives. The ED BHI leads strategies for integrating behavioral health across the health care delivery system and populations served. The ED BHI serves as a member of the executive team, and with the CMO, DCMO and the Executive Director of Clinical Operations.

Executive Director, Equity and Community Health (ED ECH) is responsible for the management and oversight of CalOptima Health's Equity and Community Health department. The ED ECH oversees the development and implementation of companywide strategies to advance health equity, strengthen community partnerships, and promote equitable access to care that improves health outcomes for all members. The ED ECH serves as a member of the executive team. The ED ECH reports to the CHEO, and in partnership with the CMO, DCMO and Executive Director of Clinical Operations, supports efforts to promote adherence to established quality improvement and health equity strategies. The ED ECH also collaborates with leaders across the organization in efforts to integrate community health across the delivery system and populations served.

Physical and Behavioral Health Medical Directors *(hereinafter referred to "Medical Directors")* are appointed by the CMO and/or DCMO and are responsible to adhere to and oversee the direction of the UM Program and objectives, as well as evaluation of the UM Program. Medical Directors have primary assigned oversight functions and accountabilities but may provide coverage and back up as needed. Medical Directors serve as committee chairs to ensure decisions are made based on clinical relevance and in the best interest of our members.

- The Medical Director who oversees UM ensures quality medical service delivery to members managed directly by CalOptima Health and is responsible for medical direction and clinical decision making in UM. The Medical Directors serve as the senior-

level physicians designated to oversee the implementation of the UM Program. The Medical Directors ensure that an appropriately licensed professional conducts reviews on cases that do not meet medical necessity and uses evidence-based review criteria/guidelines for any potential adverse determinations of care and/or service, as well as monitors documentation for adequacy. In collaboration with the CMO and/or DCMO, the Medical Director also provides supervisory oversight and administration of the UM Program and oversees the UM activities and clinical decisions of staff that work in concurrent, prospective and retrospective medical management activities. The Medical Director monitors for documentation adequacy and works with the clinical staff that support the UM process. The Medical Director provides clinical education and in-service training to staff, presenting key topics on clinical pathways and treatments relating to actual cases being worked in UM, as well as educates on industry trends and community standards in the clinical setting. The Medical Director of UM ensures physician availability to staff during both normal business hours and on call after hours. As the Chair of the UMC and the Benefit Management Subcommittee, the Medical Director of UM facilitates the biweekly UM Workgroup meetings and participates in the CalOptima Health Medical Directors Forum and QIHEC.

- The Medical Director who oversees the behavioral health program is a double board-certified Psychiatrist specializing in Child and Adolescent Psychiatry and is a participating member of the UMC, QIHEC and CPRC. The Medical Director provides consultation and oversight to the UM Program, including guidance on criteria review and development to ensure parity. The Medical Director supports the behavioral health aspects of the UM Program. The Medical Director also provides leadership and program development in the creation and/or improvement of services and systems ensuring the integration of physical and BH care services for CalOptima Health members. Clinical oversight is also provided for BH benefits and services provided to members. The Medical Director works closely with all departments to ensure appropriate access and coordination of behavioral health care services, improves member and provider satisfaction with services and ensures quality BH outcomes.
- The Medical Director oversees specialty programs and services, as a key member of the medical management team, and is responsible for the Medi-Medi programs, MLTSS programs, and Case Management programs. The Medical Director is also the chair of the Pharmacy & Therapeutics committee (P&T). The Medical Director provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima Health operational and support departments, other health networks in an oversight capacity for UM and CM, including PHM, disease management and health education programs, and clinical quality oversight of the Program of All-Inclusive Care for the Elderly (PACE) Center.

UM Program Leadership

CalOptima Health uses appropriate licensed health care professionals to process and/or supervise UM activities. The UM Program health care professionals:

- Provide day-to-day supervision of assigned UM staff.
- Participate in staff training.
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
- Monitor documentation for adequacy.
- Are available on site or by telephone.

In compliance with Department of Health Care Services (DHCS) contract requirements and National Coalition Quality Assurance (NCQA) standards, medical necessity decisions are supervised by, Medical Directors, licensed Registered Nurses, licensed Vocational Nurses, other approved licensed staff.

Director, Utilization Management is responsible for the planning, organization, implementation and evaluation of all activities and personnel engaged in UM departmental operations. This position provides leadership and direction to the UM department, ensures compliance with all local, state and federal regulations. The Director, Utilization Management, ensures that accreditation standards are current and all policies and procedures meet current requirements. The Director, Utilization Management oversees CalOptima Health's UM Program for CalOptima Health Community Network, CalOptima Health Direct and the delegated HNs. The Director serves as a liaison for various internal and external committees, workgroups, and operational meetings.

Senior Director, Hospital Relations and Inpatient Clinical Support leads clinical operational effectiveness across hospitals, CalOptima Health and health network partners. This role ensures patient access through quality outcomes and a system approach that supports inpatient care, transitional care services and communication among care teams. The Senior Director leads direct coordination and partnership with our hospitals, providers and health networks to enhance communication and serve CalOptima Health members.

The Director, Clinical System Configuration and Portfolio Management (Medical Management) is responsible for providing oversight of clinical system contracts/ liaising and configuration request prioritization and tracking. The director leads development of protocols to track, prioritize and oversee clinical system integration, new and change request tracking and completions, defect management and process enhancement recommendations to create continued automation and efficiencies. The director oversees internal and external entities and adherence to clinical configuration deadlines and outcomes for optimal delivery of care.

Director, Behavioral Health Integration is responsible for the planning, organization monitoring, and evaluation of all activities and personnel engaged in the BH UM operations. The director tracks and analyzes changes in the behavioral health care delivery environment and program opportunities affecting CalOptima Health members. The director is available to assist CalOptima Health in integrating physical and BH care services. This position provides leadership and direction to the BH UM team to ensure compliance with all local, state, and federal regulations, that accreditation standards are current, and all policies and procedures meet current requirements. The director serves as a liaison for various internal and external committees, workgroups, and operational meetings.

Director, Credentialing is responsible for initial credentialing and credentialing of providers contracted with CalOptima Health. This position is also responsible for oversight and monitoring of credentialed providers including those providers that are credentialed by delegated entities.

Director, Quality Improvement is responsible for assigned day-to-day operations of the Quality Management operations, including the Quality Improvement and Health Equity Transformation Program (QIHETP) and annual Work Plan. Responsibilities include handling potential quality issues (PQIs), conducting facility site and medical record reviews, ensuring physical accessibility compliance, maintaining NCQA Health Plan and Health Outcomes Accreditation, and working with the ED Quality Improvement and the Quality Improvement Health Equity Committee (QIHEC) to oversee and implement the QIHETP and its Work Plan.

Director, Quality Analytics, is responsible for leading collection, tracking and reporting of quality performance measures, including HEDIS and Stars metrics, as required by regulatory entities. The director conducts data analysis to inform root cause analysis, identify opportunities for improvement, and measure effectiveness of interventions. This role provides data analytical direction to support quality measurement activities for the agencywide QIHETP.

Director, Medicare Stars and Quality Initiative is responsible for leading implementation of quality initiatives to improve quality outcomes for Medi-Cal and Medicare products, including HEDIS, member satisfaction, access and availability, and Medicare Stars. Provides data analytical direction to support quality measurement activities for the organization wide QIHETP by managing, executing and coordinating QI activities and projects.

Director, Internal Audit oversees and conducts regulatory compliance audits and monitoring of CalOptima Health's internal operations with an emphasis on transparency, efficiency and effectiveness and in accordance with state/federal requirements, CalOptima Health policies, and industry best practices. The director validates that CalOptima Health's business areas perform consistently with CMS and DHCS requirements for all programs. The director leads the department in the application of auditing and monitoring to validate adequate performance

relative to both quality and timeliness. Additionally, the director is responsible for the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls. The position interacts with the Board of Directors, CalOptima Health Executives, Compliance Committee, departmental management, and legal counsel.

Sr. Manager, Utilization Management RN/LVN (Prior Authorization (PA)) manages the day-to-day operational activities of the prior authorization department to ensure staff compliance with CalOptima Health policies and procedures, regulatory and accreditation agency requirements. The Sr. Manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members. The Sr. Manager leads inventory management process improvements to maximize efficiencies and ensure regulatory compliance. The Sr. Manager also establishes and maintains collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Manager, Utilization Management RN/LVN (Inpatient Services (IP)) manages the day-to-day operational activities of the inpatient department to ensure staff comply with CalOptima Health policies and procedures, regulatory and accreditation agency requirements. The Manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members while establishing and maintaining collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Supervisor, Utilization Management RN/LVN(IP) provides day-to-day supervision of assigned UM staff. The supervisor monitors and oversees daily work assignments and activities to ensure that service standards are met and makes recommendations regarding assignments based on assessment of workload. The Supervisor is a resource to the IP staff regarding CalOptima Health policies and procedures, as well as regulatory and accreditation agency requirements governing inpatient concurrent review and authorization processing, while providing ongoing monitoring and development of staff through training activities. The Supervisor also monitors documentation for adequacy--including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours and during weekend/holiday on call schedules.

Supervisor, Utilization Management RN/LVN (PA) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met. The Supervisor assigns cases based on assessment of workload and provides ongoing monitoring and development of staff through training activities. This role is a resource to the Prior Authorization staff regarding CalOptima Health policies and procedures as well as

regulatory requirements governing prior and retrospective authorization processing. The Supervisor also monitors documentation adequacy, including clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition. Supervisory staff are available both on-site and telephonically for all UM staff during regular business hours and during weekend/holiday on call schedules.

The following staff positions provide direct support for the UM Department's organizational/operational functions and activities:

Letter Team Medical Case Managers (RN/LVN) draft and evaluate modification and denial letters for adequate documentation, utilization of appropriate criteria, and assurance that the letter is written in plain language that a layperson understands.

Medical Case Managers (RN/LVN) provide inpatient and outpatient utilization reviews and authorization of services in support of members. Medical Case Managers are responsible for assessing the medical appropriateness, quality and cost effectiveness of proposed inpatient hospital and outpatient medical/surgical services, in accordance with established evidence-based criteria. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Medical Authorization Assistants (MAA) are responsible for interacting with practitioners, members, family, and other customers. Medical Authorization Assistants staff members who are not qualified health care professionals are under the direct supervision of a licensed clinician. Non-licensed team members process service requests that do not require application of clinical judgement. They perform routine medical administrative tasks specific to the assigned unit and office support functions. MMAs can administratively authorize services according to departmental guidelines and under the oversight of UM nurse reviewers and Medical Directors.

Quality Improvement (QI) Nurse Specialists Utilization Management (LVN) are responsible for conducting routine oversight, and monitoring and auditing of internal UM activities to ensure compliance with state, federal and accreditation standards. Monitoring activities include reviewing and auditing prior authorizations, continuity of care files, NEMT files, and inpatient records. They also involve addressing Corrective Action Plan (CAP) findings and identifying opportunities for process improvement. The QI Nurse Specialist serves as a Jiva subject matter expert (SME), reviews and responds to Regulatory Affairs and Compliance (RAC) requests and requests for validation (RVD), assists with updates to policies and department desktop procedures. The QI Nurse Specialist assists the Delegation Oversight Department in oversight

and monitoring of Health Network Key Performance Indicators (KPIs) and UM letter implementation.

Pharmacy Staffing Resources

The following staff positions provide support for Pharmacy operations:

Director, Clinical Pharmacy develops, implements and administers all aspects of the CalOptima Health pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs, and oversees the day-to- day functions of the contracted pharmacy benefit management vendor (PBM). The director is also responsible for administration of pharmacy services delivery and has frequent interaction with external contacts including local and state agencies, contracted service vendors, pharmacies and pharmacy organizations.

Manager, Clinical Pharmacist supports the Pharmacy Director and staff in developing and implementing strategies for targeted drug utilization and disease state management. These strategies aim to control costs and improve health care quality and outcomes for members enrolled in CalOptima Health delegated health plans and CalOptima Health Direct. Using various approaches—such as provider and plan profiling, member drug profile reviews, updating drug utilization criteria, and case-by-case interventions, the Pharmacy Manager promotes clinically appropriate prescribing practices that align with CalOptima Health and national guidelines. Additionally, the Pharmacy manager continuously researches, develops, and updates drug utilization management strategies and intervention techniques. The Pharmacy manager develops and implements methods to measure the results of these programs and assists the Pharmacy director in preparing drug monographs and reports for the Pharmacy & Therapeutics (P&T) Committee. The Manager, Clinical Pharmacist, interacts frequently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interactions with external contacts, including the pharmacy benefit managers' clinical department staff.

Clinical Pharmacists assist the Pharmacy director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of health care provided to members enrolled in CalOptima Health delegated health plans and CalOptima Health Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima Health, as well as national, practice guidelines. On an ongoing basis, they research, develop, and update drug UM

strategies and intervention techniques, and develop and implement methods to measure the results of these programs.

The Clinical Pharmacists assist the Pharmacy director in preparing drug monographs and reports for the P&T Committee, interact with other department staff as needed to perform the duties of the position, and have frequent interactions with external contacts, including the pharmacy benefit managers' clinical department.

Pharmacy Resident program occurs within an integrated managed care setting. The residents are trained in the role of the pharmacist in the development and implementation of clinical practice guidelines, formulary development, medication use management, pharmacy benefit design, pharmacy network management, pharmacy benefit management, and drug-use policy development. In addition, residents are trained to function as leaders in developing and implementing pharmaceutical care plans for specific patients in an integrated health plan and delivery system setting.

LTSS Staffing Resources

Director, Long-Term Services and Supports develops, manages and implements LTSS programs including Long-Term Care (LTC) facility authorization services for room and board, CBAS and MSSP. The LTSS Director also manages the staff associated with those programs.

Manager, Long-Term Services and Supports (CBAS/LTC/MSSP) develops and manages the LTSS department's operations and staff. The manager ensures that service standards are met, and operations are consistent with CalOptima Health's policies and regulatory and accrediting agency requirements to ensure high quality and responsive services for CalOptima Health's members who are eligible for and/or receiving LTSS.

Supervisor, Long-Term Services and Supports (CBAS/LTC/MSSP) is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of LTSS to members in the community and institutionalized setting.

Medical Case Managers, Long-Term Services and Supports (MCM LTSS) are part of an advanced specialty collaborative practice responsible for case management, care coordination and function, providing coordination of care, and ongoing case management services for qualified CalOptima Health members in LTC facilities and members receiving CBAS and MSSP. They provide case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the members' needs. The MCM LTSS

acts as liaisons to Orange County community agencies, CBAS centers, skilled nursing facilities, members and providers.

Behavioral Health Integration Staffing Resources

Sr Manager, Behavioral Health CalOptima Health manages the day-to-day operational activities of the department to ensure staff compliance with CalOptima Health policies and procedures, regulatory and accreditation agency requirements. The Sr. Manager develops, implements and maintains processes and strategies to ensure the delivery of quality health care services to members. The Sr. Manager leads inventory management processes for improvement to maximize efficiencies and ensure regulatory compliance. The Sr. Manager also establishes and maintains collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

Supervisor, Behavioral Health, (BH) provides day-to-day supervision of assigned staff, monitors and oversees assigned daily work activities to ensure that service standards are met and makes recommendations regarding assignments based on assessment of workload. The Supervisor is provides guidance to BH staff regarding CalOptima Health policies and procedures, as well as regulatory and accreditation agency requirements governing prior authorization and concurrent review and authorization processing. The BH Supervisor provides ongoing monitoring and development of staff through training activities. The Supervisor also monitors documentation for adequacy, including appropriateness of clinical documentation to make a clinical determination, and audits documentation to assure consistent application of the appropriate clinical guideline to the member's clinical condition

Medical Case Managers (MCM BH-RN/LVN or MCM Licensed BH Clinician) provide inpatient and outpatient utilization review and authorization of services in support of members. They are responsible for assessing the medical appropriateness, quality and cost effectiveness of proposed inpatient psychiatric hospital and outpatient BH services, in accordance with established evidence-based criteria. All potential denial and/or modifications of provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Medical Authorization Assistants Behavioral Health (MAA BH) are responsible for interacting with practitioners, members, family, and other customers. Staff members who are not qualified health care professionals are under the direct supervision of a licensed clinician. Non-licensed team members process service requests that do not require application of clinical judgement. They perform routine medical administrative tasks specific to the assigned unit and office support functions. They can administratively authorize services according to departmental guidelines and under the oversight of UM nurse reviewers and Medical Directors.

Qualifications and Training

CalOptima Health hires staff who are highly qualified clinical individuals with extensive experience and expertise in UM and CM. Qualifications and educational requirements are delineated in the position job description of the respective position.

Each new employee is provided an intensive hands-on training and orientation program with a staff preceptor. Topics included in the new hire program vary as applicable to specific job descriptions. Examples of topics may include but are not limited to:

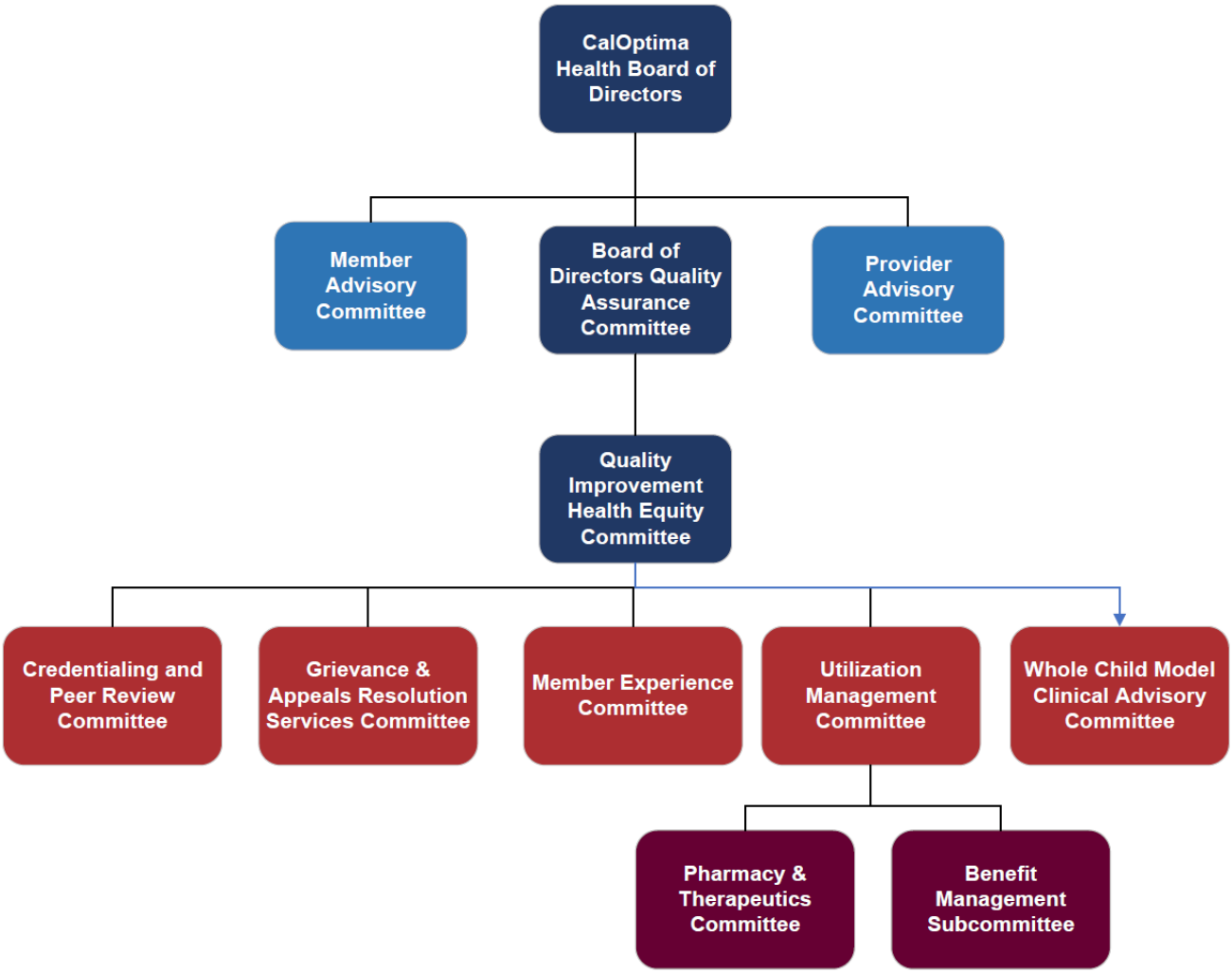
- CalOptima Health New Employee Orientation
- HIPAA and Privacy/Corporate Compliance
- Diversity, Inclusion, and Unconscious Bias
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- UM and CM Program, policies/procedures, etc.
- Medical Management information system data entry
- Application of Review Criteria/Guidelines
- Appeals process
- Seniors and Persons with Disabilities (SPD) awareness training
- OneCare (OC) training

CalOptima Health encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima Health.

CalOptima Health and its delegated HN UM staff do not permit or provide compensation or anything of value to its employees, agents or contractors based on the percentage or the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination.

Utilization Management Committee (UMC)

Figure 4: Diagram representing the committee structure



Utilization Management Committee (UMC)

The UMC is led by a CalOptima Health Medical Director. This senior level physician has oversight of UM activities including but not limited to implementation, supervision, program oversight, and evaluation of the UM Program.

The UMC promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UMC is multidisciplinary and provides a comprehensive approach to support the UM Program in the management of resource allocation through systematic monitoring of medical necessity and quality, while maximizing the cost effectiveness of the care and services provided to members.

The UMC monitors the utilization of health care services by CalOptima Health Direct, CalOptima Health Community Care Network and through the delegated HMOs, PHCs and SRGs, to identify areas of under or over utilization that may adversely impact member care. The UMC is responsible for the annual review and approval of medical necessity criteria and protocols, and the UM policies and procedures. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, ensure coordination of care, ensure appropriate use of services and resources, and improve member and practitioner satisfaction with the UM process.

The UMC meets at least quarterly and coordinates an annual review and revision of the UM Program Description, as well as reviews and approves the Annual UM Program Evaluation.

UMC documents are reviewed and approved by the QIHEC and QAC and ultimately the Board of Directors. UMC meeting minutes and recommendations for UM program improvement activities made are included in the Board of Director updates as appropriate. The UMC routinely submits meeting minutes as well as written reports regarding analyses of the above tracking and monitoring processes and the status of corrective action plans to the QIHEC. Oversight and operating authority of UM activities is delegated to the UMC, overseen by the CMO and deputy CMO. UMC reports up to QIHEC and ultimately to QAC and the Board of Directors.

Conflict of Interest

CalOptima Health maintains a Conflict-of-Interest policy to identify, evaluate, and address potential social, economic, and professional conflicts of interest. CalOptima Health requires that all individuals who serve on the UMC or who otherwise make decisions on UM, quality oversight and activities, disclose any actual, perceived, or potential conflicts of interest that arise in the course and scope of serving in such capacity.

All employees who make or participate in the making of decisions that may foreseeably have a material effect on economic interests file a Statement of Economic Interests form on an annual basis.

Participating Physician

A participating physician is a physician that holds a current California license. Changes to participating physicians are communicated to the UMC Program Specialist and UMC Chairperson. Changes include but are not limited to; change in Health Network affiliation or closing a physician panel.

Internal Medical Directors and external physicians are credentialed and go through a recredentialing process every three years. The credentialing process includes annual verification of licenses, disciplinary actions and work history.

On a monthly basis, the CalOptima Health Human Resources Department requests a list of UMC members to monitor for provider exclusion or preclusion in accordance with CalOptima Health Policy HH.2021 Exclusion and Preclusion Monitoring.

Confidentiality

CalOptima Health has policies and procedures to protect and promote proper handling of confidential and privileged medical record information that are overseen by the Department of Compliance and assigned Privacy Officer. During the onboarding process, all CalOptima Health employees--including contracted professionals, who have access to confidential or member information sign a written statement for maintaining confidentiality. In addition, all non-employee Committee members are required to sign a Confidentiality Agreement on an annual basis. Invited guests must sign a Confidentiality Agreement at the time of Committee attendance.

UMC Scope and Responsibilities

The scope and responsibilities of the UMC include but are not limited to:

- Provide oversight and overall direction for the continuous improvement of the UM Program, consistent with CalOptima Health's strategic goals and priorities. This includes oversight and direction relative to UM functions and activities performed by both CalOptima Health and its delegated HNs.
- Oversee the UM activities and compliance with federal and state statutes and regulations, as well as contractual and NCQA requirements that govern the UM process.
- Review and approve the UM / CM Integrated Program Description, medical necessity criteria, UMC Charter, UM policies, and the UM Program Evaluation on an annual basis.
- Review and analyze UM operational and outcome data; review trends and/or utilization patterns presented at committee meetings and make recommendations for further action.
- Review and approve annual UM metric targets and goals.
- Review progress toward UM Program goals on a quarterly basis, providing input for improving the effectiveness of initiatives and projects.
- Promote a high level of satisfaction with the UM Program across members, practitioners, stakeholders, and client organizations by examining results of annual

member and practitioner satisfaction surveys to determine overall satisfaction with the UM Program, identifying areas for performance improvement, and evaluate performance improvement initiatives.

- Review, assess, and recommend utilization management best practices used for selected diagnoses or disease classes.
- Conduct review of under/over utilization monitoring and make recommendations in accordance with UM Policy and Procedure GG.1532: Over and Under Utilization Monitoring; make recommendations for improving performance on identified over/under utilization.
- Review and provide recommendations for improvement, as needed, to reports submitted by the following:
    - Benefit Management Subcommittee (BMSC)
    - P&T Committee
    - Report to the QIHEC on a quarterly basis, communicating significant findings and making recommendations related to UM issues.

Departments Reporting Relevant Information on UM Issues include:

- Delegation Oversight
- Behavioral Health
- Grievance and Appeals
- LTSS
- Pharmacy

UMC Membership

Voting Members in the UMC Committee include:

- Chief Medical Officer (Specialty: Emergency Medicine)
- Chief Health Equity Officer who oversees Equity and Community Health (Specialty: Doctor of Public Health and Licensed Social Worker)
- Deputy Chief Medical Officer (Specialty: Internal Medicine)
- Medical Director who oversees Utilization Management, UMC Chairperson (Specialty: Family Practice)
- Medical Director who oversees UM Delegation Oversight and Health Networks (Specialty: Internal Medicine)
- Medical Director who oversees Behavioral Health Program (Specialty: Psychiatry [Child/Adolescent & Adult])
- Medical Director who oversees Senior Programs (Specialty: Internal Medicine)

- Medical Director who oversees Whole-Child Model Program (Specialty: Medicine/Pediatrics)
- Medical Director who oversees Quality and Analytics (Specialty: Pediatrics)
- Medical Director who oversees California Advanced and Innovating Medi-Cal (CalAIM) (Specialty: Family Medicine and Addition Medicine)
- Executive Director, Clinical Operations (Master of Science in Gerontology, Certified Case Manager)
- Executive Director, Behavioral Health Integration (Licensed Professional Clinical Counselor, Certified Case Manager)
- Outside Practitioner 1 (Specialty: Family Medicine)
- Outside Practitioner 2 (Specialty: Family Medicine)
- Outside Practitioner 3 (Specialty: Neurology)
- Outside Practitioner 4 (Specialty: Internal Medicine/Neurological & Critical Care Medicine)

Participating members of the UMC that don't have voting rights, but present data, program outcomes and updates to policies include:

- Director, Utilization Management
- Director, Behavioral Health Integration
- Director, Quality Improvement
- Director, Pharmacy
- Sr. Manager, Utilization Management
  - UM Manager, Inpatient Services

Benefit Management Subcommittee (BMSC)

The BMSC is a subcommittee of the UMC. The BMSC is chartered by the UMC to establish a process for maintaining a consistent set of benefits and benefit interpretations for all lines of business. The BMSC establishes a single source for the revisions and updates to CalOptima Health's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Medi-Cal Managed Care Division (MMCD), local and national coverage determinations, All Plan Letters (APLs) and the Medi-Cal Manual.

[1] Participating practitioners from the community are selected to be representative of the health care delivery system, and include primary care, high volume specialists and administrative practitioners. At least six outside practitioners are assigned to the committee to ensure that at least three are present each meeting as part of the quorum requirements.

BMSC Scope

The BMSC is responsible for the following:

- Revising and updating CalOptima Health's authorization rules.
- Making recommendations regarding the need for prior authorization for specific services.
- Clarifying financial responsibility of the benefit, when needed.
- Recommending benefit decisions to the UMC.
- Communicating benefit changes to staff responsible for implementation.

BMSC Voting Membership

The following individuals have voting privileges for BMSC:

- Medical Director who oversees UM services— Chairperson
- Medical Director who oversees Population Health and Equity
- Medical Director who oversees Behavioral Health
- Executive Director, Clinical Operations
- Executive Director, Behavioral Health Integration
- Director, UM (Alternate; Manager, Prior Authorization)
- Director, Behavioral Health Integration (Alternate: Sr Manager Behavioral Health Integration)
- Director, Claims (Alternate: Manager, Claims/Coding Initiatives)
- Director, Pharmacy (Alternate: Manager, Clinical Pharmacist)

The BMSC meets quarterly, at a minimum, and reports recommendations to the UMC on a quarterly basis.

UM Workgroup

The UM Workgroup is a sub-workgroup under the UMC. The Workgroup meets bi-monthly and includes staff members from UM, CM, BHI, Medical Directors and Grievance and Appeals Resolution Services (GARS). Roles and responsibilities of this Workgroup include but are not limited to:

- Provide input to the development and processes of the UM Program.
- Provide input to key performance metrics, measures, and goals.
- Provide input and recommend criteria and protocols for approving new technology, treatment, and diagnostic procedures.
- Review, assess, and recommend internal utilization management best practices.
- Review outcome data, trend studies, and key performance indicators.

- Provide input on UM Department policies and procedures and desktop procedures.
- Identify opportunities to optimize UM processes.

The UM Workgroup reviews utilization data and analyzes patterns and outliers to inform decisions regarding what item requires prior authorization and when prior authorization is no longer required. Data review includes but is not limited to:

- Review of services to determine medical necessity based on evidence-based guidelines and validation that the service(s) provides the best outcome for the member.
- Review of the frequency and variability of use of the service(s), evaluate if the service(s) are being used appropriately or in excess, and evaluate appropriate use of services to ensure member safety.
- Identification of services that are complex, experimental or require specialized training or to be performed in a specialized facility.
- Assess if prior authorization will ensure delivery of high quality of care and prevent complications or adverse outcomes.
- Consider alternative treatments.
- Ensure adherence to guidelines established by regulatory bodies and align prior authorization with industry standards to CalOptima Health Managed Care Plans.
- Incorporate stakeholder feedback.
- Establish review frequency.

The goals of the UM Workgroup include but are not limited to:

- Ensure regulatory and accreditation compliance is met.
- Provide ongoing review and input for current process improvement initiatives.
- Ensure policies and procedures are current and comply with new and modified regulatory initiatives.
- Ensure key performance indicators are met and/or process improvements are initiated when appropriate.

Additional Sub Workgroups of the UM Workgroup include:

- High-Risk Management Workgroup
- Over/Under Utilization Workgroup
- Early and Periodic Screening Diagnosis Treatment (EPSDT) Workgroup
- Enhanced Case Management (ECM) Clinical Oversight Workgroup
- Skilled Nursing Facility (SNF) Workgroup

High-Risk Management Workgroup

The High-Risk Management Workgroup (also known as Bed Day Reduction Workgroup) was established in 2023. In 2024 the name changed and the workgroup was combined with the UM Authorization Strategy Workgroup. The High-Risk Management Workgroup is a cross-departmental, Medical Director-lead workgroup designed to evaluate utilization data. The workgroup is responsible for improving patient outcomes by implementing interventions to optimize utilization in the Emergency Department (ED), inpatient facilities and long-term care settings. The focus of the workgroup is to implement clinical strategies to reduce unnecessary ED visits/hospitalizations, decrease the length of stay in acute care and long-term acute care facilities, and target high-risk members for preventative interventions.

Over/Underutilization Workgroup

CalOptima Health utilization monitoring is tracked by the Over/Under Utilization Workgroup consisting of representatives from the UM leadership team, enterprise analytics, Medical Directors and Ad-hoc participants who support clinical programs and operations. The workgroup monitors metrics, analyzes performance, identifies trends, and implements action plans for impacting over and underutilization. Actions and outcomes from this workgroup are reported up through the UMC.

Early and Periodic Screening Diagnosis Treatment (EPSDT) Workgroup

The EPSDT Workgroup brings together representation from the Medical Directors, Case Management, Utilization Management, Behavioral Health Integration, Delegation Oversight, and Quality Analytics to address EPSDT services available to eligible Members under the age of 21. The EPSDT workgroup began in April 2024 and continues to monitor and ensure that members receive medically necessary EPSDT services as required by DHCS APL 23-005.

Enhanced Case Management (ECM) Clinical Oversight Workgroup

The purpose of the ECM Clinical Oversight Workgroup is to oversee and monitor protocols for clinical assurances for members enrolled in ECM. The goals of the workgroup are to ensure members are receiving appropriate clinical care and related social services and to support ECM providers serving members.

ECM Workgroup is composed of CalAIM Executive Director, CalAIM Directors, CalAIM Medical Director, Behavioral Health Medical Director, Clinical Operations Executive Director, Sr. Director (Clinical Operations), Behavioral Health Integration Executive Director, and Project Manager.

Skilled Nursing Facility (SNF) Workgroup

The Skilled Nursing Facility (SNF) Workgroup was established in 2025 to enhance the concurrent review process--including the appeal process, for skilled nursing facility inpatient stays. The SNF Workgroup ensures staff are cross trained for concurrent review coverage of inpatient cases.

Integration of Utilization Management and Quality Management

Programmatic Integration and Cross-Functional Synergy: The Utilization management (UM) and Case Management (CM) Integrated Program operates as a unified framework, ensuring seamless continuity across Behavioral Health (BH), Long-Term Services and Supports (LTSS), and Pharmacy and Therapeutics (P&T). This holistic structure is closely linked with Credentialing, Compliance, and Delegation Oversight to maintain a rigorous "Triple Aim" approach to care delivery. By aligning these specialized areas, CalOptima Health ensures that clinical decisions are not made in a silo but are instead informed by a comprehensive view of the member's medical, behavioral, and social needs. The UM CM Integrated Program is annually evaluated and submitted for review and approval by the Utilization Management committee (UMC), Quality Improvement Health Equity Committee (QIHEC) and Quality Assurance committee (QAC). A final review and approval is made by the Board of Directors.

Quality Indicators and Patient Safety Integration: CalOptima Health's UM review process is anchored in evidence-based quality indicators prescribed by the CalOptima Health Patient Safety Plan. As medical case managers conduct UM functions, they actively surveil, identify and document potential safety events or care gaps using formalized reporting tools. These findings are forwarded to the Quality Improvement (QI) Department for formal review and resolution, facilitating a **Continuous Quality Improvement (CQI)** loop.

- Bidirectional Data Exchange: CalOptima Health emphasizes the bidirectional flow of information between UM and QI to identify trends in hospital readmissions, medication adherence, and preventive screening opportunities.

- HEDIS Alignment: Quality indicators are specifically selected to align with HEDIS measures, such as Transitions of Care and Follow-Up After Emergency Department Visits.
- Regulatory & Delegation Oversight: CalOptima Health's Delegation Oversight team conducts quarterly audits to ensure that all delegated entities adhere to these integrated standards, maintaining the integrity of clinical data and the safety of members.
- Outcome-Driven Care Delivery: As a result of this integration, the utilization of services is directly correlated with clinical quality and member outcomes. By leveraging data from UM and CM encounters, the QI Department can implement targeted interventions that reduce avoidable complications and improve the overall efficacy of the healthcare delivery system.

Paradigms of the outcome-driven care delivery include:

- The UM Program is evaluated, revised and prepared for approval by the UM and Behavioral Health (BHI) Director in conjunction with the Executive Director of Clinical Services, Executive Director of Behavioral Health Integration, Chief Medical Officer, and Deputy Chief Medical Director prior to submission for committee review and approval.
- Utilization data including, but not limited to, denials, unused authorizations, bed day utilization data, ED utilization data, provider preventable conditions, and trends representing potential over or underutilization, is collected, aggregated and analyzed.
- UM staff may identify potential quality issues and/or provider preventable conditions during utilization of review activities. These issues are referred to the QI staff for evaluation.
- The UMC is a subcommittee of the QIHEC and routinely reports activities to the QIHEC.
- The QIHEC reports to the Board of Directors QAC.

Integration with Other Processes

The UM CM Integrated Program, BH Program, LTSS Program, P&T, QI, Credentialing, Compliance, and Delegation Oversight are closely linked in function and process. The UM process uses quality indicators as a part of the review process and provides the results to the QI Department. As case managers perform the functions of UM, quality indicators, prescribed by CalOptima Health as part of the patient safety plan, are identified. The required information is documented in the appropriate form and forwarded to the QI Department for review and resolution. As a result, utilization of services is interrelated with the quality and outcome of the services.

Any adverse information that is gathered through interaction between UM staff and the practitioner or facility staff is vital to the re-credentialing process. Such information may relate, for example, to specific case management decisions, discharge planning, prior authorization of

non-covered benefits. The information is forwarded to the QI Department in the format prescribed by CalOptima Health for review and resolution as needed. The CMO or Medical Director determines if the information warrants additional review by CalOptima Health's Credentialing and Peer Review Committee (CPRC). If committee review is not warranted, the information is filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

UM policies and processes also serve as integral components in preventing, detecting and responding to Fraud and Abuse among practitioners and members. The UM Department works closely with the Compliance Officer and the Fraud and Abuse Unit to resolve any potential issues that may be identified. In addition, CalOptima Health coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

- Early childhood intervention
- State protective and regulatory services
- Women, Infant and Children Services (WIC)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Health Check
- Services provided by local public health departments

Review and Authorization of Services

Medical Necessity Review

Medical necessity review requires consideration of the members' clinical needs, evaluation of available services within the local delivery system and application of evidenced based guidelines and CalOptima Health policies to provide quality care in the most appropriate setting.

Covered services are those medically necessary health care services provided to members as outlined in CalOptima Health's contract with CMS and the State of California for Medi-Cal and OneCare. Medically necessary means all covered services or supplies are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

For Medicare, covered services that are reasonable and necessary for diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C section 1395y.

Medical necessity for members receiving MLTSS is determined by using a member's current needs assessment and is consistent with person-centered planning.

CalOptima Health UM processes consist of ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure quality medically necessary services are provided in the most appropriate setting. Appropriate to the situation, physicians, pharmacists or psychologists review and determine all final denial or modification decisions for requested medical and BH care services. The review of the denial of a pharmacy prior authorization is completed by a qualified physician or pharmacist.

CalOptima Health's UM Department is responsible for the review and authorization of health care services for CalOptima Health Direct Administrative (COD-A) and CCN members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services
- Continuity of care review
- Admission review
- Post-stabilization review
- Concurrent/Continued stay review for selected conditions
- Discharge Planning review
- Retrospective review
- Evaluation for potential transplant services for HN members

The following standards and considerations are applied when reviewing prior authorizations, inpatient concurrent review, and retrospective review requests:

- Evidence-based clinical criteria or guidelines are applied consistently and regularly reviewed and updated.
- Member circumstances and characteristics are considered when applying criteria to address the individual needs of the member. These characteristics include, but are not limited to:
    - Age
    - Co-morbidities
    - Complications
    - Progress of treatment
    - Psychological/Psychosocial situation
    - Home environment, when applicable
- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. If member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational

determination, the request is forwarded to the UM Medical Director to determine an appropriate course of action.

- Clinical rationale and reasons for decisions are clearly documented in the medical management system, including the criteria used to make the determination.
- The Medical Director may be contacted by calling their direct dial number listed at the bottom of the provider denial notification or through contacting the UM Department during the review process. A CalOptima Health Case Manager may also coordinate communication between the CalOptima Health Medical Director and requesting practitioner. All peer-to-peer discussions are documented within the CalOptima Health clinical documentation platform.
- Notification to members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency timeframes, and members and providers are notified of appeals and grievance procedures.
- Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima Health's Grievance and Appeals Resolution Services (GARS) process, and as the member's condition requires.
- Medical conditions requiring time sensitive services are reviewed in accordance with the appropriate CalOptima Health Policy and Procedure.
- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing.
- Records, including documentation of an oral notification or written Notice of Action, are retained for a minimum of 10 years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law.
- The requesting provider may be notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request.
- Medi-Cal members are notified in writing of any decision to deny, modify, or delay a service.
- OneCare members are notified in writing of all determinations.
- All providers are encouraged to request information regarding the criteria used in making clinical determination. Contact can be made directly with the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action or UM Coverage letter. A provider may request a discussion with the Medical Director (Peer-to-Peer), or a copy of the specific criteria utilized.

Supporting documents used to make medical necessity determinations may include, but are not limited to:

- Office and hospital records

- A documented history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- Evidenced based criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics, circumstances and information
- Information from responsible family members

The data collection process shall not be burdensome to the member and provider.

The UMC and BMSC reviews the Prior Authorization List regularly, in conjunction with CalOptima Health's CMO, Medical Directors and Executive Director of Clinical Operations and UM Management, to determine if any services should be added or removed from the list. The Provider Services, Member Services and Network Management areas are also consulted on proposed revisions to the Prior Authorization List. Such decisions are based on CalOptima Health program requirements, and/or to meet federal or state statutory or regulatory requirements. Practitioners are appropriately notified when such modifications are made.

Prior Authorization

Prior Authorization requires the provider or practitioner to submit a formal Authorization Request Form (ARF) medical necessity determination request, and all relevant clinical information related to the request to CalOptima Health prior to the service being rendered. Upon receipt, the prior authorization request is screened for eligibility and benefit coverage and assessed for medical necessity and appropriateness of the health care services proposed, including the setting in which the proposed care will take place.

Prior Authorization is required for selected services, such as non-emergency inpatient admissions, elective out-of-network services, certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization Required List located in the provider

section on the CalOptima Health website at www.caloptima.org. Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process, which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

CalOptima Health's medical management system is a member-centric system utilizing evidence-based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social, and personal care needs of members supporting the identification of cultural diversity and complex care needs.

The CalOptima Health Provider Portal allows for non-urgent and urgent online authorizations to be submitted by providers and processed electronically. The provider portal functionality includes referral intelligence rules, approved by clinical leadership to auto-adjudicate when criteria are met. The referral intelligence rules, and auto-adjudication trends are reviewed quarterly at a minimum to identify potential misuse or utilization issues that require follow up. Practitioners may also submit referrals and requests to the UM Department by mail, fax and/or telephone.

Second Opinions

A second opinion may be requested when there is a question concerning the diagnosis, options for surgery or other treatment of a health condition, or when requested by any member of the member's health care team, including the member, member representative, parent and/or guardian. A social worker exercising custodial responsibility may also request a second opinion. Authorization for a second opinion is granted to a network practitioner or an out-of-network practitioner if there is no in-network practitioner available.

Extended Specialist Services

Established processes are in place by which a member requiring ongoing care from a specialist may request a standing authorization. Additionally, CalOptima Health provides guidance on how members with life-threatening conditions or diseases that require specialized medical care over a prolonged period can request and obtain access to specialists and specialty care centers.

Out-of-Network Providers

The decision to authorize use of an out-of-network provider is based on several factors including, but not limited to, continuity of care, availability and location of an in-network provider of the same specialty and expertise, and lack of an in-network provider with the specialty and expertise.

Appropriate Professionals for UM Decision Process

An appropriately licensed health care professional supervises all medical necessity review decisions. The UM decision process requires that qualified; licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the UM Nurse Case Managers (NCM) or BH Medical Case Manager forwards the request to the appropriate qualified, licensed health practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial, modification, reduction, or termination of services based on medical necessity. All practitioners or pharmacists rendering decisions must have education, training, and professional experience in medical or clinical practice, and must have a current unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima Health distributes an affirmation statement about incentives to members in the Member Handbook, annually to all members in the Annual Notices Newsletter, and at least annually to all practitioners and employees who make UM decisions. The affirmation statement affirms that UM decision making is based only on appropriateness of care and services and existence of coverage and that CalOptima Health does not specifically reward practitioners or other individuals for issuing denials of coverage. CalOptima Health ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

Pharmaceutical Management

Pharmaceutical Management is overseen by the CMO and the Director, Clinical Pharmacy Management for CalOptima Health. All policies and procedures utilized by CalOptima Health related to pharmaceutical management include the criteria used to adopt the procedure, as well as a process that uses clinical evidence from appropriate external organizations. The pharmaceutical management program is reviewed at least annually by P&T and updated as new pharmaceutical information becomes available.

Policies and procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals and are made available to practitioners via the provider newsletter and/or CalOptima Health website.

The P&T Committee is responsible for the development of the Medi-Cal physician-administered drug prior authorization list and the OneCare Formulary, which is based on sound clinical evidence, and is reviewed at least annually by practicing practitioners and pharmacists. Updates to the Formulary are communicated to both members and providers.

Since January 1, 2022, pharmacy determinations for the Medi-Cal outpatient pharmacy benefit moved to the Medi-Cal fee-for-service program, Medi-Cal Rx.

Medicare

CalOptima Health does not delegate OneCare Pharmacy UM responsibilities. Pharmacy coverage determinations follow required CMS timeliness guidelines and medical necessity review criteria.

Pharmacy Benefit Manager (PBM)

The PBM is responsible for some pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, pharmacy help desk, clinical services and quality improvement functions. The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity, the PBM is monitored according to the Audit & Oversight department's policies and procedures.

Behavioral Health Determinations

Medi-Cal

CalOptima Health's BHI department performs prior authorization review for Behavioral Health Treatment (BHT)/Applied Behavioral Analysis (ABA) services and transcranial magnetic stimulation (TMS). Prior authorization requests are reviewed by BH Medical Case Managers. All determinations are based on CalOptima UM hierarchical criteria.

Medicare

CalOptima Health's BHI department performs prior authorization review functions for OneCare covered BH services. Services requiring prior authorization include inpatient psychiatric care, partial hospitalization program, intensive outpatient program, opioid treatment program electro convulsive therapy (ECT), and transcranial magnetic stimulation (TMS). Prior authorization requests are reviewed by BH Medical Case Managers.

UM Hierarchical Criteria

CalOptima Health conducts Utilization Review using UM hierarchical criteria for medical, BH, and pharmacy medical necessity decisions that are objective, nationally recognized, evidence-based standards of care and include input from recognized experts in the development, adoption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate. Clinical guideline criteria are published on the

CalOptima Health website to be accessible and available for members, providers, and the public upon request. Such criteria and guidelines include, but are not limited to:

Medi-Cal

- Medi-Cal Provider Manual and Department of Health Care Services (DHCS) All Plan Letter's (APL)CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook
- Milliman Care Guidelines (MCG)
- Drug Compendia Micromedex
- DrugDex and American Hospital Formulary Service Drug Information (AHFS-DI)
- Peer-Reviewed Medical Literature
- National Comprehensive Cancer Network Guidelines (NCCN)
- Other: Medical Societies, National Guidelines, and other Authoritative Publications:
- Hayes Criteria
- World Professional Association for Transgender Health (WPATH)
- U.S. Food and Drug Administration (FDA)
- Centers for Disease Control and Prevention (CDC)
- American Board of Medical Specialties
- Up To Date
- Optum Current Procedural Coding Expert (Encoder Pro)
- Preventive Health Guidelines (e.gl, U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG) Guidelines
- National Guideline Clearinghouse, and
- National Correct Coding Initiative (NCCI) Policy Manual

Medicare (OneCare)

- CMS National Coverage Determinations (NCD), including NCD with Coverage Evidence Development (CED)
- CMS Local Coverage Determination (LCD) (Noridian Local Contractor for California)
- CMS Local Coverage Article (LCA)
- CMS Manuals (Medicare Benefit Policy Manual, Medicare National (NCD) Manual, Medicare Claims Processing Manual, etc.)
- National Correct Coding Initiative (NCCI) Policy Manual
- CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook

- Drug Compendia: Micromedex, DrugDex, American Hospital Formulary Service-Drug Information (AHFS-DI), Clinical Pharmacology
- National Comprehensive Cancer Network Guidelines (NCCN) Drugs and Biologics Compendium, Lexi Drugs, National Comprehensive Cancer Network® (NCCN) Drugs and Biologics Compendium, Lexi-Drugs;
- Internal criteria, such as:
- MCG Care Guidelines
- CMS LCD/LCA (Non-California)
- Department of Health Care Services (DHCS) Treatment Authorization Review (TAR) Requirement
- Other: Medical Societies, National Guidelines, and other Authoritative Publications:
- Hayes Criteria
- World Professional Association for Transgender Health (WPATH)
- U.S. Food and Drug Administration (FDA)
- Centers for Disease Control and Prevention (CDC)
- American Board of Medical Specialties
- Up To Date
- Optum Current Procedural Coding Expert (Encoder Pro)
- Preventive Health Guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG) Guidelines
- National Guideline Clearinghouse
- National Comprehensive Cancer Network (NCCN) Guidelines

Whole Child Model (WCM)

- California Children Services (CCS) Numbered Letters and CCS Information Notices
- Medi-Cal Provider Manual and DHCS APLs
- CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook
- MCG Care Guidelines
- Drug Compendia: Micromedex, DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology
- National Comprehensive Cancer Network Guidelines (NCCN)
- Other: Medical Societies, National Guidelines, and other Authoritative Publications:
- Hayes Criteria
- World Professional Association for Transgender Health (WPATH)

- U.S. Food and Drug Administration (FDA)
- Centers for Disease Control and Prevention (CDC)
- American Board of Medical Specialties
- Up To Date
- Optum Current Procedural Coding Expert (Encoder Pro)
- Preventive Health Guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG) Guidelines
- National Guideline Clearinghouse
- National Correct Coding Initiative (NCCI) Policy Manual

Due to the dynamic state of medical/health care practices, each medical decision must be case-specific, and based on current medical knowledge and practice, regardless of available practice guidelines, as well as based on the member's individual needs. Listed criteria in fields other than primary care, such as OB/GYN, surgery, etc., are primarily appended for guidance concerning medical care of the condition or the need for a referral.

Clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics, and the American College of Obstetrics and Gynecology) are used in conjunction with national guideline criteria in review for medical necessity. Additional guidelines may include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, World Professional Association for Transgender Health (WPATH), Lead Screening, Immunizations, and ADHD/ADD guidelines for both adults and children.

Board Certified Clinical Consultants

In some cases, such as for authorization of a specific procedure or service, BH, or certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, In these instances, the Medical Director may consult with a board-certified physician from the appropriate specialty or qualified BH professionals as determined by the Medical Director, for additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside of CalOptima Health may be contacted, when necessary to avoid a conflict of interest, as defined by CalOptima Health to include situations in which the practitioner who would normally advise on an UM decision made the original request for authorization or determination, or is affiliated with the same practice group as the practitioner who made the original request or determination.

Practitioner and Member Access to Criteria

At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting the UM Department or may discuss the UM decision with

CalOptima Health's Medical Director per the peer-to-peer process. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the UM Department. The manual also outlines CalOptima Health's UM policies and procedures. On an annual basis, all contracted hospitals receive an in-service to review all required provider trainings, including operational and clinical information such as UM timeliness of decisions. In addition, Provider Relations also provides any related policies regarding UM timeliness of decisions, as needed. Similar information is found in the Member Handbook and clinical criteria is located on the CalOptima Health website at www.CalOptimaHealth.org.

Inter-Rater Reliability (IRR)

At least annually, the UM Managers evaluate the consistency with which Medical Directors and other clinical staff involved in UM apply UM criteria in decision-making. If an opportunity for improvement is identified through this process, UM and Medical Director leadership take corrective action(s). Newly hired UM staff are required to successfully complete IRR testing prior to being released from training oversight. IRR results are reported to the UMC and QIHEC on an annual basis and any actions taken for performance below the established benchmark of 90% are discussed and recommendations taken from UMC.

Provider and Member Communication

Members and practitioners can access UM staff at least eight hours a day during normal business hours for inbound collect or toll-free calls at (888) 587-8088 or outbound calls regarding UM issues or questions about the UM process. TTY services for deaf, hard of hearing or speech impaired members are available toll free at 711. These phone numbers are included in the Member Handbook, on the CalOptima Health website, and in all member letters and materials. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services. Except as otherwise provided below, communications received after normal business hours are returned the next business day and communications received after midnight on Monday–Friday are responded to on the same business day. CalOptima Health has Medical Director and UM coverage 24 hours a day, 7 days a week through after-hours answering services.

Inbound and outbound communications include directly speaking with practitioners and members, fax correspondence, electronic or telephonic communications (e.g., sending email messages or leaving voicemail messages). Staff identify themselves by name, title, and CalOptima Health UM Department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM Department are automatically routed to an on call contracted vendor. The vendor is not a delegated UM entity and therefore does not make authorization decisions. Vendor staff take authorization information and share

the information with CalOptima Health staff for follow-up and response the next business day. In cases requiring immediate response, vendor staff contact the CalOptima Health on-call nurse. CalOptima Health will review and process authorizations outside business hours, as necessary, including decisions to approve, deny or modify authorization requests which are made by CalOptima Health on-call UM Medical Director. A log is shared daily identifying activity and follow-up needed the following day.

Access to Physician Reviewer

The CalOptima Health Medical Director or appropriate practitioner reviewer (BH and clinical pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation, and the provider newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Health Medical Director who made a denied determination may be contacted by calling their direct number listed at the bottom of the provider denial notification or through contacting the UM Department. A CalOptima Health Case Manager may also coordinate communication between the Medical Director and requesting practitioner. All peer-to-peer discussions are documented within the clinical documentation platform

UM Staff Access to Clinical Expertise

The CMO and Medical Directors have the authority, accountability, and responsibility for denial determinations and follow sound clinical and professional judgment. Contracted HNs that are delegated for UM responsibilities utilize a Medical Director, or designee, as the sole authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes, etc.

Requesting Copies of Medical Records

During prospective, retrospective, inpatient and concurrent review requests, copies of medical records are required to validate medical necessity for the requested service. In those cases, only the necessary or pertinent sections of the record are required to determine medical necessity and appropriateness of the services requested. Medical records may also be requested to complete an investigation of a member grievance, appeal, or when a potential quality of care

issue is identified through the UM process Confidentiality of information necessary to conduct UM activities is maintained at all times.

Sharing Information

CalOptima Health's UM staff share all clinical and demographic information on individual patients among various areas of the agency (e.g., discharge planning, case management, ECH, health education, etc.) to avoid duplicate requests for information from members or practitioners. Pertinent medical records are stored in a single system which services as the source of truth for decision making.

Provider Communication to Member

CalOptima Health's UM Program does not prohibit or restrict health care professionals from acting within the lawful scope of practice or advising or advocating on behalf of a member including but not limited to the following:

- The member's health status, medical care, or treatment options, including any alternative treatments that may be self-administered.
- Any information the member needs to decide among all relevant treatment options.
- The risks, benefits and consequences of treatment or absence of treatment.
- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Timeliness of UM Decisions

UM decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for providers to notify CalOptima Health of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner. These turnaround time requirements are dictated by regulatory bodies such as DHCS, CMS, and NCQA.

UM Decision and Notification Timelines

Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification (May be Electronic or Written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Routine (Non-urgent) Pre-Service Prospective or outpatient service requests. All necessary information is received at time of initial request.	Approve, Modify, or Deny as expeditiously as the member's health condition requires not to exceed 5 business days from receipt of the information reasonably necessary to render a decision, and no longer than 7 calendar days from date of receipt of the request.	**Practitioner: Electronic/Written** Within 24 hours of making the Decision, not to exceed 7 calendar days from date of receipt of the request.	**Practitioner: Electronic /Written** Within 24 hours of making the decision, not to exceed 7 calendar days from date of receipt of the request. **Member: Written** Within 2 business days of the decision not to exceed 7calendar days from date of receipt of the request.
Routine (Non-urgent) Pre-Service – Extension Needed • Additional clinical information required. • Require consultation by an Expert Reviewer. • Additional examination or tests to be performed.	Approve, Modify, or Deny within 5 business days from receipt of the information reasonably necessary to render a decision, and no longer than 14 calendar days from the receipt of the request. • The decision may be delayed /deferred, and the time limit extended an additional 14 calendar days from the Medical Director pend request, only where the member or member's provider requests an extension, or CalOptima Health can provide justification upon request by the State for the need for additional information and how it is in the member's interest. **Additional Clinical Information required:** The decision may be deferred, and the time limit extended an additional 7 calendar days when a member or provider requests the extension, or CalOptima Health justifies a need for additional information and can demonstrate how the extension is in the member's best interest. There is reasonable likelihood that receipt of such information would lead to approval of the request.	**Practitioner: Electronic/Written** Written notice of "Delay" must be sent within 24 hours of making the decision to delay, not to exceed 7 calendar days from the date of receipt of initial request for services. **Member: Written** Written notice of "Delay" must be sent within 2 business days of making the decision to delay, not to exceed 14 calendar days from receipt the date of the initial request for services. **Letters Must Include:** • The additional information needed to render the decision, • The type of expert reviewer and/or the additional examinations or tests required, • The anticipated date on which a decision will be rendered.	**Practitioner: Electronic/Written** Written notice of "Delay" must be sent within 24 hours of making the decision to delay, not to exceed 7 calendar days from the date of receipt of the initial request for services. **Member: Written** Written notice of "Delay" must be sent within 2 business days of making the decision to delay, not to exceed 14 calendar days from the date of receipt of the initial request for services. **Letters Must Include:** • The additional information needed to render the decision, • The type of expert reviewer and/or the additional examinations or tests required, • The anticipated date on which a decision will be rendered.
	Additional information received If requested information is received, the decision must be made within 5 business days of date of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service. **Additional information incomplete or not received** If the Provider does not comply with the request for additional information the decision must be made no later than 28 calendar days from the date of receipt of the initial request with the information that is available.	**Practitioner:** Within 24 hours of making the Decision, not to exceed 28 calendar days from the date of receipt of the request.	**Practitioner: Electronic/Written** Within 24 hours of making the decision, not to exceed 28 calendar days from the date of receipt of the request. **Member: Written** Within 2 business days of making the decision, not to exceed 28 calendar days from the date of receipt of the request for service.

Working days = Monday through Friday excluding California State Holidays
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Back to Agenda Back to Item

Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification (May be Electronic or Written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Expedited Authorization (Pre-Service) Provider or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain maintain or regain maximum function. All necessary information received at time of initial request.	**Approve, Deny, or Modify** as expeditiously as the Member's health condition requires not to exceed 72 hours from the date and time of receipt of the request.	**Practitioner: Electronic/Written** Within 24 hours of making the decision not to exceed 72 hours from the date and time of receipt of request.	**Practitioner: Electronic/Written** Within 24 hours of making the decision not to exceed 72 hours from the date and time of receipt of request. **Member: Written** Within 2 business days of making the decision, not to exceed 72 hours of receipt of request.
Expedited Authorization (Pre-Service) - Extension Needed • Additional clinical information required. • Require consultation by an Expert reviewer. • Additional examination or tests to be performed.	**Additional Clinical Information required:** The decision may be deferred, and the time limit extended an additional 14 calendar days when a Member or Provider requests the extension, or CalOptima Health justifies a need for additional information and can demonstrate how the extension is in the Member's best interest. There is reasonable likelihood that receipt of such information would lead to approval of the request.	**Practitioner: Electronic/Written** Written notice of "Delay" must be sent within 24 hours of the decision to delay not to exceed 72 hours after MCPs receipt of initial request for services. **Member: Written** Written notice of "Delay" must be sent within 2 business days of making the decision to delay, not to exceed 72 hours from receipt of the initial request for services. **Letters Must Include:** • The additional information needed to render the decision, • The type of expert reviewer and/or the additional examinations or tests required, • The anticipated date on which a decision will be rendered.	**Practitioner: Electronic/Written** Written notice of "Delay" must be sent within 24 hours of the decision to delay, not to exceed 72 hours after receipt of the initial request for services. **Member: Written** Written notice of "Delay" must be sent within 2 business days of making the decision to delay not to exceed 72 hours from receipt of the initial request for services. **Letters Must Include:** • The additional information needed to render the decision, • The type of expert reviewer and/or the additional examinations or tests required, • The anticipated date on which a decision will be rendered.
	Additional information received If requested information is received, decision must be made within 1 business day of the date receipt of information not to exceed 17 calendar days from the date of receipt of the request for services. **Additional information incomplete or not received** If the Provider does not comply with the request for additional information, the decision must be made no later than 17 calendar days from the date of receipt of the initial request with the information that is available.	**Practitioner: Electronic/Written** Within 24 hours of making the decision not to exceed 17 calendar days from the date of receipt of request.	**Practitioner: Electronic/Written** Within 24 hours of making the decision not to exceed 17 calendar days from the date of receipt of the request. **Member: Written** Within 2 business days of making the decision, not to exceed 17 calendar days from the date of receipt of the request for service.

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Back to Agenda Back to Item

Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Initial Notification PRACTITIONER APPROVALS (Notification May Be Electronic/Written)	Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member
Concurrent & Urgent Concurrent (Inpatient) • Provider or CalOptima Health determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services). Care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the patient. All necessary information is received at the time of the initial request.	Approve, Deny, or Modify the admission as expeditiously as the member's health condition requires, not to exceed 72 hours from receipt of the request.	**Practitioner: Electronic/Written Notification** must be provided to the treating provider within 24 hours of making the final decision, not to exceed 72 hours from the discharge (This is not a regulatory requirement- it is contract based)	**Practitioner: Electronic/Written** Notification must be provided to the treating provider within 24 hours of making the final decision not to exceed 72 hours from the discharge. **Member: Written** For denials and modifications only: Within 2 business days of making the decision not to exceed 72 hours
Concurrent & Urgent Concurrent (Inpatient) - Extension Needed • Additional clinical information required. • Require consultation by an Expert Reviewer. • Additional examination or tests to be performed. Care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.	**Additional Clinical Information required:** The decision may be deferred, and the time limit extended an additional 14 calendar days when a member or provider requests the extension, or CalOptima Health justifies a need for additional information and can demonstrate how the extension is in the member's best interest. There is reasonable likelihood that receipt of such information would lead to an approval of the request.	**Practitioner: Electronic/Written** Written notice of "Delay" must be sent within 24 hours of the decision the delay not to exceed 72 hours of receipt of the initial request for services. **Member: Written** Written notice of "Delay" must be sent within 2 business days of making the decision to delay, not to exceed 72 hours from receipt of the initial request for services. **Letters Must Include:** • The additional information needed to render the decision, • The type of expert reviewer and/or the additional examinations or tests required, • The anticipated date on which a decision will be rendered.	**Practitioner: Electronic/Written** Written notice of "Request for Clinical Review" must be sent within 24 hours of the decision to extend, not to exceed 72 hours of receipt of the initial request for services. **Member: Written** (This process does not apply to the member for IP/ concurrent review) **Letters Must Include:** • The additional information needed to render the decision, • The type of expert reviewer and/or the additional examinations or tests required, • The anticipated date on which a decision will be rendered.

Back to Agenda Back to Item

	Additional information received: If requested information is received, decision must be made within 1 business day of receipt of the information not to exceed 17 calendar days from the date of receipt of the request for services. **Additional information incomplete or not received** If the provider does not comply with the request for additional information the decision must be made no later than 17 calendar days from receipt of the initial request with the information that is available.	**Practitioner: Electronic/Written** Notification must be provided to the treating provider within 24 hours of making the decision not to exceed 17 calendar days from receipt of the request.	**Member: Written** For Denials and Modifications only: Within 2 business days of making the decision, not to exceed 17 calendar daysof receipt of the request.

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Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification PRACTITIONER APPROVALS (Notification May Be Electronic/Written)**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Member**
Retrospective Review (Post-Service)	Within 30 calendar days from receipt of the request.	**Practitioner: Electronic/Written** Within 24 hours of making the decision not to exceed 30 calendar days from receipt of the request.	**Practitioner: Electronic/Written** Within 24 hours of making the decision not to exceed 30 calendar days from receipt of the request. **Member: Written** Within 30 calendar days of receipt of request.
Hospice (Inpatient Care)	Within 24 hours of receipt of the request.	**Practitioner: Electronic/Written** Within 24 hours of receipt of the request.	**Practitioner: Electronic/Written** Within 24 hours of receipt of the request. **Member: Written** Within 24 hours of receipt of the request.

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Back to Agenda Back to Item

Attachment B
TIMEFRAMES FOR ONECARE DECISIONS AND NOTIFICATIONS

OneCare Decision and Notification Timelines		
Type of Request	**Decision**	**Notification Timeframe**
Standard Integrated Organization Determinations Prior Authorization/Prospective or outpatient service requests.	Approve or Deny no later than 7 calendar days from receipt of the request. **Extensions: CalOptima Health and it's delegated Health Networks may not extend deadlines for Integrated Organization Determinations for the OneCare line of business.**	**Practitioner:** **Decision: Electronic or Written** Within 24 hours of making the decision. not to exceed 7calendar days (includes weekends and holidays) of receipt of the request **Practitioner/Member: Written** Within 2 business days of the decision. not to exceed 7 calendar days (includes weekends and holidays) of receipt of the request **For favorable determinations, issue an approval notification. For partially favorable or adverse determinations, issue the Coverage Decision Notice .**
Expedited Integrated Organization Determinations Prior Authorization/Prospective or outpatient service requests.	Approve, or Deny as expeditiously as possible, but no later than 72 hours from receipt of the request. Must request the necessary information from the provider within 24 hours of receipt of the request. **Extensions: CalOptima Health and it's delegated Health Networks may not extend the deadlines for Integrated Organization Determinations.**	**Practitioner:** **Decision: Electronic or Verbal Notification** Within 24 hours of making the decision, not to exceed 72 hours of receipt of the request **Member: Written or Verbal Notification** Within 24 hours of the determination, not to exceed 72 hours of receipt of the request. **Practitioner/Member: Written** When successful verbal notification is given, it must be followed by written notification within 3 calendar days of the successful verbal notification.
Expedited Authorization (Pre-Service) **If Expedited Criteria are not met**	If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: • Automatically transfer the request to the standard timeframe. The 7 calendar day period begins the day the request was received for an expedited determination.	If the request is not deemed to be expedited, notify the member (within 72 hours) oral notification of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notification. • Use the Expedited Criteria Not Met template to provide written notice. The written notice must include: 1) Explain that CalOptima Health will automatically transfer and process the request using the 7- day timeframe for standard determinations. 2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination. 3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member. 4) Provide instructions about the expedited grievance process and its time frames.

Back to Agenda Back to Item

Attachment B
TIMEFRAMES FOR ONECARE DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Notification Timeframe
Urgent Concurrent (Inpatient) Requests where a provider indicates or CalOptima Health/Health Network determines that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, ma int a in or regain maximum function.	Approve or Deny within 72 hours of the admission notification. **Extension:** May extend the time frame, by up to 7 calendar days from the admission notification, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner: Electronic** Within 24 hours of making the decision. **Member: Written** Within 2 business days of making the decision.
Concurrent (Inpatient) Concurrent review of inpatient treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of CalOptima Health's/Health Network's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that	Approve or Deny within 72 hours of the last approved day or decision consistent with the urgency of the member's medical condition. **Extension:** May extend the time frame 48 hours or up to 7 calendar days, under the following conditions: • Additional supporting clinical information is needed.	**Practitioner/Member: Electronic or Verbal** Within 24 hours of final decision **Practitioner/Member: Written** Within 3 calendar days of final decision.
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from date of receipt of the request)	Decision within 30 calendar days from date of receipt of the request.	**Practitioner: Written** Within 30 calendar days of date of receipt of the request **Member: Written** Within 30 calendar days of date of receipt of request.
Hospice - Inpatient Care	Within 24 hours of receipt of the request.	**Practitioner: Electronic or Verbal** Within 24 hours of making the decision **Practitioner /Member:** Written Within 2 business days of making the decision

Working days = Monday through Friday excluding California State Holidays
https://www.calhr.ca.gov/employees/pages/state-holidays.aspx

Back to Agenda Back to Item

Attachment B
TIMEFRAMES FOR ONECARE DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Important Message (IM) from Medicare	Important Message (IM) from MedicareDetailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices (Concurrent)	Hospitals are responsible for delivery of the Important Message from Medicare (IM): 1. Within 2 calendar days of admission to a hospital inpatient setting. 2. No more than 2 calendar days prior to discharge from a hospital inpatient setting. 3. CalOptima Health/Health Network is responsible for the delivery of the Detailed Notice of Discharge (DND) when members appeal a discharge. 4. DND must be delivered no later than noon of the day after notification by QIO (Quality Improvement Organization)	Hospitals must issue the IM within 2 calendar days of admission. Hospitals must issue the IM no more than 2 calendar days prior to discharge from an inpatient stay.	CalOptima Health must issue the DND to both the member and QIO as early as possible but no later than noon of the day after notification by the QIO.

Working days = Monday through Friday excluding California State Holidays
https://www.calhr.ca.gov/employees/pages/state-holidays.aspx

Back to Agenda Back to Item

Pharmacy Prior Authorization Determination Timelines

Medi-Cal Pharmacy Prior Authorization Determination Timelines*

**Medi-Cal Timelines for determination apply to pharmacy authorization requests managed by CalOptima Health*

Medi-Cal Pharmacy Prior Authorization Determination Timelines		
Type of Request	**Determination Timeline**	**Notification Timeline**
Standard (Non-urgent) Preservice All necessary information received at time of initial request.	A decision to approve, modify, or deny is required within 24 hours of receipt of the request.	**Provider:** Within 24 hours of receipt of the request. **Member (modify or deny only):** Within 24 hours of receipt of the request.
Standard (Non-urgent) Preservice - Information Needed Additional clinical information required.	A decision to approve, modify, or deny is required within 24 hours of receipt of the request.	**Provider:** Within 24 hours of receipt of the request. **Member (modify or deny only):** Within 24 hours of receipt of the request.
Expedited (Urgent) Preservice/Concurrent All necessary information received at time of initial request.	A decision to approve, modify, or deny is required within 24 hours of receipt of the request.	**Provider:** Within 24 hours of receipt of the request. **Member** (modify or deny only): Within 24 hours of receipt of the request
Expedited (Urgent) Preservice/Concurrent - Information Needed Additional clinical information required.	A decision to approve, modify, or deny is required within 24 hours of receipt of the request.	**Provider:** Within 24 hours of receipt of the request. **Member** (modify or deny only): Within 24 hours of receipt of the request
Post-Service/Retrospective	A decision to approve, modify, or deny is required within 30 calendar days of receipt of the request.	**Provider:** Within 30 calendar days of receipt of the request. **Member:** Within 30 calendar days of receipt of the request.

Attachment C
TIMEFRAMES FOR PHARMACY DECISIONS AND NOTIFICATIONS

OneCare Pharmacy Part D Determination Timelines

OneCare Pharmacy Part D Determination Timelines		
Type of Request	**Determination Timeline**	**Notification Timeline (Member and Prescriber)**
Standard (Non-urgent) Preservice/Concurrent	A decision to approve or deny is required within 72 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from when the request was received for exception requests submitted by members, without prescriber supporting statement (PSS)).	Within 72 hours of receipt of the request or prescriber supporting statement for member exception request (not to exceed seven calendar days from when the request was received for members exception requests, without prescriber supporting statement (PSS)). If successful verbal notification is made, written notification made within 3 calendar days of verbal notification.
Expedited (Urgent) Preservice/Concurrent	A decision to approve or deny is required within 24 hours of receipt of the request or prescriber supporting statement for exception requests (not to exceed seven calendar days from when the request was received for exception requests submitted by members, without prescriber supporting statement (PSS)).	Within 24 hours of receipt of the request or prescriber supporting statement for member exception request (not to exceed seven calendar days from when the request was received for members exception requests, without prescriber supporting statement (PSS)). If successful verbal notification is made, written notification made within 3 calendar days of verbal notification.
Post-service/Retrospective	A decision to approve or deny is required within 14 calendar days of the initial receipt of the request.	Within 14 calendar days of the initial receipt of the request.

Emergency Services

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, a person who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined based on lists of diagnoses or symptoms.

Emergency room services are available 24 hours per day, 7 days per week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima Health also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a plan network practitioner, or plan representative, instructs a member to seek emergency services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as follows:

Authorization for Post-Stabilization Inpatient Services

Post stabilization services are covered services related to an emergency medical condition provided after a member is stabilized to maintain, improve, or resolve the member's condition.

In accordance with Title 28 CCR 1300.71.4, when a member is stabilized, the Emergency Department (ED) provider believes the member requires additional medically necessary services and may not be discharged safely, CalOptima Health or the HN must approve or deny the request for post-stabilization care within 30 minutes of the request for a Medi-Cal member and within 60 minutes for a OneCare member. This requirement applies to both contracted and non-contracted providers. If CalOptima Health or a HN does not respond within the 30-minute (Medi-Cal) or 60-minute timeframe (OneCare), post-stabilization inpatient services are considered approved.

A hospital is required to notify CalOptima Health of a Post-Stabilization request for services prior to admission.

Retrospective Review

Retrospective review is an initial review of services that require prior authorization for which the services have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima Health notification and/or authorization and when there was no opportunity for pre-service review. Retrospective authorization is only permitted in accordance with CalOptima Health Policy and Procedure GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers which states the following:

1. The request is made within sixty (60) calendar days after the initial date of service and one of the following conditions apply:
2. The Member has Other Health Coverage (OHC); or
3. The Member's medical condition is such that the Provider or Practitioner was unable to verify the Member's eligibility for Medi-Cal, or OneCare, as applicable, at the time of service.

If supporting documentation satisfies the administrative waiver of notification requirements of the policy, the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is approved. If the supporting documentation is questionable, the UM Nurse Case Manager or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. Medical necessity of post-service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

Admission/Inpatient Review Process

Contracted facilities are required to notify CalOptima Health of all inpatient admissions within 24 hours of admission. The inpatient review process assesses the clinical status of the member and verifies the need for continued hospitalization. Information assessed during the review includes but is not limited to:

- Clinical information to support the appropriateness and level of service being provided
- Validation of the diagnosis
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care

- Additional days/service/procedures requested
- Reasons for the extension of the treatment or service

Utilizing evidenced based clinical guidelines, inpatient and concurrent review is conducted throughout the member's inpatient stay and with each approved hospital day based on review of the patient's condition and evaluation of medical necessity. Inpatient review can occur on-site or telephonically. The frequency of review is based on the severity/complexity of the member's condition and/or necessary treatment and discharge planning activity.

If, at any time, services cease to meet inpatient clinical criteria and discharge criteria are met and/or alternative care options exist, the Nurse Case Manager refers the case to the Medical Director for review. If the Medical Director determines the case no longer meets medical necessity for inpatient care, a Notice of Action (NOA)/UM Coverage Determination letter is issued immediately by fax and telephone to the hospital and mailed to the member. If the member is a OneCare member, verbal notification is also provided.

The need for case management or discharge planning services is assessed during the admission review, with each inpatient admission, and with consideration for the most appropriate alternative to inpatient care. If at any time UM staff become aware of potential quality of care issues, the concern is referred to CalOptima Health QI Department for investigation and resolution.

Discharge Planning Review

Discharge planning begins at the time of an inpatient admission and is designed to identify and initiate safe, quality-driven treatment intervention for post-hospital care needs. Discharge planning is a coordinated effort between the facility and CalOptima Health and includes participation from but not limited to the attending physician, hospital discharge planner, UM staff, complex discharge team, Case Management team, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review include:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention.
- Development of an individual care plan involving an appropriate multidisciplinary team and family members involved in the member's care.
- Communication with the attending physician and member, when appropriate, to suggest alternate health care resources.

- Communication to the attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization.
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge planning staff, and UM staff.

UM staff obtain medical record information and based on discharge review criteria/guidelines, identifies the need for discharge to a lower level of care. If the attending physician orders discharge to a lower level of care, UM staff assist the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the UM Medical Director as previously noted in the Inpatient Review Process.

Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, denial, or termination of any service based on medical necessity or benefit limitations.

Upon any adverse determination for medical or behavioral health services made by a CalOptima Health Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner.

Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the timeframes as noted in CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization. The written notification is composed using lay language that is easily understandable at a sixth grade reading level and includes member-specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and timeframes for appeal of the decision. All templates for written notifications of decision making are DHCS and CMS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. A CalOptima Health Medical Director or appropriate practitioner reviewer (BH practitioner, pharmacist, etc.) serves as the point of contact for the peer-to-peer discussion. The process for a practitioner to speak to the

Medical Director is outlined in the denial letter coversheet as well as provided at the time of verbal notification of the denial.

Grievance and Appeal Process

CalOptima Health has a comprehensive review system to address matters when Medi-Cal and OC members wish to exercise their right to contest the UM decision to deny, delay or modify a request for services, or terminate a previously approved service. This process is initiated by contact from a member, a member's representative or treating practitioner. Requests for members enrolled in COD or one of the contracted HMOs, PHCs and SRGs are submitted to CalOptima Health's Grievance and Appeals Resolution Services (GARS) by phone, fax, mail, online web submission or in person submission. The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution.

The grievance process is in accordance with CalOptima Health Member Complaint Policy. HH.1102: Member Grievance for our Medi-Cal line of business and Policy MA.9002 Member Grievance Process for our OneCare line of business. The appeal process is in accordance with CalOptima Health Appeal Policy GG.1510: Member Appeal Process for our Medi-Cal line of business and MA.9015: Standard Integrated Appeals for our OneCare line of business. These policies define processes including but not limited to:

- Collection of information and/or medical records related to the grievance or appeal.
- Communication with the member and provider.
- Thorough evaluation of the substance of the grievance or appeal.
- Review of the investigation for a grievance or medical records for an appeal.
- Resolution of operational or systems issues and of medical review decision.
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case.

The grievance and appeal process for all CalOptima Health Networks is handled by CalOptima Health GARS department. CalOptima Health collaborates with the community provider or delegated entity to gather the necessary information and support documentation. If a member is not satisfied with the appeal decision, he/she may file for a State Hearing with the California Department of Social Services. This process is in accordance with CalOptima Health Policy, HH.1108: State Hearing Process and Procedure. Grievances and appeals may be initiated by a member, a member's representative, or a practitioner. An Appeal may be processed as expedited or standard and will be handled as expeditiously as the member's health requires.

All medical necessity decisions are made by a licensed physician reviewer. Grievances and appeals are reviewed by an objective reviewer separate from the reviewer who made the initial denial determination.

The Medical Director or designee evaluates grievances regarding the denial, delay, termination, or modification of care or service. The Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An “Expert Panel” roster is maintained from which, either via Letter of Agreement or Contract, a Board-Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is under appeal.

CalOptima Health sends written notification to the member and/or practitioner of the outcome of the review in accordance with regulatory defined time limits. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues are identified during the investigation process, the issue identified in the review is directed to Quality Improvement for further review and a Potential Quality Issue (PQI) investigation is opened. PQI investigations are confidential and peer protected and are a separate process from the grievance and appeal review.

All members have a right to access copies of all documents relevant to the member’s appeal. Documentation requests may be submitted by calling the CalOptima Health Customer Service department.

Expedited Appeals and Grievances

Expedited appeals and grievances are managed in an accelerated fashion to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member or could jeopardize the member’s ability to regain maximum functionality. A member, member’s authorized representative or provider may request the grievance or appeal process to be expedited if there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, risk for adverse health outcome if not decisioned quickly, or potential loss of life, limb, or major bodily function. All expedited grievance or appeal requests that meet the expedited criteria shall be reviewed and resolved in an expeditious manner as the matter requires, but no later than 72 hours after receipt, except for OneCare expedited grievances which are reviewed and resolved no later than 24 hours after receipt. At the time of the request, the information is reviewed, and a decision is made regarding the expedited appeal criteria.

State Hearing

CalOptima Health Medi-Cal members have the right to request a State Hearing from the California Department of Social Services once the appeal process has been exhausted. A member may file a request for a State Hearing within 120 days from the Notice of Appeal Resolution. CalOptima Health and delegated HNs comply with State Aid Paid Pending requirements, as applicable. Information and education on filing a State Hearing are included annually in the member newsletter, in the member's evidence of coverage, and with each adverse Notice of Appeal Resolution sent to the member or the member's representative.

Independent Medical Review

OneCare members have a right to request an independent review if they disagree with the termination of services from a Skilled Nursing Facility (SNF), home health agency or a comprehensive outpatient rehabilitation facility. CMS contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. CalOptima Health is notified when a request is made by a member or member representative. CalOptima Health supports the process by providing medical records for the QIO's review. The QIO notifies the member or member representative and CalOptima Health of the outcome of their review. If the decision is overturned, CalOptima Health complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

Provider Preventable Conditions

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.

There are two types of PPCs:

1. Health care acquired conditions (HCAC) occurring in inpatient acute care hospitals.
2. Other provider preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified, the PPC is reported to CalOptima Health's QI department for further research and reporting to government and/or regulatory agencies, and to claims for possible overpayment recovery.

Long-Term Services and Supports

Long Term Care (LTC)

The LTC case management program includes authorizations for the following facilities:

- Nursing Facility Level A (NF-A) Custodial Intermediate LOC.
- Intermediate Care Level of Care (CCR Title 22 Section 51334(/)) In order to qualify for intermediate care services, a patient shall have a medical condition which needs an out-of-home protective living arrangement with 24-hour supervision and skilled nursing care or observation on an ongoing intermittent basis to abate health deterioration. Intermediate care services emphasize care aimed at preventing or delaying acute episodes of physical or mental illness and encouragement of individual patient independence to the extent of his ability.
- Nursing Facility Level B (NF-B).
- Skilled Level of Care.
- Skilled Nursing Level of Care (CCR Title 22 Section 51335 (j)) In order to qualify for skilled nursing facility services, a member shall have a medical condition which needs visits by a physician at least every 60 days, one or more physical disabilities, and constantly available skilled nursing services.
- Subacute care.
- Adult subacute care is a level of care that is defined as a level of care needed by a patient who does not require hospital acute care, but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a skilled nursing facility.
- Pediatric subacute care is a level of care needed by a person less than 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function.
- Subacute patients require special medical equipment, supplies, and treatments such as ventilators, tracheostomies, total parenteral nutrition, tube feeding and complex wound management care.

Facilities are required to notify CalOptima Health of admissions within 24 hours and submit authorization requests within 21 days. Nurse Case Managers assess a member's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to MSSP, IHSS, CalAIM or CBAS. Referrals to case management can also be made upon discharge when a member's needs

indicate a referral is appropriate. In addition, the LTC staff provide education to facilities and their staff at the request of the facility and when new programs are implemented.

Community-Based Adult Services (CBAS)

CBAS is an outpatient, facility-based program offering day-time care and health and social services to frail seniors and adults with disabilities. CBAS enables participants to remain living at home instead of in a nursing facility. Services offered through CBAS centers may include but are not limited to health care coordination; meal service (at least one per day at center); medication management; mental health services; nursing services; personal care and social services; physical, occupational and speech therapy; recreational activities; training and support for family and caregivers; and transportation to and from the center. In addition to the facility-based benefit, the CBAS benefit has allowance for members to receive Emergency Remote Services (ERS) in lieu of attending the center when they are experiencing an event that precludes them from attending the center in person. By allowing for ongoing support while the member is experiencing a public or personal emergency, the CBAS can continue to coordinate care and services on the member's behalf.

Multipurpose Senior Services Program (MSSP)

CalOptima Health is an approved MSSP site through California Department of Aging (CDA). The Multipurpose Senior Services Program (MSSP) provides social and health care services for people 60 or older who may have a disability or could be at risk for going into a nursing home. MSSP care managers work with the member, their family and others who may help support the member. The goal is to give members a chance to stay in their homes and enjoy a higher quality of life. To qualify for MSSP services, CalOptima Health members must: Be 60 years of age or older, have a possible need for nursing home care and be receiving Medi-Cal with an MSSP qualifying aid code.

Registered nurses (RNs) and social workers review the member's and family's needs and create a care plan with the member to meet his or her needs. MSSP buys some services or items that cannot be found through other resources, connects the member to services that meet the care plan goals, regularly review the member's needs to track the progress of services, and help the member keep services and find new ones.

MSSP care managers coordinate a wide range of services based on the members' needs, such as:

- Community-Based Adult Services (formerly Adult Day Health Care)
- Medical equipment such as walkers, canes, grab bars, wheelchairs, hospital beds, bath chairs, etc.
- Non-medical equipment such as medical alert systems, ramps, heaters, fans, etc.

    - Personal care, homemaker chore services and caregiver relief
    - Transportation
    - Minor housing repairs
- Counseling for mental illness or medical issues

Over/Under Utilization

Over/under utilization monitoring is tracked and monitored by the UM leadership team, the UM Workgroup, identified stakeholders, the Medical Director Team and reported to UMC. Over/under utilization data is reviewed by the UMC on a quarterly basis to monitors metrics, discusses performance, address identified trends, enhance the analysis, and identify interventions for decreasing over/under utilization.

Over/under utilization monitoring and performance are reported to the QIHEC on a quarterly basis.

The UMC may track and monitor over/under utilization data in the following areas to include but not limited to:

    - ED utilization
    - Bed day utilization
    - Readmission rates
    - Pharmacy utilization measures
    - Member and grievance data
    - Identified Trends from Fraud, Waste and Abuse investigations
    - Select HEDIS rates for selected measures
    - PCP and specialist referral pattern analysis
    - Member utilization patterns
    - Trends in UM-related complaints
    - Potential quality issues
- Behavioral health measures
- other areas as identified

Program Evaluation

The UM Program is evaluated at least annually, and modifications are made as necessary based on outcomes and opportunities. The Deputy Chief Medical Director, Executive of Clinical Operations and UM Director evaluate the impact of the UM Program by using:

    - Member complaint, grievance, and appeal data

- Results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction survey results
- Relevant UM data
- Practitioner profiles
- DUR profiles (where applicable)

The evaluation encompasses all aspects of the UM Program. Problems and/or concerns are identified through the evaluation process, and recommendations for improvements or barrier removal are provided. The evaluation and recommendations are submitted to the UMC for review, action and follow-up. The final document is then submitted to the Board of Directors through the QIHEC and QAC for approval.

Satisfaction with the UM Process

CalOptima Health provides an explanation of the GARS process, State Fair Hearing, and Independent Medical Review (IMR) processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers and postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima Health QI Department for investigation and resolution.

Annually, CalOptima Health evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include but are not limited to member satisfaction survey results such as Consumer Assessment of Healthcare Providers and Systems (CAHPS); member/provider complaints and appeals that relate specifically to UM; provider satisfaction surveys with specific questions about the UM process; and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the collective information indicates areas of dissatisfaction, CalOptima Health develops an action plan and interventions to improve the areas of concern. Actions may include but are not limited to staff retraining and member/provider education.

Case Management Process

The Case Manager is responsible for planning, organizing and coordinating all necessary services required or requested, and facilitating communication between the member's PCP, the member,

family members (at the member's discretion), other practitioners, facility personnel, other health care delivery organizations and community resources, as applicable.

Program Updates and/or Changes

Each year, based upon the evaluation and review of member satisfaction and effectiveness data, CalOptima Health updates the Case Management process to better address member needs. Evaluation results are shared with staff and training is provided to ensure understanding of any programmatic changes to the current process for the upcoming year. Updates and/or changes to the Case Management program and process include but are not limited to the following:

- Ongoing development of the clinical documentation platform to enhance functionality of assessments, care plans, and outputs and provide continued training in clinical standards of care, NCQA PHM 5: Complex Case Management Standards, and techniques for effective case management to both CalOptima Health and Health Network staff.
- Creation of additional tools to assist CalOptima Health and Health Network staff to ensure all elements of NCQA PHM 5 are addressed.
- Provision of targeted outreach and case management to support members who are risk stratified as high risk. Develop best practices for outreaching and improving overall care of high-risk members who primarily utilize the emergency department for care.

2. Continuation of development of specialized outreach and management for special populations, such as members struggling with pain, behavioral health issues, or who may be experiencing homelessness. Enhance training in resources and engagement to care management staff, with the goal of increasing member engagement in case management.

Team Composition and Roles

The Case Management Department consists of functional teams that focus on specific program activities. The multidisciplinary teams are composed of Case Managers, Social Workers, and Personal Care Coordinators to meet the needs of the member. Case Managers are assigned a variable size caseload with consideration for the complexity of the cases they manage. The Case Management teams include Health Risk Assessment and Health Needs Assessment, Health Network Liaison, an Oversight Clinical Team and a Direct Clinical Team.

The following staff positions provide support for organizational/operational CM Department's functions and activities:

Sr. Director, Clinical Operations oversees the Case Management and Long-Term Services and Supports (LTSS) programs within CalOptima Health. The Sr. Director ensures that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Health Community Network and CalOptima Health Direct Network. The Sr.

Director is responsible for programmatic oversight, strategic planning and ongoing compliance with all local, state and federal regulations and accreditation standards according to the CalOptima Health mission and vision.

Director of Care Management directs all Case Management programs for CalOptima Health members to ensure that case management functions are properly and consistently implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Health Community Network and CalOptima Health Direct. The Director is responsible for all departmental compliance with all local, state, and federal regulations, ensures that accreditation standards are current, and all policies and procedures meet current requirements.

Manager of Case Management provides shared responsibility for the daily operations, activities, and projects for the Case Management department. The Manager works under the general direction of the Director of Case Management and in partnership with the other department managers to provide performance management and development of the case management staff and departmental projects. This position ensures compliance with department policies and procedures and supports the implementation of departmental projects. The Manager may be required to attend joint operational and community meetings and is responsible for monitoring case management reports and reporting to management or committees.

Case Management Supervisor is responsible for the daily operation of case management activities, the implementation of new programs and compliance with regulations. The Supervisor provides guidance to staff and directly handles complex case management referrals. This role is accountable for establishing quality and productivity standards for the team and ensuring compliance with department policies and procedures in collaboration with the manager. The Supervisor serves as a resource for CalOptima Health's providers, health networks and community partners.

Medical Case Manager (Ambulatory) / Care Manager is responsible for providing ongoing case management services for CalOptima Health's members. The Medical Case Manager facilitates communication and coordination among all participants of the health care team and the member to ensure the services provided promote quality and cost-effective outcomes.

Health Network Liaison is a liaison between the delegated Health Networks (HN) and CalOptima Health, assisting members assigned to the delegated HN with coordination of care and service-related issues. Additionally, the Health Network Liaison provides consultation to the health networks and groups to improve overall compliance with regulations and standards. The liaison is a resource for members, HN Case Managers, Personal Care Coordinators (PCCs), and community partners to address medical, behavioral and psychosocial concerns.

Social Worker provides administrative case management and coordination of benefits for community resources and services. The Social Worker serves as a departmental resource regarding benefits and available resources for the aged, behavioral health, foster care and the disabled population. The Social Worker also serves as a liaison to Orange County based community agencies.

Personal Care Coordinators (PCC) support CalOptima Health members in completing a Health Risk Assessment (HRA) and ensure communication of the HRA and care plan with the member, Primary Care Provider (PCP) and health care team. The PCCs also identify barriers to members' care and assist in improving these barriers for all levels of care. The PCC role works closely with the PCP and health care team to ensure members have access to timely services and coordination of care.

Program Assistant provides support to staff, including but not limited to preparing meeting materials, maintaining minutes, routing documents, conducting data entry and handling of incoming and outgoing correspondence per administrative policy. Provides administrative support for specific and/or ongoing projects, such as generating reports, logs, calendars, and mailings, applying general business practices, as well as CalOptima Health policies and procedures under the direction of the Director.

Data Analyst performs analysis and reports data related to Case Management projects to ensure that case management goals and objectives are accomplished within specified time frames, through the judicious and efficient use of CalOptima Health resources.

QI Nurse Specialist is responsible for overseeing regulatory reports and audits for the entire Case Management department to ensure regulatory compliance, implementing and monitoring policy changes to case management reporting, and providing quality review of submitted health network data to meet Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), and National Committee for Quality Assurance (NCQA) requirements. In addition, the QI Nurse Specialist performs analysis and reports data related to the Case Management projects and ensures that Case Management goals and objectives are accomplished within specified time frames. The QI Nurse Specialist interacts with other internal CalOptima Health departments, health networks, and external agencies.

While CalOptima Health enjoys a robust array of internal case management resources, case management activities are also performed by the Health Networks. The Health Networks utilize their own case management staff to manage CalOptima Health's members who are assigned to them. Case management departments at the Health Networks are staffed with Case Managers, Social Workers, Pharmacists, and unlicensed support staff. While these staff are supervised by the

Health Networks, they participate in CalOptima Health specific training and are overseen by CalOptima Health.

Staff Training/Education

CalOptima Health recruits highly qualified individuals with extensive experience and expertise in Case Management for staff positions. Required qualifications and educational criteria are specified within the respective position descriptions.

Each new employee is provided with orientation and job specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job description:

- CalOptima Health New Employee Orientation and Boot Camp (CalOptima Health programs)
- HIPAA and Privacy
- Fraud, Waste and Abuse, Compliance and Code of Conduct training
- Use of technical equipment (phones, computers, printers, facsimile process, etc.)
- Workplace Harassment Prevention training
- Cultural Competency, Bias or Inclusion and Trauma-Informed Care training
- OneCare Model of Care Training
- Dementia Care Specialists
- Case Management Program: policies/procedures and desk top processes, etc.
- Medical Information System data entry
- QI Referral Process

3. Other training offered as appropriate

Case/Care Managers are monitored for appropriate application of NCQA requirements and case management documentation. Training opportunities are identified through regular administration of proficiency evaluations and addressed upon identification. Any employee who fails the evaluation is provided with additional training and provided with a work improvement process. Formal training, including seminars and workshops, is provided to all Case Management staff on an annual basis. Delegated Health Network staff participate annually in CalOptima Health model of care training.

CalOptima Health encourages and supports continuing education and training for employees, increasing employee competency in their present jobs and/or preparing them for career advancement within CalOptima Health. Each year, a specific budget is set for continuing education for licensed and certified CM employees.

Coordination of Care

Coordination of services and benefits is a key function of Case Management, both during inpatient acute episodes of care as well as for complex or special needs cases that are referred to the Case Management department for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services, and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. In order to maintain access to appropriate services and because Medi-Cal is always the payer of last resort, CalOptima Health must coordinate benefits with other payers the member may utilize including but not limited to Medicare, Worker's Compensation, and commercial insurance.

Other attempts to promote continuity and coordination of care include notifications to members affected by a PCP or practice group termination from CalOptima Health. CalOptima Health assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. In certain situations, if the provider termination is due to a reason other than a quality issue, continuity of care may also be explored to continue treatment with the provider. CalOptima Health also coordinates continuity of care with other Managed Care Plans when a new member comes into CalOptima Health, or a member terminates from CalOptima Health to enroll in a new health plan.

CalOptima Health uses multiple data sources to identify a member for case management. Data sources may include but are not limited to:

- Pharmacy data
- Health Risk/Needs Assessment
- Claims or encounter data
- Hospital Discharge data
- Utilization Management data
- Data supplied by purchasers
- Data provided by member or caregiver
- Data supplied by practitioners
- Risk Stratification and Segmentation (RSS)
- Health Information Form (HIF)

Members enter the case management program through multiple avenues. Referrals to case management may be made through but not limited to:

- Member self-referral
- Member's authorized representative/family referral
- Practitioner/Provider referral
- Customer Service referral
- Discharge Planner referral
- Disease Management program referral
- Community Agency referral
- HN referral
- Utilization Management referral
- Long-term Services and Supports referral

The case management program is built on evidence-based guidelines and includes a documented process to assess the needs of the member population. It establishes clear program goals and uses standardized mechanisms, such as data analysis, to identify members who may benefit from case management. Referrals can come through multiple avenues, and members are followed across the continuum of care—from outpatient or ambulatory settings to inpatient care. Eligible members are informed about case management services and have the option to accept or decline participation.

As the case manager documents activities, care plan goals, and interventions. the case management system automatically records essential details, including the case manager's name, date, time of actions, and prompts for required follow-up. Clinical practice guidelines and algorithms guide initial assessments and ongoing management.

As part of the case management process, individualized care plans are developed, implemented, and modified through an interdisciplinary, collaborative process involving providers, members, and their families or caregivers. These plans prioritize goals that reflect the member's preferences and include self-management strategies.

Case managers coordinate services to ensure appropriate levels of care and resources, document all findings, and continuously monitor, reassess, and adjust care plans to maintain quality, timeliness, and effectiveness. Data and member feedback are analyzed to identify opportunities for improvement, and any quality-of-care issues are referred to the Quality Improvement Department.
The program also coordinates carved-out services such as Medi-Cal Dental, addresses mental health needs through Behavioral Health referrals, and connects members to Population

Health/Disease Management programs, LTSS, and other resources. Finally, continuity of care needs are assessed in collaboration with the Utilization Management department.

The initial assessment of the member is used to assign the member to a programmatic level aligned to the programmatic needs identified through the assessment. The initial assessment includes the following:

- Member health status, including condition-specific issues
- Documentation of clinical history, including medications. Initial assessment of the activities of daily living (ADL).
- Assessment of behavioral health status
- Assessment of social drivers of health (SDOH)
- Evaluation of cultural and linguistic needs
- Evaluation of visual and hearing needs
- Evaluation of caregiver resources
- Evaluation of available benefits
- Evaluation of community resources
- Assessment of life-planning activities

Upon acceptance of a member into the CM Program, the Case Manager will develop a Case Management Plan based on the outcomes of the initial assessment, member-feedback, and member's clinical history. The Case Management Plan identifies the interventions required to provide appropriate care to the member.

A Case Management Plan includes Development of prioritized SMART goals with consideration for:

- Member or caregiver's goals or preferences
- Member or caregiver's desired level of involvement in case management plan
- Identification of barriers to meeting goals and complying with the case management plan
- Development of schedules for follow-up and communication with member Development and communication of member self-management plans
- Assessment of progress against case management plans and goals, and modification as needed

Coordination of Carved Out Services

CalOptima Health provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap-around services that enhance their medical benefits.

Memorandum of Understanding (MOU) with other community agencies and programs, such as the HCA/California Children's Services and Orange County Behavioral Health Plan (BHP). The CM staff and delegated entity practitioners are responsible for identification of such cases and coordination of referrals to appropriate State agencies and specialist care according to the member's benefit coverage. The Case Management Department assists members with the transition to other care, if necessary, when benefits end. Support may include informing members about ways to obtain continued care through other sources, such as community resources or waiver services.

Case Management Programs include identification and referral of a member eligible for community and/or Federal Medicaid Waiver programs, including, but not limited to:

- Specialty Mental Health Services (SMHS)
- Drug Medi-Cal Organized Delivery System (DMC-ODS) for substance use services
- California Children's Services (CCS) (for intercounty transfers)
- Regional Center of Orange County (RCOC)
- Local Education Agency (LEA)
- Genetically Handicapped Persons Program (GHPP)
- AIDS Waiver Program
- 1915 (c) Home and Community Based Services
- Assisted Living Waiver (ALW)
- Home and Community-Based Alternative (HCBA) Waiver
- Home and Community-Based Services Waiver for the Developmentally Disabled (HCBS-DD) Waiver
- Multipurpose Senior Services Program (MSSP)
- Tuberculosis Program (Direct Observation Therapy)
- Targeted Case Management (TCM)

Clinical Practice

CalOptima Health is committed to serving the needs of all members and places additional emphasis on the coordination of care for vulnerable populations. Approved clinical practice guidelines and nationally recognized protocols are used to guide treatment and care provided to the members. Following clinical practice guidelines or nationally recognized protocols is challenging for the CalOptima Health membership as many of their needs are socioeconomic in nature and not a consideration for recognized guidelines or protocols. Evidence-based clinical guidelines do not address many of the supplemental benefits or community-based resources that may be critical to a comprehensive care plan for these individuals. Lack of transportation may create obstacles to care, yet the member may not meet criteria for non-emergency medical

transportation. Members who are at the end of life may be inappropriate for certain preventive care screenings.

When use of a clinical practice guideline or nationally recognized protocol is challenging or inappropriate for an individual member the following steps may be taken:

1. ICT is convened with the member, the member's PCP, and specialists (if appropriate).
2. Participants of the ICT review the case and mutually develop an Individualized Care Plan (ICP), prioritized per member's preferences.
3. PCP or Case Manager facilitates referrals and linkages to identified supplemental benefits, community referrals and resources.

When a member's specific clinical requirements indicate the need for an alternative approach, decisions to modify clinical practice guidelines or nationally recognized protocols are made by the member, PCP or specialists, in consultation with other members of the health care team. The care team members review the member's current health status, limitations, social support, barriers, and treatment approach, which include any modifications needed in the clinical practice guidelines that support the ICP. Timeframes are established for each of the action items of the ICP to ensure successful completion of these tasks, identification of barriers, and attainment of goals. Updated ICP is shared with the care team members including but not limited to the members, caregivers, and PCP.

To address the unique needs of our members, CalOptima Health offers supplemental benefits, which can be accessed either through self-referral or via referral by a treating practitioner. These benefits are intended to aid members in maintaining optimal health status, either by providing health care services not covered by Medicare or Medi-Cal (e.g., vision care), by addressing barriers to access to care (e.g., Non-Medical Transportation), or by promoting regular physical activity (gym benefit).

Types of Case Management Services

The Case Management program supports members through individualized programs that meet each member's unique needs and preferences. Members are leveled into programmatic levels that include tailored interventions designed to support the members' needs at that level of care. Programmatic levels include Basic Case Management, Care Coordination, and Complex Case Management.

Members may also qualify for specialty programs such as Children and Youth with Special Health Care needs, Whole Child Model, Transitional Care Services, Transplant, and Palliative Care.

Basic Case Management

Basic case management activities by the primary care practitioner include:

1. A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a member's health and functional needs.
2. Services are provided by the Primary Care Physician (PCP) or by a PCP supervised Physician Assistant (PA), Nurse Practitioner (NP), or Certified Nurse Midwife, as the Medical Home.
3. Coordination of services outside the health plan, such as community social services or specialty mental health or Drug Medi-Cal services, are considered basic case management services.

Care Coordination

Care coordination consists of case management provided to Members who are at stratified at moderate risk but have an acute or chronic medical condition that requires coordinated support. Care coordination includes assessment, ICP, and coordination of resources in order to maintain the Members in the least restrictive setting. Care Coordination is provided by the Member's Health Network in collaboration with their PCP and specialists, as appropriate.

Complex Case Management (CCM)

Complex Case Management is provided to Members who are stratified at high risk. Complex Case management requires assessment, ICP, and coordination of resources in order to maintain the Members in the least restrictive setting. It is provided by the Member's Health Network, in collaboration with their PCP and specialists, as appropriate.

Complex Case Management is available to CalOptima Health members who include but are not limited to:

- A Member who is stratified as high-risk, defined as:
- A Member who has a medically complex condition, including the most frequently managed conditions; or

4. High risk groups, that may include, but are not limited to:
5. Spinal Injuries;
6. Transplants;
7. Cancer;
8. Serious Trauma;
9. AIDS;
10. Multiple chronic illnesses; and

- Chronic illnesses that result in high utilization
- A Member who has a complex social situation that affects the medical management of the Member's care;
- A Member who requires an extensive use of resources; or
- A Member who has an illness or condition that is severe, and the level of management necessary is very intensive.

CalOptima Health uses this criterion when data mining and as a guideline for internal and external referral sources to identify members who would benefit from CCM .

Children and Youth with Special Health Care Needs Case Management

Children and Youth with Special Health Care Needs (CYSHCN) include infants, children, and youth from birth to age 21 who have one or more chronic physical, developmental, behavioral, or emotional conditions, and require special health and support services.

Case Management staff ensure coordination of care with other entities that provide services for Children and Youth with Special Health Care Needs (e.g., mental health, substance abuse, Regional Center, CCS, local education agency, child welfare agency).

Whole Child Model (WCM)Case Management

Children and youth who meet condition-specific eligibility are supported through Whole Child Model Case Management. Whole Child Model Case Management includes:

- Assigning Case Management staff such as a (PCC) or a licensed care manager to each CCS-eligible Member.
- Case Management staff shall serve as the Member's assigned primary point of contact with CalOptima Health or a Health Network.
- Performing initial and periodic outreach to assist the Member with Care Coordination.
- Providing information, education and ongoing support, as appropriate.
- Assisting the Member and the Member's family in understanding the CCS-eligible Member's health, availability of eligible services, and how to access those services.
- Assisting as point of contact for other care managers and service Providers that serve WCM members, including ECM and Community Supports providers.

Transitional Care Services (TCS)

In January 1, 2023 DHCS outlined a phased approach in the Population Health Management (PHM) Policy Guide to provide Transitions of Care Services. Transitional Care Services are provided to members transitioning between levels of care. Transitions may include between and out of hospitals, institutions, other acute care facilities and skilled nursing facilities, post-acute

care facilities or long-term care settings. Members meeting the definition of TCS High Risk, per DHCS definition, receive outreach from designated TCS staff.

The goal of outreach is to address all member needs after hospitalization, including scheduling follow-up visits with the PCP, reviewing medications, coordinating transportation, and resolving discharge-related items such as home health services and durable medical equipment. Additional focus areas include connecting members to resources that promote independence, such as IHSS, CBAS and MSSP as well as CalAIM Community supports. The TCS program continues to strengthen outreach efforts to support transitions of care such as through text messaging, initiated in October 2024.

TCS program responsibilities include:

- Ensuring assigned members receive all appropriate TCS services, regardless of care setting- including inpatient facilities, discharging facilities and community based organizations.
- Collaborating and communicating with members, family members, guardians and support persons to promote safe and effective transitions.
- Facilitating collaboration, communication and coordination with hospitals, emergency departments, LTSS, and providers including PCP, physicians, nurses, social workers, discharge planners and service providers.

While not required to perform all tasks directly, TCS staff are accountable for ensuring the completion of all transitional care management activities, including:

- Discharge risk assessments.
- Discharge planning documentation.
- Coordination of post-discharge services.

11. Promotion of continuity of care and reduction of avoidable readmission by ensuring all needed services and supports are in place post hospitalization and clear communication across care teams.

For members enrolled with Case Management or ECM, the assigned Case Manager provides TCS for recently discharged members. The CM point of contact provides tools and support to promote and maintain the member's self-management skills, helping reduce the risk of readmission and improve the member's quality of life. TCS is provided to ensure members are supported from discharge planning until they have been successfully connected to all needed services and supports.

Special Programs

Transplant Program

The CalOptima Health Transplant Program provides the resources and tools needed to proactively manage members identified as potential transplant candidates. The CalOptima Health Transplant Program is coordinated by the Medical Director, UM Department and CM Department staff who work in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence or CMS certified Centers for OneCare.

CalOptima Health Utilization Management will notify Case Management about members who have been referred for transplant evaluation. Case Management follows all identified members and assists members as needed with transplant related issues. Coordination and support occur throughout the transplant continuum--during the transplant evaluation process, while the member is waiting to procure an organ, and post-transplant for one year.

Members are monitored on an inpatient and outpatient basis and followed through the transplant continuum. Coordination occurs between the member, physician and facilities to assure timely, efficient and coordinated access to the appropriate level of care and services within the member's benefit structure. This structure allows the Transplant Program to benefit the member, the community of transplant staff and the facilities. CalOptima Health monitors and maintains oversight of the Transplant Program and reports to the UM Committee regarding oversight of accessibility, timeliness, and quality of the transplant protocols.

Transplants for Medi-Cal members are not delegated to the HMOs, PHCs or SRGs.

Palliative Care Services

The CalOptima Health Case Management and Utilization Management teams work collaboratively to ensure access to Palliative Care services. Palliative care consists of patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care may be provided concurrently with curative care and does not require the member to have a life expectancy of six months or less.

Palliative care is provided by a trained team of doctors, nurses and other specialists who work together with the member's practitioner team to provide an extra layer of support. Eligibility for palliative care, as defined by DHCS APL 18-020 must be met.

2025 Utilization Management Program Evaluation

Quality Assurance Committee Meeting

March 19, 2026

Dr. Robin Hatam, Medical Director

Kelly Giardina, Executive Director, Clinical Operations

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

2025 Utilization Management (UM) Program Evaluation

- Annually evaluates the effectiveness of the UM Program
- Lookback period Q4 2024-Q3 2025

UM Program Accomplishments:

- Improved inventory management and oversight
- Report refinements
- PSA oversight and monitoring
- Established Pediatric Clinical Review team
- Provider portal automation and capabilities
- Prior Authorization Standardization project
- Expanded transplant services to include Loma Linda
- Removed preventative and screening prior authorization requirements for OneCare
- Enhanced Transitional Care Services (TCS) and assigned dedicated Medical Director
- Launched Skilled Nursing Facility (SNF) Workgroup
- Ushur Campaign expanded to support TCS

CalOptima Health

Member Satisfaction- CAHPS Results

CAHPS Response	2024	2025
% Adult members reported they usually or always got an appointment with a specialist as soon as needed	67.70%	75.6% ▲
% Adult members felt it was usually or always easy to get the care, tests, or treatment needed	84.80%	87.2% ▲
% Child members reported they usually or always got an appointment with a specialist as needed	68.30%	66.1% ▼
% Child members felt it was usually or always easy to get the care, tests, or treatment a child needed	81.73%	84.1% ▲

▼▲ **Denotes comparison to prior year**

Source: 2025 CAHPS Survey

CalOptima Health

Adult Medi-Cal Expansion & TANF 18+ Inpatient Utilization

Metric	Goal	2024 Q4	2025 Q1	2025 Q2	2025 Q3
Admits/1000 PTMPY	107.1	121.0 ▲	114.2 ▲	105.4 ▼	116.8 ▲
Days/1000 PTMPY	441.2	537.7 ▲	499.3 ▲	471.3 ▲	501.8 ▲
ALOS	3.7	4.4 ▲	4.4 ▲	4.5 ▲	4.3 ▲
Readmit %	14.7%	18.6% ▲	16.2% ▲	16.2% ▲	17.8% ▲
ED Visits / 1000 PTMPY	459.4	530.2 ▲	507.7 ▲	483.7 ▲	516.2 ▲

▼ ▲ Denotes comparison to goal

CCN/COD., Duals, LTC/Acute Rehab, & WCM excluded
Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2024 – Q3 2025.

CalOptima Health

Pediatric Medi-Cal TANF <18 (Non WMC) Inpatient Utilization

Metric	Goal	2024 Q4	2025 Q1	2025 Q2	2025 Q3
Admits/1000 PTMPY	13.9	34.7 ▲	28.3 ▲	27.2 ▲	26.8 ▲
Days/1000 PTMPY	193.7	489.8 ▲	378.5 ▲	326.5 ▲	331.0 ▲
ALOS	13.2	14.1 ▲	13.4 ▲	12.0 ▼	12.4 ▼
Readmit %	2.0%	1.1% ▼	0.0% ▼	0.0% ▼	0.0% ▼
ED Visits / 1000 PTMPY	349.1	421.8 ▲	405.7 ▲	331.9 ▼	330.1 ▼

▼ ▲ Denotes comparison to goal

CCN/COD only, Duals, LTC/Acute Rehab, & WCM excluded
Source: Membership and Utilization Trends Tableau report,
Data reflecting Q4 2043 – Q3 2025.

CalOptima Health

SPD Medi-Cal Inpatient Utilization

Metric	Goal	2024 Q4	2025 Q1	2025 Q2	2025 Q3
Admits/1000 PTMPY	**n/a**	262.8	240.6	239.0	234.2
Days/1000 PTMPY	**n/a**	1,507.6	1,509.2	1,372.7	1,332.8
ALOS	**n/a**	5.7	6.3	5.7	5.7
Readmit %	**n/a**	24.7%	22.4%	22.8%	25.4%
ED Visits / 1000 PTMPY	**n/a**	684.7	660.7	633.3	637.0

CCN/COD only, Duals, LTC/Acute Rehab, & WCM excluded
Source: Membership and Utilization Trends Tableau report,
Data reflecting Q4 2024 – Q3 2025.

CalOptima Health

LTC Medi-Cal Inpatient Utilization

Metric	Goal	2024 Q4	2025 Q1	2025 Q2	2025 Q3
Admits/1000 PTMPY	**n/a**	514.3	716.7	519.6	486.7
Days/1000 PTMPY	**n/a**	3,480.0	5,000.0	3,085.3	3,041.8
ALOS	**n/a**	6.8	7.0	5.9	6.3
Readmit %	**n/a**	12.5%	35.1%	17.9%	13.8%
ED Visits / 1000 PTMPY	**n/a**	308.6	266.7	373.5	365.0

CCN/COD only, Duals, LTC/Acute Rehab, & WCM excluded
Source: Membership and Utilization Trends Tableau report,
Data reflecting Q4 2024 – Q3 2025.

CalOptima Health

WCM Inpatient Utilization

Metric	Goal	2024 Q4	2025 Q1	2025 Q2	2025 Q3
Admits/1000 PTMPY	**n/a**	316.9	315.1	294.9	289.6
Days/1000 PTMPY	**n/a**	2,368.3	2,720.1	2,847.1	1,875.9
ALOS	**n/a**	7.5	8.6	9.7	6.5
Readmit %	**n/a**	5.1%	4.8%	4.3%	10.1%
ED Visits/1000 PTMPY	**717.4**	733.8 ▲	802.8 ▲	620.3 ▼	613.0 ▼

▼▲ **Denotes comparison to goal**

CCN/COD only, Duals, LTC/Acute Rehab, & WCM excluded
Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2024 – Q3 2025.

CalOptima Health

OneCare Inpatient Utilization

Metric	Goal	2024 Q4	2025 Q1	2025 Q2	2025 Q3
Admits/1000 PTMPY	**309**	275.2 ▼	282.3 ▼	278.8 ▼	268.6 ▼
Days/1000 PTMPY	**1892.8**	1,573.7 ▼	1,598.1 ▼	1,668.5 ▼	1,341.9 ▼
ALOS	**6.1**	5.7 ▼	5.7 ▼	6.0 ▼	5.0 ▼
Readmit %	**15.80%**	18.6% ▲	16.6% ▲	18.3% ▲	13.7% ▼
ED Visits / 1000 PTMPY	**649.5**	554.2 ▼	559.8 ▼	599.1 ▼	649.3 ▼

▼▲ **Denotes comparison to goal**

CCN/COD only,LTC/Acute Rehab excluded
Source: Membership and Utilization Trends Tableau report,
Data reflecting Q4 2024 – Q3 2025.

CalOptima Health

Prior Authorization Referrals Processed- Medi-Cal and OneCare

Referrals continued to increase across in the reporting period. Turnaround compliance remained above goal of 95% in the reporting period.

Referrals Processed	
Routine	322,576
Urgent	88,345
Retro	17,339
Total*	428,260

Referrals Processed	
Faxed	63,835
COLAs (Portal)	356,481
Auto Auth	*162,682*
Other (E-mail, phone, internal referral)	7,944
Total*	428,260

Turnaround Time Compliance (TAT)	
Routine	99.9% ▲
Urgent	99.9% ▲
Retro	99.7% ▲

**Note: Referrals processed includes all LOB; MC, OneCare, and PACE. Auto-Auth is a subset of Portal authorization volume.*

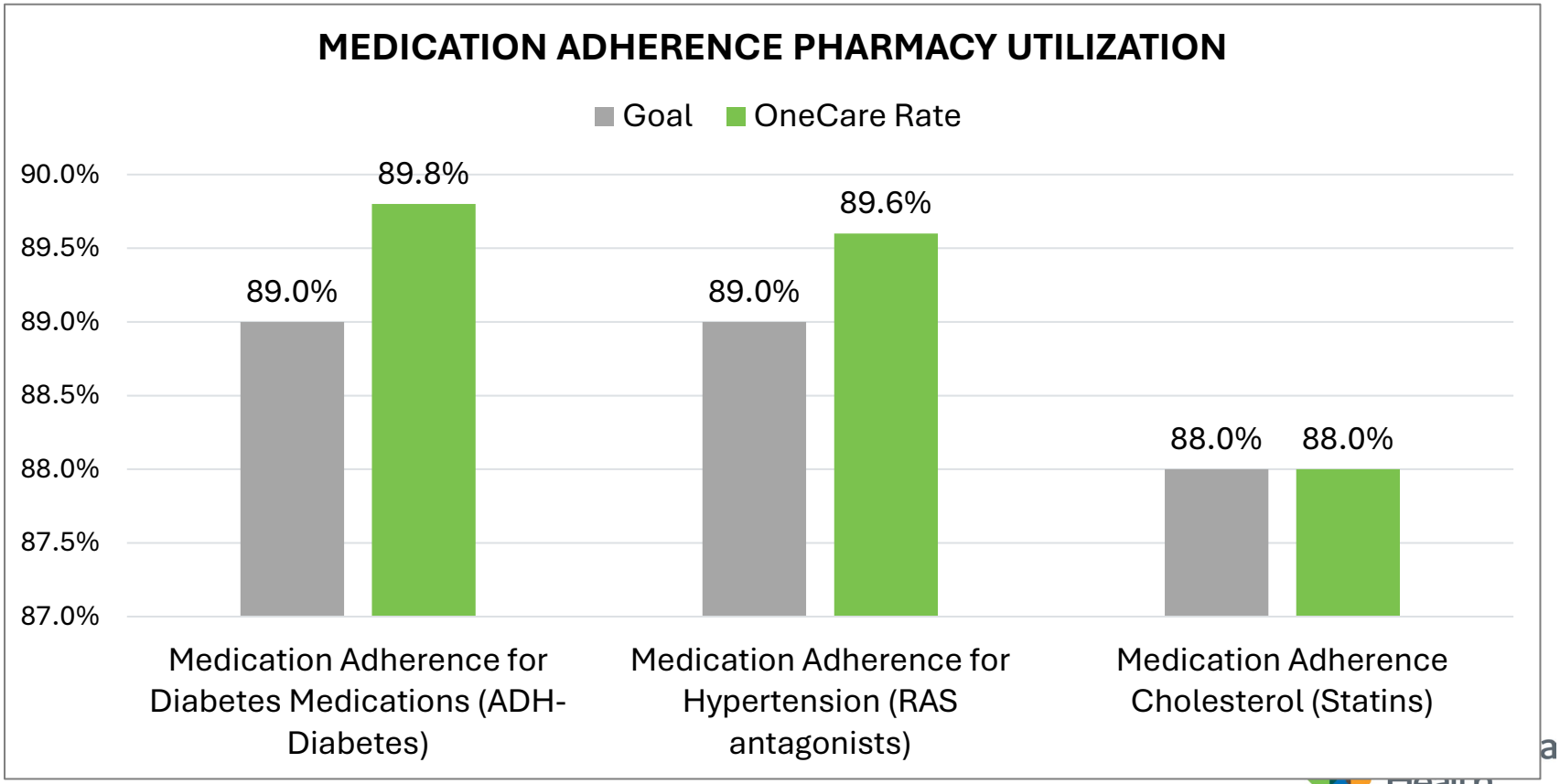
▲▼ **Denotes comparison to goal**

Sources: Report ad-hoc data pulled 12/5/25 for Q4 2024-Q3 2025 for Referrals Processed charts.
Turnaround Time Compliance (TAT) pulled from Authorization Inventory Jiva Tableau for YTD 205. Data pulled on 12/14/25

CalOptima Health

Pharmacy Utilization

Goals were met for all three adherence measures through November 2025. Interventions included but were not limited to provider faxes, distribution of educational materials to member, comprehensive medication reviews, member telephonic outreach, pharmacy outreach, member IVR campaigns and member text campaigns.



Source: CMS Acumen Jan – November 2025.

Inter-Rater Reliability (IRR)

All clinical reviewers within the Medical Management Department passed IRR testing with a score of 90% or greater.

Department	IRR Score
UM Clinical Staff: Prior Authorization	94.4% ▲
UM Clinical Staff: Inpatient services	91.7% ▲
Utilization Management	95.8% ▲
UM Physical Therapist	100.0% ▲
Medical Directors (UM)	96.3% ▲
Pharmacy: RPh	98.4% ▲
LTSS: LTC	95.0% ▲
LTSS: CBAS	97.0% ▲
LTSS: MSSP	96.7% ▲
CalAIM	100.0% ▲
Behavioral Health	99.5% ▲
Medical Directors (BH)	100.0% ▲

▲▼ **Denotes comparison to goal**

Source: https://learn.mcg.com/local/mcg_reports/index.php?c=report&a=completion

2026 UM and CM Integrated Program Description

Kelly Giardina, Executive Director of Clinical Operations

Dr. Robin Hatam, Medical Director

UM Program Goals and Initiatives

- Timely and efficient treatment authorizations
- Coordination and continuity of care
- Support of member through transitions of care including addressing complex discharge needs
- Oversight and support of access, availability, and timeliness of care
- Member and provider satisfaction
- Identifying and addressing over and under-utilization of care
- Promotion of health literacy, prevention and improved member outcomes

CalOptima Health

Integration of Quality Program Initiatives

- Comprehensive Community Cancer Screening
  As of report period (1/1/2025-6/30/2025), a total of 25,661 screenings have been completed through the Comprehensive Community Cancer Screening and Support Program.

Breast Cancer Screening	4,684	Colorectal Cancer Screening	9,417
Cervical Cancer Screening	10,833	Lung Cancer Screening	727

- Five Year Hospital Quality Program 2023-2027 – Improve quality of care to members through increased patient safety efforts & performance driven processes.
- Unified framework ensuring continuity: Behavioral health (BH), Long-Term Services and Supports (LTSS), and Pharmacy.
- Collaboration with Credentialing, Compliance and Delegation Oversight.
- Clinical decision-making consists of a comprehensive view of the member's medical, behavioral, and social needs.
- Utilization of services is evaluated to address clinical quality and member outcomes.
- Continuous quality loop in clinical programs including; Bidirectional data exchange; HEDIS alignment; Regulatory and Delegation Oversight.

CalOptima Health

Sub-Committee Framework

Pharmacy and Therapeutics Committee (P&T):	Designed to promote access to clinically sound, cost-effective pharmaceutical care for all CalOptima Health Members. Subcommittee reviews drug utilization, prior authorization criteria, and CalOptima Health Policies with regulatory requirements. Provides updates on outcomes of pharmacy measures relating to HEDIS, STARS rating, disease management programs, and QI studies to drive improvements in quality of care for members.
Benefit Management Subcommittee (BMSC):	Established to maintain a consistent set of benefits and clinical interpretation for all lines of business. Implements a single source for revisions and updates to CalOptima Health's authorization rules based on benefit updates. Benefit sources include, but are not limited to, Medi-Cal Managed Care Division (MMCD), local and national coverage determinations, All Plan Letters (APLs) and the Medi-Cal Manual.

UM Sub Workgroups Framework

High Risk Management:	Identifies interventions to optimize **utilization** in the **Emergency Department (ED)**, inpatient facilities and long-term care settings and improve patient outcomes. Implements clinical strategies to **reduce unnecessary ED visits/hospitalizations**, **decrease length of stay** in acute care and long-term acute care facilities, to reduce readmissions, and target high-risk members for preventive interventions.
Over/Under Utilization:	**Monitors utilization** of CalOptima Health by tracking metrics, discussing performance, addressing trends, contributing to the analysis and action plan for **decreasing over and underutilization** that is reported up through UMC.
Gender Affirming Care:	**Equitable support** for the continuum of care for our members undergoing **gender affirming care and treatment**. Oversees policy and procedure alignment**, identifies and addresses challenges** in member care by enhancing and streamlining CM and UM workflows. **Proactively addresses gaps in care** through collaboration with community supports and network providers.

UM Sub Workgroups Framework

Early and Periodic Screening Diagnosis Treatment (EPSDT):	**Address EPSDT services** across all clinical teams to ensure provision of services available to eligible members. Ensures and monitors that **members receive medically necessary EPSDT** services as required by APL.
Enhanced Care Management (ECM) Clinical Oversight:	**Educate providers, support, and monitor protocols for clinical oversight** for members enrolled in ECM. Ensures members are receiving appropriate clinical care and related social services and to support ECM providers serving members.
Skilled Nursing Facility (SNF):	**Enhance concurrent review process** for inpatient stays, ensure staff are crossed trained for SNF concurrent review coverage. Initiate a strategy for **SNF physician specialty services** through contracted provider. Enhance use of **SNF add-on rates** for complex hospital discharges.

UM Sub Workgroups Framework

Behavioral Health Quality Improvement (BHQI) Workgroup:	The BHQI Workgroup focuses on improving behavioral health integration by evaluating the effectiveness of current interventions and identifying opportunities for quality enhancement. When gaps are found, the team collaborates to design and implement new strategies that promote better outcomes and support integrated, high-quality care.

Over/Under Utilization Goal Revision

Dr. Robin Hatam, Medical Director

Over/Under Utilization Goals

Goals updated Q4 2025 based on revised data

Metric	Medi-Cal Adult 18+		Medi-Cal Peds Non-WCM		SPD		LTC		OneCare		WCM	
GOAL	PRIOR	NEW	PRIOR	NEW	PRIOR	NEW	PRIOR	NEW	PRIOR	NEW	PRIOR	NEW
Admit PTMPY	107.1	114.9	13.9	29.1	-	241.5	-	583.2	309.0	261.5	-	N/A
ALOS	3.7	4.3	13.2	12.2	-	5.7	-	7.8	6.1	5.5	-	N/A
Days PTMPY	551.2	515.9	193.7	374.7	-	1,438.7	-	4,501.1	1,892.8	1,520.3	-	N/A
Readmit %	14.7%	16.4%	2.0%	2.2%	-	21.6%	-	23.3%	15.8%	14.6%	-	N/A
ER util. PTMPY	459.4	499.7	349.1	382.8	-	642.9	-	271.3	649.5	549.7	717.4	653.9

Goals set based on a 5% reduction from the average of Prior 4 Quarters (Q2 2024-Q1 2025)

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Appendix

Prior Authorization Turn Around Time – Medi-Cal and OneCare

Prior authorization turnaround time compliance for prospective routine and urgent and retrospective cases remained complaint at or above 95% for the reporting period.

Prior Authorization Turnaround Time Compliance (TAT) Q4 2024 - Q3 2025						
Year	Goal	Quarter	Month	Prospective Routine	Prospective Urgent	Retro Post Service
2024	95%	Q4	Oct	100.0% ▲	99.8% ▲	100.0% ▲
			Nov	99.8% ▲	99.8% ▲	99.6% ▲
			Dec	99.9% ▲	99.8% ▲	99.8% ▲
2025	95%	Q1	Jan	100.0% ▲	100.0% ▲	100.0% ▲
			Feb	98.9% ▲	98.6% ▲	99.3% ▲
			March	99.8% ▲	99.2% ▲	98.7% ▲
	95%	Q2	April	99.8% ▲	99.6% ▲	95.1% ▲
			May	99.8% ▲	99.6% ▲	97.1% ▲
			June	99.7% ▲	99.5% ▲	99.7% ▲
	95%	Q3	July	99.7% ▲	99.7% ▲	98.7% ▲
			Aug	99.8% ▲	99.7% ▲	99.0% ▲
			Sept	99.9% ▲	99.9% ▲	96.7% ▲

▼ ▲ Denotes comparison to goal

Source: Authorization Inventory Tableau Data Q4 2043-Q3 2025. Data pulled 11/18/2025

CalOptima Health

Inpatient Turn Around Time – Medi-Cal and OneCare

Inpatient urgent concurrent review and retro post service turnaround time remained compliant at 95% or higher throughout the reporting period.

Inpatient Turnaround Time Compliance (TAT) Q4 2024 - Q3 2025 (CCN/COD)					
Year	Goal	Quarter	Month	Concurrent Review	Retro Post Service
2024	95%	Q4	Oct	98.0% ▲	95.2% ▲
			Nov	95.6% ▲	100.0% ▲
			Dec	95.5% ▲	97.1% ▲
2025	95%	Q1	Jan	97.7% ▲	97.2% ▲
			Feb	98.4% ▲	96.9% ▲
			March	98.0% ▲	98.3% ▲
	95%	Q2	April	97.8% ▲	96.8% ▲
			May	97.3% ▲	98.8% ▲
			June	98.2% ▲	100.0% ▲
	95%	Q3	July	97.9% ▲	98.7% ▲
			Aug	99.0% ▲	100.0% ▲
			Sept	98.5% ▲	100.0% ▲

▲▼ Denotes comparison to goal

Source: Authorization Inventory Tableau Data Q4 2043-Q3 2054. Data pulled 11/18/25

CalOptima Health

CBAS Turn Around Time

CBAS turnaround time (TAT) remained compliant above goal of 95% throughout the reporting period

CBAS Turnaround Time Compliance (TAT) Q4 2024 - Q3 2025			
Year	**Goal**	**Quarter**	**TAT Compliance**
2024	**95%**	**Q4**	96.0% ▲
2025	**95%**	**Q1**	99.7% ▲
	95%	**Q2**	100.0% ▲
	95%	**Q3**	100.0% ▲

▲▼ **Denotes comparison to goal**

Source: Jiva UM Decision TAT Detail Report – CBAS Referrals processed Q4 2024-Q3 2025

CalOptima Health

LTC and CBAS
Potential Nursing Home Eligible

Members Residing in LTC / Potential Nursing Home Eligible					
Year	**Quarter**	**LOB**	**Residing in LTC / Potentially Nursing Home Eligible**	**% Residing in LTC**	**Change From Previous Qtr.**
2024	**Qtr 4**	Medi-Cal	4,911 / 146,655	3.4%	0.06%
		One Care	147 / 17,042	0.9%	0.10%
2025	**Qtr 1**	Medi-Cal	4,840 / 148,135	3.3%	0.10%
		One Care	149 / 17,367	0.9%	0%
	Qtr 2	Medi-Cal	5,916 / 150,751	3.9%	-0.60%
		One Care	147 / 17,786	0.8%	0.03%
	Qtr 3	Medi-Cal	4,813 / 153,236	3.1%	0.80%
		One Care	152 / 18,124	0.8%	-0.01%

Source: Jiva Inpatient Census Report and Tableau Membership Report

CalOptima Health

Quality Initiative

- CalOptima Health analyzed provider grievances, provider UM appeals, and provider claims disputes to assess the provider experience.
  - Top reason for provider grievances was dispute of recoupment notices and disagreement with FWA audit results
  - Top reasons for provider UM appeals were denials for no medical necessity, no prior authorization obtained prior to services, and retroactive authorization denied for non-timely submission. The majority of provider UM appeals were upheld at 95% upheld.
- Potential Quality Issues (PQIs) are reviewed by CalOptima Health Medical Directors. PQIs that are leveled as quality-of-care are presented individually to the Credential and Peer Review Committee.

Potential Quality Issues (PQIs)					
Issue	**Q1 2025**	**Q2 2025**	**Q3 2025**	**Q4 2025**	**TOTAL**
Authorization denied or delayed	8	21	10	2	**41**
Authorization issues	0	0	0	2	**2**
Delay of service	0	0	2	0	**2**
Failure to notify the member of the referral	2	0	0	1	**3**
Failure to refer	3	6	4	2	**15**
Failure to submit referral timely	4	5	3	0	**12**
Referral submitted to wrong specialist or specialty	0	6	2	0	**8**
Total	**17**	**38**	**21**	**7**	**83**

Q4 is October and November data only. Source CORE Report QI0089

Data Trends and Findings from UMC | Utilization

Data as of Q3 2025 ,CCN/COD only; LTAC and Acute Rehab excluded, MC excludes Duals/WCM

Metric	Medi-Cal Adult 18+		Medi-Cal Peds Non-WCM		SPD		LTC		OneCare		WCM	
	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual	Goal	Actual
ALOS	114.9	116.8 ▼	29.1	26.8 ▲	241.5	234.2 ▲	583.2	486.7 ▲	261.5	268.6 ▼	N/A	289.6
Admit PTMPY	4.3	4.3 ▲	12.2	12.4 ▼	5.7	5.7 ▲	7.8	6.3 ▲	5.5	5.0 ▲	N/A	6.5
Days PTMPY	515.9	501.8 ▲	374.7	331.0 ▲	1,438.7	1,332.8 ▲	4,501.1	3,041.8 ▲	1,520.3	1,341.9 ▲	N/A	1,875.9
Readmit %	16.4%	17.8% ▼	2.2%	0.0% ▲	21.6%	25.4% ▼	23.3%	13.8% ▲	14.6%	13.7% ▲	N/A	10.1%
ED util. PTMPY	499.7	516.2 ▼	382.8	330.1 ▲	642.9	636.9 ▲	271.3	365.0 ▼	549.7	649.3 ▼	653.9	613.0 ▲
Membership (Q3)	136,579		32,459		13,730		265		3,783		1,188	

Note: Goals reflect revised targets

▲▼ **Denotes comparison to goal**

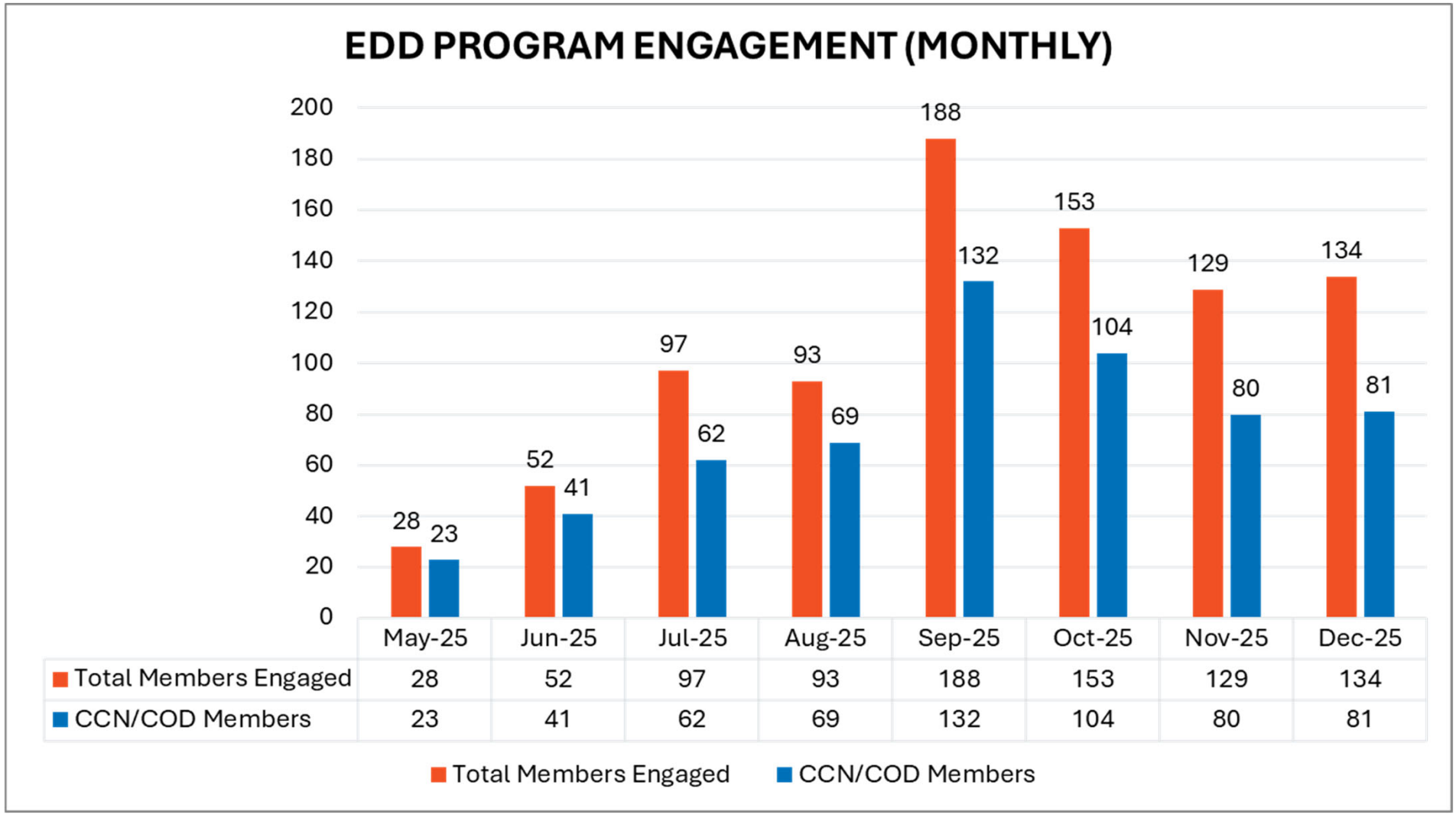
Source: Membership and Utilization Trends dashboard data as of 1/9/2026 pulled 1/26/2026

CalOptima Health

Emergency Department Diversion

Dr. Robin Hatam, Medical Director

Emergency Department Diversion



Source: Manually tracked

Slide 37

GK1 [@Evans, Michelle] please update Q4 2025 and Annual program plans
Giardina, Kelly, 2026-01-28T18:59:50.259

1 0 [@Giardina, Kelly] -updated.
Evans, Michelle, 2026-02-02T16:46:08.229

GK1 1 TY!
Giardina, Kelly, 2026-02-02T21:53:38.673

Back to Agenda Back to Item

Emergency Department Diversion

Program Enhancements

- Continued onsite activities with tailored resources and referrals based on identified member needs.
- Weekly workgroup: Strengthen real-time collaboration through weekly review and follow-up on actionable recommendations.
- Continuity of care enhancements with warm handoffs to HN, TCS, ECM and CM teams.
- Share program with HN for awareness and purpose of warm handoffs.
- OneCare Outreach: initiated in December for follow-up post-ED discharge for PCP appointments.
- Recuperative Care Support- improve facility and member support with process for identifying bed days.

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Transitional Care Services

TCS Goal and Results

- **Goal:** Increase successful interactions for TCS high-risk members within 7 day of discharge by 10% by end of December 2025

- **Results:**

Successful interactions for TCS high-risk members within 7 day of discharge			
Year	**Goal**	**Quarter**	**TCS Engagement**
2025	70.7%	Q1	60.7% ▼
	70.7%	Q2	68.3% ▼
	70.7%	Q3	73.0% ▲
	70.7%	Q4	66.77% ▼

▲▼ **Denotes comparison to goal**

Random sample audit

CalOptima Health

UM Program Performance & Sub-Workgroup updates

Kelly Giardina, Executive Director, Clinical Operations

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Q4 2025: Sub Workgroup Updates

Over/Under Utilization	• Review of utilization data of lumbar MRIs, varicose vein treatments, home health utilization and other categories • ER high utilization workgroup started with weekly meetings ongoing • Addition of high-risk “movers” to weekly workgroup
High-Risk Management	• Analyzed key traits of ER utilization populations for direct and health networks. • Launched subgroup to analyze top ER utilizers for trends and interventions
EPSDT	• Enhanced Dashboard to include autism versus development screenings • DHCS Audit preparation • Monitoring/oversight discussion of EPSDT services (PDN and speech therapy)
SNF	• Continued discussion with SNFist group • GARS appeal process checklist developed • Review Quality Improvement Organization (QIO) appeal data to improve documentation and discussed QIO reconsideration process
Population Health Management (PHM)	• Sunset PHM Committee: Population Health, Disease Management and Health Education updates and outcomes to be shared in UMC/ QIHEC

Inpatient Turn Around Time

Inpatient Turnaround Time Compliance (TAT) Q1 2025 – Q4 2025 (CCN/COD)					
Year	**Goal**	**Quarter**	**Month**	**Concurrent Review**	**Retro Post Service**
2025	**95%**	**Q1**	**Jan**	97.7% ▲	97.2% ▲
			Feb	98.4% ▲	96.9% ▲
			March	98.0% ▲	98.3% ▲
	95%	**Q2**	**April**	97.8% ▲	96.8% ▲
			May	97.3% ▲	98.8% ▲
			June	98.2% ▲	100.0% ▲
	95%	**Q3**	**July**	97.9% ▲	98.7% ▲
			Aug	99.0% ▲	100.0% ▲
			Sept	98.5% ▲	100.0% ▲
	95%	**Q4**	**Oct**	98.6% ▲	100.0% ▲
			Nov	97.8% ▲	98.3% ▲
			Dec	98.2% ▲	98.8% ▲

IP Turnaround Time met the 95% goal for all months of the reporting period.

Source: Source: Authorization Inventory Tableau. Filtered to UM Concurrent Review Data Q1 2025 – Q4 2025. Data pulled 1/26/2026

▲▼ **Denotes comparison to goal**

CalOptima Health

Prior Authorization Turn Around Time

Prior Authorization Turnaround Time Compliance (TAT) Q1 2025 – Q4 2025 (CCN/COD)						
Year	**Goal**	**Quarter**	**Month**	**Prospective Routine**	**Prospective Urgent**	**Retro Post Service**
2025	**95%**	**Q1**	**Jan**	99.9% ▲	99.9% ▲	99.8% ▲
			Feb	99.9% ▲	99.9% ▲	99.7% ▲
			March	99.9% ▲	99.7% ▲	98.6% ▲
	95%	**Q2**	**April**	99.9% ▲	99.9% ▲	99.1% ▲
			May	99.9% ▲	99.8% ▲	99.7% ▲
			June	100.0% ▲	100.0% ▲	100.0% ▲
	95%	**Q3**	**July**	100.0% ▲	99.9% ▲	99.9% ▲
			Aug	99.9% ▲	99.9% ▲	100.0% ▲
			Sept	99.9% ▲	99.9% ▲	100.0% ▲
	95%	**Q4**	**Oct**	99.9% ▲	99.8% ▲	100.0% ▲
			Nov	100.0% ▲	99.9% ▲	99.8% ▲
			Dec	99.9% ▲	99.9% ▲	100.0% ▲

Prior authorization turnaround time met goal of 95% for all reporting periods.

Source: Authorization Inventory Tableau. Filtered to UM Prior Auth
Data Q1 2025- Q4 2025 pulled 1/26/2026

▲▼ **Denotes comparison to goal**

CalOptima Health

LTSS Turn Around Time
Q1 2025 – Q4 2025

CalAIM Turnaround Time Compliance (TAT)				
Year	**Goal**	**Quarter**	**Routine**	**Expedited**
2025	95%	Q1	89.5% ▼	100.0% ▲
	95%	Q2	99.3% ▲	97.0% ▲
	95%	Q3	99.1% ▲	100.0% ▲
	95%	Q4	99.5% ▲	93.6% ▼

LTC Turnaround Time (TAT) Determination Completed within 5 Business Days			
Year	**Goal**	**Quarter**	**TAT Compliance Rate**
2025	95%	Q1	98.7% ▲
	95%	Q2	99.4% ▲
	95%	Q3	99.4% ▲
	95%	Q4	99.6% ▲

CBAS Turnaround Time (TAT) Determination Completed within 5 Business Days			
Year	**Goal**	**Quarter**	**TAT Compliance Rate**
2025	95%	Q1	99.9% ▲
	95%	Q2	100.0% ▲
	95%	Q3	100.0% ▲
	95%	Q4	100.0% ▲

CBAS Inquiry to Determination Completed within 30 Days			
Year	**Goal**	**Quarter**	**CBAS**
2025	95%	Q1	99.3% ▲
	95%	Q2	100.0% ▲
	95%	Q3	100.0% ▲
	95%	Q4	100.0% ▲

▲▼ **Denotes comparison to goal**

CalOptima Health

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 19, 2026
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

6. Recommend that the Board of Directors Receive and File the 2025 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Plan Evaluation, and Approve the 2026 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Plan

Contacts

Javier Sanchez, Executive Director, Medicare Programs, (714) 986-6115
Donna Frisch, M.D., PACE Medical Director, (714) 714-8974
Monica Macias-Garcia, LCSW, PACE Director, (714) 468-1077

Recommended Actions

Recommend that the Board of Directors:

1. Receive and File the 2025 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Plan Evaluation, and
2. Approve the 2026 Program of All-Inclusive Care for the Elderly Quality Improvement Plan.

Background

The Program of All-Inclusive Care for the Elderly (PACE) is viewed as a natural extension of CalOptima Health's commitment to integration of acute and long-term care services for its members. This program provides the link between CalOptima Health's healthy, elderly senior members with those senior members who need costly long-term nursing home care. PACE is a unique model of managed care service delivery in which the PACE organization is a combination of the health plan and the provider who provides direct service delivery. As of December 31, 2025, CalOptima Health PACE had 543 active members enrolled. Independent evaluations of PACE have consistently shown that it is a highly effective program for its target population that delivers high-quality outcomes and participant satisfaction.

PACE organizations are required to have a written Quality Improvement (QI) Plan that is evaluated annually. The results of the evaluation can directly lead to the revisions made to the following year's QI Plan. The QI Plan reflects the full range of services furnished by CalOptima Health PACE. The goal of the QI Plan is to improve future performance through effective improvement activities driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff.

The 2025 PACE Quality Assessment and Performance Improvement Plan Evaluation analyzes the core clinical and service indicators to determine if the 2025 QI Plan achieved its key performance goals for the year. In 2026, CalOptima Health PACE continues to expand participant services, update quality element goals, and efforts to ensure comprehensive care. The 2026 PACE QI Plan reflects CalOptima Health's efforts to achieve a high level of quality while also focusing on improving health outcomes and access for program participants.

Back to Agenda

Discussion

CalOptima Health PACE updated the 2026 PACE QI Plan to ensure that it is aligned with health network and strategic organizational changes. This will ensure that CalOptima health meets all regulatory requirements and standards in a consistent manner. The 2026 PACE QI Plan, created through a collaboration of the PACE QI Committee members, refines the PACE quality elements based on the current population's health needs. The 2026 PACE QI Plan challenges the PACE team to strive for improvement in areas of treatment, service, and health outcomes.

In 2026 PACE proposes:

1. To ensure that CalOptima Health PACE eligible participants receive the most up-to-date vaccines to prevent spread of communicable disease and lessen the risk of serious illness from infection.
2. To assist program participants in completing advanced health care directives to ensure that their health care wishes are followed.
3. To raise the benchmark goals of CalOptima Health PACE quality metrics to provide highest quality of care for program participants.

Fiscal Impact

The recommended actions have no additional fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2025-26 Operating Budget. Staff will include expenditures for the period of July 1, 2026, through December 31, 2026, in the FY 2026-27 Operating Budget.

Rationale for Recommendation

PACE organizations are required to establish a QI program. The Centers for Medicare & Medicaid Services (CMS) requires that PACE organizations develop, implement, maintain, and evaluate an effective, data-driven QI program. In addition, PACE organizations must have a written QI plan that is collaborative and interdisciplinary in nature. The PACE governing body must review the plan annually and revise it, if necessary. Approval of the recommended actions will ensure CalOptima Health PACE complies with these CMS requirements.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. 2025 PACE QI Work Plan Evaluation
2. 2026 Proposed PACE QI Work Plan (Redline version)
3. 2026 Proposed PACE QI Work Plan (Clean version)
4. PowerPoint Presentation: 2025 PACE QI Work Plan Evaluation and 2026 Proposed PACE QI Work Plan

/s/ Michael Hunn *03/12/2026*
Authorized Signature **Date**

Back to Agenda

CalOptima Health Program of All-Inclusive Care for the Elderly

2025

Quality Improvement Plan

Annual Evaluation

Back to Agenda Back to Item

SIGNATURE PAGE

PACE Quality Improvement Committee Chairperson:

_____ _____

Donna Frisch, M.D. **Date**
Medical Director, PACE

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____

Jose Mayorga, M.D. **Date**

Board of Directors Chairperson:

_____ _____

Vicente Sarmiento **Date**

TABLE OF CONTENTS

EXECUTIVE SUMMARY 4

SECTION 1: PROGRAM STRUCTURE 4

SECTION 2: PACE QAPI PROGRAM 5

Major Accomplishments 5

SECTION 3: STRATEGIC GOALS AND OBJECTIVES 6

Accomplishments 6

SECTION 4: SUMMARY OF ACCOMPLISHMENTS, BARRIERS, AND ACTIONS 7

PACE Membership at a Glance 7

2025 Quality Improvement Work Plan — Elements by Category: 8

Quality of Care and Services 8

Access and Availability 15

Utilization Management 16

Enrollment/Disenrollment 19

Transportation 21

Meals 23

Participant Satisfaction 23

SECTION 5: 2025 HEALTH PLAN MANAGEMENT 24

Grievances 24

Appeals 25

Quality Incidents 26

Medication Errors 27

Falls Without Injury 27

Denials of Prospective Enrollees 28

SECTION 6: 28

QUALITY INITIATIVES 28

SECTION 7: OPPORTUNITIES FOR IMPROVEMENT IN 2026 29

SUMMARY 30

APPENDIX: 2025 PACE QI EVALUATION 30

2025 CalOptima Health PACE

Quality Improvement (QI) Plan Annual Evaluation

Executive Summary

The CalOptima Health PACE program continued to enroll new participants and saw our highest ever enrollment numbers by the close of 2025. When CalOptima Health PACE first opened for operations on October 1, 2013, we had 13 enrolled participants. We have seen sustained growth in enrollment throughout the past 12 years and at the end of 2025, we reached a milestone number of 543 participants enrolled.

Despite a small COVID-19 surge in Q3 of 2025, we were able to provide all necessary face-to-face services for participants with their providers, clinic, and rehabilitation staff. We have worked diligently to provide as many in-person services to our participants as possible, while also assessing risk factors for spreading disease and implementing processes to mitigate these risks. All COVID-19 cases are tracked and trended for potential center-wide outbreaks and participants who test positive are treated following the latest CDC guidelines for treatment and isolation to prevent spread.

The multicultural background and the diversity of our participant population provides a very vibrant and engaging environment at PACE. Among our PACE participants, the primary languages are 73% Spanish, 12% English, and 9% Vietnamese. Other languages spoken include Tagalog, Arabic, Chinese, Hindi, Persian, Portuguese, Russian, Telegu, Gujarati, Urdu and Korean. CalOptima Health PACE ensures that participants are provided with opportunities to communicate in their preferred language using professional interpreter services and that PACE staff provide culturally competent care for each of our members.

The purpose of the CalOptima Health PACE QI Plan is to improve the quality of health care for participants, improve on the patient experience, ensure appropriate use of resources, provide oversight to contracted services, communicate quality and process improvement activities and outcomes, and reduce the potential risk to health and safety of PACE participants through ongoing risk management. This is done via data-driven assessment of the program which in turn drives continuous QI for the entire PACE organization. It is designed and organized to support the mission, values, and goals of CalOptima Health PACE.

The goal of the CalOptima Health PACE QI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff. The 2025 PACE QI Workplan Evaluation helps to identify key areas that offer opportunities for improvement that will be incorporated into the 2026 PACE QI Plan.

Section 1: Program Structure

The CalOptima Health PACE QI Plan is developed by the PACE Quality Improvement Committee (PQIC). It is then reviewed and approved by the CalOptima Health Board of Directors' Quality Assurance Committee (QAC) and then approved by the CalOptima Health Board of Directors annually. The 2025 PACE QI Plan was reviewed and approved by the CalOptima Health Board of Directors on April 3rd, 2025.

The CalOptima Health PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI Manager ensures timely collection and completeness of data with the support of the PACE QI Program Specialists. Ultimately, oversight of the PACE QI Plan is provided by the CalOptima Health Board of Directors.

The CalOptima Health PACE QI Plan incorporates continuous QI methodology that focuses on the specific needs of CalOptima Health's PACE participants.

- It is organized to identify and analyze significant opportunities for improvement in health care and service.
- It fosters the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals.
- It is focused on QI activities carried out on an ongoing basis to ensure that any quality-of-care issues are identified and corrected.

SECTION 2: PACE QAPI PROGRAM

Major Accomplishments

In 2025, CalOptima Health PACE's accomplishments include:

1. Milestone enrollment number of 543 enrolled participants.
2. Provided infection control training to all staff in accordance with CDC, California Department of Health Care Services (DHCS) and California Department of Public Health (CDPH) directives.
3. Implemented a plan to assist eligible participants with receiving the latest recommended COVID-19 vaccine, which became available in September 2025.
4. Continued to increase PACE Day center activities and attendance.
5. 12, 207 home delivered meals distributed throughout 2025.
6. 83.9% of participants received their annual Influenza vaccine, with continuation of vaccination efforts into Q1 2026.
7. 93% of eligible participants completed their recommended Pneumococcal vaccine series.
8. Continued enhanced care coordination program for PACE participants with End Stage Renal Disease on dialysis. In 2025, PACE cared for 38 participants with dialysis needs.
9. 97% of participants had their medications reconciled within 7 days of hospital and/or Skilled Nursing Facility (SNF) discharge, meeting our established goals.
10. 94.2% of participants with diabetes completed an annual eye exam, meeting our established goals.
11. Utilization:
    a. Only 0.27% of participants were placed in long-term custodial care in 2025.
    b. Continued the PACE Emergency Room (ER) Diversion program, with hospitalization utilization goals met for 2025.
    c. Continued to provide in-house specialist health care including podiatry, dental, geriatrician and nephrology services for improved access and coordination of health care.
12. 100% of staff competency assessments were completed. Year-round staff training was provided covering a broad area of topics including infection control, emergency responses,

grievances, appeals, service delivery requests, and participant rights.

SECTION 3: STRATEGIC GOALS AND OBJECTIVES

Accomplishments

1. The QI program is organized to identify and analyze significant opportunities for improvement in clinical services, health care, and utilization. Accomplished and evidenced by:
    a. The ongoing Health Plan Management System (HPMS) and QI individual metric data collection and analysis.
    b. The ongoing PACE QI activities and initiatives.
2. The quality of clinical care and services and patient safety provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population. Accomplished and evidenced by:
    a. The monitoring of member grievances and complaints.
    b. The monthly meeting with the contracted transportation vendor.
    c. The daily morning inpatient and nursing facility clinical reviews by the medical case manager nurse.
    d. The ongoing infection control activities, specifically tracking, reporting, and treatment of all infectious disease cases.
    e. Collaboration with the CalOptima Health Compliance department for identification of potential quality issues that may involve fraud, waste, abuse, confidentiality, security, etc.
    f. The PACE Clinic Workflows to efficiently address participant health care issues.
3. The continuity and coordination of health care between specialists and primary care practitioners, and between medical and behavioral health practitioners. Accomplished and evidenced by:
    a. The Interdisciplinary Team (IDT) meetings at CalOptima Health PACE.
    b. Continued presence of physicians and nurse practitioners during IDT meetings.
    c. Addition of preferred specialists who regularly provide services within the PACE clinic.
    d. The coordination of health care found in the ER Diversion Program.
4. The accessibility and availability of appropriate clinical care and a network of providers with experience in providing health care to the geriatric population. Accomplished and evidenced by:
    a. The number of grievances that have been tracked and trended.
    b. Podiatry and dental staff providing on-site health care.
5. The qualifications and practice patterns of all individual providers in the Medi-Cal network to deliver quality health care and service. Accomplished and evidenced by:
    a. The credentialing and peer review process.
    b. Annual performance evaluations of all CalOptima Health PACE employees.

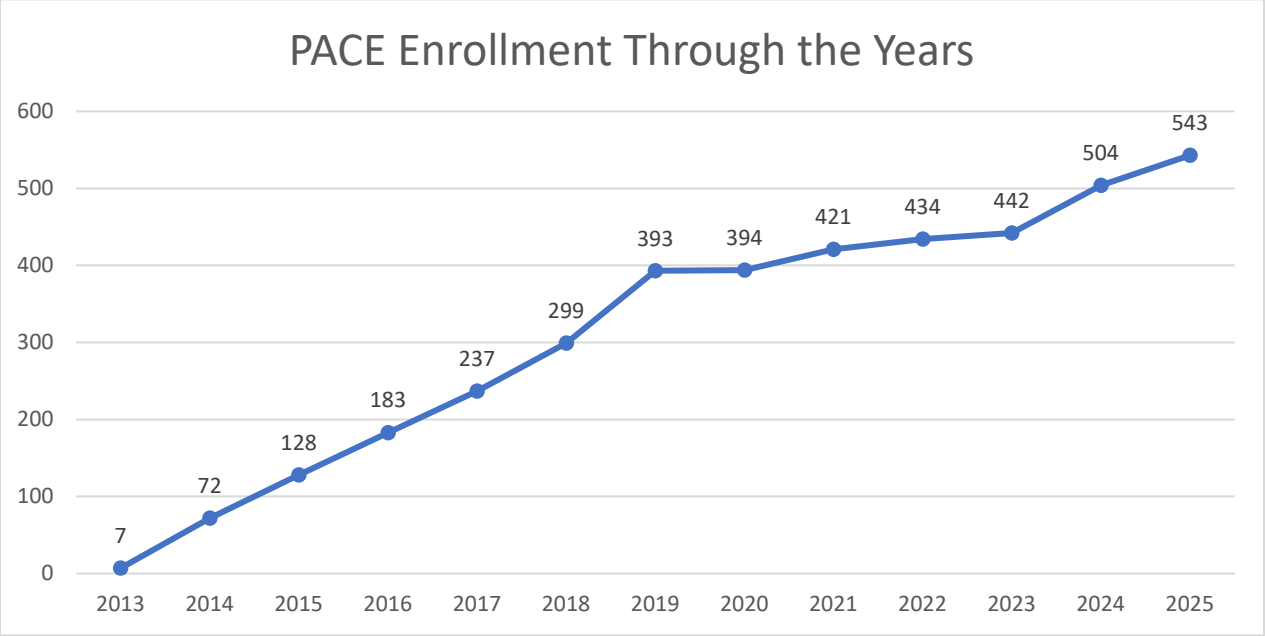
Back to Agenda Back to Item

6. Member and provider satisfaction, including the timely resolution of complaints and grievances. Accomplished and evidenced by:
    a. Summary and resolutions of grievances.
    b. The ongoing input from the PACE Member Advisory Committee meetings.
7. Risk prevention and risk management processes. Accomplished and evidenced by:
    a. The QI activities which occur around all quality incidents and including root cause analyses and recommendation for improvement and follow up.
    b. Physical therapy driven groups designed to prevent future falls.
8. Compliance with regulatory agencies and accreditation standards. Accomplished and evidenced by:
    a. Successful submission of quality data as required by CMS and DHCS each quarter.
9. Compliance with clinical practice guidelines and evidence-based medicine. Accomplished and evidenced by:
    a. The adoption of the National PACE Association Preventative Guidelines.
    b. The use of clinical practice standards.
    c. On-going PACE staff training.
10. Support the organization's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently. Accomplished and evidenced by:
    a. Tracking, trending, and analyzing utilization management (UM) data monthly.
    b. The coordination of health care found in the ER Diversion Program.
    c. The weekly PACE leadership team meetings.
    d. Participation in the CalOptima Health QI, UM, and Credentialing and Peer Review Committee meetings.
    e. Participation in the CalOptima Health Board of Directors and the Board of Directors' Quality Assurance Committee meetings.

SECTION 4: SUMMARY OF ACCOMPLISHMENTS, BARRIERS, AND ACTIONS

PACE Membership at a Glance

CalOptima Health PACE offers a community-based program that provides all necessary medical health care coordination and social services support in one location to the frail and elderly within our community. The goal of keeping seniors healthy in their homes and maintaining their independence continues to be our mission.



As illustrated in the membership graph, PACE has seen a steady enrollment trend over the years.

In 2026, our goals for program growth remain intact and strategies are in place to expand our ability to serve even more participants in Orange County. With approval from the CalOptima Health Board of Directors and regulatory agencies, the PACE program intends to open an additional center in Orange County to better serve the needs of seniors throughout the county.

2025 Quality Improvement Work Plan — Elements by Category:

Quality of Care and Services

QI25.01 PACE QAPI Plan and Work Plan will be evaluated annually

Approved by the CalOptima Health Board of Directors on April 3, 2025.

QI25.02 PACE QAPI Plan and Work Plan will be reviewed and updated annually

Approved by the CalOptima Health Board of Directors on April 3, 2025.

QI25.03 Increase Influenza immunization rates for all eligible PACE participants

Goal: Greater than or equal to 94% of eligible participants will have their annual influenza vaccination by December 31, 2025.

Goal: Not Met

Data/Analysis: 84% of participants received the influenza vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement: With a year-end vaccination rate of 84%, we fell short in meeting our 2025 goal. Our influenza vaccination efforts for the 2025/2026 flu season will extend through Q1 of 2026 where we will continue to reach out to those unvaccinated participants who have not already declined this vaccination. Vaccines were pre-ordered in late spring from our distributer, and we began our process when vaccines arrived in September 2025. Monthly reports were generated by our QI department identifying those participants who still required the vaccine, and this was shared with the primary care providers (PCPs) and registered nurses (RNs) who personally reached out to the unvaccinated participants. It

is important to note that CalOptima Health PACE reported zero influenza outbreaks among our participants or staff in 2025. We will change our goal to greater than or equal to 90% influenza vaccination in 2026. This goal maintains very high standards for vaccination while also recognizing the vaccine fatigue occurring amongst our participants post COVID-19 pandemic.

QI25.04 Increase Pneumococcal immunization rates for all eligible PACE participants

Goal: Greater than or equal to 94% of eligible participants will have their Pneumococcal vaccination by December 31, 2025.

Goal: Not Met

Data/Analysis: 93% of participants received the pneumococcal vaccination by the year end.

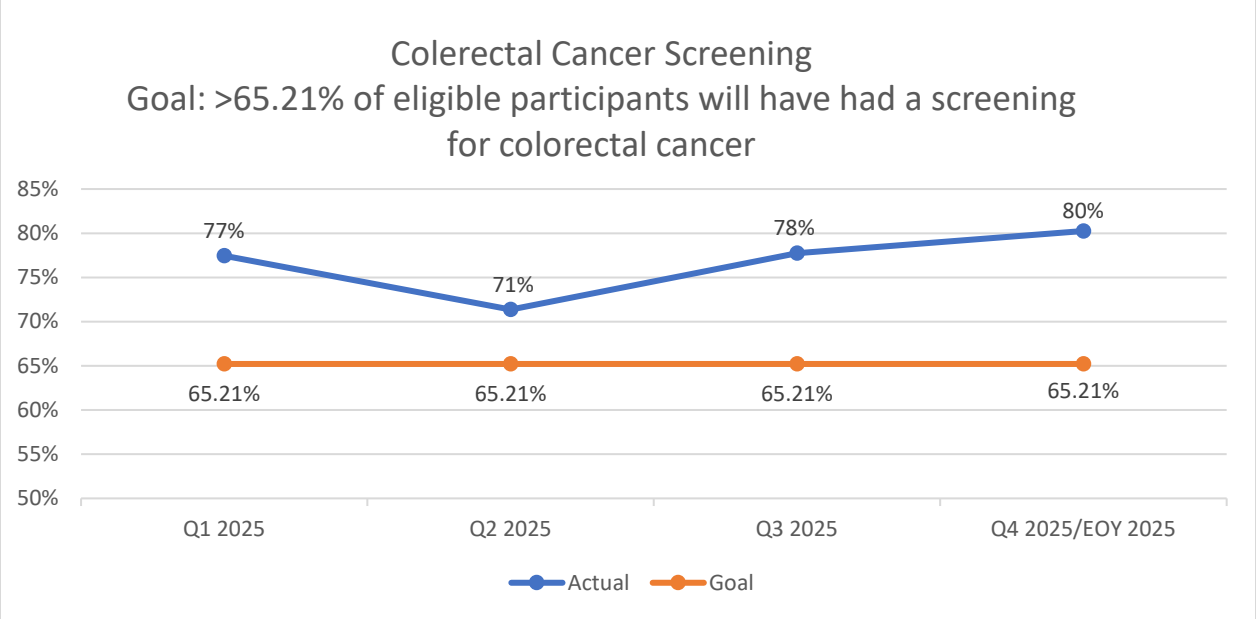
Summary and Key Findings/Opportunities for Improvement: By the end of 2025, 93% of our eligible participants had completed pneumococcal vaccination, very narrowly missing our goal of 94%. Throughout the year, the PACE QI department provided detailed reports to the clinic which specified which participants still needed the vaccination. That report was then shared with all providers. We will change our goal to greater than or equal to 90% pneumococcal vaccination in 2026. This goal maintains very high standards for vaccination while also recognizing the vaccine fatigue occurring amongst our participants post COVID-19 pandemic.

QI25.05 Increase the number of participants who complete Colon Cancer Screening

Goal: > 65.21% of eligible participants will have had a screening for colorectal cancer by December 31st, 2025 (Comparable to the 2023 MEDICARE Quality Compass HEDIS 33.33rd percentile).

Goal: Met

Data/Analysis: 80% of eligible participants had a screening for colorectal cancer by December 31st, 2025.



Summary and Key Findings/Opportunities for Improvement: We were able to meet and exceed our goal for the year already by Q1 2025. We will continue this element into 2026 to ensure that our PACE participants are receiving the best possible chance at identifying colorectal cancer in its early stages when prognosis is better. We will increase our goal to >69.66% of

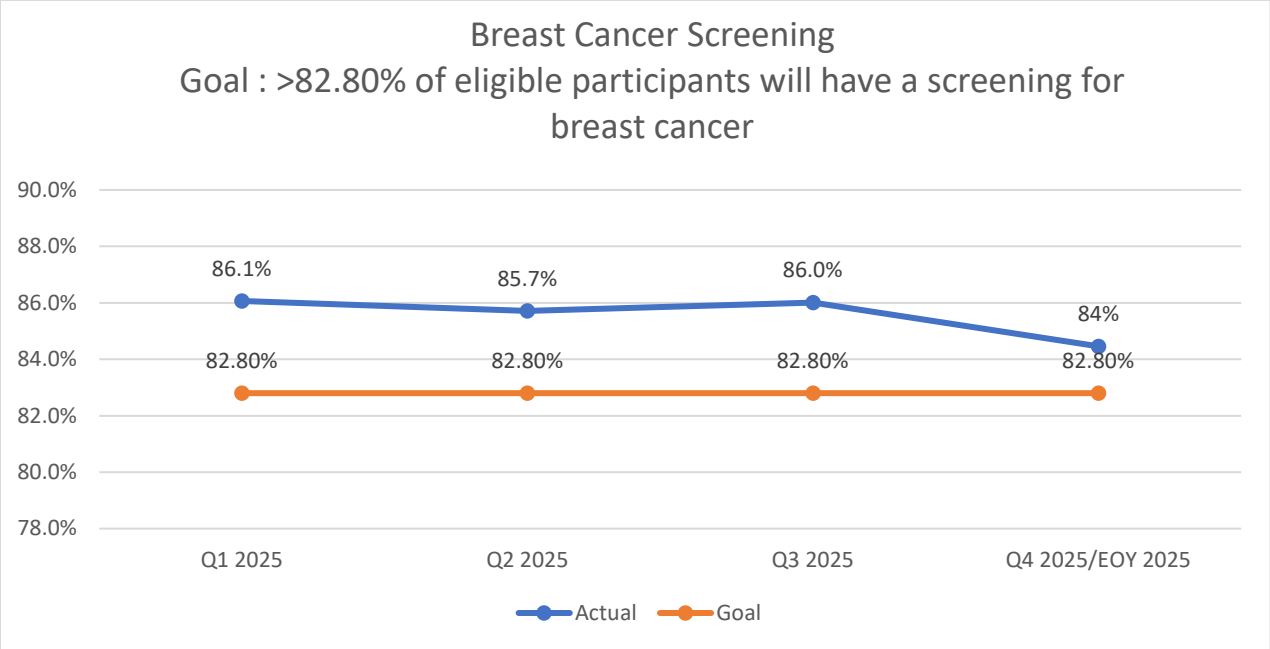
eligible participants will have had a screening for colorectal cancer by December 31st, 2026 (Comparable to the 2024 MEDICARE Quality Compass HEDIS 50th percentile).

QI25.06 Increase the number of participants who complete Breast Cancer Screening

Goal: >82.80% of eligible participants will have a screening for breast cancer by December 31st, 2025 (Comparable to the 2023 MEDICARE Quality Compass HEDIS 90th percentile).

Goal: Met

Data/Analysis: 84% of eligible participants had a screening for breast cancer by December 31st, 2025.



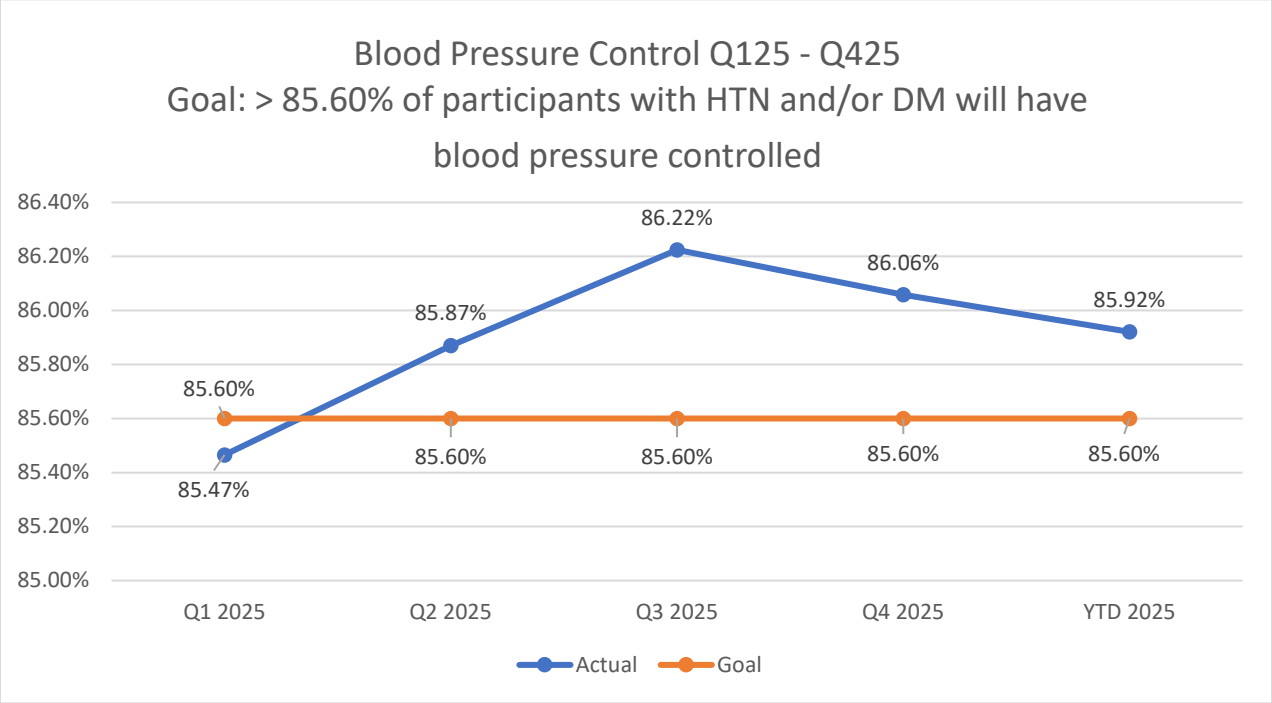
Summary and Key Findings/Opportunities for Improvement: We were able to meet and exceed our goal for the year already by Q1 2025. We will continue this element in 2026 to ensure the earliest possible detection of breast cancer for our PACE participants. We will increase our goal to >83.60% of eligible participants will have a screening for breast cancer by December 31st, 2026 (Comparable to the 2024 MEDICARE Quality Compass HEDIS 90th percentile).

QI25.07 Increase the percentage of PACE participants with diabetes and/or hypertension who have their blood pressure under control (<140/90 mm hg)

Goal: >85.60% of participants with Hypertension and/or Diabetes will have their blood pressure controlled (Comparable to the 2023 MEDICARE Quality Compass HEDIS 90th percentile)

Goal: Met

Data/Analysis: The 2025 EOY final average was 85.92%.



Summary and Key Findings/Opportunities for Improvement: Starting in Q2 2025 were able to meet our overall average blood pressure monitoring goal for 2025. Blood pressure control is measured as regular readings of <140/90 mm Hg.

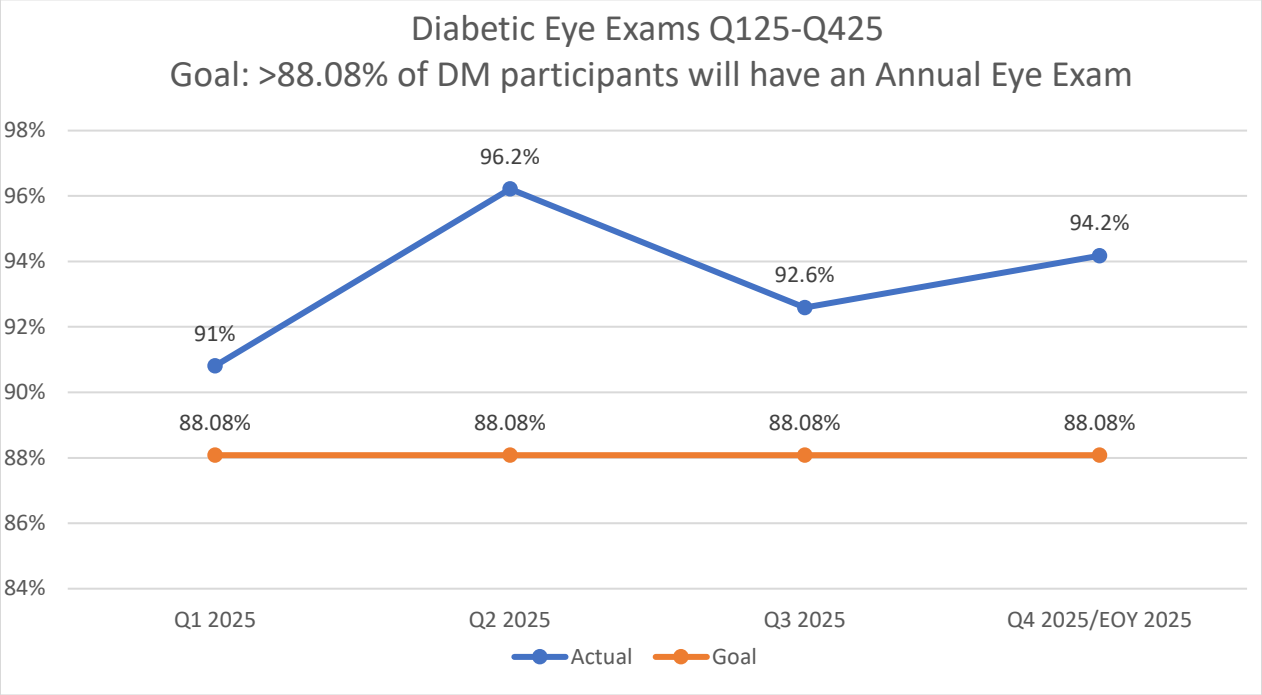
The 2026 goal will be increased from >85.60% to >87.21%. (Comparable to the 2024 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in 2026 QI Work Plan).

QI25.08 Increase the percentage of PACE participants with diabetes who have had their annual diabetic eye exam completed

Goal: >88.08% of Diabetic participants will have an Annual Eye Exam (Comparable to the 2023 MEDICARE Quality Compass HEDIS 95th percentile)

Goal: Met

Data/Analysis: The 2025 final rate was 94.2%.



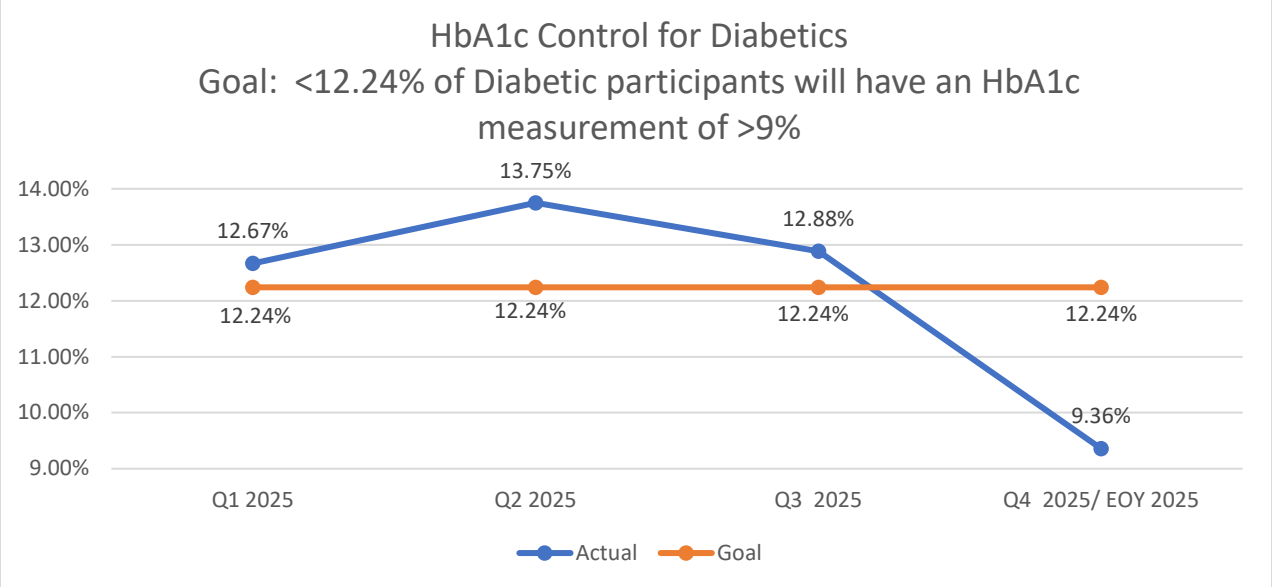
Summary and Key Findings/Opportunities for Improvement:

We exceeded our target goal, with 94.2% of diabetic participants having received an annual eye exam by the end of 2025. With the assistance of monthly reports generated by the PACE QI team, providers were alerted to those diabetic participants who still required their annual eye exam. Those participants were then scheduled for an appointment. In 2026, the goal will be increased to >89.04% of Diabetics will have an Annual Eye Exam (Comparable to the 2024 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in 2026 QI Work Plan).

QI25.09 Increase the percentage of PACE participants with diabetic blood sugar control

Goal: <12.24% of Diabetic participants will have an HbA1c measurement of >9% (Comparable to the 2023 MEDICARE Quality Compass HEDIS 90th percentile)
Goal: Met

Data/Analysis: 2025 ended with a rate of 9.36%.



Back to Agenda Back to Item

Summary and Key Findings/Opportunities for Improvement: With close monitoring of PACE participant's blood sugar levels, we were able to meet our stated goal by the end of 2025. In 2026 we will change our goal to <12.50% of Diabetic participants will have an HbA1c measurement of >9% (Comparable to the 2024 MEDICARE Quality Compass HEDIS 66th percentile). Strategies to reach this goal include the following:

- Diabetic initiative of reviewing each diabetic patient monthly with RD, RN, Geriatrician, Medical Director and Provider. Adding the social worker when behavioral issues or families need to intervene.
- Continuous glucose monitoring devices.
- Check-ins by RN Biweekly (if HbA1c >12) or monthly (in HbA1c >9)
- GLP-1 medications that have had a profound impact on the HbA1c and weight loss.
- Staff Pharmacists help to optimize medication.
- Registered Dietician education with medically tailored meals and nutritional support.
- Home Health administering weekly injectable medication in the home, when needed.

QI25.10 Ensure participants are assessed for Osteoporosis

Goal: 75% of eligible participants will have a bone density scan to assess for Osteoporosis

Goal: Met

Data/Analysis: The 2025 final rate was 87%.

Quarters 2025	Rate
Q1	83%
Q2	87%
Q3	87%
Q4	90%
Average	**87%**

Summary Key Findings/Opportunities for Improvement: In 2025, we focused on ensuring that all eligible participants were scanned for osteoporosis risk using Dual-energy X-ray absorptiometry (DEXA). For 2025 we adapted this element to focus specifically on all women over 65 years old, who have the highest risk for osteoporosis and bone fractures. We have met our goals for monitoring Osteoporosis repeatedly over the past several year and will not continue this goal into 2026. We will continue to closely monitor our older at risk adults in order to both diagnose and treat osteoporosis.

QI25.11 Reduce number of falls reported by PACE enrollees

Goal: <72 Falls reported per quarter in 2025.

Goal: Not Met

Data/Analysis:

Quarters 2025	# Falls Per Quarter
Q1	72
Q2	91
Q3	121
Q4	77
Average	**90**

Summary Key Findings/Opportunities for Improvement:

We did meet our fall goals in 2025, with many of the falls determined to be repeat falls reported to us by a small number of participants. The PACE program has developed multiple strategies for preventing recurrent falls. After each fall, the rehabilitation team of licensed physical and occupational therapists determines if fall is mechanical or related to any medical problems of participant. The PCP and nursing team check on medical factors and provide referrals and other interventions, as necessary. Pharmacy and provider work together to check medications if need to be adjusted for cases that concern loss of balance, dizziness, or muscle weakness. Rehabilitation, homecare coordinator, and social worker provide interventions for mechanical falls such as tripping and or any changes in participant's environment and living situation. All other disciplines provide their input and interventions as the need arises. In 2026 we will continue our increased surveillance of repeat fallers by continuing mandatory home assessments and follow up completed by PACE to reduce total number of falls at home. We will change our goal to reduce the number of falls sustained by PACE enrollees to ≤150 falls per 1000 participants.

QI25.12 Monitor participants who are receiving prescription opioids for 15 days or more days at an average milligram morphine equivalent (MME) dose of 90mg

Goal: 100% of participants receiving high dose opioids for 15 or more days at an average MME 90mg will be reevaluated monthly by their treating provider.

Goal: Not Met

Data/Analysis: The final 2025 rate was 87.5%

Quarters 2025	# Participants on high dose opioids with PCP follow up
Q1	1 out of 1 participant reevaluated (100%)
Q2	1 out of 1 participant reevaluated (100%)
Q3	1 out of 1 participant reevaluated (100%)
Q4	1 out of 2 participant reevaluated (50%)

Summary and Key Findings/Opportunities for Improvement: In 2025 we met out goal of 100% provider opioid evaluation in each quarter, except in Q4. Over the past few years, we have very few participants who exceed the established recommendations of daily morphine MME dosing, and will therefore be discontinuing this element. We will continue to work closely with our participants to ensure safety and adherence to pain management plans.

QI25.13 Increase the percentage of participants for whom medications were reconciled within 7 days of hospital and/or skilled nursing discharge

Goal: ≥ 93% of participants will have their medications reconciled within 7 calendar days of hospital discharge or skilled nursing facility (SNF) in 2025.

Goal: Met

Data/Analysis: 97% of participants had medications reconciled within 7 days post discharge in 2025.

Quarters 2025	# Participants with Medication Reconciliation within 7 days of discharge
Q1	98%
Q2	96%
Q3	100%
Q4	94%
Average	97%

Summary and Key Findings/Opportunities for Improvement: Reconciliation of medications post hospital and/or skilled nursing facility discharge remains one of our clinical priorities. Our assigned clinic staff maintain a close relationship with our participants across all levels of health care to improve the continuity of care. This partnership allows for prompt medication reconciliation after hospital discharge or skilled nursing stay. Our clinical pharmacists play a vital part in the reconciliation process as well as dedicated additional clinical staff members assigned to handle reconciliation for hospital and SNF discharges. We will maintain this important element in 2026.

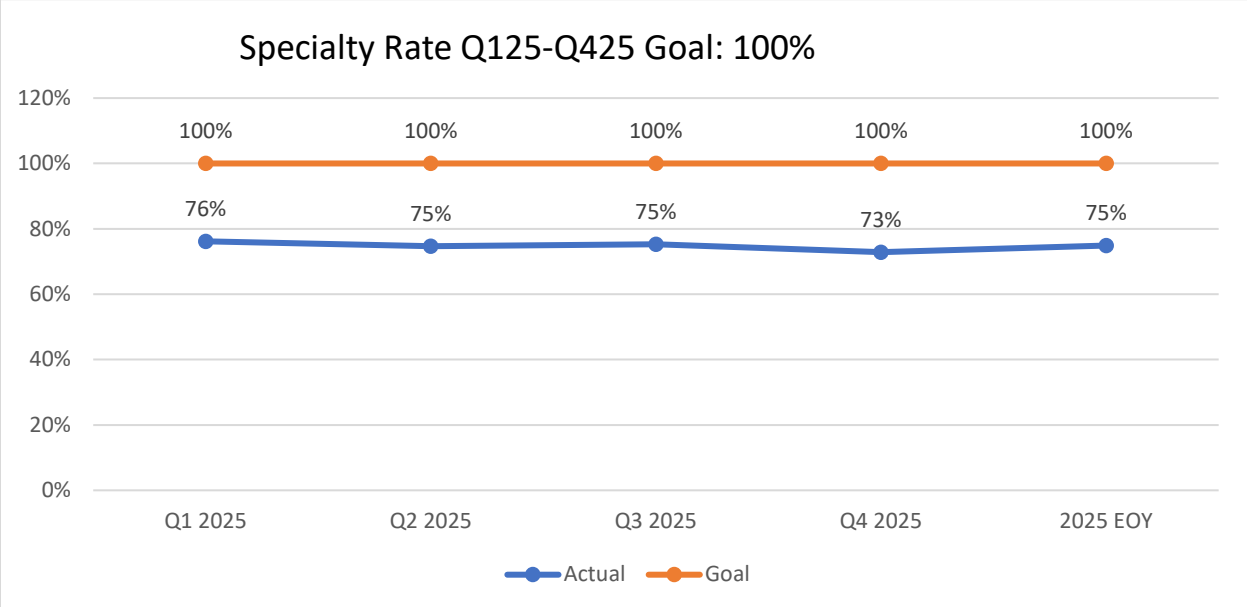
Access and Availability

QI25.14 Improve access to specialty health care providers

Goal: ≥ 100% of specialty health care authorizations will be scheduled within 7 calendar days in 2025

Goal: Not Met

Data/Analysis: The 2025 end of year average rate was 75%.



Summary and Key Findings/Opportunities for Improvement: Our PACE clinic and scheduling department continues to develop strategies to improve access to specialty health care.

In 2026 we were tasked with a new challenge based on changes to scheduling requirements as part of the 2025 CMS Final Rule requirements for scheduling. Per 42 CFR 460.98(c)(2), The PACE organization must arrange or schedule the delivery of interdisciplinary team approved services, other than medications, as expeditiously as the participant's health condition requires, but *no later than 7 calendar days* after the date the interdisciplinary team or member of the interdisciplinary team first approves the service. We face many challenges in attempting to meet these time constraints. These challenges include availability of specialists, utilization management oversight, staffing, outside processes, and a transition to a new EHR system. We will continue this goal into 2026, with a bi-weekly scheduling work group designed to investigate and resolve all noted challenges by the end of the year.

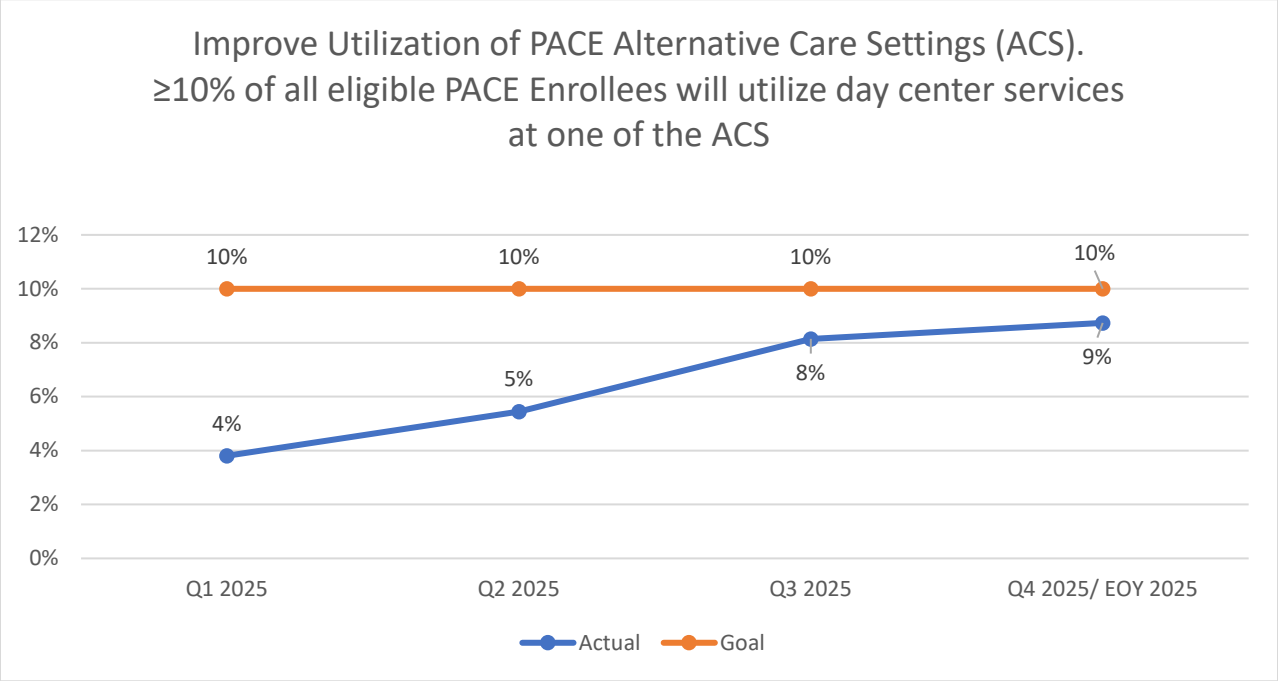
Utilization Management

QI25.15 Improve the rate of participants who attend PACE Alternative Care Settings (ACS)

Goal: ≥10% of all eligible PACE Enrollees will utilize day center services at one of the PACE Alternative Care Settings by end of 2025.

Goal: Not Met

Data/Analysis: The 2025 ending rate was 9%.



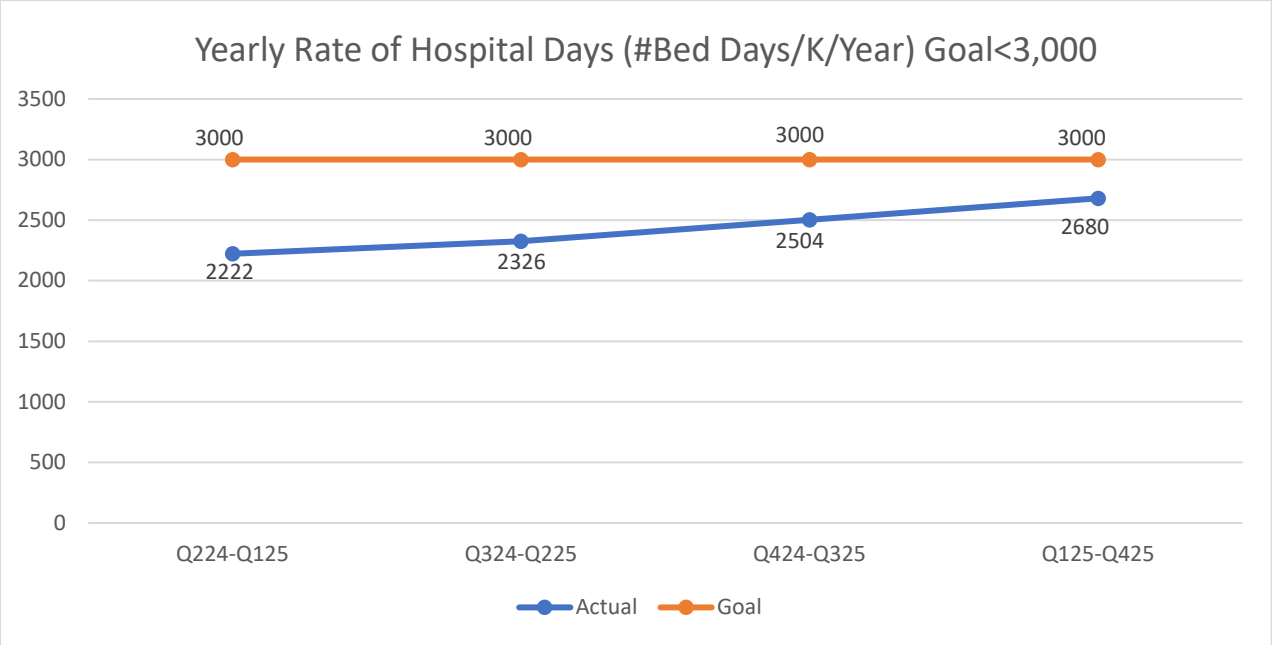
Summary and Key Findings/Opportunities for Improvement: We came very close to meeting our 10% goal in 2025. In 2026, we will be raising this goal to 12% ACS utilization. We plan to accomplish this goal by adding 1-2 additional ACS contracted sites and continuing to identify participants whose needs would be best supported at one our ACS sites closer to their homes.

QI25.16 Reduce the rate of acute hospital days by PACE participants

Goal: < 3,000 hospital days per 1000 per year in 2025.

Goal: Met

Data/Analysis: The 2025 ending rate was 2680 bed days per 1000 per year.



Summary/Key Findings/Opportunities for Improvement

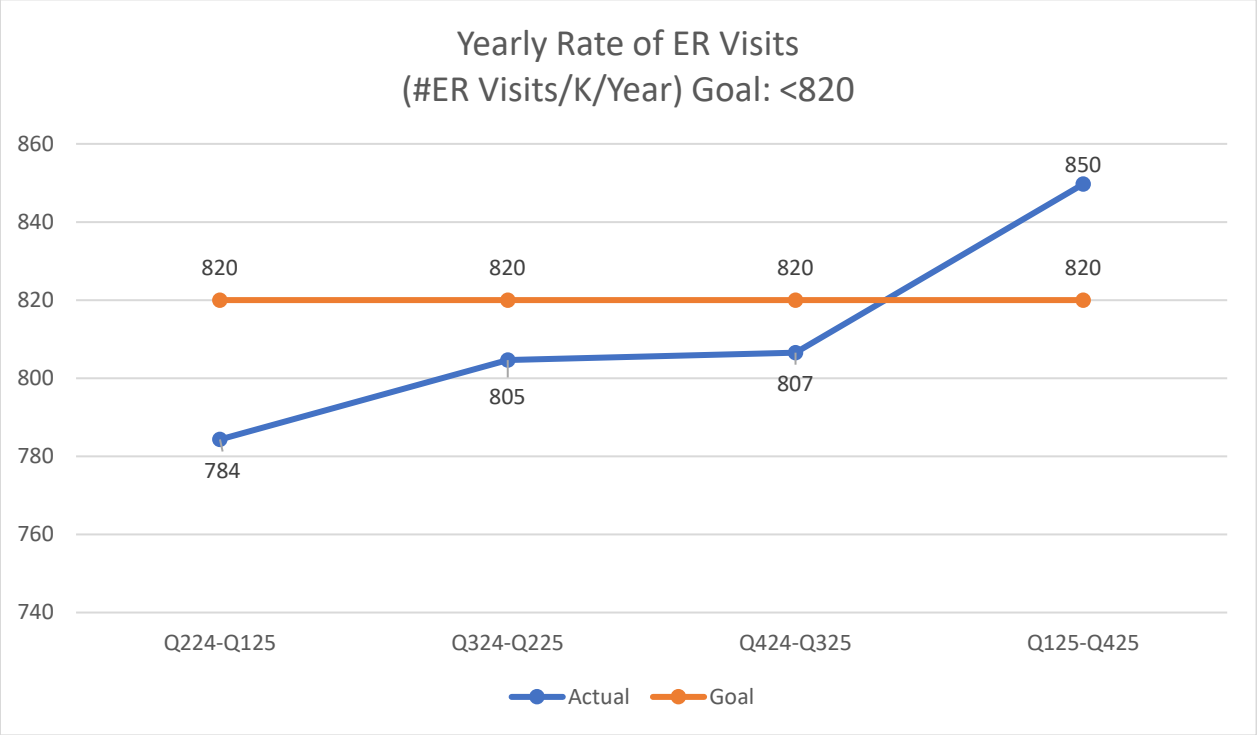
CalOptima Health PACE met our goal of <3,000 hospital days per 1000 per year by the end of 2025. Despite the high number of medically complex patients that are part of our program, we were able to sustain the overall number of hospital bed days and meet our end of year goal in 2025. PACE participants hospital days are monitored and analyzed by the PACE QI department who works with the PACE Medical Director and clinical teams to develop strategies to lower that rate through preventative health care and education. We will maintain this element as part of the 2026 Work Plan, while lowering our goal to <2,800 hospital days per 1000 per year by the end.

QI25.17 Reduce the rate of ER utilization by PACE participants

Goal: <820 emergency room visits per 1000 per year in 2025

Goal: Not Met

Data/Analysis: The 2025 ending rate was **850** emergency room visits per 1000 per year.



Summary and Key Findings/Opportunities for Improvement:

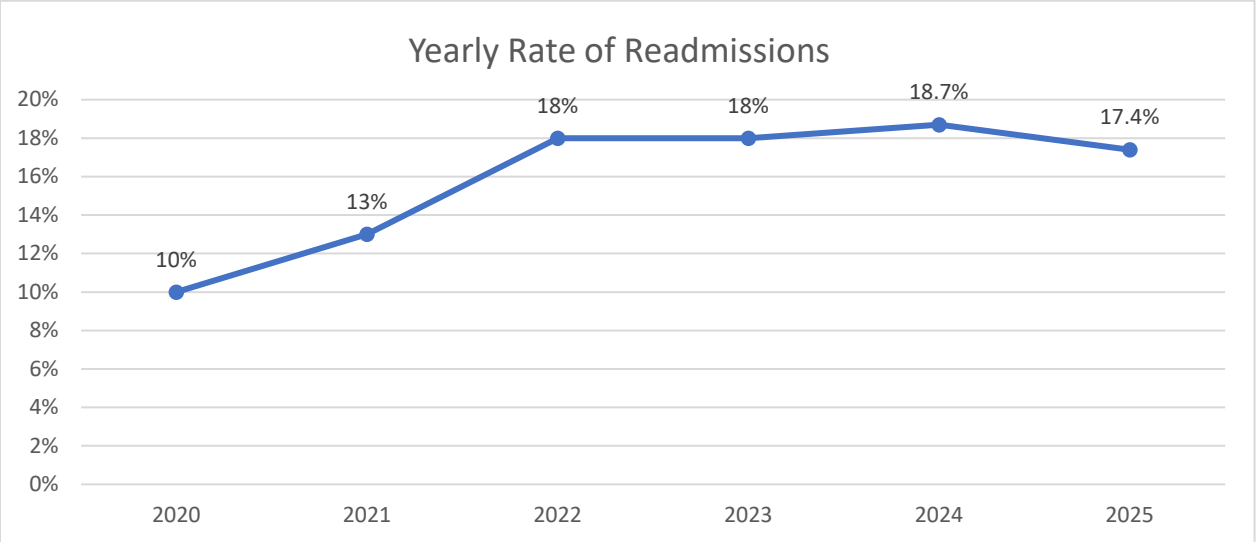
We were unable to meet our goals in Q4 2025 due to the medical complexity of our increasing census. ER utilization by PACE participants is monitored and analyzed by the PACE QI department who work with the PACE Medical Director and clinical teams to develop strategies to lower ER utilization rates. Additionally, using our 24-hour on-call provider service, we provide round-the-clock assessment of participants and provide ER diversion as warranted. In 2026 we plan to maintain this high level of utilization management without changing our goal.

QI25.18 Reduce the 30-day all cause readmission rates by PACE participants

Goal: Less than 14% 30-day all cause readmissions in 2025.

Goal: Not Met

Data/Analysis: The 2025 end of year rate was 17.4%



Summary and Key Findings/Opportunities for Improvement:

PACE readmission rates tend to have variance due to small groups of participants with very high level medical needs. We ended 2025 with a 17.4% 30-day readmission rate which indicates a slight reduction from the past 3 years. Our major challenges are high number of participants on dialysis and the overall higher needs of our specific PACE participant population- especially those who are at end of life. In 2026, we will change our goal to <20% 30 day all cause readmission. Our strategies to achieve this goal are: primary care provider follow up in person with participants soon after discharge- two visits instead of one, utilizing geriatric specialist, consider palliative care consultation, and clinic team look at and discuss encounter type of readmission cases in morning huddle and during IDT meetings.

QI25.192 Decrease the percentage of participants who are placed in a long-term custodial health care facility

Goal: <4% of participants will reside in long-term (custodial) health care (LTC) in 2025.

Goal: Met

Data/Analysis: 2025 rate was 0.27% of the PACE enrollment resided in long-term care.

Summary and Key Findings/Opportunities for Improvement: We ended 2025 with only 0.27% of our participants residing in LTC under custodial care. One of the most important tenets of the PACE program is to help our participants continue to live safely within their own homes for as long as possible rather than moving to a nursing home or other institution. On occasion, PACE participants do need temporary placement in LTC as a custodial health care measure. These are participants with complex medical conditions that require complicated workups, specialty health care, or who have difficulty with maintaining their health care plan on their own at home. These participants benefit from placement in LTC facilities until their health is stabilized and they can be reassessed and reeducated regarding their health plan. Due to our high level of care coordination and low level of custodial care needs, we will no longer monitor this as a quality element in 2026. PACE staff will continue with documentation of participant choice in service options, including to remain with PACE under custodial care vs. disenrollment to other options.

Enrollment/Disenrollment

QI25.20 Increase the qualified lead to enrollment conversion rate

Goal: Increase the qualified lead to enrollment conversion rate to 70% in 2025.

Goal: Not Met

Data/Analysis: Final average rate for 2025 was 69%.

Quarters 2025	Rate
Q1	49%
Q2	74%
Q3	68%
Q4	84%
EOY	**69%**

Summary and Key Findings/Opportunities for Improvement: In 2025, despite jumps in Q2 and Q4, we were unable to meet our end of year average goal in the percentage of qualified leads to

enrollment. The declines in conversions in Q1 and Q3 are most likely due to reaching out to a broader range of potential participants, some of whom may be less likely to make it to the final stage of the enrollment process. Additionally, there has been more competition in the community, with two other PACE centers open and enrolling from the same population and service areas in Orange County. In 2026 we will change the focus of this enrollment element from conversion to increasing the expediency of the enrollment process. The new goal for 2026 will be that 80% of new PACE participants will be enrolled into the PACE program in ≤45 days from their initial inquiry.

QI25.21 Decrease the number of controllable disenrollment within the first 3 months of enrollment

Goal: The percentage of participants who disenroll for controllable reasons from the program within the first 3 months of enrollment will be less than 6%

Goal: Not Met

Data/Analysis: Final average rate was 9.73%.

Quarters 2025	Rate
Q1	0%
Q2	8.33%
Q3	8.33%
Q4	21.43%
Average	**9.73%**

Summary and Key Findings/Opportunities for Improvement: In 2025, we did not meet our year end average goal to reduce the number of participants who disenroll for controllable reasons within their first 3 months with the PACE program. We will maintain this goal, since we look at these early disenrollments as a chance to find potential gaps in participant education about our program and processes during enrollment. We use this information to improve our procedures for onboarding new participants.

One of our strategies to achieve this goal is that Marketing and Enrollment Manager will work their team to ensure that all participants are educated on the important details of enrolling in our program and are able to use the teach back method to ensure they comprehend the changes they will need to make when joining PACE, such as giving up their current physicians- a known reason for disenrollment <3 months. Sixth grade language should be used by enrollment staff to convey difficult to understand concepts in the PACE Enrollment Agreement. Additionally, the enrollment staff will be re-educated to identify any potential barriers or issues during the enrollment process that may lead to immediate disenrollment from program and determine their suitability for our CalOptima Health PACE program. We have also developed a retention committee that meets regularly to closely reviews all controllable disenrollments and discuss opportunities for improvement.

QI25.22 Decrease the PACE attrition rate

Goal: Maintain a PACE participant attrition rate of ≤8%

Goal: Met

Data/Analysis: Final average rate was 5.42%.

Quarters 2025	Rate
Q1	5.03%
Q2	4.67%
Q3	6.79%
Q4	5.16%
Average	**5.42%**

Summary and Key Findings/Opportunities for Improvement:

PACE met our end of year goal in reducing the attrition rate. This goal was accomplished through examination into each potential disenrollments by PACE Center Manager and the SW team to discover the members' reasons for potential disenrollment and implement interventions to prevent disenrollment whenever possible. Disenrollment interventions include one-on-on meeting with participants and their family members, complaint investigation, and case management to ensure that participant's medical, physical, emotional, social needs are being met by our program. We will maintain this element with the same goal for 2026.

Transportation

QI25.23 and QI25.24: Improve contracted transportation performance

Goal QI25.23: 100% of transportation trips will be less than 60 minutes in 2025

Goal: Not Met

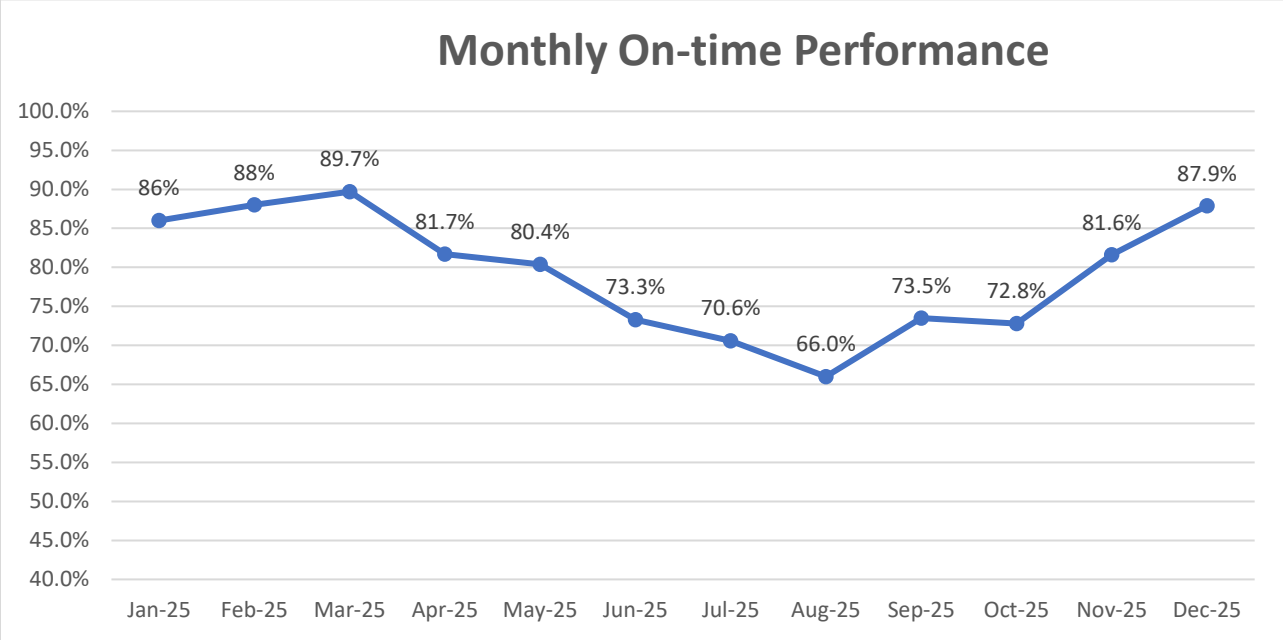
Quarters 2025	Rate
Q1	99.93%
Q2	99.77%
Q3	99.67%
Q4	99.86%
EOY Average	**99.81%**

Summary and Key Findings/Opportunities for Improvement: Regarding transportation performance goal that all one-way trips be 60 minutes or less, PACE fell just shy of the 100% goal, with an EOY average rate of 99.81%. We will continue this element in 2026.

Goal QI25.24: ≥92% of all transportation rides will be on time in 2025

Goal: Not Met

Quarters 2025	Rate
Q1	87.9%
Q2	78.5%
Q3	70%
Q4	80.8%
EOY Average	**79%**



Summary and Key Findings/Opportunities for Improvement: For 2025, the contracted transportation vendor ended the year with an on-time performance average rate of 79%, falling short of the goal that ≥92% of all transportation rides would be on time in 2025. On time performance is an extremely important area as it affects transportation related grievances, overall satisfaction with services, and PACE member retention. PACE leadership continues to work very closely with the contracted transportation team though daily operational discussion, monthly performance review meetings, grievance review, and participant satisfaction surveys. In 2025 we added additional vans to the fleet in order to assist in improving performance goals. In 2026 we are finalizing a contract with a transportation subcontractor that will help with our dialysis trips which contributes to high utilization.

QI25.25: Transportation Satisfaction

Goal: ≥93.2% Satisfaction with Transportation Services summary score on the 2025 PACE Satisfaction Survey

Goal: Met

Data/Analysis: Transportation Satisfaction score for 2025 was 94%

Summary and Key Findings/Opportunities for Improvement: In Summer/Fall 2025, CalOptima Health PACE once again contracted with Vital Research to conduct the annual Participant Satisfaction Survey. Vital Research interviewed our participants both in person and via telephone to gauge the participant's satisfaction with CalOptima Health PACE services. This is a standardized survey completed by PACE organizations throughout California and the United States.

In 2025 we improved our transportation performance rating, and we were able to meet and exceed our transportation satisfaction goals, with a weighted summary score above the national average. In 2026 we will maintain our goal at ≥93.2% compared with the 2025 national averages. Our 2026 Quality Workplan also includes a Quality Initiative to address participant concerns with transportation to raise satisfaction and reduce grievances.

Meals

QI25.26: Meal satisfaction

Goal: ≥ 72% Satisfaction with Meals summary score on the 2025 PACE Satisfaction Survey

Goal: Met

Data/Analysis: The 2025 Satisfaction with Meals rate was 80%

Summary and Key Findings/Opportunities for Improvement:

In 2025, we met our benchmark with 80% of PACE participants indicating satisfaction with their meals, far exceeding the 2025 PACE national average of 73.6%. Survey responses indicated that most participants are satisfied with the look, taste and variety of meals provided by PACE. In 2025 we made an active effort to present a variety of meals which were not only nutritious, but also consistent with the cultural background of our participants. We will continue to monitor this domain in 2026, looking to continue with satisfaction at or above the national average.

Home Care

QI25.27: Home Care satisfaction

Goal: ≥ 85.5% Satisfaction with Home Care summary score on the 2025 PACE Satisfaction Survey

Goal: Met

Data/Analysis: The 2025 Satisfaction with Home Care rate was 88%

Summary and Key Findings/Opportunities for Improvement: As part of our 2025 PACE quality workplan, we added a new measure related to Home Care satisfaction. We recognized that the home care services that PACE provides through our contracted vendors play an important role in our participant's ability to maintain living safely and comfortably in their homes. We were able to greatly improve upon our 2024 satisfaction score of 83% in this area. This was accomplished by hiring a Home Care supervisor to have oversight of PACE home care coordinators and to review services received by the participants to ensure vendors are providing proper care. We intend to continue this goal into 2026, looking to surpass the 2025 national average of 85.7% satisfaction.

Participant Overall Satisfaction

QI25.27 Improve the *overall* satisfaction of participants and their families with the CalOptima Health PACE program

Goal: Greater than or equal to 87.3% Overall Satisfaction Weighted Average on the 2025 PACE Satisfaction Survey.

Goal: Met

Data/Analysis: The 2025 Overall Satisfaction rate was 93%

Summary and Key Findings/Opportunities for Improvement:

The *overall* satisfaction score was 93% which was both a significant increase in satisfaction from 2024, as well as several percentage points above the 2025 PACE national average.

We saw an increase in satisfaction scores from 2025 across all PACE domains and exceeded the national averages in each area. In 2026 we hope to continue excellence in participant satisfaction, and achieve a satisfaction score above the national average.

SECTION 5: 2025 HEALTH PLAN MANAGEMENT

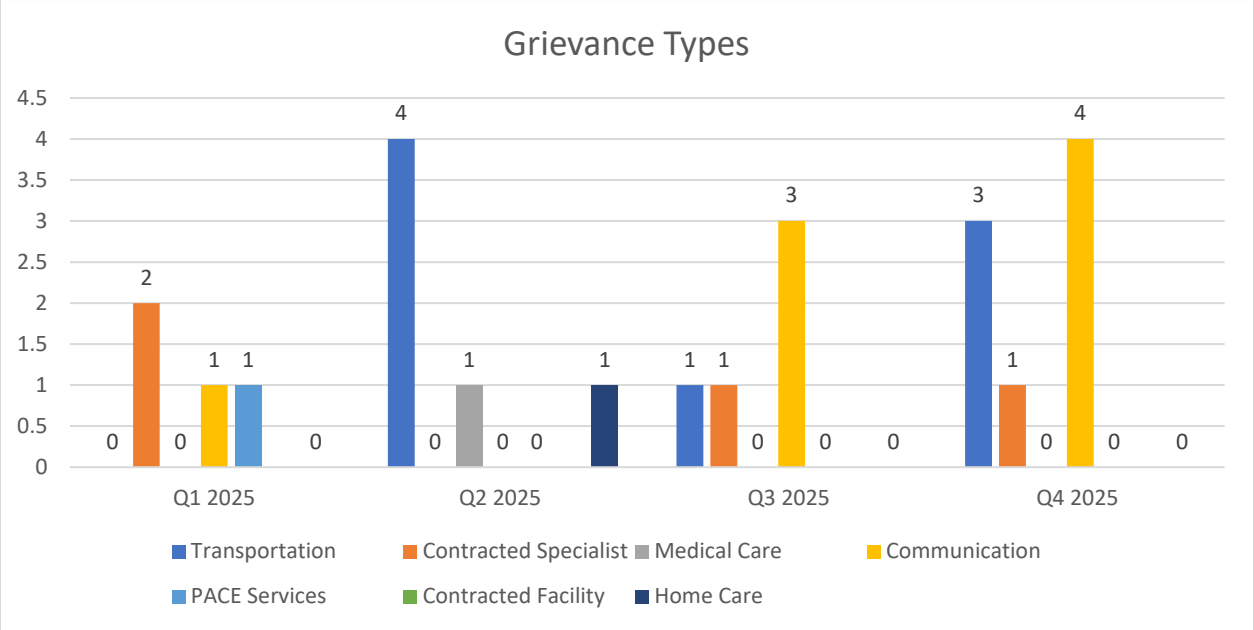
2025 HPMS: Quality information is reported to CMS on a quarterly basis via the Health Plan Management System (HPMS) and to DHCS via email. The following elements are reported:

1. Grievances
2. Appeals
3. Quality Incidents which require Root Cause Analysis
4. Medication Errors
5. Immunizations (evaluated in the Quality-of-Care section of this report)
6. Falls without Injury
7. ER Visits (evaluated in the Utilization Management section of this report)
8. Denials of Prospective Enrollees

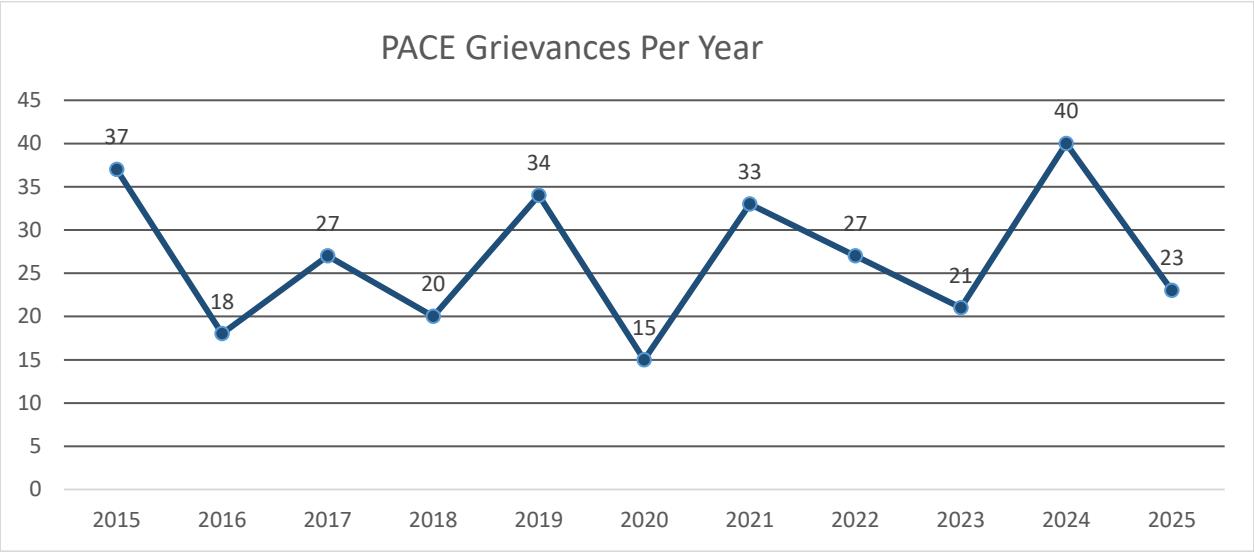
Grievances

Data Analysis:

Quarterly Grievances Q1 2025–Q4 2025



PACE Grievances Per Year 2015–2025

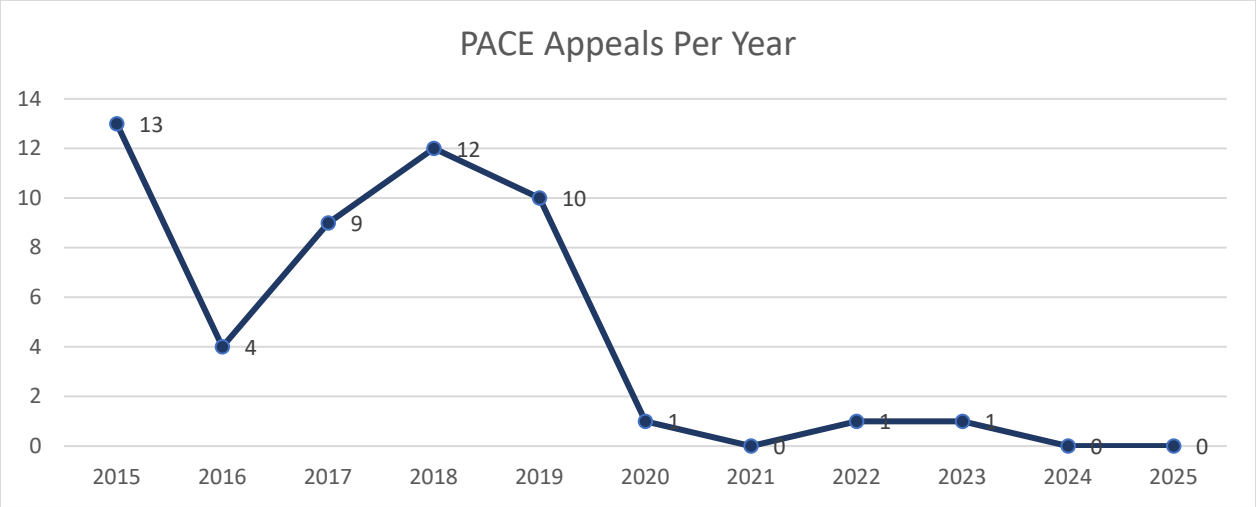


In 2025, we saw a decrease in the number of grievances filed by participants. Many of the grievances that were filed were transportation related issues such as being picked up late. PACE service issues/communication related issues generally stemmed from dissatisfaction with ability to be seen by quickly by specialists or perceived lack of communication regarding appointments. All grievances are investigated by our QI department and a resolution to the grievance is provided to the participant within a 30-day period. To fully resolve all transportation related grievances, we share the grievances directly with our contracted transportation provider, Secure Transportation, and their Quality Assurance department. The Secure QA department thoroughly researches each grievance and provides us with their investigation and resolution notes. Additionally, grievance issues are discussed during our monthly scheduled Secure Transportation meeting with the transportation leadership team. Corrective action plans are used as needed. Most participants filing grievances are satisfied with the resolutions reached by the PACE QI department. As with previous years, we will continue to monitor and observe trends with grievances filed.

Appeals

Data Analysis:

PACE Appeals Per Year 2015–2025

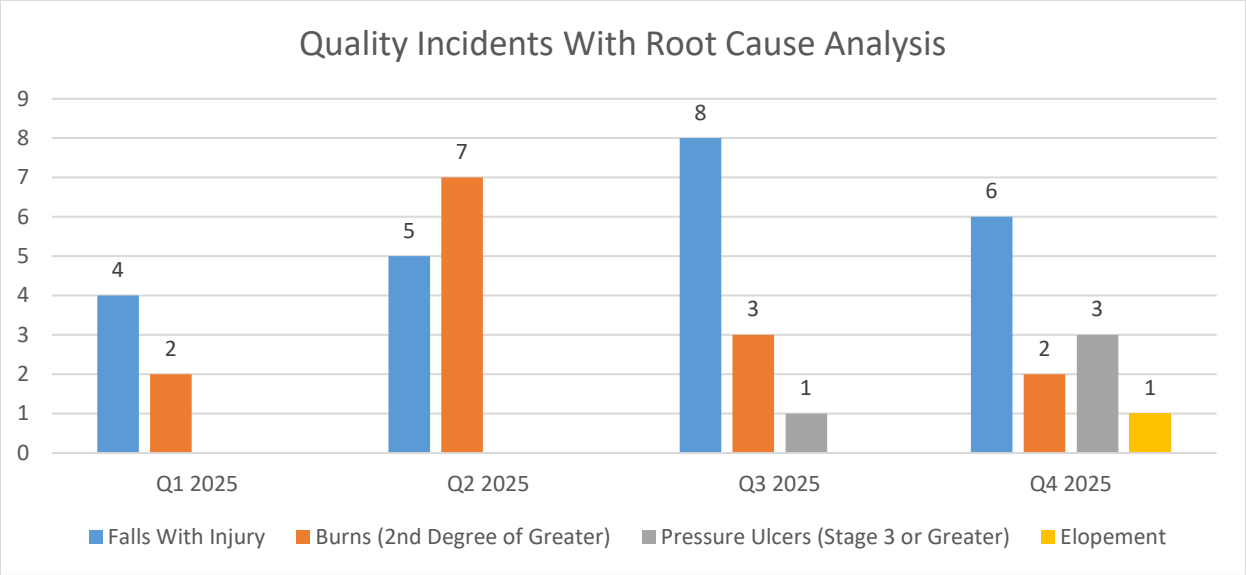


There were no PACE participant appeals in 2025. All participants are offered the right to appeal denials or partial denials of service determination requests (SDRs) if the IDT has determined that the participant does not need their requested item of service. Despite several denials of SDRs in 2025 and providing participant with information about their right to appeal the decision, none chose to do so. PACE continues to follow all regulatory processes with regards to Grievances, SDRs, Appeals and Participant Rights as outlined by regulatory agencies CMS and DHCS.

Quality Incidents

Description of Reportable Incidents: All quality incidents are monitored by the PACE QI team following PACE Quality Data Monitoring & Reporting Guidance document issued by CMS. Quality incidents including falls with injury, elopements, burns, pressure ulcers (stage III–IV, unstageable), motor vehicle accidents and infectious disease outbreaks and are reported to CMS and DHCS. Essentially, the objective is to monitor the health and safety of PACE participants as well as the effectiveness of our risk management and QI program. All quality incidents are reported to the QI team with an ensuing root cause analysis (RCA) completed for each incident as required. The RCA begins with the QI team investigating the incident (what, where and when) then followed by a meeting of appropriate disciplines such as nursing, social worker, and rehabilitation services. Potential causes of the incident are discussed and interventions to prevent further occurrences are implemented.

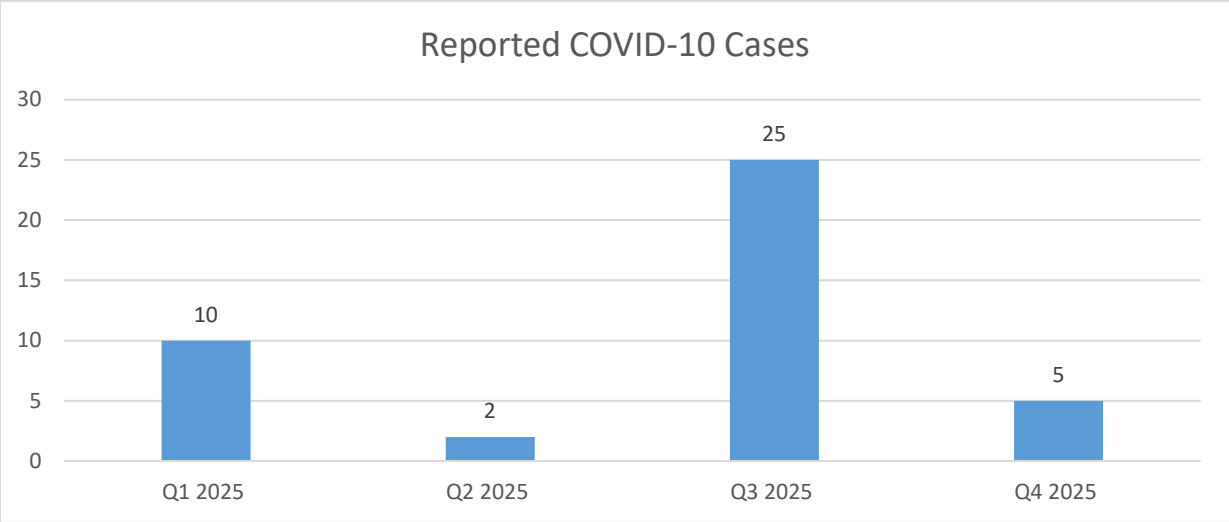
Data Analysis:



Falls with injury (fracture or hospitalization related to the fall) are generally one of the most prevalent type of reportable quality event at PACE. As in previous years, most falls in 2025 were either a result of non-use of durable medical equipment or lack of family supervision of participants who are at risk for falls at home.

PACE also continued to monitor for infectious disease outbreaks related to COVID-19 cases. Similar to the trends noted in both 2023 and 2024, In quarter 3 of 2025, we experienced a small surge of community based COVID-19 cases. All participants with a reported case of COVID-19 infection had follow up from the PACE clinic nurse and primary health care provider to assess needs. The anti-viral medication Paxlovid was provided in all appropriate cases, as well as any

medication needed for symptom relief. Additionally, all cases were reviewed by QI in compliance with the established PACE Infection Control manual. There were no PACE deaths from COVID-19 reported in 2025.

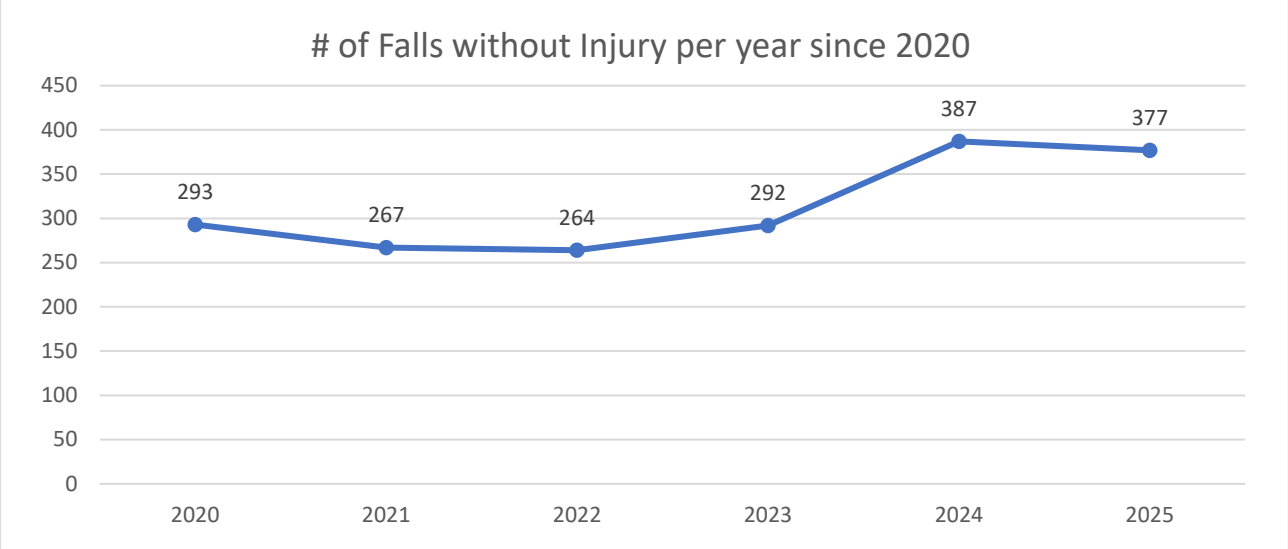


Medication Errors

A total of 6 medication errors were reported in 2025, an increase from 2024. All but one of the medication error was investigated and found to be the fault of the contracted pharmacy. None of these medication errors resulted in any injury to participants. Changes made to reduce potential errors include: Pharmacy technicians re-educated to review National Drug Code and initial bottles. Pharmacy technicians re-educated to double-check that the DOB matches the correct patient profile during the verifying prescriptions process. Pharmacy implemented a mandatory double-check process prior to delivery. Pharmacy added a same-name alert to the prescription processing screen to prompt verification of patient identity prior to dispensing and delivery. Spot checks are completed to ensure communication flow between PACE and contracted pharmacy.

Falls Without Injury

Data Analysis**:**



In 2025, we saw a decrease in falls without injury from the 2024 figures. CalOptima Health PACE records and investigates all reported falls, no matter how minor.

Most falls continue to occur in the community, specifically in the participant's home environment. CalOptima Health PACE has spearheaded fall prevention groups among the high fall risk participants, with the goal of continued decreasing fall trends.

Disciplines, including physicians, nurses, social workers, physical and occupational therapy, and clinical pharmacy, continue to collaborate to develop participant-specific strategies for fall prevention. PACE is using an individualized approach to falls. Once any of the disciplines get information from participants and/or families via wellness calls related to a fall, they will send a Clinic Service Request to clinic and rehab for quick intervention. Rehab then reaches out to participant/family to provide immediate education and follow-up. If further evaluation and skilled rehab is warranted, PACE will ask the participant to do an in-person visit at PACE center. In this way, PACE maintains a direct response to each and every fall reported in a timely manner.

Denials of Prospective Enrollees

In 2025, only 4 total prospective enrollees were denied enrollment to CalOptima Health PACE. In 3 of the cases the denial was initiated by the DHCS due to the participant not meeting the Level-Of-Care needs required to enrollee in PACE. In the other case, the denial was initiated by the PACE enrollment team and approved by DHCS, because the prospective enrollee's health and safety would be jeopardized by living in a community setting.

SECTION 6: QUALITY INITIATIVES

In 2025, we focused on our Quality Initiatives to improve the participant's experience and assure optimal clinical outcomes. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, strategies, and measurable interventions to meet our goals. The statuses of PACE Quality Initiatives are presented to the PQIC on a quarterly basis. The program's four quality initiatives for 2025 were:

- Advance Health Care Directive
    - This initiative focused on increasing the number of PACE participants who have a completed Advance Health Directive (AHCD) scanned into their medical record. The PACE leadership team created a plan to be implemented by the PACE Center Manager and the Social Work team, with a goal of ≥ 55% of participants having a completed AHCD in 2025. We ended 2025 with 39% of participants having a scanned AHCD in their medical record, not meeting out goal. Some challenges faced in completing this goal include difficulty with getting proper ID needed (due to participants lacking proper documentation) and difficulty with participants understanding the complex documents due to health literacy issues. In 2026 we will continue our goal of ≥ 55% with an AHCD. Our strategies to reach this goal include the following: Enrollment team will introduce the idea of the AHCD during the enrollment process, creation of new structure and process by the new PACE center Manager, and potentially doing home visits to help assist with paperwork, which will make it easier to complete.

- Dental Satisfaction Quality Initiative
  - This initiative focused on increasing participant satisfaction with contracted dental services. PACE wants to provide participants with comprehensive education regarding the process for dental procedures with a focus on reduced pain and increased function. PACE Enrollment Coordinators highlighted what dental services are provided (ex/routine cleanings) and what are not (ex/cosmetic dentistry) during the enrollment process for new participants. Clinic administrative staff followed up each month with at least 5 randomly chosen participants who received dental services, to find any areas of dissatisfaction that could be addressed in a timely manner. The goal was ≤ 1 dental related grievance per quarter in 2025. This goal was not met in Q1, but *was* met in Q2, Q3, and Q4. There is total of 2 dental related grievance reported throughout 2025. We will continue this initiative in 2026 with an updated questionnaire.

- Transportation Satisfaction Quality Initiative
  - This initiative focused on increasing participant satisfaction with contracted transportation services, by providing participants with timely resolutions to transportation related issues as noted within a transportation complaint log. The PACE Center Manager in conjunction with Secure Transportation Manager and PACE Clinic Manager reviewed and resolved all complaints received by PACE participants regarding PACE transportation in a timely manner. The goal was ≤ 3 **valid** transportation related grievance per quarter in 2025. The validity of each grievance is determined by the Secure Transportation Quality Assurance department based on thorough investigation of each complaint. The goal was met in Q1, Q3, and Q4, however we had 4 valid grievances each in Q2, not meeting our goal in that quarter. As noted in the previous discussion regarding transportation performance, strategies have been put into place to reduce dissatisfaction with contracted transportation services. We will continue this initiative into 2026.

- COVID-19 Vaccination
  - This initiative focused on increasing the number of PACE participants who have received the latest CDC approved COVID-19 vaccine, with a goal of ≥50% by the end of 2025. Exclusions: Participants who enroll in the program in December 2025. We reached out highest percentage in Q2 2025 at 41.1%, but ended the year at 16%. This data is difficult to measure on a quarterly and annual basis due to changing regulations and recommendations and the timing and release of latest approved vaccine. We will not continue this initiative into 2026; however, we will continue to offer participants all recommended vaccinations at our PACE center.

SECTION 7: OPPORTUNITIES FOR IMPROVEMENT IN 2026

1. **Improve the Quality of Care (QOC) for Participants**
   a. Updating all pneumococcal, COVID and influenza vaccine processes to always follow the latest CDC recommendations.
   b. Raising the benchmark goal for our cancer screening elements for breast and colorectal cancer.
   c. Raising the benchmark goals for diabetic eye exams.
   d. Raising the benchmark goal for blood pressure monitoring element.

2. **Ensure the Safety of Participants and Clinical Care**
    a. Continuing efforts to reduce falls at home including home assessment review for repeat fallers.
3. **Ensure the Appropriate Use of Resources**
    a. Inpatient Utilization
        i. Further expansion of our complex case management program with individualized interventions with a focus on high-risk participants, especially those who are under dialysis treatment.
        ii. Continuing to refine the ER diversion process to treat participants with minor ailments in their homes using the PACE clinic team as well as after hours on-call physicians services.
        iii. Adjusting our benchmark goals for acute Hospitalization to reduce the number of visits.
    b. Specialty Care
        i. Increasing the number of core PACE specialists who are willing to work closely with our PACE organization and receive training in the PACE Model of Care.
        ii. Adjusting our timeline goals for scheduling to improve timeliness of specialty appointments.
4. **Improve Participant Experience**
    a. Grievances and potential quality issues monitoring and thorough analysis. Use of transportation, scheduling and customer service logs to resolve minor participant issues immediately as they are reported.
    b. Exploring the potential use of more frequent in-house meal satisfaction surveys and make refinements to our meal program based on that feedback.
5. **Ensure Appropriate Access and Availability**
    a. Improving utilization of our PACE Alternative Care Setting (ACS) sites with the goal of opening additional sites in 2026.

SUMMARY

CalOptima Health PACE developed and implemented systems using evidence-based guidelines that incorporate data and best practices tailored to the frail and elderly participants within our community. Our focus is to prevent institutionalization of these participants and enable them to live safely at home with the support of PACE services. To accomplish our goals, we target many aspects of the health care continuum, such as preventive care, case management and disease management, closing any potential gaps. Through our ongoing data analysis, we are positioned to identify opportunities for improvement resulting in optimal clinical outcomes and participant satisfaction. Although individual measures may vary in their level of accomplishment, our overall effort as a program has been a considerable success. As we continue to monitor our performance and refine our methods, we are confident that our QI efforts will continue to have a positive impact on our participants.

APPENDIX: 2025 PACE QI EVALUATION

2025 CalOptima PACE Quality Improvement (QI) Work Plan

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total or Avg.	Met/Not Met
QI25.01	Improve the Quality of Care for Participants	2024 PACE QAPI Plan and Work Plan Annual Evaluation	2024 PACE QAPI Plan will be evaluated by CalOptima Health Quality Assurance Committee in March 2025	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/12/2025	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Met
QI25.02	Improve the Quality of Care for Participants	2025 PACE QI Plan and Work Plan Annual Oversight	PACE QI Plan and Work Plan will be updated, reviewed and approved by CalOptima Health Quality Assurance Committee in March 2025	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/12/2025	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Met
QI25.03	Improve the Quality of Care for Participants	Influenza Immunization Rates	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 2025	Improve compliance with influenza immunization recommendations (Exclusions defined within the 2025 PACE Quality Improvement Plan Description)	Q1, Q3 and Q4 2025	12/31/2025	PACE Medical Director	90.60%	Not Met	N/A	N/A	49.0%	Not Met	84.0%	Not Met	84.0%	Not Met
QI25.04	Improve the Quality of Care for Participants	Pneumococcal Immunization Rates	≥94% of eligible participants will have completed their pneumococcal vaccination by December 31st, 2025	Improve compliance with pneumococcal immunization recommendations (Exclusions defined within the 2025 PACE Quality Improvement Plan Description)	Quarterly	12/31/2025	PACE Medical Director	93%	Not Met	93.3%	Not Met	94%	Met	93%	Not Met	93%	Not Met
QI25.05	Improve Quality of Care for Participants	Colorectal Cancer Screening	>65.21% of eligible participants will have had a screening for colorectal cancer by December 31st, 2025 (Comparable to the 2023 MEDICARE Quality Compass HEDIS 33.33rd percentile)	Improve compliance with colorectal cancer screening recommendations for older adults by tracking the percentage of colonoscopies and/or FIT tests completed for our participants (Exclusions defined within the 2025 PACE Quality Improvement Plan Description)	Quarterly	12/31/2025	PACE Medical Director	77%	Met	71%	Met	78%	Met	80%	Met	80%	Met
QI25.06	Improve Quality of Care for Participants	Breast Cancer Screening	>82.80% of eligible participants will have a screening for breast cancer by December 31st, 2025 (Comparable to the 2023 MEDICARE Quality Compass HEDIS 90th percentile)	Improve compliance with breast cancer screening recommendations for older adults by tracking the percentage of mammograms completed for our participants (Exclusions defined within the 2025 PACE Quality Improvement Plan Description)	Quarterly	12/31/2025	PACE Medical Director	86.1%	Met	85.7%	Met	86.0%	Met	84%	Met	84%	Met
QI25.07	Improve the Quality of Care for Participants	Controlling High Blood Pressure	>85.60% of participants with Hypertension *and/or* Diabetes will have their blood pressure controlled (Comparable to the 2023 MEDICARE Quality Compass HEDIS 90th percentile)	PACE participants with hypertension and/or diabetes will have their blood pressure regularly monitored and adequately controlled, as defined by readings of <140/90 mmHG. (Exclusions defined within the 2025 PACE Quality Improvement Plan Description)	Quarterly	12/31/2025	PACE Medical Director	85.47%	Not Met	85.87%	Met	86.22%	Met	86.06%	Met	85.92%	Met
QI25.08	Improve the Quality of Care for Participants	Diabetic Eye Care	>88.08% of Diabetic participants will have an Annual Eye Exam (Comparable to the 2023 MEDICARE Quality Compass HEDIS 95th percentile)	PACE participants with diabetes will be monitored by their Primary Care Providers to ensure they maintain healthy vision through annual examination by eye doctor (Exclusions defined within the 2025 PACE Quality Improvement Plan Description)	Quarterly	12/31/2025	PACE Medical Director	91%	Met	96.2%	Met	94.6%	Met	94.2%	Met	94.2%	Met
QI25.09	Improve the Quality of Care for Participants	Diabetic Blood Sugar Control	<12.24% of Diabetic participants will have an HbA1c measurement of >9% (Comparable to the 2023 MEDICARE Quality Compass HEDIS 70th percentile)	PACE participants with diabetes will be monitored by their Primary Care Providers to ensure they maintain blood sugar control as measured by HbA1c lab work (Exclusions defined within the 2025 PACE Quality Improvement Plan Description)	Quarterly	12/31/2025	PACE Medical Director	12.67%	Not Met	13.75%	Not Met	12.88%	Not Met	9.36%	Met	9.36%	Met
QI25.10	Improve the Quality of Care for Participants	Osteoporosis Monitoring	75% of eligible participants will have a bone density scan to assess for Osteoporosis	Medical records of all eligible participants will be reviewed to see if they have had a bone density scan within the past 5 years. If not, a scan will be completed on that participant (Exclusions defined within the 2025 PACE Quality Improvement Plan Description)	Quarterly	12/31/2025	PACE Medical Director	83%	Met	87%	Met	87%	Met	90%	Met	87%	Met
QI25.11	Ensure the Safety of Participants	Reduce Percentage of Falls Reported by PACE Enrollees	<72 falls reported per quarter in 2025	The PACE Center manager will work with the Rehabilitation Department to review all participants who have repeated falls within each quarter. Participants who have repeated falls will have a documented home assessment and follow up completed by PACE to reduce total number of falls. (Exclusions defined within the 2025 PACE Quality Improvement Plan Description)	Quarterly	12/31/2025	PACE Center Manager	72	Not Met	91	Not Met	121	Not Met	77	Not Met	90	Not Met
QI25.12	Ensure the Safety of Clinical Care	Monitoring of Risks from High Dosage Opioid Use	100% of members receiving opioids for 15 or more days at an average of 90 MME/day will be reevaluated monthly by their treating provider in 2025.	The PACE Primary Care Providers will provide monthly monitoring any participant who is receiving prescription opioids for≥15 days at an average milligram morphine dose MME >90 MME/day (Exclusions defined within the 2025 PACE Quality Improvement Plan Description)	Quarterly	12/31/2025	PACE Medical Director	100%	Met	100%	Met	100%	Met	50%	Not Met	87.50%	Not Met
QI25.13	Improve the Quality of Care for Participants	Medication Reconciliation Post Discharge (MRP)	≥93% of participants will have their medications reconciled within 7 calendar days of hospital and/or skilled nursing facility discharge in 2025	The PACE QI Department will work with the PACE Clinic, Pharmacist and Providers to ensure that participant medications are reviewed in a timely matter after discharge.	Quarterly	12/31/2025	PACE Pharmacist and PACE Clinical Operations Manager	98%	Met	96%	Met	100%	Met	94%	Met	97%	Met
QI25.14	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	100% of specialty care authorizations will be scheduled within 7 calendar days in 2025	Appointments for specialty care will be scheduled within 7 calendar days to improve access to specialty care	Quarterly	12/31/2025	PACE Clinical Operations Manager	76%	Not Met	75%	Not Met	75%	Not Met	73%	Not Met	75%	Not Met
QI25.15	Ensure Appropriate Access and Availability	Improve Utilization of PACE Alternative Care Settings (ACS)	≥10% of all eligible PACE Enrollees will utilize day center services at one of the PACE Alternative Care Settings by end of 2025.	Eligible participants will be scheduled for day center services to be provided by one of our contracted ACS (Exclusions defined within the 2025 PACE Quality Improvement Plan Description)	Quarterly	12/31/2025	PACE Center Manager and PACE Program Manager for Community Based Services	4%	Not Met	5%	Not Met	8%	Not Met	9%	Not Met	9%	Not Met

Back to Agenda

Back to Item

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person	Q1 Results	Q1 Action	Q2 Results	Q2 Action	Q3 Results	Q3 Action	Q4 Results	Q4 Action	EOY Total or Avg.	Met/Not Met
QI25.16	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	<3,000 hospital days per 1000 per year	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education (Exclusions defined within the 2025 PACE Quality Improvement Plan Description)	Quarterly	12/31/2025	PACE Medical Director	2222	Met	2326	Met	2504	Met	2680	Met	2680	Met
QI25.17	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	<820 emergency room visits per 1000 per year	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2025	PACE Medical Director	784	Met	805	Met	807	Met	850	Not Met	850	Not Met
QI25.18	Ensure Appropriate Use of Resources	30-Day All Cause Readmission Rates	<14% 30-day all cause readmission	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement (Exclusions defined within the 2025 PACE Quality Improvement Plan Description)	Quarterly	12/31/2025	PACE Medical Director	16.9%	Not Met	16.9%	Not Met	17.3%	Not Met	18.5%	Not Met	17.4%	Not Met
QI25.19	Ensure Appropriate Use of Resources	Long Term Care Placement	<4% of members will reside in long term care	PACE participants placed in long term custodial care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2025	PACE Medical Director and PACE Center Manager	0.07%	Met	0.13%	Met	0.44%	Met	0.43%	Met	0.27%	Met
QI25.20	Improve Participant Experience	Enrollment/Disenrollment	The Qualified Lead-to-Enrollment conversion rate will be 70% in 2025	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement	Quarterly	12/31/2025	PACE Marketing and Enrollment Manager	49%	Not Met	74%	Met	68%	Not Met	84%	Met	69%	Not Met
QI25.21	Improve Participant Experience	Enrollment/Disenrollment	The percentage of participants who disenroll for controllable reasons from the PACE program within the first 3 months of enrollment will be less than 6%	Review and analyze the participants who disenrolled from PACE within 3 months of enrollment (for controllable reasons) to develop strategies for improvement	Quarterly	12/31/2025	PACE Marketing and Enrollment Manager and PACE Center Manager	0.00%	Met	8.33%	Not Met	8.33%	Not Met	21.43%	Not Met	9.73%	Not Met
QI25.22	Improve Participant Experience	Enrollment/Disenrollment	Maintain a PACE participant attrition rate of ≤8 %	PACE will create focus groups to identify areas that need operational improvement to strategically support growth in 2025.	Quarterly	12/31/2025	PACE Center Manager and PACE Director	5.03%	Met	4.67%	Met	6.79%	Met	5.16%	Met	5.42%	Met
QI25.23	Improve Participant Experience	Transportation Performance	100% of transportation trips will be less than 60 minutes in 2025	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2025	PACE Center Manager	99.93%	Not Met	99.77%	Not Met	99.67%	Not Met	99.86%	Not Met	99.81%	Not Met
QI25.24	Improve Participant Experience	Transportation Performance	≥92% of all transportation rides will be on-time in 2025	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. Validate reports with ride-along to ensure accuracy of reported times.	Quarterly	12/31/2025	PACE Center Manager	87.9%	Not Met	78.5%	Not Met	70.0%	Not Met	80.8%	Not Met	79.0%	Not Met
QI25.25	Improve Participant Experience	Transportation Satisfaction	≥93.2% Satisfaction with Transportation Services (2024 PACE National Average) on the 2025 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve participant satisfaction with the PACE Transportation program	Annually	12/31/2025	PACE Center Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	94%	Met
QI25.26	Improve Participant Experience	Participant Satisfaction with Meals	≥72% Satisfaction with Meals (2024 PACE National Average) on the 2025 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant satisfaction with the meals within the PACE program.	Annually	12/31/2025	PACE Center Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	80%	Met
QI25.27	Improve Participant Experience	Participant Satisfaction Home Care	≥85.5% Satisfaction with Home Care Service (2024 PACE National Average) on the 2025 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve participant satisfaction with the Home Care services at PACE	Annually	12/31/2025	PACE Center Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	88%	Met
QI25.28	Improve Participant Experience	Overall Participant Satisfaction	≥87.3% on the Overall Satisfaction-Weighted Average (2024 PACE National Average) on the 2025 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve overall participant satisfaction with the PACE program	Annually	12/31/2025	PACE Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	94%	Met

Back to Agenda

Back to Item

CALOPTIMA HEALTH PROGRAM ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) QUALITY IMPROVEMENT PLAN DESCRIPTION

2026~~5~~

PACE Quality Improvement Subcommittee Chairperson:

Donna Frisch, M.D. **Date**
Medical Director, PACE

Board of Directors' Quality Assurance Committee Chairperson:

Jose Mayorga, M.D. **Date**

Board of Directors Chairperson:

Vicente Sarmiento~~Isabel Becerra~~ ~~———~~
Date

Back to Agenda Back to Item

Table of Contents

INTRODUCTION 4
Overview 4
Goals 4
Organizational and Committee Structure 6
PACE Quality Improvement Committee 6
PACE Focused Review Committees 6
PACE Member Advisory Committee 7
2026 Committee Organization Structure — Diagram 8
QUALITY AND PERFORMANCE IMPROVEMENT ACTIVITIES, OUTCOMES AND REPORTING 8
Quality Indicators and Opportunities for Improvement 8
Utilization of Services 8
Participant and Caregiver Satisfaction 9
Clinically Relevant Data- Quality Workplan Elements 9
Effectiveness and Safety of Staff-Provided and Contract-Provided Services 11
Non-Clinical Areas 11
Priority Setting for Performance Improvement Initiatives 12
External Monitoring and Reporting 12
Unusual Quality Incidents and Participant Monitoring 12
Corrective Action Plans (CAP) 13
Urgent Corrective Measures 13
Re-Evaluation and Follow-Up 13
Quality Initiatives 14
ANNUAL REVIEW OF PACE QI PLAN 15
APPENDIX A (SEE ATTACHMENT) 15
~~INTRODUCTION ..... 3~~
~~Overview ..... 3~~
~~Goals ..... 3~~
~~Organizational and Committee Structure ..... 5~~
~~PACE Quality Improvement Committee ..... 5~~
~~PACE Focused Review Committees ..... 5~~
~~PACE Member Advisory Committee ..... 6~~

2025 Committee Organization Structure — Diagram 6
QUALITY AND PERFORMANCE IMPROVEMENT ACTIVITIES, OUTCOMES AND REPORTING 7
Quality Indicators and Opportunities for Improvement 7
Utilization of Services 7
Participant and Caregiver Satisfaction 7
Clinically Relevant Data- Quality Workplan Elements 8
Effectiveness and Safety of Staff-Provided and Contract-Provided Services 9
Non-Clinical Areas 10
Priority Setting for Performance Improvement Initiatives 10
External Monitoring and Reporting 11
Unusual Quality Incidents and Participant Monitoring 11
Corrective Action Plans (CAP) 12
Urgent Corrective Measures 12
Re-Evaluation and Follow-Up 12
Quality Initiatives 12
ANNUAL REVIEW OF PACE QI PLAN 13
APPENDIX A (SEE ATTACHMENT) 13

Back to Agenda Back to Item

INTRODUCTION

The Quality Improvement (QI) Plan Description at CalOptima Health's Program of All-Inclusive Care for the Elderly (PACE) is the data-driven assessment program that drives continuous QI for all the services at CalOptima Health PACE. It is designed and organized to support the mission, values, and goals of the PACE program.

Overview

- The goal of the CalOptima Health PACE QI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff.
- The CalOptima Health PACE QI Plan is developed by the PACE Quality Improvement Committee (PQIC). As CalOptima Health's governing body, the Board of Directors has the final authority to review and approve the QI Plan annually and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate. The PACE QI Plan is comprised of both the PACE QI Program Description and specific goals and objectives described in the PACE QI Work Plan. (See Appendix A).
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI Manager will ensure timely collection and completeness of data.
- CalOptima Health PQIC completes an annual evaluation of the data collected throughout the year. This evaluation and analysis help to find opportunities for quality improvement and drives appropriate additions or revisions in the QI Plan to the goals and objectives for the following year.

Goals

- **Improve the quality of health care for participants.**
    - Ensure all QI activities fit into a well-integrated system that oversees quality of health care and coordination of all services.
    - Ensure the QI program involves all providers of care within PACE.
    - Implement population health management (PHM) techniques, such as immunizations, for specific participant populations.
    - Identify and address areas for improvement that arise from unusual incidents.
    - Monitor, analyze and report the aggregated data elements required by the Centers for Medicare & Medicaid Services (CMS) via the Health Plan Management System (HPMS) to identify areas needing quality improvement.
    - Communicate relevant QI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee (PMAC), and the CalOptima Health Board of Directors.
    - Share results of QI identified benchmarks with staff and contracted providers at least annually.
    - Involve the physicians and other health care providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of health care. Professional standards of CalOptima Health PACE staff will be measured against those outlined by their respective licensing agencies in the State of California (e.g. California Board of Nursing, etc.).
    - Ensure that all levels of care are consistent with professionally recognized standards of practice.

- Assure compliance with the regulatory requirements of all responsible agencies.

- **Improve the participant experience.**
  - Use the annual participant satisfaction survey, grievances and appeals, and feedback from participant committees to identify areas for improvement related to participant experience.
  - Provide education to staff on the multiple dimensions of the PACE participant experience.
  - Identify and implement ways to better engage participants in the PACE experience (e.g., menu selection and PMAC).
  - Evaluate customer service, access, and timeliness of health care provided by contracted licensed providers.
  - Monitor and track transportation services in terms of on-time performance and trips less than 60 minutes in duration.
  - Ensure participant's end of life wishes are discussed and documented in the Physician's Order for Life Sustaining Treatment (POLST) and in an Advance Health Care Directives which honors participants' wishes as well as advance directive rights.
- **Ensure the appropriate use of resources.**
  - Review and analyze utilization data regularly, including hospital admissions, Emergency Room (ER) visits, and hospital 30-day all-cause readmissions, to identify high-risk participants and opportunities for improvement in complex case management.
  - Review documentation and coordination of health care for participants receiving services in institutional settings and investigate any potential infractions in the quality of care provided in these settings.
  - Ensure high levels of coordination and communication between specialists and primary care providers (PCPs).
  - Ensure high levels of coordination and communication between inpatient facilities, nursing facilities and PACE PCPs.
  - Review and analyze clinic medical records to ensure appropriate documentation and coding.
- **Ensure the safety of clinical care.**
  - Reduce potential risks to the health and safety of PACE participants through ongoing risk management.
  - Ensure that every member of the PACE staff organization has responsibility for risk assessment and management.
  - Monitor, report and perform a Root Cause Analysis on all participant-involved events resulting in a significant adverse outcome, for the purpose of identifying areas for quality improvement.
  - Monitor and track falls occurring in the PACE Day Center, in the home and within the community.
  - ~~Monitor and track the use of prescription opioids at high dosages.~~
  - Meet or exceed community standards for credentialing of licensed providers.
  - Monitor staff and contractors to ensure that appropriate standards of health care are met.
- **Ensure appropriate access and availability.**
  - Monitor and analyze the PACE provider network continuously to ensure appropriate levels of access.
  - Monitor and analyze access to specialty health care.
  - Continue to develop the network of Alternative Care Setting (ACS) sites to ensure the program can provide services to all Orange County residents who qualify and are interested in joining PACE.

Back to Agenda Back to Item

Organizational and Committee Structure

CalOptima Health Board of Directors provides oversight and direction to CalOptima Health PACE. The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QI Plan efforts to flourish. The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the QI programs at CalOptima Health — including the CalOptima Health PACE QI Program — to the Board's Quality Assurance Committee (QAC), which performs the functions of CalOptima Health's Quality Improvement Committee (QIC) described in CalOptima Health's state and federal contracts, and to CalOptima's Chief Executive Officer who is responsible to allocate operational resources to fulfill quality objectives.

The QAC is a subcommittee of the Board and consists of currently active Board members. The QAC reviews the quality and utilization data that are discussed in the PQIC reports. The QAC provides progress reports, reviews the annual PACE QI Plan, and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

PACE Quality Improvement Committee

Purpose
This committee provides oversight for the overall administrative and clinical operations of PACE and will meet, at a minimum, once a quarter. The PQIC will review all QI initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. The PQIC may create Ad Hoc Focus Review Committees for limited time periods to address quality problems in any clinical or administrative process that have been identified as critical to participants, families, or staff. Potential areas for improvement will be identified through analysis of the data and through root cause analysis. This meeting will be chaired by the PACE Medical Director who will report on its activities to QIC, QAC, and the Board. The PACE Program Director or PACE QI Manager may facilitate the meeting in the PACE Medical Director's absence. The PACE Program Director or the PACE QI Manager may report up to the QAC if the PACE Medical Director is not available.

Membership
Membership shall be comprised of the PACE Medical Director, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI Manager, PACE QI Program Specialist(s), PACE Program Manager of Community-Based Programs and the PACE Intake/Enrollment Manager. At least four regular members shall constitute a quorum. The PACE Medical Director will act as the standing chair of the committee.

PACE Focused Review Committees

Purpose
These committees will be formed to respond to or to proactively address specific quality issues that rise to the level of warranting further study and action. Key performance elements are routinely reviewed by PACE staff as part of ongoing operations, including, but not limited to, deaths and other adverse outcomes, inpatient utilization and other clinical areas that indicate significant over/under utilization.

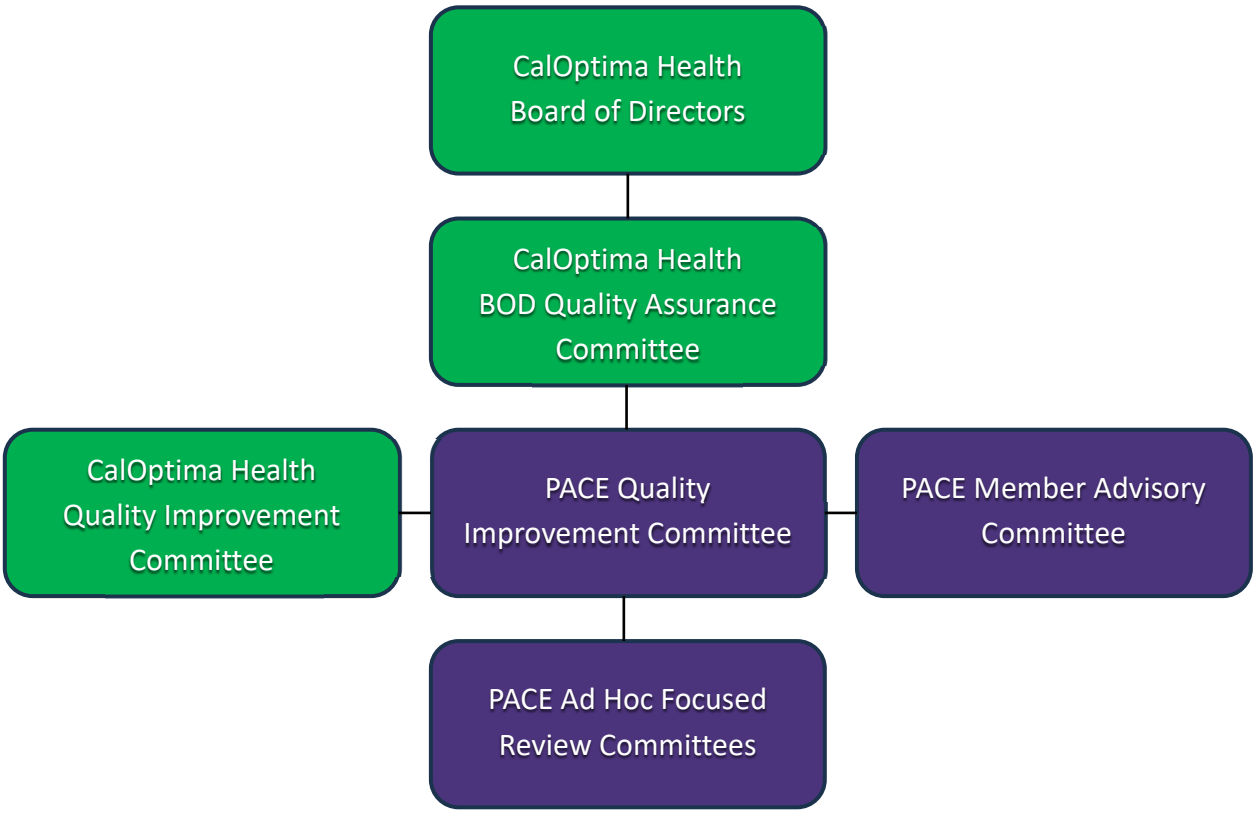
Membership
Membership will be flexible based on those with knowledge of the specific issues being addressed but will consist of at least four members to include at least two of the following positions and/or functions: PACE Medical Director, PACE QI Manager, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI Program Specialist(s), PACE Marketing and Enrollment Manager, PACE Program Manager of Community-Based Programs and/or direct care staff. The Committee will be chaired by the PACE Medical Director, PACE Clinical Medical Director, PACE Director, PACE Center Manager or PACE QI Manager. The chair will report on activities and results to the PQIC. The committee will meet on an ad hoc basis as needed to review those critical indicators assigned to them by the PQIC.

PACE Member Advisory Committee

Purpose
The PACE Member Advisory Committee (PMAC) provides recommendations to the Board on issues related to participant health care concerns that arise with participant care decisions and program operations from a community perspective. A member of the PMAC shall report its activities to QAC, which then will be reported to the Board. The PACE Program Director, PACE QI Manager, or the PACE Center Manager shall report its activities to the PQIC.

Membership
The PMAC is comprised of participants and/or their representatives and community representatives from which participants are referred. PMAC membership is open to all participants and/or caregivers and no application process is required. Information related to upcoming PMAC meetings is disseminated through announcements at the PACE Day Center floor and email/telephonic correspondence and all interested participants are invited to join. Participants and representatives of participants shall constitute a majority of membership. The committee will be comprised of at least seven members. At least four regular members shall constitute a quorum. The PACE Program Director will act as the standing chair and will facilitate the committee. The PACE Center Manager or PACE QI Manager may facilitate the meeting in the PACE Director's absence.

20265 Committee Organization Structure — Diagram



QUALITY AND PERFORMANCE IMPROVEMENT ACTIVITIES, OUTCOMES AND REPORTING

Quality Indicators and Opportunities for Improvement

Routine quality indicators appropriate to the PACE population are identified for analysis and trending. These indicators are related to the care and services provided at PACE. The indicators and opportunities for performance improvement are identified through:

Utilization of Services

- PACE will collect, analyze, and report any utilization data it deems necessary to evaluate both quality of health care and fiscal well-being of the organization including:
    - Hospital Bed Days
        - Exclusion criteria:
            - Participants who are hospitalized in long term acute care hospitals for >90 days.
    - ER Visits
    - 30-Day All-Cause Readmissions
        - Exclusion criteria:
            - Participants who are re-hospitalized within 30 days of discharge for

scheduled visits such as cancer treatment.

- ~~Participants residing in Long Term Care (LTC) facilities under custodial care.~~

- Data analysis will allow for investigation into both overutilization and underutilization of resources to provide quality improvement and ensure the appropriate use of resources.

Participant and Caregiver Satisfaction

- PACE will survey program participants and their caregivers on at least an annual basis. Additionally, PACE will look for other opportunities for feedback to improve quality of services throughout the year. CalOptima Health PACE will attempt to surpass National Averages of other PACE programs for the following areas:
  - Transportation Satisfaction
  - Meal Satisfaction
  - Home Care Satisfaction
  - Overall Satisfaction
- ~~Due to the nature of the participants in PACE, caregiver feedback is an integral part of our data elements.~~
- The PMAC shall provide direct feedback on satisfaction to the PACE leadership staff.
- Grievance data is reviewed and analyzed quarterly for trends and opportunities for improvement.
- PACE will monitor the percentage of participants who disenroll from PACE within 3 months ~~90 da~~of enrollment ~~ys~~ *for controllable reasons*.
- PACE will monitor attrition rate to identify any need for operational improvement to strategically support continued growth in 2026~~5~~.

Clinically Relevant Data- Quality Workplan Elements

- Clinical measures from the 2026~~5~~ QI Work Plan elements which include:
  - Influenza Immunizations Rates
    - Exclusion criteria:
      - Participants who have dx of Palliative Care Approach, ICD-10 Z51.5
      - Participants with diagnosis of History of Guillain Barre, ICD-10: Z86.69 ~~G61.0~~
      - Participants who are allergic to Influenza vaccine
  - Pneumococcal Immunizations Rates
    - Exclusion criteria:
      - Participants who enroll in the program in December 2026~~5~~
      - Participants who have dx of Palliative Care Approach, ICD-10 Z51.5
      - Participants who are allergic to Pneumococcal vaccine
  - Colon Cancer Screening
    - Inclusion criteria:
      - Participants enrolled for at least six months
    - Exclusion criteria
      - Participants who are 76 years and older as of December 31, 2026~~5~~
      - Participants who have dx of Palliative Care Approach (ICD-10: Z51.5)
      - Participants who have a dx of Frailty (ICD-10: R54)
  - Breast Cancer Screening
    - Inclusion criteria:
      - Women enrolled for at least six months
    - Exclusion criteria

- Participants who are 76 years and older as of December 31, 2026~~5~~
- Participants who have dx of Palliative Care Approach (ICD-10: Z51.5)
- Participants who have a dx of Frailty (ICD-10: R54)
- Participants with Hx of Breast Cancer dx who have had a double mastectomy

- Controlling High Blood Pressure
  - Inclusion criteria:
    - Participants with a dx of Hypertension (ICD-10: I.10) and/or Diabetes (multiple ICD.10 codes used).
    - Enrolled for at least six months
  - Exclusion criteria:
    - Participants who are 76 years and older as of December 31, 2026~~5~~
    - Participants who have dx of Palliative Care Approach (ICD-10: Z51.5)
    - Participants who have a dx of Frailty (ICD-10: R54)
    - Participants with End Stage Renal Disease, noted as ESRD or STAGE 5 renal disease.
- Diabetes Care: Annual Eye Exams
  - Inclusion criteria:
    - Diagnosis of Diabetes Mellitus (multiple ICD.10 codes used).
    - Enrolled for at least six months
  - Exclusion criteria:
    - Participants who have dx of Palliative Care Approach, ICD-10 Z51.5
    - Participants who are 76 years and older as of December 31, 2026~~5~~
    - Participants who are legally blind in both eyes.
    - Participants who had a normal eye exam in the past year.
- Diabetes Care: HbA1c Control for Diabetics
  - Inclusion criteria:
    - Diagnosis of Diabetes Mellitus (multiple ICD.10 codes used).
    - Enrolled for at least six months
  - Exclusion criteria:
    - Participants who are 76 years and older as of December 31, 2026~~5~~
    - Participants who have dx of Palliative Care Approach (ICD-10 Z51.5)
    - Participants who have a dx of Frailty (ICD-10 code R54)
- ~~Monitoring Participants for Osteoporosis~~
  - ~~Inclusion criteria~~
    - ~~Women over 65 years old~~
    - ~~Enrolled for at least six months~~
  - ~~Exclusion criteria:~~
    - ~~Participants who have dx of Palliative Care Approach, ICD-10: Z515~~
    - ~~Participants with End Stage Renal Disease, noted as ESRD or STAGE 5 renal disease.~~
- Reduce Number of Falls Reported at PACE
  - Exclusion criteria:
    - Participants who have a fall in a hospital or skilled nursing facility (SNF).
    - Participants who report 4 or more ~~than 3~~ falls in one quarter
- ~~Monitoring of Risks from High Dosage Opioid Use~~

Back to Agenda Back to Item

- ~~Inclusion criteria:~~
  - ~~Receiving prescription opioids milligram morphine dose MME >90 MME/day for ≥15 days.~~
- ~~Exclusion criteria:~~
  - ~~Participants on Hospice Care~~
  - ~~Participants with short term (<15 days) high dosage opioids.~~

- Medication Reconciliation within 7 calendar days post discharge ~~Post Discharge~~ from hospital or SNF.
- Access to Specialty Care services. Services scheduled within 7 calendar days of ordering. ~~.~~

Effectiveness and Safety of Staff-Provided and Contract-Provided Services

- This will be measured by participants' ability to achieve treatment goals as reviewed by the Interdisciplinary Team (IDT) with each reassessment, care plan update, and review of medical record documentation.
- All clinical and certain non-clinical positions (direct care) have competency profiles specific to their positions.
- Annual competency evaluations of PACE staff.
- PACE will monitor providers by methods such as review of providers' QI activities, medical record review, grievance investigations, observation of care and interviews.
- Unannounced visits to inpatient provider sites will be made by PACE staff, as necessary.
- Oversight of contracted Alternative Care Sites (ACS), assuring compliance to PACE regulations (including, but not limited to participant rights, infection control, emergency preparedness, staff competencies) as well as CalOptima Health guidelines (e.g. HIPAA, FWA, licensing, etc.).

Non-Clinical Areas

- The PACE PQIC has oversight of all services and activities offered by PACE.
- Member grievances will be forwarded to the PACE QI Department for investigation, tracking, trending, and data gathering. These results will be shared with the PACE Director and leadership for review and further direction regarding any corrective actions that may be implemented. Participants and caregivers will be informed of the results of the investigations and will be assisted with furtherment of the process as needed. Results will also be reported to PQIC for direction on how appropriate staff should implement any corrective actions.
- Member appeals for denied or partially denied service determination requests will be forwarded to the PACE QI Department for tracking, trending and data gathering and the PACE Director or PACE Medical Director for review. The case will then be forwarded to a third party with the appropriate licensure for review. The third-party reviewer's decision shall be reviewed by the PACE QI manager and either the PACE Director or the PACE Medical Director. The results will be immediately shared with participant via telephone and/or written letter with information about additional rights to appeal, should the decision not be in the participant's favor.
- Continued integration of telehealth to expand access to care.
- Increased utilization of Alternative Care Settings in 2026~~5~~, including raising our ~~a~~ goal from ~~that~~ 10% to 12% of all eligible PACE Enrollees will utilize day center services at one of the PACE ACS sites by the end of 2026~~5~~.

- Transportation services will continue to be monitored through monthly metrics and grievance trending. Complaints will be tracked and addressed via the Transportation Log. The monthly report generated by the transportation vendor will be reviewed at the monthly transportation leadership meeting and will be reported quarterly to the PQIC. The PACE Center Manager and other leadership staff will monitor transportation services with periodic ride-along. The times gathered during the ride-along will be compared against the data in the transportation reports to ensure accuracy.
- Meal quality will be monitored through participant satisfaction surveys, as well as comments solicited by the PMAC.
- Life safety will be monitored internally via quarterly fire drills and annual disaster preparedness training ~~mock code and disaster drills,~~ as well as regulatory agency inspections.
- Plans of correction on problems noted will be implemented by center staff, reviewed by the PACE Program Director, PACE Medical Director or the PACE QI Manager, and presented to the PQIC.
- The internal environment will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise.

Priority Setting for Performance Improvement Initiatives

- Potential impact on quality of care, clinical outcomes, improved participant function and improved participant quality of life.
- Potential impact on participant access to necessary care or services.
- Potential impact on participant safety.
- Participant, caregiver, or other customer satisfaction.
- Potential impact on efficiency and cost-effectiveness.
- Potential mitigation of high risk, high volume, or high frequency events.
- Relevance to the mission and values of PACE.

External Monitoring and Reporting

PACE will report both aggregate and individual-level data to CMS and DHCS to allow them to monitor PACE performance. This includes certain Unusual Quality Incidents, Health Outcomes Survey Modified (HOS-M) participation, and any other required reporting elements. Certain data elements are tracked in response to federal and state mandates and will be reported through the PACE monitoring module of Health Plan Management System (HPMS). The following data is reported to both CMS via HPMS and Department of Health Care Services (DHCS) via email, on a quarterly basis or more often as needed:

- Grievances
- Appeals
- Unusual Incidents
- Medication Errors
- Immunizations
- Enrollment Data
- Denials of Prospective Enrollees
- Falls without Injury
- ER Visits

Unusual Quality Incidents and Participant Monitoring

- When unusual incidents meet specified thresholds, PACE must notify CMS through HPMS

and DHCS via email. PACE must complete a Root Cause Analysis (RCA) with the appropriate PACE IDT members and share the results with CMS and DHCS. The goal of this analysis is to identify any potential systems failures and improvement opportunities. CMS and DHCS may ask for further exposition and follow up for each individual quality incident case during the quarterly conference call with CalOptima Health PACE. Examples of Unusual Quality Incidents include:

  - Deaths related to suicide or homicide, unexpected and with active coroner investigation.
  - Falls that result in death, a fracture or an injury requiring hospitalization related directly to the fall.
  - Infectious disease outbreaks that meet the threshold of three or more cases linked to the same infectious agent within the same time frame, including COVID-19 infections.
  - Pressure injuries Stage 3, Stage 4, or Unstageable acquired while enrolled in PACE.
  - Elopement by cognitively impaired participants.
  - Adverse drug reactions.
  - Foodborne disease outbreak.
  - Burns 2nd degree or higher.

- Health Outcomes Survey-Modified (HOS-M)
  - PACE will participate in the annual Medicare HOS-M to assess the frailty of the of our participant population. .
- Other external reporting requirements
  - Suspected elder abuse shall be reported to appropriate state agency.
  - Equipment failure or serious adverse reaction to any administered medications will be reported to the Food and Drug Administration (FDA).
  - Any infectious disease outbreak will be reported to the Centers for Disease Control and Prevention (CDC) and the Orange County Health Care Agency.
  -

Corrective Action Plans (CAP)

- When opportunities for improvement are identified, a corrective plan will be created.
- Each CAP will include an explanation of the problem, the individual who is responsible for implementing the CAP, the time frame for each step of the plan, and an evaluation process to determine effectiveness.
- CAPs from contracted providers will be requested by the QI Manager or another member of the PQIC, as appropriate.

Urgent Corrective Measures

- Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the PACE Medical Director and the PACE Director.
- The QI Manager and/or QI Medical Case Manager will consult with relevant PACE staff and be responsible for developing an appropriate corrective plan within 24 hours of notification.
- Urgent corrective measures will be discussed during IDT morning meetings and, when appropriate, with participants.
- Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, etc. will be implemented immediately.

Re-Evaluation and Follow-Up

- Monitoring activities will be conducted to determine the effectiveness of plans of action. The timeliness of follow-up is dependent upon the following:
    - Severity of the problem
    - Frequency of occurrence
    - Impact of the problem on participant outcomes
    - Feasibility of implementation
- If follow-up shows the desired results have been achieved, the issue will be re-evaluated on a periodic basis to ensure continued improvement.
- If follow-up indicates that the desired results are not being achieved, then a more in-depth analysis of the problem and further determination of the source of variation are needed. A subcommittee of the PQIC or other workgroup may be established to address specific problems.
- All quality assessment and improvement steps and follow-up results will be shared with appropriate staff for discussion.

Quality Initiatives

- Quality Initiatives will be implemented as an adjunct to the PACE QI Plan. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, strategies, and measurable interventions to meet our goals. The status of each PACE Quality Initiative is presented to the PQIC on a quarterly basis. The program's quality initiatives for 2026~~5~~ are:
    - Advance Health Care Directive (AHCD)
        - This initiative will focus on increasing the number of PACE participants who have a completed Advance Health Care Directive in their medical chart. The PACE leadership team has created a plan to be implemented by the PACE Center Manager and the Social Work team, with a goal of ≥ 55% of participants having a completed AHCD by the end of 202~~65~~.
        - Exclusions:
            - ~~Participants with MMSE <16. OR~~
            - ~~Participants with MMSE 16 or >, but~~ who have a capacity letter scanned into chart ~~(new exclusion for 2025).~~
    - Dental Satisfaction Initiative
        - This initiative will focus on increasing participant satisfaction with contracted dental services, to provide participants with comprehensive education regarding the process for dental procedures with a focus on reduced pain and increased function. The PACE Enrollment Coordinators will highlight for new enrollees what dental services are provided (ex/routine cleanings) and what are not (ex/cosmetic dentistry). Clinic administrative staff will follow up each month with 5 randomly chosen participants who received dental services from a dental specialist to find any areas of dissatisfaction that can be addressed in a timely manner. The goal will be for PACE to have ≤ 1 dental related grievance per quarter in 2026.
    - Transportation Satisfaction Initiative
        - Focuses on increasing the participant satisfaction with contracted transportation services, providing participants with timely resolutions to transportation related issues that are in transportation log.
        - PACE Center manager in conjunction with Secure transportation manager,

Back to Agenda Back to Item

and PACE Clinic Manager will review and resolve all complaints received by PACE participants regarding PACE transportation in a timely manner.
    - Goal is ≤ 3 valid transportation related grievance per quarter in 2026.

~~- COVID-19 Immunization~~
    - ~~This initiative will focus on increasing the number of PACE participants who have received the latest CDC approved COVID-19 vaccine, with a goal of ≥50% by the end of 2025.~~
    - ~~Exclusions:~~
        - ~~Participants who enroll in the program in December 2025~~
- ~~Participant Satisfaction~~
    - ~~As measured by number of grievances related to area of review. At this time PACE is awaiting the results of the 2024 Integrated Satisfaction Measurement for PACE (I-SAT) survey before determining which areas to focus on for goal creation. The results of this survey have been delayed until Friday, February 28, 2025.~~

ANNUAL REVIEW OF PACE QI PLAN

- The PACE QI Plan will be assessed annually for effectiveness.
- Enhancements to the plan will be made through appropriate additions and revisions to the specific goals and objectives in the QI Work Plan.
- The Board will review and approve the PACE QI Plan and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate, to assure organizational oversight and commitment.

APPENDIX A (SEE ATTACHMENT)

20256 CalOptima PACE Quality Improvement (QI) Work Plan							
QAPI Item#	**Goal**	**Description**	**Objective**	**Activity**	**Reporting Frequency**	**Target completion**	**Responsible Person**
QI256.01	**Improve the Quality of Care for Participants**	**20245 PACE QAPI Plan and Work Plan Annual Evaluation**	20245PACE QAPI Plan will be evaluated by CalOptima Health Quality Assurance Committee in March 20256	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/12/202519/2026	PACE Medical Director
QI256.02	**Improve the Quality of Care for Participants**	**20256 PACE QI Plan and Work Plan Annual Oversight**	PACE 2026 QI Plan and Work Plan will be updated, reviewed and approved by CalOptima Health Quality Assurance Committee in March 20256	PACE QAPI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/12/202519/2026	PACE Medical Director
QI256.03	**Improve the Quality of Care for Participants**	**Influenza Immunization Rates**	≥940% of eligible participants will have their annual influenza vaccination by December 31st, 20256	Improve Maintain compliance with influenza immunization recommendations (Exclusions defined within the 20256 PACE Quality Improvement Plan Description)	Q1, Q3 and Q4 20256	12/31/20256	PACE Medical Director
QI256.04	**Improve the Quality of Care for Participants**	**Pneumococcal Immunization Rates**	≥940% of eligible participants will have completed their pneumococcal vaccination by December 31st, 20256	Improve Maintain compliance with pneumococcal immunization recommendations (Exclusions defined within the 20256 PACE Quality Improvement Plan Description)	Quarterly	12/31/20256	PACE Medical Director
QI256.05	**Improve Quality of Care for Participants**	**Colorectal Cancer Screening**	>65.21 69.66% of eligible participants will have had a screening for colorectal cancer by December 31st, 20256 (Comparable to the 20234 MEDICARE Quality Compass HEDIS 33.33rd 50th percentile)	Improve compliance with colorectal cancer screening recommendations for older adults by tracking the percentage of colonoscopies and/or FIT tests completed for our participants (Exclusions defined within the 20256 PACE Quality Improvement Plan Description)	Quarterly	12/31/20256	PACE Medical Director
QI256.06	**Improve Quality of Care for Participants**	**Breast Cancer Screening**	>82.80 83.60% of eligible participants will have a screening for breast cancer by December 31st, 20256 (Comparable to the 20234 MEDICARE Quality Compass HEDIS 90th percentile)	Improve compliance with breast cancer screening recommendations for older adults by tracking the percentage of mammograms completed for our participants (Exclusions defined within the 20256 PACE Quality Improvement Plan Description)	Quarterly	12/31/20256	PACE Medical Director
QI256.07	**Improve the Quality of Care for Participants**	**Controlling High Blood Pressure**	>85.6087.21% of participants with Hypertension *and/or* Diabetes will have their blood pressure controlled (Comparable to the 20234 MEDICARE Quality Compass HEDIS 90th percentile)	PACE participants with hypertension and/or diabetes will have their blood pressure regularly monitored and adequately controlled, as defined by readings of <140/90 mmHG. (Exclusions defined within the 20256 PACE Quality Improvement Plan Description)	Quarterly	12/31/20256	PACE Medical Director
QI256.08	**Improve the Quality of Care for Participants**	**Diabetic Eye Care**	>88.08 89.04% of Diabetic participants will have an Annual Eye Exam (Comparable to the 20234 MEDICARE Quality Compass HEDIS 95th percentile)	PACE participants with diabetes will be monitored by their Primary Care Providers to ensure they maintain healthy vision through annual examination by eye doctor (Exclusions defined within the 20256 PACE Quality Improvement Plan Description)	Quarterly	12/31/20256	PACE Medical Director
QI256.09	**Improve the Quality of Care for Participants**	**Diabetic Blood Sugar Control**	<12.2412.50% of Diabetic participants will have an HbA1c measurement of >9% (Comparable to the 20234 MEDICARE Quality Compass HEDIS 7066th percentile)	PACE participants with diabetes will be monitored by their Primary Care Providers to ensure they maintain blood sugar control as measured by HbA1c lab work (Exclusions defined within the 20256 PACE Quality Improvement Plan Description)	Quarterly	12/31/20256	PACE Medical Director

Back to Agenda

Back to Item

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
~~QI25.10~~	~~Improve the Quality of Care for Participants~~	~~Osteoporosis Monitoring~~	~~75% of eligible participants will have a bone density scan to assess for Osteoporosis~~	~~Medical records of all eligible participants will be reviewed to see if they have had a bone density scan within the past 5 years. If not, a scan will be completed on that participant (Exclusions defined within the 2025 PACE Quality Improvement Plan Description)~~	~~Quarterly~~	~~12/31/2025~~	~~PACE Medical Director~~
QI2~~5~~6.1~~10~~	Ensure the Safety of Participants	Reduce Percentage of Falls Reported by PACE Enrollees	~~<72 falls reported per quarter in 2025~~ Reduce the number of falls sustained by PACE enrollees to ≤150 falls per 1000 participants	The PACE Center manager will work with the Rehabilitation Department to review all participants who have repeated falls within each quarter. Participants who have repeated falls will have a documented home assessment and follow up completed by PACE to reduce total number of falls. (Exclusions defined within the 202~~5~~6 PACE Quality Improvement Plan Description)	Quarterly	12/31/202~~5~~6	PACE Center Manager
~~QI25.12~~	~~Ensure the Safety of Clinical Care~~	~~Monitoring of Risks from High Dosage Opioid Use~~	~~100% of members receiving opioids for 15 or more days at an average of 90 MME/day will be reevaluated monthly by their treating provider in 2025.~~	~~The PACE Primary Care Providers will provide monthly monitoring any participant who is receiving prescription opioids for ≥15 days at an average milligram morphine dose MME >90 MME/day (Exclusions defined within the 2025 PACE Quality Improvement Plan Description)~~	~~Quarterly~~	~~12/31/2025~~	~~PACE Medical Director~~
QI2~~5~~6.1~~3~~1	Improve the Quality of Care for Participants	Medication Reconciliation Post Discharge (MRP)	≥93% of participants will have their medications reconciled within 7 calendar days of hospital and/or skilled nursing facility discharge in 202~~5~~6	The PACE QI Department will work with the PACE Clinic, Pharmacist and Providers to ensure that participant medications are reviewed in a timely matter after discharge.	Quarterly	12/31/202~~5~~6	PACE Pharmacist and PACE Clinical Operations Manager
QI2~~5~~6.1~~4~~2	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	100% of specialty care authorizations will be scheduled within 7 calendar days in 202~~5~~6	Appointments for specialty care will be scheduled within 7 calendar days after ordering to improve access to specialty care	Quarterly	12/31/202~~5~~6	PACE Clinical Operations Manager
QI2~~5~~6.1~~5~~3	Ensure Appropriate Access and Availability	Improve Utilization of PACE Alternative Care Settings (ACS)	≥1~~0~~2% of all eligible PACE Enrollees will utilize day center services at one of the PACE Alternative Care Settings by end of 202~~5~~6.	Eligible participants will be scheduled for day center services to be provided by one of our contracted ACS (Exclusions defined within the 202~~5~~6 PACE Quality Improvement Plan Description)	Quarterly	12/31/202~~5~~6	PACE Center Manager and PACE Program Manager for Community Based Services
QI2~~5~~6.1~~6~~4	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	<~~3,000~~2,800hospital days per 1000 per year	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education (Exclusions defined within the 202~~5~~6 PACE Quality Improvement Plan Description)	Quarterly	12/31/202~~5~~6	PACE Medical Director
QI2~~5~~6.1~~7~~5	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	<820 emergency room visits per 1000 per year	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/202~~5~~6	PACE Medical Director

Back to Agenda

Back to Item

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI256.186	Ensure Appropriate Use of Resources	30-Day All Cause Readmission Rates	<1420% 30-day all cause readmission	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement (Exclusions defined within the 20256 PACE Quality Improvement Plan Description)	Quarterly	12/31/20256	PACE Medical Director
~~QI25.19~~	~~Ensure Appropriate Use of Resources~~	~~Long Term Care Placement~~	~~<4% of members will reside in long term care~~	~~PACE participants placed in long term custodial care will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education~~	~~Quarterly~~	~~12/31/20256~~	~~PACE Medical Director and PACE Center Manager~~
QI256.2017	Improve Participant Experience	Enrollment/Disenrollment	~~The Qualified Lead to Enrollment conversion rate will be 70% in 2025~~ 80% of participants will be enrolled into the PACE program in ≤45 days from their initial inquiry.	~~Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement~~ Time from first contact with prospective participant until enrollment will be monitored. Strategies for reducing time to enrollment defined within the 2026 Quality Improvement Plan Description.	Quarterly	12/31/20256	PACE Marketing and Enrollment Manager
QI256.2118	Improve Participant Experience	Enrollment/Disenrollment	The percentage of participants who disenroll for controllable reasons from the PACE program within the first 3 months of enrollment will be less than 6%	Review and analyze the participants who disenrolled from PACE within 3 months of enrollment (for controllable reasons) to develop continued strategies for improvement	Quarterly	12/31/20256	PACE Marketing and Enrollment Manager and PACE Center Manager
QI256.2219	Improve Participant Experience	Enrollment/Disenrollment	Maintain a PACE participant attrition rate of ≤8 %	PACE will create focus groups to identify areas that need operational improvement to strategically support growth in 20256.	Quarterly	12/31/20256	PACE Center Manager and PACE Director
QI256.2320	Improve Participant Experience	Transportation Performance	100% of transportation trips will be less than 60 minutes in 20256	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/20256	PACE Center Manager
QI256.2421	Improve Participant Experience	Transportation Performance	≥92% of all transportation rides will be on-time in 20256	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes. ~~Validate reports with ride-along to ensure accuracy of reported times.~~	Quarterly	12/31/20256	PACE Center Manager
~~QI25.25-27~~	~~Improve Participant Experience~~	~~Participant Satisfaction Elements~~	~~PACE will set goals for participant satisfaction for 3 elements chosen based on the results of our 2024 Integrated Satisfaction Mesaurement for PACE (I-SAT), which will be available 2/28/25.~~	~~Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve participant satisfaction with the PACE program~~	~~Annually~~	~~12/31/20256~~	~~PACE Center Manager and PACE Director~~
QI26.22	Improve Participant Experience	Participant Satisfaction with Transportation	≥93.2% Satisfaction with Transportation Services (2025 PACE National Average) on the 2026 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve participant satisfaction with the PACE Transportation program	Annually	12/31/2026	PACE Center Manager and PACE Director
QI26.23	Improve Participant Experience	Participant Satisfaction with Meals	≥73.6% Satisfaction with Meals (2025 PACE National Average) on the 2026 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant satisfaction with the meals within the PACE program.	Annually	12/31/2026	PACE Center Manager and PACE Director

Back to Agenda

Back to Item

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI26.24	Improve Participant Experience	Participant Satisfaction with Home Care	≥85.7% Satisfaction with Home Care Service (2025 PACE National Average) on the 2026 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve participant satisfaction with home home care at the program	Annually	12/31/2026	PACE Center Manager and PACE Director
QI26.25	Improve Participant Experience	Overall Participant Satisfaction	≥87.9% on the Overall Satisfaction-Weighted Average (2025 PACE National Average) on the 2026 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve overall participant satisfaction with the PACE program	Annually	12/31/2026	PACE Center Manager and PACE Director

Back to Agenda

Back to Item

CALOPTIMA HEALTH PROGRAM ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) QUALITY IMPROVEMENT PLAN DESCRIPTION

2026

PACE Quality Improvement Subcommittee Chairperson:

Donna Frisch, M.D. **Date**
Medical Director, PACE

Board of Directors' Quality Assurance Committee Chairperson:

Jose Mayorga, M.D. **Date**

Board of Directors Chairperson:

Vicente Sarmiento **Date**

Back to Agenda Back to Item

Table of Contents

INTRODUCTION 3
Overview 3
Goals 3
Organizational and Committee Structure 5
PACE Quality Improvement Committee 5
PACE Focused Review Committees 5
PACE Member Advisory Committee 6
2026 Committee Organization Structure — Diagram 7
QUALITY AND PERFORMANCE IMPROVEMENT ACTIVITIES, OUTCOMES AND REPORTING 7
Quality Indicators and Opportunities for Improvement 7
Utilization of Services 7
Participant and Caregiver Satisfaction 8
Clinically Relevant Data- Quality Workplan Elements 8
Effectiveness and Safety of Staff-Provided and Contract-Provided Services 9
Non-Clinical Areas 10
Priority Setting for Performance Improvement Initiatives 10
External Monitoring and Reporting 11
Unusual Quality Incidents and Participant Monitoring 11
Corrective Action Plans (CAP) 12
Urgent Corrective Measures 12
Re-Evaluation and Follow-Up 12
Quality Initiatives 12
ANNUAL REVIEW OF PACE QI PLAN 13
APPENDIX A (SEE ATTACHMENT) 13

INTRODUCTION

The Quality Improvement (QI) Plan Description at CalOptima Health's Program of All-Inclusive Care for the Elderly (PACE) is the data-driven assessment program that drives continuous QI for all the services at CalOptima Health PACE. It is designed and organized to support the mission, values, and goals of the PACE program.

Overview

- The goal of the CalOptima Health PACE QI Plan is to improve future performance through effective improvement activities, driven by identifying key objective performance measures, tracking them, and reliably reporting them to decision-making and care-giving staff.
- The CalOptima Health PACE QI Plan is developed by the PACE Quality Improvement Committee (PQIC). As CalOptima Health's governing body, the Board of Directors has the final authority to review and approve the QI Plan annually and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate. The PACE QI Plan is comprised of both the PACE QI Program Description and specific goals and objectives described in the PACE QI Work Plan. (See Appendix A).
- The PACE Medical Director has oversight and responsibility for implementation of the PACE QI Plan. The PACE QI Manager will ensure timely collection and completeness of data.
- CalOptima Health PQIC completes an annual evaluation of the data collected throughout the year. This evaluation and analysis help to find opportunities for quality improvement and drives appropriate additions or revisions in the QI Plan to the goals and objectives for the following year.

Goals

- **Improve the quality of health care for participants.**
    - Ensure all QI activities fit into a well-integrated system that oversees quality of health care and coordination of all services.
    - Ensure the QI program involves all providers of care within PACE.
    - Implement population health management (PHM) techniques, such as immunizations, for specific participant populations.
    - Identify and address areas for improvement that arise from unusual incidents.
    - Monitor, analyze and report the aggregated data elements required by the Centers for Medicare & Medicaid Services (CMS) via the Health Plan Management System (HPMS) to identify areas needing quality improvement.
    - Communicate relevant QI activities and outcomes to the PACE staff and contractors, the PACE Member Advisory Committee (PMAC), and the CalOptima Health Board of Directors.
    - Share results of QI identified benchmarks with staff and contracted providers at least annually.
    - Involve the physicians and other health care providers in establishing the most current, evidenced-based clinical guidelines to ensure standardization of health care. Professional standards of CalOptima Health PACE staff will be measured against those outlined by their respective licensing agencies in the State of California (e.g. California Board of Nursing, etc.).
    - Ensure that all levels of care are consistent with professionally recognized standards of practice.

    - Assure compliance with the regulatory requirements of all responsible agencies.
- **Improve the participant experience.**
    - Use the annual participant satisfaction survey, grievances and appeals, and feedback from participant committees to identify areas for improvement related to participant experience.
    - Provide education to staff on the multiple dimensions of the PACE participant experience.
    - Identify and implement ways to better engage participants in the PACE experience (e.g., menu selection and PMAC).
    - Evaluate customer service, access, and timeliness of health care provided by contracted licensed providers.
    - Monitor and track transportation services in terms of on-time performance and trips less than 60 minutes in duration.
    - Ensure participant's end of life wishes are discussed and documented in the Physician's Order for Life Sustaining Treatment (POLST) and in an Advance Health Care Directives which honors participants' wishes as well as advance directive rights.
- **Ensure the appropriate use of resources.**
    - Review and analyze utilization data regularly, including hospital admissions, Emergency Room (ER) visits, and hospital 30-day all-cause readmissions, to identify high-risk participants and opportunities for improvement in complex case management.
    - Review documentation and coordination of health care for participants receiving services in institutional settings and investigate any potential infractions in the quality of care provided in these settings.
    - Ensure high levels of coordination and communication between specialists and primary care providers (PCPs).
    - Ensure high levels of coordination and communication between inpatient facilities, nursing facilities and PACE PCPs.
    - Review and analyze clinic medical records to ensure appropriate documentation and coding.
- **Ensure the safety of clinical care.**
    - Reduce potential risks to the health and safety of PACE participants through ongoing risk management.
    - Ensure that every member of the PACE staff organization has responsibility for risk assessment and management.
    - Monitor, report and perform a Root Cause Analysis on all participant-involved events resulting in a significant adverse outcome, for the purpose of identifying areas for quality improvement.
    - Monitor and track falls occurring in the PACE Day Center, in the home and within the community.
    - Meet or exceed community standards for credentialing of licensed providers.
    - Monitor staff and contractors to ensure that appropriate standards of health care are met.
- **Ensure appropriate access and availability.**
    - Monitor and analyze the PACE provider network continuously to ensure appropriate levels of access.
    - Monitor and analyze access to specialty health care.
    - Continue to develop the network of Alternative Care Setting (ACS) sites to ensure the program can provide services to all Orange County residents who qualify and are interested in joining PACE.

Organizational and Committee Structure

CalOptima Health Board of Directors provides oversight and direction to CalOptima Health PACE. The Board has the final authority to ensure that adequate resources are committed and that a culture is created that allows the QI Plan efforts to flourish. The Board, while maintaining ultimate authority, has delegated the duty of immediate oversight of the QI programs at CalOptima Health — including the CalOptima Health PACE QI Program — to the Board's Quality Assurance Committee (QAC), which performs the functions of CalOptima Health's Quality Improvement Committee (QIC) described in CalOptima Health's state and federal contracts, and to CalOptima's Chief Executive Officer who is responsible to allocate operational resources to fulfill quality objectives.

The QAC is a subcommittee of the Board and consists of currently active Board members. The QAC reviews the quality and utilization data that are discussed in the PQIC reports. The QAC provides progress reports, reviews the annual PACE QI Plan, and makes recommendations to the full Board regarding these items, which are ultimately approved by the Board.

PACE Quality Improvement Committee

Purpose
This committee provides oversight for the overall administrative and clinical operations of PACE and will meet, at a minimum, once a quarter. The PQIC will review all QI initiatives, review the results of monitoring activities, provide oversight for proposed changes to improve quality of service and review follow-up of all changes implemented. The PQIC may create Ad Hoc Focus Review Committees for limited time periods to address quality problems in any clinical or administrative process that have been identified as critical to participants, families, or staff. Potential areas for improvement will be identified through analysis of the data and through root cause analysis. This meeting will be chaired by the PACE Medical Director who will report on its activities to QIC, QAC, and the Board. The PACE Program Director or PACE QI Manager may facilitate the meeting in the PACE Medical Director's absence. The PACE Program Director or the PACE QI Manager may report up to the QAC if the PACE Medical Director is not available.

Membership
Membership shall be comprised of the PACE Medical Director, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI Manager, PACE QI Program Specialist(s), PACE Program Manager of Community-Based Programs and the PACE Intake/Enrollment Manager. At least four regular members shall constitute a quorum. The PACE Medical Director will act as the standing chair of the committee.

PACE Focused Review Committees

Purpose
These committees will be formed to respond to or to proactively address specific quality issues that rise to the level of warranting further study and action. Key performance elements are routinely reviewed by PACE staff as part of ongoing operations, including, but not limited to, deaths and other adverse outcomes, inpatient utilization and other clinical areas that indicate significant over/under utilization.

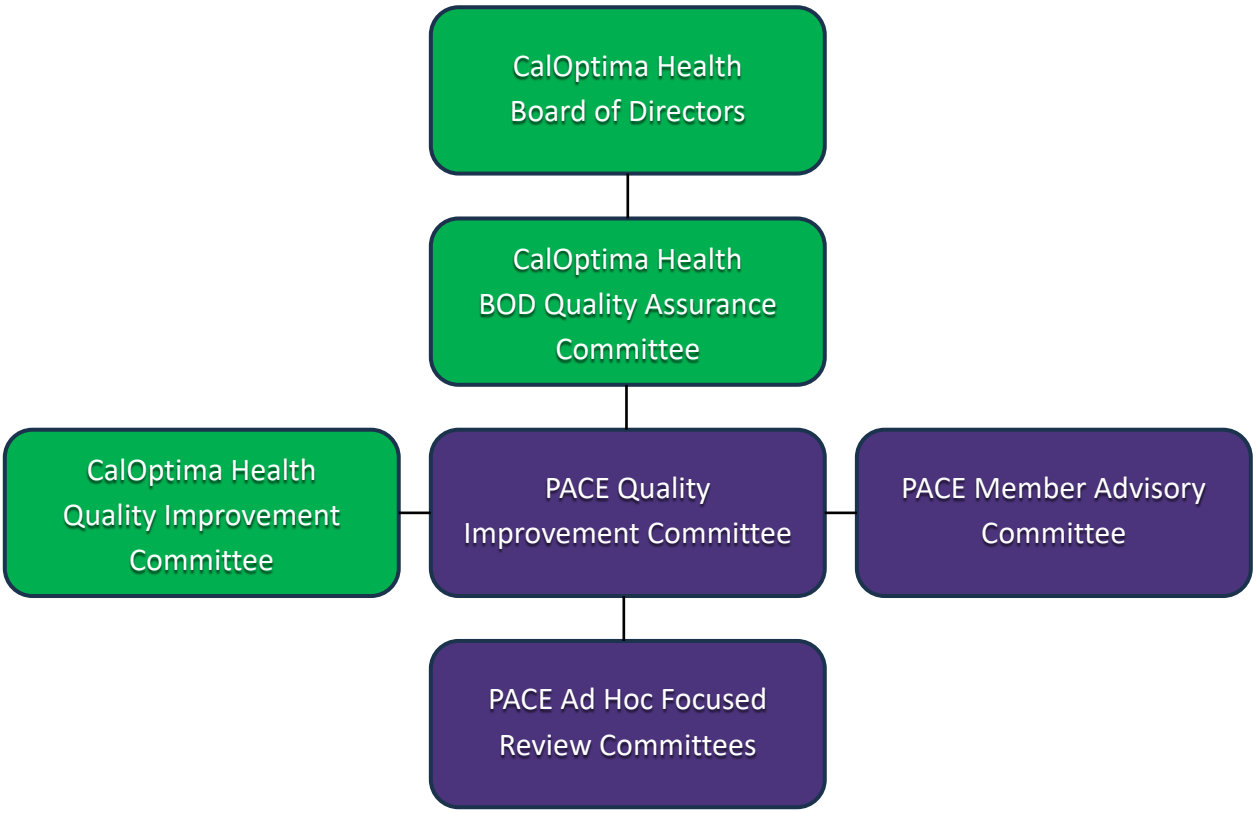
Membership
Membership will be flexible based on those with knowledge of the specific issues being addressed but will consist of at least four members to include at least two of the following positions and/or functions: PACE Medical Director, PACE QI Manager, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI Program Specialist(s), PACE Marketing and Enrollment Manager, PACE Program Manager of Community-Based Programs and/or direct care staff. The Committee will be chaired by the PACE Medical Director, PACE Clinical Medical Director, PACE Director, PACE Center Manager or PACE QI Manager. The chair will report on activities and results to the PQIC. The committee will meet on an ad hoc basis as needed to review those critical indicators assigned to them by the PQIC.

PACE Member Advisory Committee

Purpose
The PACE Member Advisory Committee (PMAC) provides recommendations to the Board on issues related to participant health care concerns that arise with participant care decisions and program operations from a community perspective. A member of the PMAC shall report its activities to QAC, which then will be reported to the Board. The PACE Program Director, PACE QI Manager, or the PACE Center Manager shall report its activities to the PQIC.

Membership
The PMAC is comprised of participants and/or their representatives and community representatives from which participants are referred. PMAC membership is open to all participants and/or caregivers and no application process is required. Information related to upcoming PMAC meetings is disseminated through announcements at the PACE Day Center floor and email/telephonic correspondence and all interested participants are invited to join. Participants and representatives of participants shall constitute a majority of membership. The committee will be comprised of at least seven members. At least four regular members shall constitute a quorum. The PACE Program Director will act as the standing chair and will facilitate the committee. The PACE Center Manager or PACE QI Manager may facilitate the meeting in the PACE Director's absence.

2026 Committee Organization Structure — Diagram



QUALITY AND PERFORMANCE IMPROVEMENT ACTIVITIES, OUTCOMES AND REPORTING

Quality Indicators and Opportunities for Improvement

Routine quality indicators appropriate to the PACE population are identified for analysis and trending. These indicators are related to the care and services provided at PACE. The indicators and opportunities for performance improvement are identified through:

Utilization of Services

- PACE will collect, analyze, and report any utilization data it deems necessary to evaluate both quality of health care and fiscal well-being of the organization including:
    - Hospital Bed Days
        - Exclusion criteria:
            - Participants who are hospitalized in long term acute care hospitals for >90 days.
    - ER Visits
    - 30-Day All-Cause Readmissions
        - Exclusion criteria:
            - Participants who are re-hospitalized within 30 days of discharge for

scheduled visits such as cancer treatment.

- Data analysis will allow for investigation into both overutilization and underutilization of resources to provide quality improvement and ensure the appropriate use of resources.

Participant and Caregiver Satisfaction

- PACE will survey program participants and their caregivers on at least an annual basis. Additionally, PACE will look for other opportunities for feedback to improve quality of services throughout the year. CalOptima Health PACE will attempt to surpass National Averages of other PACE programs for the following areas:
    - Transportation Satisfaction
    - Meal Satisfaction
    - Home Care Satisfaction
    - Overall Satisfaction
- The PMAC shall provide direct feedback on satisfaction to the PACE leadership staff.
- Grievance data is reviewed and analyzed quarterly for trends and opportunities for improvement.
- PACE will monitor the percentage of participants who disenroll from PACE within 3 months of enrollment *for controllable reasons*.
- PACE will monitor attrition rate to identify any need for operational improvement to strategically support continued growth in 2026.

Clinically Relevant Data- Quality Workplan Elements

- Clinical measures from the 2026 QI Work Plan elements which include:
    - Influenza Immunizations Rates
        - Exclusion criteria:
            - Participants who have dx of Palliative Care Approach, ICD-10 Z51.5
            - Participants with diagnosis of History of Guillain Barre, ICD-10: Z86.69
            - Participants who are allergic to Influenza vaccine
    - Pneumococcal Immunizations Rates
        - Exclusion criteria:
            - Participants who enroll in the program in December 2026
            - Participants who have dx of Palliative Care Approach, ICD-10 Z51.5
            - Participants who are allergic to Pneumococcal vaccine
    - Colon Cancer Screening
        - Inclusion criteria:
            - Participants enrolled for at least six months
        - Exclusion criteria
            - Participants who are 76 years and older as of December 31, 2026
            - Participants who have dx of Palliative Care Approach (ICD-10: Z51.5)
            - Participants who have a dx of Frailty (ICD-10: R54)
    - Breast Cancer Screening
        - Inclusion criteria:
            - Women enrolled for at least six months
        - Exclusion criteria
            - Participants who are 76 years and older as of December 31, 2026
            - Participants who have dx of Palliative Care Approach (ICD-10: Z51.5)

- Participants who have a dx of Frailty (ICD-10: R54)
- Participants with Hx of Breast Cancer dx who have had a double mastectomy

- Controlling High Blood Pressure
  - Inclusion criteria:
    - Participants with a dx of Hypertension (ICD-10: I.10) and/or Diabetes (multiple ICD.10 codes used).
    - Enrolled for at least six months
  - Exclusion criteria:
    - Participants who are 76 years and older as of December 31, 2026
    - Participants who have dx of Palliative Care Approach (ICD-10: Z51.5)
    - Participants who have a dx of Frailty (ICD-10: R54)
    - Participants with End Stage Renal Disease, noted as ESRD or STAGE 5 renal disease.
- Diabetes Care: Annual Eye Exams
  - Inclusion criteria:
    - Diagnosis of Diabetes Mellitus (multiple ICD.10 codes used).
    - Enrolled for at least six months
  - Exclusion criteria:
    - Participants who have dx of Palliative Care Approach, ICD-10 Z51.5
    - Participants who are 76 years and older as of December 31, 2026
    - Participants who are legally blind in both eyes.
    - Participants who had a normal eye exam in the past year.
- Diabetes Care: HbA1c Control for Diabetics
  - Inclusion criteria:
    - Diagnosis of Diabetes Mellitus (multiple ICD.10 codes used).
    - Enrolled for at least six months
  - Exclusion criteria:
    - Participants who are 76 years and older as of December 31, 2026
    - Participants who have dx of Palliative Care Approach (ICD-10 Z51.5)
    - Participants who have a dx of Frailty (ICD-10 code R54)
- Reduce Number of Falls Reported at PACE
  - Exclusion criteria:
    - Participants who have a fall in a hospital or skilled nursing facility (SNF).
    - Participants who report 4 or more falls in one quarter
- Medication Reconciliation within 7 calendar days post discharge from hospital or SNF.
- Access to Specialty Care services. Services scheduled within 7 calendar days of ordering.

Effectiveness and Safety of Staff-Provided and Contract-Provided Services

- This will be measured by participants' ability to achieve treatment goals as reviewed by the Interdisciplinary Team (IDT) with each reassessment, care plan update, and review of medical record documentation.
- All clinical and certain non-clinical positions (direct care) have competency profiles specific to their positions.

- Annual competency evaluations of PACE staff.
- PACE will monitor providers by methods such as review of providers' QI activities, medical record review, grievance investigations, observation of care and interviews.
- Unannounced visits to inpatient provider sites will be made by PACE staff, as necessary.
- Oversight of contracted Alternative Care Sites (ACS), assuring compliance to PACE regulations (including, but not limited to participant rights, infection control, emergency preparedness, staff competencies) as well as CalOptima Health guidelines (e.g. HIPAA, FWA, licensing, etc.).

Non-Clinical Areas

- The PACE PQIC has oversight of all services and activities offered by PACE.
- Member grievances will be forwarded to the PACE QI Department for investigation, tracking, trending, and data gathering. These results will be shared with the PACE Director and leadership for review and further direction regarding any corrective actions that may be implemented. Participants and caregivers will be informed of the results of the investigations and will be assisted with furtherment of the process as needed. Results will also be reported to PQIC for direction on how appropriate staff should implement any corrective actions.
- Member appeals for denied or partially denied service determination requests will be forwarded to the PACE QI Department for tracking, trending and data gathering and the PACE Director or PACE Medical Director for review. The case will then be forwarded to a third party with the appropriate licensure for review. The third-party reviewer’s decision shall be reviewed by the PACE QI manager and either the PACE Director or the PACE Medical Director. The results will be immediately shared with participant via telephone and/or written letter with information about additional rights to appeal, should the decision not be in the participant’s favor.
- Continued integration of telehealth to expand access to care.
- Increased utilization of Alternative Care Settings in 2026, including raising our goal from 10% to 12% of all eligible PACE Enrollees will utilize day center services at one of the PACE ACS sites by the end of 2026.
- Transportation services will continue to be monitored through monthly metrics and grievance trending. Complaints will be tracked and addressed via the Transportation Log. The monthly report generated by the transportation vendor will be reviewed at the monthly transportation leadership meeting and will be reported quarterly to the PQIC. The PACE Center Manager and other leadership staff will monitor transportation services with periodic ride-along. The times gathered during the ride-along will be compared against the data in the transportation reports to ensure accuracy.
- Meal quality will be monitored through participant satisfaction surveys, as well as comments solicited by the PMAC.
- Life safety will be monitored internally via quarterly fire drills and annual disaster preparedness training as well as regulatory agency inspections.
- Plans of correction on problems noted will be implemented by center staff, reviewed by the PACE Program Director, PACE Medical Director or the PACE QI Manager, and presented to the PQIC.
- The internal environment will be monitored through ongoing preventive maintenance of equipment and through repair of equipment or physical plant issues as they arise.

Priority Setting for Performance Improvement Initiatives

- Potential impact on quality of care, clinical outcomes, improved participant function and

improved participant quality of life.
- Potential impact on participant access to necessary care or services.
- Potential impact on participant safety.
- Participant, caregiver, or other customer satisfaction.
- Potential impact on efficiency and cost-effectiveness.
- Potential mitigation of high risk, high volume, or high frequency events.
- Relevance to the mission and values of PACE.

External Monitoring and Reporting

PACE will report both aggregate and individual-level data to CMS and DHCS to allow them to monitor PACE performance. This includes certain Unusual Quality Incidents, Health Outcomes Survey Modified (HOS-M) participation, and any other required reporting elements. Certain data elements are tracked in response to federal and state mandates and will be reported through the PACE monitoring module of Health Plan Management System (HPMS). The following data is reported to both CMS via HPMS and Department of Health Care Services (DHCS) via email, on a quarterly basis or more often as needed:

- Grievances
- Appeals
- Unusual Incidents
- Medication Errors
- Immunizations
- Enrollment Data
- Denials of Prospective Enrollees
- Falls without Injury
- ER Visits

Unusual Quality Incidents and Participant Monitoring

- When unusual incidents meet specified thresholds, PACE must notify CMS through HPMS and DHCS via email. PACE must complete a Root Cause Analysis (RCA) with the appropriate PACE IDT members and share the results with CMS and DHCS. The goal of this analysis is to identify any potential systems failures and improvement opportunities. CMS and DHCS may ask for further exposition and follow up for each individual quality incident case during the quarterly conference call with CalOptima Health PACE. Examples of Unusual Quality Incidents include:
    - Deaths related to suicide or homicide, unexpected and with active coroner investigation.
    - Falls that result in death, a fracture or an injury requiring hospitalization related directly to the fall.
    - Infectious disease outbreaks that meet the threshold of three or more cases linked to the same infectious agent within the same time frame, including COVID-19 infections.
    - Pressure injuries Stage 3, Stage 4, or Unstageable acquired while enrolled in PACE.
    - Elopement by cognitively impaired participants.
    - Adverse drug reactions.
    - Foodborne disease outbreak.
    - Burns 2nd degree or higher.
- Health Outcomes Survey-Modified (HOS-M)
    - PACE will participate in the annual Medicare HOS-M to assess the frailty of the of our

participant population. .

- Other external reporting requirements
    - Suspected elder abuse shall be reported to appropriate state agency.
    - Equipment failure or serious adverse reaction to any administered medications will be reported to the Food and Drug Administration (FDA).
    - Any infectious disease outbreak will be reported to the Centers for Disease Control and Prevention (CDC) and the Orange County Health Care Agency.

Corrective Action Plans (CAP)

- When opportunities for improvement are identified, a corrective plan will be created.
- Each CAP will include an explanation of the problem, the individual who is responsible for implementing the CAP, the time frame for each step of the plan, and an evaluation process to determine effectiveness.
- CAPs from contracted providers will be requested by the QI Manager or another member of the PQIC, as appropriate.

Urgent Corrective Measures

- Problems that are found to threaten the immediate health and safety of participants or staff will be reported immediately to the PACE Medical Director and the PACE Director.
- The QI Manager and/or QI Medical Case Manager will consult with relevant PACE staff and be responsible for developing an appropriate corrective plan within 24 hours of notification.
- Urgent corrective measures will be discussed during IDT morning meetings and, when appropriate, with participants.
- Disciplinary action and/or the use of appropriate community resources such as Adult Protective Services, notification and cooperation with law enforcement agencies, emergency placement of participants, etc. will be implemented immediately.

Re-Evaluation and Follow-Up

- Monitoring activities will be conducted to determine the effectiveness of plans of action. The timeliness of follow-up is dependent upon the following:
    - Severity of the problem
    - Frequency of occurrence
    - Impact of the problem on participant outcomes
    - Feasibility of implementation
- If follow-up shows the desired results have been achieved, the issue will be re-evaluated on a periodic basis to ensure continued improvement.
- If follow-up indicates that the desired results are not being achieved, then a more in-depth analysis of the problem and further determination of the source of variation are needed. A subcommittee of the PQIC or other workgroup may be established to address specific problems.
- All quality assessment and improvement steps and follow-up results will be shared with appropriate staff for discussion.

Quality Initiatives

- Quality Initiatives will be implemented as an adjunct to the PACE QI Plan. Quality Initiatives identify areas of improvement ultimately leading to enhanced clinical outcomes, appropriate

changes in systems and overall participant satisfaction. PACE Quality Initiatives specify expected outcomes, strategies, and measurable interventions to meet our goals. The status of each PACE Quality Initiative is presented to the PQIC on a quarterly basis. The program's quality initiatives for 2026 are:

- Advance Health Care Directive (AHCD)
  - This initiative will focus on increasing the number of PACE participants who have a completed Advance Health Care Directive in their medical chart. The PACE leadership team has created a plan to be implemented by the PACE Center Manager and the Social Work team, with a goal of ≥ 55% of participants having a completed AHCD by the end of 2026.
  - Exclusions:
    - Participants who have a capacity letter scanned into chart
- Dental Satisfaction Initiative
  - This initiative will focus on increasing participant satisfaction with contracted dental services, to provide participants with comprehensive education regarding the process for dental procedures with a focus on reduced pain and increased function. The PACE Enrollment Coordinators will highlight for new enrollees what dental services are provided (ex/routine cleanings) and what are not (ex/cosmetic dentistry). Clinic administrative staff will follow up each month with 5 randomly chosen participants who received dental services from a dental specialist to find any areas of dissatisfaction that can be addressed in a timely manner. The goal will be for PACE to have ≤ 1 dental related grievance per quarter in 2026.
- Transportation Satisfaction Initiative
  - Focuses on increasing the participant satisfaction with contracted transportation services, providing participants with timely resolutions to transportation related issues that are in transportation log.
  - PACE Center manager in conjunction with Secure transportation manager, and PACE Clinic Manager will review and resolve all complaints received by PACE participants regarding PACE transportation in a timely manner.
  - Goal is ≤ 3 valid transportation related grievance per quarter in 2026.

ANNUAL REVIEW OF PACE QI PLAN

- The PACE QI Plan will be assessed annually for effectiveness.
- Enhancements to the plan will be made through appropriate additions and revisions to the specific goals and objectives in the QI Work Plan.
- The Board will review and approve the PACE QI Plan and direct the PACE Medical Director to revise the QI Plan, as necessary and appropriate, to assure organizational oversight and commitment.

APPENDIX A (SEE ATTACHMENT)

2026 CalOptima PACE Quality Improvement (QI) Work Plan

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI26.01	**Improve the Quality of Care for Participants**	**2025 PACE QAPI Plan and Work Plan Annual Evaluation**	2025 PACE QAPI Plan will be evaluated by CalOptima Health Quality Assurance Committee in March 2026	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/19/2026	PACE Medical Director
QI26.02	**Improve the Quality of Care for Participants**	**2026 PACE QI Plan and Work Plan Annual Oversight**	PACE 2026 QI Plan and Work Plan will be updated, reviewed and approved by CalOptima Health Quality Assurance Committee in March 2026	PACE QAPI Plan and Work Plan will be approved and adopted on an annual basis	Annually	3/19/2026	PACE Medical Director
QI26.03	**Improve the Quality of Care for Participants**	**Influenza Immunization Rates**	≥90% of eligible participants will have their annual influenza vaccination by December 31st, 2026	Maintain compliance with influenza immunization recommendations (Exclusions defined within the 2026 PACE Quality Improvement Plan Description)	Q1, Q3 and Q4 2026	12/31/2026	PACE Medical Director
QI26.04	**Improve the Quality of Care for Participants**	**Pneumococcal Immunization Rates**	≥90% of eligible participants will have completed their pneumococcal vaccination by December 31st, 2026	Maintain compliance with pneumococcal immunization recommendations (Exclusions defined within the 2026 PACE Quality Improvement Plan Description)	Quarterly	12/31/2026	PACE Medical Director
QI26.05	**Improve Quality of Care for Participants**	**Colorectal Cancer Screening**	>69.66% of eligible participants will have had a screening for colorectal cancer by December 31st, 2026 (Comparable to the 2024 MEDICARE Quality Compass HEDIS 50th percentile)	Improve compliance with colorectal cancer screening recommendations for older adults by tracking the percentage of colonoscopies and/or FIT tests completed for our participants (Exclusions defined within the 2026 PACE Quality Improvement Plan Description)	Quarterly	12/31/2026	PACE Medical Director
QI26.06	**Improve Quality of Care for Participants**	**Breast Cancer Screening**	>83.60% of eligible participants will have a screening for breast cancer by December 31st, 2026 (Comparable to the 2024 MEDICARE Quality Compass HEDIS 90th percentile)	Improve compliance with breast cancer screening recommendations for older adults by tracking the percentage of mammograms completed for our participants (Exclusions defined within the 2026 PACE Quality Improvement Plan Description)	Quarterly	12/31/2026	PACE Medical Director
QI26.07	**Improve the Quality of Care for Participants**	**Controlling High Blood Pressure**	>87.21% of participants with Hypertension *and/or* Diabetes will have their blood pressure controlled (Comparable to the 2024 MEDICARE Quality Compass HEDIS 90th percentile)	PACE participants with hypertension and/or diabetes will have their blood pressure regularly monitored and adequately controlled, as defined by readings of <140/90 mmHG. (Exclusions defined within the 2026 PACE Quality Improvement Plan Description)	Quarterly	12/31/2026	PACE Medical Director
QI26.08	**Improve the Quality of Care for Participants**	**Diabetic Eye Care**	>89.04% of Diabetic participants will have an Annual Eye Exam (Comparable to the 2024 MEDICARE Quality Compass HEDIS 95th percentile)	PACE participants with diabetes will be monitored by their Primary Care Providers to ensure they maintain healthy vision through annual examination by eye doctor (Exclusions defined within the 2026 PACE Quality Improvement Plan Description)	Quarterly	12/31/2026	PACE Medical Director
QI26.09	**Improve the Quality of Care for Participants**	**Diabetic Blood Sugar Control**	<12.50% of Diabetic participants will have an HbA1c measurement of >9% (Comparable to the 2024 MEDICARE Quality Compass HEDIS 66th percentile)	PACE participants with diabetes will be monitored by their Primary Care Providers to ensure they maintain blood sugar control as measured by HbA1c lab work (Exclusions defined within the 2026 PACE Quality Improvement Plan Description)	Quarterly	12/31/2026	PACE Medical Director

Back to Agenda

Back to Item

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI26.10	Ensure the Safety of Participants	Reduce Percentage of Falls Reported by PACE Enrollees	Reduce the number of falls sustained by PACE enrollees to ≤150 falls per 1000 participants	The PACE Center manager will work with the Rehabilitation Department to review all participants who have repeated falls within each quarter. Participants who have repeated falls will have a documented home assessment and follow up completed by PACE to reduce total number of falls. (Exclusions defined within the 2026 PACE Quality Improvement Plan Description)	Quarterly	12/31/2026	PACE Center Manager
QI26.11	Improve the Quality of Care for Participants	Medication Reconciliation Post Discharge (MRP)	≥93% of participants will have their medications reconciled within 7 calendar days of hospital and/or skilled nursing facility discharge in 2026	The PACE QI Department will work with the PACE Clinic, Pharmacist and Providers to ensure that participant medications are reviewed in a timely matter after discharge.	Quarterly	12/31/2026	PACE Pharmacist and PACE Clinical Operations Manager
QI26.12	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	100% of specialty care authorizations will be scheduled within 7 calendar days in 2026	Appointments for specialty care will be scheduled within 7 calendar days after ordering to improve access to specialty care	Quarterly	12/31/2026	PACE Clinical Operations Manager
QI26.13	Ensure Appropriate Access and Availability	Improve Utilization of PACE Alternative Care Settings (ACS)	≥12% of all eligible PACE Enrollees will utilize day center services at one of the PACE Alternative Care Settings by end of 2026.	Eligible participants will be scheduled for day center services to be provided by one of our contracted ACS (Exclusions defined within the 2026 PACE Quality Improvement Plan Description)	Quarterly	12/31/2026	PACE Center Manager and PACE Program Manager for Community Based Services
QI26.14	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	<2,800hospital days per 1000 per year	PACE participants hospital days will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education (Exclusions defined within the 2026 PACE Quality Improvement Plan Description)	Quarterly	12/31/2026	PACE Medical Director
QI26.15	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	<820 emergency room visits per 1000 per year	ER utilization by PACE participants will be monitored and analyzed by the PACE QI department who will work with the PACE interdisciplinary and clinical teams to develop strategies to lower that rate through preventative care and education	Quarterly	12/31/2026	PACE Medical Director
QI26.16	Ensure Appropriate Use of Resources	30-Day All Cause Readmission Rates	<20% 30-day all cause readmission	30-day all cause readmission rates for hospitalized PACE participants will be monitored and analyzed by the PACE QI department who will work with PACE interdisciplinary and clinical teams to find opportunities for quality improvement (Exclusions defined within the 2026 PACE Quality Improvement Plan Description)	Quarterly	12/31/2026	PACE Medical Director
QI26.17	Improve Participant Experience	Enrollment/Disenrollment	80% of participants will be enrolled into the PACE program in ≤45 days from their initial inquiry.	Time from first contact with prospective participant until enrollment will be monitored. Strategies for reducing time to enrollment defined within the 2026 Quality Improvement Plan Description.	Quarterly	12/31/2026	PACE Marketing and Enrollment Manager
QI26.18	Improve Participant Experience	Enrollment/Disenrollment	The percentage of participants who disenroll for controllable reasons from the PACE program within the first 3 months of enrollment will be less than 6%	Review and analyze the participants who disenrolled from PACE within 3 months of enrollment (for controllable reasons) to develop continued strategies for improvement	Quarterly	12/31/2026	PACE Marketing and Enrollment Manager and PACE Center Manager

Back to Agenda

Back to Item

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI26.19	Improve Participant Experience	Enrollment/Disenrollment	Maintain a PACE participant attrition rate of ≤8%	PACE will create focus groups to identify areas that need operational improvement to strategically support growth in 2026.	Quarterly	12/31/2026	PACE Center Manager and PACE Director
QI26.20	Improve Participant Experience	Transportation Performance	100% of transportation trips will be less than 60 minutes in 2026	Ensure all PACE participants are on the vehicle for less than 60 minutes per trip. Monitor and analyze one-hour violations, define areas for improvement and implement interventions to maintain compliance with regulation	Quarterly	12/31/2026	PACE Center Manager
QI26.21	Improve Participant Experience	Transportation Performance	≥92% of all transportation rides will be on-time in 2026	Review and analyze transportation records to track transportation rides with a scheduled and actual trip time of +/- 15 minutes.	Quarterly	12/31/2026	PACE Center Manager
QI26.22	Improve Participant Experience	Participant Satisfaction with Transportation	≥93.2% Satisfaction with Transportation Services (2025 PACE National Average) on the 2026 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve participant satisfaction with the PACE Transportation program	Annually	12/31/2026	PACE Center Manager and PACE Director
QI26.23	Improve Participant Experience	Participant Satisfaction with Meals	≥73.6% Satisfaction with Meals (2025 PACE National Average) on the 2026 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve the participant satisfaction with the meals within the PACE program.	Annually	12/31/2026	PACE Center Manager and PACE Director
QI26.24	Improve Participant Experience	Participant Satisfaction with Home Care	≥85.7% Satisfaction with Home Care Service (2025 PACE National Average) on the 2026 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve participant satisfaction with home care at the PACE program	Annually	12/31/2026	PACE Center Manager and PACE Director
QI26.25	Improve Participant Experience	Overall Participant Satisfaction	≥87.9% on the Overall Satisfaction-Weighted Average (2025 PACE National Average) on the 2026 PACE Satisfaction Survey	Review and analyze the annual satisfaction survey results, define areas for improvement and implement interventions to improve overall participant satisfaction with the PACE program	Annually	12/31/2026	PACE Center Manager and PACE Director

Back to Agenda

Back to Item

2025 PACE Quality Work Plan Evaluation and 2026 Proposed Quality Work Plan

CalOptima Health Board of Directors

Quality Assurance Committee

March 19, 2026

Donna Frisch, MD, PACE Medical Director

Monica Macias-Garcia, PACE Director

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

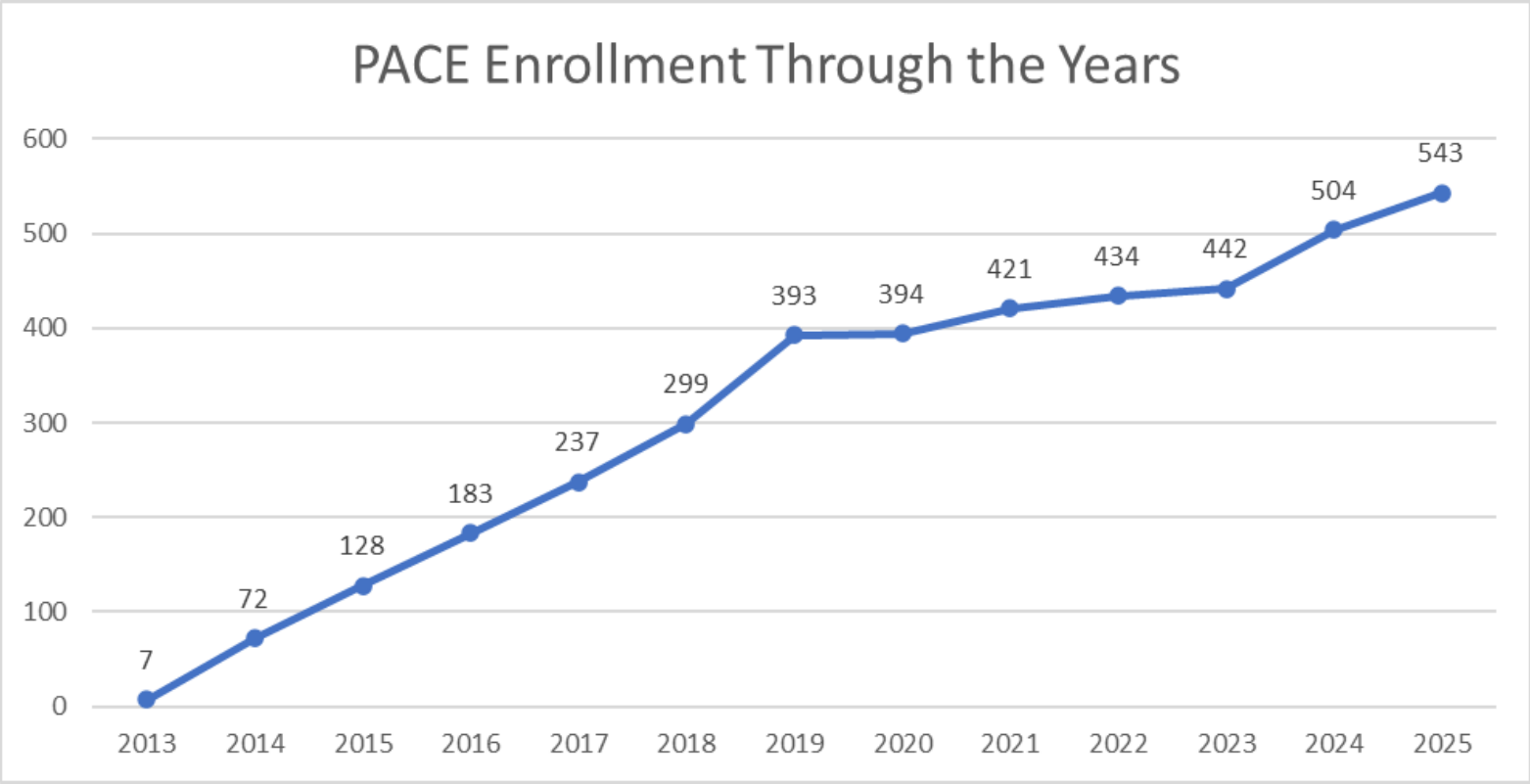
Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

2025 PACE Quality Work Plan Evaluation and 2026 Work Plan- Non-Clinical Elements

Monica Macias-Garcia, PACE Director

CalOptima Health PACE Membership Growth 2013-2025



2025 saw PACE's highest number of active enrollees since opening in 2013. We reached a landmark number of 543 PACE enrollees by December 31st 2025.

CalOptima Health

2025 Participant Satisfaction Survey

Domain	2024 Reporting Period	2025 Reporting Period
Transportation	90%	94%
Center Aides	98%	98%
Home Care	83%	88%
Medical Care	93%	95%
Health Care Specialist	91%	94%
Behavioral Wellness	95%	98%
Telehealth	90%	90%
Social Worker	96%	98%
Meals	79%	80%
Rehabilitation Therapy and Exercise	92%	99%
Recreational Therapy	86%	88%
General Service Delivery	93%	94%
Overall Satisfaction*	**90%**	**93%**

- Met or surpassed 2024 satisfaction percentages in all measures
- Surpassed ALL quality work plan satisfaction goals in 2025

CalOptima Health

2025 Overall Satisfaction in Comparison to other California PACE Programs

Overall Satisfaction	National Average	CalPACE 2024	CalPACE 2025	CalOptima Health PACE 2024	CalOptima Health PACE 2025	Organization 1	Organization 2	Organization 3	Organization 4	Organization 5	Organization 6	Organization 7	Organization 8	Organization 9	Organization 10	Organization 11	Organization 12	Organization 13	Organization 14	Organization 15	Organization 16	Organization 17	Organization 18	Organization 19	Organization 20	Organization 21	Organization 22	Organization 23	Organization 24	Organization 25	Organization 26	Organization 27
Do you feel the services provided by [center name] meet your needs?	87.1%	90%	89%	90%	96%	88%	94%	94%	87%	86%	80%	100%	93%	88%	74%	88%	93%	97%	93%	83%	98%	88%	94%	80%	97%	90%	85%	92%	100%	87%	85%	84%
Do you look forward to the services offered by [center name]?	88.7%	92%	93%	93%	98%	86%	97%	100%	92%	95%	91%	100%	90%	87%	81%	94%	98%	94%	96%	85%	96%	94%	93%	91%	98%	85%	89%	95%	100%	90%	91%	90%
Do the services you receive from [center name] help you improve or maintain your quality of life?	91.0%	93%	93%	92%	99%	90%	96%	98%	93%	89%	92%	100%	94%	94%	86%	91%	100%	97%	93%	89%	98%	96%	98%	81%	99%	95%	94%	97%	100%	92%	93%	90%
Would you recommend [center name] to a close friend or relative in need of this kind of care?	89.7%	92%	92%	89%	97%	88%	93%	98%	92%	93%	93%	100%	94%	87%	87%	92%	89%	95%	93%	86%	98%	91%	92%	93%	97%	85%	92%	98%	100%	94%	88%	88%
Was the decision to enroll in [center name] the right decision for you?	96.4%	N/A	97%	N/A	99%	96%	N/A	98%	97%	99%	99%	100%	96%	98%	94%	92%	98%	98%	97%	93%	100%	92%	100%	100%	100%	97%	96%	98%	100%	97%	98%	96%
Overall, would you rate the care you receive from [center name] as:	93.4%	95%	94%	91%	97%	96%	96%	100%	93%	92%	94%	100%	95%	93%	91%	94%	98%	95%	94%	88%	98%	96%	99%	91%	98%	90%	96%	97%	100%	96%	93%	92%
How likely would you be to recommend [center name] to a friend or family member?	58	62	68	72	83	70	79	64	54	64	63	88	72	66	52	69	69	74	65	51	89	72	82	69	68	60	75	85	84	69	62	61
Overall Satisfaction Score*	87.9%	88%	89%	90%	93%	89%	91%	96%	88%	85%	85%	98%	91%	92%	83%	89%	99%	93%	91%	89%	93%	91%	93%	84%	91%	93%	89%	89%	95%	88%	86%	87%

- In 2025, the National Average Overall Satisfaction Score was 87.9%- we beat score by **5.1%**
- In 2025, the CalPACE Overall Satisfaction Score was 89%- we beat score by **4%**
- In 2025, Out of the 27 other California PACE centers, 4 had higher scores, 4 had tie scores and 19 had lower overall scores than CalOptima Health PACE

PACE CalOptima Health

2026 PACE (QI) Work Plan Elements Changes

- In 2026, some of the PACE Quality Workplan Elements have had changes to their timeframes for data collection, goals, or exclusions
- Complete descriptions of each element with discussion of these changes are available for review in the 2025 PACE Quality Workplan Review and the 2026 PACE Quality Improvement Plan Description

CalOptima Health

2026 PACE (QI) Work Plan Elements

- **Improved Elements- Operational**
  - The following operational elements' objectives have been updated to align with PACE growth and retention needs
    - *Improve Utilization of PACE Alternative Care Settings (ACS)*
      - *Increase goal from 10% utilization to 12%*
    - *Expediency in enrollment process*
      - *Increase percentage of participants who are enrolled into the PACE program ≤45 days from their initial inquiry.*
    - *Satisfaction with PACE services*
      - *Satisfaction goals increased for the following areas:*
        - *Transportation*
        - *Meals*
        - *Home Care*
        - *Overall Satisfaction*

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2026 PACE Quality Initiatives

- **Advance Health Care Directive**
  - The goal for 2026 is ≥ 55% of participants will have a completed AHCD by the end 2026. Center Manager and Social Work Supervisor have developed new strategies to meet this initiative in 2026, focusing on new program enrollees
- **Dental Satisfaction**
  - The goal for 2026 is ≤ 1 dental related grievance per quarter in 2026. Focus on provide participants with comprehensive education regarding the process for dental procedures. Clinic administrative staff completes 5 randomly chosen participants who received dental services to find any areas of dissatisfaction that can be addressed in a timely manner.

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2026 PACE Quality Initiatives

- **Transportation Satisfaction**
  - The goal for 2026 is ≤ 3 valid transportation related grievance per quarter in 2026. Focused on provide participants with timely resolutions to transportation related issues that are in transportation log.
  - PACE Center manager in conjunction with Secure transportation manager, PACE Clinic Manager, and Qi Manager review and resolve all complaints received by PACE participants regarding PACE transportation in a timely manner.

2025 PACE Quality Work Plan Evaluation and 2026 Work Plan- Clinical Elements

Donna Frisch, MD, PACE Medical Director

2025 PACE Clinical Accomplishments

- 84% Influenza immunization by Q4 2025
- 93% Pneumococcal immunization by Q4 2025
- 94.2% of participants with diabetes completed an annual eye exam
- Met established goals for controlling blood pressure in our participants with hypertension and/or diabetes
- Met establish goals for lowering HbA1c in our diabetic participants

CalOptima Health

2025 Workplan Element: Breast Cancer Screening

Goal: > 82.80% of qualifying participants will have a screening for breast cancer (Comparable to the 2023 MEDICARE Quality Compass HEDIS 90th percentile)

Higher Is Better		**Medicare Quality Compass 2023 HEDIS Percentiles**			
Domain	**2025 PACE Rate**	50th Percentile	67th Percentile	75th Percentile	**90th Percentile (PACE Goal)**
Breast Cancer Screening	**84%**	71.88%	75.65%	78.57%	**82.80%**

2026 PACE (QI) Work Plan Elements

- **Removed Elements**
  - *Osteoporosis Monitoring*
    - This goal was consistently met for the past several years. PACE PCPs will continue to ensure appropriate screening
  - *Monitoring of Risks from High Dosage Opioid Use*
    - Over the past few years PACE has only had an average of **one** participant on high ~~does~~ dose opioids. PCPs and pharmacy team will continue to monitor
  - Long Term Custodial Care
    - PACE's goal is to keep participants safe in their homes, and need for custodial care is rare. Will continue to monitor and report LTC use monthly to CalOptima accounting dept
  - *COVID-19 Immunization Rates*
    - This element will continue to be monitored regularly and vaccines offered as recommended

Rev. 3/19/26

CalOptima Health

2026 PACE (QI) Work Plan Elements

- **Improved Elements- Clinical**
  - The following clinical elements' objectives have all been updated to align with the most recent Medicare Quality Compass HEDIS goals:
    - *Colorectal Cancer Screening*
    - *Breast Cancer Screening*
    - *Controlling High Blood Pressure*
    - *Diabetic Eye Care*
    - *Diabetic Blood Sugar Control*
  - In each of these areas we have looked to improve upon our previous goals by raising percentages in 2026

Recommended Action

- Recommend approval of the 2025 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Improvement Plan Evaluation
- Recommend approval of the 2026 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Improvement Plan Description

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CalOptima Health Board Action Agenda Referral

Action To Be Taken March 19, 2026
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

7. Recommend that the Board of Directors Approve the Modifications to Quality Improvement Policies

Contacts

Richard Lopez, M.D., Medical Director, Medical Management, 657-900-1483
Linda Lee, MPH, Executive Director, Quality Improvement, 657-900-1069

Recommended Actions

Recommend that the Board of Directors approve modifications to the following CalOptima Health policies pursuant to Covered California requirements:

- GG.1650: Credentialing and Recredentialing of Practitioners; and
- GG.1651: Assessment and Re-Assessment of Organizational Providers.

Background

CalOptima Health regularly reviews its policies to ensure they are up to date and aligned with federal and state health care program requirements, regulatory and contractual obligations, as well as CalOptima Health operations.

Discussion

Below are the existing Quality Improvement policies and a summary of the modifications:

- ***GG.1650: Credentialing and Recredentialing of Practitioners [Covered California (Effective 2027), Medi-Cal, OneCare, PACE]*** describes the process by which CalOptima Health evaluates and determines whether to approve or decline practitioners for participation in CalOptima Health programs. CalOptima Health staff revised this policy pursuant to CalOptima Health's requirements for the Covered California line of business, and the revisions include the following:
    - Adding verbiage throughout the entire policy to comply with National Committee for Quality Assurance (NCQA), Department of Managed Health Care (DMHC), and Centers for Medicare & Medicaid Services (CMS) regulations and standards.
    - Adopting the credentialing and recredentialing conducted by Federally Qualified Health Center (FQHC) Look-Alike clinics.
    - Adopting timelines for notification to practitioners of receipt of a complete credentialing application, credentialing decisions for said practitioner, and when exceptions apply to the requirement.
    - Adopting the use of the Council for Affordable Quality Health credentialing form and processes for credentialing and recredentialing.

Back to Agenda

- ***GG.1651: Assessment and Reassessment of Organizational Providers [Covered California (Effective 2027), Medi-Cal, OneCare, PACE]*** describes the process by which CalOptima Health evaluates and determines whether to approve or decline organizational providers (OPs) for participation in CalOptima Health programs. CalOptima Health staff revised this policy pursuant to CalOptima Health's requirements for Covered California, and revisions include the following:
    - Adding verbiage throughout the entire policy to comply with NCQA, DMHC, and CMS regulations and standards.
    - Adopting the credentialing and recredentialing conducted by FQHC Look-Alike clinics for OPs.
    - Adopting timelines for notification to OPs of receipt of a complete credentialing application, credentialing decisions for said OP, and when exceptions apply to this requirement.

Fiscal Impact

The recommended action to modify CalOptima Health Policies GG.1650 and GG.1651 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2025-26 Operating Budget.

Rationale for Recommendation

The recommended action will ensure CalOptima Health is compliant with contractual and regulatory guidance provided by its regulators (*e.g.*, Department of Health Care Services, CMS, and DMHC). The updated policies will supersede the prior versions.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. GG.1650: Credentialing and Recredentialing of Practitioners Final Policy Packet
2. GG.1651: Assessment and Reassessment of Organizational Providers Final Policy Packet

/s/ Michael Hunn *03/12/2026*
Authorized Signature **Date**

Back to Agenda

Policy:	GG.1650
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Quality Improvement
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	04/01/2026
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 20260319 QAC Review Only

I. PURPOSE

This policy defines the process by which CalOptima Health evaluates and determines whether practitioners meet the qualifications for participation in CalOptima Health programs.

II. POLICY

A. CalOptima Health shall establish guidelines by which CalOptima Health shall evaluate and select practitioners to participate in CalOptima Health, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima Health may delegate its authority to perform Medi-Cal screening and enrollment activities to a Delegate. If CalOptima Health chooses to delegate this function, the following shall occur:

1. The delegation must be in a written subcontract or agreement, where CalOptima Health remains contractually responsible for the completeness and accuracy of the screening and enrollment activities.

2. CalOptima Health shall evaluate the Delegate's ability to perform these activities, including an initial review to ensure that the Delegate has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

3. CalOptima Health shall continuously monitor, evaluate, and approve the delegated functions.

4. CalOptima Health shall notify the Department of Health Care Services (DHCS) sixty (60) calendar days prior to delegating the screening and enrollment to a Delegate and shall submit policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

C. CalOptima Health may delegate Credentialing and Recredentialing activities to a Delegate, including Health Networks or a Credentialing Verification Organization (CVO), in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

Back to Agenda Back to Item

1. Delegates shall perform functions that, at minimum, meet the requirements as outlined in this policy.

2. CalOptima Health may accept evidence of NCQA Provider Organization Certification in lieu of a monitoring site visit of delegated physician organization.

D. The Chief Medical Officer (CMO) or Designee shall have direct responsibility over and actively participate in the Credentialing program. The responsibilities include, but are not limited to, chairing the Credentialing and Peer Review Committee (CPRC), reviewing and approving practitioner files, and ensuring Credentialing policies are adhered to.

E. CalOptima Health's CPRC shall be responsible for reviewing a practitioner's Credentialing information and determining such practitioner's participation in CalOptima Health~~.~~, consistent with DHCS, National Committee for Quality Assurance (NCQA), and Department of Managed Health Care (DMHC), and Centers for Medicare and Medicaid (CMS) regulations and standards.

F. CalOptima Health and its Delegates shall ensure that any practitioner in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS is screened and enrolled with DHCS in the Medi-Cal Program in accordance with DHCS All Plan Letter (APL) 22-013: Provider Credentialing/Re-credentialing and Screening /Enrollment, including any superseding APL, and Title 42, CFR, Part 455.

1. State-level enrollment pathways are available either through the DHCS' Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway.

2. CalOptima Health may enroll providers through the screening and enrollment process outlined in Section III.G, in compliance with DHCS requirements, or CalOptima Health may direct network providers to enroll through a state-level enrollment pathway.

3. Practitioners that do not have a state level enrollment pathway do not need to be enrolled in Medi-Cal but must comply with CalOptima Health's vetting process.

G. CalOptima Health and its Delegates may allow practitioners in its Medi-Cal provider network to participate in the network for up to one hundred twenty (120) calendar days if the practitioner has a pending enrollment application in review with DHCS' PED or a DHCS approved screening and enrollment process.

1. CalOptima Health and its Delegates shall terminate its contract with the practitioner no later than fifteen (15) calendar days of the practitioner receiving notification from DHCS that the practitioner has been denied enrollment of the Medi-Cal program, or upon the expiration of the first one hundred twenty (120) calendar day period.

2. CalOptima Health and its Delegates shall not continue to contract with a practitioner during the period in which the practitioner resubmits its enrollment application to DHCS or approved screening and enrollment process and shall only re-initiate a contract upon the practitioner's successful enrollment as a Medi-Cal practitioner.

3. If the practitioner termination impacts Member access, CalOptima Health shall notify DHCS prior to terminating the practitioner and shall submit a plan of action for continuity of services for review and approval before the termination.

For 2026.2.19 QAC Review Only

Back to Agenda Back to Item

H. CalOptima Health and its Delegates shall credential, prior to services being rendered, and recredential all contracted practitioners that render services to Members and are:

1. Licensed, certified, or registered by the state of California to practice independently (without direction or supervision);

   a. CalOptima Health shall not require the licensure of a health professional employed by a tribal health program under the state or local law where the Tribal Health Program is located, if the professional is licensed in another state, in accordance with 25 United States Code (USC) § 1621t.

   b. CalOptima Health and ~~Delegated~~its Delegates shall allow out-of-state licensed psychologists, clinical social workers, marriage and family therapists, or professional clinical counselors to provide Specialty Mental Health Services (SMHS) or mental health services under the Medi-Cal program with an approved Professional Licensing Waiver (PLW) from DHCS.

2. Contracted with CalOptima Health to provide care under CalOptima Health's programs (including those practitioners who render care in contracted Federally Qualified Health Centers (FQHC) and community clinics that perform Primary Care and Specialty Care services);

3. In an independent relationship with CalOptima Health;

   a. An independent relationship exists when the CalOptima Health directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as a primary care practitioner; and

4. Providing care to Members under CalOptima Health's programs.

I. CalOptima Health and its Delegates shall credential and recredential all contracted practitioners that render services to Members in the following settings:

1. Individual or group practices;

2. Locum Tenens:

   a. CalOptima Health shall provisionally credential the practitioner if the locum tenens works less than sixty (60) calendar days.

   b. CalOptima Health shall fully credential the practitioner if the locum tenens works sixty (60) calendar days or more.

3. Facilities;

4. Telemedicine/telehealth (i.e., virtual care visit); or

5. Rental and preferred provider organization networks.

J. CalOptima Health and its Delegates shall credential and recredential the following practitioners including, but not limited to:

1. Medical Doctor (MD);

For 20260319 QAC Review Only

Back to Agenda Back to Item

2. Doctor of Osteopathy (DO);

3. Doctor of Chiropractic Medicine (DC);

4. Doctor of Dental Surgery (DDS);

5. Doctor of Podiatric Medicine (DPM);

6. Nurse Practitioners (NP); and

7. Other medical practitioners who may be within the scope of Credentialing (e.g., Physician Assistant)

    a. Behavioral health practitioners, including but not limited to:

        i. Psychiatrists and other physicians

        ii. Addiction medicine specialists

        iii. Doctoral or master's level psychologists

        iv. Master's-level clinical social workers

        v. Master's-level clinical nurse specialists or psychiatric nurse practitioners

        vi. Other behavioral healthcare specialists who may be within the scope of credentialing (e.g., licensed professional counselors, qualified autism services (QAS) providers also known as applied behavior analysis providers)

K. CalOptima Health and its Delegates shall credential and recredential Non-Physician Medical Practitioners (NMP) who meet license and state board requirements for the scope of their practice and who do not have an independent relationship with CalOptima Health.

1. Credentialed and recredentialed NMPs include:

    a. NMPs who provide services under the supervision of a practicing, licensed, and credentialed Physician Practitioner and have executed a signed agreement as required by the applicable state of California board with the NMP;

        i. Physician supervision is not required for services rendered by certain classes of Nurse Practitioners (NPs) pursuant to California Business Professional Code (BPC) §§ 2837.103 and 2837.104;

    b. NMPs who provide services as part of an Organized Health Care System that is credentialed with CalOptima Health and have a signed agreement as required by the applicable state of California board between the NMP and the Organized Health Care System; or

    c. NMPs who are not Physician Assistants (PAs) and who provide services under the employment agreement of a credentialed Physician Practitioner.

2. An NMP shall notify CalOptima Health immediately if the supervising Physician Practitioner no longer meets the CalOptima Health Credentialing requirements, or if there is a change in the

For 20260319 QAC Review Only

Back to Agenda Back to Item

supervising Physician Practitioner, or NMP's employment with the entity or Organized Health System.

L. For practitioners in the Medi-Cal provider network not required to be credentialed and/or who do not have a corresponding state-level enrollment pathway, CalOptima Health shall at minimum verify the qualifications and vet the practitioner for the following:

1. Sufficient experience to provide services similar to the services for which they are contracted to provide within the service area;

2. Business licensing that meets industry standards, if applicable;

3. No history of Fraud, Waste, and/or abuse;

4. No recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

5. No history of liability claims against the practitioner.

M. CalOptima Health does not credential or recredential:

1. Practitioners who practice exclusively within the inpatient setting (*e.g.*, hospitalists) and provide care for a Member only as a result of the Member being directed to the hospital or inpatient setting.

2. Practitioners who practice exclusively within freestanding facilities and provide care for a Member only as a result of the Member being directed to the facility (*e.g.*, diagnostic radiologists, urgent care, emergency medicine).

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima Health delegates Utilization Management functions (Credentialing of pharmacies and their professional and technical staff shall be conducted by the PBM, in accordance with CalOptima Health Policy ~~GG.1406~~MA.5012: Pharmacy Network Credentialing and Access).

4. Covering practitioners who do not have an independent relationship with CalOptima Health.

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., external physician reviewer).

6. Health care professionals who are permitted to furnish services only under the direct supervision of another practitioner.

7. Students, residents, and fellows, where applicable.

8. Rental network practitioners who provide out-of-area care only, and Members are not required or given an incentive to seek care from them.

9. Health care professionals who are permitted to furnish services as part of a letter of agreement (LOA) or a continuity of care arrangement.

N. CalOptima Health adopts the Credentialing and Recredentialing conducted by Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes and does not credential or recredential practitioners

For 20260319 QAC Review Only

who practice exclusively within a FQHC or FQHC Look-Alikes and who provide care for a Member only as a result of the Member being directed to the FQHC or FQHC Look-Alikes.

O. CalOptima Health and its Delegates shall recredential a practitioner at least every three (3) years, utilizing a thirty-six (36) month cycle to the month, not to the day.

P. CalOptima Health and its Delegates shall ensure that all practitioners maintain current California licensure and shall monitor various state and federal boards, agencies, and databanks for adverse activities in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

Q. CalOptima Health and its Delegates shall notify the practitioner, in writing, of the Credentialing or Recredentialing decision within thirty (30) calendar days of the date of the approval or denial of the application.

~~R.~~

~~S.~~R. CalOptima Health and its Delegates shall not discriminate against any practitioner during the Credentialing and Recredentialing process.

1. CalOptima Health and its Delegates shall not discriminate, in terms of participation, reimbursement, or indemnification, against any practitioner who is acting within the scope of their license, certification, or registration under federal and state law, solely on the basis of the license, or certification. This prohibition shall not preclude CalOptima Health from:

   a. Refusing to grant participation to a practitioner in excess of the number necessary to meet the needs of Members;

   b. Using different reimbursement amounts for different specialties, or for different practitioners in the same specialty; and

   c. Implementing measures designed to maintain quality and control costs consistent with CalOptima Health's responsibilities.

2. CalOptima Health and its Delegates shall not discriminate against a practitioner that serves high-risk populations or specializes in the treatment of costly conditions.

3. CalOptima Health and its Delegates shall not base Credentialing and Recredentialing decisions on a practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient's insurance coverage, in which the practitioner specializes.

~~T.~~S. CalOptima Health and its Delegates shall maintain the confidentiality of Credentialing and Recredentialing files, in accordance with CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information.

~~U.~~T. CalOptima Health and its Delegates shall ensure that information collected on the application is no more than six (6) months old from the date of the final decision made by the respective Credentialing committee.

1. CalOptima Health and its Delegates shall notify the Covered California practitioner within ten (10) business days to verify receipt and inform the applicant whether the application is complete.

2. CalOptima Health and its Delegates shall notify the Medi-Cal, OneCare, or PACE practitioner within thirty (30) calendar days to verify receipt and inform the applicant whether the application is complete

For 20260319 QAC Review Only

~~1.~~3. If CalOptima Health or a Delegate is unable to render a decision within six (6) months, the application shall be considered expired, and Credentialing will re-initialize.

U. Except as provided in CalOptima Health Policy GG.1608: Full Scope Site Reviews, CalOptima Health does not delegate the Facility Site Review (FSR) and Medical Record Review (MRR) processes to a Health Network. CalOptima Health assumes all authority, responsibility, and coordination of FSRs, MRRs, and Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to incorporate the documents to support review prior to Credentialing decisions.

III. PROCEDURE

A. Practitioner Initial Credentialing

1. A practitioner shall initiate the Credentialing process with CalOptima Health or a Delegate.

a. Upon receipt of interest and/or request from the practitioner, CalOptima Health or its Delegate shall send a notification electronically, explaining the expectations for completion and submission of the Credentialing application and required documents.

b. CalOptima Health and its Delegates shall utilize the most recent versions of the Council for Affordable Quality Health Care (CAQH) credentialing form and processes for Credentialing and Recredentialing. CalOptima Health and/or its Delegates shall only request additional information from an applicant practitioner to clarify and confirm information that is provided on the CAQH credentialing form, including verification of information not specifically disclosed on the practitioner's application.

~~b.~~c. Practitioners shall meet the Minimum Provider Standards as outlined in CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards, and CalOptima Health will verify that the Physician Practitioner meets the minimum standards as provided in that policy.

~~c.~~d. Practitioners shall submit a current, signed, and dated application with attestation to CalOptima Health.

~~d.~~e. CalOptima Health or its Delegate shall assess and verify the qualifications of a practitioner and make a credentialing decision within one hundred eighty days (180) of the signed attestation date.

~~e.~~f. CalOptima Health or its Delegate shall assess and verify the qualifications of a Behavioral Health Provider in the Covered California provider network within sixty (60) days after receiving a complete Credentialing application in accordance with California Health & Safety Code § 1374.197.

i. CalOptima Health or its Delegate shall provide written acknowledgement of receipt and inform the Behavioral Health Provider whether the application is complete and includes all the elements necessary for CalOptima to conduct its credentials verification process, within seven (7) business days of receiving a Credentialing application.

~~f.~~g. CalOptima Health shall provide written acknowledgement to an Indian Health Care Provider (IHCP) within fifteen (15) days of receiving a complete Credentialing application in

For 20260319 QAC Review Only

Back to Agenda Back to Item

accordance with DHCS APL 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members, or a superseding APL.

~~g.~~h. Practitioners shall attest to:

i. Any work history gap that exceeds six (6) months and include written clarification;

ii. The essential functions of the position that the practitioner cannot perform, with or without accommodation (i.e., health status);

iii. Lack of present illegal drug use that impairs current ability to practice;

iv. History of criminal convictions;

v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;

vi. Current malpractice insurance coverage; and

vii. The correctness and completeness of the application.

~~h.~~i. Practitioners shall complete an HIV/AIDS Specialist Screening Form, and HIV/AIDS Specialists shall attest to meet the qualifications specified in 28 California Code of Regulations (CCR) § 1300.74.16(e).

~~i.~~j. All Credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

~~j.~~k. A practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

~~k.~~l. CalOptima Health and its Delegate shall return an incomplete application to a practitioner, and such incomplete application will not be processed until the practitioner submits all the required information.

~~l.~~m. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the application withdrawn.

i. If an application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.

~~m.~~n. An NMP, other than a PA, who does not have an independent relationship with CalOptima Health or a Delegate, and is supervised by a Physician Practitioner, must include a signed supervisory agreement or delegation of services agreement indicating the name of supervising Physician Practitioner who is practicing, licensed, and credentialed by CalOptima Health; stating the NMP agrees to follow protocols developed for practice by the supervising Physician Practitioner based on skills and area of specialty or provide a copy of the employment agreement with the credentialed practitioner.

~~n.~~o. A PA who does not have an independent relationship with CalOptima Health or a Delegate and is supervised by Physician Practitioner or has an agreement with an Organized Health Care System, must include:

For 20260319 QAC Review Only

i. A delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed, and credentialed by CalOptima Health; statement that the NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed Physician Practitioner; or

ii. A signed Practice Agreement between the NMP and the Organized Health Care System stating that the PA agrees to follow protocols developed for practice by the Organized Health Care System based on skills and area of specialty or provide a copy of the Practice Agreement with the credentialed Organized Health Care System.

2. Upon receipt of a complete Credentialing application, CalOptima Health, its Delegates, or CVO shall verify the information provided through primary source or a contracted agent of the primary source using NCQA-accepted and/or industry-recognized verification sources. This information includes, but is not limited to:

   a. A current, valid California license to practice in effect at the time of the Credentialing decision (verification time limit: 120 calendar days);

   b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians (verification time limit: 120 calendar days);

   c. Education and training, including evidence of graduation from an appropriate professional school, continuing education requirements, and if applicable, completion of residency and specialty training;

   d. Current (within last three (3) years) full scope FSR/MRR, and PARS for Primary Care practitioners in the Medi-Cal provider network, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews;

   e. Active enrollment status with Medi-Cal for providers in the Medi-Cal provider network, as required; and

   f. Medicare program enrollment opt-out status (i.e. not on the opt-out list).

3. CalOptima Health, its Delegates, or CVO shall collect and verify the following information from each practitioner, as applicable, but need not verify this information through a primary source (see Attachment A). This information includes, but is not limited to:

   a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The practitioner shall provide a written explanation of any gaps of six (6) months or more (verification time limit: 180 calendar days);

   b. Confirmation that the practitioner has hospital admitting staff privileges that are in good standing or confirmation that the practitioner refers patients to hospital-based practitioners (hospitalists), as applicable;

      i. History of any suspension or curtailment of hospital and clinic privileges.

      ii. Any alternative admitting arrangements must be documented in the Credentialing file.

For 20260319 QAC Review Only

c. A valid Drug Enforcement Administration (DEA) or valid Controlled Dangerous Substances (CDS) certificate, if applicable, in effect at the time of the Credentialing decision; DEA certificate must show an address within the state of California;

i. DEA and CDS-eligible practitioner who do not have a certificate, and for whom prescribing controlled substance is in the scope of their practice shall have in place a designated practitioner to write prescriptions on their behalf;

ii. This requirement is not applicable for practitioner who do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances; however, such practitioners must provide a written description of their process for handling instances when a patient requires a controlled substance.

d. Current malpractice insurance in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision (verification time limit: 120 calendar days);

i. For Behavioral Health Service Providers, the minimum amounts shall be no less than one million dollars ($1,000,000.00) per incident and one million dollars ($1,000,000.00) aggregate per year at the time of the Credentialing decision (verification time limit: 120 calendar days).

e. Practitioner information entered in the National Practitioner Data Bank (NPDB), including malpractice history, (verification time limit: 120 calendar days) if applicable;

f. No exclusion or preclusion from participation at any time in federal or state health care programs based on conduct within the last ten (10) years, as set forth in 42 USC § 1320a-7(a), as follows:

i. A conviction of a criminal offense related to the delivery of an item, or service, under federal, or state, health care programs;

ii. A felony conviction related to neglect or abuse of patients in connection with the delivery of a health care item or service;

iii. A felony conviction related to health care fraud; or

iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

g. No history of professional liability claims that resulted in settlements or judgments paid by, or on behalf of, the practitioner in the last five (5) years;

h. No history of state sanctions, restrictions on licensure, or limitations on scope of practice, which may include accusations, probation, a previously filed 805 and 805.1 report with a licensing board; and

i. HIV/AIDS Specialist Screening Form and Attestation from each practitioner, as applicable.

For 20260319 QAC Review Only

4. CalOptima Health, a Delegate, or CVO shall verify qualifications for the following practitioner types in the Medi-Cal provider network in accordance with the following CalOptima Health policies:

   a. For doulas and comply with the requirements, in accordance with CalOptima Health Policy GG.1707: Doula Services.

   b. For Community Health Workers (CHW) and comply with the requirements in accordance with CalOptima Health Policy GG.1213: Community Health Worker Services.

B. Practitioner Recredentialing

1. CalOptima Health or a Delegate shall recredential a practitioner at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima Health, its Delegate, or CVO shall:

   a. Collect and/or verify, where applicable, at a minimum, all of the information required for initial Credentialing, as set forth in Section III.A of this policy, including any change in work history, except historical data already verified at the time of the initial Credentialing of the practitioner; and

   b. Include documentation that information from other sources, such as the following data, was incorporated in the decision-making process, which shall have been reviewed no more than one hundred twenty (120) calendar days before the Recredentialing decision is made.

      i. Member Grievances and Appeals, including number and type during the past three (3) years;

      ii. A review of any Grievances, or quality cases, filed against a practitioner in the last three (3) years;

      iii. Information from quality review activities;

      iv. Member satisfaction, if applicable; and

      v. Compliance with the terms of the practitioner's contract.

   c. All Recredentialing applications must include the attestations as contained in the practitioner's initial Credentialing application and shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

2. Current (within the last three (3) years) full scope FSR/MRR and PARS, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews.

3. CalOptima Health or its Delegate shall ensure that all practitioners maintain current DEA certification and medical malpractice insurance and shall validate this information at Recredentialing review.

4. CalOptima Health or its Delegate shall ensure that all practitioners maintain current California licensure in the interval between Recredentialing cycles.

For 20260319 QAC Review Only

a. CalOptima Health or its Delegate documents the license expiration date into the Credentialing files and/or system and monitors all licenses that will expire monthly.

b. CalOptima Health or its Delegate monitors the NPDB and/or the state licensing board for suspensions, restrictions, revocations, surrenders, and disciplinary actions on a monthly basis according to Policy GG.1607 Monitoring Adverse Actions.

C. Practitioner Rights

1. Applicants for Credentialing will receive practitioner rights included in the Credentialing application, as follows:

a. Right to review information:

i. Practitioners will be notified of their right to review information that CalOptima Health or its Delegate has obtained to evaluate the practitioner's Credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (*e.g.*, malpractice insurance carriers, state licensing boards), but does not extend to review of information, references, or recommendations protected by law from disclosure (*i.e.*, peer-review protected information).

b. Right to correct erroneous information:

i. All practitioners will be notified by email or certified mail when Credentialing information obtained from other sources during Credentialing varies from that provided by the practitioner in the Credentialing application;

ii. All practitioners have the right to correct erroneous information, as follows:

a) The practitioner has forty-eight (48) hours, excluding weekends, from date of notification to correct erroneous information;

b) Requests for correction of erroneous information must be submitted by email or certified mail on the practitioner's letterhead with a detailed explanation regarding the erroneous information, as well as copy(ies) of corrected information; and

c) For practitioners credentialed directly CalOptima Health, mailed submissions must be sent to CalOptima Health's Quality Improvement (QI) Department using the following address or email:

Attn: Quality Improvement Department – Credentialing
CalOptima Health
505 City Parkway West
Orange CA 92868

Email: mycredentialingupdates@caloptima.org

d) For practitioners credentialed by a Delegate, the practitioner shall contact their Delegate directly to address any erroneous information.

For 2026-03-19 QAC Review Only

Back to Agenda Back to Item

iii. CalOptima Health is not required to reveal the source of information, if the information is not obtained to meet CalOptima Health's Credentialing verification requirements, or if federal or state law prohibits disclosure.

iv. Documentation of receipt of corrections:

a) CalOptima Health or its Delegate shall document receipt of corrected information in the practitioner's Credentialing file.

b) A practitioner shall be notified via fax, email, or certified letter to document receipt of the identified erroneous information.

v. Right to be notified of application status

a) Practitioners may receive the status of their Credentialing or Recredentialing application, upon request.

b) Practitioners can contact the QI Department by phone or e-mail requesting the status of their application. The QI Department will aim to respond within seven (7) business day of the status of the practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing Committee

1. CalOptima Health or its Delegates shall designate a Credentialing committee that uses a peer-review process to make recommendations and decisions regarding credentialing and recredentialing.

2. CalOptima Health shall designate the Credentialing and Peer Review Committee (CPRC) that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing for practitioners in CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for the Elderly.

3. CPRC shall include representation from a range of practitioners participating in the organization's network and shall be responsible for reviewing a practitioner's Credentialing and Recredentialing files and determining the practitioner's participation in CalOptima Health programs.

4. Completed Credentialing and Recredentialing files will either be presented to the CMO or Designee on a clean file list for signature or will be presented at CPRC for review and approval.

a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no more than one (1) professional review or malpractice claim(s) that resulted in settlements or judgments greater than twenty-five thousand dollars ($25,000) paid by, or on behalf of, the practitioner within the last seven (7) years from the date of the Credentialing or Recredentialing review.

i. A clean file shall be considered approved and effective on the date that the CMO or Designee reviews and approves a practitioner's Credentialing, or Recredentialing, file, and deems the file clean.

ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for final approval and be reflected in the meeting minutes.

For 20260319 QAC Review Only

Back to Agenda Back to Item

b. Files that do not meet the clean file review process and that require further review by CPRC include, but are not limited to, those files that include more than one (1) malpractice claim that resulted in a settlement or judgment greater than twenty-five thousand dollars ($25,000), or NPDB query identifying medical board investigations, or other actions.

i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application.

ii. CPRC shall give thoughtful consideration to the information presented in the Credentialing file, which consideration shall be reflected in the minutes of the CPRC meeting.

iii. CPRC meetings and decisions may take place in real-time, or as a virtual meeting via telephone or video conference but may not be conducted through e-mail.

5. Practitioner files identified as not meeting Credentialing criteria with exceptions or potential exceptions, which may include serious quality deficiencies that result in the suspension or termination of a practitioner, shall be referred to the CMO or designee for review.

a. The CMO or Designee shall review each file for practitioners who do not meet Credentialing criteria and make recommendations regarding approving or denying Credentialing of the practitioner to the CPRC. For practitioner files not meeting criteria on an administrative basis only, the file may be approved or denied by the CMO or Designee.

6. The CPRC shall make a final determination based on the practitioners' ability to deliver care based on the Credentialing information collected from the file review process and that is verified prior to making a Credentialing decision.

a. The QI Department shall send the practitioner a decision letter within thirty (30) calendar days of the decision indicating:

i. Acceptance;

ii. Acceptance with restrictions along with appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners; or

iii. Denial of the application along with appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners, with a letter of explanation forwarded to the applicant.

b. CalOptima Health and its Delegates shall make a determination regarding the credentials of a Covered California practitioner within ninety (90) days after receiving a completed practitioner credentialing application, including all required third-party verifications. CalOptima Health and its Delegates shall notify a practitioner, if successfully approved, of the activation within ten (10) business days of approval if the approval occurs prior to the end of the ninety (90)-day timeline. The ninety (90)-day timeline shall apply only to the credentialing process and does not include contracting completion. If CalOptima Health and its Delegates do not meet the ninety (90)-day requirement, the practitioner's credentials shall be provisionally approved for one hundred twenty (120) days unless any of the following apply:

For 20260319 QAC Review Only

Back to Agenda Back to Item

i. The practitioner is subject to discipline by the licensing entity for the practitioner.

ii. The practitioner has one or more adverse action reports or one or more reports of malpractice payments filed with the National Practitioner Data Bank (NPDB).

iii. The practitioner has not been credentialed by CalOptima Health or its Delegates in the past five (5) years.

c. CalOptima Health shall render a final Credentialing decision for Medi-Cal, OneCare and PACE practitioners within one hundred ~~eighty (180~~twenty (120) calendar days from the date of ~~the~~a completed application, which includes a signed attestation that confirms the correctness and completeness of the application.

i. ~~If CalOptima Health is unable to render a decision~~ Application attestations must be signed within the one hundred eighty ~~-~~(180) calendar days ~~from the date of~~ prior to the ~~signed attestation for any practitioner, during~~Credentialing decision. If the practitioner's ~~Credentialing or Recredentialing process,~~attestation expires prior to the Credentialing decision, the practitioner must ~~attest~~reattest that the information on the application remains correct and complete, by resigning and redating the attestation.

ii. As of January 1, 2027, CalOptima Health and its Delegates shall notify the practitioner within ten (10) business days to verify receipt and inform the applicant whether the application is complete.

7. If CalOptima Health terminates a practitioner during the Recredentialing process for administrative reasons (*i.e.*, the practitioner failed to provide complete Credentialing information) and not for quality reasons (*i.e.,* medical disciplinary cause or reason), CalOptima Health may reinstate the practitioner within thirty (30) calendar days of termination and is not required to perform initial Credentialing. However, CalOptima Health must re-verify credentials that are no longer within the verification time limit. If the reinstatement would be more than thirty (30) calendar days after termination, CalOptima Health must perform initial Credentialing of such practitioner.

a. Termination of privileges includes failure or refusal to renew a contract or to renew, extend, or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.

E. CalOptima Health and its Delegates shall monitor and prevent discriminatory practices. Activities, including, but are not limited to:

1. Monitoring:

a. Conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that practitioners are not discriminated against as set forth in Section II.Q.;

b. Review practitioner complaints to determine if there are complaints alleging discrimination; and

c. On a quarterly basis, the QI Department shall review Grievances, Appeals, and potential quality-of-care issues for complaints alleging discrimination and will report outcomes to the CPRC for review and determination.

For 20260319 QAC Review Only

2. Prevention:

    a. The QI Department shall maintain a heterogeneous CPRC and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

    b. QI Department staff shall remove identifying information, such as name and affiliation, from the practitioner and provider files when presenting cases to CPRC to remove bias and prevent discrimination.

F. Upon acceptance and approval of a Credentialing application, the QI Department shall share the credentialing profile with Contracting, Provider Relations, and Provider Data Management Service (PDMS) Departments. This practitioner profile shall be generated from the Credentialing database to ensure that the information is consistent with data verified during the Credentialing process (*i.e.*, education, training, Board Certification, and specialty). The PDMS Department will enter the contract and Credentialing data into CalOptima Health's core business system and/or will verify the Credentialing data in the system, which updates pertinent information into the online provider directory.

G. Practitioner Screening and Enrollment (Medi-Cal Providers Only)

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) practitioners or obtain a PED approval letter as an acceptable form of initial enrollment verification conducted by DHCS.

2. If a practitioner is already enrolled with DHCS as a Medi-Cal FFS practitioner, then the practitioner screening and enrollment process does not need to be completed by CalOptima Health.

3. If a practitioner is not already enrolled with DHCS as a Medi-Cal FFS practitioner, then CalOptima Health may complete screening and enrollment established by CalOptima Health.

    a. CalOptima Health shall notify DHCS and submit its P&Ps for approval prior to implementation. The P&Ps must define the scope of their enrollment process if CalOptima Health does not enroll all provider types.

    b. CalOptima Health shall complete the process and provide the applicant with a written determination on CalOptima Health letterhead within one hundred twenty (120) calendar days of its receipt of a practitioner application.

    c. CalOptima Health shall submit a list of its newly enrolled practitioners every six months to CalOptima Health's DHCS Managed Care Operations Division (MCOD) contract manager.

    d. CalOptima Health shall collect all the appropriate information, data elements, and supporting documentation required for each provider type and ensure that the application is reviewed for both accuracy and completeness.

        i. CalOptima Health shall inform practitioners seeking to enroll with CalOptima Health of the differences between CalOptima Health's and DHCS's provider enrollment processes, including the practitioner's right to enroll through DHCS, at the time of application. CalOptima Health will provide required disclosures that include, but are not limited to, the following elements:

For 2026.03.19 QAC Review Only

Back to Agenda Back to Item

a) A statement that certain enrollment functions will not be performed by CalOptima Health but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.

b) A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a practitioner chooses to enroll through CalOptima Health, including provisional practitioner status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal CalOptima Health's decision to suspend the enrollment process.

c) A provision informing the practitioner that if CalOptima Health receives any information that impacts the practitioner's eligibility for enrollment, CalOptima Health will suspend processing of the practitioner's enrollment application and make the practitioner aware of the option to apply through DHCS' Medi-Cal FFS practitioner enrollment process.

d) A statement clarifying that in order for the practitioner to participate in the Medi-Cal FFS program, the practitioner must enroll through DHCS, and that enrolling through DHCS will also make the practitioner eligible to contract with CalOptima Health.

ii. CalOptima Health may collect an application fee, not to exceed the Medi-Cal FFS enrollment application fee amount.

iii. CalOptima Health shall obtain the practitioner's consent in order to share information relating to the practitioner's application and eligibility with DHCS.

iv. CalOptima Health shall collect and maintain the original signed Medi-Cal Provider Agreement and Network Provider Agreement for each practitioner.

v. CalOptima Health shall maintain all practitioner enrollment documentation in a secure manner to ensure confidentiality of the practitioner's personal information.

vi. Enrollment records shall be made available upon request to DHCS, CMS or other authorized governmental agencies.

e. Practitioners that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by 42 CFR § 455.104.

i. Practitioners who are unincorporated sole proprietors are not required to disclose the ownership or control information.

ii. Upon CalOptima Health's request, a practitioner must submit within thirty-five (35) calendar days:

a) Full and complete information about the ownership of any subcontractor with whom the practitioner has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of the request; and

For 20260319 QAC Review Only

b) Any significant business transactions between the practitioner and any wholly owned supplier, or between the practitioner and any subcontractor, during the five (5)-year period ending on the date of the request.

f. CalOptima Health shall screen initial practitioner applications, including applications for a new practice location, and any applications received in response to a practitioner's reenrollment or revalidation request to determine the practitioner's categorical risk level as limited, moderate, or high.

i. If a practitioner fits within more than one risk level, CalOptima Health must screen the practitioner at the highest risk level.

ii. A practitioner's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated practitioner lists, and criminal background checks.

iii. CalOptima Health shall not enroll a practitioner who fails to comply with the screening criteria for that practitioner's assigned level of risk.

g. Practitioners are subject to screening based on verification of the following requirements:

i. Limited-Risk Practitioners:

a) Meet state and federal requirements;

b) Hold a license certified for practice in the state and has no limitations from other states; and

c) Have no suspensions or terminations on state and federal databases.

ii. Medium-Risk Practitioners:

a) Screening requirements of limited-risk practitioners; and

b) Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to CalOptima Health and DHCS is accurate and to determine compliance with state and federal enrollment requirements.

iii. High-Risk Practitioners:

a) Screening requirements of medium-risk practitioners; and

b) Criminal background checks based in part on a set of fingerprints.

h. CalOptima Health and DHCS shall adjust the categorical risk level when any of the following circumstances occur:

i. The state imposes a payment suspension on a practitioner based on a credible allegation(s) of Fraud, Waste, or abuse.

ii. The practitioner has an existing Medicaid overpayment based on Fraud, Waste, or abuse.

For 20260319 QAC Review Only

iii. The practitioner has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten (10) years, or when a state or federal moratorium on a provider type has been lifted.

iv. The practitioner would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six (6) months.

i. Additional criteria for high-risk practitioners

i. Any person with a five percent (5%) or more direct or indirect ownership and is a high-risk applicant or where information discovered in the onsite or data analysis may lead to this type of request.

ii. CalOptima Health shall direct practitioners to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website and ensure that practitioners include the correct agency information on the Live Scan form when submitting their application. The agency-specific information shall include the following information:

Applicant Submission

Field	**Entry**
ORI (Code assigned by DOJ)	CA0341600
Authorized Applicant Type	High Risk Medi-Cal Provider
Type of License/Certification/Permit OR Working Title	MCMC

Contributing Agency Information

Field	**Entry**
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509
Street Address or PO Box	1700 K Street; MS 2200
Contact Name	MCMC
City	Sacramento
State	CA
ZIP Code	95811
Contact Telephone Number	(916) 750-1509

iii. When fingerprinting is required, CalOptima Health must furnish the practitioners with the Live Scan form and instructions on where to deliver the completed form.

iv. The practitioner must deliver the completed Live Scan form to the California DOJ and is responsible for paying for any Live Scan processing fees.

v. CalOptima Health shall notify DHCS upon initiation of each criminal background check for a practitioner that has been designated as high risk.

vi. CalOptima Health shall maintain the security and confidentiality of all of the information it receives from DHCS relating to the practitioner's high-risk designation and the results of the criminal background checks.

j. Site Visits

For 20260319 QAC Review Only

i. CalOptima Health shall conduct pre- and post-enrollment site visits of medium-risk and high-risk practitioners to verify that the information submitted to CalOptima Health and DHCS is accurate and to determine the applicant's compliance with state and federal enrollment requirements.

ii. CalOptima Health shall conduct post-enrollment site visits for medium-risk practitioners at least every five (5) years and their high-risk practitioners every three (3) years or as necessary to verify that the information submitted to CalOptima Health and DHCS is accurate and determine if practitioners are in compliance with state and federal enrollment requirements.

iii. Onsite visits may be conducted for many reasons, including, but not limited to, the following:

a) The practitioner was temporarily suspended from the Medi-Cal program;

b) The practitioner's license was previously suspended;

c) There is conflicting information in the practitioner's enrollment application;

d) There is conflicting information in the practitioner's supporting enrollment documentation; and

e) As part of the practitioner enrollment process, CalOptima Health receives information that raises a suspicion of fraud.

k. Federal and State Database Checks

i. CalOptima Health shall check the following databases to verify the identity and determine the exclusion and/or enrollment status of all practitioners:

a) Social Security Administration's Death Master File;

b) National Plan and Provider Enumeration System (NPPES);

c) List of Excluded Individuals/Entities (LEIE);

d) System for Award Management (SAM);

e) CMS' Medicare Exclusion Database (MED);

f) DHCS' Suspended and Ineligible Provider List;

g) Restricted Provider Database (RPD); and

h) CHHS Open Data Portal.

ii. CalOptima Health shall also review the SAM, LEIE, and RPD databases on a regular basis, and at least monthly, to ensure that contracted practitioners continue to meet enrollment criteria and take appropriate action in connection with the exclusion.

For 20260319 QAC Review Only

iii. Any practitioners terminated from the Medicare or Medicaid/Medi-Cal program may not participate in CalOptima Health's practitioner network.

l. If CalOptima Health declines to enroll a practitioner, it must refer the practitioner to DHCS for further enrollment options.

m. If CalOptima Health acquires information, either before or after enrollment, that may impact the practitioner's eligibility to participate in the Medi-Cal program, or a practitioner refuses to submit to the required screening activities, CalOptima Health may decline to accept that practitioner's application.

n. If at any time CalOptima Health determines that it does not want to contract with a prospective practitioner, and/or that the prospective practitioner will not meet enrollment requirements, CalOptima Health must immediately suspend the enrollment process of that practitioner.

o. CalOptima Health is not obligated to establish an appeal process for screening and enrollment decisions. Practitioners may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.

p. All practitioners must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process at least every five (5) years to ensure that all enrollment information is accurate and up-to-date.

q. CalOptima Health shall retain all practitioner screening and enrollment materials and documents for ten (10) years.

r. CalOptima Health shall make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

IV. ATTACHMENT(S)

A. CalOptima Health Primary Source Verification Table

V. REFERENCE(S)

A. Assembly Bill (AB) 1041
~~A.~~B. California Business and Professions Code §§ 805, 2837.103, 2837.104 and 3500-3502.3
~~B.~~C. California Evidence Code §1157
~~C.~~D. California Health & Safety Code §§1374.197, 1374.198, and 1380.2
~~D.~~E. CalOptima Health Contract for Health Care Services
~~E.~~F. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~F.~~G. CalOptima Health Contract with Covered California
~~G.~~H. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~H.~~I. CalOptima Health PACE Program Agreements
~~I.~~J. CalOptima Health Policy GG.1213: Community Health Worker Services
~~J. CalOptima Health Policy GG.1406: Pharmacy Network: Credentialing and Access~~
K. CalOptima Health Policy GG.1602: Non-Physician Medical Practitioner (NMP) Scope of Practice
L. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities

For 20260319 QAC Review Only

Back to Agenda Back to Item

M. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
N. CalOptima Health Policy GG.1608: Full Scope Site Reviews
O. CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners
P. CalOptima Health Policy GG.1619: Delegation Oversight
Q. CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians
R. CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards
S. CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers
T. CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information
U. CalOptima Health Policy GG.1707: Doula Services
V. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
W. CalOptima Health Policy MA.5012: Pharmacy Network: Credentialing and Access
~~W.~~X. CalOptima Health Policy MA.9006: Provider Complaint Process
~~X.~~Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-009: Adult Immunizations as a Pharmacy Benefit (Revised 12/23/2016)
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing / Recredentialing and Screening / Enrollment (Revised 01/02/2025)
V. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031) (Revised 11/03/2023)
W. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006: Community Health Worker Services Benefit (Supersedes APL 22-016)
Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
U. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
V. National Committee for Quality Assurance (NCQA) Standards and Guidelines
W. Title 42, Code of Federal Regulations (CFR), §§ 422.204(a), 422.205, 438.12, 438.214, 460.64, 460.71, and Part 455, Subpart E
X. Title 42, United States Code (USC), §1320a-7(a)
Y. Title XVIII and XIV of the Social Security Act

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/28/2015	Department of Health Care Services (DHCS)	Approved as Submitted
09/20/2018	Department of Health Care Services (DHCS)	Approved as Submitted
10/13/2020	Department of Health Care Services (DHCS)	No Reply 60 Days
05/05/2022	Department of Health Care Services (DHCS)	Approved as Submitted
10/26/2022	Department of Health Care Services (DHCS)	Approved as Submitted
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
07/11/2023	Department of Health Care Services (DHCS)	Approved as Submitted
06/13/2024	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors

FC 2319 QAC Review Only

Back to Agenda Back to Item

Date	Meeting
04/07/2022	Regular Meeting of the CalOptima Board of Directors
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors
	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	09/06/2018	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2019	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2020	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	04/07/2022	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	04/01/2023	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	05/01/2024	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE

Back to Agenda Back to Item

Action	Date	Policy	Policy Title	Program(s)
Revised	11/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	01/01/2026	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	04/01/2026	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE

For 20260319 QAC Review

Back to Agenda Back to Item

IX. GLOSSARY

Term	Definition
Abuse	Covered California: Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Appeal (Member)	Covered California: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR § 438.408(b).

For 20260319 QAC Review Only

Back to Agenda Back to Item

Term	Definition
	OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and § 423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR § 460.122.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Covered California: *Effective 01/01/2027 for CalOptima Health*	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.

For 20260319 QAC Review Only

Term	Definition
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Credentialing Verification Organization (CVO)	For purposes of this policy, an organization that collects and verifies Credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Facility Site Review (FSR)	A DHCS tool utilized to assess the quality, safety and accessibility of primary care physicians (PCPs) and high-volume specialist physician offices.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 CFR § 455.2, Welfare and Institutions Code § 14043.1(i).
Grievance	Covered California: A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.

For 20260519 QAC Review Only

Term	Definition
	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR § 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
HIV/AIDS Specialist	A physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four (4) criteria: 1. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; 2. Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; 3. Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications: (A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and (B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or 4. Meets the following qualifications: (A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and (B) Has completed any of the following: 1. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or 2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or 3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical

For 2026 3.19 QAC Review Only

Back to Agenda Back to Item

Term	Definition
	education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.
Indian Health Care Provider (IHCP)	A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (IHCIA) at 25 USC § 1603.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	An individual enrolled in a CalOptima program.
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.
National Committee for Quality Assurance (NCQA)	An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.
Organized Health Care System	Includes a licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code, an outpatient setting as described in Chapter 1.3 (commencing with Section 1248) of Division 2 of the Health and Safety Code, a health facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, a county medical facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code, an accountable care organization, a home health agency, a physician's office, a professional medical corporation, a medical partnership, a medical foundation, and any other entity that lawfully provides medical services and is in compliance with Article 18 (commencing with Section 2400) of Chapter 5.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy Credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.
Physician Practitioner	A licensed practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), furnishing covered services.
Practice Agreement	The writing, developed through collaboration among one or more physicians and surgeons and one or more physician assistants, that defines the medical services the physician assistant is authorized to perform pursuant to BPC § 3502 and that grants approval for physicians and surgeons on the staff of an Organized Health Care System to supervise one or more physician assistants in the Organized Health Care System. Any reference to a delegation of services

For 2026 01 QAC Review Only

Back to Agenda Back to Item

Term	Definition
	agreement relating to physician assistants in any other law shall have the same meaning as a Practice Agreement.
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a PCP.
Recredentialing	The process by which the qualifications of practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Specialty Care	For purposes of this policy, specialty care given to Members by referral by other than a PCP.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.
Utilization Management (UM)	Requirements or limits on coverage. UM may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.
Waste	Covered California: Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls. Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

For 20260519 QAC Review Only

Policy:	GG.1650
Title:	**Credentialing and Recredentialing of Practitioners**
Department:	Quality Improvement
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	04/01/2026
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 20260319 QAC Review Only

I. PURPOSE

This policy defines the process by which CalOptima Health evaluates and determines whether practitioners meet the qualifications for participation in CalOptima Health programs.

II. POLICY

A. CalOptima Health shall establish guidelines by which CalOptima Health shall evaluate and select practitioners to participate in CalOptima Health, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima Health may delegate its authority to perform Medi-Cal screening and enrollment activities to a Delegate. If CalOptima Health chooses to delegate this function, the following shall occur:

1. The delegation must be in a written subcontract or agreement, where CalOptima Health remains contractually responsible for the completeness and accuracy of the screening and enrollment activities.

2. CalOptima Health shall evaluate the Delegate's ability to perform these activities, including an initial review to ensure that the Delegate has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

3. CalOptima Health shall continuously monitor, evaluate, and approve the delegated functions.

4. CalOptima Health shall notify the Department of Health Care Services (DHCS) sixty (60) calendar days prior to delegating the screening and enrollment to a Delegate and shall submit policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

C. CalOptima Health may delegate Credentialing and Recredentialing activities to a Delegate, including Health Networks or a Credentialing Verification Organization (CVO), in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

Back to Agenda Back to Item

1. Delegates shall perform functions that, at minimum, meet the requirements as outlined in this policy.

2. CalOptima Health may accept evidence of NCQA Provider Organization Certification in lieu of a monitoring site visit of delegated physician organization.

D. The Chief Medical Officer (CMO) or Designee shall have direct responsibility over and actively participate in the Credentialing program. The responsibilities include, but are not limited to, chairing the Credentialing and Peer Review Committee (CPRC), reviewing and approving practitioner files, and ensuring Credentialing policies are adhered to.

E. CalOptima Health's CPRC shall be responsible for reviewing a practitioner's Credentialing information and determining such practitioner's participation in CalOptima Health, consistent with DHCS, National Committee for Quality Assurance (NCQA), and Department of Managed Health Care (DMHC), and Centers for Medicare and Medicaid (CMS) regulations and standards.

F. CalOptima Health and its Delegates shall ensure that any practitioner in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS is screened and enrolled with DHCS in the Medi-Cal Program in accordance with DHCS All Plan Letter (APL) 22-013: Provider Credentialing/Re-credentialing and Screening /Enrollment, including any superseding APL, and Title 42, CFR, Part 455.

1. State-level enrollment pathways are available either through the DHCS' Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway.

2. CalOptima Health may enroll providers through the screening and enrollment process outlined in Section III.G, in compliance with DHCS requirements, or CalOptima Health may direct network providers to enroll through a state-level enrollment pathway.

3. Practitioners that do not have a state level enrollment pathway do not need to be enrolled in Medi-Cal but must comply with CalOptima Health's vetting process.

G. CalOptima Health and its Delegates may allow practitioners in its Medi-Cal provider network to participate in the network for up to one hundred twenty (120) calendar days if the practitioner has a pending enrollment application in review with DHCS' PED or a DHCS approved screening and enrollment process.

1. CalOptima Health and its Delegates shall terminate its contract with the practitioner no later than fifteen (15) calendar days of the practitioner receiving notification from DHCS that the practitioner has been denied enrollment of the Medi-Cal program, or upon the expiration of the first one hundred twenty (120) calendar day period.

2. CalOptima Health and its Delegates shall not continue to contract with a practitioner during the period in which the practitioner resubmits its enrollment application to DHCS or approved screening and enrollment process and shall only re-initiate a contract upon the practitioner's successful enrollment as a Medi-Cal practitioner.

3. If the practitioner termination impacts Member access, CalOptima Health shall notify DHCS prior to terminating the practitioner and shall submit a plan of action for continuity of services for review and approval before the termination.

For 2026.3.19 QAC Review Only

Back to Agenda Back to Item

H. CalOptima Health and its Delegates shall credential, prior to services being rendered, and recredential all contracted practitioners that render services to Members and are:

1. Licensed, certified, or registered by the state of California to practice independently (without direction or supervision);

   a. CalOptima Health shall not require the licensure of a health professional employed by a tribal health program under the state or local law where the Tribal Health Program is located, if the professional is licensed in another state, in accordance with 25 United States Code (USC) § 1621t.

   b. CalOptima Health and its Delegates shall allow out-of-state licensed psychologists, clinical social workers, marriage and family therapists, or professional clinical counselors to provide Specialty Mental Health Services (SMHS) or mental health services under the Medi-Cal program with an approved Professional Licensing Waiver (PLW) from DHCS.

2. Contracted with CalOptima Health to provide care under CalOptima Health's programs (including those practitioners who render care in contracted Federally Qualified Health Centers (FQHC) and community clinics that perform Primary Care and Specialty Care services);

3. In an independent relationship with CalOptima Health;

   a. An independent relationship exists when the CalOptima Health directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom a Member can select as a primary care practitioner; and

4. Providing care to Members under CalOptima Health's programs.

I. CalOptima Health and its Delegates shall credential and recredential all contracted practitioners that render services to Members in the following settings:

1. Individual or group practices;

2. Locum Tenens:

   a. CalOptima Health shall provisionally credential the practitioner if the locum tenens works less than sixty (60) calendar days.

   b. CalOptima Health shall fully credential the practitioner if the locum tenens works sixty (60) calendar days or more.

3. Facilities;

4. Telemedicine/telehealth (i.e., virtual care visit); or

5. Rental and preferred provider organization networks.

J. CalOptima Health and its Delegates shall credential and recredential the following practitioners including, but not limited to:

1. Medical Doctor (MD);

For 20260319 QAC Review Only

2. Doctor of Osteopathy (DO);

3. Doctor of Chiropractic Medicine (DC);

4. Doctor of Dental Surgery (DDS);

5. Doctor of Podiatric Medicine (DPM);

6. Nurse Practitioners (NP); and

7. Other medical practitioners who may be within the scope of Credentialing (e.g., Physician Assistant)

    a. Behavioral health practitioners, including but not limited to:

        i. Psychiatrists and other physicians

        ii. Addiction medicine specialists

        iii. Doctoral or master's level psychologists

        iv. Master's-level clinical social workers

        v. Master's-level clinical nurse specialists or psychiatric nurse practitioners

        vi. Other behavioral healthcare specialists who may be within the scope of credentialing (e.g., licensed professional counselors, qualified autism services (QAS) providers also known as applied behavior analysis providers)

K. CalOptima Health and its Delegates shall credential and recredential Non-Physician Medical Practitioners (NMP) who meet license and state board requirements for the scope of their practice and who do not have an independent relationship with CalOptima Health.

1. Credentialed and recredentialed NMPs include:

    a. NMPs who provide services under the supervision of a practicing, licensed, and credentialed Physician Practitioner and have executed a signed agreement as required by the applicable state of California board with the NMP;

        i. Physician supervision is not required for services rendered by certain classes of Nurse Practitioners (NPs) pursuant to California Business Professional Code (BPC) §§ 2837.103 and 2837.104;

    b. NMPs who provide services as part of an Organized Health Care System that is credentialed with CalOptima Health and have a signed agreement as required by the applicable state of California board between the NMP and the Organized Health Care System; or

    c. NMPs who are not Physician Assistants (PAs) and who provide services under the employment agreement of a credentialed Physician Practitioner.

2. An NMP shall notify CalOptima Health immediately if the supervising Physician Practitioner no longer meets the CalOptima Health Credentialing requirements, or if there is a change in the

For 20260319 QAC Review Only

Back to Agenda Back to Item

supervising Physician Practitioner, or NMP's employment with the entity or Organized Health System.

L. For practitioners in the Medi-Cal provider network not required to be credentialed and/or who do not have a corresponding state-level enrollment pathway, CalOptima Health shall at minimum verify the qualifications and vet the practitioner for the following:

1. Sufficient experience to provide services similar to the services for which they are contracted to provide within the service area;

2. Business licensing that meets industry standards, if applicable;

3. No history of Fraud, Waste, and/or abuse;

4. No recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

5. No history of liability claims against the practitioner.

M. CalOptima Health does not credential or recredential:

1. Practitioners who practice exclusively within the inpatient setting (*e.g.*, hospitalists) and provide care for a Member only as a result of the Member being directed to the hospital or inpatient setting.

2. Practitioners who practice exclusively within freestanding facilities and provide care for a Member only as a result of the Member being directed to the facility (*e.g.*, diagnostic radiologists, urgent care, emergency medicine).

3. Pharmacists who work for a Pharmacy Benefit Manager (PBM) to which CalOptima Health delegates Utilization Management functions (Credentialing of pharmacies and their professional and technical staff shall be conducted by the PBM, in accordance with CalOptima Health Policy MA.5012: Pharmacy Network Credentialing and Access).

4. Covering practitioners who do not have an independent relationship with CalOptima Health.

5. Practitioners who do not provide care for a Member in a treatment setting (e.g., external physician reviewer).

6. Health care professionals who are permitted to furnish services only under the direct supervision of another practitioner.

7. Students, residents, and fellows, where applicable.

8. Rental network practitioners who provide out-of-area care only, and Members are not required or given an incentive to seek care from them.

9. Health care professionals who are permitted to furnish services as part of a letter of agreement (LOA) or a continuity of care arrangement.

N. CalOptima Health adopts the Credentialing and Recredentialing conducted by Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes and does not credential or recredential practitioners

For 20260319 QAC Review Only

Back to Agenda Back to Item

who practice exclusively within a FQHC or FQHC Look-Alikes and who provide care for a Member only as a result of the Member being directed to the FQHC or FQHC Look-Alikes.

O. CalOptima Health and its Delegates shall recredential a practitioner at least every three (3) years, utilizing a thirty-six (36) month cycle to the month, not to the day.

P. CalOptima Health and its Delegates shall ensure that all practitioners maintain current California licensure and shall monitor various state and federal boards, agencies, and databanks for adverse activities in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

Q. CalOptima Health and its Delegates shall notify the practitioner, in writing, of the Credentialing or Recredentialing decision within thirty (30) calendar days of the date of the approval or denial of the application.

R. CalOptima Health and its Delegates shall not discriminate against any practitioner during the Credentialing and Recredentialing process.

1. CalOptima Health and its Delegates shall not discriminate, in terms of participation, reimbursement, or indemnification, against any practitioner who is acting within the scope of their license, certification, or registration under federal and state law, solely on the basis of the license, or certification. This prohibition shall not preclude CalOptima Health from:

   a. Refusing to grant participation to a practitioner in excess of the number necessary to meet the needs of Members;

   b. Using different reimbursement amounts for different specialties, or for different practitioners in the same specialty; and

   c. Implementing measures designed to maintain quality and control costs consistent with CalOptima Health's responsibilities.

2. CalOptima Health and its Delegates shall not discriminate against a practitioner that serves high-risk populations or specializes in the treatment of costly conditions.

3. CalOptima Health and its Delegates shall not base Credentialing and Recredentialing decisions on a practitioner's race, ethnicity, national identity, gender, age, sexual orientation, or the type of procedure, or patient's insurance coverage, in which the practitioner specializes.

S. CalOptima Health and its Delegates shall maintain the confidentiality of Credentialing and Recredentialing files, in accordance with CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information.

T. CalOptima Health and its Delegates shall ensure that information collected on the application is no more than six (6) months old from the date of the final decision made by the respective Credentialing committee.

1. CalOptima Health and its Delegates shall notify the Covered California practitioner within ten (10) business days to verify receipt and inform the applicant whether the application is complete.

2. CalOptima Health and its Delegates shall notify the Medi-Cal, OneCare, or PACE practitioner within thirty (30) calendar days to verify receipt and inform the applicant whether the application is complete

For 20260319 QAC Review Only

3. If CalOptima Health or a Delegate is unable to render a decision within six (6) months, the application shall be considered expired, and Credentialing will re-initialize.

U. Except as provided in CalOptima Health Policy GG.1608: Full Scope Site Reviews, CalOptima Health does not delegate the Facility Site Review (FSR) and Medical Record Review (MRR) processes to a Health Network. CalOptima Health assumes all authority, responsibility, and coordination of FSRs, MRRs, and Physical Accessibility Review Surveys (PARS) and reports its findings to Health Networks to incorporate the documents to support review prior to Credentialing decisions.

III. PROCEDURE

A. Practitioner Initial Credentialing

1. A practitioner shall initiate the Credentialing process with CalOptima Health or a Delegate.

   a. Upon receipt of interest and/or request from the practitioner, CalOptima Health or its Delegate shall send a notification electronically, explaining the expectations for completion and submission of the Credentialing application and required documents.

   b. CalOptima Health and its Delegates shall utilize the most recent versions of the Council for Affordable Quality Health Care (CAQH) credentialing form and processes for Credentialing and Recredentialing. CalOptima Health and/or its Delegates shall only request additional information from an applicant practitioner to clarify and confirm information that is provided on the CAQH credentialing form, including verification of information not specifically disclosed on the practitioner's application.

   c. Practitioners shall meet the Minimum Provider Standards as outlined in CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards, and CalOptima Health will verify that the Physician Practitioner meets the minimum standards as provided in that policy.

   d. Practitioners shall submit a current, signed, and dated application with attestation to CalOptima Health.

   e. CalOptima Health or its Delegate shall assess and verify the qualifications of a practitioner and make a credentialing decision within one hundred eighty days (180) of the signed attestation date.

   f. CalOptima Health or its Delegate shall assess and verify the qualifications of a Behavioral Health Provider in the Covered California provider network within sixty (60) days after receiving a complete Credentialing application in accordance with California Health & Safety Code § 1374.197.

      i. CalOptima Health or its Delegate shall provide written acknowledgement of receipt and inform the Behavioral Health Provider whether the application is complete and includes all the elements necessary for CalOptima to conduct its credentials verification process, within seven (7) business days of receiving a Credentialing application.

   g. CalOptima Health shall provide written acknowledgement to an Indian Health Care Provider (IHCP) within fifteen (15) days of receiving a complete Credentialing application in accordance with DHCS APL 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members, or a superseding APL.

For 20260519 QAC Review Only

Back to Agenda Back to Item

h. Practitioners shall attest to:

   i. Any work history gap that exceeds six (6) months and include written clarification;

   ii. The essential functions of the position that the practitioner cannot perform, with or without accommodation (i.e., health status);

   iii. Lack of present illegal drug use that impairs current ability to practice;

   iv. History of criminal convictions;

   v. History of any loss, or limitation, of licensure, or privileges, or disciplinary activity;

   vi. Current malpractice insurance coverage; and

   vii. The correctness and completeness of the application.

i. Practitioners shall complete an HIV/AIDS Specialist Screening Form, and HIV/AIDS Specialists shall attest to meet the qualifications specified in 28 California Code of Regulations (CCR) § 1300.74.16(e).

j. All Credentialing applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

k. A practitioner shall ensure that all information included in a Credentialing application is no more than six (6) months old.

l. CalOptima Health and its Delegate shall return an incomplete application to a practitioner, and such incomplete application will not be processed until the practitioner submits all the required information.

m. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the application withdrawn.

   i. If an application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.

n. An NMP, other than a PA, who does not have an independent relationship with CalOptima Health or a Delegate, and is supervised by a Physician Practitioner, must include a signed supervisory agreement or delegation of services agreement indicating the name of supervising Physician Practitioner who is practicing, licensed, and credentialed by CalOptima Health; stating the NMP agrees to follow protocols developed for practice by the supervising Physician Practitioner based on skills and area of specialty or provide a copy of the employment agreement with the credentialed practitioner.

o. A PA who does not have an independent relationship with CalOptima Health or a Delegate and is supervised by Physician Practitioner or has an agreement with an Organized Health Care System, must include:

   i. A delegation of services agreement indicating name of supervising Physician Practitioner who is practicing, licensed, and credentialed by CalOptima Health; statement that the

For 20260319 QAC Review Only

Back to Agenda Back to Item

NMP agrees to follow protocols developed for practice by the supervising physician based on skills and area of specialty or provide a copy of the employment agreement with the credentialed Physician Practitioner; or

ii. A signed Practice Agreement between the NMP and the Organized Health Care System stating that the PA agrees to follow protocols developed for practice by the Organized Health Care System based on skills and area of specialty or provide a copy of the Practice Agreement with the credentialed Organized Health Care System.

2. Upon receipt of a complete Credentialing application, CalOptima Health, its Delegates, or CVO shall verify the information provided through primary source or a contracted agent of the primary source using NCQA-accepted and/or industry-recognized verification sources. This information includes, but is not limited to:

   a. A current, valid California license to practice in effect at the time of the Credentialing decision (verification time limit: 120 calendar days);

   b. Board Certification, as applicable, unless exempt from the Board Certification requirement pursuant to CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians (verification time limit: 120 calendar days);

   c. Education and training, including evidence of graduation from an appropriate professional school, continuing education requirements, and if applicable, completion of residency and specialty training;

   d. Current (within last three (3) years) full scope FSR/MRR, and PARS for Primary Care practitioners in the Medi-Cal provider network, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews;

   e. Active enrollment status with Medi-Cal for providers in the Medi-Cal provider network, as required; and

   f. Medicare program enrollment opt-out status (i.e. not on the opt-out list).

3. CalOptima Health, its Delegates, or CVO shall collect and verify the following information from each practitioner, as applicable, but need not verify this information through a primary source (see Attachment A). This information includes, but is not limited to:

   a. Work history, including all post-graduate activity in the last five (5) years (on initial Credentialing). The practitioner shall provide a written explanation of any gaps of six (6) months or more (verification time limit: 180 calendar days);

   b. Confirmation that the practitioner has hospital admitting staff privileges that are in good standing or confirmation that the practitioner refers patients to hospital-based practitioners (hospitalists), as applicable;

      i. History of any suspension or curtailment of hospital and clinic privileges.

      ii. Any alternative admitting arrangements must be documented in the Credentialing file.

For 20260319 QAC Review Only

c. A valid Drug Enforcement Administration (DEA) or valid Controlled Dangerous Substances (CDS) certificate, if applicable, in effect at the time of the Credentialing decision; DEA certificate must show an address within the state of California;

i. DEA and CDS-eligible practitioner who do not have a certificate, and for whom prescribing controlled substance is in the scope of their practice shall have in place a designated practitioner to write prescriptions on their behalf;

ii. This requirement is not applicable for practitioner who do not prescribe controlled substances and that in their professional judgment, the patients receiving their care do not require controlled substances; however, such practitioners must provide a written description of their process for handling instances when a patient requires a controlled substance.

d. Current malpractice insurance in the minimum amounts of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) aggregate per year at the time of the Credentialing decision (verification time limit: 120 calendar days);

i. For Behavioral Health Service Providers, the minimum amounts shall be no less than one million dollars ($1,000,000.00) per incident and one million dollars ($1,000,000.00) aggregate per year at the time of the Credentialing decision (verification time limit: 120 calendar days).

e. Practitioner information entered in the National Practitioner Data Bank (NPDB), including malpractice history, (verification time limit: 120 calendar days) if applicable;

f. No exclusion or preclusion from participation at any time in federal or state health care programs based on conduct within the last ten (10) years, as set forth in 42 USC § 1320a-7(a), as follows:

i. A conviction of a criminal offense related to the delivery of an item, or service, under federal, or state, health care programs;

ii. A felony conviction related to neglect or abuse of patients in connection with the delivery of a health care item or service;

iii. A felony conviction related to health care fraud; or

iv. A felony conviction related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

g. No history of professional liability claims that resulted in settlements or judgments paid by, or on behalf of, the practitioner in the last five (5) years;

h. No history of state sanctions, restrictions on licensure, or limitations on scope of practice, which may include accusations, probation, a previously filed 805 and 805.1 report with a licensing board; and

i. HIV/AIDS Specialist Screening Form and Attestation from each practitioner, as applicable.

For 20260319 QAC Review Only

4. CalOptima Health, a Delegate, or CVO shall verify qualifications for the following practitioner types in the Medi-Cal provider network in accordance with the following CalOptima Health policies:

   a. For doulas and comply with the requirements, in accordance with CalOptima Health Policy GG.1707: Doula Services.

   b. For Community Health Workers (CHW) and comply with the requirements in accordance with CalOptima Health Policy GG.1213: Community Health Worker Services.

B. Practitioner Recredentialing

1. CalOptima Health or a Delegate shall recredential a practitioner at least every three (3) years after initial Credentialing. At the time of Recredentialing, CalOptima Health, its Delegate, or CVO shall:

   a. Collect and/or verify, where applicable, at a minimum, all of the information required for initial Credentialing, as set forth in Section III.A of this policy, including any change in work history, except historical data already verified at the time of the initial Credentialing of the practitioner; and

   b. Include documentation that information from other sources, such as the following data, was incorporated in the decision-making process, which shall have been reviewed no more than one hundred twenty (120) calendar days before the Recredentialing decision is made.

      i. Member Grievances and Appeals, including number and type during the past three (3) years;

      ii. A review of any Grievances, or quality cases, filed against a practitioner in the last three (3) years;

      iii. Information from quality review activities;

      iv. Member satisfaction, if applicable; and

      v. Compliance with the terms of the practitioner's contract.

   c. All Recredentialing applications must include the attestations as contained in the practitioner's initial Credentialing application and shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

2. Current (within the last three (3) years) full scope FSR/MRR and PARS, as applicable, pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews.

3. CalOptima Health or its Delegate shall ensure that all practitioners maintain current DEA certification and medical malpractice insurance and shall validate this information at Recredentialing review.

4. CalOptima Health or its Delegate shall ensure that all practitioners maintain current California licensure in the interval between Recredentialing cycles.

For 20260319 QAC Review Only

Back to Agenda Back to Item

a. CalOptima Health or its Delegate documents the license expiration date into the Credentialing files and/or system and monitors all licenses that will expire monthly.

b. CalOptima Health or its Delegate monitors the NPDB and/or the state licensing board for suspensions, restrictions, revocations, surrenders, and disciplinary actions on a monthly basis according to Policy GG.1607 Monitoring Adverse Actions.

C. Practitioner Rights

1. Applicants for Credentialing will receive practitioner rights included in the Credentialing application, as follows:

a. Right to review information:

i. Practitioners will be notified of their right to review information that CalOptima Health or its Delegate has obtained to evaluate the practitioner's Credentialing application, attestation, or curriculum vitae. This includes non-privileged information obtained from any outside source (*e.g.*, malpractice insurance carriers, state licensing boards), but does not extend to review of information, references, or recommendations protected by law from disclosure (*i.e.*, peer-review protected information).

b. Right to correct erroneous information:

i. All practitioners will be notified by email or certified mail when Credentialing information obtained from other sources during Credentialing varies from that provided by the practitioner in the Credentialing application;

ii. All practitioners have the right to correct erroneous information, as follows:

a) The practitioner has forty-eight (48) hours, excluding weekends, from date of notification to correct erroneous information;

b) Requests for correction of erroneous information must be submitted by email or certified mail on the practitioner's letterhead with a detailed explanation regarding the erroneous information, as well as copy(ies) of corrected information; and

c) For practitioners credentialed directly CalOptima Health, mailed submissions must be sent to CalOptima Health's Quality Improvement (QI) Department using the following address or email:

Attn: Quality Improvement Department – Credentialing
CalOptima Health
505 City Parkway West
Orange CA 92868

Email: mycredentialingupdates@caloptima.org

d) For practitioners credentialed by a Delegate, the practitioner shall contact their Delegate directly to address any erroneous information.

For 2026-03-19 QAC Review Only

Back to Agenda Back to Item

iii. CalOptima Health is not required to reveal the source of information, if the information is not obtained to meet CalOptima Health's Credentialing verification requirements, or if federal or state law prohibits disclosure.

iv. Documentation of receipt of corrections:

a) CalOptima Health or its Delegate shall document receipt of corrected information in the practitioner's Credentialing file.

b) A practitioner shall be notified via fax, email, or certified letter to document receipt of the identified erroneous information.

v. Right to be notified of application status

a) Practitioners may receive the status of their Credentialing or Recredentialing application, upon request.

b) Practitioners can contact the QI Department by phone or e-mail requesting the status of their application. The QI Department will aim to respond within seven (7) business day of the status of the practitioner's application with respect to outstanding information required to complete the application process.

D. Credentialing Committee

1. CalOptima Health or its Delegates shall designate a Credentialing committee that uses a peer-review process to make recommendations and decisions regarding credentialing and recredentialing.

2. CalOptima Health shall designate the Credentialing and Peer Review Committee (CPRC) that uses a peer-review process to make recommendations and decisions regarding Credentialing and Recredentialing for practitioners in CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for the Elderly.

3. CPRC shall include representation from a range of practitioners participating in the organization's network and shall be responsible for reviewing a practitioner's Credentialing and Recredentialing files and determining the practitioner's participation in CalOptima Health programs.

4. Completed Credentialing and Recredentialing files will either be presented to the CMO or Designee on a clean file list for signature or will be presented at CPRC for review and approval.

a. A clean file consists of a complete application with a signed attestation and consent form, supporting documents, and verification of no more than one (1) professional review or malpractice claim(s) that resulted in settlements or judgments greater than twenty-five thousand dollars ($25,000) paid by, or on behalf of, the practitioner within the last seven (7) years from the date of the Credentialing or Recredentialing review.

i. A clean file shall be considered approved and effective on the date that the CMO or Designee reviews and approves a practitioner's Credentialing, or Recredentialing, file, and deems the file clean.

ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for final approval and be reflected in the meeting minutes.

For 20260319 QAC Review Only

Back to Agenda Back to Item

b. Files that do not meet the clean file review process and that require further review by CPRC include, but are not limited to, those files that include more than one (1) malpractice claim that resulted in a settlement or judgment greater than twenty-five thousand dollars ($25,000), or NPDB query identifying medical board investigations, or other actions.

i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application.

ii. CPRC shall give thoughtful consideration to the information presented in the Credentialing file, which consideration shall be reflected in the minutes of the CPRC meeting.

iii. CPRC meetings and decisions may take place in real-time, or as a virtual meeting via telephone or video conference but may not be conducted through e-mail.

5. Practitioner files identified as not meeting Credentialing criteria with exceptions or potential exceptions, which may include serious quality deficiencies that result in the suspension or termination of a practitioner, shall be referred to the CMO or designee for review.

a. The CMO or Designee shall review each file for practitioners who do not meet Credentialing criteria and make recommendations regarding approving or denying Credentialing of the practitioner to the CPRC. For practitioner files not meeting criteria on an administrative basis only, the file may be approved or denied by the CMO or Designee.

6. The CPRC shall make a final determination based on the practitioners' ability to deliver care based on the Credentialing information collected from the file review process and that is verified prior to making a Credentialing decision.

a. The QI Department shall send the practitioner a decision letter within thirty (30) calendar days of the decision indicating:

i. Acceptance;

ii. Acceptance with restrictions along with appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners; or

iii. Denial of the application along with appeal rights information, in accordance with CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners, with a letter of explanation forwarded to the applicant.

b. CalOptima Health and its Delegates shall make a determination regarding the credentials of a Covered California practitioner within ninety (90) days after receiving a completed practitioner credentialing application, including all required third-party verifications. CalOptima Health and its Delegates shall notify a practitioner, if successfully approved, of the activation within ten (10) business days of approval if the approval occurs prior to the end of the ninety (90)-day timeline. The ninety (90)-day timeline shall apply only to the credentialing process and does not include contracting completion. If CalOptima Health and its Delegates do not meet the ninety (90)-day requirement, the practitioner's credentials shall be provisionally approved for one hundred twenty (120) days unless any of the following apply:

For 20260319 QAC Review Only

Back to Agenda Back to Item

i. The practitioner is subject to discipline by the licensing entity for the practitioner.

ii. The practitioner has one or more adverse action reports or one or more reports of malpractice payments filed with the National Practitioner Data Bank (NPDB).

iii. The practitioner has not been credentialed by CalOptima Health or its Delegates in the past five (5) years.

c. CalOptima Health shall render a final Credentialing decision for Medi-Cal, OneCare and PACE practitioners within one hundred twenty (120) calendar days from the date of a completed application, which includes a signed attestation that confirms the correctness and completeness of the application.

i. Application attestations must be signed within the one hundred eighty (180) calendar days prior to the Credentialing decision. If the practitioner's attestation expires prior to the Credentialing decision, the practitioner must reattest that the information on the application remains correct and complete, by resigning and redating the attestation.

ii. As of January 1, 2027, CalOptima Health and its Delegates shall notify the practitioner within ten (10) business days to verify receipt and inform the applicant whether the application is complete.

7. If CalOptima Health terminates a practitioner during the Recredentialing process for administrative reasons (*i.e.*, the practitioner failed to provide complete Credentialing information) and not for quality reasons (*i.e.,* medical disciplinary cause or reason), CalOptima Health may reinstate the practitioner within thirty (30) calendar days of termination and is not required to perform initial Credentialing. However, CalOptima Health must re-verify credentials that are no longer within the verification time limit. If the reinstatement would be more than thirty (30) calendar days after termination, CalOptima Health must perform initial Credentialing of such practitioner.

a. Termination of privileges includes failure or refusal to renew a contract or to renew, extend, or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.

E. CalOptima Health and its Delegates shall monitor and prevent discriminatory practices. Activities, including, but are not limited to:

1. Monitoring:

a. Conduct periodic audits of Credentialing files (in-process, denied, and approved files) to ensure that practitioners are not discriminated against as set forth in Section II.Q.;

b. Review practitioner complaints to determine if there are complaints alleging discrimination; and

c. On a quarterly basis, the QI Department shall review Grievances, Appeals, and potential quality-of-care issues for complaints alleging discrimination and will report outcomes to the CPRC for review and determination.

2. Prevention:

For 20260319 QAC Review Only

Back to Agenda Back to Item

a. The QI Department shall maintain a heterogeneous CPRC and will require those responsible for Credentialing decisions to sign a statement affirming that they do not discriminate.

b. QI Department staff shall remove identifying information, such as name and affiliation, from the practitioner and provider files when presenting cases to CPRC to remove bias and prevent discrimination.

F. Upon acceptance and approval of a Credentialing application, the QI Department shall share the credentialing profile with Contracting, Provider Relations, and Provider Data Management Service (PDMS) Departments. This practitioner profile shall be generated from the Credentialing database to ensure that the information is consistent with data verified during the Credentialing process (*i.e.*, education, training, Board Certification, and specialty). The PDMS Department will enter the contract and Credentialing data into CalOptima Health's core business system and/or will verify the Credentialing data in the system, which updates pertinent information into the online provider directory.

G. Practitioner Screening and Enrollment (Medi-Cal Providers Only)

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) practitioners or obtain a PED approval letter as an acceptable form of initial enrollment verification conducted by DHCS.

2. If a practitioner is already enrolled with DHCS as a Medi-Cal FFS practitioner, then the practitioner screening and enrollment process does not need to be completed by CalOptima Health.

3. If a practitioner is not already enrolled with DHCS as a Medi-Cal FFS practitioner, then CalOptima Health may complete screening and enrollment established by CalOptima Health.

a. CalOptima Health shall notify DHCS and submit its P&Ps for approval prior to implementation. The P&Ps must define the scope of their enrollment process if CalOptima Health does not enroll all provider types.

b. CalOptima Health shall complete the process and provide the applicant with a written determination on CalOptima Health letterhead within one hundred twenty (120) calendar days of its receipt of a practitioner application.

c. CalOptima Health shall submit a list of its newly enrolled practitioners every six months to CalOptima Health's DHCS Managed Care Operations Division (MCOD) contract manager.

d. CalOptima Health shall collect all the appropriate information, data elements, and supporting documentation required for each provider type and ensure that the application is reviewed for both accuracy and completeness.

i. CalOptima Health shall inform practitioners seeking to enroll with CalOptima Health of the differences between CalOptima Health's and DHCS's provider enrollment processes, including the practitioner's right to enroll through DHCS, at the time of application. CalOptima Health will provide required disclosures that include, but are not limited to, the following elements:

For 20260319 QAC Review Only

Back to Agenda Back to Item

a) A statement that certain enrollment functions will not be performed by CalOptima Health but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.

b) A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a practitioner chooses to enroll through CalOptima Health, including provisional practitioner status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal CalOptima Health's decision to suspend the enrollment process.

c) A provision informing the practitioner that if CalOptima Health receives any information that impacts the practitioner's eligibility for enrollment, CalOptima Health will suspend processing of the practitioner's enrollment application and make the practitioner aware of the option to apply through DHCS' Medi-Cal FFS practitioner enrollment process.

d) A statement clarifying that in order for the practitioner to participate in the Medi-Cal FFS program, the practitioner must enroll through DHCS, and that enrolling through DHCS will also make the practitioner eligible to contract with CalOptima Health.

ii. CalOptima Health may collect an application fee, not to exceed the Medi-Cal FFS enrollment application fee amount.

iii. CalOptima Health shall obtain the practitioner's consent in order to share information relating to the practitioner's application and eligibility with DHCS.

iv. CalOptima Health shall collect and maintain the original signed Medi-Cal Provider Agreement and Network Provider Agreement for each practitioner.

v. CalOptima Health shall maintain all practitioner enrollment documentation in a secure manner to ensure confidentiality of the practitioner's personal information.

vi. Enrollment records shall be made available upon request to DHCS, CMS or other authorized governmental agencies.

e. Practitioners that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by 42 CFR § 455.104.

i. Practitioners who are unincorporated sole proprietors are not required to disclose the ownership or control information.

ii. Upon CalOptima Health's request, a practitioner must submit within thirty-five (35) calendar days:

a) Full and complete information about the ownership of any subcontractor with whom the practitioner has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of the request; and

For 20260319 QAC Review Only

b) Any significant business transactions between the practitioner and any wholly owned supplier, or between the practitioner and any subcontractor, during the five (5)-year period ending on the date of the request.

f. CalOptima Health shall screen initial practitioner applications, including applications for a new practice location, and any applications received in response to a practitioner's reenrollment or revalidation request to determine the practitioner's categorical risk level as limited, moderate, or high.

i. If a practitioner fits within more than one risk level, CalOptima Health must screen the practitioner at the highest risk level.

ii. A practitioner's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated practitioner lists, and criminal background checks.

iii. CalOptima Health shall not enroll a practitioner who fails to comply with the screening criteria for that practitioner's assigned level of risk.

g. Practitioners are subject to screening based on verification of the following requirements:

i. Limited-Risk Practitioners:

a) Meet state and federal requirements;

b) Hold a license certified for practice in the state and has no limitations from other states; and

c) Have no suspensions or terminations on state and federal databases.

ii. Medium-Risk Practitioners:

a) Screening requirements of limited-risk practitioners; and

b) Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to CalOptima Health and DHCS is accurate and to determine compliance with state and federal enrollment requirements.

iii. High-Risk Practitioners:

a) Screening requirements of medium-risk practitioners; and

b) Criminal background checks based in part on a set of fingerprints.

h. CalOptima Health and DHCS shall adjust the categorical risk level when any of the following circumstances occur:

i. The state imposes a payment suspension on a practitioner based on a credible allegation(s) of Fraud, Waste, or abuse.

ii. The practitioner has an existing Medicaid overpayment based on Fraud, Waste, or abuse.

For 20260319 QAC Review Only

iii. The practitioner has been excluded by the Office of Inspector General or another state's Medicaid program within the previous ten (10) years, or when a state or federal moratorium on a provider type has been lifted.

iv. The practitioner would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six (6) months.

i. Additional criteria for high-risk practitioners

i. Any person with a five percent (5%) or more direct or indirect ownership and is a high-risk applicant or where information discovered in the onsite or data analysis may lead to this type of request.

ii. CalOptima Health shall direct practitioners to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website and ensure that practitioners include the correct agency information on the Live Scan form when submitting their application. The agency-specific information shall include the following information:

Applicant Submission

Field	**Entry**
ORI (Code assigned by DOJ)	CA0341600
Authorized Applicant Type	High Risk Medi-Cal Provider
Type of License/Certification/Permit OR Working Title	MCMC

Contributing Agency Information

Field	**Entry**
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509
Street Address or PO Box	1700 K Street; MS 2200
Contact Name	MCMC
City	Sacramento
State	CA
ZIP Code	95811
Contact Telephone Number	(916) 750-1509

iii. When fingerprinting is required, CalOptima Health must furnish the practitioners with the Live Scan form and instructions on where to deliver the completed form.

iv. The practitioner must deliver the completed Live Scan form to the California DOJ and is responsible for paying for any Live Scan processing fees.

v. CalOptima Health shall notify DHCS upon initiation of each criminal background check for a practitioner that has been designated as high risk.

vi. CalOptima Health shall maintain the security and confidentiality of all of the information it receives from DHCS relating to the practitioner's high-risk designation and the results of the criminal background checks.

j. Site Visits

For 20260319 QAC Review Only

i. CalOptima Health shall conduct pre- and post-enrollment site visits of medium-risk and high-risk practitioners to verify that the information submitted to CalOptima Health and DHCS is accurate and to determine the applicant's compliance with state and federal enrollment requirements.

ii. CalOptima Health shall conduct post-enrollment site visits for medium-risk practitioners at least every five (5) years and their high-risk practitioners every three (3) years or as necessary to verify that the information submitted to CalOptima Health and DHCS is accurate and determine if practitioners are in compliance with state and federal enrollment requirements.

iii. Onsite visits may be conducted for many reasons, including, but not limited to, the following:

a) The practitioner was temporarily suspended from the Medi-Cal program;

b) The practitioner's license was previously suspended;

c) There is conflicting information in the practitioner's enrollment application;

d) There is conflicting information in the practitioner's supporting enrollment documentation; and

e) As part of the practitioner enrollment process, CalOptima Health receives information that raises a suspicion of fraud.

k. Federal and State Database Checks

i. CalOptima Health shall check the following databases to verify the identity and determine the exclusion and/or enrollment status of all practitioners:

a) Social Security Administration's Death Master File;

b) National Plan and Provider Enumeration System (NPPES);

c) List of Excluded Individuals/Entities (LEIE);

d) System for Award Management (SAM);

e) CMS' Medicare Exclusion Database (MED);

f) DHCS' Suspended and Ineligible Provider List;

g) Restricted Provider Database (RPD); and

h) CHHS Open Data Portal.

ii. CalOptima Health shall also review the SAM, LEIE, and RPD databases on a regular basis, and at least monthly, to ensure that contracted practitioners continue to meet enrollment criteria and take appropriate action in connection with the exclusion.

For 20260319 QAC Review Only

Back to Agenda Back to Item

iii. Any practitioners terminated from the Medicare or Medicaid/Medi-Cal program may not participate in CalOptima Health's practitioner network.

l. If CalOptima Health declines to enroll a practitioner, it must refer the practitioner to DHCS for further enrollment options.

m. If CalOptima Health acquires information, either before or after enrollment, that may impact the practitioner's eligibility to participate in the Medi-Cal program, or a practitioner refuses to submit to the required screening activities, CalOptima Health may decline to accept that practitioner's application.

n. If at any time CalOptima Health determines that it does not want to contract with a prospective practitioner, and/or that the prospective practitioner will not meet enrollment requirements, CalOptima Health must immediately suspend the enrollment process of that practitioner.

o. CalOptima Health is not obligated to establish an appeal process for screening and enrollment decisions. Practitioners may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.

p. All practitioners must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process at least every five (5) years to ensure that all enrollment information is accurate and up-to-date.

q. CalOptima Health shall retain all practitioner screening and enrollment materials and documents for ten (10) years.

r. CalOptima Health shall make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

IV. ATTACHMENT(S)

A. CalOptima Health Primary Source Verification Table

V. REFERENCE(S)

A. Assembly Bill (AB) 1041
B. California Business and Professions Code §§ 805, 2837.103, 2837.104 and 3500-3502.3
C. California Evidence Code §1157
D. California Health & Safety Code §§1374.197, 1374.198, and 1380.2
E. CalOptima Health Contract for Health Care Services
F. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
G. CalOptima Health Contract with Covered California
H. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
I. CalOptima Health PACE Program Agreements
J. CalOptima Health Policy GG.1213: Community Health Worker Services
K. CalOptima Health Policy GG.1602: Non-Physician Medical Practitioner (NMP) Scope of Practice
L. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
M. CalOptima Health Policy GG.1607: Monitoring Adverse Actions

For 20260319 QAC Review Only

Back to Agenda Back to Item

N. CalOptima Health Policy GG.1608: Full Scope Site Reviews
O. CalOptima Health Policy GG.1616: Fair Hearing Plan for Practitioners
P. CalOptima Health Policy GG.1619: Delegation Oversight
Q. CalOptima Health Policy GG.1633: Board Certification Requirements for Physicians
R. CalOptima Health Policy GG.1643: Minimum Provider Credentialing Standards
S. CalOptima Health Policy GG.1651: Assessment and Re-Assessment of Organizational Providers
T. CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information
U. CalOptima Health Policy GG.1707: Doula Services
V. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
W. CalOptima Health Policy MA.5012: Pharmacy Network: Credentialing and Access
X. CalOptima Health Policy MA.9006: Provider Complaint Process
Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-009: Adult Immunizations as a Pharmacy Benefit (Revised 12/23/2016)
U. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing / Recredentialing and Screening / Enrollment (Revised 01/02/2025)
V. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024: Doula Services (Supersedes APL 22-031) (Revised 11/03/2023)
W. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members
X. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006: Community Health Worker Services Benefit (Supersedes APL 22-016)
Y. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
U. Medicare Managed Care Manual, Chapter 6: Relationships with Providers
V. National Committee for Quality Assurance (NCQA) Standards and Guidelines
W. Title 42, Code of Federal Regulations (CFR), §§ 422.204(a), 422.205, 438.12, 438.214, 460.64, 460.71, and Part 455, Subpart E
X. Title 42, United States Code (USC), §1320a-7(a)
Y. Title XVIII and XIV of the Social Security Act

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
04/28/2015	Department of Health Care Services (DHCS)	Approved as Submitted
09/20/2018	Department of Health Care Services (DHCS)	Approved as Submitted
10/13/2020	Department of Health Care Services (DHCS)	No Reply 60 Days
05/05/2022	Department of Health Care Services (DHCS)	Approved as Submitted
10/26/2022	Department of Health Care Services (DHCS)	Approved as Submitted
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
07/11/2023	Department of Health Care Services (DHCS)	Approved as Submitted
06/13/2024	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/01/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors

For 19 QAC Review Only

Back to Agenda Back to Item

Date	Meeting
11/06/2025	Regular Meeting of the CalOptima Health Board of Directors
	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	09/06/2018	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2019	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2020	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	04/07/2022	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	04/01/2023	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	05/01/2024	GG.1650	Credentialing and Recredentialing of Practitioners	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE

Back to Agenda Back to Item

Action	Date	Policy	Policy Title	Program(s)
Revised	11/01/2025	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	01/01/2026	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE
Revised	04/01/2026	GG.1650	Credentialing and Recredentialing of Practitioners	Covered California Medi-Cal OneCare PACE

1

For 20260319 QAC Review

Back to Agenda Back to Item

IX. GLOSSARY

Term	Definition
Abuse	Covered California: Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services. Medi-Cal: Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program. OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima Health and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima Health and the OneCare program.
Appeal (Member)	Covered California: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR § 438.408(b).

For 20260319 QAC Review Only

Back to Agenda Back to Item

Term	Definition
	OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and § 423.566(b). These procedures include reconsideration or redetermination, a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR § 460.122.
Behavioral Health Provider	A licensed practitioner including, but not limited to, physicians, nurse specialists, psychiatric nurse practitioners, licensed psychologists (PhD or PsyD), licensed clinical social worker (LCSW), marriage and family therapist (MFT or MFCC), professional clinical counselors and qualified autism service providers, furnishing covered services.
Board Certification/Certified	Certification of a physician by one (1) of the boards recognized by the American Board of Medical Specialties (ABMS), or American Osteopathic Association (AOA), as meeting the requirements of that board for certification.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Covered California: *Effective 01/01/2027 for CalOptima Health*	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.

For 20260319 QAC Review Only

Term	Definition
Credentialing and Peer Review Committee (CPRC)	The Credentialing and Peer Review (CPRC) Committee makes decisions, provides guidance, and provides peer input into the CalOptima provider selection process and determines corrective action necessary to ensure that all practitioners and providers who provide services to CalOptima Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Quality Improvement (QI) Committee.
Credentialing Verification Organization (CVO)	For purposes of this policy, an organization that collects and verifies Credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Facility Site Review (FSR)	A DHCS tool utilized to assess the quality, safety and accessibility of primary care physicians (PCPs) and high-volume specialist physician offices.
Federally Qualified Health Center (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 CFR § 455.2, Welfare and Institutions Code § 14043.1(i).
Grievance	Covered California: A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.

For 20260519 QAC Review Only

Back to Agenda Back to Item

Term	Definition
	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of care furnished, as defined by the federal PACE regulation 42 CFR § 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
HIV/AIDS Specialist	A physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four (4) criteria: 1. Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; 2. Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; 3. Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications: (A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and (B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or 4. Meets the following qualifications: (A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and (B) Has completed any of the following: 1. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or 2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or 3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical

For 20260319 QAC Review Only

Back to Agenda Back to Item

Term	Definition
	education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.
Indian Health Care Provider (IHCP)	A health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (IHCIA) at 25 USC § 1603.
Medical Record Review (MRR)	A DHCS tool utilized to audit PCP medical records for format, legal protocols, and documented evidence of the provision of preventive care and coordination and continuity of care services.
Member	An individual enrolled in a CalOptima program.
Minimum Physician Standards	Minimum standards that must be met in order for a Physician to be credentialed and contracted for participation in CalOptima programs.
National Committee for Quality Assurance (NCQA)	An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.
Non-Physician Medical Practitioner (NMP)	A licensed practitioner, including but not limited to, a Nurse Practitioner (NP), Certified Nurse Midwife (CNM), Licensed Midwife (LM), Certified Nurse Specialists (CNS), Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech Therapist (ST), or Audiologist furnishing covered services.
Organized Health Care System	Includes a licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code, an outpatient setting as described in Chapter 1.3 (commencing with Section 1248) of Division 2 of the Health and Safety Code, a health facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, a county medical facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code, an accountable care organization, a home health agency, a physician's office, a professional medical corporation, a medical partnership, a medical foundation, and any other entity that lawfully provides medical services and is in compliance with Article 18 (commencing with Section 2400) of Chapter 5.
Pharmacy Benefit Manager (PBM)	The entity that performs certain functions and tasks including, but not limited to, pharmacy Credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including specialist and ancillary service providers.
Physician Practitioner	A licensed practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), furnishing covered services.
Practice Agreement	The writing, developed through collaboration among one or more physicians and surgeons and one or more physician assistants, that defines the medical services the physician assistant is authorized to perform pursuant to BPC § 3502 and that grants approval for physicians and surgeons on the staff of an Organized Health Care System to supervise one or more physician assistants in the Organized Health Care System. Any reference to a delegation of services

For 20260319 QAC Preview Only

Back to Agenda Back to Item

Term	Definition
	agreement relating to physician assistants in any other law shall have the same meaning as a Practice Agreement.
Primary Care	For purposes of this policy, a basic level of health care usually rendered in an ambulatory setting by a PCP.
Recredentialing	The process by which the qualifications of practitioners is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima program.
Specialty Care	For purposes of this policy, specialty care given to Members by referral by other than a PCP.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.
Utilization Management (UM)	Requirements or limits on coverage. UM may include, but is not limited to, prior authorization, quantity limit, or step therapy restrictions.
Waste	Covered California: Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls. Medi-Cal: The overutilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act, as stated in CMS' Fraud, Waste, and Abuse Toolkit. OneCare: The overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to a CalOptima Health Program. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources.

1

For 20260519 QAC Review Only

Back to Agenda Back to Item

CalOptima Health Primary Source Verification Table

Primary Source Verification – Licensure

Licensure	Source of Verification	Method of Verification
MD – Medical Board of California	https://search.dca.ca.gov/ https://www.mbc.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DO- Osteopathic Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DC- California Board of Chiropractic	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DDS- Dental Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DPM- California Board of Podiatric Medicine	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Psychology	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Behavioral Sciences	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer Affairs Acupuncture Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Health Primary Source Verification Table

Licensure	Source of Verification	Method of Verification
Department of Consumer Affairs CA State Board of Optometry	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Board of Registered Nursing	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
California Department of Consumer Affairs. Physician Assistant Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Physical Therapy Board of California	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer Affairs California Board of Occupational Therapy	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Department of Consumer affairs Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board	https://search.dca.ca.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Health Primary Source Verification Table

Primary Source Verification – DEA

DEA	https://apps.deadiversion.usdoj.gov/RDA/ **Login and Password required	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Copy of current DEA certificate	Visual inspection of certificate and stored in Credentialing database.

Primary Source Verification – Board Certification

Certification	Source of Verification	Method of Verification
Board Certification	American Board of Medical Specialties https://certifacts.abms.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Osteopathic Association (AOA) https://osteopathic.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Professional Psychology https://www.abpp.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated
	American Board of Foot and Ankle Surgery (ABFAS) https://www.abfas.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Oral and Maxillofacial Surgery (ABOMS) https://www.aboms.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically

CalOptima Health Primary Source Verification Table

Certification	Source of Verification	Method of Verification
		tracked and dated.
Nursing Board	Nursing Board Certification for Nurse Practitioners/Advance Practice Nurses American Academy of Nurse Practitioners Certification Board (AANPCB) www.aanpcert.org/ American Nursing Credentialing Center (ANCC)https://www.nursingworld.org/ancc/ National Certification Corporation (NCC) www.nccwebsite.org	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Pediatric Nursing Certification Board (PNCB) www.pncb.org American Association of Critical Care Nurses (AACN) www.aacn.org	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Midwifery	American Midwifery Certification Board (AMCB) http://www.amcbmidwife.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
Physician Assistant	National Commission on Certification of PA's (NCCPA) https://portal.nccpa.net/verifypac	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

CalOptima Health Primary Source Verification Table

Primary Source Verification – Education & Training

Education	Source of Verification	Method of Verification
Education & Training	Board certification by ABMS or AOIA in practicing specialty	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	American Board of Multiple Specialties in Podiatry. http://abmsp.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AMA Physician Master File https://www.ama-assn.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AOIA Official Osteopathic Physician Profile Report https://www.aoaprofiles.org/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Contact the training institution to verify the highest level of training; or State Licensing Agency, as applicable	Letter from institution is reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	National Student Clearing House http://nscverifications.org/welcome-toverification-serives/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	National Board of Physicians and Surgeons (NBPAS) https://nbpas.org/	Verified sources are reviewed and stored in Credentialing

CalOptima Health Primary Source Verification Table

		database. All sources are electronically tracked and dated.

Primary Source Verification – Malpractice History

Malpractice Information	Source of Verification	Method of Verification
Malpractice History	National Practitioner Data Bank (NPDB) https://www.npdb.hrsa.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Primary Source Verification –Sanctions and other sources

Sanction Information	Source of Verification	Method of Verification
State & Federal Sanctions and Other Sources	National Practitioner Data Bank (NPDB) https://www.npdb.hrsa.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	System for Award Management-SAM https://sam.gov/search/?index=_all&page=1&sort=modifiedDate&sfm%5Bstatus%5D%5Bis_active%5D=true	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Office of Inspector General https://exclusions.oig.hhs.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
State &	Medi-Cal Suspended & Ineligible List https://files.medi Provider Suspended and	Verified sources are reviewed and

CalOptima Health Primary Source Verification Table

Sanction Information	Source of Verification	Method of Verification
Federal Sanctions and Other Sources	Ineligible List (S&I List) - Provider Suspended and Ineligible List (S&I List) - California Open Data	stored in Credentialing database. All sources are electronically tracked and dated.
	CMS Preclusion List https://portal.cms.gov/wps/portal/unauthportal/home/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Drug Code Limitation Listing of practitioners and/or medical groups placed on P/DCL sanction, https://files.medi-cal.ca.gov/pubsdoco/pdcl_home.aspx	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	Department of Health Care Service (DHCS)-Restricted Provider Database	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	CMS.gov Centers for Medicare & Medicaid Services – Medicare Opt-Out Physicians https://www.cms.gov/Medicare/ Provider-EnrollmentandCertification/MedicareProviderSupEnroll/OptOutAffidavits.html For a listing of all physicians and practitioners that are currently opted out of Medicare: https://data.cms.gov/tools/provider opt-out-affidavits-look-up-tool https://data.cms.gov/provider-characteristics/medicare-provider-supplier-enrollment/opt-out-affidavits/data	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AMA Physician Master File	Verified sources

CalOptima Health Primary Source Verification Table

Sanction Information	Source of Verification	Method of Verification
Other Sanction Sources		are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
	AOIA Physician Profile report	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.

Screening and Enrollment

Sanction Information	Source of Verification	Method of Verification
Social Security Death Master File (DMF). National Technical Information Services (NTIS) is the only authorized official distributor of the Death Master file on the web.	**Social Security Death Master File (DMF) Website** https://evoconportal.com/dmfportal/login.php **National Technical Information Services (NTIS)** https://classic.ntis.gov/products/ssa-dmf/#	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
National Plan and Provider Enumeration System (NPPES)	https://nppes.cms.hhs.gov/NPPES/Welcome.do Search NPI Records https://npiregistry.cms.hhs.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronicall

CalOptima Health Primary Source Verification Table

Sanction Information	Source of Verification	Method of Verification
		y tracked and dated.
List of Excluded Individuals/Entities (LEIE)	Office of Inspector General https://exclusions.oig.hhs.gov/	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
System for Award Management (SAM)	System for Award Management-SAM https://sam.gov/search/?index=_all&page=1&sort=modifiedDate&sfm%5Bstatus%5D%5Bis_active%5D=true	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
CMS' Medicare Exclusion Database (MED)	CMS Preclusion List https://portal.cms.gov/wps/portal/unauthportal/home/ Receive from IS Dept	Verified sources are reviewed and stored in Credentialing database. All sources are electronically tracked and dated.
DHCS' Suspended and Ineligible Provider List	Medi-Cal Suspended & Ineligible List - https://data.chhs.ca.gov/dataset/provider-suspended-and-ineligible-list-s-i-list/resource/48630a37-b5ba-4d3d-af54-e82b30e658a0	Verified sources are reviewed and stored in Credentialin

CalOptima Health Primary Source Verification Table

Sanction Information	Source of Verification	Method of Verification
	Provider Suspended and Ineligible List (S&I List) - Provider Suspended and Ineligible List (S&I List) - California Open Data	g database. All sources are electronicall y tracked and dated.
Restricted Provider Database (RPD)	Department of Health Care Service (DHCS)- Restricted Provider Database Receive from IS Dept	Verified sources are reviewed and stored in Credentialin g database. All sources are electronicall y tracked and dated.
CHHS Open Data Portal (Medical Enrollment)	Medi Cal FFS Provider Listing | Medi Cal FFS Provider Listing | DHCS GIS Data Hub (arcgis.com) https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers/resource/d652b210-ec3d-4a92-b7e0-e55c3dcbc7dc	Verified sources are reviewed and stored in Credentialin g database. All sources are electronicall y tracked and dated.
Ordering, referring, and prescribing (ORP)	https://mcweb.apps.prd.cammis.medi-cal.ca.gov/orp	Verified sources are reviewed and stored in Credentialin g database. All sources are electronicall y tracked

CalOptima Health Primary Source Verification Table

Sanction Information	Source of Verification	Method of Verification
		and dated.

Policy:	GG.1651
Title:	**Assessment and Reassessment of Organizational Providers**
Department:	Quality Improvement
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	04/01/2026
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 20260319 QAC Review Only

I. PURPOSE

This policy describes the process by which CalOptima Health evaluates and determines a Provider, including an Organizational Provider (OP), rendering consolidated, facility-based services and/or billing for health care services not directly rendered and billed by a professional Provider, eligibility to participate in CalOptima Health programs.

II. POLICY

A. CalOptima Health shall establish guidelines for evaluation of OPs participation eligibility in CalOptima Health programs, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima Health may delegate authority to perform Medi-Cal screening and enrollment activities to a Health Network or Delegate. If CalOptima Health chooses to delegate this function, the follow shall occur:

1. The delegation shall be in a written subcontract or agreement, where CalOptima Health remains contractually responsible for the completeness and accuracy of the screening and enrollment activities.

2. CalOptima Health shall evaluate the Health Network or Delegate's ability to perform these activities, including an initial review to ensure that the Health Network or Delegate has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

3. CalOptima Health shall continuously monitor, evaluate, and approve the delegated functions.

4. CalOptima Health shall notify the Department of Health Care Services (DHCS) sixty (60) calendar days prior to delegating the screening and enrollment to a Health Network or Delegate and shall submit policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

Back to Agenda Back to Item

C. CalOptima Health may delegate the Assessment and Reassessment of OPs to a Delegate or Credentialing Verification Organization, in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. A Credentialing Delegate shall perform delegated Credentialing functions that, at minimum, meet the requirements as outlined in this policy.

D. The Chief Medical Officer (CMO) or Designee shall have direct responsibility over and shall actively participate in the assessment and Reassessment of an OP.

E. The CalOptima Health Credentialing and Peer Review Committee (CPRC) shall be responsible for reviewing an OP's application information and CalOptima Health's findings for determining an OP's participation in CalOptima Health's Provider network, consistent with DHCS, National Committee for Quality Assurance (NCQA), and Department of Managed Health Care (DMHC), and Centers for Medicare and Medicaid (CMS) regulations and standards. No later than January 1, 2028, the CPRC shall use up-to-date CAQH credentialing forms and processes – as applicable and available – to credential and recredential OPs and only request additional information from an OP to clarify and confirm information provided on the applicable and available CAQH credentialing form.

F. CalOptima Health shall assess or reassess OPs, including, but not limited to, the following:

1. Acute Rehabilitation Facilities;

2. Behavioral Health Facility/Substance Abuse Providers (Inpatient, Residential or Ambulatory);

3. Birthing Centers;

4. Certified Hospice Providers;

5. Chronic Dialysis Clinic;

6. Clinical/Medical Laboratory;

7. Community Based Adult Services (CBAS) Providers;

8. Community Clinic;

9. Dialysis (End-Stage Renal Disease) Center/Facility;

10. Customized/Durable Medical Equipment (DME) Providers;

11. Federally Qualified Health ~~Clinic;~~Center (FQHC);

12. FQHC Look-Alikes

~~12.~~13. Free Clinic;

~~13.~~14. Health Access Program;

~~14.~~15. Home Health Agencies;

~~15.~~16. Hospice and Palliative Care Providers;

For 20260319 QAC Review Only

Back to Agenda Back to Item

~~16.~~17. Hospitals;

~~17.~~18. Indian Health Care Providers or Facilities;

~~18.~~19. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);

~~19.~~20. Emergency/Non-Emergency and Medical/Non-Medical Ground Transportation;

a. For Transportation Network Companies (TNC), CalOptima Health is not responsible for Credentialing drivers, in accordance with DHCS All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses.

~~20.~~21. Non-Emergency Medical Transportation;

~~21.~~22. Prosthetics and Orthotics;

~~22.~~23. Qualified Autism Services (QAS) also known as Applied Behavior Analysis (ABA) Groups;

~~23.~~24. Radiology Center (Free Standing);

~~24.~~25. Rehabilitation Center/Clinic (Outpatient for Physical Therapy, Occupational Therapy, and Speech Pathology);

~~25.~~26. Religious Non-Medical Health Care Institution;

~~26.~~27. Residential Care Facilities for the Elderly;

~~27.~~28. Rural Health Clinic;

~~28.~~29. Skilled Nursing Facilities/Long Term Care Facility;

~~29.~~30. Surgical Center (Free Standing);

~~30.~~31. Transplant Programs (Organ Procurement Organization); and

~~31.~~32. Urgent Care Center (Free Standing).

~~32.~~33. Medical Groups

a. Medical groups shall prohibit employment or contracting with practitioners or OPs (or entities that employ or contract with such practitioners or OPs) that are Excluded/sanctioned from participation in Medicare or Medi-Cal or are Excluded on any other state or federal Exclusion, sanction, restriction or Preclusion list.

G. CalOptima Health and Delegates shall ensure that any Provider in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS, is screened and enrolled with DHCS in the Medi-Cal program in accordance with DHCS APL 22-013: Provider Credentialing/Recredentialing and Screening/Enrollment, including any superseding APL, and Title 42, CFR, Part 455, and as described in Sections III.A. and III.B. of this Policy.

For 20260319 QAC Review Only

1. State-level enrollment pathways are available either through the DHCS Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway.

2. CalOptima Health may enroll providers through the screening and enrollment process outlined in Section III.E, in compliance with DHCS requirements, or CalOptima Health may direct network Providers to enroll through a state-level enrollment pathway.

3. Providers that do not have a state-level enrollment pathway do not need to be enrolled with Medi-Cal but must comply with CalOptima Health's vetting process.

4. Provider enrollment requirements shall be waived for Letters of Agreement (LOA), or single-case agreements with out-of-state transplant programs.

H. Providers in the Medi-Cal provider network not having a corresponding state-level enrollment pathway, including but not limited to Community Supports Providers (*e.g.*, housing agencies, medically tailored meal programs), and certain Enhanced Care Management (ECM) Providers, are not required to enroll in the Medi-Cal program and CalOptima Health shall vet the qualifications of the Provider or Provider organization to ensure Providers have:

1. Sufficient experience to provide services similar to the specific service for which they are contracted to provide within the service area;

2. Business licensing that meets industry standards;

3. History of fraud, waste, and/or abuse;

4. Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

5. History of liability claims against the Provider.

I. CalOptima Health and its Delegates may allow Providers in its Medi-Cal provider network to participate in the network for up to one hundred twenty (120) calendar days if the Provider has a pending enrollment application in review with DHCS' PED or a DHCS approved screening and enrollment process.

1. CalOptima Health and its Delegates shall terminate its contract with the Provider no later than fifteen (15) calendar days of the Provider receiving notification from DHCS that the Provider has been denied enrollment of the Medi-Cal program, or upon the expiration of the first one hundred twenty (120) calendar day period.

2. CalOptima Health and its Delegates shall not continue to contract with a Provider during the period in which the Provider resubmits its enrollment application to DHCS or approved screening and enrollment process and shall only re-initiate a contract upon the Provider's successful enrollment as a Medi-Cal Provider.

3. If the Provider termination impacts Member access, CalOptima Health shall notify DHCS prior to terminating the Provider and shall submit a plan of action for continuity of services for review and approval before the termination.

J. CalOptima Health and its Delegates shall require that the OP be successfully assessed prior to contracting and every three (3) years thereafter, except as otherwise specified in this policy.

For 2026 0.19 QAC Review Only

1. CalOptima Health and its Delegates shall confirm that the OP is in good standing with state and federal regulatory agencies,

2. CalOptima Health and its Delegates shall require OPs to be reviewed and approved by an accrediting body or have received an on-site quality assessment consistent with the provisions of this policy if the Provider is not accredited, as applicable.

K. Upon initial assessment, Reassessment, and on a monthly basis if required, CalOptima Health and its Delegates shall confirm:

1. Medi-Cal participation status of the OP and

2. Medicare participation status for the following OPs:

a. Hospitals;

b. Home Health Agencies (HHAs);

c. Hospices;

d. Clinical Laboratories;

e. Skilled Nursing Facilities (SNFs);

f. Comprehensive Outpatient Rehabilitation Facilities (CORFs);

g. Outpatient Physical Therapy and Speech Pathology Providers;

h. Ambulatory Surgical Centers (ASCs);

i. Providers of end-stage renal disease services;

j. Providers of outpatient diabetes self-management training;

k. Portable x-ray suppliers;

l. Rural ~~health~~Health Clinic (RHCs); and

m. ~~Federally Qualified Health Center (FQHCs).~~FQHCs; and

~~m.~~n.FQHC Look-Alikes.

L. If an OP is denied approval to participate in the CalOptima Health Provider network, CalOptima Health or its Delegates shall notify, in writing, such OP within thirty (30) calendar days of the reason for its decision.

M. No later than January 1, 2027, CalOptima and its Delegates shall make a determination regarding the credentials of a Covered California OP within ninety (90) days after receiving a completed OP credentialing application, including all required third-party verifications. CalOptima and its Delegates shall notify an OP, if successfully approved, of the activation within ten (10) business days of approval if the approval occurs prior to the end of the ninety (90)-day timeline. The ninety (90)-day

For 20260319 QAC Review Only

timeline shall apply only to the credentialing process and does not include contracting completion. If CalOptima Health and its Delegates do not meet the ninety (90)-day requirement, the OP's credentials shall be provisionally approved for one hundred twenty (120) days unless any of the following apply:

1. The OP is subject to discipline by the licensing entity for the OP.

2. The OP has one or more adverse action reports or one or more reports of malpractice payments filed with the National Practitioner Data Bank (NPDB).

3. The OP has not been credentialed by CalOptima Health or its Delegates in the past five (5) years.

N. CalOptima and its Delegates shall make a determination regarding the credentials of a Medi-Cal, OneCare or PACE OP within one hundred twenty (120) days after receiving a completed OP credentialing application, including all required third-party verifications.

~~L.~~O. An OP shall have the right to file a complaint about the decision in accordance with CalOptima Health Policies HH.1101: CalOptima Health Provider Complaint and MA.9006: Contracted Provider Complaint Process, as applicable.

~~M.~~P. CalOptima Health and its Delegates shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Health Policy GG.1659: System Controls of Provider Credentialing.

III. PROCEDURE

A. OP Initial Assessment

1. Upon notification of an intent to contract, CalOptima Health and its Delegates shall confirm the OP is in good standing with state and/or federal regulatory agencies based on an examination of the sources listed in Section III.A.2. of this policy.

2. The OP shall submit an application, signed, and dated by an authorized official of the OP, along with the following supplemental documentation:

   a. OPs shall include a roster listing the Practitioners associated with the OP, where applicable, as part of the application;

   b. OPs shall ensure that all information included in the assessment application is no more than six (6) months old;

      i. CalOptima Health and its Delegates shall return an incomplete application to an OP, and such incomplete application will not be processed until the OP submits all the required information.

      ii. CalOptima Health and its Delegates shall notify the Covered California OP within ten (10) business days to verify receipt and inform the applicant whether the application is complete.

      iii. CalOptima Health and its Delegates shall notify the Medi-Cal, OneCare or PACE OP within thirty (30) calendar days to verify receipt and inform the applicant whether the application is complete .

For 20260319 QAC Review Only

~~ii.~~iv. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the application withdrawn and will close the Credentialing file, if applicable.

~~iii.~~v. If an application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.

c. Confirmation that the OP is compliant with any other applicable state or federal requirements and possesses a business license (or business tax certificate), as applicable.

d. Accreditation and/or government-issued certification from the following entities, as applicable:

i. The Joint Commission certificate of accreditation, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization for hospitals, ambulatory surgery centers, skilled nursing facilities, and home health agencies;

ii. Accreditation Association for Ambulatory Health Care (AAAHC) for outpatient settings, including ambulatory surgery centers, office-based surgery facilities, endoscopy centers, medical and dental group practices, community health centers, and retail clinics;

iii. Commission on Accreditation of Rehabilitation Facilities (CARF) for aging services, behavioral health, child and youth services, vision rehabilitation services, medical rehabilitation, Durable Medical Equipment, prosthetics and orthotics supplies, and opioid treatment programs;

iv. Community Health Accreditation Program (CHAP) for home health agencies, hospice Providers, pharmacies, home medical equipment suppliers, private duty nursing, palliative care, and infusion therapy nursing;

v. American Board for Certification (ABC) for prosthetists, orthotists, and pedorthists;

vi. American Speech-Language-Hearing Association (ASHA) for speech, language, hearing, and audiology certification;

vii. DME or Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS) Accreditation Commission for Health Care, Inc. (ACHC);

viii. Commission on Accreditation of Ambulance Services (CAAS) for ambulance organizations;

ix. College of American Pathologist (CAP) for laboratories, biorepositories, and reproductive laboratories;

x. Healthcare Quality Association on Accreditation (HQAA) for home medical equipment suppliers, DMEPOS, and pharmacies;

xi. Inter-Societal Accreditation Commission (IAC) for radiology or diagnostic imaging Providers, and procedure-based modalities;

~~xi.~~xii. Det Norske Veritas Germanischer Lloyd (DNV GL)-Health Care for hospitals;

For 20260319 QAC Review Only

~~xii.~~xiii. National Dialysis Accreditation Commission (NDAC) for the accreditation of end state renal disease facilities; and

~~xiii.~~xiv. The California Department of Public Health (CDPH) for hospitals, ambulatory surgery centers, home health agencies, hospices, dialysis centers, Community Based Adult Services centers, skilled nursing facilities, Federal Qualified Health Centers verifications.

e. If an OP is not accredited, CalOptima Health shall conduct an on-site quality review with criteria for each type of Provider used for the assessment, and the process for ensuring that the Providers credential their Practitioners;

i. The Provider may submit evidence of a CMS or state quality review in lieu of a site visit.

a) The CMS or state quality review must be no more than three (3) years old. If the review is older than three (3) years, then CalOptima Health shall conduct its own onsite quality review.

ii. If a Provider has satellite facilities that follow the same policies and procedures as the Provider, the site visits may be limited to a main facility.

f. Certificate of current professional liability insurance of at least the minimum amounts required by provider type per the Contract for Health Care Services, as applicable;

g. A copy of any history of sanctions, Preclusions, Exclusions, suspensions, or terminations from Medicare and/or Medi-Cal, as applicable;

h. A copy of the PED certificate validating active enrollment in Medi-Cal, if applicable;

i. Active panels with the California Children's Services Program, if applicable;

j. Staff roster and copy of all staff certifications, or licensure, if applicable;

k. A valid Type 2 National Provider Identifier (NPI) number; and

l. All contracted laboratory-testing sites must have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

3. CalOptima Health shall conduct and communicate the results of a Facility Site Review (FSR) for community clinics and free-standing urgent care centers in providing services to Members in CalOptima Health's Medi-Cal provider network pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews to incorporate the documents to support review prior to approval decisions.

4. All participation applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

5. CalOptima Health or its Delegates shall review the history of professional liability claims that resulted in settlements or judgements paid by, or on behalf of, the OP in the last five (5) years.

B. Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Assessment

For 20260319 QAC Review Only

1. Requirements for an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) seeking to participate in CalOptima Health's Medi-Cal program:

   a. A CalOptima Health Ancillary Facility Network Provider Application, also known as the OP application, in accordance with Section III.A.2. of this policy.

   b. An ICF/DD Attestation, in accordance with DHCS APL 24-011: Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care, or superseding APL, signed under penalty of perjury attesting that the following Credentialing requirements are satisfied:

      i. Completion of the CalOptima Health Provider training within the last two (2) years;

      ii. A facility site audit from a state agency;

      iii. No change in five percent (5%) ownership disclosure;

      iv. Possession of an active CDPH license and CMS certification; and

      v. In good standing as a Regional Center vendor.

   c. W-9 request for taxpayer identification number and certification.

   d. City or county business license (excluding ICF/DD-H and N homes with six (6) or less residents)

   e. Certificate of insurance for professional and general liability of at least the minimum amounts required by Provider type, in accordance with the DHCS contract for Medi-Cal, as applicable.

C. OP Reassessment

1. CalOptima Health or its Delegates shall reassess an OP at least every three (3) years after initial assessment. At the time of Reassessment, CalOptima Health shall:

   a. Collect and/or verify, at a minimum, all of the information required for initial assessment as set forth in Section III.A. of this Policy;

   b. Incorporate the following data in the decision-making process:

      i. Quality review activities, including but not limited to:

         a) Enrollment and other information from DHCS, CMS, or another agency, as applicable;

         b) CalOptima Health quality review results, including, but not limited to, Grievances, Appeals, potential quality issue cases, and compliance cases, as applicable;

         c) Review of FSR or Physical Accessibility Review Survey (PARS) results for provider in the Medi-Cal provider network, as applicable; and

         d) Review of medical records, as applicable.

For 20260319 QAC Review Only

ii. Member experience, if applicable;

iii. Liability claims history, if applicable; and

iv. Compliance with the terms of the Provider's contract.

c. ICF/DDs will be reassessed every two (2) years through re-submission of the requirements in Section III.B. of this policy.

i. If an ICF/DD has a change to any requirement attested to between the years ICF/DDs are reassessed, an ICF/DD must report that change to CalOptima Health along with any required documentation within ninety (90) days of when the change occurred.

2. CalOptima Health or its Delegates shall ensure that an OP has current appropriate licensure, accreditation (if applicable), and insurance at all times during such OP's participation in CalOptima Health.

C. Upon initial assessment, Reassessment, and on a monthly basis, CalOptima Health or its Delegates shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS Preclusion List, Medi-Cal Suspended & Ineligible (S&I), and DHCS Restricted Provider Database. CalOptima Health shall immediately suspend any OP identified on the sanction lists in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

D. Credentialing Committee

1. CalOptima Health or its Delegates shall designate a Credentialing committee that uses a peer-review process to make recommendations and decisions regarding Assessment and Reassessment.

2. CalOptima Health's Credentialing and Peer Review Committee (CPRC) shall make recommendations and decisions regarding an OP's eligibility to participate in CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for the Elderly.

3. Completed OP files will either be presented to the CMO or Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

a. A clean file consists of a complete signed application, required supporting documents that are current and valid, and verification that there have been no liability claim(s) that resulted in settlements or judgments paid by, or on behalf of, the OP within the last seven (7) years from the date of the assessment, and confirmation that the OP is in good standing with state and federal regulatory agencies.

i. A clean file shall be considered approved and effective on the date that the CMO or Designee, reviews and approves an OP's assessment and Reassessment file, and deems the file clean.

~~i.~~ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for final approval and reflected in the meeting minutes.

For 20260319 QAC Review Only

b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of liability claim(s) that resulted in settlements, or judgments, paid by or on behalf of the OP.

i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application. Files that are incomplete will not be processed until the Provider submits all the required information.

ii. CPRC minutes shall reflect thoughtful consideration by the CPRC of the information presented in the file.

iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via telephone or video conferencing, but may not be conducted through e-mail.

4. ~~Provider~~OP files identified as not meeting Credentialing criteria with exceptions or potential exceptions shall be referred to the CMO or Designee for review.

a. The CMO or Designee shall review each file for ~~Providers~~OPs who do not meet Credentialing criteria and make recommendations regarding approving or denying Credentialing of the Provider to the CPRC. For ~~Provider~~OP files not meeting criteria on an administrative basis only, the file may be approved or denied by the CMO or Designee.

5. The CPRC shall make a final determination on the OP's ability to participate in CalOptima Health programs based on the information reviewed as specified in this policy.

a. The CalOptima Health Quality Improvement Department shall send the OP, or applicant, a decision letter within thirty (30) calendar days of the decision indicating:

i. Acceptance; or

ii. Denial of the application, along with information regarding the right to file a complaint, with a letter of explanation forwarded to the applicant.

b. CalOptima Health shall activate the Covered California OP upon successful approval if the approval occurs prior to the end of the ninety (90)-day timeline from receipt of a completed application.

6. Upon acceptance of the participation application, the CalOptima Health Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting, Provider Relations, and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and Provider data into CalOptima Health's core business system, which updates pertinent information into the online Provider Directory.

E. Provider Screening and Enrollment (Medi-Cal Providers Only)

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) Providers or obtain a PED approval letter as an acceptable form of initial enrollment verification conducted by DHCS.

2. If a Provider is already enrolled with DHCS as a Medi-Cal FFS Provider, then the Provider screening and enrollment process does not need to be completed by CalOptima Health.

For 20260319 QAC Review Only

3. If a Provider is not already enrolled with DHCS as a Medi-Cal FFS Provider, then the CalOptima Health may complete screening and enrollment established by CalOptima Health.

   a. CalOptima Health shall notify DHCS and submit its P&Ps for approval prior to implementation. The P&Ps must define the scope of their enrollment process if CalOptima Health does not enroll all Provider types.

   b. CalOptima Health shall complete the process and provide the applicant with a written determination on CalOptima Health letterhead within one hundred twenty (120) calendar days of its receipt of a Provider application.

   c. CalOptima Health shall submit a list of its newly enrolled Providers every six months to CalOptima Health's DHCS Managed Care Operations Division (MCOD) contract manager.

   d. CalOptima Health shall collect all the appropriate information, data elements, and supporting documentation required for each Provider type and ensure that the application is reviewed for both accuracy and completeness.

      i. CalOptima Health shall inform Providers seeking to enroll with CalOptima Health, of the differences between CalOptima Health's and DHCS' Provider enrollment processes, including the Provider's right to enroll through DHCS, at the time of application. CalOptima Health will provide required disclosures that include, but are not limited to, the following elements:

         a) A statement that certain enrollment functions will not be performed by CalOptima Health but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.

         b) A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a Provider chooses to enroll through CalOptima Health, including provisional Provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal CalOptima Health's decision to suspend the enrollment process.

         c) A provision informing the Provider that if CalOptima Health receives any information that impacts the Provider's eligibility for enrollment, CalOptima Health will suspend processing of the Provider's enrollment application and make the Provider aware of the option to apply through DHCS' Medi-Cal FFS Provider enrollment process.

         d) A statement clarifying that in order for the Provider to participate in the Medi-Cal FFS program, the Provider must enroll through DHCS, and that enrolling through DHCS will also make the Provider eligible to contract with CalOptima Health.

      ii. CalOptima Health may collect an application fee, not to exceed the Medi-Cal FFS enrollment application fee amount.

      iii. CalOptima Health shall obtain the Provider's consent in order to share information relating to the Provider's application and eligibility with DHCS.

      iv. CalOptima Health shall collect and maintain the original signed Medi-Cal Provider Agreement and Network Provider Agreement for each Provider.

For 20260519 QAC Review Only

v. CalOptima Health shall maintain all Provider enrollment documentation in a secure manner to ensure confidentiality of the Provider's personal information.
vi. Enrollment records shall be made available upon request to DHCS, CMS or other authorized governmental agencies.

e. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by 42 CFR § 455.104.

i. Providers who are unincorporated sole proprietors are not required to disclose the ownership or control information.

ii. Upon CalOptima Health's request, a Provider must submit within thirty-five (35) calendar days:

a) Full and complete information about the ownership of any subcontractor with whom the Provider has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12)-month period ending on the date of the request; and,

b) Any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the five (5)-year period ending on the date of the request.

f. CalOptima Health shall screen initial Provider applications, including applications for a new practice location, and any applications received in response to a Provider's reenrollment or revalidation request to determine the Provider's categorical risk level as limited, moderate, or high.

i. If a Provider fits within more than one risk level, CalOptima Health must screen the Provider at the highest risk level.

ii. A Provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated Provider lists, and criminal background checks.

iii. CalOptima Health shall not enroll a Provider who fails to comply with the screening criteria for that Provider's assigned level of risk.

g. Providers are subject to screening based on verification of the following requirements:

i. Limited-Risk Providers:

a) Meet state and federal requirements;

b) Hold a license certified for practice in the state and has no limitations from other states; and

c) Have no suspensions or terminations on state and federal databases.

ii. Medium-Risk Providers

For 20260319 QAC Review Only

a) Screening requirements of limited-risk Providers; and

b) Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to CalOptima Health and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

iii. High-Risk Providers:

a) Screening requirements of medium-risk Providers; and

b) Criminal background checks based in part on a set of fingerprints

h. CalOptima Health and DHCS shall adjust the categorical risk level when any of the following circumstances occur:

i. The state imposes a payment suspension on a Provider based on a credible allegation(s) of fraud, waste, or abuse.

ii. The Provider has an existing Medicaid overpayment based on fraud, waste, or abuse.

iii. The Provider has been Excluded by the Office of Inspector General or another state's Medicaid program within the previous ten (10) years, or when a state or federal moratorium on a provider type has been lifted.

iv. The Provider would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six months.

i. Additional criteria for high-risk Providers

i. Any person with a five percent (5%) or more direct or indirect ownership in a high-risk applicant or where information discovered in the onsite or data analysis may lead to this type of request.

ii. CalOptima Health shall direct Providers to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website and ensure that Providers include the correct agency information on the Live Scan form when submitting their application. The agency-specific information shall include the following information:

Applicant Submission

Field	**Entry**
ORI (Code assigned by DOJ)	CA0341600
Authorized Applicant Type	High-Risk Medi-Cal Provider
Type of License/Certification/Permit OR Working Title	MCMC

Contributing Agency Information

Field	**Entry**
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509

For 20260319 QAC Review Only

Field	Entry
Street Address or PO Box	1700 K Street MS 2200
Contact Name	MCMC
City	Sacramento
State	CA
ZIP Code	95811
Contact Telephone Number	(916) 750-1509

iii. When fingerprinting is required, CalOptima Health must furnish the Provider with the Live Scan form and instructions on where to deliver the completed form.

iv. The Provider must deliver the completed Live Scan form to the California DOJ and is responsible for paying for any Live Scan processing fees.

v. CalOptima Health shall notify DHCS upon initiation of each criminal background check for a Provider that has been designated as high-risk.

vi. CalOptima Health shall maintain the security and confidentiality of all of the information it receives from DHCS relating to the Provider's high-risk designation and the results of the criminal background checks.

j. Site Visits

i. CalOptima Health shall conduct pre- and post-enrollment site visits of medium-risk and high-risk Providers to verify that the information submitted to CalOptima Health and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements.

ii. CalOptima Health shall conduct post-enrollment site visits for medium-risk Providers at least every five (5) years, and their high-risk Providers every three (3) years or as necessary to verify that the information submitted to CalOptima Health and DHCS is accurate and determine if Providers are in compliance with state and federal enrollment requirements.

iii. Onsite visits may be conducted for many reasons, including, but not limited to, the following:

a) The Provider was temporarily suspended from the Medi-Cal program;

b) The Provider's license was previously suspended;

c) There is conflicting information in the Provider's enrollment application;

d) There is conflicting information in the Provider's supporting enrollment documentation; and

e) As part of the Provider enrollment process, CalOptima Health receives information that raises a suspicion of fraud.

k. Federal and State Database Checks

For 20260319 QAC Review Only

i. CalOptima Health shall check the following databases to verify the identity and determine the Exclusion and/or enrollment status of all Providers:

a) Social Security Administration's Death Master File;

b) National Plan and Provider Enumeration System (NPPES);

c) List of Excluded Individuals/Entities (LEIE);

d) System for Award Management (SAM);

e) CMS' Medicare Exclusion Database (MED);

f) DHCS' Suspended and Ineligible Provider List;

g) Restricted Provider Database (RPD); and

h) CHHS Open Data Portal.

ii. CalOptima Health shall also review the SAM, LEIE, and RPD databases on a regular basis, and at least monthly, to ensure that contracted Providers continue to meet enrollment criteria and take appropriate action in connection with the Exclusion.

iii. Any Provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in CalOptima Health's Provider network.

l. If CalOptima Health declines to enroll a Provider, it must refer the Provider to DHCS for further enrollment options.

m. If the CalOptima Health acquires information, either before or after enrollment that may impact the Provider's eligibility to participate in the Medi-Cal program, or a Provider refuses to submit to the required screening activities, CalOptima Health may decline to accept that Provider's application.

n. If at any time CalOptima Health determines that it does not want to contract with a prospective Provider, and/or that the prospective Provider will not meet enrollment requirements, CalOptima Health must immediately suspend the enrollment process.

o. CalOptima Health is not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.

p. All Providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process at least every five (5) years to ensure that all enrollment information is accurate and up to date.

q. CalOptima Health shall retain all Provider screening and enrollment materials and documents for ten (10) years.

r. CalOptima Health shall make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

For 20260319 QAC Review Only

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Assembly Bill (AB) 1041
~~A.~~B. California Evidence Code, §1157
A. California Health & Safety Code §§1374.198, and 1380.2.
~~B.~~C. CalOptima Health Contract for Health Care Services
~~C.~~D. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~D.~~E. CalOptima Health Contract with Covered California
~~E.~~F. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~F.~~G. CalOptima Health PACE Program Agreement
~~G.~~H. CalOptima Health Policy GG.1355: CalAIM Community Supports
~~H.~~I. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
~~I.~~J. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
~~J.~~K. CalOptima Health Policy GG.1608: Full Scope Site Reviews
~~K.~~L. CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information
~~L.~~M. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
~~M.~~N. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
~~N.~~O. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (Revised: 10/14/2022)
~~O.~~P. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (Supersedes APL 17-010)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Recredentialing and Screening/Enrollment (Supersedes APL 19-004) (Revised: 08/24/2022)
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (Supersedes APL 09-009)
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-011: Intermediate Care Facilities for Individuals With Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 23-023)
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
S. Medicare Managed Care Manual Chapter 6-70 Institutional Provider and Supplier Certification
T. National Committee of Quality Assurance (NCQA) Standards CR7 – Assessment of Organizational Providers
U. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 455.450 and Parts 424 and 431
V. Title 42, United States Code, §1320a-7(a)
W. Title 45, Code of Federal Regulations, Part 455
X. Title XVIII and XIV of the Social Security Act

VI. REGULATORY AGENCY APPROVAL(S)

For 20260319 QAC Review Only

Date	Regulatory Agency	Response
07/15/2020	Department of Health Care Services (DHCS)	Approved as Submitted
04/20/2022	Department of Health Care Services (DHCS)	File and Use
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
08/14/2023	Department of Health Care Services (DHCS)	File and Use
05/02/2024	Department of Health Care Services (DHCS)	Approved as Submitted
10/16/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors
11/06/2025	Regular Meeting of the CalOptima Board Health of Directors
	Regular Meeting of the CalOptima Board Health of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	06/04/2020	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	04/07/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	03/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	08/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	02/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE

Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	10/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	11/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	01/01/2026	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	04/01/2026	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE

For 20260319 Q

IX. GLOSSARY

Term	Definition
Appeal	Covered California: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR § 438.408(b). OneCare: As defined at 42 CFR §§ 422.561 and 423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §§ 422.566(b) and 423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR § 460.122.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

For 20260319 QAC Review Only

Term	Definition
Community Supports	Substitute services or settings to those required under the California Medicaid State Plan that CalOptima Health may select and offer to their Members pursuant to 42 CFR § 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.
Covered California: *Effective 01/01/2027 for CalOptima Health*	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.
Credentialing Peer Review Committee	Peer review body who reviews Provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
Credentialing Verification Organization (CVO)	For purposes of this policy, an organization that collects and verifies Credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Durable Medical Equipment (DME) and Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS)	Covered California: An item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use outside an institutional setting and includes: Mobility devices, including walkers and manual and power wheelchairs and scooters; augmented communications devices, such as speech generating devices, communications boards, and apps; continuous positive airway pressure (CPAP) machines; portable oxygen; hospital beds; for diabetes

For 20260319 QAC Review Only

Term	Definition
	blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices); infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other Drugs); standard curved handle or quad canes and replacement supplies; standard or forearm crutches and replacement supplies; dry pressure pads for a mattress; nebulizers and supplies; peak flow meters; IV pole; tracheostomy tube and supplies; enteral pumps and supplies; bone stimulators; cervical traction (over door); phototherapy blankets for treatment of jaundice in newborns; lactation supplies (one breast pump and the necessary supplies to operate it as prescribed by a doctor for each pregnancy at no cost); and dialysis care equipment for home hemodialysis and home peritoneal dialysis as described in "dialysis care." This definition does not cover neuromodulators; comfort, convenience, or luxury equipment or features; or repair or replacement of equipment due to loss or misuse. Medi-Cal: Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home. OneCare: Medical equipment prescribed by a licensed Practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Excluded or Exclusion	Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.
Facility Site Review	A DHCS tool utilized to assess the quality, safety and accessibility of primary care physicians (PCPs) and high-volume specialty care provider offices.
Grievance	Covered California: A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions

For 2026 IQAC Review

Term	Definition
	pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of 17 care furnished, regardless of whether remedial action is requested, as defined by the federal PACE regulation 42 CFR § 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Member	An individual enrolled in a CalOptima Health program.
National Committee for Quality Assurance (NCQA)	An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.
Organizational Provider (OP)	For purposes of this policy, organizations or institutions that are contracted to provide medical services such as, but not limited to: hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Precluded or Preclusion	A type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

For 20260319 QAC Review Only

Term	Definition
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare Provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician Provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the Providers of Covered Services under Medicare Part B.
Reassessment	The process by which Provider status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima Health program.
Regional Center (RC)	A non-profit, community-based entity that is contracted by Department of Developmental Services (DDS) and develops, purchases and manages services for Members with developmental disabilities and their families.

For 20260319 QAC Review Only

Policy:	GG.1651
Title:	**Assessment and Reassessment of Organizational Providers**
Department:	Quality Improvement
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	06/01/2017
Revised Date:	04/01/2026
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☒ PACE

For 20260319 QAC Review Only

I. PURPOSE

This policy describes the process by which CalOptima Health evaluates and determines a Provider, including an Organizational Provider (OP), rendering consolidated, facility-based services and/or billing for health care services not directly rendered and billed by a professional Provider, eligibility to participate in CalOptima Health programs.

II. POLICY

A. CalOptima Health shall establish guidelines for evaluation of OPs participation eligibility in CalOptima Health programs, in accordance with applicable laws, regulations, and regulatory guidance.

B. CalOptima Health may delegate authority to perform Medi-Cal screening and enrollment activities to a Health Network or Delegate. If CalOptima Health chooses to delegate this function, the follow shall occur:

1. The delegation shall be in a written subcontract or agreement, where CalOptima Health remains contractually responsible for the completeness and accuracy of the screening and enrollment activities.

2. CalOptima Health shall evaluate the Health Network or Delegate's ability to perform these activities, including an initial review to ensure that the Health Network or Delegate has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities.

3. CalOptima Health shall continuously monitor, evaluate, and approve the delegated functions.

4. CalOptima Health shall notify the Department of Health Care Services (DHCS) sixty (60) calendar days prior to delegating the screening and enrollment to a Health Network or Delegate and shall submit policies and procedures (P&Ps) that outline the delegation authority, as well as CalOptima Health's monitoring and oversight activities.

Back to Agenda Back to Item

C. CalOptima Health may delegate the Assessment and Reassessment of OPs to a Delegate or Credentialing Verification Organization, in accordance with CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities.

1. A Credentialing Delegate shall perform delegated Credentialing functions that, at minimum, meet the requirements as outlined in this policy.

D. The Chief Medical Officer (CMO) or Designee shall have direct responsibility over and shall actively participate in the assessment and Reassessment of an OP.

E. The CalOptima Health Credentialing and Peer Review Committee (CPRC) shall be responsible for reviewing an OP's application information and CalOptima Health's findings for determining an OP's participation in CalOptima Health's Provider network, consistent with DHCS, National Committee for Quality Assurance (NCQA), and Department of Managed Health Care (DMHC), and Centers for Medicare and Medicaid (CMS) regulations and standards. No later than January 1, 2028, the CPRC shall use up-to-date CAQH credentialing forms and processes – as applicable and available – to credential and recredential OPs and only request additional information from an OP to clarify and confirm information provided on the applicable and available CAQH credentialing form.

F. CalOptima Health shall assess or reassess OPs, including, but not limited to, the following:

1. Acute Rehabilitation Facilities;
2. Behavioral Health Facility/Substance Abuse Providers (Inpatient, Residential or Ambulatory);
3. Birthing Centers;
4. Certified Hospice Providers;
5. Chronic Dialysis Clinic;
6. Clinical/Medical Laboratory;
7. Community Based Adult Services (CBAS) Providers;
8. Community Clinic;
9. Dialysis (End-Stage Renal Disease) Center/Facility;
10. Customized/Durable Medical Equipment (DME) Providers;
11. Federally Qualified Health Center (FQHC);
12. FQHC Look-Alikes
13. Free Clinic;
14. Health Access Program;
15. Home Health Agencies;
16. Hospice and Palliative Care Providers;

For 20260319 QAC Review Only

Back to Agenda Back to Item

17. Hospitals;

18. Indian Health Care Providers or Facilities;

19. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD);

20. Emergency/Non-Emergency and Medical/Non-Medical Ground Transportation;

    a. For Transportation Network Companies (TNC), CalOptima Health is not responsible for Credentialing drivers, in accordance with DHCS All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses.

21. Non-Emergency Medical Transportation;

22. Prosthetics and Orthotics;

23. Qualified Autism Services (QAS) also known as Applied Behavior Analysis (ABA) Groups;

24. Radiology Center (Free Standing);

25. Rehabilitation Center/Clinic (Outpatient for Physical Therapy, Occupational Therapy, and Speech Pathology);

26. Religious Non-Medical Health Care Institution;

27. Residential Care Facilities for the Elderly;

28. Rural Health Clinic;

29. Skilled Nursing Facilities/Long Term Care Facility;

30. Surgical Center (Free Standing);

31. Transplant Programs (Organ Procurement Organization); and

32. Urgent Care Center (Free Standing).

33. Medical Groups

    a. Medical groups shall prohibit employment or contracting with practitioners or OPs (or entities that employ or contract with such practitioners or OPs) that are Excluded/sanctioned from participation in Medicare or Medi-Cal or are Excluded on any other state or federal Exclusion, sanction, restriction or Preclusion list.

G. CalOptima Health and Delegates shall ensure that any Provider in its Medi-Cal provider network for whose provider type has an enrollment pathway with DHCS, is screened and enrolled with DHCS in the Medi-Cal program in accordance with DHCS APL 22-013: Provider Credentialing/Recredentialing and Screening/Enrollment, including any superseding APL, and Title 42, CFR, Part 455, and as described in Sections III.A. and III.B. of this Policy.

For 20260319 QAC Review Only

1. State-level enrollment pathways are available either through the DHCS Provider Enrollment Division (PED) or another state department with a recognized enrollment pathway.

2. CalOptima Health may enroll providers through the screening and enrollment process outlined in Section III.E, in compliance with DHCS requirements, or CalOptima Health may direct network Providers to enroll through a state-level enrollment pathway.

3. Providers that do not have a state-level enrollment pathway do not need to be enrolled with Medi-Cal but must comply with CalOptima Health's vetting process.

4. Provider enrollment requirements shall be waived for Letters of Agreement (LOA), or single-case agreements with out-of-state transplant programs.

H. Providers in the Medi-Cal provider network not having a corresponding state-level enrollment pathway, including but not limited to Community Supports Providers (*e.g.*, housing agencies, medically tailored meal programs), and certain Enhanced Care Management (ECM) Providers, are not required to enroll in the Medi-Cal program and CalOptima Health shall vet the qualifications of the Provider or Provider organization to ensure Providers have:

1. Sufficient experience to provide services similar to the specific service for which they are contracted to provide within the service area;

2. Business licensing that meets industry standards;

3. History of fraud, waste, and/or abuse;

4. Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

5. History of liability claims against the Provider.

I. CalOptima Health and its Delegates may allow Providers in its Medi-Cal provider network to participate in the network for up to one hundred twenty (120) calendar days if the Provider has a pending enrollment application in review with DHCS' PED or a DHCS approved screening and enrollment process.

1. CalOptima Health and its Delegates shall terminate its contract with the Provider no later than fifteen (15) calendar days of the Provider receiving notification from DHCS that the Provider has been denied enrollment of the Medi-Cal program, or upon the expiration of the first one hundred twenty (120) calendar day period.

2. CalOptima Health and its Delegates shall not continue to contract with a Provider during the period in which the Provider resubmits its enrollment application to DHCS or approved screening and enrollment process and shall only re-initiate a contract upon the Provider's successful enrollment as a Medi-Cal Provider.

3. If the Provider termination impacts Member access, CalOptima Health shall notify DHCS prior to terminating the Provider and shall submit a plan of action for continuity of services for review and approval before the termination.

J. CalOptima Health and its Delegates shall require that the OP be successfully assessed prior to contracting and every three (3) years thereafter, except as otherwise specified in this policy.

For 20260319 QAC Review Only

Back to Agenda Back to Item

1. CalOptima Health and its Delegates shall confirm that the OP is in good standing with state and federal regulatory agencies,

2. CalOptima Health and its Delegates shall require OPs to be reviewed and approved by an accrediting body or have received an on-site quality assessment consistent with the provisions of this policy if the Provider is not accredited, as applicable.

K. Upon initial assessment, Reassessment, and on a monthly basis if required, CalOptima Health and its Delegates shall confirm:

1. Medi-Cal participation status of the OP and

2. Medicare participation status for the following OPs:

a. Hospitals;

b. Home Health Agencies (HHAs);

c. Hospices;

d. Clinical Laboratories;

e. Skilled Nursing Facilities (SNFs);

f. Comprehensive Outpatient Rehabilitation Facilities (CORFs);

g. Outpatient Physical Therapy and Speech Pathology Providers;

h. Ambulatory Surgical Centers (ASCs);

i. Providers of end-stage renal disease services;

j. Providers of outpatient diabetes self-management training;

k. Portable x-ray suppliers;

l. Rural Health Clinic (RHCs); and

m. FQHCs; and

n. FQHC Look-Alikes.

L. If an OP is denied approval to participate in the CalOptima Health Provider network, CalOptima Health or its Delegates shall notify, in writing, such OP within thirty (30) calendar days of the reason for its decision.

M. No later than January 1, 2027, CalOptima and its Delegates shall make a determination regarding the credentials of a Covered California OP within ninety (90) days after receiving a completed OP credentialing application, including all required third-party verifications. CalOptima and its Delegates shall notify an OP, if successfully approved, of the activation within ten (10) business days of approval if the approval occurs prior to the end of the ninety (90)-day timeline. The ninety (90)-day

For 20260319 QAC Review Only

Back to Agenda Back to Item

timeline shall apply only to the credentialing process and does not include contracting completion. If CalOptima Health and its Delegates do not meet the ninety (90)-day requirement, the OP's credentials shall be provisionally approved for one hundred twenty (120) days unless any of the following apply:

1. The OP is subject to discipline by the licensing entity for the OP.

2. The OP has one or more adverse action reports or one or more reports of malpractice payments filed with the National Practitioner Data Bank (NPDB).

3. The OP has not been credentialed by CalOptima Health or its Delegates in the past five (5) years.

N. CalOptima and its Delegates shall make a determination regarding the credentials of a Medi-Cal, OneCare or PACE OP within one hundred twenty (120) days after receiving a completed OP credentialing application, including all required third-party verifications.

O. An OP shall have the right to file a complaint about the decision in accordance with CalOptima Health Policies HH.1101: CalOptima Health Provider Complaint and MA.9006: Contracted Provider Complaint Process, as applicable.

P. CalOptima Health and its Delegates shall maintain the confidentiality of Credentialing files, in accordance with CalOptima Health Policy GG.1659: System Controls of Provider Credentialing.

III. PROCEDURE

A. OP Initial Assessment

1. Upon notification of an intent to contract, CalOptima Health and its Delegates shall confirm the OP is in good standing with state and/or federal regulatory agencies based on an examination of the sources listed in Section III.A.2. of this policy.

2. The OP shall submit an application, signed, and dated by an authorized official of the OP, along with the following supplemental documentation:

   a. OPs shall include a roster listing the Practitioners associated with the OP, where applicable, as part of the application;

   b. OPs shall ensure that all information included in the assessment application is no more than six (6) months old;

      i. CalOptima Health and its Delegates shall return an incomplete application to an OP, and such incomplete application will not be processed until the OP submits all the required information.

      ii. CalOptima Health and its Delegates shall notify the Covered California OP within ten (10) business days to verify receipt and inform the applicant whether the application is complete.

      iii. CalOptima Health and its Delegates shall notify the Medi-Cal, OneCare or PACE OP within thirty (30) calendar days to verify receipt and inform the applicant whether the application is complete .

For 20260319 QAC Review Only

Back to Agenda Back to Item

iv. If the required information is not received within sixty (60) calendar days of the date of initial receipt of application, CalOptima Health shall consider the application withdrawn and will close the Credentialing file, if applicable.

v. If an application has been withdrawn and the applicant wishes to apply to be credentialed, a new application must be submitted to CalOptima Health.

c. Confirmation that the OP is compliant with any other applicable state or federal requirements and possesses a business license (or business tax certificate), as applicable.

d. Accreditation and/or government-issued certification from the following entities, as applicable:

i. The Joint Commission certificate of accreditation, or another Centers for Medicare & Medicaid Services (CMS)-deemed accreditation organization for hospitals, ambulatory surgery centers, skilled nursing facilities, and home health agencies;

ii. Accreditation Association for Ambulatory Health Care (AAAHC) for outpatient settings, including ambulatory surgery centers, office-based surgery facilities, endoscopy centers, medical and dental group practices, community health centers, and retail clinics;

iii. Commission on Accreditation of Rehabilitation Facilities (CARF) for aging services, behavioral health, child and youth services, vision rehabilitation services, medical rehabilitation, Durable Medical Equipment, prosthetics and orthotics supplies, and opioid treatment programs;

iv. Community Health Accreditation Program (CHAP) for home health agencies, hospice Providers, pharmacies, home medical equipment suppliers, private duty nursing, palliative care, and infusion therapy nursing;

v. American Board for Certification (ABC) for prosthetists, orthotists, and pedorthists;

vi. American Speech-Language-Hearing Association (ASHA) for speech, language, hearing, and audiology certification;

vii. DME or Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS) Accreditation Commission for Health Care, Inc. (ACHC);

viii. Commission on Accreditation of Ambulance Services (CAAS) for ambulance organizations;

ix. College of American Pathologist (CAP) for laboratories, biorepositories, and reproductive laboratories;

x. Healthcare Quality Association on Accreditation (HQAA) for home medical equipment suppliers, DMEPOS, and pharmacies;

xi. Inter-Societal Accreditation Commission (IAC) for radiology or diagnostic imaging Providers, and procedure-based modalities;

xii. Det Norske Veritas Germanischer Lloyd (DNV GL)-Health Care for hospitals;

For 20260319 QAC Review Only

xiii. National Dialysis Accreditation Commission (NDAC) for the accreditation of end state renal disease facilities; and

xiv. The California Department of Public Health (CDPH) for hospitals, ambulatory surgery centers, home health agencies, hospices, dialysis centers, Community Based Adult Services centers, skilled nursing facilities, Federal Qualified Health Centers verifications.

e. If an OP is not accredited, CalOptima Health shall conduct an on-site quality review with criteria for each type of Provider used for the assessment, and the process for ensuring that the Providers credential their Practitioners;

i. The Provider may submit evidence of a CMS or state quality review in lieu of a site visit.

a) The CMS or state quality review must be no more than three (3) years old. If the review is older than three (3) years, then CalOptima Health shall conduct its own onsite quality review.

ii. If a Provider has satellite facilities that follow the same policies and procedures as the Provider, the site visits may be limited to a main facility.

f. Certificate of current professional liability insurance of at least the minimum amounts required by provider type per the Contract for Health Care Services, as applicable;

g. A copy of any history of sanctions, Preclusions, Exclusions, suspensions, or terminations from Medicare and/or Medi-Cal, as applicable;

h. A copy of the PED certificate validating active enrollment in Medi-Cal, if applicable;

i. Active panels with the California Children's Services Program, if applicable;

j. Staff roster and copy of all staff certifications, or licensure, if applicable;

k. A valid Type 2 National Provider Identifier (NPI) number; and

l. All contracted laboratory-testing sites must have either a Clinical Laboratory Improvement Act (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

3. CalOptima Health shall conduct and communicate the results of a Facility Site Review (FSR) for community clinics and free-standing urgent care centers in providing services to Members in CalOptima Health's Medi-Cal provider network pursuant to CalOptima Health Policy GG.1608: Full Scope Site Reviews to incorporate the documents to support review prior to approval decisions.

4. All participation applications shall be signed. Faxed, digital, electronic, scanned, or photocopied signatures are acceptable; however, signature stamps are not acceptable.

5. CalOptima Health or its Delegates shall review the history of professional liability claims that resulted in settlements or judgements paid by, or on behalf of, the OP in the last five (5) years.

B. Intermediate Care Facility for the Developmentally Disabled (ICF/DD) Assessment

For 20260319 QAC Review Only

1. Requirements for an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) seeking to participate in CalOptima Health's Medi-Cal program:

    a. A CalOptima Health Ancillary Facility Network Provider Application, also known as the OP application, in accordance with Section III.A.2. of this policy.

    b. An ICF/DD Attestation, in accordance with DHCS APL 24-011: Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care, or superseding APL, signed under penalty of perjury attesting that the following Credentialing requirements are satisfied:

        i. Completion of the CalOptima Health Provider training within the last two (2) years;

        ii. A facility site audit from a state agency;

        iii. No change in five percent (5%) ownership disclosure;

        iv. Possession of an active CDPH license and CMS certification; and

        v. In good standing as a Regional Center vendor.

    c. W-9 request for taxpayer identification number and certification.

    d. City or county business license (excluding ICF/DD-H and N homes with six (6) or less residents)

    e. Certificate of insurance for professional and general liability of at least the minimum amounts required by Provider type, in accordance with the DHCS contract for Medi-Cal, as applicable.

C. OP Reassessment

1. CalOptima Health or its Delegates shall reassess an OP at least every three (3) years after initial assessment. At the time of Reassessment, CalOptima Health shall:

    a. Collect and/or verify, at a minimum, all of the information required for initial assessment as set forth in Section III.A. of this Policy;

    b. Incorporate the following data in the decision-making process:

        i. Quality review activities, including but not limited to:

            a) Enrollment and other information from DHCS, CMS, or another agency, as applicable;

            b) CalOptima Health quality review results, including, but not limited to, Grievances, Appeals, potential quality issue cases, and compliance cases, as applicable;

            c) Review of FSR or Physical Accessibility Review Survey (PARS) results for provider in the Medi-Cal provider network, as applicable; and

            d) Review of medical records, as applicable.

For 20260319 QAC Review Only

ii. Member experience, if applicable;

iii. Liability claims history, if applicable; and

iv. Compliance with the terms of the Provider's contract.

c. ICF/DDs will be reassessed every two (2) years through re-submission of the requirements in Section III.B. of this policy.

i. If an ICF/DD has a change to any requirement attested to between the years ICF/DDs are reassessed, an ICF/DD must report that change to CalOptima Health along with any required documentation within ninety (90) days of when the change occurred.

2. CalOptima Health or its Delegates shall ensure that an OP has current appropriate licensure, accreditation (if applicable), and insurance at all times during such OP's participation in CalOptima Health.

C. Upon initial assessment, Reassessment, and on a monthly basis, CalOptima Health or its Delegates shall monitor the Medicare and Medi-Cal Sanction Lists, which include Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), CMS Preclusion List, Medi-Cal Suspended & Ineligible (S&I), and DHCS Restricted Provider Database. CalOptima Health shall immediately suspend any OP identified on the sanction lists in accordance with CalOptima Health Policy GG.1607: Monitoring Adverse Actions.

D. Credentialing Committee

1. CalOptima Health or its Delegates shall designate a Credentialing committee that uses a peer-review process to make recommendations and decisions regarding Assessment and Reassessment.

2. CalOptima Health's Credentialing and Peer Review Committee (CPRC) shall make recommendations and decisions regarding an OP's eligibility to participate in CalOptima Health Community Network, CalOptima Direct, or Program of All-Inclusive Care for the Elderly.

3. Completed OP files will either be presented to the CMO or Designee, on a clean file list for signature, or will be presented at CPRC for review and approval.

a. A clean file consists of a complete signed application, required supporting documents that are current and valid, and verification that there have been no liability claim(s) that resulted in settlements or judgments paid by, or on behalf of, the OP within the last seven (7) years from the date of the assessment, and confirmation that the OP is in good standing with state and federal regulatory agencies.

i. A clean file shall be considered approved and effective on the date that the CMO or Designee, reviews and approves an OP's assessment and Reassessment file, and deems the file clean.

ii. Clean file lists approved by the CMO or Designee shall be presented at the CPRC for final approval and reflected in the meeting minutes.

b. Files that do not meet the clean file review process and require further review by CPRC include but are not limited to those files that include a history of liability claim(s) that resulted in settlements, or judgments, paid by or on behalf of the OP.

For 20260319 QAC Review Only

Back to Agenda Back to Item

i. Non-clean list files will be reviewed by CPRC for determination to accept, or deny, the application. Files that are incomplete will not be processed until the Provider submits all the required information.

ii. CPRC minutes shall reflect thoughtful consideration by the CPRC of the information presented in the file.

iii. CPRC meetings and decisions may take place in real-time, as a virtual meeting via telephone or video conferencing, but may not be conducted through e-mail.

4. OP files identified as not meeting Credentialing criteria with exceptions or potential exceptions shall be referred to the CMO or Designee for review.

   a. The CMO or Designee shall review each file for OPs who do not meet Credentialing criteria and make recommendations regarding approving or denying Credentialing of the Provider to the CPRC. For OP files not meeting criteria on an administrative basis only, the file may be approved or denied by the CMO or Designee.

5. The CPRC shall make a final determination on the OP's ability to participate in CalOptima Health programs based on the information reviewed as specified in this policy.

   a. The CalOptima Health Quality Improvement Department shall send the OP, or applicant, a decision letter within thirty (30) calendar days of the decision indicating:

      i. Acceptance; or

      ii. Denial of the application, along with information regarding the right to file a complaint, with a letter of explanation forwarded to the applicant.

   b. CalOptima Health shall activate the Covered California OP upon successful approval if the approval occurs prior to the end of the ninety (90)-day timeline from receipt of a completed application.

6. Upon acceptance of the participation application, the CalOptima Health Quality Improvement Department shall generate a Provider profile and forward the Provider profile to the Contracting, Provider Relations, and Provider Data Management Service (PDMS) Departments. The PDMS Department will enter the contract and Provider data into CalOptima Health's core business system, which updates pertinent information into the online Provider Directory.

E. Provider Screening and Enrollment (Medi-Cal Providers Only)

1. CalOptima Health shall access the California Health and Human Services' (CHHS) Open Data Portal to obtain a list of currently enrolled Medi-Cal fee-for-service (FFS) Providers or obtain a PED approval letter as an acceptable form of initial enrollment verification conducted by DHCS.

2. If a Provider is already enrolled with DHCS as a Medi-Cal FFS Provider, then the Provider screening and enrollment process does not need to be completed by CalOptima Health.

3. If a Provider is not already enrolled with DHCS as a Medi-Cal FFS Provider, then the CalOptima Health may complete screening and enrollment established by CalOptima Health.

For 20260319 QAC Review Only

a. CalOptima Health shall notify DHCS and submit its P&Ps for approval prior to implementation. The P&Ps must define the scope of their enrollment process if CalOptima Health does not enroll all Provider types.

b. CalOptima Health shall complete the process and provide the applicant with a written determination on CalOptima Health letterhead within one hundred twenty (120) calendar days of its receipt of a Provider application.

c. CalOptima Health shall submit a list of its newly enrolled Providers every six months to CalOptima Health's DHCS Managed Care Operations Division (MCOD) contract manager.

d. CalOptima Health shall collect all the appropriate information, data elements, and supporting documentation required for each Provider type and ensure that the application is reviewed for both accuracy and completeness.

   i. CalOptima Health shall inform Providers seeking to enroll with CalOptima Health, of the differences between CalOptima Health's and DHCS' Provider enrollment processes, including the Provider's right to enroll through DHCS, at the time of application. CalOptima Health will provide required disclosures that include, but are not limited to, the following elements:

      a) A statement that certain enrollment functions will not be performed by CalOptima Health but will continue to be performed by DHCS, including fingerprinting, criminal background checks, and decisions to deny or terminate enrollment.

      b) A notice that some of the enrollment requirements and rights found in the state enrollment process may not be applicable when a Provider chooses to enroll through CalOptima Health, including provisional Provider status with Medi-Cal FFS, processing timelines of the enrollment application, and the ability to appeal CalOptima Health's decision to suspend the enrollment process.

      c) A provision informing the Provider that if CalOptima Health receives any information that impacts the Provider's eligibility for enrollment, CalOptima Health will suspend processing of the Provider's enrollment application and make the Provider aware of the option to apply through DHCS' Medi-Cal FFS Provider enrollment process.

      d) A statement clarifying that in order for the Provider to participate in the Medi-Cal FFS program, the Provider must enroll through DHCS, and that enrolling through DHCS will also make the Provider eligible to contract with CalOptima Health.

   ii. CalOptima Health may collect an application fee, not to exceed the Medi-Cal FFS enrollment application fee amount.

   iii. CalOptima Health shall obtain the Provider's consent in order to share information relating to the Provider's application and eligibility with DHCS.

   iv. CalOptima Health shall collect and maintain the original signed Medi-Cal Provider Agreement and Network Provider Agreement for each Provider.

   v. CalOptima Health shall maintain all Provider enrollment documentation in a secure manner to ensure confidentiality of the Provider's personal information.

For 2026-3-19 QAC Review Only

vi. Enrollment records shall be made available upon request to DHCS, CMS or other authorized governmental agencies.

e. Providers that apply as a partnership, corporation, governmental entity, or nonprofit organization must disclose ownership or control information as required by 42 CFR § 455.104.

i. Providers who are unincorporated sole proprietors are not required to disclose the ownership or control information.

ii. Upon CalOptima Health's request, a Provider must submit within thirty-five (35) calendar days:

a) Full and complete information about the ownership of any subcontractor with whom the Provider has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12)-month period ending on the date of the request; and,

b) Any significant business transactions between the Provider and any wholly owned supplier, or between the Provider and any subcontractor, during the five (5)-year period ending on the date of the request.

f. CalOptima Health shall screen initial Provider applications, including applications for a new practice location, and any applications received in response to a Provider's reenrollment or revalidation request to determine the Provider's categorical risk level as limited, moderate, or high.

i. If a Provider fits within more than one risk level, CalOptima Health must screen the Provider at the highest risk level.

ii. A Provider's designated risk level is also affected by findings of license verification, site reviews, checks of suspended and terminated Provider lists, and criminal background checks.

iii. CalOptima Health shall not enroll a Provider who fails to comply with the screening criteria for that Provider's assigned level of risk.

g. Providers are subject to screening based on verification of the following requirements:

i. Limited-Risk Providers:

a) Meet state and federal requirements;

b) Hold a license certified for practice in the state and has no limitations from other states; and

c) Have no suspensions or terminations on state and federal databases.

ii. Medium-Risk Providers

a) Screening requirements of limited-risk Providers; and

For 20260319 QAC Review Only

b) Pre-enrollment and post-enrollment onsite visits to verify that the information submitted to CalOptima Health and DHCS is accurate, and to determine compliance with state and federal enrollment requirements.

iii. High-Risk Providers:

a) Screening requirements of medium-risk Providers; and

b) Criminal background checks based in part on a set of fingerprints

h. CalOptima Health and DHCS shall adjust the categorical risk level when any of the following circumstances occur:

i. The state imposes a payment suspension on a Provider based on a credible allegation(s) of fraud, waste, or abuse.

ii. The Provider has an existing Medicaid overpayment based on fraud, waste, or abuse.

iii. The Provider has been Excluded by the Office of Inspector General or another state's Medicaid program within the previous ten (10) years, or when a state or federal moratorium on a provider type has been lifted.

iv. The Provider would have been prevented from applying for enrollment due to a moratorium and the moratorium was lifted in the past six months.

i. Additional criteria for high-risk Providers

i. Any person with a five percent (5%) or more direct or indirect ownership in a high-risk applicant or where information discovered in the onsite or data analysis may lead to this type of request.

ii. CalOptima Health shall direct Providers to fill out Form BCIA 8016 on the California Department of Justice (DOJ) website and ensure that Providers include the correct agency information on the Live Scan form when submitting their application. The agency-specific information shall include the following information:

Applicant Submission

Field	**Entry**
ORI (Code assigned by DOJ)	CA0341600
Authorized Applicant Type	High-Risk Medi-Cal Provider
Type of License/Certification/Permit OR Working Title	MCMC

Contributing Agency Information

Field	**Entry**
Agency Authorized to Receive Criminal Record Information	Department of Health Care Services
Mail Code (Five-digit code assigned by DOJ)	19509
Street Address or PO Box	1700 K Street MS 2200
Contact Name	MCMC
City	Sacramento

For 20260319 QAC Review Only

Field	Entry
State	CA
ZIP Code	95811
Contact Telephone Number	(916) 750-1509

iii. When fingerprinting is required, CalOptima Health must furnish the Provider with the Live Scan form and instructions on where to deliver the completed form.

iv. The Provider must deliver the completed Live Scan form to the California DOJ and is responsible for paying for any Live Scan processing fees.

v. CalOptima Health shall notify DHCS upon initiation of each criminal background check for a Provider that has been designated as high-risk.

vi. CalOptima Health shall maintain the security and confidentiality of all of the information it receives from DHCS relating to the Provider's high-risk designation and the results of the criminal background checks.

j. Site Visits

i. CalOptima Health shall conduct pre- and post-enrollment site visits of medium-risk and high-risk Providers to verify that the information submitted to CalOptima Health and DHCS is accurate, and to determine the applicant's compliance with state and federal enrollment requirements.

ii. CalOptima Health shall conduct post-enrollment site visits for medium-risk Providers at least every five (5) years, and their high-risk Providers every three (3) years or as necessary to verify that the information submitted to CalOptima Health and DHCS is accurate and determine if Providers are in compliance with state and federal enrollment requirements.

iii. Onsite visits may be conducted for many reasons, including, but not limited to, the following:

a) The Provider was temporarily suspended from the Medi-Cal program;

b) The Provider's license was previously suspended;

c) There is conflicting information in the Provider's enrollment application;

d) There is conflicting information in the Provider's supporting enrollment documentation; and

e) As part of the Provider enrollment process, CalOptima Health receives information that raises a suspicion of fraud.

k. Federal and State Database Checks

i. CalOptima Health shall check the following databases to verify the identity and determine the Exclusion and/or enrollment status of all Providers:

a) Social Security Administration's Death Master File;

For 20260319 QAC Review Only

b) National Plan and Provider Enumeration System (NPPES);

c) List of Excluded Individuals/Entities (LEIE);

d) System for Award Management (SAM);

e) CMS' Medicare Exclusion Database (MED);

f) DHCS' Suspended and Ineligible Provider List;

g) Restricted Provider Database (RPD); and

h) CHHS Open Data Portal.

ii. CalOptima Health shall also review the SAM, LEIE, and RPD databases on a regular basis, and at least monthly, to ensure that contracted Providers continue to meet enrollment criteria and take appropriate action in connection with the Exclusion.

iii. Any Provider terminated from the Medicare or Medicaid/Medi-Cal program may not participate in CalOptima Health's Provider network.

l. If CalOptima Health declines to enroll a Provider, it must refer the Provider to DHCS for further enrollment options.

m. If the CalOptima Health acquires information, either before or after enrollment that may impact the Provider's eligibility to participate in the Medi-Cal program, or a Provider refuses to submit to the required screening activities, CalOptima Health may decline to accept that Provider's application.

n. If at any time CalOptima Health determines that it does not want to contract with a prospective Provider, and/or that the prospective Provider will not meet enrollment requirements, CalOptima Health must immediately suspend the enrollment process.

o. CalOptima Health is not obligated to establish an appeal process for screening and enrollment decisions. Providers may only appeal a suspension or termination to DHCS when the suspension or termination occurs as part of DHCS' denial of the Medi-Cal FFS enrollment application.

p. All Providers must resubmit and recertify the accuracy of their enrollment information as part of the revalidation process at least every five (5) years to ensure that all enrollment information is accurate and up to date.

q. CalOptima Health shall retain all Provider screening and enrollment materials and documents for ten (10) years.

r. CalOptima Health shall make all screening and enrollment documents and materials promptly available to DHCS, CMS, and any other authorized governmental entities upon request.

IV. ATTACHMENT(S)

Not Applicable

For 20260319 QAC Review Only

V. REFERENCE(S)

A. Assembly Bill (AB) 1041
B. California Evidence Code, §1157
A. California Health & Safety Code §§1374.198, and 1380.2.
C. CalOptima Health Contract for Health Care Services
D. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
E. CalOptima Health Contract with Covered California
F. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
G. CalOptima Health PACE Program Agreement
H. CalOptima Health Policy GG.1355: CalAIM Community Supports
I. CalOptima Health Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
J. CalOptima Health Policy GG.1607: Monitoring Adverse Actions
K. CalOptima Health Policy GG.1608: Full Scope Site Reviews
L. CalOptima Health Policy GG.1659: System Controls of Provider Credentialing Information
M. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
N. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-015: Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (Revised: 10/14/2022)
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-008: Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (Supersedes APL 17-010)
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-013: Provider Credentialing/Recredentialing and Screening/Enrollment (Supersedes APL 19-004) (Revised: 08/24/2022)
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (Supersedes APL 09-009)
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-011: Intermediate Care Facilities for Individuals With Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care (Supersedes APL 23-023)
R. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's Services Whole Child Model Program (Supersedes APL 23-034)
S. Medicare Managed Care Manual Chapter 6-70 Institutional Provider and Supplier Certification
T. National Committee of Quality Assurance (NCQA) Standards CR7 – Assessment of Organizational Providers
U. Title 42, Code of Federal Regulations, §§422.204(a), 422.205, 455.450 and Parts 424 and 431
V. Title 42, United States Code, §1320a-7(a)
W. Title 45, Code of Federal Regulations, Part 455
X. Title XVIII and XIV of the Social Security Act

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
07/15/2020	Department of Health Care Services (DHCS)	Approved as Submitted
04/20/2022	Department of Health Care Services (DHCS)	File and Use
01/09/2023	Department of Health Care Services (DHCS)	Approved as Submitted
08/14/2023	Department of Health Care Services (DHCS)	File and Use

For 20260519 QAC Review Only

Date	Regulatory Agency	Response
05/02/2024	Department of Health Care Services (DHCS)	Approved as Submitted
10/16/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
06/01/2017	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors
04/07/2022	Regular Meeting of the CalOptima Board of Directors
11/06/2025	Regular Meeting of the CalOptima Board Health of Directors
	Regular Meeting of the CalOptima Board Health of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2017	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	01/01/2018	GG.1651	Credentialing and Recredentialing of Healthcare Delivery Organizations	Medi-Cal OneCare OneCare Connect PACE
Revised	06/04/2020	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	04/07/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare OneCare Connect PACE
Revised	12/31/2022	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	03/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	08/01/2023	GG.1651	Assessment and Re-Assessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	02/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	04/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	10/01/2024	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE

Back to Agenda Back to Item

Action	Date	Policy	Policy Title	Program(s)
Revised	04/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Medi-Cal OneCare PACE
Revised	05/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	11/01/2025	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	01/01/2026	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE
Revised	04/01/2026	GG.1651	Assessment and Reassessment of Organizational Providers	Covered California Medi-Cal OneCare PACE

For 20260319 QAC R

Back to Agenda Back to Item

IX. GLOSSARY

Term	Definition
Appeal	Covered California: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the required timeframes for standard and expedited resolution of grievances and appeals in accordance with Health & Safety Code § 1368. Medi-Cal: A review by CalOptima Health of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR § 438.408(b). OneCare: As defined at 42 CFR §§ 422.561 and 423.560, the procedures that deal with the review of adverse initial determinations made by the plan on health care services or benefits under Part C or D the enrollee believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the enrollee) or on any amounts the enrollee must pay for a service or drug as defined in 42 CFR §§ 422.566(b) and 423.566(b). These appeal procedures include a plan reconsideration or redetermination (also referred to as a level 1 appeal), a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (Council), and judicial review. PACE: A Member's action taken with respect to the PACE organization's noncoverage of, modification of, or nonpayment for, a service including denials, reductions or termination of services, as defined by federal PACE regulation 42 CFR § 460.122.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.

For 20260319 QAC Review Only

Term	Definition
Community Supports	Substitute services or settings to those required under the California Medicaid State Plan that CalOptima Health may select and offer to their Members pursuant to 42 CFR § 438.3(e)(2) when the substitute service or setting is medically appropriate and more cost-effective than the service or setting listed in the California Medicaid State Plan.
Covered California: *Effective 01/01/2027 for CalOptima Health*	The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider or an entity's professional or technical competence, and may include registration, certification, licensure and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services. PACE: The recognition of professional or technical competence. The process involved may include registration, certification, licensure, and professional association membership.
Credentialing Peer Review Committee	Peer review body who reviews Provider information and files and makes recommendations and decisions regarding Credentialing and Recredentialing
Credentialing Verification Organization (CVO)	For purposes of this policy, an organization that collects and verifies Credentialing information.
Delegate	An organization or entity granted authority to perform an activity on behalf of CalOptima within agreed-upon parameters. Any party that enters into an acceptable written arrangement below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.
Department of Health Care Services (DHCS)	The single State department responsible for the administration of the Medi-Cal Program, California Children's Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health related programs as provided by statute and/or regulation.
Department of Managed Health Care (DMHC)	The State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Durable Medical Equipment (DME) and Durable Medical Equipment Prosthetics Orthotics Supplier (DMEPOS)	Covered California: An item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use outside an institutional setting and includes: Mobility devices, including walkers and manual and power wheelchairs and scooters; augmented communications devices, such as speech generating devices, communications boards, and apps; continuous positive airway pressure (CPAP) machines; portable oxygen; hospital beds; for diabetes

For 20260319 QAC Review Only

Term	Definition
	blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices); infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other Drugs); standard curved handle or quad canes and replacement supplies; standard or forearm crutches and replacement supplies; dry pressure pads for a mattress; nebulizers and supplies; peak flow meters; IV pole; tracheostomy tube and supplies; enteral pumps and supplies; bone stimulators; cervical traction (over door); phototherapy blankets for treatment of jaundice in newborns; lactation supplies (one breast pump and the necessary supplies to operate it as prescribed by a doctor for each pregnancy at no cost); and dialysis care equipment for home hemodialysis and home peritoneal dialysis as described in "dialysis care." This definition does not cover neuromodulators; comfort, convenience, or luxury equipment or features; or repair or replacement of equipment due to loss or misuse. Medi-Cal: Medically Necessary medical equipment as defined by 22 CCR section 51160 that a Provider prescribes for a Member that the Member uses in the home, in the community, or in a facility that is used as a home. OneCare: Medical equipment prescribed by a licensed Practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
Excluded or Exclusion	Suspension, exclusion, or debarment from participation in Federal and/or state health care programs.
Facility Site Review	A DHCS tool utilized to assess the quality, safety and accessibility of primary care physicians (PCPs) and high-volume specialty care provider offices.
Grievance	Covered California: A written or oral expression of dissatisfaction regarding CalOptima Health, a Health Network, or a Provider, including quality of care concerns, Member's complaint about a delay or denial of payment on a claim, and shall include a complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative. A complaint is the same as a Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction, including, but not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions

For 2026 10 QAC Review

Term	Definition
	pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. PACE: A complaint, either written or oral, expressing dissatisfaction with service delivery or the quality of 17 care furnished, regardless of whether remedial action is requested, as defined by the federal PACE regulation 42 CFR § 460.120.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, health care service plan, such as a Health Maintenance Organization (HMO), Subcontractor, or First Tier Entity, that contracts with CalOptima Health to provide Covered Services to Members.
Member	An individual enrolled in a CalOptima Health program.
National Committee for Quality Assurance (NCQA)	An organization responsible for the accreditation of managed care plans and other health care entities and for developing and managing health care measures that assess the Quality of Care and services that Members receive.
Organizational Provider (OP)	For purposes of this policy, organizations or institutions that are contracted to provide medical services such as, but not limited to: hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, End-Stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), Managed Long Term Services and Supports (MLTSS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers and methadone clinics, non-emergency medical transportation (NEMT), mobile blood bank, community home support services for housing, non-medical service practitioners.
Physical Accessibility Review Survey (PARS)	A DHCS tool used to assess the level of physical accessibility of provider sites, including PCPs, high volume specialists and ancillary service providers, and CBAS centers.
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Precluded or Preclusion	A type of exclusion. The CMS Preclusion List is a list of Providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

For 20260319 QAC Review Only

Term	Definition
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare Provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician Provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the Providers of Covered Services under Medicare Part B.
Reassessment	The process by which Provider status is verified in order to make determinations relating to their continued eligibility for participation in the CalOptima Health program.
Regional Center (RC)	A non-profit, community-based entity that is contracted by Department of Developmental Services (DDS) and develops, purchases and manages services for Members with developmental disabilities and their families.

1

For 20260319 QAC Review Only

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 19, 2026
Regular Meeting of the CalOptima Health Board of Directors
Quality Assurance Committee

Report Item

8. Recommend that the Board of Directors Approve the CalOptima Health Applied Behavior Analysis Pay-for-Value Program for Measurement Period 2026-27

Contacts

Carmen Katsarov, LPCC, CCM, Executive Director Behavioral Health Integration, (714) 796-6168
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Recommended Action

Recommend that the Board of Directors approve the CalOptima Health Applied Behavior Analysis Pay-for-Value Program for the measurement periods between July 1, 2026, through June 30, 2027.

Background

On May 2, 2024, the CalOptima Health Board of Directors approved the Applied Behavior Analysis (ABA) Pay-for-Value (P4V) Program for measurement periods July 1, 2024, through June 30, 2026, and payout periods from July 1, 2025, through June 30, 2027. The ABA P4V Program is designed to support the delivery of high-quality health care and is available to contracted ABA providers who choose to participate. The core objectives of the program are to:

- Recognize and reward demonstrated quality performance.
- Provide comparative performance information on CalOptima Health's ABA providers for members, providers and the public; and
- Provide industry benchmarks and data-driven feedback to ABA providers on their P4V performance.

Discussion

The ABA P4V Program originally included eight performance metrics covering areas across quality, care experience, care effectiveness, and care access. Following a review after the first completed measurement period by Behavioral Health Initiative (BHI) leadership, Financial Analysis, and BHI's Board-Certified Behavior Analyst, three metrics were discontinued:

- Analysis of Barriers to Direct Service Delivery.
- Treatment Goal Advancement; and
- Parent or Guardian Reported Progress.

Due to low response rates from both providers and members, driven by extensive data-entry required by the providers into the CalOptima Health Provider Portal and reliance on members completing surveys on their mobile phones, the results were too low to produce statistically valid results. Even with the removal of these three metrics, results from the two completed measurement periods indicate overall improvement among providers. After discontinuing these metrics, each remaining measure was weighed equally at 2% for a total possible incentive of 10%.

Back to Agenda

Program Framework

- Measurement Periods between July 1, 2026, through June 30, 2027.
- Data Source: Claims and encounter submissions.
- Review Frequency: Semi-annual performance review.

Measurement Processes and Incentive Payments

CalOptima Health calculates provider rating scores semi-annually, enabling providers to track their performance and progress through scorecards. Incentive payments are distributed based on the final calculation and validation of each measure's rate. To qualify, ABA providers must maintain an active contract with CalOptima Health through the measurement and payout periods and be in good standing as determined by the Audit and Oversight Department.

Measurement and Payout Periods

Based on performance during the measurement period, providers may earn up to a 10% premium payment on adjudicated claims in the prospective payment period by meeting program metrics. The table below identifies the recommended measurement and payout periods for the program:

Measurement Periods	Prospective Payout Periods
July 1 – December 31, 2026	July 1 – December 31, 2027
January 1 – June 30, 2027	January 1 – June 30, 2028

Fiscal Impact

Staff estimate the annual fiscal impact for operating the ABA P4V will not exceed $13.0 million. Management will include the expected earned pool funding in future operating budgets.

Rationale for Recommendation

The ABA P4V Program will continue to improve the quality of care for CalOptima Health members.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachments

1. Prior Board Action dated May 2, 2024, "Approve the CalOptima Health Applied Behavior Analysis Pay-for-Value Program"
2. FY 2027 ABA P4V Program Metrics
3. ABA P4V Presentation

Rev. 3/19/26

/s/ Michael Hunn *03/12/2026*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 2, 2024
Regular Meeting of the CalOptima Health Board of Directors

Report Item
17. Approve the CalOptima Health Applied Behavior Analysis Pay-for-Value Program

Contacts
Carmen Katsarov, LPCC, CCM, Executive Director Behavioral Health Integration, (714) 796-6168
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Recommended Actions
Approve the CalOptima Health Applied Behavior Analysis Pay-for-Value Program effective July 1, 2024, through June 30, 2027.

Background
CalOptima Health previously had an Applied Behavior Analysis (ABA) Pay-for-Value (P4V) Program from January 2021 through December 2022. A newly created ABA P4V Program was designed with the goal to provide quality health care and will be available to contracted ABA Providers to participate in. The core objectives of the program are to:

- Recognize and reward demonstrated quality performance;
- Provide comparative performance information on CalOptima Health's ABA providers for members, providers, and the public; and
- Provide industry benchmarks and data-driven feedback to ABA providers on their P4V performance.

Discussion
The Behavioral Health Integration leadership partnered with consultants to conduct "listening sessions" with ABA providers and collect feedback and recommendations for a newly designed ABA P4V Program. The information obtained from the sessions included recommendations from the providers including: (1) the need to clearly understand the data used to measure performance; (2) an increased collaboration about the program design; and (3) the incentive payment frequency.

Due to the absence of current research and literature for ABA quality measures, a structured approach for selecting the measures involved reviewing and incorporating clinical industry best practices. This effort resulted in CalOptima Health and its consultants developing a proprietary designed ABA P4V Program.

Program Performance Categories
The ABA P4V Program will involve measures categorized in the following areas: (1) quality; (2) assessment; (3) care effectiveness; (4) care access; and (5) care experience. Each of the categories will have a weight between 1% and 1.5%, to total 10%. The providers that meet or exceed the target for each performance measure in each of the five categories can earn up to a 10% incentive payment premium on future claims.

Back to Agenda Back to Item

Program Methodology
Data Collection: Data will be captured by various methods including claims/encounter data, provider attestation forms, and digital surveys.

Measurement Review: Staff will review measurements semi-annually.

Measurement Period and Payout
Based on the measurement period's performance, providers may earn up to a 10% premium payment during adjudication of claims during the prospective payment period by achieving any or all the program elements. CalOptima Health has sole discretion to modify measurement targets semi-annually to drive maximum quality performance and will provide regular reports to the CalOptima Health Quality Assurance Committee. The table below provides more information on the measurement period and monthly prospective payments for the ABA P4V program.

Measurement Period	Prospective Payment Period
July – December 2024	July – December 2025
January – June 2025	January – June 2026
July – December 2025	July – December 2026
January – June 2026	January – June 2027

Measurement Processes and Incentive Payments
CalOptima Health staff calculates the rating score semi-annually. This score allows providers to track their performance and progress through scorecards. The distribution of the performance incentive payment is based on the final calculation and validation of each measure's rate. To be eligible for this payment, ABA providers must maintain a contract with CalOptima Health throughout the measurement period, be currently contracted, and be in good standing, as determined by the Audit and Oversight Department.

Fiscal Impact
Staff estimates that the annual fiscal impact for operating this ABA P4V Program is not to exceed $10.6 million. Management will include the expected earned pool funding in future operating budgets.

Rationale for Recommendation
The ABA Provider P4V Program will improve the quality of care for our CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None

/s/ Michael Hunn *04/26/2024*
Authorized Signature **Date**

Back to Agenda Back to Item

FY 2027 ABA P4V Program Metrics

Metric	Weight Value
1. Client Received Monthly Direct Services	2%
2. Client Received 10% or More Supervision	2%
3. Client Received Monthly In-Person BCBA/BMC Field Visits	2%
4. Client Received Timely Treatment	2%
5. Client Received Monthly Parent Training Visits	2%
Total Incentive	**10%**

CalOptima Health

Behavioral Health Integration Applied Behavior Analysis and Mental Health Providers Pay-for-Value Programs

Quality Assurance Committee Meeting

March 19, 2026

Carmen Katsarov, Executive Director, Behavioral Health Integration

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Background: Behavioral Health Integration (BHI) Pay-for-Value Programs

- Applied Behavior Analysis (ABA) Pay-for-Value (P4V)
  - Board Approved May 2, 2024
  - Program start date July 1, 2024
- Mental Health Providers Pay-for-Value
  - Board Approved November 7, 2024
  - Program start date January 1, 2025
- Providers can qualify for up to a 10% incentive applied to adjudicated paid claims during the payout period

CalOptima Health

ABA P4V Program

- Program Framework
  - Measurement Period: **Every 6 months**
  - Data Source: Claims and encounter submissions
  - Review Frequency: Semi-annual performance review

Measurement Period	Review Period	Payout Period
Jul 1 – Dec 31, 2024	Jan 1 - Jun 30, 2025	Jul 1 – Dec 31, 2025
Jan 1 – Jun 30, 2025	Jul 1 - Dec 31, 2025	Jan 1 – Jun 30, 2026
Jul 1 – Dec 31, 2025	**Jan 1 – Jun 30, 2026**	Jul 1 – Dec 31, 2026
Jan 1 – Jun 30, 2026	Jul 1 – Dec 31, 2026	Jan 1– Jun 30, 2027

As of March 2026 the highlighted area marks where we are in the ABA P4V program

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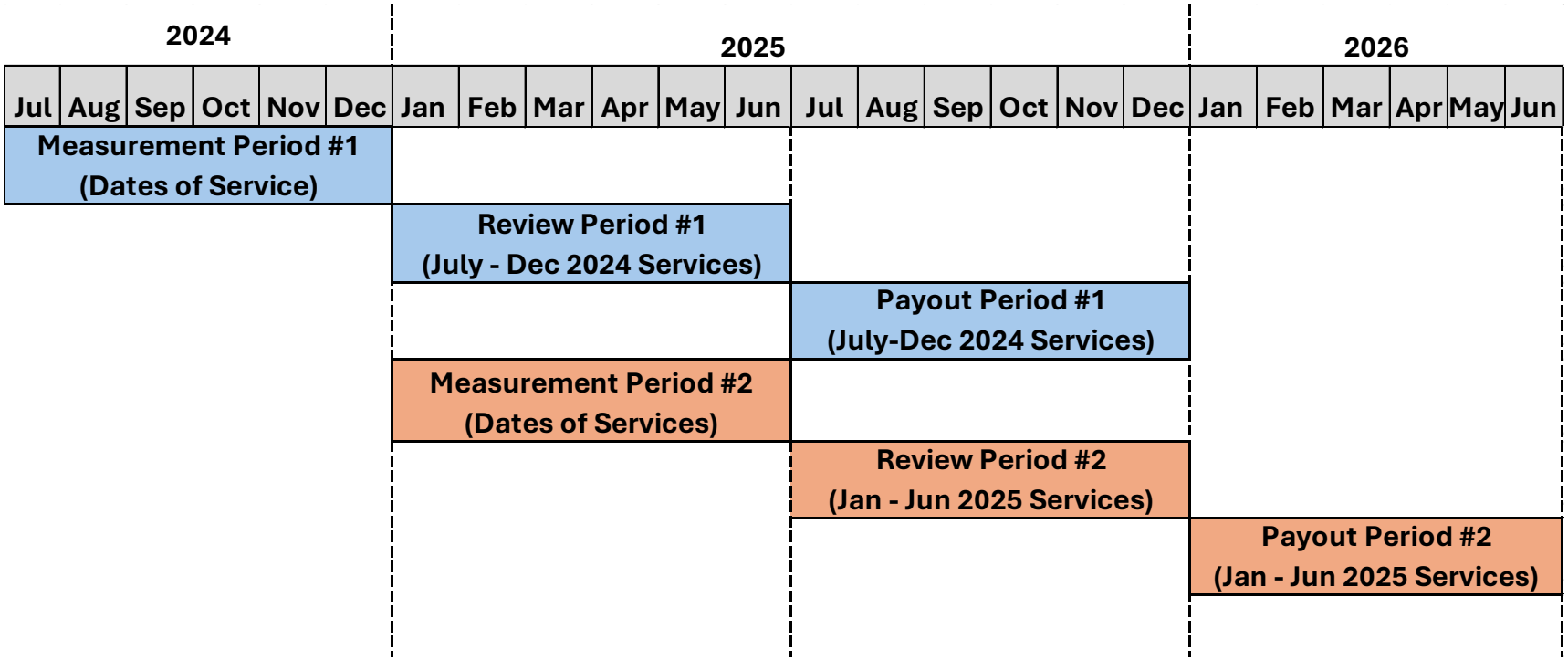
ABA P4V Program Metrics

	Category	Metric	Jul1 – Dec 31, 2024 Metric Value %	Jan 1 – Jun 30, 2025 Metric Value %
1	Quality	Client Received Monthly Direct Services	1.5%	2.0%
2	Quality	Client Received 10% or More Supervision	1.5%	2.0%
3	Quality	Client Received Monthly In-Person BCBA/BMC Field Visits	1.5%	2.0%
4	Care Experience	Client Received Timely Treatment	1.0%	2.0%
5	Care Experience	Client Received Monthly Parent Training Visits	1.0%	2.0%
6	Quality	Analysis of Barriers to Direct Service Delivery	1.5%	Metric discontinued
7	Quality	Treatment Goal Advancement	1.0%	Metric discontinued
8	Care Experience	Parent or Guardian Reported Progress (survey)	1.0%	Metric discontinued
		Total Incentive	**10%**	**10%**

ABA P4V Program Metrics (cont.)

- Beginning with the measurement period January 1–June 30, 2025, metric 6, 7 and 8 were discontinued.
- Reasons for discontinuation
  - Dependent on provider response and completed member surveys (vs. claims/encounters)
  - Member and provider burden
  - Low response rates → lacked statistical validity

Prospective Payout



CalOptima Health

ABA P4V Provider Performance

	Metric	MP Jul – Dec 2024 (N = 68)	MP Jan – Jun 2025 (N = 70)
1	Client Received Monthly Direct Services	56%	61%
2	Client Received 10% or More Supervision	18%	31%
3	Received Monthly In-Person BCBA/BMC Field Visits	44%	46%
4	Client Received Timely Treatment	4%	21%
5	Client Received Monthly Parent Training Visits	34%	29%
6	Analysis of Barriers to Direct Service Delivery	1%	Discontinued
7	Treatment Goal Advancement	34%	Discontinued
8	Parent or Guardian Reported Progress (survey)	32%	Discontinued

Measurement Periods Incentive Payout

	MP: July 1 – Dec 31, 2024	MP: Jan 1 – Jun 30, 2025
Percentage of Participating Providers Achieving 1 or More Metrics	81%	74%
Incentive Payout	As of February 2026 $1,654,183	$2,026,769*

*Important Note: Estimate based on claims with dates of service in the measurement period

CalOptima Health

Mental Health Providers Pay-for-Value

Mental Health (MH) P4V Program

- Program Framework
  - Measurement Period: **Every 6 months**
  - Data Source: Claims and encounter submissions, lab attestations, and mental health assessments
  - Review Frequency: Semi-annual performance review

Measurement Period	Review Period	Payout Period
Jan 1 – Jun 30, 2025	Jul 1 - Dec 31, 2025	Jan 1 – Jun 30, 2026
Jul 1 – Dec 31, 2025	Jan 1 – Jun 30, 2026	Jul 1 – Dec 31, 2026
Jan 1 – Jun 30, 2026	Jul 1 – Dec 31, 2026	Jan 1– Jun 30, 2027
Jul 1 – Dec 31, 2026	Jan 1 – June 30, 2026	Jul 1 – Dec 31, 2027

Highlighted area marks where we are in the MH P4V program

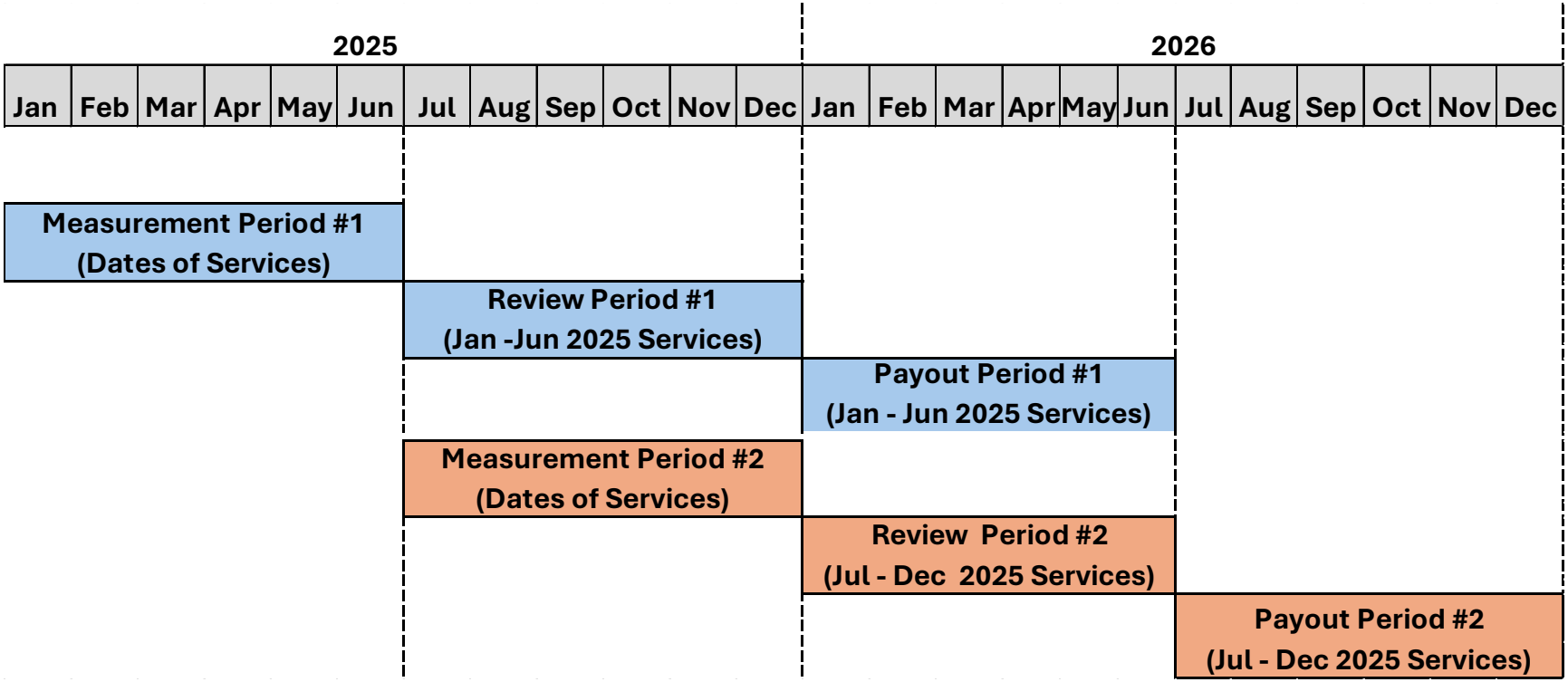
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MH P4V Program Metrics

	Category	Metric	Jan 1 – Jun 30, 2025 Metric Value %
1	Quality	Timely Follow-up after BH/SUD ED visit	2.0%
2	Quality	Timely Follow-up after initial visit	2.0%
3	Quality	Effective ongoing care	1.0%
4	Capacity Growth	Capacity / Panel Growth	2.0%
5	Care Effectiveness	Quality monitoring of essential labs and diagnostics	1.0%
6	Care Effectiveness	Clinical Measurement of Care	1.0%
7	Care Effectiveness	Care Experience (Member Satisfaction) survey	1.0%
		Total Incentive	**10%**

Metrics apply to January 1 – June 30, 2025 Measurement Period

Prospective Payout



CalOptima Health

MH Provider P4V Performance

	Metric	MP: Jan 1 – Jun 30, 2025
1	Timely Follow-up after BH/SUD ED visit	33%
2	Timely Follow-up after initial visits	22%
3	Effective ongoing care	5%
4	Capacity / Panel Growth	77%
5	Quality monitoring of essential labs and diagnostics	N/A
6	Clinical Measurement of Care	N/A
7	Care Experience (Member Satisfaction) survey	0%

Metrics apply to Measurement Period January 1 – June 30, 2025

Metrics 5 & 6 official start date Measurement Period July 1 – December 31, 2025

Estimated Incentive Payout

Currently in the payout period Jan 1 – June 30, 2026

	MP: Jan 1 – Jun 30, 2025*
Percentage of Participating Providers Achieving 1 or More Metrics	81%
Estimated Incentive Payout	$1,339,002

*Important Note: Claims dollars correspond to services during the measurement period and are estimated values.

CalOptima Health

BHI P4V Programs Next Steps

- ABA P4V
  - QAC approve the program for measurement period July 1, 2026, through June 30, 2027.
  - Present as a Consent Item for the May 7, 2026, Board of Directors Meeting to continue the program.
- MH P4V
  - Update QAC in Oct 2026

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CalOptima Health Board Action Agenda Referral

Action To Be Taken March 19, 2026
Regular Meeting of the CalOptima Health Board of Directors'
Quality Assurance Committee

Report Item

9. Recommend that the Board of Directors Approve a Modification to CalOptima Health's Calendar Year 2026 Member Health Rewards

Contacts

Michael Hunn, Chief Executive Officer, (714) 246-8570
Kelly Giardina, Executive Director, Clinical Operations, (657) 900-1013
Linda Lee, MPH, Executive Director, Quality Improvement, (657) 900-1069

Recommended Action

Approve a modification to Calendar Year 2026 Member Health Rewards for Medi-Cal to increase the postpartum check-up provider attestation reward from $25 to $50, effective July 1, 2026.

Background

On November 6, 2025, the CalOptima Health Board of Directors approved the Calendar Year 2026 Member Health Rewards for Medi-Cal and OneCare. This action enabled CalOptima Health to strengthen its primary care relationships, improve the quality of care delivered to its members by promoting preventive care, early identification, and chronic care management, and identify opportunities to coordinate care based on annual wellness visits. Staff propose increasing the postpartum check-up incentive to maximize impact and advance CalOptima Health's strategic priorities, as part of its commitment to maternal health improvement and member engagement.

Discussion

Because incentives can motivate members to establish primary and specialty care relationships and pursue recommended preventive care and screenings, many health plans adopt health rewards as a best practice to enhance preventive care. While CalOptima Health has promoted the postpartum checkup health rewards, recent data show that CalOptima Health needs to make additional efforts to achieve greater impact.

Currently, based on 2024 rates, CalOptima Health ranks last among all managed care plans (MCPs) in California for postpartum compliance. This highlights the need for stronger engagement strategies and more effective member incentives. Postpartum visits are a vital part of maternal health care. They allow providers to assess physical recovery, screen for postpartum depression, evaluate other complications, support breastfeeding, and address immediate needs related to high-quality member care – all while ensuring regulatory compliance. Despite its importance, postpartum visit completion rates for CalOptima Health are lower than those of other MCPs in the state. Increasing the incentive to $50 will help increase engagement among at-risk members by boosting their motivation and engagement in postpartum care and improve compliance rates. Improving this incentive aligns with CalOptima Health's enhanced maternal health strategy and demonstrates CalOptima Health's commitment to improving maternal health, meeting DHCS's quality expectations.

Back to Agenda

To support members in completing their postpartum visits, CalOptima Health will also implement a coordinated care management strategy that integrates postpartum reminders into all care activities during late pregnancy and after delivery. A combination of direct member contact, digital engagement, community outreach, and provider education will be incorporated into the enhanced maternal health program to improve postpartum appointment adherence. Enhanced member outreach and education will include phone reminders, mailed incentive forms, text message campaigns, and follow-up calls to help with care coordination needs, such as appointment scheduling and overcoming barriers to care.

Therefore, staff recommend modifying the incentive amount for the postpartum checkup to $50 for calendar year 2026. The enhanced maternal health activities are expected to raise member awareness about the importance of postpartum care, reduce missed appointments by addressing logistical barriers, and reinforce the postpartum visit as a key milestone in the maternal health journey. The increased incentive, along with other enhanced interventions, is expected to boost the postpartum measure by at least 5% in calendar year 2026.

Members receive a gift card upon completing the qualifying event and submitting the health reward form. Providers may attest to completion of the qualifying event on behalf of members using the same health reward form. When budgeting, staff assumed a member participation rate of 15-20% based on historical participation, and the improved access to incentives combined with increased incentive amounts will likely yield an increase in member engagement and outcomes. Staff anticipate the increased participation to fall within the originally estimated 15-20% participation range. If participation rates surpass these assumptions and the budget, staff will return to the Board of Directors for additional funding requests at future meetings.

Fiscal Impact

The recommended action has no additional fiscal impact on the operating budget. The net estimated cost to increase the incentive amount for the postpartum check-up provider attestation reward from $25 to $50 for the period of July 1, 2026, through December 31, 2026, is $24,000. Staff anticipates that unearned funds from the Measurement Year 2024 Medi-Cal Pay for Value Performance Program will be sufficient to fund the recommended action.

Rationale for Recommendation

While the rewards were carefully designed, staff propose increasing the postpartum check-up incentive to better align with CalOptima Health's strategic goals of improving maternal health, promoting equity, and meeting DHCS maternal health quality standards.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt

Attachment

1. Postpartum Rewards Visual Workflow
2. Postpartum Rewards Presentation

Back to Agenda

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
November 6, 2025	Approve CalOptima Health's Calendar Year 2026 Member Health Rewards	Calendar Year 2026	$7.3 million

/s/ Michael Hunn *03/12/2026*
Authorized Signature **Date**

Back to Agenda

Postpartum Health Rewards Member Journey



Step 1: Schedule Your Postpartum Appointment

- The visit should occur anytime between 7 and 84 days after delivery.
- Make sure your appointment is confirmed.



Step 2: Attend Your Appointment

- Ask any questions you may have.
- Record these details:
  -Provider's name
  -Date of delivery
  -Date of postpartum appointment



Step 3: Submit the Reward Form

- Visit the CalOptima Health website: https://caloptima.govfa.net/53
- Complete the Postpartum Checkup Reward Form by January 31, 2027.



Step 4: Receive Your Reward

- CalOptima Health will verify your visit and mail your reward.
- Please allow up to 90 days for processing.

Back to Agenda Back to Item

Postpartum Health Rewards

Quality Assurance Committee

March 20, 2026

Kelly Giardina, MSG, CCM

Executive Director, Clinical Operations

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Background & Objective

- CY 2026 Member Health Rewards were approved to strengthen primary care relationships and preventive care.
- **Performance gap:** In 2024, CalOptima Health ranked **last** among California MCPs for postpartum follow-up visit compliance, with a rate of 81.11%, compared to the average of 87.11%. Stronger engagement is required.
- **Clinical importance**: Postpartum visits assess physical recovery, screen for depression, evaluate complications, support breastfeeding, and ensure regulatory compliance.
- **Incentives work**: Raising to **$50** is expected to boost motivation and compliance among at-risk members.

Source: MY 2024 MCP Plan-Level Public Rate Sheet

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Implementation Approach

- **Coordinated care management**: Integrate postpartum reminders across late pregnancy and post-delivery touchpoints.
- **Member & provider engagement**: Combine direct member contact, digital engagement, community outreach, and provider education.
- **Strategy**: Phone reminders, mailed incentive forms, text campaigns, and follow-up calls to assist with scheduling and barrier resolution.

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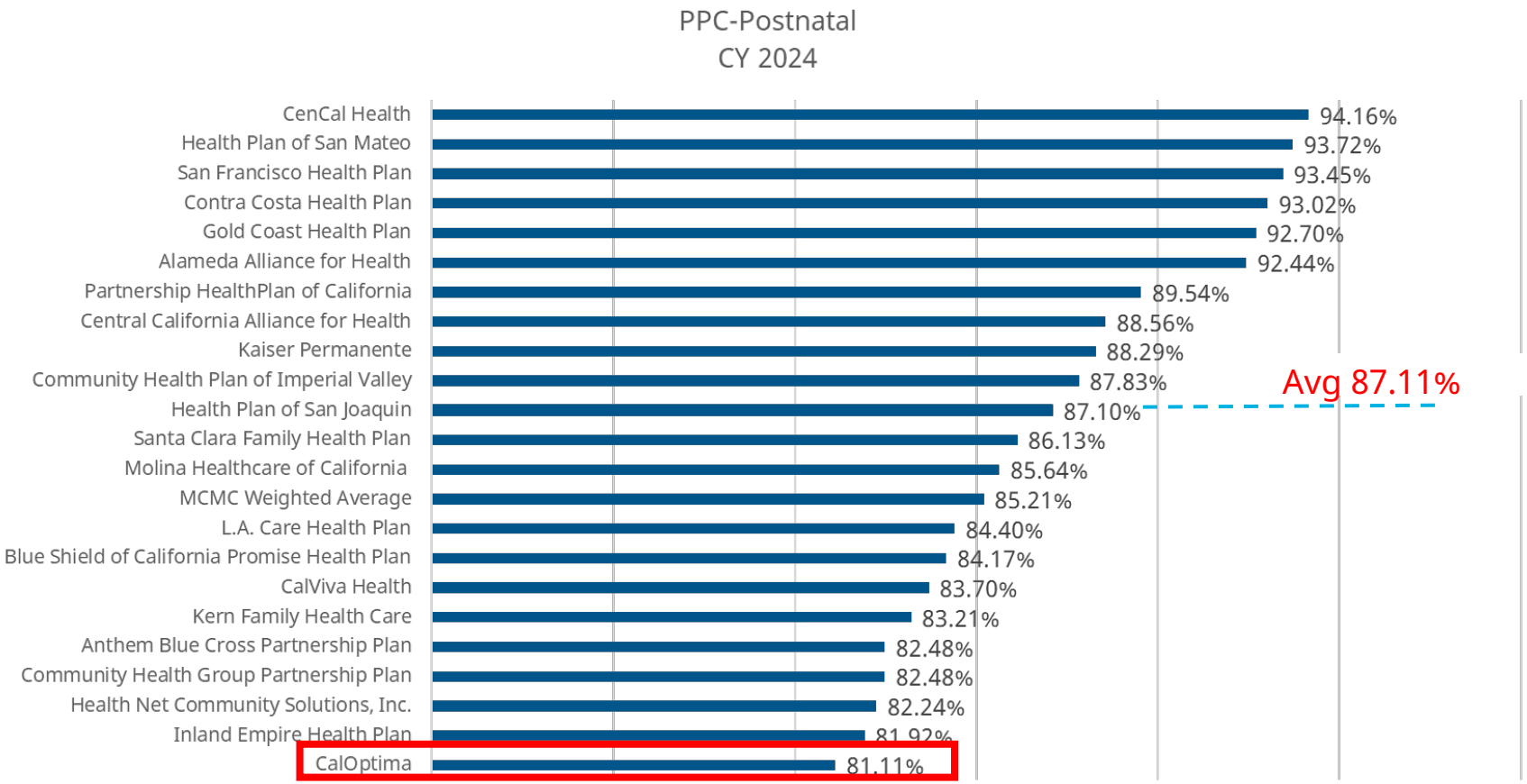
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Appendix

Maternal Health Outcomes are Below Medi-Cal Plan Average



Source: MY 2024 MCP Plan-Level Public Rate Sheet

Requirements

- Updated Population Management (PHM) Policy Guide
  - PHM Policy Guide Updated January 2026
- APL 24-004: Quality Improvement and Health Equity Transformation Requirements.
  - https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL%202024/APL24-004.pdf
- DHCS Bold Goals
  - https://www.dhcs.ca.gov/services/Documents/2025-Comprehensive-Quality-Strategy.pdf
- Comprehensive Perinatal Support Service
  - https://www.dhcs.ca.gov/services/Pages/CPSP.aspx
- DRAFT Omnibus APL Overview
  - https://www.dhcs.ca.gov/Documents/Omnibus-Maternity-APL-Overview-Tribal-IHCP-Reps-Meeting.pdf

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Fourth Quarter 2025 Summary of the Quality Improvement Health Equity Committee

Quality Assurance Committee Meeting

March 19, 2026

Linda Lee, Executive Director, Quality Improvement

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Quality Improvement Health Equity Committee (QIHEC) Actions in Fourth Quarter 2025

- QIHEC oversees and monitors the Quality Improvement Health Equity Transformation Program (QIHETP) Annual Work Plan
- In Quarter 4, 2025, QIHEC evaluated the following topics:
  - QIHEC Subcommittee reports
  - CalOptima Health programs and business functions
  - Quality performance measures, including OneCare Star measures and Managed Care Accountability Set (MCAS) measures
  - National Committee for Quality Assurance (NCQA) Accreditation

QIHEC Actions in Fourth Quarter 2025

- QIHEC evaluated the following topics:
  - Quality oversight functions, including credentialing, potential quality issues (PQIs), credentialing of providers and facility site reviews (FSRs)
  - Performance Improvement Projects (PIPs)
  - Access and availability, including appointment availability and network adequacy
  - Member experience, including customer service performance, grievances, data from member experience surveys
  - Coordination of care

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QIHEC Findings/Outcomes

- CalOptima Health successfully completed the submission for NCQA Health Outcomes Survey Accreditation (formerly known as Health Equity Accreditation), meeting all submission requirements and deadlines.
- The CalOptima Health Comprehensive Community Cancer Screening Program (CCCSP) expanded mobile mammography services:
  - Screened 212 members year-to-date
  - Increased clinic participation from three to eight for FY 2025–26.

QIHEC Findings/Outcomes

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) measure improved by 8.98% for Medi-Cal and 11.46% for OneCare from Q2 to Q3, 2025.
- Student Behavioral Health Incentive Program
  - Achieved a 38% increase in behavioral health staff
  - Expanded telehealth access for over 260,000 students through Hazel Health
  - Children's Hospital of Orange County (CHOC) opened 10 well spaces and launched specialized autism care
  - Western Youth Services provided on-demand training accessed by 65% of districts.

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QIHEC Findings/Outcomes

- Based on the 2025 Language Services Experience Survey, 100% of staff surveyed and over 90% of members surveyed were satisfied with the language services received.
- Achieved the Centers for Medicare & Medicaid Services (CMS) four-star rating in Health Risk Assessment (HRA) completion for 2025.
  - 76.83% of newly enrolled members completed a care plan within 90 days
  - 95.1% of members have a care plan completed within the past year.

QIHEC Findings/Outcomes

- By Q3 2025, 84% of OneCare members had a well visit in the current year and 87% within the past 12 months.
- By Q3, 2025, Prenatal and Postpartum Care (PPC) measure rates were significantly higher compared to the same time last year and are on track to reach the goal.
  - 81.56% of pregnant members received timely prenatal care.
  - 69.39% of pregnant members received timely postpartum care.

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QIHEC Findings/Outcomes

- Based on the Disease Management Satisfaction Survey, 98% of surveyed members reported a positive experience with the Disease Management Program.
- The Health Education Program referrals increased 24% over the past two years.
- Enhanced Care Management (ECM) services exceeded expectations.
  - Served approximately 9,500 members, surpassing the target of 2,842.
  - The total number of providers has increased by 12, bringing the network to 61 ECM providers.

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QIHEC Recommendations in Fourth Quarter 2025

- QIHEC made the following requests and/or recommendations:
  - The Transitional Care Services (TCS) flyer to be distributed to committee members.
  - Staff to focus on a strategy to boost member participation for in-home glucose screening tests
  - Clarification as to whether the Timely Access Survey TAS) included telehealth vendors

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QIHEC Actions: Sub-Committee Oversight

- QIHEC accepted and filed the following items:
  - Presentation: Credentialing Peer Review Committee Oversight Update
  - PowerPoint Slides: Member Experience Committee Oversight Update
  - PowerPoint Slides: Utilization Management Committee Update (appendix)
  - PowerPoint Slides: Whole Child Model Clinical Advisory Committee Update
  - Grievance and Appeals Resolution Services Committee Meeting Minutes_August 12, 2025_Final
  - Member Experience Committee Meeting Minutes_July 15, 2025_Final
  - Population Health Management Committee Meeting Minutes_August 21, 2025_Final
  - Utilization Management Committee Meeting Minutes_August 21, 2025_Final
  - Whole Child Model Clinical Advisory Committee Meeting Minutes_August 19, 2025_Final

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QIHEC Sub-Committee Report

Back to Agenda

Subcommittee Actions in Fourth Quarter 2025: Credentialing and Peer Review

- Approved two policies, the credentialing clean/closure list and the potential quality issue (PQI) closure list.
- Reported one preventable provider condition (PPC) to the Department of Health Care Services (DHCS).
- As part of the fair hearing process, monitored three physicians on a probationary status.
- Identified 14 providers on sanction lists that resulted in 13 provider terminations
- Terminated one provider due to facility site review (FSR)/medical record review (MRR) non-compliance.

Subcommittee Actions in Fourth Quarter 2025: Member Experience

- Met all specialty time/distance requirements and bed capacity standards for Q3 2025.
- Timely Access Survey adopted the Department of Managed Health Care (DMHC) Provider Appointment Availability (PAAS) Methodology with a one-year survey cycle.
- Continue to monitor corrective action plans (CAPs) issued for health networks (HNs) not meeting timely access standards.

Subcommittee Actions in Fourth Quarter 2025: Utilization Management

- Approved 2026 utilization goals for inpatient bed days and emergency department (ED) visits (set at a 5% reduction from prior-year performance).
- Approved revisions to 16 utilization management policies and procedures.
- Benefits Management Subcommittee (BMSC) reviewed 53 codes.
- Pharmacy and Therapeutics (P&T) Committee updated the Physician Administered Drug (PAD) Prior Authorization (PA) list and the OneCare formulary.

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Subcommittee Actions in Fourth Quarter 2025: Grievances & Appeals Resolution Services Committee (GARS)

- The GARS reviewed and accepted:
  - Member grievances and appeals trends
  - Provider dispute resolutions (PDRs)
  - Remediation activities for identified issues
- Remediation Activities
  - Weekly meetings with the transportation vendor, MotiveCare, to address providers' eligibility and scheduling issues.
  - Provided education to HNs on authorization requirements to reduce appeal overturns.

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Subcommittee Actions in Fourth Quarter 2025: Whole Child Model (WCM) Clinical Advisory Committee (CAC)

- Approved WCM CAC Committee charter to align with the updated DHCS All Plan Letter.
- Requested analysis of unique member counts and follow-up care for higher-risk scores.

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APPENDIX

Back to Agenda

QIHEC Actions: Program Oversight

- Approved the dissolution of the Population Health Management Committee (PHMC) that previously reported to QIHEC
- QIHEC reviewed and approved the following:
  - September 9, 2025, meeting minutes; October 14, 2025; November 4, 2025, meeting minutes
  - QIHEC Charter (updated)
  - Critical Incident Reporting Form

QIHEC Actions: Program Oversight

- QIHEC accepted and filed the following items:
  - 2025 QIHETP Work Plan Quarter 3 update
  - Hospital Transitions of Care (TCS) Flyer 2025
  - PowerPoint Presentation Slides on Delegation Oversight (appendix)

QIHEC Actions: Policy Review

- QIHEC reviewed and approved the following policies:
  - GG.1603: Medical Records Maintenance
  - GG.1621: Community-Based Adult Services (CBAS) Quality Assurance and Site Visits
  - GG.1633: Board Certification Requirements for Physicians
  - GG.1643: Minimum Provider Credentialing Standards
  - GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
  - GG.1815: Long Term Services and Support Quality of Care Reporting
  - GG.1620: Quality Improvement Health Equity Committee (QIHEC)

Quality Improvement Health Equity Committee (QIHEC) Purpose

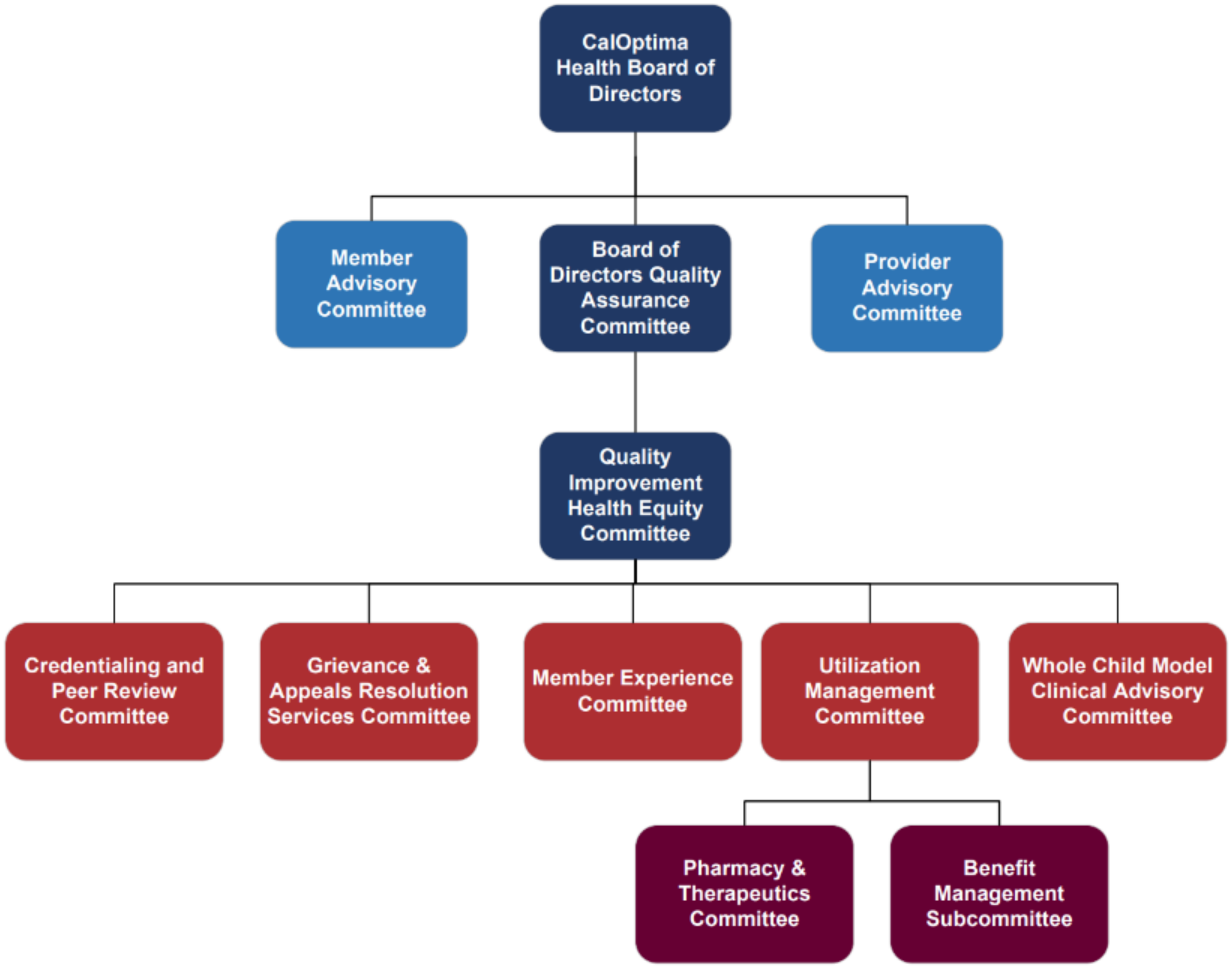
- QIHEC provides overall direction for continuous quality improvement and health equity processes
- QIHEC oversees activities that are consistent with CalOptima Health's strategic goals and priorities
- QIHEC monitors compliance with regulatory and licensing requirements related to Quality Improvement and Health Equity (QIHE) projects and activities

QIHEC's Responsibilities

- Analyzes and evaluates the results of Quality Improvement and Health Equity (QIHE) activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other committees
- Institutes actions to address performance deficiencies, including policy recommendations; and
- Ensures appropriate follow-up of identified performance deficiencies

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Quality Improvement and Health Equity Governance



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National Committee for Quality Assurance Health Equity Accreditation Update

Quality Assurance Committee Meeting

March 19, 2026

Linda Lee, Executive Director, Quality Improvement

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Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

National Committee for Quality Assurance (NCQA) Health Equity Accreditation Survey

- NCQA awarded CalOptima Health with an "Accredited" status for Health Equity Accreditation on December 16, 2025.
- CalOptima Health met all applicable Health Equity Accreditation standards and received full points, earning a score of 100%.
- The recognition took effect on December 16, 2025, and remains valid through December 16, 2028.

Summary and Next Steps

- Effective January 15, 2026, NCQA renamed the Health Equity Accreditation to Health Outcomes Accreditation.
- NCQA released the newly revised 2026 Health Outcomes Standards.
- CalOptima Health will assess the new standards against current processes and deliverables, train staff on the new standards and begin to prepare for the next survey submission in 2028.

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APPENDIX

Back to Agenda

NCQA Health Equity Accreditation Timeline

Survey	Review Time Period	Submission Date
Health Equity Accreditation (HEA)	April 07, 2025-October 07, 2025 (6 months)	October 7, 2025

NCQA Health Equity Accreditation Progress

Status	Actions	Timeline
Completed	• CalOptima Health prepared and finalized all documents and shared them with HMA for review.*	• January 2025-September 2025
	• CalOptima Health uploaded all final documents to the NCQA's Interactive Review Tool (IRT) for submission.	• October 1-6, 2025
	• NCQA Health Equity Survey Submission	• October 6, 2025
	• CalOptima Health responded to initial issues and uploaded additional supporting documents	• November 7, 2025
	• NCQA Closing Conference Call	• December 1, 2025
	• CalOptima Health received Health Equity Accreditation Preliminary Report	• December 3, 2025
	• CalOptima Health reviewed and commented on the Preliminary Report	• December 5, 2025

*HMA consultants reviewed: policies and procedures, desk-top level procedures, training materials, survey materials, language service contracts, reports, program descriptions, program evaluation(s), and minutes.

NCQA Health Equity Accreditation Progress

Status	Actions	Timeline
Completed	• NCQA's Review Oversight Committee (ROC) to review and certify survey results • CalOptima Health to receive the Final Report and Certification*	• December 5-15, 2025 • December 16, 2025
In-Progress	• 2026 Health Outcomes Standards Training • Perform readiness assessment	• March 2026 • February 2026 - April 2026

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Hospital Quality Program Update

Quality Assurance Committee Meeting
March 19, 2026

Linda Lee, Executive Director, Quality Improvement

Our Mission

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Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Background

- Within the framework of CalOptima's provider model, hospitals and their affiliated physicians are integral components of the delivery of health services to members.
- CalOptima Health recognizes the critical role that hospital partners play on the delivery of care to our members.

Background (Continued)

- For many years, CalOptima Health has been providing quality incentive payments to Health Networks to drive improvement in quality outcomes and member satisfaction
- In December 2022, the CalOptima Health Board of Directors approved a five-year Hospital Quality Program to drive hospital performance.

Pay for Value Framework

- CalOptima Health utilizes three metrics for the Pay for Value framework: quality, patient experience, and hospital safety.
- To minimize hospital burden, CalOptima Health uses publicly available data listed on CMS Hospital Compare and the Leapfrog Group websites.

Measurement Areas	Data Source	Measurement Values
Quality	Hospital Compare*	1 to 5 stars
Patient Experience	Hospital Compare*	1 to 5 stars
Hospital Safety	Leapfrog Group^	Grade A, B, C, D, or F

***Hospitals not listed on Hospital Compare for quality and patient experience will be assessed using the Leapfrog Rating.**

^Hospitals not listed on either Hospital Compare or Leapfrog will not quality for incentive payments

Back to Agenda

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Pay for Value Rewards

- CalOptima Health's Hospital Quality Program rewards hospitals based on the following:

Metrics	Percent of Incentive Pool	Performance	Incentive
Quality	40%	5 stars 4 stars 3 stars 1 – 2 stars	100% of incentive 75% of incentive 50% of incentive 0% of incentive
Patient Experience	40%	5 stars 4 stars 3 stars 1 – 2 stars	100% of incentive 75% of incentive 50% of incentive 0% of incentive
Hospital Safety	20%	Grade A Grade B Grade C Grade D or F	100% of incentive 75% of incentive 50% of incentive 0% of incentive

Use of Leapfrog Quality Rating

- The Leapfrog Ratings are used in the Hospital Quality measures as mapped below for hospitals that cannot report to CMS.

Metrics	Leapfrog Ratings Domains	Measurement Values
Quality	Critical Care Pediatric Care Care for Elective Outpatient Surgery Patients	Scale of 1 to 4
Patient Experience	Experience of Children and Their Parents	Scale of 1 to 4
Hospital Safety Grade	Patient Rights and Ethics Preventing Patient Harm Medication Safety Healthcare-Associated Infections	Scale of 1 to 4

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Pay for Value Rewards- Leapfrog Rating

- The Leapfrog Ratings will be assessed for performance using the same weights and a scale of 1 to 4:

Metrics	Percent of Incentive Pool	Performance	Incentive
Quality	40%	4 3 2 1	100% of incentive 75% of incentive 50% of incentive 0% of incentive
Patient Experience	40%	4 3 2 1	100% of incentive 75% of incentive 50% of incentive 0% of incentive
Hospital Safety	20%	4 3 2 1	100% of incentive 75% of incentive 50% of incentive 0% of incentive

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Incentive Timeframe

- $30 million per year for five years 2023-2027
- Incentive awards are based on performance compared to quality thresholds and allocated based on the sum of claims and encounter inpatient days gathered six months after the end of the measurement period, to allow for data lag.
- CalOptima Health provided a ramp-up period to allow hospitals to participate in CMS/Leapfrog reporting.
- During this time, CalOptima Health provided hospital reporting incentive payments in an amount of $150,000 per eligible hospital per calendar year

Hospital Quality Funding Pool for 2024

- Total annual pool: $30 million
- Total incentives earned: **$16,737,814**
- Funds remaining: $13,262,186

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Hospital Performance Comparison 2023-2024

Hospitals	2023			2024		
	Hospital Quality Stars Rating	Hospital Patient Survey Rating	Leapfrog Hospital Safety Grade	Hospital Quality Stars Rating	Hospital Patient Survey Rating	Leapfrog Hospital Safety Grade
Anaheim Global Medical Center	N/A	2	C	N/A	N/A	C
Anaheim Regional Medical Center	3	2	B	3	2	B
Chapman Global Medical Center	1	1	D	1	2	C
Children's Hospital of Orange County	5	5	B	5	3	A
Foothill Regional Medical Center	N/A	1	N/A	N/A	1	N/A
Hoag Memorial Hospital Presbyterian	5	4	A	5	3	A
Long Beach Memorial Medical Center	2	3	C	2	3	C
Memorial Care Orange Coast Medical Center	4	3	C	3	3	B
Memorial Care Saddleback Medical Center	3	3	B	4	4	A
Orange County Global Medical Center	1	2	D	2	1	C
Pomona Valley Hospital Medical Center	4	3	A	3	3	A
Providence Mission Hospital	4	3	B	4	3	A
Providence St. Joseph Hospital	4	4	B	4	3	C
Providence St. Jude Medical Center	4	3	B	4	3	A
South Coast Global Medical Center	N/A	1	D	N/A	N/A	C
UCI – Fountain Valley	2	1	D	2	2	C
UCI – Los Alamitos	1	2	D	3	2	D
UCI Medical Center	4	4	A	4	3	A
UCI – Placentia Linda	2	3	C	2	2	B
UCSD Medical Center – San Diego	N/A	N/A	N/A	5	3	B
Whittier Hospital Medical Center	3	2	B	2	2	A

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Hospital Earnings Comparison 2023-2024

Hospitals	2023		2024	
	Maximum Incentive Possible	Incentive Earned	Maximum Incentive Possible	Incentive Earned
Anaheim Global Medical Center	$265,834	$26,583	$297,814	$29,781
Anaheim Regional Medical Center	$1,413,638	$494,773	$1,166,360	$408,226
Chapman Global Medical Center	$155,157	$0	$147,516	$14,752
Children's Hospital of Orange County	$3,598,119	$3,418,213	$3,467,166	$2,773,733
Foothill Regional Medical Center	$627,218	$0	$841,665	$0
Hoag Memorial Hospital Presbyterian	$1,940,663	$1,746,597	$2,247,838	$1,798,271
Long Beach Memorial Medical Center	$207,276	$62,183	$153,211	$45,963
Memorial Care Orange Coast Medical Center	$1,120,696	$672,418	$875,167	$481,342
Memorial Care Saddleback Medical Center	$412,305	$226,768	$373,293	$298,635
Orange County Global Medical Center	$2,013,149	$0	$2,078,340	$207,834
Pomona Valley Hospital Medical Center	$29,354	$20,548	$45,685	$27,411
Providence Mission Hospital	$1,305,806	$848,774	$1,265,808	$886,065
Providence St. Joseph Hospital	$2,881,640	$2,161,230	$3,393,805	$2,036,283
Providence St. Jude Medical Center	$1,355,978	$881,386	$1,239,588	$867,712
South Coast Global Medical Center	$359,887	$0	$318,206	$31,821
UCI – Fountain Valley	$3,456,890	$0	$805,911	$80,591
UCI – Los Alamitos	$404,816	$0	$98,521	$19,704
UCI Medical Center	$5,881,296	$4,705,037	$9,237,655	$6,466,359
UCI – Placentia Linda	$360,336	$108,101	$69,388	$10,408
UCSD Medical Center – San Diego	-	-	$323,636	$242,727
Whittier Hospital Medical Center	$53,167	$18,608	$50,982	$10,196
Totals	$27,843,225	$15,391,219	$28,497,555	$16,737,814

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Hospital Earnings 2024

Hospital	Hospital Quality STARS Rating	Hospital Patient Survey Rating	Leapfrog Hospital Safety Guide	Maximum Incentive Possible	Incentive Earned
Anaheim Community Hospital, LLC	N/A	N/A	N/A	$1,589	$0
Children's Hospital at Mission	N/A	N/A	N/A	$414,344	$0
Children's Hospital of Los Angeles	N/A	N/A	N/A	$158,243	$0
City of Hope National Medical Center	N/A	N/A	N/A	$143,676	$0
College Hospital Costa Mesa	N/A	N/A	N/A	$0	$0
Encompass Health Rehabilitation Hospital of Tustin	N/A	N/A	N/A	$215,713	$0
Kindred Hospital - Brea	N/A	N/A	N/A	$568,879	$0
Totals				$1,502,444	$0

These facilities qualify for grants of $150,000 if they agree to report data to CMS and/or Leapfrog.

Hospitals not listed on Hospital Compare for quality and patient experience will be assessed using the Leapfrog Rating.

Hospitals not listed on either Hospital Compare or Leapfrog will not quality for incentive payments

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Quality Improvement Strategies

Quality Assurance Committee Meeting

March 19, 2026

Linda Lee, Executive Director, Quality Improvement

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Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Member-Facing Strategy Overview

- Our member-facing strategy is about meeting members where they are:
  - Offering services in their home if they prefer,
  - Helping them schedule PCP appointments, and
  - Breaking down access barriers by directly scheduling tests, such as mammograms, to make care easier and more convenient.

At-Home Quality Programs for Members

Program	Details	Target Population
Annual Wellness Visit (AWV)	• Comprehensive AWV • Point-of-care lab testing and other preventive services • Referral to providers/facilities for cancer screenings	CalOptima Health Community Network (CHCN) members due for an AWV with multiple quality care gaps
Diabetes	• HbA1c test via finger prick • Kidney health evaluation via urine collection	CHCN members due for the GSD and/or KED HEDIS measures*
Colorectal Cancer Screening	• Cologuard testing	CHCN members due for the COL HEDIS measure*

*GSD: Glycemic Status Assessment for Patients with Diabetes; KED: Kidney Health Evaluation for Patients with Diabetes; COL: Colorectal Cancer Screening

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At-Home Visit Program Results

Target Population:
OneCare CalOptima Health Community Network (CHCN) members due for an AWV with multiple quality care gaps

Timeframe:
1/1/2026 - 2/17/2026

1,431
Total Eligible Members

323
Home Visits Completed

93%
Of Members Tested - HbA1c Result < 9
(69/74 Mbrs)

Reflects services completed between 1/1/2026 – 2/17/2026

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At-Home Diabetes Testing Program Results

Line of Business	Total Sent: HbA1c Kits	Response Rate	Total Sent: Kidney Health Evaluation Kits	Response Rate	Total Sent: Combo Kits*	Response Rate
Medicare	27	14.81%	425	8.00%	114	3.51%
Medi-Cal	134	1.49%	870	2.76%	1,368	2.70%
Total	161	3.73%	1,295	4.48%	1,482	2.77%

Results reflect services completed between 12/6/2025 and 2/3/2026; *combo kits include both HbA1c and kidney health evaluation tests

At-Home Colorectal Cancer Screening Program Results

Line of Business	Cologuard Tests Distributed	Cologuard Tests Completed	Response Rate
Medicare	719	115	16.0%
Medi-Cal	14,295	1,352	9.5%
Total	15,014	1,467	9.8%

Results reflect services completed between 11/18/2025 and 1/13/2026

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Lessons Learned / Key Takeaways

- Confirm addresses prior to sending at-home lab kits to decrease volume of returned mail
- Wrap-around communication is key
  - Priming text prior to the initiative (example on following slide)
  - Follow-up reminder text
  - Follow-up phone call
- Include ‘how to’ videos with digital messaging

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At-Home Visit Program: Priming Text

- We are working with <*provider name*> to offer you care from the comfort of your home. Look for a call soon from <*provider phone number*> to schedule an at-home wellness visit.

Telephonic Outreach Program Results

- Our outbound telephonic outreach strategy utilizes a vendor to contact CalOptima Health members across all lines of business
- 19 HEDIS measures are addressed as part of these campaigns
- The results below reflect calls made in 2025:
  - Total members outreached: 305,336
  - Contact rate: 12.34% (37,675 / 305,343)

Reflects calls made from January – December 2025

Telephonic Outreach Program Results by Domain

Domain	Members Reached	Appointments Scheduled	Appointment Rate
Adult Preventive Care / Older Adult	29,372	17,784	61%
Cancer Prevention	16,865	10,392	62%
Child & Adolescent Health	117,590	65,421	56%
Chronic Disease Management	25,178	16,069	64%
Reproductive Health	77	23	30%
Total	**189,082**	**109,689**	**58%**

Reflects calls made from January – December 2025

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Grant Management Activities and Updates

Quality Assurance Committee Meeting

March 19, 2026

Kelly Bruno-Nelson, Executive Director, Medi-Cal and CalAIM

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

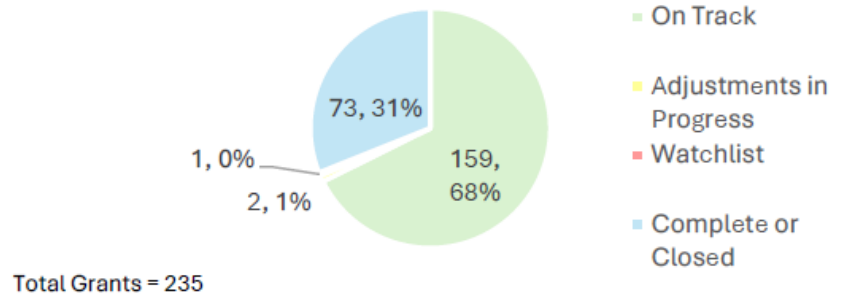
Grant Management Updates

- The Grant Management Department was established in April 2025 to provide consistent oversight and administration of all CalOptima Health grantmaking activities.
- The following report provides a synopsis of CalOptima Health's overall grant program, the portfolios that represent different community investment efforts, and all related grant agreements.

Grants Monitoring Report

CalOptima Health Grants Monitoring Report
Prepared March 9, 2026

Current Pulse Check Across All CalAIM Grants



Total Grants = 235

Grant Assessment Key

Grant program is on track for timeline, objectives and budget. All reports and progress meet expectations.

Grant program is delayed or off track and adjustments are in progress. Staff is actively working with grantee to address program or spending performance. The program is not at risk, but needs additional attention to ensure it stays aligned.

Grant program is on a watch list and not progressing enough toward outcomes or spending. Grantees are completing Performance Improvement Plans. Staff are actively involved to ensure program can be returned to "on track." Executive team or legal counsel advise on any potential agreement amendments, recoupment of funds, or other actions needed.

Grant program completed or terminated upon mutual agreement.

Pg.	Portfolios Under Active Management*	Portfolio Value	# of Grants	Status Breakdown Across Each Portfolio
2	Behavioral Health Grants	$ 9,571,250	3	3
3	Street Medicine	$ 23,460,083	7	4 | 1 | 2
4	HHIP- Round 1	$ 36,631,423	35	6 | 1 | 28
5	HHIP- Round 2	$ 52,300,000	15	9 | 6
6	HHIP- Round 3	$ 25,780,000	14	7 | 7
7	HHIP – Round 4	$ 2,700,000	6	6
8	Pulse for Good	$ 660,000	22	15 | 7

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Grants Monitoring Report (continued)

| | | |

Quality Improvement Grant Program (MY 2023)

- Began oversight of this portfolio in April 2025.
- 37 grants totaling $4.6 million to 15 unique organizations.
- In the process of closing out these grants with 13 having or in the process of having no cost extensions.
- Grantees working to improve specific, selected quality measures (MCAS and Stars):

1. AltaMed
2. CHOC Health Alliance
3. CHOICE Health Network
4. Clarke Lew Medical Corporation
5. Friends of Family Health Center
6. Hurtt Family Health Clinic Inc
7. KCS Health Center
8. Noble Mid-Orange County
9. Optum
10. Prospect Medical Systems
11. Providence Medical Foundation
12. Share Ourselves
13. St. Jude Neighborhood Health Centers
14. UCI Health Family Health Center
15. Vista Community Clinic

Quality Improvement Grant Program (MY 2024)

- Only health networks are eligible in subsequent rounds.
- Can only apply for quality measures where they do not already have active grants.
- May request up to $125,000 for every 5% planned improvement upon a measure; for up to $250,000 for MCAS measures and $250,000 for Star measures.
- Received and are processing 11 requests.
- A second MY2024 request period is anticipated for later this year.

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Board of Directors'

Quality Assurance Committee Meeting

March 19, 2026

Quality Improvement Health Equity Committee (QIHEC) Fourth Quarter 2025 Report

QIHEC Summary		
QIHEC Chair(s)	Quality Medical Director and Chief Health Equity Officer	
Reporting Period	Quarter 4, 2025	
QIHEC Meeting Dates	October 14, 2025, November 4, 2025, December 9, 2025	
Topics Presented and Discussed in QIHEC or subcommittees during the reporting period	• Access and Availability • Adolescent Care • Adult Wellness and Prevention • Appropriate Testing for Pharyngitis (CWP) and Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) • Behavioral Health Integration (BHI) • Benefit Management Subcommittee (BMSC) • California Advancing and Innovating Medi-Cal (CalAIM) • Case Management (CM) program • Comprehensive Community Cancer Screening Program • Consumer Assessment of Healthcare Providers and Systems (CAHPS) • Care Management and Care Coordination • Chronic Conditions Management • Continuity & Coordination of Care • Credentialing and Recredentialing • Cultural and Linguistics Appropriate Services Program • Customer Service	• Health Education • Health Risk Assessments • Health Needs Assessments • Healthcare Effectiveness Data and Information Set (HEDIS) • Initial Health Appointment • Language Accessibility • Long-Term Care Support and Services • Managed Care Accountability Set (MCAS) • Maternal and Child Health • Medicare Advantage Star Program Rating • Medication Adherence • Medication Management • Member Experience (MemX) • National Committee for Quality Assurance (NCQA) Accreditation • Network Adequacy • OneCare Model of Care • Pediatric Wellness and Prevention • Performance Improvement Projects • Pharmacy & Therapeutics (P&T) Subcommittee

	• Delegation Oversight • Demographic Data Collection • Department of Health Care Services (DHCS) Non-Clinical Performance Improvement Project (PIP) • Depression Screening • Diabetes Care • Emergency Department Diversion Program • Enhanced Care Management (ECM) • Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) • Facility Site Review (FSR)/Medical Record Review (MRR)/Physical Accessibility Review Survey (PARS) • Grievance & Appeals Resolution Services (GARS)	• Plan All-Cause Readmission (PCR) • Policy • Population Health Management (PHM) • Potential Quality Issues (PQIs) • Prenatal and Postpartum Care • Preventive and Screening Services • Maternal Care • Quality Compliance Report • Quality Improvement Health Equity Work Plan • Quality Metrics • Student Behavioral Health Incentive Program • Transitional Care Services (TCS) • Utilization Management Committee • Whole Child Model (WCM)

QIHEC Actions in Quarter 4, 2025

QIHEC Approved the Following Items:

- September 9, 2025, meeting minutes; October 14, 2025; November 4, 2025, meeting minutes
- Seven Quality Improvement or Health Equity policies:
  - GG.1603: Medical Records Maintenance
  - GG.1621: Community-Based Adult Services (CBAS) Quality Assurance and Site Visits.
  - GG.1633: Board Certification Requirements for Physicians
  - GG.1643: Minimum Provider Credentialing Standards
  - GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
  - GG.1815: Long Term Services and Support Quality of Care Reporting
  - GG.1620: Quality Improvement Health Equity Committee (QIHEC)
- QIHEC Charter with the following changes: a 75% attendance requirement, quarterly activity summaries to the Board and DHCS (also publicly posted), expanded documentation of meeting materials, and formal integration of health equity into the committee's purpose.
- Critical Incident Reporting form to align with the DHCS definition of a critical incident.

Accepted and filed the following items:

- 2025 QI Work Plan Quarter 3 update
- Hospital Transitional Care Services (TCS) Flyer 2025
- Appendix: Credentialing Peer Review Committee Oversight Update
- Appendix: Member Experience Committee Oversight Update
- Appendix: Utilization Management Committee Update
- Appendix: Whole Child Model Clinical Advisory Committee Update
- Appendix: Delegation Oversight
- Grievance and Appeals Resolution Services Committee Meeting Minutes_August 12, 2025_Final
- Member Experience Committee Meeting Minutes_July 15, 2025_Final
- Population Health Management Committee Meeting Minutes_August 21, 2025_Final

QIHEC Actions in Quarter 4, 2025

- Utilization Management Committee Meeting Minutes_August 21, 2025_Final
- Whole Child Model Clinical Advisory Committee Meeting Minutes_August 19, 2025_Final

QIHEC Quarter 4, 2025 Highlights

- Chief Medical Officer (CMO) Updates
  - Emphasized the importance of flu shots and diabetes control.
  - Highlighted the need for improved diabetes control and underuse of Glucagon-Like Peptide-1 (GLP-1) medications for quality of care and improved Star Ratings and noted GLP-1 benefits beyond glycemic control (e.g., sleep apnea, cardiac events).
  - Warned about long-term dangers of high blood sugar
  - Recognized Behavioral Health team for obtaining new data from the Orange County Health Care Agency (OCHCA).
  - Reported a 12% improvement in the mental illness follow-up (FUM) measure due to new data.
- Quality Improvement Compliance Report - During the fourth quarter of 2025, the QIHEC reported no new compliance issues.
- Follow-up reports:
  - At the committee's request, staff reported, at the October 2025 QIHEC meeting, on resources, best practices, and education on new Behavioral Health (BH) measures that have been shared and/or implemented, which include the following: distributed a HEDIS tip tool sheet in August 2025 as part of the weekly Health Network communications, began coordinating in-person visits to behavioral health prescribing provider offices for direct education, provided daily emergency department visit feeds to CalOptima Health's HNs to support timely outreach, worked with Information Technology on developing provider portal reports, with two Emergency Department (ED) follow-up measures expected to be posted in October and the remaining BH measures in November. Best practice letters and tip sheets to providers, based on Associate Professional Clinical Counselor (APCC) data, will be sent to providers once the data is available
  - At the committee's request, staff shared the TCS flyer that was attached to the September meeting minutes at the October 2025 QIHEC meeting.
  - At the committee's request, staff reported efforts to increase member participation in in-home glucose screening tests at the October 2025 QIHEC meeting. Staff reported that CalOptima Health partnered with Quest Diagnostics to provide at-home A1c and kidney testing kits for diabetic members in the CalOptima Health Community Network (CHCN). Progress toward making these kits available to eligible members is ongoing.
  - At the committee's request, staff confirmed that all TeleMed2U providers were included in the survey's universe pull at the October 2025 QIHEC meeting.
  - Across the August, November, and December QIHEC meetings, staff reported and later followed up on compliance issues involving delayed Health Risk Assessments (HRAs) and Health Needs Assessments (HNAs) for OneCare and Whole Child Model (WCM) members. The QIHEC sought clarification on the affected member types. The initial issue, identified in late June, stemmed from IT problems, incomplete member lists, delays in transmitting completed HRAs to health networks, and member identification logic errors. In total, the August report noted 62 affected OneCare and 118 WCM members, while the November and December updates confirmed 108 OneCare members experienced HRA transmission delays and 147 WCM members were impacted by HNA-related noncompliance—146 for annual outreach and one for an initial HNA. All OneCare HRA cases have since been resolved, with care plans completed and shared, and individualized care plan (ICP)

QIHEC Quarter 4, 2025 Highlights

timeliness remained compliant under All Plan Letter (APL) 2024-015. A Corrective Action Plan (CAP) was initiated, resulting in new reporting processes and information technology (IT) improvements, including better call list generation and FTP data transfers.
  - At the committee's request, staff provided the committee with the numerator and denominator data for both Follow-Up After Emergency Department Visit for Mental Illness (FUM) and Follow-Up After Emergency Department Visit for Substance Use (FUA) data at the November QIHEC meeting. For July, the FUA measure data represented a shortfall of 233 members needed to meet the MPL. For the FUM measure, the gap was 525 members missing timely follow-up care. Staff emphasized that integrating county data into CalOptima Health's HEDIS software has already shown positive results, improving performance by 12 percentage-points in August, and is expected to help achieve the 50th percentile goal. The data presented reflected only internal sources, with county data to be incorporated into upcoming quarterly reports.
  - At the committee's request, staff shared an update on efforts related to interventions for suicidal ideation and prevention. At present, there is no available data on these issues for CalOptima Health members. However, staff is assessing the feasibility of obtaining such data from the County, which may require additional time. The committee will revisit this topic once the data becomes accessible.
- National Committee of Quality Assurance (NCQA) Accreditation – CalOptima Health successfully submitted for NCQA Health Outcomes Survey Accreditation (formerly known as Health Equity Accreditation), meeting all required standards and deadlines. The organization also continued preparations for the upcoming Health Plan Accreditation (HPA) survey submission and file reviews, scheduled for 2027. Policy and charter updates were made to ensure alignment with the latest DHCS and NCQA requirements. Ongoing training and readiness assessments are in place to maintain compliance with evolving accreditation standards. Overall, CalOptima Health remains on track with all NCQA accreditation activities and continues to prioritize quality and equity in care delivery.
- CalOptima Health Comprehensive Community Cancer Screening Program (CCCSP) - CCCSP is advancing efforts to improve cancer screening access through point-of-care self-test kits and educational materials for grantees, clarifying differences between self-collection and at-home kits. Most of the 15 community grantees met benchmark metrics and received continued funding, while one grantee was working with the quality team to resolve data discrepancies. The program also expanded mobile mammography services, screening 212 members year-to-date and increasing clinic participation from three to eight for FY 2025–26. Approximately $89,000 remains in the operational budget for upcoming events.
- Behavioral Health Services –There was mixed progress across behavioral health measures:
  - Schizophrenia - Adherence to antipsychotic medications rose by 8.98% (Medi-Cal) and 11.46% (OneCare), while diabetes screening increased by 18.98%. Still below target but trending positively.
  - Care Coordination and Follow-Up Care – FUM and FUA measures showed a slight increase. TeleMed2U outreach and collaborative efforts continue.
  - Performance Improvement Projects (PIPs) Medi-Cal BH - Case Management enrollment within 14 days of ED visits exceeded targets with a 1.24% increase over baseline. Work continues to improve the timeliness of provider notifications.
- School-Based Mental Health Services – While the Student Behavioral Health Incentive Program ended in December 2025, efforts around school-based mental health services led to a 38% increase in behavioral health staff, improved screening processes, and expanded telehealth access for over 260,000 students through Hazel Health. Children's Hospital of Orange County (CHOC) opened 10 well spaces and launched specialized autism care, while Western Youth Services provided on-demand training accessed

QIHEC Quarter 4, 2025 Highlights

by 65% of districts. Telehealth services were extended through 2025–2026, and a real-time referral platform was introduced to improve care coordination.

- Language Services – Sexual Orientation and Gender Identity (SOGI) data collection averaged only 3% in 2025 despite outreach efforts. For 2026, Health Equity standards will shift to broader member-level data, adding disability and geographic elements. CalOptima Health is updating policies and systems to meet these new requirements
- Network Cultural Responsiveness: Data Collection on Member Demographic Information - Spanish remains the highest-volume language for written translation, and Russian was added as a new threshold language in August, with 442 translation requests completed since then. Oral interpretation services are also available for members who cannot read written translations, ensuring equitable access to information.
- Experience with Language Services - Satisfaction with language services was high, 100% among staff and over 90% among members, though survey response rates were low. Planned improvements include leadership engagement and simpler surveys.
- Diversity, Equity, and Inclusion (DEI) training program - CalOptima Health's DEI training program was on hold pending a legal review, with more detailed status shared at a future meeting
- Introduction to Community Reinvestment – Staff introduced DHCS's Community Reinvestment requirement, which mandates plans with positive net income to reinvest earnings into local communities. CalOptima Health qualifies and will focus on health access, behavioral health initiatives, and equity improvements, with the first plan due in Q2 2026 after board approval.
- Special Needs Plan (SNP) Model of Care (MOC) - CalOptima Health achieved the Centers for Medicare & Medicaid Services (CMS) cut point for a four-star rating in HRA completion for 2025. This milestone reflects years of targeted interventions and outreach efforts aimed at improving member engagement and compliance. Care plan completion rates were strong: 76.83% of newly enrolled members completed a care plan within 90 days, and 95.1% of members had a care plan completed within the past year. Member collaboration in care planning showed modest improvement, with 37.4% participation for initial care plans and 32.7% for annual care plans. As of September 2025, 84% of OneCare members had a well visit in the current year and 87% within the past 12 months, increasing to 88% when excluding newly enrolled members. Multiple outreach campaigns, including text messaging and phone calls, are ongoing to close this gap.
- Quality Performance Measure Update:
  - Maternal and Child Health: Prenatal (81.56%) and postpartum care (68.39%) measure rates are significantly higher than those in June 2024 and are on track to reach the goal.
  - Medication Management Update - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) and Appropriate Testing for Pharyngitis (CWP) are performing slightly behind last year's pace. As part of the intervention strategy, top antibiotic prescribers have been identified, and targeted education and support will be provided to improve prescribing practices and align with clinical guidelines.
  - Medication Adherence - Staff reported improved July 2025 Star medication adherence rates for diabetes, hypertension, and cholesterol compared to last year, with slower declines. Outreach on 8,000 prescriptions achieved a 41% refill success rate, led by pharmacy outreach (50.7%). SortPak mail service enrollment had a 15.2% success rate, supporting overall adherence and Star performance.
  - Pediatric and Adolescent Wellness - EPSDT/Children's Preventive and Screening Services – CalOptima Health showed improvement in pediatric and adolescent wellness measures, with immunization-related metrics like Childhood Immunization Status (CIS) and Immunizations for

QIHEC Quarter 4, 2025 Highlights

Adolescents (IMA) already meeting Minimum Performance Levels (MPLs). Other measures are trending upward. Outreach has shifted to personalized strategies, providing individualized vaccine status and directing members to their providers, supported by data-driven efforts to close documentation gaps.

- Adult Wellness – CalOptima Health reported improvements in adult preventive care, with cervical cancer screening trending upward and breast and colorectal screenings at 62%, on track for at least a three-star CMS rating. Adult immunization rates improved across all categories, with influenza and zoster vaccines meeting targets. Key initiatives include at-home colorectal testing and standing orders for mammography to streamline scheduling and follow-up.
- Maternity Care for Black Members - CalOptima Health addresses disparities in prenatal and postpartum care for Black members, whose rates (78.87% prenatal, 64.79% postpartum) lag overall population averages. Initiatives include enrolling members in the Black Infant Health (BIH) program, promoting doula services, and leveraging community partnerships, such as HEAL, to improve access and engagement. Digital strategies and culturally affirming support aim to close gaps and enhance maternal health outcomes
- Medi-Cal PIP - CalOptima Health's state-mandated PIP focuses on increasing well-child visits for Black/African American children ages 0–15 months, aiming for at least six visits by 15 months. As of August 2025, performance was 32.26%, significantly below the overall population rate of 46.74%, highlighting a critical disparity. Strategies include layered outreach messaging, improved provider awareness through stratified performance data, and collaborative efforts with Health Networks to drive targeted interventions and close gaps in early childhood preventive care.
- Chronic Conditions: Members with Hypertension- CalOptima Health is working to improve hypertension management, with current performance at 38.04% for Medi-Cal (goal: 67.88%) and 40% for OneCare, placing it at a one-star level. Initiatives include launching Cozeva Payer One for real-time data exchange, enabling providers to close care gaps more efficiently, and expanding electronic medical record (EMR) integration. Outreach strategies feature telephonic education, text/email campaigns, and distribution of blood pressure monitors through standing orders to remove access barriers.
- OneCare Chronic Care Improvement Projects (CCIPs): Diabetes Emerging Risk - CalOptima Health is working to improve diabetes care for OneCare members through targeted strategies. Key initiatives include at-home lab kits for HbA1c and kidney health testing (launching November 2025), text outreach for health coaching, and dashboards to identify high-risk members. These efforts aim to close care gaps, improve outcomes, and boost CMS Star ratings.
- Chronic Conditions: Members with Diabetes - CalOptima Health is improving diabetes care for Medi-Cal and OneCare members, focusing on eye exams, HbA1c control, and kidney health evaluations. Performance is trending upward, supported by new initiatives like at-home lab kits for HbA1c and kidney testing, text outreach for health coaching, and dashboards to identify high-risk members

- Plan All-Cause Readmission (PCR) - The PCR metric compares the observed number of readmissions to the expected number based on risk-adjusted benchmarks. Medi-Cal O/E ratio improved to 0.0933 (goal: 0.8937); OneCare readmissions decreased to 11.72% (goal: 8%). A lower O/E ratio indicates better performance because fewer readmissions occurred than predicted. Key actions include provider education, promotion of TCM codes, and piloting a transitional care assessment to reduce readmissions.
- Emergency Department (ED) Member Support - CalOptima Health launched the ED Member Support Program in early 2025 to improve engagement and care transitions. The program includes warm handoffs

QIHEC Quarter 4, 2025 Highlights

to internal and delegated networks, SNF placements from the ED, and referrals to services like Transitional Care, Case Management, and Community Supports under CalAIM. Engagement has steadily grown, with 188 members engaged in September, and new tools have been integrated into the Jiva system to streamline workflows. Plans include expanding to UCI Medical Center using a telephonic support model.

- Cultural Responsiveness – Practitioner Data - CalOptima Health collected provider demographic data on race, ethnicity, and language (REL). The 2025 goal was a 10% response rate, but current participation remains low, 2.83% for race/ethnicity and 3.4% for language fluency. Outreach strategies include direct email and phone campaigns, "Lunch and Learn" sessions, and the integration of REL forms into credentialing and provider data processes. These efforts aim to enhance culturally appropriate care and identify gaps in provider diversity.
- CalOptima Health's Disease Management program - Focuses on diabetes, asthma, and cardiovascular disease. In 2025, the program transitioned to Clinical Operations to better align with case management and introduced enhancements, including condition-specific health coaching, mailed education materials, and refined stratification to target high-risk members. A new text-based outreach approach significantly improved engagement and satisfaction, with 98% of surveyed members reporting positive experiences. A pilot targeting members with urgent needs achieved higher success rates via text opt-in than via cold calls, leading to improved PCP scheduling and medication support. The program also streamlined assessments, reducing time by over 50%, and implemented dashboards and simplified provider communications. For diabetes, interventions prioritize members with elevated A1c and no recent PCP visit, and early data indicate notable A1c reductions among those on GLP-1 medications. Overall, the update highlighted strong engagement, operational efficiencies, and plans for ongoing outcome tracking and collaboration with health networks.
- Increase Primary Care Utilization - Initial Health Appointment – IHA performance averaged 32.24% across networks and 24.60% excluding CHOC and CHCN, with higher rates (70.56%) for members under 18 months. Strategies included member engagement through outreach campaigns, provider education, and enhanced monitoring. CalOptima Health passed the DHCS audit due to strong documentation. A revised benchmark for 2026 will be proposed in Q1 to support improved compliance.
- Health Education Program – Staff reported a 24% increase in referrals over two years, continuing virtual and telephonic education after suspending in-person sessions in late 2025. Key enhancements included the launch of Healthwise Coach within Jiva for personalized content delivery and plans for HealthHub, a centralized wellness portal with interactive tools and multilingual support, set for a December soft launch
- CalAIM Community Supports and Enhanced Care Management (EMC) Update – ECM services far exceeded targets, serving about 9,500 members versus the original goal of 2,842, supported by 12 new providers, bringing the total to 61. Street Medicine achieved 94% PCP connection and 98% linkage to ECM and housing navigation, though housing placement remains challenging, with 18 members housed in 2025 (34 total since inception). Audits for all 50 housing-related providers will begin in January 2026, and expansion of Street Medicine services to Santa Ana is planned for early 2026
- Delegation Oversight - In Q3 2025, CalOptima Health conducted four audits, including combined audits for AMVI Care, Prospect Medical Group, and United Care Medical Group, and a separate audit for Noble Mid-Orange County. Findings primarily involved Utilization Management compliance, such as delays in issuing coverage decision letters, inaccurate or incomplete Notice of Action letters, and translation errors in member communications. CAPs were issued to Prospect, United Care, and Noble for these issues. Broader trends from 2024–2025 audits highlighted recurring concerns in case management, regulatory implementation, claims accuracy, credentialing, and timely notifications.

QIHEC Quarter 4, 2025 Highlights

- Managed Care Accountability Set (MCAS) MPL Measures- Nine MCAS measures have met the MPL, but several remain below target, including HbA1c Poor Control, Timeliness of Prenatal Care, Well-Child Visits, Cervical Cancer Screening, Controlling High Blood Pressure, and Postpartum Care. Behavioral health follow-up measures improved but are still under MPL. Contributing factors include changes in methodology, such as excluding telehealth visits and shifting cervical cancer screening to Electronic Clinical Data Systems (ECDS). To close gaps, CalOptima Health conducts supplemental data collection, medical record reviews, and retrieves missing lab results.
- Value-Based Payment Program: Health Network Pay for Value (P4V) - For Medi-Cal Measurement Year 2024, CalOptima Health adopted a new Integrated Healthcare Association (IHA) methodology to calculate quality performance and improvement on a 0–10 scale. Performance points are based on percentile benchmarks, and improvement points compare current rates to prior-year rates. Combined ratings showed variation across networks, with CHOC achieving the highest score (4.8) and others ranging from 1.49 to 3.54. CAHPS results highlighted member experience as a key improvement area, with CHOC leading at 4.78 and most networks scoring below 2.5. Overall, the update emphasized opportunities to improve quality measures and member experience across networks.

QIHEC Subcommittee Report Summary in Quarter 4, 2025

Credentialing Peer Review Committee (CPRC)

CPRC held regular meetings on July 24, 2025, August 28, 2025, and September 25, 2025, and approved the minutes from their previous meetings. CPRC held closed session meetings on July 24 and September 25 to address physicians undergoing a fair hearing.

- Policies Approved by CPRC in Q4 2025:
  - GG.1633 – Board Certification Requirements for Physicians (added the National Board of Physicians and Surgeons as a recognized certifying body)
  - GG.1643 – Minimum Physician Standards (expanded scope and made minor changes)
- CPRC Reviewed, Accepted and Filed
  - PQI (Potential Quality Issue) closure list report Q3 without findings.
  - Credentialing and Recredentialing Clean List and Closure Reports for Q3 2025 without findings.
- Fair Hearings & Monitoring: Three physicians are on a probationary status and are being monitored.
- Ongoing Monitoring: Fourteen providers were identified through sanction lists, resulting in 13 terminations in accordance with policy.
- Delegation Oversight presented credentialing delegation oversight and reported an open CAP for one delegated group.
- Compliance Reports
  - One Provider Preventable Condition was reported to DHCS in Q1 2025
  - Incident Report - Critical incident reports increased in Q2 and Q3, primarily related to caregiver abuse/neglect and Orange County Transportation Authority (OCTA) transportation errors involving members with dementia; a PQI was initiated to address these issues.
  - CPRC reviewed a new Grievance Report on data from January to June 2025.
- Provider Action Workgroup was introduced to review practitioners with high grievance volumes and outlier performance, considering factors such as Facility Site Reviews (FSRs) and HEDIS scores, fraud/waste/abuse concerns, and credentialing status to inform future recommendations.
- Potential Quality Issues (PQIs)

QIHEC Subcommittee Report Summary in Quarter 4, 2025

  - CPRC reviewed PQI Statistics for Q2 and PQI Trends from January to June 2025, noting a significant reduction in the overall number of PQIs, compared to previous periods, which was attributed to increased support from medical directors and enhanced provider education. Most PQIs were related to documentation and medical records, particularly among behavioral health providers.
  - In Q2 2025, CPRC met to conduct a peer review and leveled four providers at a three and leveled four providers at a two. No cases presented at CPRC this quarter were leveled at a one.
- Credentialing Activity in Q3
  - There were 440 initial credentialing applications and 330 recredentialing applications. Of the initial applications, 339 were from behavioral health providers, highlighting continued efforts to expand the behavioral health network.
  - One provider did not meet the 120-day credentialing standard for initial credentialing, and four Applied Behavioral Analyst (ABA) providers did not meet the 36-month credentialing standard.
- Facility Site Reviews (FSR) and Medical Record Reviews (MRRs)
  - In Q3 2025, one provider was terminated due to FSR/MRR non-compliance.
  - In Q3 2025, there was a decrease in the number of providers who failed an audit, reflecting improved compliance.

Grievance & Appeals Resolution Services Committee (GARS)

GARS met on November 12, 2025, and approved the meeting minutes from August 12, 2025.

- The GARS reviewed and accepted:
  - Member grievances and appeals trends
  - Provider dispute resolutions (PDRs)
  - Remediation activities for identified issues
- Grievance Trends (Q3 2025)
  - Medi-Cal: 4,547 grievances were handled in Q3, with an increase in Quality of Service and Billing categories and a decrease in Quality of Care and Access. Primary drivers include the following:
    - Provider service complaints (staff behavior, poor phone etiquette, lack of callbacks)
    - Transportation issues (driver punctuality, scheduling, attitude)
    - CalAIM-related concerns (meal delivery mix-ups, housing deposit assistance).
      Grievance rate remains below the NCQA threshold of 5 per 1,000 member months.
  - OneCare: 584 grievances were handled in Q3, and trends are similar to Medi-Cal. Discrimination grievances increased in Q3, primarily related to the Americans with Disabilities Act (ADA), language access, and race/ethnicity. Most cases were unsubstantiated; members were educated on interpreter services; providers confirmed compliance with protocols.
- Appeals Trends (Q3 2025)
  - Medi-Cal: 307 appeals were handled, with 95 overturned (31%), mainly inpatient care and injectables. Top reasons for overturn include new information and medical necessity. Actions taken include shared rationales for overturns with health networks and educating on post-stabilization authorization requirements.
  - OneCare: 62 appeals were handled, with 19 overturned for similar reasons. The highest overturn percentage is in injectable services (67%).
- Remediation Activities
  - Weekly meetings with MotiveCare and internal teams to resolve providers' eligibility and scheduling issues.
  - Continued monitoring to ensure grievance rates remain below benchmarks.
  - Education provided to health networks on authorization requirements to reduce appeal overturns.

QIHEC Subcommittee Report Summary in Quarter 4, 2025

Member Experience Committee (MemX)

MemX met on October 7, 2025, and approved the July 15, 2025, meeting minutes.
The MemX Committee reviewed:

- Medicare Focus Group findings
- Network adequacy and timely access updates
- Voice-of-Member feedback and improvement strategies

- Medicare Focus Group Findings:
  - Practical benefits are most valued: access to doctors, drug coverage, dental, vision, language services, transportation, and flex incentives.
  - Members requested easier provider search tools.
  - 56% of non-members expressed interest in enrolling in OneCare, with higher interest among Spanish-speaking participants.
  - Transportation is a key benefit for non-members
- Network Adequacy:
  - CalOptima Health met all specialty time/distance requirements and bed capacity standards for Q3.
  - Annual Network Certification (ANC) pending DHCS review; Subcontracted Network Adequacy (SNC) audit closed with all CAPs submitted.
  - Telehealth expansion was identified as a key strategy to address specialist recruitment challenges.
  - DHCS landscape analysis completed; no follow-up required from Health Services Advisory Group (HSAG) for validation audit.
- Timely Access:
  - Decision to transition to the Provider Appointment Availability Survey (PAAS) methodology.
  - New one-year survey cycle replaces previous three-year escalation cycle.
  - DHCS report on Timely Access survey showed compliance in most areas except for urgent visit appointment times, which remain below the 70% threshold but are improving.
- Voice-of-Member Initiatives:
  - Breakout sessions focused on improving CAHPS scores in areas such as urgent care access, provider communication, and appointment scheduling.
  - Journey mapping and focus group insights will inform 2026 improvement strategies.

Population Health Management Committee (PHMC)

Approvals at QIHEC Meeting

- The PHMC has been dissolved, and its responsibilities now fall primarily under the QIHEC and the Utilization Management Committee (UMC), as indicated in Policy GG.1620.
- QIHEC now oversees functions previously managed by PHMC, including annual evaluations of QIHETP and UMC/CM programs and maintains a reporting calendar.
- The QIHEC approved and accepted for filing the PHMC Meeting Minutes from August 21, 2025, during its December 9, 2025, meeting.

Utilization Management Committee (UMC)

- Benefits Management Subcommittee (BMSC)
- Pharmacy and Therapeutics Committee (P&T)

The UMC met on November 20, 2025, and approved the minutes from the August 21, 2025, meeting.

- At the UMC meeting in November, the committee:
  - Approved 2026 utilization goals for inpatient bed days and ED visits (set at a 5% reduction from prior-year performance).

QIHEC Subcommittee Report Summary in Quarter 4, 2025

  - Approved revisions to 16 utilization management policies and procedures.
- Utilization Metrics:
  - Medi-Cal membership showed a downward trend in Q3 2025; OneCare increased slightly; Whole Child Model remained stable.
  - Acute inpatient data: Medi-Cal Temporary Assistance for the Needy (TANF) populations saw decreases in admissions, bed days, and average length of stay; OneCare had fewer admissions but more bed days and readmissions.
  - ED utilization remained stable across aid categories.
- Operational performance remained strong, with compliance rates exceeding 97% for inpatient determinations within 72 hours, 99.8% for urgent referrals within 72 hours, and nearly 100% for routine and prior authorization turnaround times.
- Workgroups addressed utilization and quality improvement through initiatives such as:
  - Breast MRI review training
  - ER high-utilizer clinical workgroup
  - Population health initiatives targeting members with high hemoglobin A1c
  - Embedding staff in ED settings
  - Preventive screening campaigns and SNP concurrent review enhancements
  - Strategies to improve skilled nursing facility (SNF) placement and star ratings.
- Performance Improvements: Transitional care services showed a 12.31% increase in member interaction within seven days post-discharge in Q3.
- Subcommittee Updates:
  - Benefits Management Subcommittee met on July 30, August 27, and September 17, 2025, reviewing prior authorization code updates.
  - Pharmacy & Therapeutics Subcommittee met on August 21, 2025, with no structural changes; updates to Medi-Cal Physician Administered Drug (PAD) Prior Authorization (PA) List and OneCare Formulary were noted.

Whole-Child Model Clinical Advisory Committee (WCM CAC)

WCM met on November 18, 2025, and approved the August 19, 2025, Meeting Minutes

- Approved updated WCM CAC Committee charter.
- WCM CAC focused on improvements, pediatric quality metrics, behavioral health screenings, and operational/regulatory updates.
- Legislative Discussion: Reviewed California AB 1064 and AB 144 regarding expanded pharmacist roles in improving immunization rates.
- Quality Metrics: Whole Child Model members had slightly higher flu vaccination rates (45%) compared to non-WCM members (38%), and the committee emphasized the need to improve vaccination rates for medically fragile populations.
- Behavioral Health Measures: Reviewed depression screening and follow-up, and data on Adverse Childhood Experience (ACE) screenings: WCM CAC requested analysis of unique member counts and follow-up care for higher-risk scores.

For more detailed information on the workplan activities, please refer to the Fourth Quarter of the 2025 QIHETP Work Plan.

Attachment

Approved at QIHEC throughout Q4 2025: Fourth Quarter 2025 QIHETP Work Plan 4Q

Member Grievances and Appeals Report Third Quarter 2025

Quality Assurance Committee Meeting

March 19, 2026

Heather Sedillo, Grievance and Appeals Resolution Services (GARS), Director

Our Mission

To serve member health with excellence and dignity, respecting the value and needs of each person.

Our Vision

Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

Agenda

- Definitions
- Executive Summary
- Grievance Volume and Trends
- Grievance Actions Taken
- Appeals Volume and Trends
- Appeals Actions Taken

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Back to Agenda

Definitions

- Grievance: An expression of dissatisfaction with any aspect of a CalOptima Health program, provider or representative.

- Appeal: A request by the member or on the member's behalf for the review of any decision to deny, modify, or discontinue a covered service.

Back to Agenda

Executive Summary

In Q3, CalOptima Health received 5,131 grievances and 369 appeals for Medi-Cal and OneCare, with an average closure rate of 23 days.

Grievances

Medi-Cal: Increased slightly by less than 1% to 4,547. Main issues: Provider/Staff Attitude, Plan Customer Service, referral delays, and appointment availability.

OneCare: Increased by 6% to 584. Main issues: Provider/Staff Attitude, Plan Customer Service, transportation services, and telephone accessibility.

Appeals

Medi-Cal: Decreased by 24% to 307, with a 31% overturn rate. Main issues: CalAIM Personal Care Hours, Housing Deposits, Day Habilitation services, and specialty care requests.

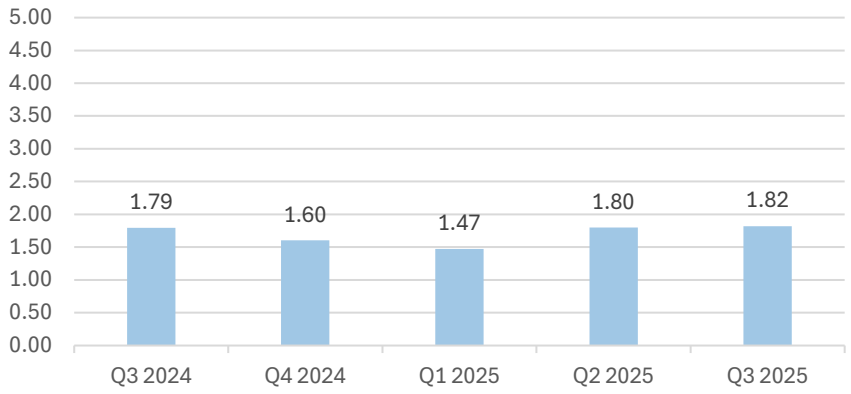
OneCare: Decreased by 35% to 62, with a 31% overturn rate. Main issues: inpatient hospital care with Non-Contracted Providers, outpatient services, and specialty care requests.

Grievances

Back to Agenda

Grievance Volume by Line of Business (LOB)

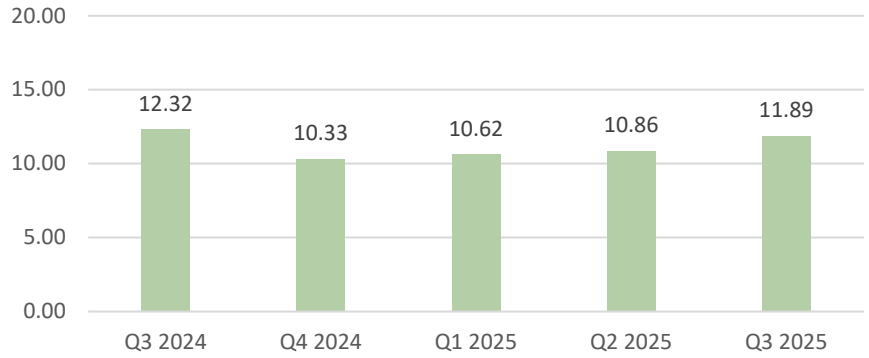
Medi-Cal
Rate per 1,000 Member Months



Total Grievances

Timeframe	Total Grievances
Q3 2025	4,781
Q2 2025	4,778
Q1 2025	3,958
Q4 2024	4,298
Q3 2024	4,817

OneCare
Rate per 1,000 Member Months



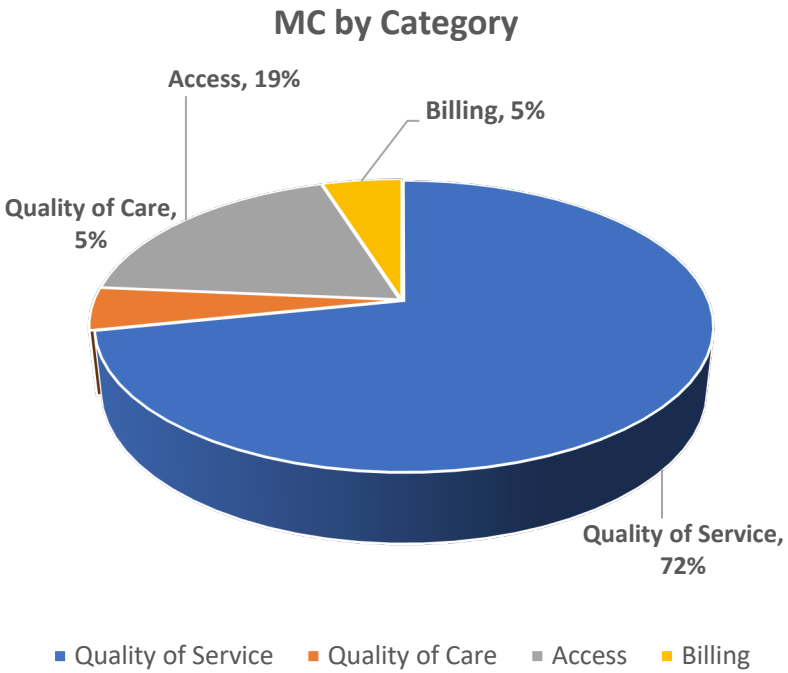
Total Grievances

Timeframe	Total Grievances
Q3 2025	643
Q2 2025	574
Q1 2025	552
Q4 2024	531
Q3 2024	639

Note: Totals on this slide include Customer Service and GARS data.

Back to Agenda

2024-2025 Grievance Type by Category



	MC GRIEVANCES				
	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025
Quality of Service	2,702	2,485	2,337	2,917	3,261
Quality of Care	586	480	364	518	213
Access	882	875	821	899	851
Billing	217	178	153	172	222
TOTAL	**4,387**	**4,018**	**3,675**	**4,506**	**4,547**

Q3 2025 Trends within each Category:

Quality of Care – Question Treatment / Care, Delay in Treatment / Care, Provider Services

Billing – Provider Direct Member Billing, Provider Balance Billing, Provider/Staff Attitude

Access – Appointment Availability, Telephone Accessibility, Delay in Referral by provider

Quality of Service – Provider Services, Transportation, CalAIM related

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Back to Agenda

Medi-Cal Grievance Trends for Q3

Quality of Service

Trend	Percentage of Total Volume
Provider Services	11% (357)
Transportation	10% (330)
CalAIM related	8% (270)

Quality of Care

Trend	Percentage of Total Volume
Question Treatment	31% (66)
Delay in Treatment	21% (45)
Provider Services	11% (23)

Access

Trend	Percentage of Total Volume
Appointment Availability	30% (258)
Telephone Accessibility	11% (97)
Delay in Referral Provider	10% (89)

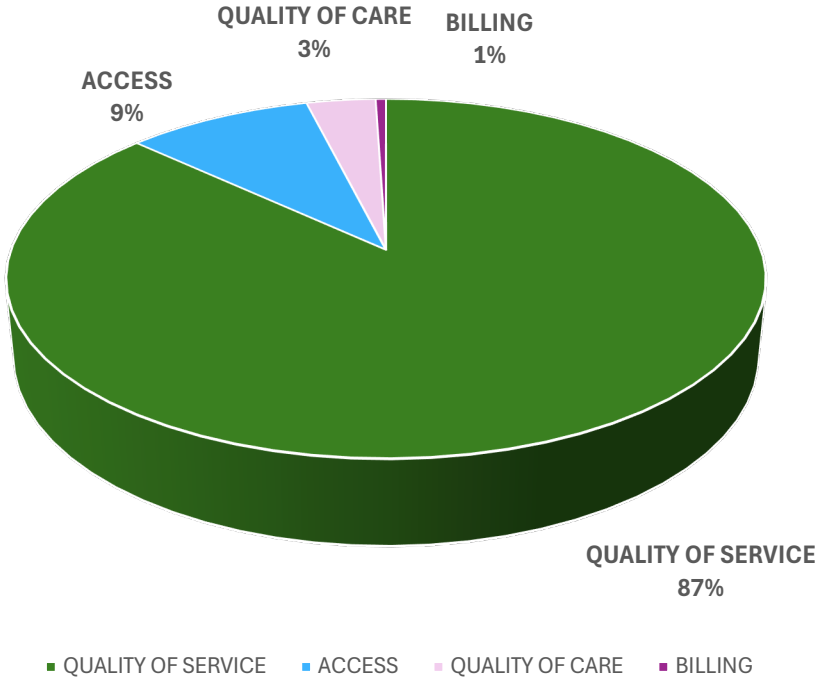
Billing

Trend	Percentage of Total Volume
Provider Direct Member Billing	65% (145)
Provider Balance Billing	32% (71)
Staff Attitude	1% (3)

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Back to Agenda

2025 Grievance Type by Category



	OneCare				
	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025
Quality of Service	371	334	302	444	507
Quality of Care	51	22	25	39	20
Access	49	49	33	57	54
Billing	15	14	11	10	3
TOTAL	**486**	**419**	**371**	**550**	**584**

Q3 Trends within each Category:

Quality of Service –Transportation NMT, CalOptima Staff, Provider Services

Quality of Care – Question Treatment / Care, Transportation NMT, Question Diagnosis

Access – Transportation NMT, Telephone Accessibility, Transportation Vendor

Billing – Provider Direct Member Billing, Balance Billing

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Back to Agenda

OneCare Grievance Trends for Q3

Quality of Service

Trend	Percentage of Total Volume
Transportation NMT	24% (124)
Transportation Vendor	12% (59)
Provider Services	9% (47)

Quality of Care

Trend	Percentage of Total Volume
Question Treatment	40% (8)
Transportation NMT	20% (4)
Question Diagnosis	10% (2)

Access

Trend	Percentage of Total Volume
Transportation NMT	17% (9)
Telephone Accessibility	15% (8)
Transportation Vendor	13% (7)

Billing

Trend	Percentage of Total Volume
Provider Direct Member Billing	33% (1)
Provider Balance Billing	64% (2)

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Actions Taken in Response to Trends

- Trends identified
  - Medi-Cal and OneCare grievances about transportation providers.
  - Medi-Cal and OneCare grievances against staff at Primary Care Physicians and Specialists visits.

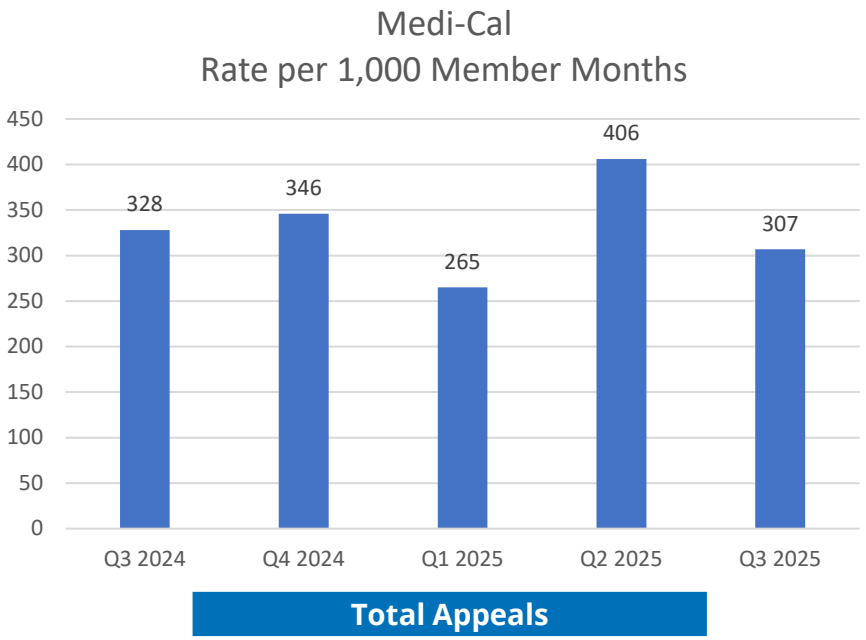
- Actions Taken
  - The vendor provided weekly reports on completed rides, focusing on dialysis transportation and improving on-time performance through monitoring and targeted oversight.
  - Provider trends identified in Q3 were Quality of Service (QOS) and Access complaints related to telephone accessibility and appointment availability at both Primary and Specialty offices. A collaborative process with Provider Services was established to review trends quarterly and implement corrective actions when needed.

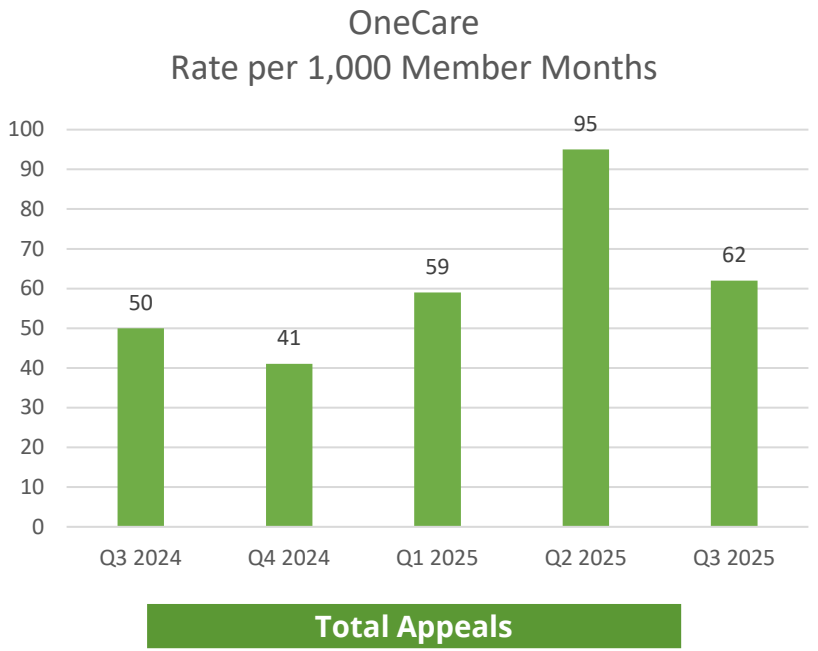
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Appeals

Back to Agenda

Appeals Volume by Line Of Business (LOB)





Q3 2025	307
Q2 2025	406
Q1 2025	265
Q4 2024	346
Q3 2024	328

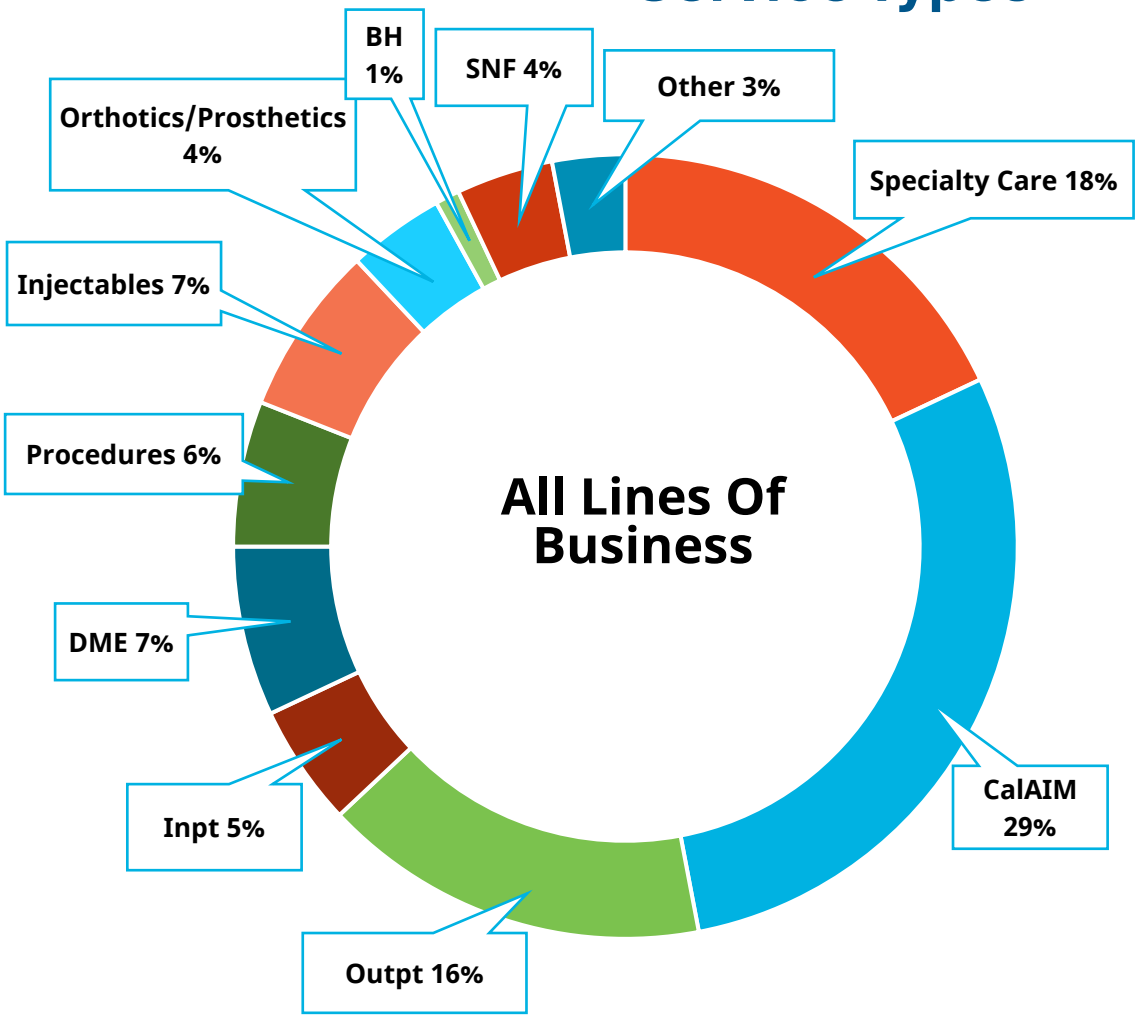
Q3 2025	62
Q2 2025	96
Q1 2025	59
Q4 2024	41
Q3 2024	50

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Back to Agenda

Appeals Overall

Service Types



Services	Qty	%
CalAIM	106	29%
Specialty Care	66	18%
Outpatient	60	16%
Injectables	26	7%
DME	26	7%
Procedures	22	6%
Inpatient	20	5%
SNF	14	4%
Orthotics /Prosthetics	13	4%
BH	5	1%
Other	11	3%

Key Notes: Decreases in CalAIM (43), Specialty care (44) and Inpatient (20), and an increase in Injectables (9) in Q3 compared to Q2.

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Back to Agenda

Medi-Cal Appeals Trends for Q3

Type	Overturn Count	Uphold Count	Total	Overturn Percentage (%)
CalAim	14	80	94	15%
Durable Medical Equipment (DME)	5	15	20	25%
Injectable	16	7	23	70%
Inpatient	2	5	7	29%
Other	5	16	21	24%
Outpatient	19	31	50	38%
Procedure	9	10	19	47%
Skilled Nursing Facility	1	13	14	7%
Specialty Care	24	35	59	41%

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OneCare Appeals Trends for Q3

Type	Upheld Count	Overturned Count	Total	Overturn Percentage (%)
Hospital Inpatient	7	6	13	46%
Outpatient Services	9	0	9	0%
Specialty Care	5	2	7	29%
CalAIM	10	2	12	17%
Injectable	1	2	3	67%
Direct Member Reimbursement	2	2	4	50%
Durable Medical Equipment	4	2	6	33%
Procedure	2	1	3	33%
Other	3	2	5	40%

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Actions Taken in Response to Trends

- Trends identified
  - Requests for specialists or higher-level care are being redirected to in-network providers who cannot treat the condition or see the member in a timely manner based on their needs and access to care standards.
  - Post service inpatient hospitalization appeals from Non-Contracted Providers.

- Actions Taken
  - After an appeal is overturned, health networks receive the review criteria for educational purposes.
  - Network overturn trends are tracked and shared with the Delegation Oversight Medical Director during quarterly meetings with Health Network partners.
  - Education provided to Health Networks on the Post-Stabilization Authorization requirements.

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Back to Agenda