NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

APRIL 3, 2025
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868
REVISED
TELECONFERENCE LOCATION:
COURTYARD SACRAMENTO AIRPORT NATOMAS
2101 RIVER PLAZA DRIVE, LOBBY, SACRAMENTO, CA 95833

BOARD OF DIRECTORS

Isabel Becerra, Chair
Maura Byron
Blair Contratto
Catherine Green, R.N.
Veronica Kelley, DSW, LCSW
Supervisor Vicente Sarmiento, Vice Chair
Supervisor Doug Chaffee
Norma García Guillén
Brian Helleland
José Mayorga, M.D.
Supervisor Janet Nguyen, Alternate

CHIEF EXECUTIVE OFFICER	OUTSIDE GENERAL COUNSEL	CLERK OF THE BOARD
Michael Hunn	James Novello Kennaday Leavitt	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 identifying the item and submit to the 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, you may do so during Public Comments. Public Comment Request Forms must be submitted prior to the beginning of the Consent Calendar and/or the beginning of Public Comments. When addressing the Board, it is requested that you state your name for the record. Address the Board as a whole through the Chair. Comments to individual Board 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 Meeting Agenda and supporting materials are available for review at CalOptima Health, 505 City Parkway West, Orange, CA 92868, Monday-Friday, 8:00 a.m. – 5:00 p.m. These materials are also available online at www.caloptima.org. Board 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://us06web.zoom.us/webinar/register/WN_sfOpVh9RSTyLkixrJVW7PQ** to Join the Meeting.
Webinar ID: **833 8333 1831**
Passcode: **762870** -- Webinar instructions are provided below.

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS
1. Chief Executive Officer Report

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

CONSENT CALENDAR
2. Minutes
   a. Approve Minutes of the March 6, 2025 Regular Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the December 11, 2024 Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee

3. Receive and File 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program Evaluation and Approve the 2025 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan

4. Approve the 2024 CalOptima Health Utilization Management Program Evaluation and the 2025 CalOptima Health Integrated Utilization Management/Case Management Program Description

5. Receive and File 2024 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Work Plan Evaluation and Approve the 2025 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Work Plan

6. Authorize and Direct Execution of Amendment 11 to Agreement 16-93274 Care Coordination Agreement with the California Department of Health Care Services in Order to Continue Operation of the Dual Eligible Special Needs Plan OneCare Program

7. Ratify Amendments to CalOptima Health's Primary and Secondary Agreements with the California Department of Health Care Services Related to Calendar Year 2024 Rate Changes

8. Ratify Amendments to CalOptima Health's Primary and Secondary Agreements with the California Department of Health Care Services Related to Calendar Year 2025 Rate Changes

9. Authorize the Chief Executive Officer to Execute Contract Amendments with Imagenet, LLC and Office Ally, Inc.

10. Ratify List of Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2024 (IGT14)

11. Authorize Actions Related to a Contract with Infomedia Group, Inc. dba Carenet Healthcare Services

12. Authorize Actions Related to the Contract with Mercury Healthcare, Inc. dba WebMD Ignite

13. Adopt Resolution No. 25-0403-01 Approving Updated CalOptima Health Human Resources Policies

14. Receive and File:
    a. February 2025 Financial Summary
    b. Compliance Report
    c. Member Grievances and Appeals Report
    d. Government Affairs Reports
    e. CalOptima Health Community Outreach and Program Summary
    f. Strategic Plan Quarterly Performance Metrics Report

REPORTS/DISCUSSION ITEMS

15. Approve Modifications to CalOptima Health Statutory and Board-Designated Reserve Funds Policy

CLOSED SESSION

CS-1. HEALTH PLAN TRADE SECRETS Pursuant to Government Code § 54956.87(b): Covered California

CS-2. HEALTH PLAN TRADE SECRETS Pursuant to Government Code § 54956.87(b): PACE

CS-3. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Pursuant to Government Code § 54956.9(d)(2): 1 Case.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors on April 3, 2025 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:
https://us06web.zoom.us/webinar/register/WN_sfOpVh9RSTyLkixrJVW7PQ

To **Join** this webinar:
https://us06web.zoom.us/s/83383331831?pwd=B7BHp2CeSZaho0gVkoxzVeLTqqXSp0.1

Phone one-tap:
+16694449171,,83383331831#,,,,*762870# US
+17207072699,,83383331831#,,,,*762870# US (Denver)

Join via audio:
+1 669 444 9171 US
+1 720 707 2699 US (Denver)
+1 253 205 0468 US
+1 253 215 8782 US (Tacoma)
+1 346 248 7799 US (Houston)
+1 719 359 4580 US
+1 312 626 6799 US (Chicago)
+1 360 209 5623 US
+1 386 347 5053 US
+1 507 473 4847 US
+1 564 217 2000 US
+1 646 558 8656 US (New York)
+1 646 931 3860 US
+1 689 278 1000 US
+1 301 715 8592 US (Washington DC)
+1 305 224 1968 US
+1 309 205 3325 US

Webinar ID: 833 8333 1831
Passcode: 762870
International numbers available: https://us06web.zoom.us/u/kiKC8pRSE

MEMORANDUM

DATE:	March 28, 2025
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — April 3, 2025, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; and Whole-Child Model Family Advisory Committee

A. Covered California Monthly Update

CalOptima Health is currently undertaking an organization-wide effort to prepare for the launch of a new Covered California line of business, effective January 1, 2027. In order to promote transparency and ensure accountability to the Board, stakeholders and broader community, a brief summary of recent readiness activities will be included in every public CEO Report starting this month through the plan launch. Since the previous Board meeting on March 6, the following activities have been completed:

- Procurement for an Operational Implementation Support consultant closed on March 6 and resulted in six bids, with a selected vendor expected to be considered by the Board on May 1, 2025
- Provider network development and provider engagement activities have begun to build an adequate and quality-focused network
- Exhibits continue to be prepared for an initial Knox-Keene Act licensure filing with the California Department of Managed Health Care (DMHC) in June 2025
- A staffing plan and Fiscal Year 2025–26 implementation budget continue to be prepared for the Board's consideration on June 5, 2025
- CalOptima Health met with Covered California leadership to discuss the Qualified Health Plan (QHP) application process and approach

B. Medi-Cal Budget Shortfall Announced

On March 17, the California State Assembly's Budget Subcommittee on Health held a hearing to receive updates from the California Department of Health Care Services (DHCS) on the status of several health-related budget issues. Most notably, the California Department of Finance (DOF) approved a $3.44 billion General Fund (GF) loan to DHCS on March 4 to cover a Medi-Cal budget deficiency through the end of March. Since this was the maximum amount that could be loaned under state law, DHCS is now requesting an additional $2.8 billion from the State Legislature to sustain Medi-Cal costs through the remainder of the current Fiscal Year (FY) 2024–25 ending on June 30. This "budget bill junior" will likely be considered in the coming weeks. At the hearing, DHCS officials cited several factors that contributed to the unexpected budget deficiency: prescription drug costs, higher overall enrollment growth (especially among seniors and undocumented immigrants), uncertain Managed Care

Organization (MCO) Tax cash flow, and a $1 billion GF loss due to the passage of Proposition 35 (MCO Tax). Timing was also an issue — last year, there was only one month of available data from several new policies before DHCS needed to make projections for the enacted budget. DHCS also noted that many states are facing budget shortfalls in their Medicaid programs due to rising health care costs. Several committee members voiced that the current challenges appear solvable, but the potential Medicaid cuts being contemplated by Congress are likely less solvable.

C. Naloxone Distribution Campaign Concludes

In August 2023, the Board approved purchasing 250,000 doses of naloxone, a life-saving medication that can reverse an overdose from opioids. CalOptima Health team executed an education and distribution plan that included instructional training videos, InfoSeries webinars, and collaboration with community-based organizations, community health centers, colleges and schools. Through partnerships with organizations like Fentanyl Solutions and Recovery Road, we distributed large quantities of naloxone directly to recovery organizations, and through community events, we distributed naloxone directly to our members and community-based organizations and providers. This week we will ship the last of our supply of naloxone. We know that this effort has saved countless lives, and we thank all of you for being part of its success. Please see the press release from our recent distribution event.

D. Federal Advocacy Efforts Continue

As a first step to unlocking the budget reconciliation process, the U.S. Senate and U.S. House of Representatives recently passed competing budget resolutions that propose topline federal spending and revenue adjustments. **The resolutions do not yet specify cuts to specific programs, such as Medicaid**. As the Senate and House work to resolve their different budget resolutions, CalOptima Health continues to participate in significant advocacy efforts to preserve Medicaid funding in collaboration with our contracted lobbyists and several trade associations. Most recently, I met directly with U.S. Reps. Dave Min and Lou Correa at their district offices in Orange County as well as virtually with U.S. Rep. Mike Levin. Next, any agreed-upon budget resolution would start a debate about specific program budget changes over the coming months. A final budget reconciliation package would then need to be drafted, considered and passed by both the Senate and House and signed by the president.

E. Member Text Campaign Vendor Sends Multiple Texts in Error

On March 13–14, a system error in our vendor-managed texting platform through Ushur, caused approximately 12,450 members to receive duplicate Medi-Cal Renewal text messages, some of which were delivered overnight. The issue resulted in 2,735 members opting out of future messages and at least one formal grievance. The root cause was a misconfiguration of the campaign workflows and settings that bypassed standard safeguards like Do Not Disturb hours and message limits. The issue was identified and resolved within 36 hours. In response, Ushur is implementing corrective actions, enhancing system monitoring and introducing new governance protocols. CalOptima Health is coordinating a recovery strategy to contact affected members, offering an apology and inviting them to re-enroll in our texting program to ensure continued access to important health updates.

F. CalOptima Health Visits State Capitol for Meetings and Hearing Testimony

CalOptima Health leadership recently traveled to Sacramento for a series of engagements at the State Capitol. First, our state association Local Health Plans of California (LHPC) held its annual briefing to educate legislative staff about local Medi-Cal plans and their priorities for the coming year. Then, CalOptima Health leaders met with nearly all of Orange County's state delegation members and/or their staff to provide updates on our own priorities and initiatives, including Covered California, street medicine expansion, maintaining state investments in the California Advancing and Innovating

Medi-Cal (CalAIM) initiative and enhanced federal engagement to protect Medicaid funding. Finally, Chief Operating Officer Yunkyung testified at a Senate Health Committee informational hearing as the sole public Medi-Cal plan representative to discuss CalOptima Health's successful rollout of Enhanced Care Management and Community Supports over the past three years in partnership with our local providers. As part of our commitment to CalAIM, CalOptima Health was one of the first Medi-Cal plans to offer all 14 Community Supports and continues to build upon these services to improve whole-person care for our members.

G. CalOptima Health Gains Media Coverage

- Following the groundbreaking event for Buena Park's Lincoln Avenue Apartments, we received media coverage on KTLA and HousingFinance.com.
- On March 3, Chapman University President Struppa recognized CalOptima Health's $5 million Workforce Development Grant to the university in his final State of the University address. It was also covered in the Orange County Register.
- On March 6, CalOptima Health distributed a press release on our Street Medicine program expansion to Santa Ana that was covered by the following news outlets:
    - Orange County Register (ran online and on the front page in the Local section)
    - NewSantaAna
    - Spectrum News

CalOptima Health

Fast Facts
April 2025

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

Membership Data* (as of February 28, 2025)

Total CalOptima Health Membership

915,201

Program	Members
Medi-Cal	897,460
OneCare (HMO D-SNP)	17,238
Program of All-Inclusive Care for the Elderly (PACE)	503

*Based on unaudited financial report and includes prior period adjustments.

Key Financial Indicators (for eight months ended February 28, 2025)

	Dashboard	YTD Actual	Actual vs. Budget ($)	Actual vs. Budget (%)
Operating Income/(Loss)	●	$83.8M	$265.7M	146.1%
Non-Operating Income/(Loss)	●	$120.8M	$77.7M	180.5%
Bottom Line (Change in Net Assets)	●	$204.6M	$343.4M	247.3%
Medical Loss Ratio (MLR) *(Percent of every dollar spent on member care)*	●	92.3%		-7.2%
Administrative Loss Ratio (ALR) *(Percent of every dollar spent on overhead costs)*	●	5.1%		1.8%

Notes:
- For additional financial details, refer to the financial packages included in the Board of Directors meeting materials.
- Adjusted MLR (without the estimated provider rate increases funded by reserves) is 87.9%.

Reserve Summary (as of February 28, 2025)

	Amount (in millions)
Board Designated Reserves*	$1,099.6
Statutory Designated Reserves	$137.7
Capital Assets (Net of depreciation)	$101.7
Resources Committed by the Board	$446.1
Board Approved Provider Rate Increase**	$385.9
Resources Unallocated/Unassigned*	$478.6
Total Net Assets	$2,649.7

* Total of Board-designated reserves and unallocated resources can support approximately 147 days of CalOptima Health's current operations.

** 5/2/24 meeting: Board of Directors committed $526.2 million for provider rate increases from 7/1/24–12/31/26.

Total Annual Budgeted Revenue **$4 Billion**

Note: CalOptima Health receives its funding from state and federal revenues only and does not receive any of its funding from the County of Orange.

CalOptima Health Fast Facts

April 2025

Personnel Summary (as of the March 8, 2025, pay period)

	Filled	Open	Vacancy % Medical	Vacancy % Administrative	Vacancy % Combined
Staff	1,332.75	45.65	53.92%	46.08%	3.31%
Supervisor	82	4	100%	--%	4.65%
Manager	119	6	16.67%	83.33%	4.80%
Director	68	8	25%	75%	10.53%
Executive	21	0	--%	--%	--%
Total FTE Count	1,622.8	64.7	47.89%	52.11%	3.83%

FTE count based on position control reconciliation and includes both medical and administrative positions.

Provider Network Data (as of March 23, 2025)

	Number of Providers
Primary Care Providers	1,320
Specialists	7,063
Pharmacies	603
Acute and Rehab Hospitals	43
Community Health Centers	65
Long-Term Care Facilities	207

Treatment Authorizations (as of January 31, 2025)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	41.51 hours
Prior Authorization – Urgent	72 hours	11.90 hours
Prior Authorization – Routine	5 days	1.20 days

Average turnaround time for routine and urgent authorization requests for CalOptima Health Community Network.

Member Demographics (as of February 28, 2025)

Member Age	
0 to 5	8%
6 to 18	22%
19 to 44	35%
45 to 64	21%
65 +	14%

Language Preference	
English	54%
Spanish	31%
Vietnamese	9%
Other	2%
Korean	2%
Farsi	1%
Chinese	<1%
Arabic	<1%

Medi-Cal Aid Category	
Expansion	39%
Temporary Assistance for Needy Families	37%
Seniors	11%
Optional Targeted Low-Income Children	7%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

March 6, 2025

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on March 6, 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 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 Isabel Becerra called the meeting to order at 2:01 p.m., and Director Maura Byron led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra, Chair; Supervisor Vicente Sarmiento, Vice Chair (left at 4:00 p.m.); Maura Byron; Supervisor Doug Chaffee; Blair Contratto (at 2:15 p.m.); Norma García Guillén; Catherine Green, R.N.; Brian Helleland; Veronica Kelley (non-voting) (left at 3:17 p.m.); Jose Mayorga, M.D.

(All Board members participated in person.)

Members Absent: None.

Others Present: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; James Novello, Outside General Counsel, Kennaday Leavitt; Nancy Huang, Chief Financial Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Sharon Dwiers, Clerk of the Board

The Clerk noted that staff is pulling Agenda Item 9 from the Consent Calendar due to a recusal.

Chair Becerra noted for the record that she is reordering the agenda to hear the Closed Session at the top of the Agenda.

CLOSED SESSION

The Board adjourned to Closed Session at 2:05 p.m. Pursuant to Government Code § 54956.87, subdivision (b) HEALTH PLAN TRADE SECRETS: Covered California and Pursuant to Government Code § 54956.9(d)(2): 1 Case CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION.

The Board returned to Open Session at 3:20 p.m., and the Clerk re-established a quorum.

ROLL CALL

Members Present: Isabel Becerra, Chair; Supervisor Vicente Sarmiento, Vice Chair (left at 4:00 p.m.); Maura Byron; Supervisor Doug Chaffee; Blair Contratto (at 2:15 p.m.); Norma García Guillén; Catherine Green, R.N.; Brian Helleland; Jose Mayorga, M.D.

(All Board members participated in person.)

Back to Agenda

Members Absent: Veronica Kelley (non-voting) (left at 3:17 p.m.)

Chair Becerra noted for the record that the Board met in Closed Session and there were no reportable actions taken.

The Clerk noted for the record that staff would like to reorder the agenda to hear Agenda Item 14.

REPORTS/DISCUSSION ITEMS

14. Approve Actions Related to the Street Medicine Program City Expansion

The Board heard public comments regarding this item, which are noted under Public Comment.

Vice Chair Sarmiento thanked the speakers and commented that Santa Ana should be proud of submitting a very strong, compelling application and noted that the Street Medicine Program application is a very competitive process. Santa Ana is disproportionately impacted by people who are unhoused and has the highest number of unsheltered individuals in the county.

All Board members expressed support for the Street Medicine Program in Santa Ana and noted that all cities could use a Street Medicine Program.

Director Byron noted that she would like to see an impact statement to find out how many families and individuals the Street Medicine Program is serving and how CalOptima Health is going to expand its reach to do this more effectively to look at the entire county.

Action: ***On motion of Vice Chair Sarmiento, seconded and carried, the Board of Directors: 1.) Approved the Notice of Interest Opportunity Evaluation Committee recommendation for one additional host-city for the expansion of CalOptima Health's Street Medicine Program; 2.) Approved the scope of work for the request for qualifications to identify a provider to implement CalOptima Health's Street Medicine Program in the newly selected city;3.) Appropriated up to $4.3 million in existing reserves to fund the two-year grant agreement with the street medicine provider selected through the request for qualifications process; and 4.) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose. (Motion carried 9-0-0)***

PRESENTATIONS/INTRODUCTIONS

1. Federal Lobbyist Update

Veronica Carpenter, Chief Administrative Officer, introduced Shawn Friesen, Principal, Chamber Hill, who provided an update on Chamber Hill's federal lobbying efforts on behalf of CalOptima Health.

Mr. Friesen thanked Ms. Carpenter for the introduction, noting that it is a privilege to be here today. He noted that staff at Chamber Hill enjoy working with the CalOptima Health team in Washington and being in regular contact with them. Mr. Friesen added that there has been a lot of noise about what is happening and what could happen as it relates to health policy, Medicaid, and the members that CalOptima Health serves. Mr. Friesen noted that he appreciated the video that staff shared of Michael

Hunn, Chief Executive Officer, and his message to staff about staying steady even in the midst of all the noise. He discussed the Congressional Budget process and its potential impact on Medicaid and highlighted the importance of government funding and the potential extension of expiring health care provisions. Mr. Friesen emphasizes the need for active engagement with the congressional delegation and other similar plans across California. Mr. Friesen added that CalOptima Health is implementing innovative programs to help its members, such as the Street Medicine Program, Behavioral Health Program, and investing in Healthcare Workforce Development, while operating in an efficient and fiscally prudent manner, which will resonate with policymakers.

Mr. Friesen responded to Board members' comments and questions.

MANAGEMENT REPORTS

2. Chief Executive Officer (CEO) Report

Mr. Hunn noted that there are several items in the report that are there for reference, and he was happy to answer any questions. In the interest of time, Mr. Hunn highlighted a few items from his report, including the opening of two new WellSpaces to better support the mental health of CalOptima Health's students. The WellSpaces opened at Marina High School in Huntington Beach and Loara High School in Anaheim. Mr. Hunn added that these WellSpaces were funded by the CalOptima Health Student Behavioral Health Incentive Program (SBHIP) for health interventions in all 29 of the Orange County school districts. CalOptima Health collaborates very closely with Rady Children's Health, Children's Hospital of Orange County, and the Orange County Department of Education on each WellSpace. The WellSpace allows students to go someplace safe, to have a conversation and access behavioral health services. Mr. Hunn thanked Carmen Katsarov, Executive Director, Behavioral Health, and her team for all the great work. Mr. Hunn noted that his message to staff last week was to ensure that CalOptima Health members are getting the care they need, that they use telehealth services if they are afraid to go into a clinic or an office, and that they get their needed immunizations, that they do not skip going for well visits for the babies, that they do not opt out of getting something critical looked at, and that they do not wait until it is time for the emergency room. Mr. Hunn encouraged members to reach out to their provider and through CalOptima Health's customer service line. He also reminded the public that there is a resource guide to help navigate these uncertain times. Mr. Hunn closed his comments with a reminder that CalOptima Health is watching all the changes very closely and is staying focused on its members.

Mr. Hunn responded to Board members' comments and questions.

3. Covered California Update

Donna Laverdiere, Executive Director, Strategic Development, presented an update on the latest activities related to CalOptima Health's joining Covered California. Ms. Laverdiere reviewed the previous Board actions related to Covered California, including the formation of a stakeholder steering committee and the approval of guiding principles. She also outlined the current implementation timeline and key focus areas for early 2025, including provider network contracting, the Department of Managed Health Care (DMHC) licensing, and operational readiness. Ms. Laverdiere also reviewed the upcoming Board actions, which include reviewing provider contract templates, selecting a vendor for operational support, and approving the DMHC licensure filing.

ADVISORY COMMITTEE UPDATES

4. Member Advisory Committee and Provider Advisory Committee Updates

Dr. John Nishimoto, Provider Advisory Committee (PAC) Chair, reported on the recent and upcoming activities of the PAC and the Member Advisory Committee (MAC). Dr. Nishimoto reviewed the various

seats that the committees are recruiting for on the MAC and PAC for 2025 through 2028. For MAC, recruitment is open for the Foster Children Representative, Member Advocation Representative, Medi-Cal Beneficiary or Authorized Family Member Representative, and a OneCare Member or Authorized Family Member Representative. For PAC, recruitment is open for the Allied Health Representative, Long Term Services and Supports Representative, Non-Physician Medical Practitioner Representative, Pharmacy Representative, and two Physician Representatives.

PUBLIC COMMENTS

- Councilman Jonathan Hernandez, Santa Ana City Council: Oral report regarding Agenda Item 14, Approve Actions Related to the Street Medicine Program City Expansion.
- Councilwoman Jessie Lopez, Santa Ana City Council: Oral report regarding Agenda Item 14, Approve Actions Related to the Street Medicine Program City Expansion.
- Konstantinos Roditis, American Ground Transportation: Oral report regarding CalOptima Health's transportation vendor ModivCare.
- Michael Arnot, Children's Cause OC: Oral report regarding ECM providers and ensuring that specialty populations are included.
- Valerie Brauks, Children & Families Coalition: Oral report to thank CalOptima Health for including Human Options as an ECM provider.

CONSENT CALENDAR

5. Minutes
   a. Approve Minutes of the February 6, 2025, Regular Meeting of the CalOptima Health Board of Directors
   b. Receive and File Minutes of the November 21, 2024, Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee

6. Approve New CalOptima Health Policy EE. 1145: Prospective Health Network

7. Approve New CalOptima Health PACE Policy PA.2003: PACE Palliative Care

8. Authorize Contract Amendment Related to CalOptima Health's Key Operational Vendor Health Management Systems, Inc.

9. Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2024
This item was pulled for discussion.

10. Approve Actions Related to a Contract with the National Opinion Research Center to Conduct a Member and Population Health Needs Assessment

11. Ratify a Sole Source Contract with Axis Technology for Data Masking Professional Services

12. Receive and File:
   a. January 2025 Financial Summaries
   b. Compliance Report

Back to Agenda

c. Government Affairs Reports
d. CalOptima Health Community Outreach and Program Summary
e. Board Approved Initiatives Report – Quarter Three

Action: ***On motion of Director Green, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 5 through 12, minus Agenda Items 9, as presented. (Motion carried 9-0-0)***

CONSENT CALENDAR

9. Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2024

Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health and left the room during the discussion and vote.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors authorized the following activities to secure Medi-Cal funds through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2024: 1.) Submission of a proposal to the California Department of Health Care Services to participate in the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2024; 2.) Pursuit of funding partnerships with eligible participating entities; and 3.) The Chief Executive Officer executing agreements with these entities and their designated providers, as necessary, to seek intergovernmental transfer funds. (Motion carried 8-0-0; Director Mayorga recused)***

REPORTS/DISCUSSION ITEMS

13. Authorize Actions Related to the Student Behavioral Health Incentive Program Funding Strategy

Action: ***On motion of Director Green, seconded and carried, the Board of Directors: 1.) Authorized modification of the previously Board-approved Student Behavioral Health Incentive Program (SBHIP) Incentive Funding Plan to support SBHIP Phase Two: a.) Reallocated to Hazel Health up to $3.5 million from the Notice of Funding Opportunity (grants to serve Medi-Cal school-aged children and youth in Orange County); b.) Allocated up to $471,000 in unallocated funding: i.) Up to $371,000 for the internal Contracting Program Support Position to manage the contracting activities supporting SBHIP; ii.) Up to $100,000 for the California School-Based Health Alliance, 2025 School Health Conference sponsorship; 2.) Authorized the Chief Executive Officer, or designee, to amend the Memorandum of Understanding with Hazel Health to extend the end date to June 30, 2026; 3.) Approved expenditures of up to $100,000 and staff participation at the 2025 School Health Conference on April 28-29, 2025, in Anaheim; a.) Made a finding that such an expenditure is for a public purpose and in furtherance of CalOptima Health's mission and statutory purpose; and b.) Authorized the Chief Executive Officer to execute agreements as necessary for the event and expenditures. (Motion carried 9-0-0)***

Back to Agenda

15. Approve Actions Related to the Equity and Practice Transformation Payment Program

Chair Becerra did not participate in this item due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers, passed the gavel to Director Contratto, and left the room during the discussion and vote. Director Helleland did not participate in this item due to his role as Chief Executive at Providence/St. Joseph Hospital and left the room during the discussion and vote.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Authorized allocation of $1.44 million in Medi-Cal Managed Care Plan Equity and Practice Transformation Program Planning Incentives to fund: a.) Up to $800,000 for a contract to provide coaching and support to Equity and Practice Transformation Program practice sites; and b.) Up to $640,000 in program support costs; 2.) Authorized the Chief Executive Officer to release a request for proposals, select a vendor, and negotiate and execute a contract for coaching and support services to practice sites through a formal procurement in accordance with CalOptima Health's Board-approved Purchasing Policy; and 3.) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose. (Motion carried 6-0-0; Chair Becerra and Director Helleland recused; Vice Chair Sarmiento absent)***

Director Contratto passed the gavel back to Chair Becerra.

16. Approve Actions Related to Professional, Ancillary, Hospital, and Health Network Contract Amendment and Templates for Covered California

Director Helleland did not participate in this item due to his role as Chief Executive at Providence/St. Joseph Hospital and left the room during the discussion and vote.

Action: ***On motion of Director Byron, seconded and carried, the Board of Directors: 1.) Approved new contract amendment and templates for Covered California, effective January 1, 2027, and forward; 2.) Authorized the Chief Executive Officer, or designee, to utilize the contract templates to negotiate agreements with new providers or amend contracts with existing contracted providers to participate in CalOptima Health's Covered California plan; and 3.) Authorized the Chief Executive Officer, or designee, with the assistance of legal counsel, to make future changes to Covered California provider contract templates to comply with statutes, regulations, or sub-regulatory guidance and CalOptima Health policies and procedures. (Motion carried 7-0-0; Director Helleland recused; Vice Chair Sarmiento absent)***

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BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Chair Becerra announced the creation of two new Board Ad Hoc Committees. The first is the Grants Ad Hoc Committee. Chair Becerra noted for the record that she recused herself from serving on the Grants Ad Hoc Committee or appointing members due to potential conflicts of interest. As a result, Vice Chair Sarmiento appointed Directors Byron and Green to serve on the ad hoc committee with Director Helleland to serve as an alternate. The second ad hoc committee is the Legislative Ad Hoc Committee. Chair Becerra appointed Vice Chair Sarmiento, Director Garcia Guillen, and herself to serve on that ad hoc committee. At the next CalOptima Health Board meeting, the ad hoc committees will report on the scope of what the ad hoc committees will be looking into.

Director Garcia Guillen, Chair of the Board's Legal Ad Hoc Committee, serving along with Director Byron and Director Helleland, noted that the ad hoc committee has been meeting at least twice a month for the last five months to ensure that the external auditor reviewing the procurement and grants from CalOptima Health has been diligent, transparent, and expedient. The Legal Ad Hoc Committee expects to have a report within a month or so, and at that time, the ad hoc committee expects to return to the Board with further details.

Board members thanked CalOptima Health staff for their efforts on the Annual Report, the 2024 Health Equity Report, and Covered California. They also congratulated the City of Santa Ana in being selected as the next city for the Street Medicine Program expansion.

Supervisor Chaffee reminded everyone about the upcoming Fishing Derby for kids on March 29 at Ralph B. Clark Regional Park. Registration begins at 7:00 a.m., and the Fishing Derby is from 8:00 to 11:00 a.m.

Chair Becerra closed the meeting by noting that CalOptima Health and the country are facing unprecedented times. She added that she is proud to be working with CalOptima Health and all the community partners and providers to stand together and reassure the community that CalOptima Health will continue to provide high quality health care even in the face of the challenges.

ADJOURNMENT

Hearing no further business, Chair Becerra adjourned the meeting at 4:41 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: April 3, 2025

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MINUTES

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

CALOPTIMA HEALTH
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

December 11, 2024

A Regular Meeting of the CalOptima Health Board of Directors' Quality Assurance Committee (Committee) was held on December 11, 2024, 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 3:01 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: Michael Hunn, Chief Executive Officer; Yunkyung Kim, Chief Operating Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Troy Szabo, Outside General Counsel, Kennaday Leavitt; Kelly Giardina, Executive Director, Clinical Operations; Ladan Khamseh, Executive Director, Operations; Sharon Dwiers, Clerk of the Board

ADVISORY COMMITTEE UPDATES

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

The Clerk of the Board noted that the update on this agenda item was in the meeting materials, and Monica Macias-Garcia, PACE Director, was available for any questions on the PACE Member Advisory Committee.

Chair Mayorga had questions regarding ongoing comments about the transportation vendor.

Monica Macias-Garcia, PACE Director, responded to Chair Mayorga's questions. Ms. Macia-Garcia reported that PACE has added two vans to the fleet to help support some of the challenges. Ms. Macias-Garcia also reported that she continues to have weekly meetings with Secure Transportation's vice president. She added that progress is being made, and PACE has reduced a lot of the one-hour violations, which were averaging about 120 per month and are now down to 49 per month.

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Director Byron asked if there has been any improvement in the vendor being able to handle the call volume.

Ms. Macias-Garcia responded that the transportation vendor is handling the call volume better. She noted that PACE has been down one scheduler and is currently recruiting to fill that position. Ms. Macias-Garcia also reported that PACE has requested an additional scheduler, which should help with the call volume.

Michael Hunn, Chief Executive Officer, added that he is also monitoring the transportation issue. He reported that one of the areas that has been identified is that when a driver takes a member to their place of residence, there is a warm handoff to an individual, and if no one is there, the driver will keep the member in the van, make another stop, and then return to that residence until there is someone to accept the member. Mr. Hunn noted that given the importance of safety of CalOptima Health's PACE members, these types of incidents will contribute to the one-hour violations. He also noted that for these types of incidents, additional documentation will be included explaining the reason that the member was not delivered home within the one-hour timeframe was for safety reasons. Mr. Hunn thanked the Board of Directors for its support in adding two vans and another scheduler, and assured the Committee members that CalOptima Health is monitoring the transportation issues very closely to ensure compliance.

2. Whole Child Model Family Advisory Committee Update
Due to a family emergency, the Whole-Child Model Family Advisory Committee Chair was unable to attend the meeting and provide a verbal report; however, the update was included in the meeting materials.

PUBLIC COMMENTS
There were no public comments.

CONSENT CALENDAR
3. Approve the Minutes of the October 9, 2024, Regular 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)***

INFORMATION ITEMS
4. Measurement Year 2023 Pay for Value Program Update
Yunkyung Kim, Chief Operating Officer, presented an update on the measurement year (MY) 2023 Pay for Value (P4V) programs, including details on the Medi-Cal and OneCare programs. Ms. Kim reported that the P4V programs were approved by the CalOptima Health Board of Directors in 2022, noting that the incentive pool is funded at a percentage of capitation amounts for the Medi-Cal program and a flat amount of $20 per member per month for the OneCare program.

Ms. Kim reviewed the Medi-Cal P4V program incentives for MY 2023, noting that health networks earned 56% of the available pool. The unearned dollars from the P4V Medi-Cal program were made available to health networks and CalOptima Community Network (CCN) primary care providers in the form of quality improvement grants.

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For the OneCare P4V program incentives for MY 2023, health networks earned 75% of the available pool with two networks, Family Choice and United Care, earning 100% of their incentive pool. Ms. Kim also noted for the record that there was a correction to the unearned incentive amount for Heritage, which shows as $1,128.00 and should show as $11,128.00, and the correction will be reflected in the archived meeting materials. Unearned P4V program incentive dollars were used in the form of health network grants for quality improvements.

Ms. Kim reviewed the next steps, noting that staff is looking at possibly investing some of the P4V unearned dollars into a data sharing platform for the entire delivery system. Staff is also looking at investments in lab services and in vision provider services. Lastly, Ms. Kim noted that staff will bring ideas back to the Committee and to the full Board of Directors for consideration.

5. Measurement Year 2023 Hospital Quality Program Update.
Mohini Sinha, M.D., Medical Director, presented an update on the MY 2023 Hospital Quality Program. Dr. Sinha reported that CalOptima Health utilizes three metrics for the P4V framework: quality, patient experience, and hospital safety. To minimize the hospital burden CalOptima Health uses publicly available data listed on the CMS Hospital Compare and the Leapfrog Group websites. Dr. Sinha noted that incentives are allocated based on performance in the three metrics used, with no incentive awarded for less than two stars and incentives can be earned starting at three stars. The total annual incentive pool for MY 2023 is $30 million, with $15 million earned and $14 million left unearned.

Mr. Hunn commended the five-star hospitals and noted he is in ongoing discussions with CalOptima Health's hospital partners on the best use of excess funds.

6. 2025 OneCare Stars Improvement Update
Dr. Mohini discussed the 2025 OneCare Stars Improvement Strategy, focusing on high-priority measures such as pharmacy and patient experience. Listening posts will be implemented to gather real-time feedback from members, with eight listening posts planned for December 2024 to February 2025. Dr. Mohini also reported that a Just-In-Time campaign will be initiated to contact patients likely to be dissatisfied and respond to a survey, or highly satisfied and unlikely to respond to a survey to promote a survey response before the CMS survey.

Richard Pitts, D.O., Ph.D., Chief Medical Officer, highlighted the aggressive stance on pharmacy measures, with a focus on triple-weighted measures for blood pressure, diabetes, and cholesterol management. Dr. Pitts noted that the pharmacy strike team has made 512 medication adherence reminder phone calls, with a 40% fill rate for patients reached.

7. Behavioral Health Quality Initiatives
Natalie Zavala, Director, Behavioral Health Integration, provided an overview of CalOptima Health's behavioral health services, including mental health, behavioral health treatment, and substance use disorder services. The Medi-Cal behavioral health delivery system is shared between each county's mental health plan and managed care plans, depending on the member's impairment level. Ms. Zavala noted that 11 behavioral health quality measures are reviewed, with some measures meeting goals and others not meeting goals. She reviewed the details of goals where CalOptima Health is achieving the goals and goals where there are opportunities for improvement. Ms. Zavala reviewed

some of the barriers to achieving goals, which included data sharing, data integrity, billing accuracy, and having two different systems of care. She also reviewed some of the interventions that CalOptima Health is taking to improve measures where it is not performing well, which include text messaging campaigns, telephonic outreach, member newsletters, and health rewards to incentivize follow-up visits and necessary lab work.

Ms. Zavala responded to Committee member comments and questions.

8. Medi-Cal Quality Initiatives

Dr. Sinha reviewed the Medi-Cal Quality Initiatives, focusing on high-priority medical measures, including blood lead screening, well child visits, and diabetes care. She noted that blood lead screening was trending higher this year, with initiatives such as health rewards and text campaigns contributing to the improvement. Dr. Sinha also noted that well child visits in the first 15 months are still a challenge due to data issues and missing visits, with efforts focused on setting up appointments and capturing data from chart reviews. For diabetes care measures, eye exams and A1c control measures were also reviewed, with initiatives such as standing orders and removing prior authorization requirements for certain tests to hopefully see improvement. Dr. Sinha reported that she is optimistic that performance will improve for these measures, with CalOptima Health's quality initiatives and education of its Medi-Cal members and providers.

9. Quarterly Reports to the Quality Assurance Committee

a. Quality Improvement Health Equity Committee Report

Marcia Choo, Director, Quality Improvement, provided a high-level summary of the Quality Improvement Health Equity Committee's activities for the third quarter of 2024. Ms. Choo provided background on the committee and its responsibilities, which includes providing overall direction for continuous quality improvement and health equity and overseeing activities consistent with CalOptima Health's strategic goals and priorities. The committee monitors compliance for regulatory and accrediting bodies and evaluates quality performance measures, utilization data, and member experience data. The committee's responsibilities also include analyzing and evaluating data, identifying performance deficiencies, and taking action to address deficiencies. The committee also oversees the Quality Improvement Health Equity Transformation Program and its annual work plan, ensuring activities are implemented and monitored.

Ms. Choo provided an overview of the various committees' activities in the third quarter, including the review and approval of policies such as Policy GG.1629: Quality Improvement and Health Equity Transformation Program. The committee accepted and filed subcommittee updates, including minutes and reports, and requested more information on topics like topical fluoride application, member incentives, behavioral health telehealth, and the Maternal Health Program.

Ms. Choo also reported that the Utilization Management Subcommittee approved its charter and two policies, recommended additional reports on care management systems and fax receipt acknowledgements, and discussed topics like durable medical equipment enhancements and transportation utilization.

Ms. Choo also reported on recent activities of the Population Health Management Committee, which included receiving a report from the Health Equity for African American League and

recommended exploring approaches to improve mental health and nutrition services within the African American community.

b. Utilization Management Committee and Clinical Operations Report
Kelly Giardina, Executive Director, Clinical Operations, discussed the annual consolidated Utilization Management Committee Sub-Workgroup evaluation report, highlighting the growth of physician leaders and the development of physician-led sub work groups.

The High-Risk Care Workgroup enhanced transitional care services, emergency department (ED) enhancements, and ED policies. The Over and Under Utilization Workgroup established utilization benchmarks and enhanced automation for high volume codes.

The Gender Affirming Care Workgroup solidified partnerships with University of California, Irvine, University of California, San Diego, Children's Hospital of Orange County, and Radiant Health to deliver care for members seeking gender affirming services.

Robin Hatam, M.D., Medical Director, discussed health network clinical oversight, including quarterly meetings with health networks to review utilization trends, denial rates, and health risk assessments.

c. Member Grievances and Appeals Report
Ladan Khamseh, Executive Director, Operations, reported on member grievances and appeals, noting a slight increase in grievances from 4170 to 4387 and a decrease in appeals from 356 to 315. The turnaround time for grievances remained consistent at 25 days, and actions were taken to address issues related to appointments with providers and medically tailored meals. Ms. Khamseh noted that some of the transportation issues were addressed by working with the transportation vendor to provide an opt-out option for members who wanted to speak to a representative. She added that the team focused on redirecting members to appropriate providers at the correct level of care and educating providers on referral practices.

Ms. Khamseh responded to Committee member comments and questions.

d. Program of All-Inclusive Care for the Elderly Report
Ms. Macias-Garcia provided an update on the PACE quality team's performance, noting that out of 27 quality initiatives, 17 were met, with challenges in areas like pneumococcal immunization rates and diabetic care. She noted that the team is working on transportation challenges, diabetic care initiatives, and advanced healthcare directives, with current metrics at 92% for pneumococcal immunization and 16% for A1C levels. Ms. Macias-Garcia added that the alternative care site utilization goal was impacted by the closure of a partner location, and efforts are being made to establish new partnerships and contracts. She commented that the team will provide a full report to the Quality Assurance Committee in 2025, outlining metrics met, not met, and any adjustments made.

COMMITTEE MEMBER COMMENTS

Director Byron expressed appreciation for the depth of information and the ease of understanding the reports, highlighting the importance of transparency and communication.

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Director Green agreed with Director Byron's comments, noting that new members can easily read and understand the reports, which is crucial for effective onboarding.

Chair Mayorga reflected on the commitment to excellence and health equity within the health plan, emphasizing the importance of member feedback and the dedication to improving health outcomes.

ADJOURNMENT

Hearing no further business, Chair Mayorga adjourned the meeting at 5:07 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: March 12, 2025

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CalOptima Health Board Action Agenda Referral

Action To Be Taken April 3, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

3. Receive and File 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program Evaluation and Approve the 2025 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

1. Receive and file the 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program (QIHETP) Evaluation; and
2. Approve the 2025 CalOptima Health QIHETP and Work Plan.

Background

CalOptima Health's QIHETP encompasses all clinical care, health and wellness services, and customer service provided to its members, which aligns with CalOptima Health's vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all members. The 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 2024 QIHETP Evaluation analyzes the core clinical and service indicators to determine if the 2024 QIHETP has achieved its key performance goals during the year.

CalOptima Health had the following achievements in 2024:

- April 2024: CalOptima Health approved nearly $25 million in workforce education grants to seven institutions in Orange County.
- June 2024: CalOptima Health approved an investment of $526.2 million to increase rates paid to network providers in Orange County.
- August 2024: CalOptima Health held its largest community event ever, the Back-to-School Health and Wellness Fair.
- August 2024: CalOptima Health launched its second Street Medicine Program in Costa Mesa in partnership with Celebrating Life Community Health Center. The following month, the CalOptima Health Street Medicine Program began in Anaheim.

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- December 2024: CalOptima Health partnered with Illumination Foundation, an Orange County-based nonprofit, to open the nation's first recuperative care center to serve medically vulnerable children and families experiencing homelessness.

In 2024, CalOptima Health remained committed to improving quality of care and quality of service. CalOptima Health expanded strategies to improve member health outcomes, member experience, and provider engagement by (i) expanding the Comprehensive Community Cancer Screening Program to include a grants program, (ii) expanding the Street Medicine Program to additional cities, and (iii) implementing a new Cultural and Linguistically Appropriate Services Program to ensure network cultural responsiveness.

Discussion

CalOptima Health staff has updated the 2025 QIHETP and Work Plan to ensure that the QIHETP it is aligned with health network and strategic organizational changes. This will ensure that all regulatory requirements and National Committee for Quality Assurance (NCQA) accreditation standards are met in a consistent manner across all lines of business.

The 2025 QIHETP and Work Plan will be flexible and able to align with strategic goals and objectives as 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 2025 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 2025 are summarized as follows:

1. Updated existing program initiatives to align with health equity and current operational practices.
2. Continued 2024 priority areas and goals:
    - Priority Area 1: Maternal Health:
        - Goal 1 – Close racial/ethnic disparities in well-child visits and immunizations by 50%.
        - Goal 2 – Close maternity care disparity for Black and Native American persons by 50%.
    - Priority Area 2: Children's Preventive Care:
        - Goal 1 - Exceed the 50th percentile for all children's preventive care measures.
    - Priority Area 3: Behavioral Health Care:

        - Goal 1 – Improve maternal and adolescent depression screening by 50%.
        - Goal 2 - Improve follow-up for mental health substance disorder by 50%.
    - Priority Area 4: Program Goals:
        - Goal 1 – Medi-Cal: Exceed the minimum performance levels for the Medi-Cal Accountability Set.
        - Goal 2 - OneCare: Attain a Four-Star Rating for Medicare.
        - Goal 3 - Attain NCQA Health Equity Accreditation.
3. Updated new program initiatives: Diversity, Equity and Inclusion Training Program.
4. Updated the Quality Improvement Program Staffing and Resources to reflect current organizational structure, including:
    - Addition of a Senior Director of Equity and Community Health.
    - Transition to a new care management platform.
    - Transition to a new HEDIS software engine.
    - Contracting with an NCQA Certified Credentialing Verification Organization.
5. Removed programs that sunset in 2024.
6. Updated sections in the QIHETP to reflect current operational processes and workflows

2025 QIHETP recommendations focus on the following goals:

1. Preventive measures and screenings identified in the Department of Health Care Services (DHCS) Quality Strategy (Bold Goals).
2. Social Determinants of Health factors and analysis of health disparities in the strategic plan for targeted quality initiatives and population health programs.
3. Expand 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 specified by the Centers for Medicare and Medicaid Services, DHCS, and NCQA accreditation standards.

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Fiscal Impact

The recommended actions have no additional fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2024-25 Operating Budget. Staff will include updated expenditures for the period of July 1, 2025, through December 31, 2025, in the FY 2025-26 Operating Budget.

Rationale for Recommendation

CalOptima Health's QIHETP outlines the health plan's annual strategy, programs, and activities to ensure that members receive quality care according to 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 on-going monitoring and evaluation, the QIHETP detects opportunities for improvement, plans quality improvement projects, and evaluates the effectiveness of improvement activities.

Concurrence

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

Attachments

1. 2024 Quality Improvement Health Equity Transformation Program Evaluation
    a. 2024 QIHETP Work Plan Q1-Q4
    b. 2024 CalOptima Health Membership (Risk Stratification)
    c. 2024 Population Health Management Impact Report
    d. 2024 Cultural and Linguistically Appropriate Services (CLAS) Evaluation
2. 2025 Quality Improvement and Health Equity Transformation Program and Work Plan
    a. 2025 QIHETP Work Plan
    b. 2025 Population Health Management Strategy and Work Plan
    c. CalOptima Health Measurement Year (MY) 2025 Medi-Cal and OneCare Pay For Value Programs
    d. 2025 Culturally and Linguistically Appropriate Services Program Description
3. 2024 QIHETP Evaluation Presentation
4. 2025 QIHETP and Work Plan Presentation

/s/ Michael Hunn *03/27/2025*
Authorized Signature **Date**

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2024 QUALITY IMPROVEMENT HEALTH EQUITY TRANSFORMATION PROGRAM EVALUATION

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2024 QUALITY IMPROVEMENT HEALTH EQUITY TRANSFORMATION 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:

_____ _____

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

Board of Directors Chair:

_____ _____

Isabel Becerra **Date**

Section 1: CalOptima Health Overview

Our Mission
Our Vision
Our Values
Our Strategic Plan

Section 2: Executive Summary

2.1 2024 Achievements
2.2 Review of 2024 Quality Improvement Health Equity Transformation Program (QIHETP) Goals
2.3 Recommendations for 2025
2.4. Recommended Priority Areas and Goals for 2025

Section 3: Program Oversight

3.1 Quality Improvement Health Equity Transformation Program Documents
3.2 Quality Improvement Health Equity Committee (QIHEC) and Subcommittees
3.2.1 Credentialing Peer Review Committee (CPRC)
3.2.2 Grievance and Appeals Resolution Services (GARS) Committee
3.2.3 Member Experience (MEMx) Committee
3.2.4 Population Health Management Committee (PHMC)
3.2.5 Utilization Management Committee (UMC)
3.2.5.1 Benefit Management Subcommittee (BMSC) Committee
3.2.5.2 Pharmacy and Therapeutics (P&T) Committee
3.2.6 Whole Child Model Clinical Advisory Committee (WCM CAC)
3.3 Assessment of QI Staff and Resources
3.4 Review of System Resources
3.5 Review of Program Structure
3.6 Cultural and Linguistic Appropriate Services Program
3.7 Delegation Oversight
3.8 Health Equity
3.6.4 Long-Term Services and Supports
3.9 Long-Term Services and Supports
3.10 National Committee for Quality Assurance (NCQA) Accreditation
3.10.1 Health Plan Accreditation
3.10.2 Health Equity Accreditation
3.11 Quality Performance Measures
3.11.1 Medi-Cal: Managed Care Accountability Set (MCAS)
3.11.2 OneCare: Stars Performance Measures
3.12 Utilization Management Program
3.13 Value-Based Payment
3.13.1 Health Network Quality Rating – Pay for Value
3.13.2 Five-Year Hospital Quality Program

Section 4: Quality of Clinical Care

4.1 Quality Oversight
4.1.1 Potential Quality Issues (PQI) and Provider Preventable Conditions
4.1.2 Facility Site and Medical Record Review

Section 5: Quality of Service

Section 6: Safety of Clinical Care

2024 CalOptima Health Quality Improvement Health Equity Transformation Program Annual Evaluation

Section 1: CalOptima Health Overview

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

Our Mission

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

Our Vision

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

Our Values

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

Our Strategic Plan

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

The five Strategic Priorities and Objectives are:

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

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

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

Section 2: Executive Summary

The 2024 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 2024. This evaluation focuses on quality activities implemented during measurement year (MY) 2024 that impacted performance to improve health care and services available to CalOptima Health members. The look-back period for the 2024 QIHETP Evaluation is Quarter (Q)1 2024 through the end of Q4 2024.

The QIHETP for 2024 outlined major program initiatives. Threaded into the initiatives continued to be 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 for care that is equitable, high-quality and value-based and considers the needs of the whole person.

In 2024, QIHETP initiatives aligned CalOptima Health's strategic priorities with a focus on health equity, social determinants of health, member engagement, improved access to care and improved quality outcomes. CalOptima Health remained focused on advancing Quality Improvement and Health Equity (QIHE) initiatives to achieve 2024 QIHE goals and objectives to provide members with access to quality health care services. CalOptima Health continued to utilize the Plan-Do-Study-Act (PDSA) and continuous quality improvement (CQI) approach to developing initiatives in 2024, which has continued into 2025. These initiatives are focused on long-term improvements in selected high-priority measures.

In 2025, based on the 2024 QI Program Evaluation, CalOptima Health will continue to support a strategy, as identified in the 2025 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 2025 QIHETP Annual Work Plan will profile key areas that offer opportunities for improvement to be implemented or continued as outlined in the 2025 QIHETP.

2.1 2024 Achievements

April 2024: CalOptima Health approved nearly $25 million in workforce education grants to seven institutions in Orange County. These grants mark the first phase of the $50 million Provider Workforce Development Initiative, the largest workforce grant ever awarded by CalOptima Health. The Initiative will help to address health disparities and better secure the future delivery of medical and behavioral health care by safety net providers. It also seeks to ease predicted shortages and gaps in the Orange County health care workforce that serves the Medi-Cal population.

June 2024: CalOptima Health approved an investment of $526.2 million to increase rates paid to health networks, hospitals, physicians, community clinics, behavioral health providers and ancillary services providers in Orange County. This investment is intended to support timely access to critical health care services for members and promote the managed care network's long-term financial stability over a 30-month period from July 2024 through December 2026.

August 2024: CalOptima Health held its largest community event ever, the Back-to-School Health and Wellness Fair, attracting more than 5,200 people to receive free services and resources to help children and families.

Summer 2024: In August, CalOptima Health launched its second Street Medicine Program in Costa Mesa in partnership with Celebrating Life Community Health Center. The following month, the CalOptima Health Street Medicine Program began in Anaheim. Across the new cities and the original program in Garden Grove, more than 500 members have received medical, behavioral and social services as part of this unique care delivery model that focuses on building trust and meeting individuals where they are.

December 2024: CalOptima Health partnered with Illumination Foundation, an Orange County-based nonprofit, to open the nation's first recuperative care center to serve medically vulnerable children and families experiencing homelessness. A $3.5 million CalOptima Health grant helped to purchase the property. We also collaborated to design a payment structure that will sustain the center's services.

Throughout the year, our executives were honored for their successful leadership at CalOptima Health. This recognition includes:

- Nancy Huang, Chief Financial Officer, was a finalist in the April 2024 Second Annual Los Angeles Times B2B OC Inspirational Women Awards, recognizing accomplished female leaders from corporations and nonprofit organizations throughout Orange County.
- Yunkyung Kim, Chief Operating Officer, was honored by the Coalition of Orange County Community Health Centers with a Community Health Center Ambassador Award in August 2024. The award recognizes CalOptima Health's work to raise awareness and support the community health movement.
- Marie Jeannis, RN, MSN, CCM, Executive Director of Equity and Community Health, was inducted into the National Coalition of 100 Black Women Inc. in August 2024. She will serve in the health education program and be part of the Orange County Chapter.
- Kelly Bruno-Nelson, DSW, Executive Director of Medi-Cal/California Advancing and Innovating Medi-Cal (CalAIM), was appointed to Orange County's Commission to End Homelessness. She will serve a two-year term, ending January 22, 2026. The Commission implements and coordinates strategies to address homelessness in Orange County.

2.2 Review of 2024 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 41.90% to 55.78% by December 31, 2024. While the target was set for the 2024 measurement year, the formal DHCS Performance Improvement Project (PIP) timeframe spans from 2023 to 2026. CalOptima Health conducted

outreach to 85 members through telephone, email and text and reached 40% (34). The rate for well-child visits (0–15 months) for African American members for MY2023 is 45.05%. While there was an increase in the rate from the year before, the goal was not met for this project and will remain an area of focus for the next 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. Goals set for the African American population were met. Rates were unavailable for the Native American population as there were no live births identified for this population in 2024. Since the denominator is low for Native Americans, CalOptima Health will focus on strategies and interventions to improve rates for prenatal and postpartum appointments in the African American population in 2025. CalOptima Health will continue to monitor rates for the Native American population 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 MY2023, 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%

For maternal depression screening, the rate increased from 8.73% in MY2022 to 14.52% in MY2023, with a 66.3% increase in material screening. For adolescent depression screening, the rate increased from 1.93% in MY2022 for both adolescents and adults to 6.75% in MY2023 for only adolescents, with over a 50% increase in the rate.

b. Improve follow-up care for mental health and substance abuse disorder by 50%

For follow-up care of mental health after an emergency room visit, the rate for follow-up within 30 days decreased from 58.83% in MY 2022 to 35.73% in MY2023, with a 39.2% decrease in follow-up care. For follow-up care of substance abuse after an emergency room visit, the rate for follow-up within 30 days decreased from 24.05% in MY2022 to 21.41% in MY2023, with an 11.0% decrease in follow-up care.

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) and Follow-up After ED Visit for Mental Illness within 30 Days (FUM). These two measures will be a focus area for CalOptima Health in 2025.

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

   CalOptima Health met a 2.5 overall star-rating for MY2023 and did not meet the goal of attaining a four-star rating.

2.3 Recommendations for 2025

For 2025, 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 2024 QIHETP Evaluation, CalOptima Health will continue to focus on the following initiatives and projects to drive improvements that impact members.

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.

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

A. Implement a Diversity, Equity and Inclusion Training Program for staff, our health networks and our network providers that includes sensitivity, diversity, cultural competency and cultural humility, and health equity training programs.
B. Leverage technology and automation in order to streamline quality operations and enhance productivity.

2.4 Recommended Priority Areas and Goals for 2025

Based on the evaluation of the 2024 QIHETP Evaluation, CalOptima Health has extended the following goals from 2024 into 2025. CalOptima Health added a goal to attain National Committee for Quality Assurance (NCQA) Health Equity Accreditation. These recommended priority areas and goals are aligned with CalOptima Health's 2022–2025 Strategic Goals and DHCS Bold Goals.

Goal 1: Maternal Health

a. Close racial/ethnic disparities in well-child visits and immunizations by 50%
b. Close maternity care disparity for Black and Native American persons by 50%

Goal 2: Children's Preventive Care

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

Goal 3: Behavioral Health Care

a. Improve maternal and adolescent depression screening by 50%
b. Improve follow-up care for mental health and substance abuse disorder by 50%

Goal 4: Program Goals

a. Medi-Cal: Exceed the MPLs for MCAS
b. OneCare: Attain a Four-Star Rating for Medicare
c. Attain NCQA Health Equity Accreditation

Section 3: Program Oversight

3.1 Quality Improvement Health Equity Transformation Program Documents	
Business Owner: Marsha Choo	Department: Quality Improvement
Support Staff: Gloria Garcia	
Products: ☒ Medi-Cal ☒OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Complete documents and obtain Board of Directors' (BOD) approval of all 2024 quality-related programs and work plans.	
Goal Met: ☒ Yes ☐ No ☐ Partial	

Work Plan Planned Activities:
• All quality documents will be completed, reviewed and approved by the following committees in Q1 2024, and by their appropriate subcommittee, where applicable.
  ○ QIHEC: 02/13/2024
  ○ QAC: 03/13/2024
  ○ Annual Board of Directors adoption by April 2024	

Status: ☒ Completed ☐ Ongoing	

Background:
Annually, CalOptima Health develops the following quality documents:
• 2024 Quality Improvement and Health Equity Transformation Program (QIHETP) Description - Developed and implemented a robust written QIHETP description that focused on improving standards of care and addressing gaps in care identified in the prior year's evaluation. The organization enhanced the QIHETP by including "new initiatives" in the program description that will outline measurable goals and objectives that CalOptima Health will focus on in subsequent years. The following quality improvement documents are included as part of the overall QIHETP:
  ○ The 2024 Population Health Strategy
  ○ The 2024 Cultural and Linguistic Program
  ○ The 2024 Pay for Value Program
• 2024 Quality Improvement and Health Equity Transformation Program (QIHETP) Work Plan — Created 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
• 2023 QI Program Evaluation — Completed a comprehensive evaluation of the 2023 QI Program and QI Work Plan at the end of the year that assesses the performance on measures and indicators, and the assessment laid the groundwork for the 2024 QIHETP
• 2024 Utilization Management (UM) Case Management (CM) Integrated Program — Developed and implemented a written UM Program that 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
• 2023 UM Evaluation — Completed a comprehensive evaluation of the 2023 UM Program at the end of the year that evaluates the impact of the UM Program
• CalOptima Health successfully completed reviews of all the above documents with the Quality Improvement Health Equity Committee (QIHEC) and/or subcommittees during 2024. The documents were reviewed and approved by both the Quality Assurance Committee of CalOptima Health's BOD and CalOptima Health's BOD
 	
Feedback from the providers who participated in the QIHEC and/or subcommittees meetings was included in program documents (i.e., program description, work plan and evaluation).	

Actions/Interventions Implemented in 2024:	

Quarter 1:	• 2024 QIHETP Description and Annual Work Plan was approved by QIHEC on 2/13/24, by QAC on 3/13/24 and by the BOD on 4/4/24 • A copy of the BOD-approved 2024 QIHETP and Work Plan was posted on CalOptima Health's public website
Quarter 2:	• 2024 QIHETP Description and Annual Work Plan was first adopted by BOD on 4/4/24. Revisions were made to the QIHETP and Work Plan, and they were approved by QAC on 6/12/24: ○ Updated QIHETP staffing and resources to reflect the current organizational structure and renamed the Population Health Managed Department as the Equity and Community Health Department ○ Updated section in the QIHETP to reflect current operational and workflows ○ Added Cultural and Linguistic Appropriate Services Program (CLAS) to QIHETP as Appendix D ○ Added cultural linguistic and health equity goals and planned activities to the QIHETP Annual Work Plan • The revised 2024 QIHETP Description and Work Plan was submitted for BOD approval at the 8/1/24 meeting
Quarter 3:	• The revised 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan was approved by the BOD on 8/1/2024, and a copy was posted on CalOptima Health's public website • Staff initiated collaboration to begin developing the 2025 QIHETP Description and Work Plan
Quarter 4:	• Staff developed a draft of the 2024 QIHETP Evaluation and the 2025 QIHETP and Work Plan to be approved in Q1 2025

Program Results:	
Identified Barriers*:*	Identified Opportunities for Improvement:
• The fourth quarter of the year is very busy for staff to complete the QIHETP Description, the Work Plan and the Evaluation.	• Quality staff will begin drafting the 2026 QIHETP and Work Plan shortly after Healthcare Effectiveness Data and Information Set (HEDIS) rates have been finalized for the year and compared to goals in Q3 of 2025. This would allow staff to focus on the evaluation documents in Q4. • Team collaboration to identify how best to draft the evaluation without having staff write the same evaluation in multiple documents. Consider having staff complete a template to populate both sections of the report and develop a table of contents for the evaluation prior to writing the evaluation sections
Conclusion: All documents were prepared and approved by the Quality Improvement Health Equity Committee (QIHEC), the Quality Assurance Committee (QAC) and the Board of Directors on time.	
Activities/Interventions to continue/add next year:	
• Quality staff to begin working on quality documents beginning in September 2025	

3.2 Quality Improvement Health Equity Committee (QIHEC) and Subcommittees	
Author: Marsha Choo	Department: Quality Improvement
Support Staff: Gloria Garcia	

Committee Purpose and Background:
The QIHEC provides overall direction for continuous quality improvement processes, oversees activities that are consistent with CalOptima Health's strategic goals and priorities, and monitors compliance with regulatory and licensing requirements related to QI projects and activities. QIHEC aims to achieve improved care and services for members and ensure that members are provided with optimal quality of care. There are six subcommittees that report to the QIHEC at least quarterly:

1) Utilization Management Committee (UMC)
    a. Pharmacy & Therapeutics Committee (P&T)
    b. Benefit Management Subcommittee (BMSC)
2) Grievance and Appeals Resolution Services (GARS) Committee
3) Credentialing and Peer Review Committee (CPRC)
4) Member Experience Committee (MEMx)
5) Population Health Management Committee (PHMC)
6) Whole Child Model Clinical Advisory Committee (WCM CAC)

The QIHEC is the primary committee responsible for QIHETP, the QIHETP Work Plan and QIHETP Evaluation. It reports to the CalOptima Health Board of Directors' Quality Assurance Committee (QAC). The QIHEC is comprised of the Chief Medical Officer (CMO), Deputy Chief Medical Officer (DCMO), CalOptima Health Chief Health Equity Officer (CHEO), CalOptima Health medical directors, CalOptima Health external physicians and community partners.

The committee is responsible for providing overall direction for continuous quality improvement processes, overseeing activities that are consistent with CalOptima Health's strategic goals and priorities, and monitoring compliance with regulatory and licensing requirements related to QIHE projects and activities. The committee provides critical feedback and guidance to the QI department on key initiatives. The QIHEC also reviews and approves all the key QIHE documents in a timely manner.

Committee chair: Quality Medical Director, a designee of the CMO

Voting Members:
The QIHEC consists of a minimum of four physicians or practitioners, with at least two practicing physicians or practitioners.

Meeting Dates:
The QIHEC meets at least eight times per calendar year.

Committee Changes in 2024*:*

- In January, Kaiser representative left the committee.
- In March, the medical director from Conifer joined as a committee member.

QIHEC charter updates were approved:

- Selected QIHEC members must meet specific membership requirements
- Changed list of CalOptima Health support from departments to staff titles
- Added that external participants must report changes in membership status (i.e. retired, leave place of work, quit) to the committee chair
- Added the following responsibilities:
    - Programs for QIHEC to approve, oversee and evaluate the Cultural and Linguistically Appropriate Service (CLAS) Program and the Population Health Management (PHM) Strategy
    - Review and evaluate the Medi-Cal and OneCare Pay for Value Programs
    - Added policy recommendations as a QIHEC responsibility

- Added that QIHEC annually reviews and assesses the compliance of the DEI training program
- Added a written summary of QIHEC activities, findings, recommendations and actions prepared after each meeting.
  - Provide a quarterly written summary of the QIHEC activities publicly available on CalOptima Health's website

Committee Actions in 2024:

- In February 2024, launched the PHM Committee to oversee PHM activities related to DHCS and NCQA. This committee includes executive representatives from across the agency as well as community leaders. A new PHMC committee was developed in 2024 to provide overall guidance to the implementation and oversight of the Population Health Management Strategy.
- The QIHEC met monthly in 2024 to review and provide feedback on key clinical and other coordination of care initiatives, including member outreach, provider education and outreach, incentives, educational materials, and more
- The committee reviewed and approved the 2024 QIHE Program Description, the 2024 QIHETP Work Plan, the 2023 QI Evaluation, the 2024 UM CM Program and the 2023 UM Evaluation. The QIHEC also reviewed and approved the PHM Strategy and the CLAS Program
- The committee reviewed and approved the policies and procedures and made recommendations regarding policy decisions
- The committee reviewed and provided feedback on key reports: Annual analysis of HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) access to care and complaints and appeals. Part of the feedback included specific actions that CalOptima Health could take to improve performance
- The committee received quarterly reports from CPRC, PHMC, UMC, MEMx, GARS and WCM CAC. These reports were summarized and presented quarterly to the QAC
- A new PHMC committee was developed in 2024 to provide overall guidance to the implementation and oversight of the Population Health Management Strategy.

Identified Barriers:	Identified Opportunities for Improvement:
• Subcommittee workflow and processes are inconsistent and do not match that of the QIHEC • There are a lot of items to cover in one committee meeting and the committee would like more time to allow for discussion.	• Committees align their workflow and processes surrounding the following: how minutes are taken, when and how to move an item to consent, how to recruit and vet potential committee members, and how to send out documents/surveys for committee members to complete.

Conclusion:
All committees were successful this year in monitoring the QIHETP and annual work plan. Quality activities in the work plan, analysis and findings were presented to committees at a quarterly cadence. Committees were able to successfully provide feedback and guidance while maintaining a clear focus on the goals.

Activities/Interventions to continue/add next year:

- Continue to hold committee meetings as scheduled in the calendar
- Quality Improvement staff to collaborate with other committee chairs and administrative support staff to identify ways to align and streamline the committee process

3.2.1 Credentialing Peer Review Committee (CPRC)	
Author: Laura Guest, RN, ANP, Manager	Department: Quality Improvement
Responsible Parties: Marsha Choo, Laura Guest and Rick Quinones	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No

Work Plan Goal/Objective:

- Report committee activities, findings from data analysis and recommendations to QIHEC

Goal Met: ☒ Yes ☐ No ☐ Partial

Work Plan Planned Activities:

- Review of Initial and Recredentialing applications approved and denied; Facility Site Review (FSR) (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions
- The committee meets at least eight times a year, maintains and approves minutes, and reports to the QIHEC quarterly

Status: ☐ Completed ☒ Ongoing

Committee Purpose and Background:
Chairperson:
Chief Medical Officer (CMO), Deputy Chief Medical Officer (DCMO) or physician designee, CalOptima Health.

Voting Members:
The CPRC consists of a minimum of five practitioners selected as a representation of practitioners from the CalOptima Health Community Network (CHCN) and the 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 CalOptima Health's Behavioral Health Medical Director, are voting members.

Meeting Frequency:
The CPRC meets a minimum of six times per year. Ad hoc CPRC meetings may be scheduled as determined by the CPRC Chair.

Goals:

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

Committee Changes in 2024:

- At the February 22, 2024, meeting, it was announced that one community physician would no longer be a member of CPRC since he had retired from practice
- At the February 22, 2024, meeting, it was announced that one community OB/GYN physician will no longer be a member of CPRC since he had retired from practice

Committee Actions in 2024

Quarter 1:	The Committee met on January 25, 2024, January 29, 2024 (ad hoc), February 22, 2024, and March 28, 2024. Informed: • The backlog of the timeliness of behavioral health credentialing applications. Temporary staff were hired to help remedy the backlog • Fair Hearing status update for five physicians • A university health system acquired four hospitals in Orange County

	• CalOptima Health is launching a cancer initiative of $50M • The BH Medical Director joined the Council of Trustees for Mission Plasticos, a not-for-profit organization to improve lives through reconstructive surgery • CalOptima Health terminated its contract with a four-hospital group • CalOptima Health was engaged in an audit by DHCS • Fair Hearing status update for five physicians Approved: • Policy GG.1651: Corrective Action Plan for Practitioners and Organizational Providers • Policy GG.1659: System Controls of Provider Credentialing Information • A certified or psychologist licensed in another state for 180 days if they have applied for Medi-Cal enrollment • American Board of General Practice/American Academy of General Physicians • Practitioner Credentialing Clean List 12/11/2023, 12/15/2023, 12/21/2023, 12/29/2023, 01/18/2024, 01/31/2024, 02/15/2024, 02/29/2024 • Practitioner Credentialing Closure List December 2023, January, February and March 2024 • Minutes of December 14, 2023, January 25, 2024, January 29, 2024 and February 22, 2024 • CPRC Committee Charter Analyzed: • Potential Quality Issue (PQI) quarterly update data and trend report, requesting detailed data on the subcategory of mismanaged care which was presented at the following meeting • Birth outcome data was reviewed since the committee had reviewed several PQIs with negative birth outcomes in recent months. It was found that CalOptima Health performed better than Orange County and California Recommendations: • Approval of the recredentialing of three practitioners with issues • Obtain additional details on the malpractice settlements for one practitioner who was approved at the next meeting • PQI leveling and actions on six PQI cases PQIs • One PQI was recommended for termination for cause; one PQI was recommended for termination for non-cause
Quarter 2:	The Committee met on April 25, 2024, May 23, 2024, and June 27, 2024 Informed: • CalOptima Health's grant of $15M to support late-stage cancer discovery • Fair Hearing status update for five physicians • Credentialing report • FSR, MRR, PARS reports • Incident and Critical Incident reports • PQI has transitioned to a new computer system called Jiva • Provider Preventable Conditions (PPCs) • The NCQA Accreditation Review Survey was completed, and CalOptima Health has been fully accredited for three years • Two primary care providers (PCPs) were identified for contract termination for failing to pass MRR audits for three consecutive years Approved: • Minutes of March 28, 2024, April 25, 2024, and May 23, 2024

	• Policy GG.1650: Credentialing and Recredentialing of Practitioners • Policy GG.1651: Assessment and Reassessment of Organizational Providers • Policy GG.1639: Post-Hospital Discharge Meds • Practitioner Credentialing Clean List 03/15/2024, 03/29/2024, 04/19/2024, 04/30/2024, 05/01/2024, 05/16/2024, 05/31/2024 • Practitioner Closure List April, May and June 2024 Recommendations: • PQI leveling and actions on 11 PQI cases • One provider PQI was recommended for a non-cause termination based on the PQI findings • One PQI was recommended for letter to the MBC (non-805 action) • Approval of the recredentialing of four practitioners with issues
Quarter 3:	The committee met on July 25, 2024, and September 26, 2024. Informed: • Going forward, all practitioners will be deidentified when presented to the committee • Fair Hearing status update for five physicians • PQI Statistics Q1 and Q2 2024 • CalOptima Health is focusing on improving STAR ratings • CalOptima Health now has Street Medicine in Anaheim, which is the third city to participate in the program Approved: • Minutes of June 23, 2024 and July 25, 2024 • Practitioner Credentialing Clean List 06/20/2024, 06/28/2024, 7/17/2024, 7/31/2024 • Practitioner Closure Report June, July and August 2024 Recommendations: • PQI leveling and actions on 10 PQI cases • One provider was recommended for a non-cause termination based on the PQI findings • Approval of the recredentialing of nine practitioners with issues; three practitioners were recommended for monthly monitoring, and one was recommended for monitoring of the grievances • Recognition of the physicians with a Canadian board certification • Practitioner Credentialing Clean List 06/20/2024, 06/28/2024, 7/17/2024, 7/31/2024 • Practitioner Closure Report June, July and August 2024 • Two of the physicians undergoing the Fair Hearing process were approved for probation with contingencies in lieu of termination
Quarter 4:	The committee met on October 24, 2024, November 21, 2024 and December 19, 2024 Informed: • CalOptima Health is collaborating with the health networks to improve medication adherence, close gaps in care and encourage annual wellness visits. • PQI statistics presented in Q3 showed that most cases are categorized as a Medical Care issue. Further details of these cases were presented in Q4 with the explanation that this data is of closed cases, all of which were reviewed and leveled by a medical director. • Fair Hearing status update for five physicians.

	• CalOptima Health implemented a Diversity, Equity and Inclusion (DEI) survey to staff and committee participants for the development of DEI resources and for the following purposes:
	  ○ Identify needs that require support
	  ○ Explore opportunities for creating a stronger work environment that can enhance engagement and support within the workplace
	  ○ Celebrate and leverage our diverse backgrounds to foster a more inclusive and innovative workplace
	Approved:
	• Minutes of September 26, 2024 and October 24, 2024
	• Practitioner Credentialing Clean List 09/30/2024 and 10/31/2024
	• Practitioner Closure Report September and October
	• CalOptima Health Policies:
	  ○ GG.1604 Confidentiality of Credentialing Files
	  ○ GG.1607 Monitoring Adverse Actions
	  ○ GG.1633 Board Certification Requirements for Physicians
	  ○ GG.1651 Assessment and Re-Assessment of Organizational Providers
	  ○ GG.1657 State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting
	  ○ GG.1659 System Controls of Provider Credentialing Information
	Analyzed: None
	Recommendations:
	• PQI leveling and actions on three PQI cases.
	• On-going Monitoring: One physician assistant and one OB/GYN will be monitored with no further action required.
	• Approval of the recredentialing of four practitioners with issues
	• FSR statistical report showed a marked increase in the number of corrective action plans (CAPs) and failed audits. The committee requested the total numbers and percentages be included in future presentations to better monitor this trend.
	• The committee requested the details of critical incident events, not just the totals, in future presentations to better understand the issues arising for the long-term support services (LTSS) members.

Identified Barriers:	Identified Opportunities for Improvement:
• The committee is challenged with finding another community OB/GYN physician to sit on the committee.	• The committee identified the Canadian board as an acceptable board and is reviewing the boards of other countries to see if they may be accepted in the future. • After receiving additional information, the committee was willing to allow physicians to be placed on probation rather than continue termination through the fair hearing process. • Recruit an OB/GYN to sit on CPRC and/or consider paying for clinical expertise in that specialty.
Conclusion: The committee was successful in conducting peer review in 2024. 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, CMS) and accreditation (NCQA) standards.	

• Promote continuous improvement of the quality of health care provided by providers in CalOptima Health Direct/CHCN and its delegated health networks. • Conduct peer-level review and evaluation of provider performance and credential information against CalOptima Health requirements and appropriate clinical standards. • Investigate patient care outcomes that raise quality and safety concerns for corrective actions, as appropriate.

3.2.2 Grievance and Appeals Resolution Services (GARS) Committee	
Business Owner: Heather Sedillo	Department: GARS
Support Staff: Amanda Acosta, Ismael Bustamante, Jamar Phillips	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: • Report committee activities, findings from data analysis and recommendations to QIHEC	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: • 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. Trends and results are presented to the committee on a quarterly basis. • The committee meets at least quarterly, maintains and approves minutes, and reports to the QIHEC quarterly.	
Status: ☐ Completed ☒ Ongoing	
Committee Purpose and Background: The GARS Committee serves to protect the rights of our members, to promote the provision of quality health care services and to ensure that the policies of CalOptima Health are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. Roles and Responsibilities: The GARS committee reviews GARS performance and any trends and provides recommendations and/or addresses each as needed. Meetings: The committee meets quarterly. In 2024, the committee met on the following dates: May 14, August 14 and November 13. Q4 committee scheduled for February 11, 2025.	
Committee Changes in 2024 • Added the following member: GARS Intake Manager	
Committee Actions in 2024	
Quarter 1:	• Recommend a discussion with Utilization Management (UM) and Regulatory Affairs and Compliance (RAC) departments related to the issue of OneCare members receiving Medi-Cal denials for "wrap benefit" services. • Identified a trend of increased applied behavioral analysis (ABA) appeals, root cause was denials issued for incomplete medical records. Provider training has been scheduled.
Quarter 2:	• Identified an increase in expedited discharge appeals/grievances — Met with Case Management (CM) and UM in April – Transition of care contacts at all health networks was shared with GARS • Informed BH providers of the appeals process and what to include in their authorization requests during a BH provider training completed in May 2024.

Quarter 3:	• Recommended and conducted a meeting with University of California, Irvine (UCI) related to appointment availability and referral delays. • Analyzed transportation grievance trends and continued with the transportation workgroup.
Quarter 4:	• Meeting schedule for February 11, 2025.

Identified Barriers:	Identified Opportunities for Improvement:
• New GARS system implementation in QI of 2024	• GARS worked closely with Zeomega and Information Technology Systems (ITS) department to map the system and create reports that better align with the department's needs for tracking and trending and committee reporting.

Conclusion: Overall, the committee was successful and has contributed to the implementation of process improvements which resulted in more positive outcomes for our members and providers. The committee also provides a forum for open dialogue and recommendations to be discussed between multiple departments involved in the Appeals and Grievances process.

Activities/Interventions to continue/add next year:

- The committee will meet at a minimum quarterly, maintain and approve minutes and report to the QIHEC quarterly.

3.2.3 Member Experience (MEMx) Committee	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Helen Syn/Carol Matthews	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Report committee activities, findings from data analysis and recommendations to QIHEC	
Goal Met: ☒ Yes ☐ No ☐ Partial	

Work Plan Planned Activities:

- The MEMx Subcommittee reviews the annual results of CalOptima Health's CAHPS or member experience surveys, monitors the provider network, including access and availability (CHCN and the health networks), reviews customer service metrics, and evaluates complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members.
- The committee meets at least quarterly, maintains and approves minutes, and reports to the QIHEC.

Status: ☐ Completed ☒ Ongoing

Committee Purpose and Background:
The purpose of MEMx is to improve the member experience and drive initiatives to achieve member experience goals established by 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. The committee is comprised of a variety of business units that impact member experience.

Committee Changes in 2024:

- Changed title from Chair to Co-Chair. The committee is co-chaired by the Executive Director, Operations and the Executive Director, Quality Improvement.
- Removed the following members:
  - Chief Medical Officer
  - Executive Director, Clinical Operations

- Executive Director, Behavioral Health
- Executive Director, Quality and Population Health Management
- Director, Program Implementation

- Added the following members:
  - Director, Contracting
  - Senior Director, Case Management
  - Director, Medicare Programs
  - Director, Operations Management
  - Director, Stars and Quality Initiatives
- Titles changed for the following members:
  - Director, Population Health Management to Director, Equity and Community Health

Meetings: The committee meets quarterly in the first month of the quarter. In 2024 the committee met on the following dates: March 24, May 22, July 16, October 9 (an ad hoc meeting) and October 15.

MEMx Roles and Responsibilities
The co-chair or designee is responsible for leading the MEMx committee in reviewing information, making recommendations and presenting MEMx at the QIHEC meetings.

The MEMx committee's responsibilities are to:
- Measure and improve the member experience to achieve organizational goals.
- Facilitate member engagement to enhance the overall experience resulting in better health outcomes.
- Review and analyze data tied to member experience and engagement and identify opportunities for improvement including, but not limited to: Access and Availability, CAHPS, Grievance and Appeals, Authorizations and Referrals, Provider Action for Non-Clinical Issues, and Potential Quality Issues (PQIs) related to member experience.
- Identify opportunities for improvement utilizing member experience and access data to enhance member experience and access to quality care.
- Review, assess and recommend industry best practices for Provider performance, member experience and access.
- Identify workgroup leads and oversee the implementation of improvement initiatives to achieve desired performance results.
- Monitor network adequacy and appointment availability standards compliant with regulatory and accrediting agency standards including but not limited to NCQA, DHCS, DMHC and CMS.
- Monitor health equity and disparities as it relates to member experience and access to care.

Committee Actions in 2024	
Quarter 1:	• Recommended to monitor tertiary level of care physicians in the CalOptima Health directory and remove them if not readily available. • Updated and streamlined the corrective action process for timely access. • Recommended communication to behavioral health providers about the TRI-rates and Proposition 56 so they understand the changes and understand the pay scale
Quarter 2:	• Recommended adding the Behavioral Health Integration (BHI) Department to quarterly key performance indicators (KPI) updates.
Quarter 3:	• Recommended to educate PCPs about collaboration codes with PCP and Behavioral Health visits.
Quarter 4:	• Recommended formation of a workgroup to improve member CAHPS scores. • Recommended improving ease of access to home blood pressure monitors by members.

Identified Barriers:	Identified Opportunities for Improvement:
• Ensuring a timely quorum.	• Ensuring all areas have reporting backup when they are unable to attend committee meetings.
Conclusion: The MEMx committee was successfully restructured in 2024, resulting in a committee structure that reports on member experience activities, provides a mechanism for multi-disciplinary engagement and collaboration, and recommends initiatives that will improve the overall member experience.	
Activities/interventions to continue/add next year:	
• The committee will meet at a minimum quarterly, maintain and approve minutes and report to the QIHEC quarterly.	

3.2.4 Population Health Management Committee (PHMC)	
Business Owner: Katie Balderas	Department: Equity and Community Health
Support Staff: Barbara Kidder Garcia /Janette Valladolid	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Work Plan Goal/Objective: • Report committee activities, findings from data analysis and recommendations to QIHEC.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: • Review, assess and approve the Population Needs Assessment (PNA), PHM strategy activities and PHM Workplan progress and outcomes. • The committee meets at least quarterly, maintains and approves minutes, and reports to the QIHEC quarterly.	
Status: ☐ Completed ☒ Ongoing	
Committee Purpose and Background: Background: The PHMC was created to ensure that all PHM initiatives meet the needs of CalOptima Health members across the continuum of care. Purpose: 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. Chair: Medical Director, Population Health and Equity Committee Members: Committee members include internal stakeholders from CalOptima Health and external partners with relevant expertise and experience. The voting members consist of the following individuals or their designee: • Medical Director, Population Health and Equity • Chief Health Equity Officer • Executive Director of Behavioral Health • Executive Director of Clinical Operations • Executive Director of Equity and Community Health • Executive Director of Medi-Cal CalAIM • Executive Director of Network Management • Executive Director of Operations Management • Director of Operational Management	

- Executive Director of Quality
- Executive Director of Strategic Development

External partners that represent:

- Community-based organizations that serve CalOptima Health members – Health Equity for African American's League (HEAAL) Executive Director
- Health network medical directors contracted to serve CalOptima Health members (CHOC Health Alliance –Senior Medical Director)
- Orange County Health Care Agency (HCA) – Assistant Deputy Director, Quality Management Services (QMS) and Behavioral Health Services (BHS)

Supported by:

- Program Manager, Sr., Equity and Community Health
- Program Manager, Equity and Community Health
- Program Coordinator, Equity and Community Health

PHMC Roles and Responsibilities:

- The chair or designee is responsible for leading the PHMC in reviewing information, making recommendations and representing the PHMC at the QIHEC meetings.
- Voting members of the PHMC are responsible for adhering to the priorities of our federal and state regulators and following the standards outlined by the NCQA, including:
  - Review, contribute to and approve the PNA annually.
  - Review, contribute to and approve the PHM Strategy annually.
  - Review, contribute to and approve the PHM Workplan annually.
  - Perform an annual evaluation of the effectiveness of the PHM Strategy, including a barrier analysis and goals.
  - The PHMC will ensure PHM Strategy and Workplan activities will:
    - Keep all members healthy by focusing on wellness and prevention services
    - Identify and manage members with high and rising risk
    - Identify and address members' health-related social needs
    - Implement separate strategies focused on members less than 21 years of age
    - Ensure effective transition planning across delivery systems or settings
    - Identify and mitigate member access, experience, and clinical outcome disparities by race, ethnicity and language to advance health equity
  - Facilitate ongoing process improvement that incorporates member feedback and the needs of the population.
  - Ensure multidisciplinary oversight of PHM initiatives to achieve desired performance results.
  - Measure and improve upon PHM initiatives to achieve PHM Strategy goals.
  - Review and evaluate PHM activities and key utilization performance indicators.
  - Review, analyze and react to results of reports for PHM initiatives including (but not limited to):
    - DHCS PHM Key Performance Indicators
    - CalOptima Health's internal member data reports
    - Various Orange County data reports
  - Institute actions to address performance deficiencies and ensure appropriate follow-up of identified performance deficiencies.

Meeting Dates: The PHMC meets quarterly, at least three times per calendar year. In 2024, the PHMC met virtually on February 29, 2024, May 16, 2024, August 15, 2024, and November 21, 2024.

<table>
<tr><td colspan="2">Committee Changes in 2024: HCA Director of Population Health and Equity resigned in August 2024, and HCA Assistant Deputy Director, QMS and BHS accepted an invitation to join PHMC in October 2024.</td></tr>
<tr><td colspan="2">Committee Actions in 2024</td></tr>
<tr><td>Quarter 1:</td><td>• The PHMC launched in February 2024.
• PHMC members reviewed and approved the 2024 PHM Strategy and Workplan at Q4 PHMC meeting in February 2024.
• Per the recommendation of the PHMC, Health Equity for African American Leagues (HEAAL) Collective and Shape Your Life (SYL) Program leadership met in March 2024 following a SYL presentation at the PHMC to discuss future collaboration efforts to expand CalOptima Health's nutrition and weight management services to Second Baptist Church.
• Provided PHMC update for QIHEC in March 2024.</td></tr>
<tr><td>Quarter 2:</td><td>• PHMC met in May 2024, which included both internal CalOptima Health updates on PHMC programs/initiatives and Community Spotlight presentation on Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) facilitated by OC HCA.
• PHMC reviewed and approved Q1 Meeting Minutes, 2024 Charter, Annual Reporting Calendar and Policy GG. 1667 (CalAIM PHM Program).
• At the request of CHOC Health Alliance (PHMC Voting Member), Equity and Community Health reviewed and revised the Maternal Health and Blood Lead Screening Local Health Jurisdiction (LHJ) Collaborative goals and objectives to include pediatricians as a focus population.
• Provided PHMC update for QIHEC in June 2024.
• Developed and published PHMC SharePoint site to house committee materials.</td></tr>
<tr><td>Quarter 3:</td><td>• PHMC met in August 2024, which included both internal CalOptima Health updates on PHM programs/initiatives and Community Spotlight presentation on the 2023 OC Black and African American's Health Equity Survey Report facilitated by HEAAL Collective.
• PHMC reviewed and approved Q2 Meeting Minutes.
• Per the recommendation of the PHMC, HEAAL Collective and CalOptima Health's Chronic Conditions program leadership met in August 2024 to initiate a partnership to develop educational materials to meet the nutritional needs of members, explore interventions for congestive heart failure and increase blood pressure monitoring utilization among CalOptima Health members.
• Provided PHMC update for QIHEC in July 2024.</td></tr>
<tr><td>Quarter 4:</td><td>• PHMC met in November 2024, which included both internal CalOptima Health updates on PHM programs/initiatives and Community Spotlight presentation on the Equity in OC Initiative: Improving Organizational Health Literacy facilitated by the Institutes for Healthcare Advancement.
• PHMC reviewed and approved Q3 Meeting Minutes and 2024 Population Needs Assessment at Q4 PHMC meeting in November 2024.
• HEAAL Collective and CalOptima Health's Behavioral Health Integration leadership met in October 2024 to explore opportunities to collaborate in future community events (e.g., Black Health Summit, OC Black History Parade and Unity Festival, Mental Health Benefits Webinar for Black CalOptima Health Members).
• Provided PHMC update for QIHEC in December 2024.</td></tr>
<tr><td colspan="2">Identified Barriers:</td><td>Identified Opportunities for Improvement:</td></tr>
<tr><td colspan="2">• Ensuring timely quorum</td><td>• Sharing meeting dates in advance</td></tr>
</table>

Conclusion: Overall, the PHMC has proven to be a successful addition to CalOptima Health's committee structure by ensuring oversight on PHMC activities and creating space for a more engaged dialogue and input from committee members.
Activities/Interventions to continue/add next year:
• PHMC plans to review, assess, and approve the 2025 PNA, PHM Strategy activities, and PHM Workplan progress and outcomes. • The committee plans to meet at least quarterly, maintain and approve minutes, and report to the QIHEC quarterly.

3.2.5 Utilization Management Committee (UMC)	
Business Owner: Stacie Oakley	Department: Utilization Management
Support Staff: Lorena Moore	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: • Report committee activities, findings from data analysis and recommendations to QIHEC.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: • UMC reviews medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. The committee meets at least quarterly, maintains and approves minutes, and reports to the QIHEC quarterly. • P&T and BMSC reports to the UMC, and minutes are submitted to UMC quarterly.	
Status: ☐ Completed ☒ Ongoing	
Committee Purpose and Background: CalOptima Health's UMC was first established in 2002. The committee is led by a CalOptima Health Medical Director and meets quarterly. The UMC reports to the QIHEC and QAC before reporting to the Board of Directors. Purpose: The purpose of the UMC is to promote optimum utilization of health care services and provide comprehensive support to the UM Program while maximizing the effectiveness of the care and services provided to the members. Roles and Responsibilities: • Provides oversight and direction for the continuous improvement of the UM program, consistent with CalOptima Health's strategic goals and priorities. This includes an oversight of UM functions and activities performed by both CalOptima Health and the delegated heath networks. • Oversees UM activities and compliance with federal and state regulations, as well as contractual and NCQA requirements. • Reviews and approves UM 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, and makes recommendations for further action. • Reviews and approves annual UM metric targets and goals and reviews progress toward these goals • Promotes a high level of satisfaction with the UM program. • Reviews, assesses and recommends utilization management best practices used for selected diagnoses or disease classes. • Reviews under/over utilization monitoring and makes recommendations for improving performance on identified over/under utilization.	

<table>
<tr><td colspan="2">

Reviews and provides recommendations for improvement, as needed, to reports submitted by BMSC and P&T.
Reports to the QIHEC on a quarterly basis.
Reports to the Board of Directors routinely through QAC.

Chair: Medical Director Medical Management

Meeting Frequency: The committee meets quarterly

Jan. 25, 2024 – This was an ad hoc meeting
Feb. 22, 2024
May 23, 2024
Nov. 21, 2024

</td></tr>
<tr><td colspan="2">Committee Changes in 2024:
In 2024 a Medical Director of Health Network oversight was added to the UMC. The following updates were made to the UMC charter in 2024:

Defined the area medical directors oversee in addition to their specialty.
Indicated the line of business the UMC supports.
Indicated the subcommittees that report to the UMC.
Indicated the departments that report relevant information to the UMC.
Added a conflict-of-interest language in addition to the attestation.
Indicated mandatory external practitioners’ attendance.
Removed that the UMC revises and updates CalOptima Health’s referral intelligence rules.

</td></tr>
<tr><td colspan="2">Committee Actions in 2024</td></tr>
<tr><td>Quarter 1:</td><td>

Ad hoc meeting was held on January 25, 2024, and the regular Quarter I 2024 meeting was held on February 22, 2024
Review and approval of the 2023 UM Program Evaluation
Review and approval of the 2024 UM/CM Integrated Program Description
Review and approval of the 2024 UM criteria and hierarchy for clinical decision-making
Review and approval of the 2024 UM Policies and Procedures
Review and approval of the UMC charter
Approval of November 16, 2023 and the January 25, 2024, meeting minutes
Review of the 2024 IRR results
Review of ABA best practices
Review of Quarter 4 2023 UM over/under utilization and metrics to include but not limited to, acute inpatient, prior authorization, emergency department (ED), Whole Child Model (WMC), pharmacy, behavioral health and Long-Term Services & Support (LTSS)
Review of CalOptima Health membership
Review of CPT code changes approved by BMSC on October 25, 2023
Launched clinical sub-workgroups that report programmatic and utilization enhancements and outcomes to UMC.
Review of UM strategic plan improvements

</td></tr>
<tr><td>Quarter 2:</td><td>

The Quarter II 2024 meeting was held on May 23, 2024
Review of available board-certified consultants available for UM clinical decision-making of complex cases
Review and approval of the 2024 UMC Charter

</td></tr>
</table>

	• Presentation by CalOptima Health ITS department resolution to Jiva fax receipt acknowledgment issues • Review and approval of UM goals • Review of Quarter 1 2024 UM over/under utilization and metrics to include but not limited to, acute impatient, prior authorization, ED, WMC, pharmacy, behavioral health and LTSS • Review of CalOptima Health membership • Review of CPT code changes approved by BMSC on February 28, 2024 • Review of UM strategic plan improvements • Presentation regarding the transition to Modivcare for non-emergency medical transportation (NEMT)/non-medical transportation (NMT) • Review and approval of UM policies and procedures • Presentation of adverse childhood experiences (ACEs) by the Medical Director of Behavioral Health • Updates from the clinical sub workgroups
Quarter 3:	• The Quarter III 2024 meeting was held on August 22, 2024 • Approval of May 23, 2024, meeting minutes • UM compliance update presentation • Review of Quarter II 2024 UM over/under utilization and metrics to include but not limited to, acute inpatient, prior authorization, ED, WMC, pharmacy, behavioral health, LTSS and NEMT/NMT services • Review of CalOptima Health membership • Review of CPT code changes approved by BMSC on June 19, 2024 • Review of UM strategic plan improvements • Review and approval of UM policies and procedures • Presentation of ACEs survey effort by the Medical Director of Behavioral Health • Review of the February 15, 2024, P&T Committee Minutes • Updates from the clinical sub workgroups
Quarter 4:	• The Quarter IV 2024 meeting was held on November 21, 2024 • Approval of the August 22, 2024, meeting minutes • UM compliance update presentation • Review of Quarter III 2024 UM over/under utilization and metrics to include but not limited to, acute inpatient, hospital facility. prior authorization, ED, WMC, pharmacy, behavioral health, LTSS and NEMT/NMT services • Review of CalOptima Health membership • Review of CPT code changes approved by BMSC on July 31, 2024 • Review of UM strategic plan improvements • Diversity, Equity and Inclusion (DEI) Survey presentation by the Medical Director, Quality • 2024 Inter-Rater Reliability assessment results review • Operational performance updates of the following sub-work groups, High-Risk Management, Over/Under Utilization, Gender Affirming Care, and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) • Review and approval of UM policies and procedures • Enhanced Care Management (ECM) update presentation by the Director CalAIM Operations

Identified Barriers:	Identified Opportunities for Improvement:
• Jiva reporting	• Enhanced reporting

• WCM reporting not aligned with DHCS specifications • Outgoing provider fax notification issues • ED utilization and readmission rate due to complex psychosocial challenges	• Refinement of UM goals • Refinement of staffing metrics and productivity standards • Enhanced prior authorization workflows • Enhanced referral intelligence rules • Enhanced provider portal capabilities • UM participation in the Stars Workgroup • Established an Over/Underutilization Workgroup and the EPSDT Workgroup
Conclusion: The UM program continues to refine programs and oversight to address member needs and clinical outcomes.	
Activities/Interventions to continue/add next year:	
• Continue to monitor over/underutilization patterns • Integration of case management and UM interventions to promote transitional care services. • Clinical operations IT configuration leader identified and expected to start QI 2025 • Interdisciplinary bi-weekly reporting consortium to address ongoing reporting needs	

3.2.5.1 Benefit Management Subcommittee (BMSC) Committee	
Business Owner: Stacie Oakley	Department: Utilization Management
Support Staff: Lorena Moore	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Goal/Objective: • Ensure new benefits are implemented in accordance with regulatory requirements, ensure new and existing codes comply with regulatory requirements, and report changes, additions or modifications to benefits to the UMC.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Planned Activities: • Review new and revised CPT/HCPC codes to determine if prior authorization is required and recommend prior authorization requirements for new and existing benefits.	
Status: ☐ Completed ☒ Ongoing	
Committee Purpose and Background: Background: BMSC is a subcommittee of the UMC and was established to create clinical oversight and governance of prior authorization codes. Chair: Medical Director Medical Management Purpose: The BMSC is charged by the UMC with providing prior authorization to new codes, ongoing review of existing codes and governance of the enterprise prior authorization list. The BMSC reports to UMC. Roles and Responsibilities: • Review of new and revised codes to determine prior authorization requirements • Communication of changes to the UMC • Oversight of enterprise prior authorization list • Oversight of approval intelligence rules	

Frequency: The BMSC meets monthly.	
Committee Changes in 2024 • In 2024, a Medical Director of Health Network oversight was added to the BMSC. • The following updates were made to the UMC charter in 2024: Removed maintenance of the benefit set.	
Committee Actions in 2024:	
Quarter 1:	• Meetings were held on February 28, 2024, March 13, 2024, and March 27, 2024. • Recommended a formal process for medical director review of codes. • Review of 84 codes determined to require prior authorization. • Review of 62 codes determined not to require prior authorization • Review of 19 codes approved for removal from the prior authorization list. • Review and approval of the 2024 Charter
Quarter 2:	• One meeting was held on June 19, 2024. • Review of 13 codes determined to require prior authorization. • Review of 2 codes determined not to require prior authorization. • Review of four codes approved for removal from the prior authorization list.
Quarter 3:	• Meetings were held on July 31, 2024, and August 28, 2024. • Review of 41 codes determined to require prior authorization. • Review of three codes determined not to require prior authorization. • Review of three codes approved for removal from the prior authorization list.
Quarter 4:	• Meetings were held on October 30, 2024, and an ad-hoc discussion took place on November 14, 2024. • Review of 17 codes determined to require prior authorization. • Review of 23 codes determined not to require prior authorization • Review of specialty mental health codes. Two codes approved for removal from the prior authorization list. • Review of four mental health services electroconvulsive therapy (ECT) determined to require prior authorization.
Identified Barriers:	Identified Opportunities for Improvement:
• Frequency and volume of code review.	• Include a consultant physician from a delegated health network.
Conclusion: The BMSC continues to refine prior authorization requirements and oversight.	
Activities/Interventions to continue/add next year:	
• Continue to review new codes for prior authorization recommendation. • Add a consultant physician from a delegated health network.	

3.2.5.2 Pharmacy and Therapeutics (P&T) Committee	
Business Owner: Kris Gericke, Pharm.D.	Department: Pharmacy Management
Support Staff: Julie Dulaney	
Products: ☒ Medi-Cal ☒ OneCare Remove	New Activity: ☐ Yes ☒ No
Goal/Objective: • Report committee activities, findings from data analysis and recommendations to QIHEC.	
Goal Met: ☒ Yes ☐ No ☐ Partial	

Planned Activities:

- Review applicable policies, medications and medication classes for formulary evaluation. Reviewed DUR projects and over/underutilization.

Status: ☐ Completed ☒ Ongoing

Committee Purpose and Background:
The P&T Committee is responsible for the development of the drug formularies, which are based on sound clinical evidence and reviewed at least annually by practicing practitioners and pharmacists. The committee includes 13 voting members who are practicing physicians or pharmacists. At least one physician and one pharmacist are required to be experts in the treatment of elderly or disabled persons. The committee chairperson is a CalOptima Health Medical Director.

P&T Committee Goals:

- Promote access to clinically sound, cost-effective pharmaceutical care for all CalOptima Health members.
- Meet CMS formulary regulatory requirements.
- Provide overall direction for the continuous improvement process and oversee that activities are consistent with CalOptima Health's strategic goals and priorities.
- Promote an interdisciplinary approach to driving continuous improvement in pharmacy utilization.
- Support compliance with regulatory and licensing requirements and accreditation standards related to pharmacy-related initiatives.
- Monitor, evaluate and act on pharmacy-related care and services provided to promote quality of care outcomes to members.

P&T Committee Responsibilities:

- Review new medications and prior authorization criteria as outlined in CalOptima Health policy GG.1409: Physician Administered Drug Prior Authorization Required List Development and Management and policy MA.6103: Pharmacy and Therapeutics Committee.
- Review individual requests for changes to the formularies from practitioners in the community.
- Review and update the OneCare formulary and Medi-Cal prior authorization list on an ongoing basis to ensure access to quality pharmaceutical care that is consistent with the program's scope of benefits.
- Review anticipated and actual utilization trends overall as well as for specific drug classes.
- Review and evaluate pharmacy-related issues related to the delivery of health care to CalOptima Health members.
- Assess outcomes of pharmacy-related Healthcare Effectiveness Data and Information Set (HEDIS) and Medicare Star measures to drive improvements.
- Review and evaluate patterns of pharmaceutical care and key utilization performance indicators.
- Evaluate and make recommendations on pharmacy issues that pertain to CalOptima Health-wide initiatives, such as treatment guidelines, disease management programs, QI studies, etc.
- Review and make recommendations on selected pharmaceutical provider educational activities.
- Recommend pharmacy-related policy decisions.

The P&T Committee meets a minimum of four times per year and reports to the UM Committee.

Committee Changes in 2024

- None

Committee Actions in 2024

Quarter 1:	• Reviewed medications and medication classes for formulary evaluation. Reviewed DUR projects and over/underutilization.

Quarter 2:	• Reviewed medications and medication classes for formulary evaluation. Reviewed DUR projects and over/underutilization.
Quarter 3:	• Reviewed medications and medication classes for formulary evaluation. Reviewed DUR projects and over/underutilization.
Quarter 4:	• Reviewed medications and medication classes for formulary evaluation. Reviewed DUR projects and over/underutilization.

Identified Barriers:	Identified Opportunities for Improvement:
• Physicians are resistant to following requirements for Star and HEDIS measures.	• Mechanism to refer physicians for poor performance in Star and HEDIS measures.

Conclusion:
Continue quarterly meetings and reporting.

Activities/Interventions to continue/add next year:

- Continue all current P&T Committee activities.

3.2.6 Whole Child Model Clinical Advisory Committee (WCM CAC)	
Business Owner: Dr. Thanh-Tam Nguyen	Department: Medical Management
Support Staff: Hannah Kim/Gloria Garcia	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No

Work Plan Goal/Objective:

- Report committee activities, findings from data analysis, and recommendations to QIHEC.

Goal Met: ☒ Yes ☐ No ☐ Partial

Work Plan Planned Activities:

- WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations.
- The committee meets at least quarterly, maintains and approves minutes, and reports to the QIHEC quarterly.
- Pediatric Risk Stratification Process (PRSP) monitoring

Status: ☒ Completed ☐ Ongoing

Committee Purpose and Background

- WCM CAC was formed in 2018 to advise on clinical issues relating to California Children's Services (CCS) conditions, including treatment authorization guidelines and serving as clinical advisers on other clinical issues relating to CCS conditions.
- CalOptima Health Chief Medical Officer or Medical Director designee chairs the WCM CAC.
- Committee participants include CCS-paneled physicians or practitioners, county CCS Medical Director, state agency Medical Director and nonprofit organization contracted by the State of California.
- WCM CAC meets at least four times per calendar year and reports to QIHEC quarterly
- Signed and dated minutes are kept for each meeting, and copies are provided to QIHEC.
- Quality Improvement staff collects annual Conflict of Interest and Confidentiality forms from all WCM CAC meeting attendees.

Committee Changes in 2024
WCM CAC charter was updated in May 2024.

- Updated the purpose following All Plan Letter (APL) 23-034 to include advice on clinical issues relating to CCS conditions.
- The state agency medical director and nonprofit organization contracted by the State of California were added as voting members.

<table>
<tr><td colspan="3">Committee Actions in 2024:
• Approved WCM CAC charter updates.
• The committee unanimously voted to keep meeting virtually.
• Monitored Pediatric Risk Stratification Process (PRSP).
• Provided clinical expert advice related to the access and care of the WCM population.</td></tr>
<tr><td>Quarter 1:</td><td colspan="2">• Reviewed the report and evaluation of WCM data</td></tr>
<tr><td>Quarter 2:</td><td colspan="2">• Reviewed the report and evaluation of WCM data
• Regional Center Orange County and Orange County Social Service Agency representatives joined the Committee.
• CHOC CCS representative resigned from serving on WCM CAC.</td></tr>
<tr><td>Quarter 3:</td><td colspan="2">• Reviewed the report and evaluation of WCM data
• A replacement was found to represent CHOC</td></tr>
<tr><td>Quarter 4:</td><td colspan="2">• Reviewed criteria and rate for 30-day readmission.
• New request for seven-day readmission.</td></tr>
<tr><td colspan="2">Identified Barriers:</td><td>Identified Opportunities for Improvement:</td></tr>
<tr><td colspan="2">• Low immunization rate.</td><td>• Enhanced collaboration with external stakeholders.
• Improve immunization rate</td></tr>
<tr><td colspan="3">Conclusion:
• Continue meeting quarterly and review WCM data.
• Continue collaborating with CCS stakeholders.</td></tr>
<tr><td colspan="3">Activities/Interventions to continue/add next year:</td></tr>
<tr><td colspan="3">• Continue all current WCM CAC activities.</td></tr>
</table>

3.3 Assessment of QI Staff and Resources

Author: Marsha Choo | Department: Quality Improvement

CalOptima Health continues to dedicate significant resources and staffing to meet the needs of the QIHETP. At the beginning of 2024, there were many vacant positions supporting quality and the QIHEC. However, throughout the year, CalOptima Health's Human Resources department worked with the business areas to fill needed positions to support the QIHETP.

In 2024, the following areas were impacted by workforce changes:

- Data Analytics Team in Quality Analytics – Data Analytics transitioned to the Enterprise Analytics team.
- Credentialing Team in Quality Improvement – Conducting provider verifications transitioned to a NCQA-certified Credentialing Verification Organization (CVO)

In 2024, CalOptima Heath added the following:

- NCQA team (a manager and two program managers)
- Director of Customer Service
- Senior Director of Equity and Community Health

In 2024, CalOptima Health filled the following vacant positions:

- Chief Information Officer to support technology
- Director or Delegation Oversight
- Director of Health Network Relations

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
- Customer Service (including outreach and engagement)
- Provider Relations and Contracting

In addition, positions were added to the quality organizational charts as they have been identified as supporting the QIHETP.

Identified Barriers:	Identified Opportunities for Improvement:
• There are a lot of quality performance measures to monitor • Improvement in outcomes may require additional resources.	• Add additional resources to support the Credentialing team with managing the inboxes, intake and expedited in-house credentialing.

Conclusion:
CalOptima Health has leveraged vendors and technology to support the QIHETP.

Activities/Interventions to continue/add next year:

- Continue to fill any vacant positions

3.4 Review of System Resources

Business Owner: Marsha Choo	Department: Quality Improvement

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

CalOptima Health contracted with an NCQA-certified credential vendor organization (CVO) in August 2024 to conduct credentialing for our providers. The implementation process took three months and the CVO credentialing provider files in Q4 2024.

CalOptima Health transitioned to a new 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 also contracted with Decision Point Analytics to run predictive analytics of our 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 also contracted with a single integrated provider lifecycle management (PLM) system for credentialing, contracting and provider data management in 2024. This system aims to integrate the process and data for the identified business units as part of the provider lifecycle management. CalOptima Health conducted implementation for most of 2024, and the platform is planned to launch in May 2025.

Identified Barriers:	Identified Opportunities for Improvement:
• Jiva reports still needed to be developed after go-live to meet regulatory reporting requirements • CVO does not use email to send out applications • A lot of workarounds needed to be developed with the CVO for the team to credential and approve files. Working with the CVO still requires a lot of administrative and manual work • Current credentialing system is outdated as CalOptima Health has not upgraded to the web-based system • Staff has been dedicating a lot of time to attend meetings to support these systems	• Collaborate with ITS to identify solutions around automation • Adding additional resources to support the credentialing area • Utilize vendors to conduct data analytical support.

Conclusion:
The transition and implementation of newly contracted vendors was successful in 2024. With ITS support, all go-live dates were met and staff have been able to successfully access vendor services.

Activities/Interventions to continue/add next year:

- Continue to work with vendors and ITS to improve the current process.
- Continue to support PLM launch in May 2025

3.5 Overall Review of QIHETP

Business Owner: Marsha Choo

Support Staff: Gloria Garcia

Assessment:
CalOptima Health had adequate staffing and resources required to meet the needs of 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.

The organization receives adequate feedback from its community practitioners about the development and implementation of the QIHE initiatives and programs. Currently, there are 11 physicians participating at the QIHEC, representing the Orange County Social Service Agency, HCA, our delegated health networks and community-based organizations. In addition, there are network providers also participating 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 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 13 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.

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. At this time, there is no need to make any changes or restructure the program.

3.6 Cultural and Linguistic Appropriate Services Program

Business Owner: Albert Cardenas

Support Staff: Carlos Soto

Executive summary:

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, medical history and health education, CalOptima Health developed a Cultural and Linguistically Appropriate Services (CLAS) Program, a part of the QIHETP that integrates culturally and linguistically appropriate services at all levels of the 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.

The following are the 2024 goals of the QIHEC/CLAS Program:

Goal 1: Implement a process to collect, store and retrieve member Race Ethnicity, Language (REL) and Sexual Orientation Gender Identity (SOGI) data.

- Developed a survey to collect data from members
- Added new fields in CalOptima Health's core system to store SOGI data
- Enhanced the core system to capture race/ethnicity in accordance with the Office of Management and Budget (OMB) standards
- Surveys were launched in September 2024
- Created a new Policy and Procedure to support the collection and storage of member data.

This goal was met and will continue to be an area of focus for 2025.

Goal 2: Evaluate language services experience from members and staff.

- Developed member and staff surveys to collect feedback on interpreter and translation services experience.
- Target implementation is Q1 2025

This goal was not met and will be carried over to the 2025 QIHEC/CLAS work plan.

Goal 3: Implement a process to collect, store and retrieve practitioner race/ethnicity/languages.

- Developed a provider satisfaction survey and launched it in September 2024.
- Store provider responses in CalOptima Health core eligibility system

This goal was met and will continue to be an area of focus for 2025.

Goal 4: Improve practitioner support in providing language services.

- Members' language preference is available in CalOptima Health's provider portal.
- Inform providers of member's language preference during customer service interactions.
- Evaluated CalOptima Health's contracted health networks' cultural and linguistics process to ensure members' language needs are being met.

This goal was met and will continue to be an area of focus for 2025.

Overall, the CLAS Program met the needs of our diverse member population, and CalOptima Health continuously monitored the progress of the CLAS goals. On a quarterly basis dedicated staff from Cultural and Linguistic (C&L) department, in collaboration with multidisciplinary work teams throughout the agency, collect and track indicators and activities specific to CLAS goals, outcomes and outputs. C&L staff prepared quarterly findings and identified potential risks to share with CalOptima Health leadership at QIHEC meetings. The CLAS goals updates were shared with CalOptima Health's MAC and PAC.

3.7 Delegation Oversight (DO)	
Business Owner: Stacy Baker/ Zulema Gomez/John Robertson	Department: Delegation Oversight
Support Staff:	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Implement annual oversight and performance monitoring for delegated activities.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: • Report on the implementation of annual delegation oversight activities and monitor delegates for regulatory and accreditation standard compliance that, at minimum, includes comprehensive annual audits.	
Status: ☒ Completed ☒ Ongoing	

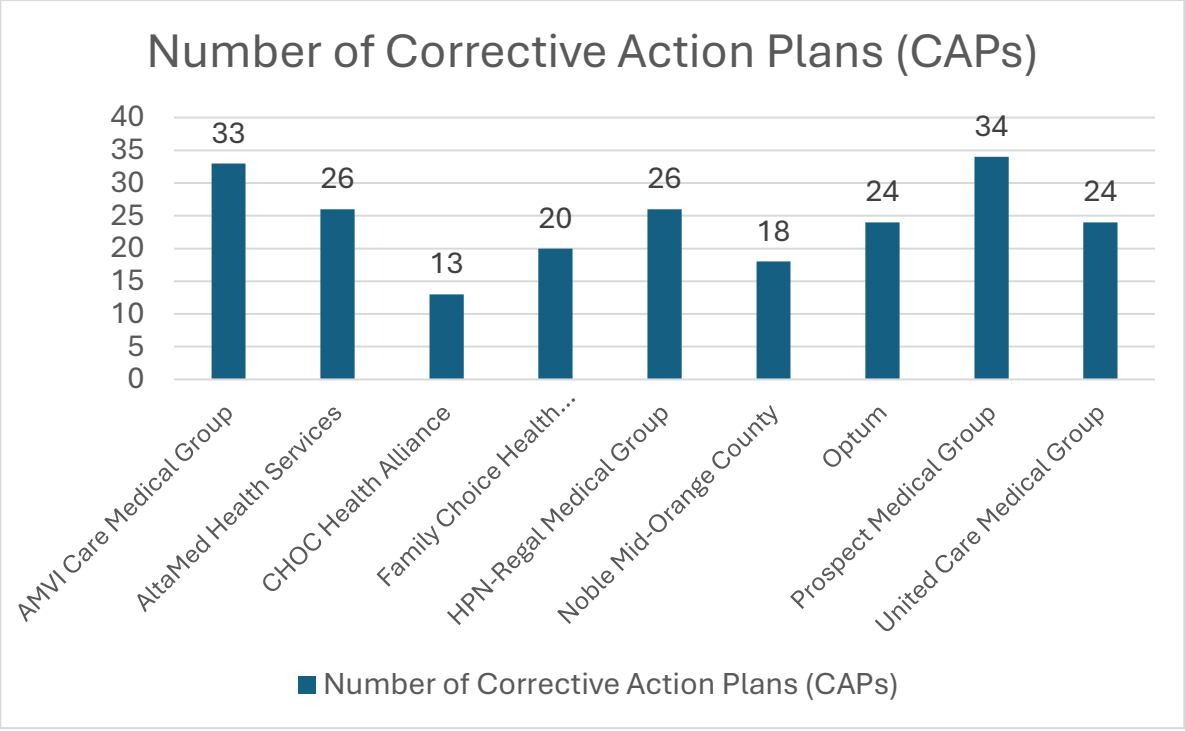
Background:
CalOptima Health contracts with health care providers who are delegated to perform certain administrative services and functions as part of their agreements with CalOptima Health. CalOptima Health performs regular oversight of the delegate's performance to ensure adherence to regulatory, 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 intended to assess the delegate's performance against benchmarks and thresholds and validate regulatory and contractual compliance.

Methodology:
An audit tool and audit preparation guide were developed for 2024, and staff utilized the tool to conduct audits for each health network in 2024.

Actions/Interventions Implemented in 2024:	
Quarter 1:	• Number of Health Network (HN) Audits Completed: 1
Quarter 2:	• Number of HN Audits Completed: 1
Quarter 3:	• Number of HN Audits Completed: 4
Quarter 4:	• Number of HN Audits Completed: 3

Program Results:

Chart A



Quantitative Analysis:
- CalOptima Health conducted an annual audit of all nine HN delegates in 2024, where one delegate was audited in Q1 2024, one was audited in Q2 2024, four were audited in Q3 2024 and three were audited in Q4 2024.
- All delegates were issued CAPs in 2024, with CHA receiving the least number of CAPs at 13 and AMVI Care Medical Group receiving the greatest number at 33 CAPs.

In 2024, a total of 218 CAPs were issued to the nine HN delegates to ensure that they are meeting their contractual obligations.

Identified Barriers:	Identified Opportunities for Improvement:
• Director of Delegation Oversight position was vacant. • HNs were dissatisfied with certain aspects of the oversight process.	• In 2024, the executive team reconfigured the DO Department reporting hierarchy • Delegation oversight audit tools were reconfigured

Conclusion: Annual audits were conducted for each contracted delegate, and CAPs were issued to health networks when findings were identified.
Activities/Interventions to continue/add next year:
• Continue to remain collaborative and transparent with the delegates. Avoid transactional communication but instead develop partnerships to provide our CalOptima Health members with the best member experience and quality work.

3.8 Health Equity	
Business Owner: Katie Balderas	Department: Equity and Community Health
Support Staff: Barbara Kidder/Tristynne Tran	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: • Identify health disparities • Increase member screening and access to resources that support SDOHs • Report on quality improvement efforts to reduce disparities	
Goal Met: ☐ Yes ☐ No ☒ Partial	
Work Plan Planned Activities: • Increase members screened for social needs (ongoing) • Implement a closed-loop referral system with resources to meet members' social needs. (ongoing) • Implement an organizational health literacy (HL4E) project (completed)	
Status: ☐ Completed ☒ Ongoing	
Background: The CalOptima Health Board of Directors approved the 2022–2025 Strategic Plan, which elevated overcoming health disparities as a key strategic priority. This priority continues to guide the development and implementation of strategic initiatives aimed at the prevention and reduction of health disparities to improve member health outcomes and eliminate care barriers. The Health Equity intervention within the Equity and Community Health department is designed to ensure that members are assessed for SDOHs, are connected to resources needed, and have access to high-quality and equitable care. Ongoing efforts include significant investments in technology that enhance both member and provider experiences as well as collaboration with stakeholders to improve health literacy as a pathway to health equity.	
Methodology: The work plan activities are geared toward the implementation of systems and processes to support the program goals. Therefore, data was gathered in the form of progress towards implementation of the different interventions. Where available data was collected on interventions and reported as part of different strategic initiatives, we included it in this evaluation.	
Actions/Interventions Implemented in 2024:	

Quarter 1:	• SDOH assessment was tested for integration with the member portal. SDOH assessment will be built into Jiva as part of the closed-loop referral integration. • The closed-loop referral vendor was selected, and the contracting process began • Among 164 staff who signed up for the HL4E training program, 59 (35%) completed the program and received their certificate.
Quarter 2:	• SDOH member assessment went live in the member portal, and the team continued to build out the assessment for integration into Jiva. • Fully executed contract was completed with FindHelp as the selected closed-loop referral vendor, and working with Jiva for integration was initiated. • HL4E certificate program continued through the end of the year to allow staff to complete their certifications. As of Q2, 73 out of 164 (45%) staff completed their certification program, and four CalOptima Health staff participated in a teach-back method of Train the Trainer training.
Quarter 3:	• The SDOH member assessment was updated with additional questions, and integration into Jiva continued. • Integration meetings with FindHelp and Jiva were kicked off, and a training space for staff was developed. • HL4E certificate program continued through the end of the year to allow staff to complete their certifications. Currently, 74 out of 164 staff have completed their certification program.
Quarter 4:	• The SDOH assessment was updated, and work was done to align the assessment in the member portal, Jiva and FindHelp. • The integration with FindHelp and Jiva began, and a dedicated training space for staff was developed. The integration was anticipated to be completed by January 2025, after which the focus would shift to staff training and tracking outcomes. • HL4E certificate program was completed December 2024, with 75 out of 164 (46%) staff having completed their certification. Any staff in the process of completing their certificate would be able to do so independently through 2025.

Program Results:

Quantitative Analysis:

A. SDOH Screening

1. Member Portal
   a. Successfully developed and integrated an SDOH assessment within the member portal to enhance the documentation of SDOH needs. Through these assessments, members are connected to community resources and support services.
2. SDOH Screening Question for AWV
   a. Provider Incentive
      i. This initiative was successfully implemented through the Medi-Cal Annual Wellness Visit (AWV) program focused on members 45 years or older, which introduced an incentive for qualified providers starting April 1, 2023. This incentive encourages providers to conduct comprehensive AWVs, report confirmed diagnoses, capture SDOH factors and document them appropriately in medical records. Incentives were issued based on completed services and compliant documentation, with payments made on a rolling basis. As of year-to-date, 30,846 Medi-Cal members have completed their AWVs, 15,351 of which were screened for SDOHs.
   b. Provider Education
      i. At the provider level, the intervention encourages the use of SDOH Z-codes to better capture and document SDOHs. To assist providers, a comprehensive SDOH ICD-10-

CM coding and reporting reference guide has been developed to ensure the accurate documentation of priority SDOH data. The tool is in the process of being reviewed and approved for broader dissemination amongst providers.

3. Jiva Integration
    a. The SDOH assessment was also incorporated into Jiva to facilitate the annual assessment of members, refer them to non-medical resources and services, and collect data to inform targeted interventions.
    b. Currently, as part of a closed-loop referral integration into Jiva, we are enhancing the SDOH assessment with additional questions.

B. Closed-Loop Referral

1. The goal of the Closed-Loop Referral initiative is to be able to support members by facilitating navigation, provider referrals, and coordination of health services across health care delivery systems and community-based organizations. Efforts to achieve these goals are progressing well.
2. Released RFP and formalized a contractual agreement with FindHelp to implement a closed-loop referral solution.
3. Collaborating with FindHelp to integrate the closed-loop referral solution into Jiva, with implementation targeted for January 2025.
4. A training schedule has been established to train super-users, with completion planned before the go-live date at the end of December 2024.
5. CalOptima Health is on track to meet the regulatory requirement for implementation by January 2025.

C. HL4E Program

1. The program aimed to enhance organizational health literacy across various systems in Orange County through collaborative efforts. CalOptima Health partnered with the Institute for Healthcare Advancement (IHA), Social Services Agency, HCA, St. Jude Health Center and community residents as part of HCA's Equity in OC Initiative. These partners worked to improve health literacy within organizations across the county. The following activities are included:
    a. Health Literacy (HL) 101: Two educational videos were developed to introduce organizational health literacy (OHL). A total of 418 CalOptima Health staff completed the video training.
    b. Health Literacy Specialist Certificate. This is a rigorous program that provides deep learning for enrollees on health literacy principles. It is composed of seven "micro-credentials:" Organizational Systems and Policies, Communications, Education, Public Health, Ethics and Language Culture and Diversity. The program was estimated to take 55–80 hours to complete, including exams. A total of 152 CalOptima Health staff enrolled in the certificate program. The program is targeted to be completed in December 2024, with 75 out of 164 staff completing their certification program. Any staff currently in the process of completing their certificate may do so independently through 2025.
    c. CalOptima Health participated in a comprehensive OHL assessment conducted by IHA. This assessment is part of a comprehensive review of CalOptima Health's organizational health literacy, conducted by IHA's Chief Policy and Research Officer, Marian Ryan, Ph.D. The aim of the assessment was to identify and prioritize improvement projects to increase OHL. The assessment includes a scan of CalOptima Health's external communications for members, including:
        i. Employee Surveys: The employee survey achieved a strong response rate, with 430 completed surveys representing 24 departments and units. This survey provides valuable insights that will guide future initiatives to enhance workforce development, quality and communication.

ii. Facility “walkthroughs:” The facility walkthrough revealed that the facility has clear signage at the main entrance, but parking directions and visitor spaces are not easily visible. The CalOptima Health building is fully accessible for individuals with disabilities. Reception staff are welcoming, use plain language and assist visitors effectively. Signage is clear and multilingual (English, Spanish, Vietnamese) in the reception area. The overall experience was positive. iii. Phone calls to CalOptima Health's main number: Four phone calls were made (two in English, two in Spanish) with response times ranging from five to 11 minutes. Staff were generally friendly, clear and patient. Two calls provided CalOptima Health information, while two others explained they couldn’t assist due to the caller not being a CalOptima Health member. “Teach-back” was not used to confirm understanding. iv. Website reviews: The website received a high score for organization (4.9), with clear navigation and well-structured content. However, it received a lower score for content (3.0) due to the lack of essential information above the fold, especially on mobile, and the absence of tailored content. CalOptima Health meets 82% of accessibility recommendations. v. Teach-Back Method Workshop: IHA facilitated a four-hour workshop for staff enrolled in the HL Specialist Certification Program to learn and practice the teach-back method. A total of 20 staff from different business units were trained, and five staff participated in a train-the-trainer course to build expertise within the organization.	
Identified Barriers:	Identified Opportunities for Improvement:

A. SDOH Screening • Foster collaboration between different departments to develop and implement a uniform set of SDOH questions to be used across all platforms, providers and departments to ensure consistency and comparability of data. B. Closed-Loop Referral • Identifying a compatible vendor with the capability to integrate into our current health management system. • Extensive contracting process given the magnitude of the project. • Aggressive implementation timelines with dependencies on vendors setting up training space for super-user training completion. • Integration of Community Partners into FindHelp is still pending. C. HL4E Program • The certificate program is a rigorous program that requires time and dedication which makes it difficult for staff to balance with their regular workload and other competing priorities.	A. SDOH Screening • Establish continuous collaboration between the Case Management, Equity and Community Health and Quality Improvement departments to ensure alignment on regulatory requirements, SDOH questions and assessment tools. B. Closed-Loop Referral • Provide cross-training for member-facing staff to ensure consistency in how SDOH assessments are conducted. • Train staff and community partners on referral workflows. • Continue to work with FindHelp for integration and onboarding of trusted community partners C. HL4E Program • Integrate the teach-back method into training and member interactions to ensure understanding and retention of key information. This method is useful in training super-users and ensuring that members fully understand the information being communicated. • Ensure essential information is displayed above the fold on both desktop and mobile versions of the website for easier accessibility and to enhance user experience.
Conclusion: The Health Equity initiatives and interventions outlined in the work plan are progressing well toward their goals of reducing health disparities and improving member health outcomes through enhanced screening, closed-loop referrals and health literacy. We've made incredible strides over the past year, such as the integration of SDOH assessments into the member portal and Jiva, the selection and contract with FindHelp for closed-loop referrals, and the health literacy certification program. While some challenges were encountered, they are being addressed through targeted improvements and cross-departmental collaboration. The program is on track to meet its goals, with efforts to streamline processes, enhance member support and foster community partnerships. Future activities will focus on completing staff training, refining screening tools and launching the closed-loop referral platform for seamless member navigation and support.	
Activities/Interventions to continue/add next year:	
• Continue to monitor improvement for SDOH Z-codes utilization • Continue to monitor SDOH assessments • Staff training on streamlined screening questions and assessments will be conducted • Launch the closed-loop referral platform as integrated into Jiva	

3.9 Long-Term Services and Supports	
Business Owner: Scott Robinson	Department: Long Term Care Supports:

Support Staff: Cathy Osborn	
Work Plan Element: Long-Term Support Services (LTSS)	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: 95% compliance with TAT	
Goal Met: ☐ Yes ☐ No ☒ Partial	
Work Plan Planned Activities:	
Status: ☐ Completed ☒ Ongoing	

Background:
Medi-Cal Managed Long Term Services and Supports (MLTSS) includes two categories with three programs. The purpose of LTSS is to prevent or delay member institutionalization by providing support to CalOptima Health members who require consistent and ongoing caregiving assistance through the coordination of three primary programs:

- Home and Community Based Services (HCBS)
- Community Adult Based Services (CBAS)
- Multipurpose Seniors Services Program (MSSP)
- Institutional/ Nursing Facility
- Long Term Care (includes, Sub-Acute care, Hospice and ICF/DD Homes)

Program Goals:

- Increase access to HCBS
- Safely decrease LTC nursing facility utilization while supporting our members to remain living in the community.
- Improve clinical and quality of living outcomes.
- Build on member choice.

Methodology:
Utilized the Jiva UM TAT detail report.

Actions/Interventions Implemented in 2024:

Quarter 1:	• Met TAT goals of 95%
Quarter 2:	• Met TAT goals of 95%
Quarter 3:	• Met TAT goals of 95%
Quarter 4:	• LTC/CBAS met TAT goals of 95%. CalAIM did not meet the goal. Additional staff have been hired to address the authorization backlog, and daily monitoring is performed. Evaluating process improvement opportunities.

Program Results:

Quantitative Analysis:
LTSS met goals for the first three quarters of the year. However, for Q4, LTC/CBAS met TAT goals of 95%, but CalAIM measures did not meet the 95% TAT goal.
November TAT =91.12%, December TAT = 56.87% (60% below goal) 1,681 authorizations out of compliance.

Identified Barriers:	Identified Opportunities for Improvement:
• Authorization backlog • Short staffing due to terminations and leave of absences • Increase in authorization volume due to changes in the referral process, the eligibility criteria, and the authorization process for several community supports.	• Monitor daily • Crosstrain staff • Obtain staff support from other clinical areas such as UM/CM • Employ temporary nursing staff and medical authorization assistants • Recruit nurses and medical authorization assistants

• General increase volume of CalAIM referrals and requests for authorizations.	• Implement mandatory overtime
Conclusion: Program met TAT goals. CalAIM TAT goals were not met in Q4 2024. Staff will evaluate the process and identify opportunities for improvement.	
Activities/Interventions to continue/add next year:	
• Additional staff have been hired to address the authorization backlog, and daily monitoring is performed. • Evaluating process improvement opportunities.	

3.10 National Committee for Quality Assurance (NCQA) Accreditation

3.10.1 Health Plan Accreditation	
Business Owner: Marsha Choo	Department: Quality Improvement
Support Staff: Veronica Gomez	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by January 1, 2026	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: • Implement activities for NCQA standards compliance for HPA and Health Plan Renewal Submission by April 30, 2024.	
Status: ☒ Completed ☐ Ongoing	
Background: CalOptima Health has been accredited by NCQA for its Medicaid line of business since 2012. In July 2024, CalOptima Health completed its fourth renewal for NCQA Health Plan Accreditation for the Medicaid-HMO product line, successfully securing accredited status through July 10, 2027. Our accreditation scores are based on annual HEDIS and CAHPS results, with the survey conducted every three years. The next submission date for CalOptima Health is scheduled for April 6, 2027, covering a look-back period from April 6, 2025, to April 6, 2027. Additionally, CalOptima Health will be required to complete a virtual file audit on May 24–25, 2027.	
Methodology: CalOptima Health undergoes re-accreditation every three years. NCQA has a look-back period of two years.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• CalOptima Health submitted a delegation worksheet, agenda for virtual file review and PHM Worksheet that list programs that involve with Interactive Contract • NCQA program manager provided status updates to stakeholders on the status of open items and areas of risk
Quarter 2:	• NCQA renewal submission was on April 30, 2024. Document submission included more than 400 documents and file review universes. • CalOptima Health had a virtual file review audit with NCQA surveyors on June 17–18, 2024. UM appeals (CHCN), UM medical denials (BH, Pharmacy) for both CHCN and delegate files, credentialing/recredentialing (CHCN and delegate), complex case management (CHCN and delegates)
Quarter 3:	• Received final report and decision results letter from NCQA on August 6, 2024.

	• Quality Improvement (QI) developed a remediation plan for elements/factors missed. • NCQA released the 2025 Health Plan (HP) Standards, which were shared with internal stakeholders in September 2024.
Quarter 4:	• NCQA consultants developed an HP work plan to monitor and track all of the deliverables needed. • Consultants performed standards training October–November 2024 (Quality Improvement, network management, member experience, UM, credentialing and recredentialing, PHM. • Consultants performed file review audits in November 2024 on UM appeals (CHCN), UM medical denials (BH, Pharmacy) for both CHCN and delegate files, credentialing/recredentialing (CHCN and delegate), complex case management (CHCN and delegates). • Consultants performed analytical reports training in December 2024.

Program Results:

- CalOptima Health was once again awarded accredited status for the fifth time in July 2024. Our NCQA Health Plan accreditation will be valid through July 10, 2027.
- CalOptima Health achieved a score of 135.50 out of a possible 140 points.
- Our NCQA Health Plan Rating was updated on September 15, 2024, and achieved a rating of 3.5 Stars.

Quantitative Analysis:
Document submission included more than 400 documents along with file review universes. CalOptima Health lost points in the NET and ME domains but still met the 80% threshold required to meet accreditation.

Point Loss Areas

- Network Management: Three issues were identified
  - NET3A-C**:** Annual reports did not reflect out-of-network utilization data for non-behavioral and BH services**.**
- Member Experience: Three issues were identified
  - ME2B: Member newsletters did not include a link or direction to specific information on the website to access subscriber information.
  - ME7C: Annual assessment reports of nonbehavioral complaints and appeals missing out-of-network utilization.
  - ME8C: Review of semiannual reports missing.

Identified Barriers:	Identified Opportunities for Improvement:
• Conflicting feedback between consultants when assessing reports. • Report writing seems to be challenging for some business owners. • File review continues to have some challenges for some delegates and internal staff.	• (QI) Update Policy GA.8060: Recruitment, Selection, and Hiring. • (PHM) Update policy GG.1211: Health Appraisals and Self-Management Tools. • (NET) sample size and response rates must be in all reports. Annual reports will need to include missing out-of-network data identified during the survey, and the CalOptima Health website needs to be updated to include hospital accreditation status. • (CR) Update Policy GG.1659: System Controls of Provider Credentialing Information. The Annual CR Audit report will need to be clearer to avoid confusion identified during submission.

	• (ME) Annual reports will need to include missing out-of-network data identified during the survey. Member newsletter minor edits needed to add missing factors. • Hire additional staff to oversee NCQA accreditation. • Train delegates on universe submission • Delegates need training on how to prepare files for NCQA audits. • Report writing training
Conclusion: Overall, the NCQA HP renewal was successful. NCQA stakeholders will work on the areas where points were lost to ensure full compliance in upcoming reports. We anticipate a successful renewal in April 2027.	
Activities/Interventions to continue/add next year:	
• Begin HPA document review • Begin development of HPA gap assessment • Kick-off meeting to begin document review and collection for the new document review look-back period (April 6, 2025–April 6, 2027) • Continue to manage the NCQA project and assist business areas in meeting all deliverables needed. • Submit NCQA HP renewal application. • Train two new program managers who will oversee NCQA Health Plan and Health Equity Accreditation submission.	

3.10.2 Health Equity Accreditation	
Business Owner: Marsha Choo	Department: Quality Improvement
Support Staff: Veronica Gomez	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☒ Yes ☐ No
Work Plan Goal/Objective: • CalOptima Health must have full Health Equity Accreditation by January 1, 2026.	
Goal Met: ☐ Yes ☐ No ☒ Partial	
Work Plan Planned Activities: • Develop strategy and work plan for Health Equity Accreditation with 50% document collection for submission.	
Status: ☐ Completed ☒ Ongoing	
Background: DHCS requires all health plans to obtain Health Equity Accreditation by January 1, 2026. We have a submission date of October 7, 2024. To meet this requirement, CalOptima Health has established a Health Equity Committee, which includes five workgroups. The Health Equity Committee receives regular status updates, while the workgroups convene frequently to share progress reports. Our look-back period is the six-month span from April 7, 2025, to October 7, 2025. To earn accreditation, CalOptima Health must meet at least 80% of applicable points.	
Methodology: To help organizations identify disparities, address social risk factors, and work toward dismantling the systemic and structural barriers that generate bias or discrimination in health care, CalOptima Health will be pursuing an initial Health Equity Accreditation which will have a six-month look-back period.	

Health Equity standards evaluate organizations on: • HE1: Organization Readiness • HE2: Race/Ethnicity, Language, Gender Identity and Sexual Orientation Data • HE3: Access and Availability of Language Services • HE4: Practitioner Network Cultural Responsiveness • HE5: Cultural and Linguistically Appropriate Service Programs • HE6: Reducing Health Care Disparities • HE7: Delegation of Health Equity Activities	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Purchased current 2024 Health Equity Standards • CalOptima Health engaged our NCQA consultant to conduct a readiness assessment and gap analysis. • NCQA consultants provided recommendations and developed a work plan. • CalOptima Health developed a Health Equity Steering Committee and five work groups for implementation. A project manager was assigned to each of the workgroups. • Reviewed 2024 HE Standards (HE1) • Work started on the member survey to collect data from members (HE2) • Evaluated existing documentation and reports provided by the previous consultant and identified the next steps (HE3) • Developed a high-level project plan
Quarter 2:	• Health Equity Accreditation project kickoff meeting on May 21, 2024 • Health Equity Guidelines and Elements Training on June 11, 2024 • Built systems and processes for the domains HE1–HE6 May 1, 2024–December 1, 2024 • CalOptima Health is engaged with NCQA consultants to conduct a readiness assessment and perform a gap analysis which was shared with executive leadership and stakeholders • Consultants provided recommendations and developed a work plan. • Identified key documents for review and/or creation (HE1) • New fields were added to the core system to collect and store all the data elements required. (Added: Sexual orientation, gender identity: was already collecting race, ethnicity and language [HE2]) • Developed the survey to collect data from members (HE2) • Revised Notice of Privacy Practice (NPP) to meet the standards (HE2) • Collect current contract amendments related to translation vendors (HE3) • Reviewed current desktop procedures (HE3) • Screenshots related to practitioner training, copies of training (HE3) • Identified team members that play a key role in meeting the elements and factors (HE4) • Identified the documents (desktop procedures, policies, and forms) that would need to be updated. (HE4) • Conducted HE5/6 discovery. (HE5/6) • Developed HE5/6 work plan and timelines. (HE5/6) • Vetted subject matter experts to participate in workstream. (HE5/6) • NCQA-HE5 Workstream launched on May 21, 2024. Developed 2024 CLAS Program, SMART goals and work plan. (HE5/6) • Implemented Health Disparity Remediation Well-Child Call Campaign for Black/African American members. (HE5/6)

Quarter 3:	• Health Management Associates (HMA) was retained by CalOptima Health to provide guidance and assistance in achieving both Health Plan (HPA) and Health Equity Accreditation (HEA) • Consultants completed kick-off meetings with CalOptima Health and HMA teams • The CalOptima Health team began uploading documents for review and has continued to share documents with the HMA team as they become available • Confirmed definitions for staff/leadership, committees and governing bodies. (HE1) • Analyzed results from Great Places to Work Survey from April 2024. (HE1) • Surveys were mailed out to members (new members over 18 years) (HE2) • Umbrella policy was drafted to document CalOptima Health's process to collect and store member data (HE2) • Worked with Communications to ensure updated tag lines were included in the annual newsletter for non-discrimination notices (HE3) • Confirmed how provider race/ethnicity, language fluency and practice languages will be collected (HE4) • Developed process on how data will be housed in Facets (HE4) • CalOptima Health Board of Directors approved 2024 CLAS Program and Workplan. (HE5/6) • Implemented 2024 CLAS Program and Workplan monitoring. (HE5/6) • Met with Inland Empire Health Plan to explore best practices to survey member experience on language services (HE6) • Established monthly monitoring reports for language service utilizations (HE6) • Stratified and analyzed CBP, HBD, PPC and WVC HEDIS measures by race and ethnicity (HE6) • Stratified and analyzed HBD HEDIS measures by language and gender (HE6) • Stratified and analyzed CAHPS measures by language and race/ethnicity (HE6)
Quarter 4:	• CalOptima Health is engaged with NCQA consultants to conduct a readiness assessment and perform a gap analysis • Consultants have been providing recommendations and have developed a work plan. • Submitted NCQA HE application and given a survey date of October 7, 2025 • Legal, Chief Health Equity Officer and Chief Human Resources Officer review of surveys and informational text (HE1) • Chief Human Resources Officer announcement during November All-Staff CalTeams Meeting (HE1) • Submitted documents to Communications for review and approval (HE1) • Privacy Protection Policy was finalized and approved by the board (HE2) • Provided member-facing staff with access to members' pronouns (HE2) • NPP will be distributed to members in the December Member Newsletter; surveys will be available in the member portal by the end of December 2024 (HE2) • In progress: Working with Customer Service to draft summary report (Net 1 A-Annual Availability of Practitioners Cultural Needs and Preferences) to be reviewed by the consultant (HE3) • Survey was sent out to all contracted providers (HE4) • All documents were finalized and updated per HE4 requirements. (HE4) • Began drafting 2024 CLAS Program Evaluation. Describing complete and ongoing activities, treading measures and barrier analysis (HE5/6) • Began drafting 2025 CLAS Program Description (HE5/6) • Developed CLAS satisfaction surveys for staff and members (HE5/6) • Developed survey dissemination plan (HE5/6)

	• Implemented Health Disparity Remediation Perinatal Care Call Campaign for Black/African American/Native America members (HE5/6) • Drafted evaluation to measure the effectiveness of the interventions to improve CLAS and reduce health inequities (HE5/6)

Program Results:

HE1 Workstream

- New DEI Umbrella Policy (Feb 2025 Board Meeting)
  - Updated HR policy GA.8060: Recruitment, Selection and Hiring (Dec 2024 Board Meeting)
  - DEI surveys for staff/leadership, QIHEC committees and board advisory committees support documents for exemption from governance bodies' requirements

HE2 Workstream:

- Developed and completed survey to collect data
- Developed and completed the Privacy Protection Policy
- Developed and completed the NPP
- Developed policy for Collection of Race, Ethnicity, Language, Sexual Orientation and Gender Identity Data Process (in final phase of revision and approval**)**

HE3 Workstream:

- Updated the following Desktop Procedures (DTPs) to include content/evidence related to NCQA certification
  1. DTP-Process for Translation Competency Test
  2. DTP-Procedure for Auditing Translation Services
  3. DTP-Procedure for Coordinating Interpreter Request via Facets and K2 Update
  4. Provider Calls DTP
  5. DTP- Processed for Translation and Review Services Timelines
- In the process of drafting NET1A summary report to share via website to our practitioners
- Drafted taglines for annual nondiscrimination notice

HE4 Workstream:

- Provider Satisfaction Survey that included health equity questions was created and sent out to all contracted practitioners
- DTP “Provider Data Collection for Cultural Responsiveness” was created to document the process of collecting provider data
- Crosswalk for Practitioner Race and Ethnicity created to include required OMB categories for the Customer Service department to use
- Provider directory updates to include HE 4 data
- New policy EE.1146 developed and created to describe the provider directory to include practitioner race/ethnicity, language fluency and practice language.
- Notification went out to members informing them that race/ethnicity data will be available if wanted.

HE5/6 Workstream:

- 2024 CLAS Program Description and SMART goals were developed and approved by CalOptima Health’s Board of Directors.
- HE6-Reporting on stratified measures
- HE6-Analysis to identify disparities.
- HE6-Developed CLAS satisfaction surveys for staff and members

Quantitative Analysis:

- Consultants have reviewed a total of 116 documents

• Responded to 49 questions • Completed two gap assessment reports. • To be determined: Pending survey results in January 2025 (HE1) • 24 contracted practitioners completed the survey with Health Equity data. (HE4) • CLAS SMART goals were on track to meet as of third quarter. Final results will be available as part of the 2024 QIHETP Evaluation. (HE5/6)	
Identified Barriers:	Identified Opportunities for Improvement:
• No authority over CalOptima Health's Board of Directors membership (HE1) • No identified barriers (HE3) • Low participation on the Provider Satisfaction Survey (< 1%) (HE4) • Capacity to implement interventions to meet SMART goals (HE5/6)	• Expanding capacity in terms of staffing, community collaborations and allocation of resources (HE5/6)
Conclusion: All workstreams are progressing well and are on schedule to meet the submission deadline.	
Activities/Interventions to continue/add next year:	
HE1 Workstream • Collect and analyze survey results • Identify opportunities and draft an action plan • Collect training documents • Collect training results reports HE3 Workstream • Follow up with contracting if new amendments are drafted. • Update DTPs (if applicable) • Finalize annual Net1 A report and share it with practitioners • Update screenshots based on the revised CalOptima Health website HE4 Workstream • Draft, review and analyze the NET1A report • Update Customer Service DTP to include how to provide race/ethnicity data when requested. Include HE4 data in the new Salesforce system to be implemented in 2025. HE5/6 Workstream • Leveraging support cross-agency support to carry out SMART goals. Continue building partnerships with the community	

3.11 Quality Performance Measures

3.11.1 Medi-Cal: Managed Care Accountability Set (MCAS)	
Business Owner: Paul Jiang	Department: Quality Analytics
Support Staff: Terri Wong	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: • Track and report quality performance measures required by regulators	
Goal Met: ☒ Yes ☐ No ☐ Partial	

Work Plan Planned Activities: • Track rates monthly • Share final results with QIHEC annually	
Status: ☒ Completed ☐ Ongoing	
Background: DHCS releases the MCAS measures each year. Part of the measures have a minimum performance level (MPL) requirement, which is the 50th percentile based on the Quality Compass.	
Methodology: Quality Analytics generates monthly MCAS measures performance reports, which monitor performance at the CalOptima Health and HN levels. The final results are reported to DHCS in June 2024.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Begin HEDIS Measurement Year (MY) 2023 data collection and reporting activities
Quarter 2:	• Continue MY2023 data collection and reporting including finalizing HEDIS compliance audit
Quarter 3:	• Final results reported at QIHEC in August 2024
Quarter 4:	• Analyze MY2023 against goals and establish goals for the following year
Program Results:	
Quantitative Analysis: • Six out of 18 MCAS selected measures that have an MPL requirement achieved the MPL • Follow-up After ED Visit for Alcohol and Other Drug Dependence within 30 days (FUA) did not meet MPL • Follow-up After ED Visit for Mental Illness within 30 days (FUM) didn't meet MPL	
Identified Barriers:	Identified Opportunities for Improvement:
• BH benefits are partially carved out • Unable to identify the ED visits in a timely manner	• Lack of data for the BH services not paid by CalOptima Health
Conclusion: Unable to identify the ED visits in a timely manner to schedule a follow-up visit and lack of data for the BH services not paid by CalOptima Health because of BH benefits carved out.	
Activities/Interventions to continue/add next year:	
• Using ADT data feed to notify providers of ED visits • Working on data exchanges with the county BH service agency.	

3.11.2 OneCare: Stars Performance Measures	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Kelli Glynn	
Products: ☐ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: • Achieve 4 or above	
Goal Met: ☐ Yes ☒ No ☐ Partial	
Work Plan Planned Activities: • Review and identify Stars measures for focused improvement efforts.	
Status: ☐ Completed ☒ Ongoing	
Background: CalOptima Health annually collects, tracks and reports quality performance measures, including the CMS Star measures, to CMS. Measures are calculated and reported at the required reporting unit	

level and are stratified according to requirements. The results are compared against NCQA national percentiles and the Star cut points as benchmarks.

Methodology:
Star ratings data are collected in various ways. For HEDIS measures, we use the HEDIS methodology. We also have survey-based measures for member experience (CAHPS) and member health outcomes (HOS). Appeals and complaints information is gathered through CMS vendors and CMS directly, in addition to call surveillance by CMS. Pharmacy data is also collected through prescription drug event data.

Actions/Interventions Implemented in 2024:	
Quarter 1:	• Stars Steering Committee • Just in Time CAHPS outreach • Ushur text campaigns • Member incentives • Bi-monthly quality meetings with HNs
Quarter 2:	• SullivanLuallin Group lunch and learns
Quarter 3:	• Stars working sessions • Exact Sciences program for colorectal cancer screening
Quarter 4:	• Pharmacy strike force team • SullivanLuallin Group Site coaching • Executive Stars Steering Committee

Program Results:

Quantitative Analysis:
Overall performance was lower for Stars compared to the previous year. The main area of concern is the member experience CAHPS survey, where there was not a single measure above 2 Stars. In addition to CAHPS, Part D measure performance continues to decrease from previous years.

Identified Barriers:	Identified Opportunities for Improvement:
• Timeliness of data • Ability to consume data from external partners on a recurring and timely basis • Vendor challenges (Transportation)	• Member experience (CAHPS) • Part D performance • Expand ADT data to allow for better coordination of care and timeliness of discharge-based measures

Conclusion: While there has been improvement in some areas, overall, the performance of the program has either decreased or been stagnant. Increased awareness and education of Stars is a key component that must improve organizationally.

Activities/Interventions to continue/add next year:

- Continue with all identified interventions above
- Stars Analytics Tool – Q1 2025
- Optimized reporting from new HEDIS software

3.12 Utilization Management Program

Business Owner: Stacie Oakley

Support Staff: Lorena Moore

Executive Summary: CalOptima Health transitioned into a new clinical documentation platform in February 2024 impacting variations in the layout of reporting UM data compared to previous versions. Workflow process improvements were enhanced and implemented in February 2024 including the transition to a new clinical documentation platform, Jiva. Efforts are reflected in the UM referral

statistics outlined above. Medi-Cal and OC prior authorization turnaround time compliance remained above goal of 95% from Q4 2023 – Q3 2024. In addition, pharmacy turnaround time compliance remained above of 95% from Q4 2023 – Q3 2024.

TANF 18+ and TANF under 18 remained above goal with the exception of TANF 18+ in Q4 2023 which was under the inpatient bed day goal. Medi-Cal and OneCare inpatient turnaround time goals were above goal in Q4 2023-Q3 2024 with the exception of February 2024 for urgent cases. Retrospective goals were not met in several quarters in Q4 2023 – Q3 2024. The utilization data showed an increase in volume of obstetric admissions in TANF 18+ and Neonatal in TANF under 18 that will be reviewed in greater detail by the medical director and clinical leadership team in routine utilization sub-workgroups, targeted UM and CM workgroups and UMC for formal reporting.

Additional improvements included the addition of one (1) Medical Director to support Medical Management Departments. Process improvements contributing to the 2024 UM Program include but are not limited to improved workflows, standardized documentation templates, enhanced LOA process, enhanced continuity of care process, enhancements of a TCS program, oversight of over and underutilization patterns, and UM oversight of CalOptima Health's delegated entities. In addition, the following workgroups were developed to concentrate on specific areas within Medical Management, Case Management Workgroup and the EPSDT Workgroup.

Staffing metrics and productivity standards were enhanced to ensure staff are working to their full capability and to address staffing needs.

The UMC, UM Medical Directors and Behavioral Health Medical Director continue to guide and support the CalOptima Health integrated UM/CM Program (medical, behavioral and pharmacy). The UMC, QIHEC and Medical Director's continued to guide and support process improvement, review and address over and under-utilization trends and continues to enhance the CalOptima Health UM/CM Program through Committee and Workgroup efforts.

3.13 Value-Based Payment

3.13.1 Health Network Quality Rating – Pay for Value	
Business Owner: Linda Lee	Department: Quality Analytics
Support Staff: Paul Jiang	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants	
Goal Met: ☐ Yes ☐ No ☒ Partial	
Work Plan Planned Activities: Share HN performance on all P4V HEDIS Measures via prospective rates report each month.	
Status: ☐ Completed ☒ Ongoing	
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.	
Methodology: Data is gathered through the HEDIS data collection methodology and through member experience CAHPS survey methodology.	

Actions/Interventions Implemented in 2024:	
Quarter 1:	• Generate and share monthly prospective rate reports with HNs and CHCN clinics and providers to show their performance on all clinical HEDIS P4V measures • Bi-monthly quality meetings with HNs • Quarterly Health Network Collaborative Quality Forum
Quarter 2:	• Health Network Comparison reporting showing performance of HNs relative to peers
Quarter 3:	• Develop P4V Program for the following year
Quarter 4:	• Health Network Report Cards that summarize their performance and Health Network Quality Rating on all clinical HEDIS P4V measures and CAHPS member experience surveys.
Program Results:	

Table A

Health Network Quality Rating Member Experience – Medi-Cal	Survey	# Measures	Total Weight	Total Points	CAHPS Rating
CalOptima Health	Adult	8	12	27	2.5
AltaMed	Adult	8	12	40.5	3.5
AMVI Care	Adult	8	12	13.5	1
CHCN	Adult	8	12	37.5	3
CHOC	Adult	5	7.5	26.5	3.5
Family Choice	Adult	8	12	16.5	1.5
Heritage-Regal	Adult	8	12	26.5	2
Noble	Adult	8	12	36	3
Optum	Child	6	9	19.5	2
Prospect	Adult	8	12	25.5	2
UCMG	Adult	8	12	15	1.5

Table B

Health Network Quality Rating HEDIS – Medi-Cal	# HEDIS Measures	Total Weight	Total Points	HEDIS Rating
CalOptima Health	15	15	53	3.5
AltaMed	15	15	51	3.5
AMVI Care	15	15	52	3.5
CHCN	15	15	53	3.5
CHOC	13	13	39	3
Family Choice	15	15	48	3
Heritage-Regal	11	11	27	2.5
Noble	15	15	45	3
Optum	15	15	43	3
Prospect	15	15	46	3
UCMG	15	15	47	3

Table C

Health Network Quality Rating Overall – Medi-Cal	# Measures	Total Weight	Total Points	Overall Rating
CalOptima Health	23	27	80	3.5
AltaMed	23	27	91.5	4
AMVI Care	23	27	65.5	3
CHCN	23	27	90.5	4
CHOC	18	20.5	64.5	3.5
Family Choice	23	27	64.5	3
Heritage-Regal	19	23	52.5	3
Noble	23	27	81	3.5
Optum	21	24	62.5	3
Prospect	23	27	71.5	3
UCMG	23	27	62	3

Table D

Health Network Quality Rating Member Experience – OneCare	# Measures	Total Weight	Total Points	CAHPS Rating
CalOptima Health	3	12	24	2
AltaMed	3	12	44	3.5
AMVI Care	3	12	28	2.5
CHCN	3	12	40	3.5
Family Choice	3	12	44	3.5
Heritage-Regal	3	12	48	4
Noble	3	12	40	3.5
Optum	3	12	52	4.5
Prospect	3	12	44	3.5
UCMG	3	12	44	3.5

Table E

Health Network Quality Rating HEDIS – OneCare	# HEDIS Measures	Total Weight	Total Points	HEDIS Rating
CalOptima Health	5	7	26	3.5
AltaMed	5	7	29	4
AMVI Care	5	7	32	4.5
CHCN	5	7	23	3.5
Family Choice	5	7	27	4
Heritage-Regal	5	7	31	4.5
Noble	5	7	19	2.5
Optum	5	7	23	3.5
Prospect	5	7	23	3.5
UCMG	5	7	27	4

Table F

Health Network Quality Rating Part D – OneCare	# Part D Measures	Total Weight	Total Points	Part D Rating
CalOptima Health	4	10	27	2.5
AltaMed	4	10	16	1.5
AMVI Care	4	10	32	3
CHCN	4	10	23	2.5
Family Choice	4	10	38	4
Heritage-Regal	4	10	22	2
Noble	4	10	16	1.5
Optum	4	10	26	2.5
Prospect	4	10	27	2.5
UCMG	4	10	43	4.5

Table G

Health Network Quality Rating Overall - OneCare	# Measures	Total Weight	Total Points	Overall Rating
CalOptima Health	12	29	77	3
AltaMed	12	29	89	3.5
AMVI Care	12	29	92	3.5
CHCN	12	29	86	3.5
Family Choice	12	29	109	4.5
Heritage-Regal	12	29	101	4
Noble	12	29	75	3
Optum	12	29	101	4
Prospect	12	29	94	3.5
UCMG	12	29	114	4.5

Quantitative Analysis: For the Medi-Cal population, two HNs saw an increase in their overall performance, three saw a decrease and five stayed the same year over year. Results were similar for the OneCare population.

Identified Barriers:	Identified Opportunities for Improvement:
• Timeliness of data • Limited supplemental data	• Optimize reporting from new HEDIS software • Increase frequency of supplemental data feeds from external partners

Conclusion: Overall, the program continues to be successful with room for improvement. The program serves as an incentive to continue to seek quality improvement.

Activities/Interventions to continue/add next year:

- Quality Grant Program – Utilizing unrealized P4V dollars to award grants to HNs for quality improvement initiatives

3.13.2 Five-Year Hospital Quality Program	
Business Owner: Linda Lee	Department: Quality Analytics
Support Staff: Ruby Nunez	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Work Plan Goal/Objective: • Report on calculation of performance, distribution of incentives, and solicitation of feedback.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: • Share hospital quality program performance	
Status: ☐ Completed ☒ Ongoing	

Background: In 2023, CalOptima Health established a Hospital Quality Program to encourage eligible facilities to improve quality of care through increased patient safety efforts and performance-driven processes. Using MY2023 data, the first incentive payments were awarded to facilities in 2024.

Methodology: The Hospital Quality Program consists of three metrics: Quality performance, Patient Experience and Hospital Safety. Hospital quality performance and patient experience data is gathered from Hospital Compare, ranging from 1 to 5 Stars. Hospital safety data is gathered from the Leapfrog Group, ranging from a grade of A to F. Hospitals not listed on Hospital Compare for quality and patient experience will be assessed using the Leapfrog rating.

Actions/Interventions Implemented in 2024:

Quarter 1:	• Review hospital quality program at joint operations meetings
Quarter 2:	• Review hospital quality program at joint operations meetings
Quarter 3:	• Calculate hospital performance and incentive amounts
Quarter 4:	• Distribute individual hospital scorecards and incentive awards

Program Results:

Hospital	Hospital Quality STARS Rating	Hospital Patient Survey Rating	Leapfrog Hospital Safety Guide	Maximum Incentive Possible	Incentive Earned
Anaheim Regional Medical Center	★★★	★★	B	$1,413,638	$494,773
Anaheim Global Medical Center	N/A	★★	C	$265,834	$26,583
Chapman Global Medical Center	★	★	D	$155,157	$0
Children's Hospital of Orange County	★★★★★	★★★★★	B	$3,598,119	$3,418,213
Foothill Regional Medical Center	N/A	★	N/A	$627,218	$0
Fountain Valley Regional Hospital & Medical Center	★★	★	D	$3,456,890	$0
Hoag Memorial Hospital Presbyterian	★★★★★	★★★★	A	$1,940,663	$1,746,597
Los Alamitos Medical Center	★	★★	D	$404,816	$0
Memorial Care Long Beach Medical Center	★★	★★★	C	$207,276	$62,183
Memorial Care Miller Children's and Women's Hospital	★★	★★★	C	$ -	$ -
Memorial Care Orange Coast Medical Center	★★★★	★★★	C	$1,120,696	$672,418
Memorial Care Saddleback Medical Center	★★★	★★★	B	$412,305	$226,768
Orange County Global Medical Center	★	★★	D	$2,013,149	$0
Placentia Linda Hospital	★★	★★★	C	$360,336	$108,101
Pomona Valley Hospital Medical Center	★★★★	★★★	A	$29,354	$20,548
Providence Mission Hospital	★★★★	★★★	B	$1,305,806	$848,774
Providence St. Joseph Hospital	★★★★	★★★★	B	$2,881,640	$2,161,230
Providence St. Jude Medical Center	★★★★	★★★	B	$1,355,978	$881,386
South Coast Global Medical Center	N/A	★	D	$359,887	$0
UCI Medical Center	★★★★	★★★★	A	$5,881,296	$4,705,037
Whittier Hospital Medical Center	★★★	★★	B	$53,167	$18,608
Totals				**$27,843,225**	**$15,391,219**

Quantitative Analysis: As this is the first year of the Hospital Quality Program, these results will be used as a baseline. Of the total incentive available, 53% was awarded to the facilities. However, nearly half of the eligible facilities, 44%, received zero of their eligible incentive dollars.

Identified Barriers:	Identified Opportunities for Improvement:
• Not every hospital is able to report data	• Discussing alternative measurement sets (i.e. pediatric hospitals) • Significant pool of unearned incentive funds

Conclusion:
The hospital quality program aims to improve quality through tracking of public data. Recognizing that improvement efforts take time to realize an impact, the hospital quality program is a multi-year initiative. 2023 is the first year of the program and establishes a foundation of performance. Future improvements

are aimed at improving performance, expanding measurement sets for hospitals that do not report to CMS, and providing options for use of unearned incentive funds.
Activities/Interventions to continue/add next year:
• Develop options to use unearned incentive funds for quality improvement initiatives • Expanding measurement sets for pediatric hospitals

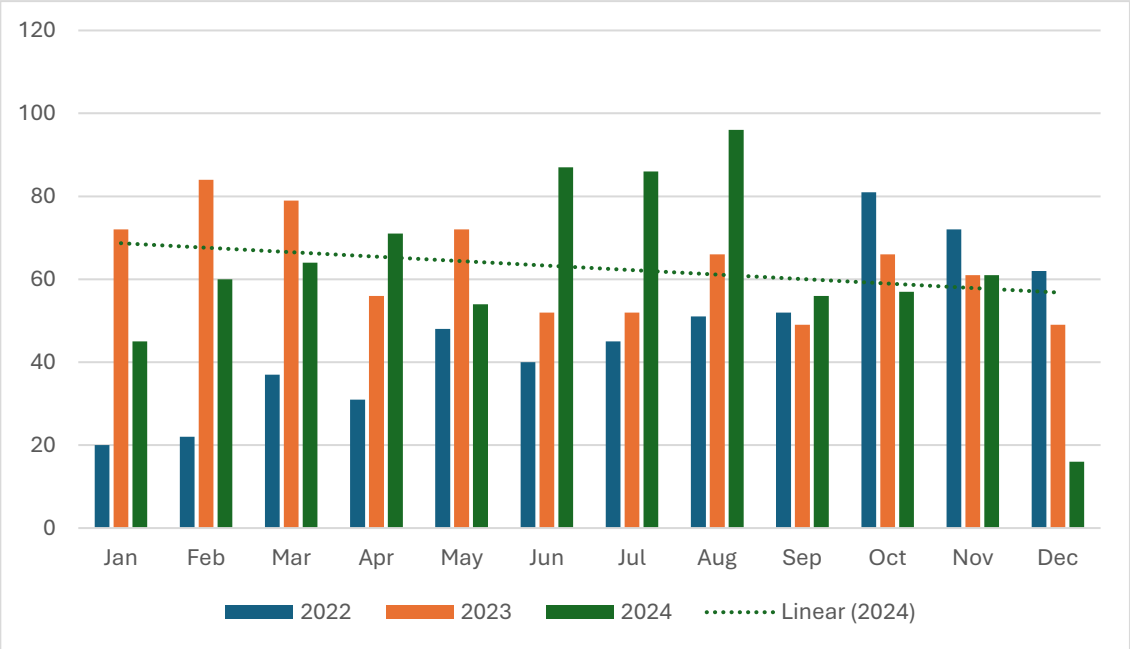
Section 4: Quality of Clinical Care

4.1 Quality Oversight

4.1.1 Potential Quality Issues (PQI) and Provider Preventable Conditions	
Author: Laura Guest, Manager	Department: Quality Improvement
Responsible Party: Laura Guest, Manager	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Referred quality of care grievances and PQIs are reviewed in a timely manner Identify quality-of-care issues and trends and implement appropriate actions. ○ PQI case initially reviewed by the medical director within 90 days of opening the case. ○ Declined Grievances reviewed by the medical director in 30 days. We have defined Declined Grievances as grievances that have a quality-of-care component, but the members choose not to file a formal grievance and are investigated as a PQI.	
Goal Met: ☐ Yes ☐ No ☒ Partial	
Work Plan Planned Activities: Review and report if conducted referred cases are properly reviewed by appropriate clinical staff, cases are leveled according to severity of findings and recommendations for actions are made, which may include a presentation to the CPRC for peer review.	
Status: ☐ Completed ☒ Ongoing	
Background: • PQIs are clinical investigations of providers to determine if the care provided meets evidence-based and community standards. Investigations include the review of all provider types in the CalOptima Health provider network, including physicians, mid-level practitioners, hospitals, home health agencies, etc. Information, which is specific to the case and may include medical records and a response to the issue, is obtained and summarized by a nurse. A medical director reviews the information, 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 on urgent clinical issues and assisting the medical directors with a clinical response, which is included in the member grievance letter sent by the GARS team.	
Actions/Interventions Implemented in 2024:	
• In May 2024, CalOptima Health implemented a new care management system (Jiva). A new module of the system, Jiva by ZeOmega, was developed specifically for PQI. Important aspects of the system were to ensure the data is solely accessible by the PQI team and that the data is provider-centric. • One additional nurse was hired in 2024 to help with the volume of PQI cases and to provide coverage for quality-of-care grievances when needed. • In July 2024, the nurses began providing coverage for the quality-of-care grievances on Fridays and the day prior to a holiday weekend until 5 p.m. to ensure that we meet the TAT for quality-of-care grievances for GARS.	

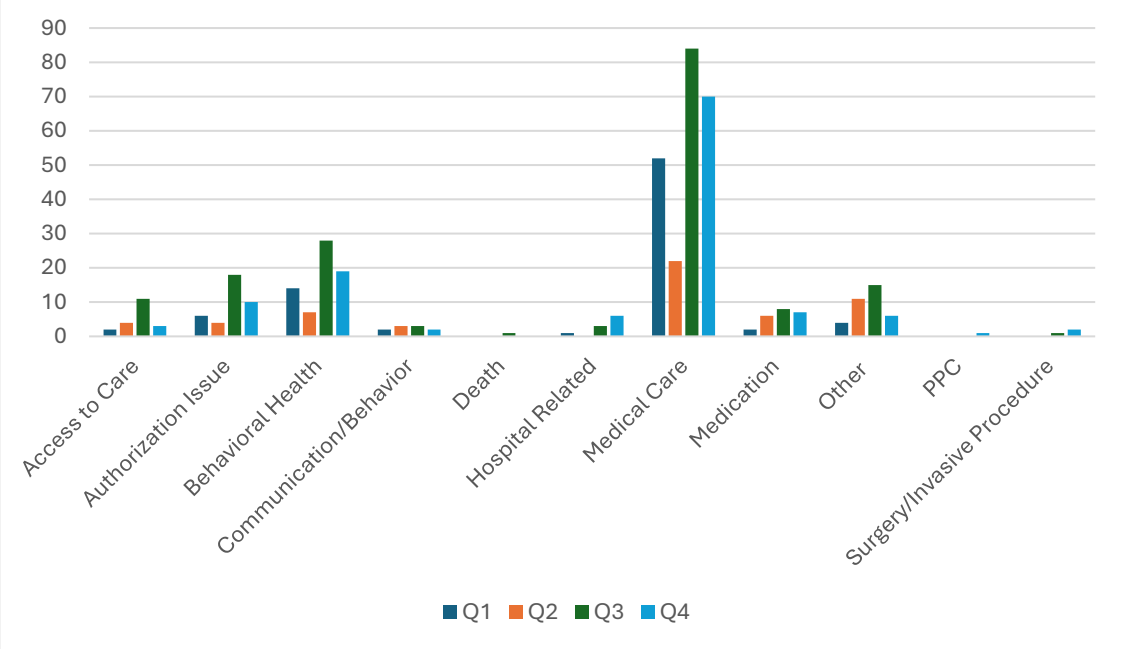
Program Results:

Chart A – Number of Newly Opened PQIs by Month 2022 to 2024



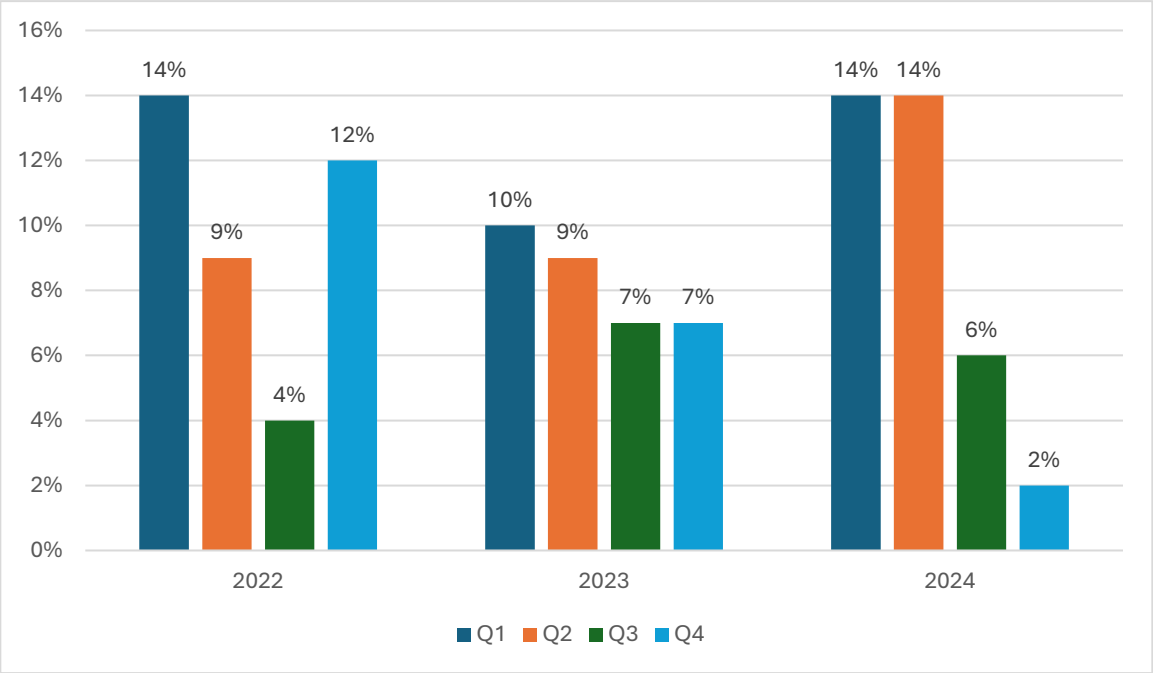
In 2024 the number of cases opened each month spiked in June, July and August, but dropped thereafter.

Chart B – Number of PQIs by Category by Quarter



The number of cases categorized as related to Medical Care was the most of all categories quarter over quarter.

Chart C – Percent of PQIs Cases Presented to CPRC



The percent of cases presented was very high in Q1 and Q2 at 14% but appears deflated in Q3 and Q4 due to the increased denominator of number of cases closed.

Quantitative Analysis:

- The overall volume of PQIs remained high in 2024. This trend continues as the medical directors are identifying more PQIs from behavioral health, appeals and inpatient stays.
- The number of cases presented to CPRC was high for Q1 and Q2. It appears to have dropped in Q3 and Q4, but the lower percentage is due to a higher number of cases closed in those quarters (the denominator).
- Quarter-over-quarter, the greatest category of PQI cases was regarding medical care.

Identified Barriers: • The PQI team transitioned from the previous care management system and utilized a shared spreadsheet to track PQIs while the Jiva system was being finalized. Use of the spreadsheet created a loss of data integrity. • From February to December 2024, the TAT was unable to be tracked in 2024 due to the change in care management system. • As PQI is a new part of the system for Jiva, there have been a number of design elements identified that need to be modified in order to make the system fully functional. Additionally, Jiva has had extensive performance issues for PQI, severely handicapping the ability of the team to complete their work efficiently. • Some medical directors have been opening PQIs for quality-of-service issues for the purpose of sending educational letters to the providers. This increased the number of PQI investigations for non-quality-of-care activities and took time away from the completion of quality-of-care investigations.	Identified Opportunities for Improvement: • Work with ITS to develop additional reporting for Jiva, including reports that will track productivity and TAT. • Continue to work with ZeOmega to re-design elements of Jiva for PQI bringing it to the baseline functionality currently in use by other departments. • Continue to work with ZeOmega to identify and resolve the performance issues for PQI. • Develop a separate process to address quality-of-service issues organizationally that offers step-wise actions to address the identified provider issues.
Conclusion: • The transition of the care management system to one that is provider-centric has created challenges with regard to data integrity, reporting and functionality. • PQI continues to support GARS in the review and member response to quality-of-care grievances. • The development of a process to address quality-of-service provider issues will assist departments organizationally and allow the PQI team to focus on quality-of-care investigations.	

4.1.2 Facility Site and Medical Record Review	
Author: Katy Noyes	Department: Quality Improvement
Responsible Party(ies): Marsha Choo, Katy Noyes	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No

Work Plan Goal/Objective:

- PCP and high-volume specialist sites are monitored utilizing the DHCS audit tool and methodology.
- Conduct initial FSRs and verify each contracted PCP site has a passing score. If CAPs are issued, the site must correct all deficiencies to close CAP prior to adding the providers to the CalOptima Health provider network and assigning members to the providers.
- Conduct initial MRRs 90–180 days following the assignment of members.
- Conduct 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.
- Utilize DHCS' most current FSR and MRR tools and standards when conducting site reviews.
- Properly document and monitor the site review status of each contracted PCP site.
- Follow the established DHCS timeline for CAP notification and completion.
- Critical Element (CE) CAPs are due within 10 business days
- FSR and MRR CAPs timelines are due within 30 calendar days
- Monitor and evaluate the CE criteria for all PCP sites between each regularly scheduled site review.
- Review the minimum number of medical records according to the number of PCPs and general patient population distribution.

Goal Met: ☒ Yes ☐ No ☐ Partial

Work Plan Planned Activities:

- Review and report conducted initial reviews for all sites with a PCP or high-volume specialists and a review every three years. Tracking and trending of reports are reported quarterly.

Status: ☐ Completed ☒ Ongoing

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, legal protocols and documented evidence 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.

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 a MRR, using the DHCS FSR and MRR tools and standards.

Actions/Interventions Implemented in 2024:

Quarter 1:	• Complete initial FSRs and MRRs per DHCS requirements. • Complete periodic FSRs and MRRs within DHCS-established timelines. • Close all issued CE, FSR and MRR CAPs within DHCS-established timelines. • Provide training and technical assistance to PCP sites. • New QI Nurse Specialist-FSR hire and training.
Quarter 2:	• Complete initial FSRs and MRRs per DHCS requirements. • Complete periodic FSRs and MRRs within DHCS-established timelines. • Close all issued CE, FSR and MRR CAPs within DHCS-established timelines. • Provide training and technical assistance to PCP sites.
Quarter 3:	• Complete initial FSRs and MRRs per DHCS requirements. • Complete periodic FSRs and MRRs within DHCS-established timelines. • Close all issued CE, FSR and MRR CAPs within DHCS-established timelines • Provide training and technical assistance to PCP sites. • QI Nurse Specialist-FSR completed DHCS Certified Site Review training.

	• New QI Nurse Specialist-FSR hire and training
Quarter 4:	• Complete initial FSRs and MRRs per DHCS requirements. • Complete periodic FSRs and MRRs within DHCS-established timelines. • Close all issued CE, FSR and MRR CAPs within DHCS-established timelines. • Provide training and technical assistance to PCP sites.

Program Results:

Table A

Type of Reviews	**Number of FSRs, MRRs Completed and CAPs Issued by Month**												
MY2024	*Totals:*	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*
Number of Initial FSRS Completed	45	1	3	0	3	11	4	3	5	7	6	2	5
Number of Initial MRRs Completed	36	3	0	3	11	2	0	4	0	4	5	4	5
Number of Periodic FSRs Completed	195	3	5	19	15	24	22	24	25	17	24	17	13
Number of Periodic MRRs Completed	200	2	3	13	17	21	28	31	26	19	23	17	16
Number of Annual FSRs Completed	23	1	2	2	0	3	1	1	4	1	5	3	1
Number of Annual MRRs Completed	24	0	1	3	0	3	1	1	4	3	5	3	0

Table B

	Periodic FSR and CE, FSR, and MRR CAP Timeliness											
MY 2024	***Jan***	***Feb***	***Mar***	***Apr***	***May***	***Jun***	***Jul***	***Aug***	***Sep***	***Oct***	***Nov***	***Dec***
Percentage of Periodic FSRs Completed by Due Dates	0% (N=3)	100% (N=5)	95% (N=18)	93% (N=14)	100% (N=24)	100% (N=22	96% (N=23)	100% (N=25)	94% (N=16)	92% (N=22)	88% (N=2	92% (N=1)
Percentage of CE CAPs Closed by Due Dates	70% (N=7)	88% (N=7)	100% (N=13)	100% (N=14)	88% (N=15)	100% (N=8	100% (N=14)	100% (N=16)	100% (N=9)	95% (N=18)	80% (N=	90% (N=1)
Percentage of FSR CAPs Closed by Due Dates	75% (N=3)	80% (N=4)	92% (N=12)	93% (N=13)	96% (N=21)	69% (N=11)	91% (N=21)	96% (N=21)	100% (N=18)	77% (N=20)	70% (N=14)	92% (N=1)
Percentage of MRR CAPs Closed by Due Dates	100% (N=6)	100% (N=9)	100% (N=17)	92% (N=22)	95% (N=18)	95% (N=20)	100% (N=21)	95% (N=19)	95% (N=19)	91% (N=21)	82% (N=14)	79% (N=3)

Quantitative Analysis:

- Initial FSRs and MRRs: Initial FSRs and MRRs were completed within established DHCS timelines. All issued CAPs were closed before providers were added to the CalOptima Health provider network and assigned members.
- Periodic FSRs: The number of periodic FSRs increased from 116 in 2023 to 195 in 2024.
- Periodic MRRs: The number of periodic MRRs increased from 136 in 2023 to 200 in 2024.
- CE CAPs: The percentage of CE CAPs closed within established DHCS timelines ranged from 70% to 100%. The average percentage of CE CAPs closed on time was 93%.
- FSR CAPs: The percentage of FSR CAPs closed within established DHCS timelines ranged from 69% to 100%. The average percentage of FSR CAPs closed on time was 87%.
- MRR CAPs: The percentage of MRR CAPs closed within established DHCS timelines ranged from 79 to 100%. The average percentage of MRR CAPs closed on time was 96%.

Identified Barriers:	Identified Opportunities for Improvement:

• Rescheduling of audits to dates after the assigned due dates. At times, provider offices will cancel their scheduled audit and not be available until after the assigned due date. Reasons for rescheduling include staffing issues at sites, COVID cases and non-compliant providers/staff. Periodic FSRs are scheduled three months in advance; it is difficult to find available days to reschedule. • Since the updates to the DHCS FSR and MRR Tools and Standards, there has been an increase in failed audits. After a failed score, an annual FSR and MRR are required. • Since the updates to the DHCS FSR and MRR Tools and Standards, there has been an increase in audit deficiencies. This increase leads to an increase in the size and number of CAPs issued. • Sites with outstanding CAPs submit incomplete documentation. If supporting documents or CAP templates are not received in a timely manner, the CAPs are not closed per DHCS timelines.	• Additional QI Nurse Specialist staff hired and in training. • Keep days available on calendar to complete rescheduled audits to meet three-year turnaround time. • Proactive communication and outreach to sites regarding pending CAPs. Emails, faxes and phone call reminders are sent.
Conclusion: FSR and MRR audits for PCP sites were completed per DHCS requirements and timelines. The program is successful.	
Activities/Interventions to continue/add next year:	
• Complete initial FSR and MRR audits per DHCS requirements • Complete periodic FSR and MRR audits within established DHCS timelines. • Close all issued CE, FSR and MRR CAPs within established DHCS timelines. • Provide training and technical assistance to PCP sites	

4.1.3 Physical Accessibility Review Surveys	
Author: Katy Noyes	Department: Quality Improvement
Responsible Party(ies): Marsha Choo, Katy Noyes	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: • PCP and high-volume specialist sites are monitored utilizing the DHCS audit tools and methodology. Other goals: • Conduct initial PARS for PCP sites in conjunction with the DHCS requirements for initial FSR. • Conduct initial PARS for high-volume specialty (HVS) sites when a newly contracted high-volume specialty provider joins the CalOptima Health provider network. • Conduct periodic PARs for PCP and HVS sites at least every three years in accordance with DHCS requirements. • Use DHCS PARS Tool Attachment C to access the physical accessibility of PCP and HVS sites. • Conduct PARS for providers of ancillary services using DHCS PARS Tool Attachment D. • Conduct PARS for Community-Based Adult Service (CBAS) centers using DHCS PARS Tool Attachment E. • Document level of access results met per site as either basic access or limited access.	

Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities:	
Status: ☐ Completed ☒ Ongoing	
Background: To ensure compliance with DHCS contractual requirements, CalOptima Health is required to access the level of physical accessibility of PCP sites, HVS provider sites, providers of ancillary services and CBAS Centers that serve a high volume of seniors and persons with disabilities (SPDs).	
Methodology: To ensure compliance with DHCS contractual requirements, CalOptima Health is required to perform PARS using DHCS PARS Tool Attachment D.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Conducted initial PARS for PCP sites in conjunction with initial FSRs. • Conducted initial PARS for HVS site when a newly contracted provider joins the CalOptima Health provider network. • Conducted periodic PARS for PCP and HVS sites at least every three years. • Conducted periodic PARS for CBAS centers at least every three years. • Conducted periodic PARS for providers of ancillary services at least every three years. • Documented level of access results as basic or limited. • Identified potential accessibility barriers and provide recommendations to increase accessibility and use of facilities.
Quarter 2:	• Conducted initial PARS for PCP sites in conjunction with initial FSRs. • Conducted initial PARS for HVS site when a newly contracted provider joins the CalOptima Health provider network. • Conducted periodic PARS for PCP and HVS sites at least every three years. • Conducted periodic PARS for CBAS centers at least every three years. • Conducted periodic PARS for providers of ancillary services at least every three years. • Documented level of access results as basic or limited. • Identified potential accessibility barriers and provide recommendations to increase accessibility and use of facilities.
Quarter 3:	• Conducted initial PARS for PCP sites in conjunction with initial FSRs. • Conducted initial PARS for HVS site when a newly contracted provider joins the CalOptima Health provider network. • Conducted periodic PARS for PCP and HVS sites at least every three years. • Conducted periodic PARS for CBAS centers at least every three years. • Conducted periodic PARS for providers of ancillary services at least every three years. • Documented level of access results as basic or limited. • Identified potential accessibility barriers and provide recommendations to increase accessibility and use of facilities.
Quarter 4:	• Conducted initial PARS for PCP sites in conjunction with initial FSRs. • Conducted initial PARS for HVS site when a newly contracted provider joins the CalOptima Health provider network. • Conducted periodic PARS for PCP and HVS sites at least every three years. • Conducted periodic PARS for CBAS centers at least every three years. • Conducted periodic PARS for providers of ancillary services at least every three years. • Documented level of access results as basic or limited.

	• Identified potential accessibility barriers and provide recommendations to increase accessibility and use of facilities.

Program Results:

Table A

	The Number of PARS Completed, Number of Basic/Limited Access, and Percentage of Basic/Limited Access per Month											
PARS MY 2024	*Jan*	*Feb*	*Mar*	*Apr*	*May*	*Jun*	*Jul*	*Aug*	*Sep*	*Oct*	*Nov*	*Dec*
Total Number of PARS	47	24	27	45	40	29	30	41	39	22	31	29
Results with Basic Access	27	12	11	20	16	13	10	18	16	6	8	12
Results with Limited Access	20	12	16	25	24	16	20	23	23	14	23	17
Percentage of PARS with Basic Access	57%	50%	41%	44%	40%	45%	33%	44%	41%	27%	26%	41%
Percentage of PARS with Limited Access	43%	50%	59%	56%	60%	55%	67%	56%	59%	73%	74%	59%

Quantitative Analysis:

- Initial and periodic PCP and HVS PARS were conducted according to DHCS requirements. The range of PARS completed each month ranged from 22 to 47. There are a greater number of sites with limited access than basic access.
- PARS for ancillary service provider sites were completed using DHCS PARS Tool Attachment D.

Identified Barriers:	Identified Opportunities for Improvement:
• The results of FSR Attachment C are informational and do not require corrective action. Although deficiencies are shared with sites, efforts to enhance access for the SPD population are encouraged, and additional information to make changes to better accommodate this population is offered, very few sites want to make changes/updates to their facilities. • One of the PARS outreach specialists was on extended jury duty in 2024.	• Complete updates to ancillary PARS templates in web-based application.

Conclusion: PARS for PCP sites, HVS sites, providers of ancillary services and CBAS centers were completed per DHCS requirements and timelines. The program is successful.

Activities/Interventions to continue/add next year:

- Conduct initial PARS for PCP sites in conjunction with initial FSRs.
- Conduct initial PARS for HVS sites when a newly contracted provider joins the CalOptima Health provider network.

• Conduct periodic PARS for PCP, ancillary and HVS sites at least every three years. • Document level of access results as basic or limited.

4.1.4 Provider-Preventable Conditions (PPCs)		
Business Owner: Marsha Choo	Department: Quality Improvement	
Support Staff: Laura Guest		
Work Plan Element: Quality-of-Care		
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No	
Work Plan Goal/Objective: Identify PPCs for reporting to DHCS, overpayment recovery and Potential Quality Issue (PQI) investigation.		
Goal Met: ☐ Yes ☐ No ☒ Partial		
Work Plan Planned Activities: Ongoing identification of PPCs through monthly review of claims data and medical record review was performed by nurses.		
Status: ☐ Completed ☒ Ongoing		
Background: CalOptima Health is required by DHCS to report PPC events in accordance with Title 42, Code of Federal Regulations (C.F.R), Section 438.3(g) and DHCS guidance, including APL 17-009: Reporting Requirements Related to Provider-Preventable Conditions. PPCs primarily occur in the hospital, but Other Provider-Preventable Conditions (OPPC) may occur in any health care setting.		
Methodology: • PPCs are identified by the medical directors when they are reviewing inpatient medical records and through claims and medical record review by nurses • When a PPC is identified, it is reported to DHCS via their web portal, reported to the Claims department for overpayment recovery and investigated as a PQI.		
Actions/Interventions Implemented in 2024:		
Quarter 1:	No PPCs were identified.	
Quarter 2:	No PPCs were identified.	
Quarter 3:	One PPC was identified at an acute care hospital as a deep vein thrombosis/pulmonary embolism. The incident occurred on June 10, 2022, was reported to DHCS on September 4, 2024, and reported to Claims on October 3, 2024.	
Quarter 4:	No PPCs were identified.	
Program Results: One PPC was identified in 2024.		
Quantitative Analysis: In 2023, two PPCs were identified, while only one was identified in 2024.		

Identified Barriers:
• The nurses have had limited time to perform the claims and medical records review to identify PCCs for the following reasons:
  ○ The nurses who perform the claims and medical records audit for PCCs also perform PQI investigations and as-needed coverage for quality-of-care grievances.
  ○ The nurses have been challenged with the care management system transition,
	Identified Opportunities for Improvement:
	• Schedule dedicated time for nurses to review the claims and order/review medical records to identify possible PPCs.	

continue to support the efforts to identify and resolve issues, and support the medical directors in use of the PQI system.	
Conclusion: PPCs are being appropriately identified and reported though dedicated time is needed to ensure all PPCs are captured.	
Activities/Interventions to continue/add next year: • Management will work with the nurses to schedule dedicated time each week to analyze claims data and request/review medical records.	

4.1.5 Provider Credentialing Program		
Author: Rick Quinones		Department: Quality Improvement
Responsible Party: Rick Quinones		
Products: ☒ Medi-Cal ☒ OneCare		New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: • All providers are credentialed according to regulatory requirements		
Goal Met: ☒ Yes ☐ No ☐ Partial		
Work Plan Planned Activities:		
Status: ☐ Completed ☒ Ongoing		
Background: The Credentialing department is responsible for ensuring all practitioners are appropriately qualified to provide care to our members. Providers must be appropriately licensed and experienced in their field. This is accomplished by applying rigorous standards that verify a practitioner's license, education, training, experience, certification, malpractice history, work history and quality of care attributes. To become a participating provider in the CalOptima Health provider network, each provider must meet the minimum qualifications outlined by DHCS, NCQA and CMS.		
Program Goals: • Credential and re-credential CHCN and BH providers • Initial credentialing of all providers to be completed 180 days from attestation date • Recredentialing to be completed within 36 months of the last credentialing date		
Actions/Interventions Implemented in 2024:		
Quarter 1:	• Hired auditors to help with the ongoing monitoring, auditing of internal files, oversight of delegated entities and the CVO.	
Quarter 2:	• Contracted with the CVO to ensure compliance and timeliness of the initial credentialing and re-credentialing files.	
Quarter 3:	• CVO implemented and the CVO went live. • Reorganization of staff within the Credentialing department. • Contracted with vendor, Salesforce/Accenture, a provider lifecycle management system, to design and implement a single integrated solution to support the business functions: Credentialing, Contract Management and Provider Data Management.	
Quarter 4:	• Brought in temporary position to help with data entry due to the increase of initial providers and other duties	
Results: The tables below depict the 2023/2024 Credentialing report for CalOptima Health.		

Table A - CalOptima Health Credentialing Statistics (CHCN Delegated Groups and CHCN Non-Delegated)

	Q4 2023	Q1 2024	Q2 2024	Q3 2024
Initials	236	186	281	223
Recredentials	744	574	674	617
Total	980	760	955	840

Table B - Credentialing Statistics – CHCN Delegated Groups

	Q4 2023	Q1 2024	Q2 2024	Q3 2024
Initials	177	132	226	205
Recredentials	649	46	579	569
Total	826	596	805	774

Table C - Credentialing Statistics – CHCN Non-Delegated

	Q4 2023	Q1 2024	Q2 2024	Q3 2024
Initials	59	54	55	18
Recredentials	95	110	95	48
Total	154	164	150	66

Quantitative Analysis:

- In Q1–Q3 2024, 127 practitioners completed the initial credentialing process, and 253 practitioners completed the re-credentialing process.
- Of those re-credentialed, 99% of those were re-credentialed successfully and timely.
- The number of those re-credentialed in a 36-month timeframe was 251.
- Initial CHCN providers credentialed show an increase from years 2021–2024.
- Increase occurred mostly with BH providers

Identified Barriers:	Identified Opportunities for Improvement:

• DHCS has created provisions for providers to be added to the provider network if they are pending Medi-Cal enrollment. This requires the team to develop new processes and workflows. • With the implementation of CalAIM, there has been an increase in credentialing (or vetting) non-traditional providers (i.e., doulas, etc.). • Considerable staff reduction in the Credentialing department after outsourcing to Credentialing Verification Organization (CVO). • Identification of issues in processes and workflows with CVO. • CVO contacts providers by mail. • Large volume of emails in the inbox	• Promote communication to improve credentialing provider approval notification. • Implement desktop procedures. • Weekly meetings with CVO to identify issues. • Clear all credentialing inboxes
Conclusion: • CalOptima Health has worked with consultants to identify strengths and opportunities for improvement. Strengths include: a. Staff has adapted to changing priorities for credentialing files. b. Staff have been cross-trained and are well-rounded in multiple types of files to credential. • Contracted with a PLM, a single integrated solution to support the business functions: credentialing, contract management and provider data management. • Contract with a vendor to obtain a single integrated provider lifecycle management system for credentialing, contracting and provider data management.	
Activities/Interventions to continue/add next year: • Clear the credentialing inboxes to ensure that we provide a timely response to providers • Require providers who are eligible to use the Council for Affordable Quality Healthcare (CAQH), electronic web-based credentialing application • Explore issuing an RFP to contract with another CVO. • CalOptima Health to launch a provider life cycle management system to integrate the contracting, credentialing and provider data systems into one so we can streamline the onboarding workflow and reduce manual work. • Hiring of additional staff to help with in-house credentialing, intake and additional duties	

4.1.6 Incident Reports	
Business Owner: Marsha Choo	Department: Quality Improvement
Support Staff: Laura Guest	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Goal/Objective: • Collect incident reports, report critical incidents and open PQI investigations as appropriate.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Planned Activities: • Nursing facilities were educated on how to report critical incidents to CalOptima Health. • Incident report statistics were reported to CPRC and QIHEC. • Critical incidents for nursing facilities and CBAS centers were reported to DHCS in January (Q4 2023), April (Q1 2024), July (Q2 2024) and October (Q3 2024).	
Status: ☐ Completed ☒ Ongoing	

Background:
Incidents for CBAS centers, including COVID-19 outbreaks, falls, and members with medical issues, are reported as they occur. Critical incidents are reported for all LTSS programs and include epidemic outbreaks, poisonings, fires, major accidents, death from unnatural causes or other catastrophes, and unusual occurrences which threaten the welfare, safety, or health of patients, and any instances of suspected or alleged abuse, neglect, exploitation, and/or mistreatment as defined by DHCS.

Methodology:
The reports are submitted to the Quality Improvement department by the nursing facilities, CBAS centers and the social workers for MSSP when an incident occurs. The report is reviewed to determine if it is an incident or a critical incident. If it is a critical incident, the report is reviewed to see if the incident was reported to Adult Protective Services (APS) or if reporting is still required. If it has not been reported, the QI will report it to APS. The incident will also be reviewed to determine if a PQI investigation is warranted, and one will be opened as needed.

Actions/Interventions Implemented in 2024:	
Quarter 1:	• In Q1, 11 critical incidents for Q4 2023 were reported to DHCS.
Quarter 2:	• In Q2, six critical incidents for Q1 2024 were reported to DHCS.
Quarter 3:	• In Q3, two critical incidents for Q2 2024 were reported to DHCS.
Quarter 4:	• In Q4, 13 critical incidents for Q3 2024 were reported to DHCS.

Program Results:
The total number of incidents and critical incidents are listed in Tables A and B below.

Table A

Incident Reports					
LTSS Program	***Q1***	***Q2***	***Q3***	***Q4***	***TOTAL***
CBAS - Non-Critical	8	12	12	17	**49**
CBAS - Falls	7	6	10	14	**37**
CBAS - COVID-19 Infections	6	22	16	2	**46**
Total	**21**	**37**	**38**	**14**	**110**

The table provides the number of incidents that occurred in CBAS centers.

Table B

Critical Incident Reports					
LTSS Program	*Q1*	*Q2*	*Q3*	*Q4*	***TOTAL***
CBAS	0	1	0	0	**1**
MSSP	3	11	6	6	**26**
Nursing Facilities	1	9	5	6	**21**
Total	**11**	**23**	**21**	**19**	**74**

The table provides the number of crucial incidents by LTSS program.

Quantitative Analysis*:*

- The number COVID-19 infections increased in Q2 and Q3 at CBAS centers.
- The overall number of incidents declined in CBAS centers in Q4.
- The overall number of critical incidents increased for nursing facilities in 2024 (21) as compared to 2023, when none were reported.

Identified Barriers:

- Prior to the pandemic, the nursing facilities regularly reported critical incidents to CalOptima Health as required by contract. However, during the pandemic and until 2024, few were reported. We believe this to be due to the frequent turnover of administrators and directors-of-nursing (DON) at the nursing facilities who are unaware of the facility's contract requirements with CalOptima Health.

Identified Opportunities for Improvement:

- In 2024, QI nurses made on-site visits to nursing facilities, educating the administrator and DON on the requirement to submit critical incident reports to CalOptima Health when the reports are submitted to the California Department of Public Health (CDPH).

Conclusion, Activities and Interventions

- We are unable to determine if there was an actual increase in the number of critical incidents or if this is simply improved reporting. Further analysis and monitoring will be performed over the course of the next year to compare 2024 with 2025.
- Regular education is recommended at nursing facilities to ensure continued reporting of critical incidents to CalOptima Health.

Activities/Interventions to continue/add next year:

- Further analysis and monitoring will be performed over the course of the next year to compare 2024 with 2025.
- Regular education is needed in the nursing facilities

4.1.7 Encounter Data Review	
Author: Kelly Klipfel/Marsha Choo	Department: Finance
Responsible Party(ies): Lorena Dabu	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Conduct regular review of encounter data submitted by health networks	
Goal Met: ☐ Yes ☐ No ☒ Partial	

Work Plan Planned Activities: Monitors health network's compliance with performance standards regarding timely submission of complete and accurate encounter data	
Status: ☒ Completed ☐ Ongoing	
Background: CalOptima Health's health networks must submit complete, timely, reasonable and accurate encounter data that adheres to the guidelines specified in the companion guides for facility and professional claim types and data format specifications. A health network submits encounter data through the CalOptima Health File Transfer Protocol (FTP) site.	
Methodology: CalOptima Health semi-annually measures a health network's compliance with performance standards with regard to the timely submission of complete and accurate encounter data in accordance with Policy EE.1124 Health Network Encounter Data Performance Standards. CalOptima Health utilizes retrospective encounter data to conduct its evaluation. The measurement year is the 12-month calendar year. CalOptima Health provides each health network with a Health Network Encounter Data Scorecard to report a health network's progress check score and annual score relating to the status of the health network's compliance with encounter data performance standards	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Results were shared with the health networks via email in February and at the February CalOptima Health Delegation Oversight Committee meeting
Quarter 2:	• N/A
Quarter 3:	• Annual CY23 report published; worked with one health network that did not meet the minimum number of measures
Quarter 4:	• N/A
Program Results:	

Table A

Encounter Performance Summary of Health Networks
CY 2023 Semi-Annual

	Completeness								Accuracy		Timeliness		
	Inpatient Match	ER Match	PMPY[1]			Lab Services PMPY	Radiology Services PMPY	PCP/ Member Match	Rejected-Records[1]		Encounter Timeliness	Total	Goal
			Ages 0 to 2	Ages 3 to 19	AGED Mbrs				Prof	Fac			
HMO04 - Kaiser	★ 98%	★ 98%	6.2	3.2	4.9	★ 9.8	★ 2.0	★ 100%	★ 0%	1%	★ 98%	7	8
HMO15 - Heritage	★ 94%	★ 95%	2.9	1.8	4.5	★ 21.0	★ 3.0	★ 100%	★ 1%	1%	★ 97%	7	8
HMO16 - Monarch	★ 93%	★ 90%	4.7	2.2	4.2	★ 12.7	★ 2.3	★ 100%	★ 0%	3%	★ 97%	7	8
HMO17 - Prospect	★ 93%	★ 95%	5.0	2.2	4.8	★ 19.5	★ 2.6	★ 100%	★ 0%	2%	★ 98%	7	8
HMO83 - Family Choice	★ 97%	★ 96%	5.6	3.0	5.3	★ 14.7	★ 1.9	★ 100%	★ 0%	0%	★ 98%	7	8
PHC20 - CHOC	★ 87%	★ 94%	★ 5.5	2.3				65%	★ 0%	0%	★ 100%	5	6
PHC58 - AMVI Care	★ 93%	★ 93%	4.7	1.9	2.4	★ 9.8	★ 1.8	★ 100%	★ 0%	1%	★ 98%	7	8
Standard	75%	75%	4.0	1.5	6.0	2.5	0.6	75%	5%	5%	75%		8
Average	94%	94%	4.9	2.4	4.0	14.6	2.3	95%	0%	1%	98%	7	
SRG64 - Noble		96%	4.0	2.0	4.3	★ 10.2	★ 1.7	★ 90%	★ 0%		★ 96%	5	6
SRG65 - Talbert		96%	3.9	1.8	4.2	★ 13.0	★ 2.5	★ 100%	★ 0%		★ 98%	5	6
SRG66 - ARTA		97%	3.3	1.6	2.9	★ 11.2	★ 1.7	★ 78%	★ 0%		★ 98%	5	6
SRG69 - Alta Med		96%	3.8	2	4.5	★ 11.4	★ 2.1	★ 100%	★ 0%		★ 98%	5	6
SRG82 - UCMG		96%	5.4	2.6	3.6	★ 9.4	★ 1.3	★ 100%	★ 0%		★ 97%	5	6
Standard			4.0	1.5	6.0	2.5	0.6	75%	5%		75%		6
Average		96%	4.1	2.0	3.9	11.0	1.9	94%	0%		97%	5	

[1]Must meet all standards

PHC20 CHOC Lab and Radiology Services are informational only

ER Gap Scores are informational only for SRG Health Networks

HMO/PHC must meet 6 to avoid a CAP

SRG must meet 5 to avoid a cap

Semi Annual PMPY is annualized. Dates of Service = 1/1/2023 - 6/30/2023; Dates of Submission for Accuracy and Timeliness = 2/1/2023 - 7/31/2023

Table B

Encounter Performance Summary of Health Networks
CY 2023 Semi-Annual

	Completeness		Accuracy	Timeliness		
	PMPY		Rejected-Records	Encounter Timeliness		
	Overall Encounters	E&M Visits	Prof		Total	Goal
HMO15 - Heritage	★ 25.8	★ 9.4	★ 1%	★ 98%	4	4
HMO16 - Monarch	★ 24.4	★ 7.5	★ 0%	★ 99%	4	4
HMO17- Prospect	★ 20.9	★ 6.3	★ 0%	★ 99%	4	4
PHC58 - AMVI	16.5	4.6	★ 0%	★ 99%	2	4
PMG21 - Family Choice	16.1	★ 6.2	★ 0%	★ 100%	3	4
PMG52 - Talbert	★ 21.0	5.8	★ 0%	★ 99%	3	4
PMG64 - Noble	19.1	★ 6.3	★ 0%	★ 98%	3	4
PMG66 - Arta	17.2	★ 6.7	★ 0%	★ 99%	3	4
PMG69 - Alta Med	★ 28.0	★ 7.1	★ 0%	★ 99%	4	4
PMG82 - UCMG	17.5	★ 6.3	★ 0%	★ 98%	3	4
Standard	20.0	6.0	5%	90%		4
Average	20.7	6.6	0.0	99%	3.3	

Must meet 3 to avoid CAP

Table C

Encounter Performance Summary of Health Networks
CY 2023 Annual

	Completeness								Accuracy		Timeliness		
	Inpatient Match	ER Match	PMPY[1]			Lab Services PMPY	Radiology Services PMPY	PCP/ Member Match	Rejected- Records[1]		Encounter Timeliness	Total	Goal
			Ages 0 to 2	Ages 3 to 19	AGED Mbrs				Prof	Fac			
HMO04 - Kaiser	98%	98%	6.3	3.6	5.1	9.7	2.2	100%	0%	1%	96%	7	8
HMO15 - Heritage	94%	94%	3.8	1.8	4.9	20.3	3.1	100%	1%	1%	94%	7	8
HMO16 - Monarch	93%	87%	5.4	2.6	5.1	15.1	2.5	100%	0%	2%	64%	6	8
HMO17 - Prospect	93%	93%	4.6	2.2	4.7	19.2	2.8	100%	0%	3%	96%	7	8
HMO83 - Family Choice	87%	90%	5.6	2.5	5.2	*15.3*	*2.0*	100%	0%	1%	94%	7	8
PHC20 - CHOC	97%	96%	5.5	3.0				80%	0%	0%	99%	6	6
PHC58 - AMVI Care	93%	91%	4.5	2.1	2.4	9.8	1.9	100%	0%	1%	96%	7	8
Standard	75%	75%	4.0	1.5	6.0	2.5	0.6	75%	5%	5%	75%		8
Average	93%	93%	5.1	2.5	4.4	14.9	2.4	97%	0%	1%	91%	7	
SRG64 - Noble		*49%*	3.8	1.9	4.3	10.3	1.6	100%	0%		94%	5	6
SRG65 - Talbert		*53%*	3.8	1.8	4.1	11.0	2.0	100%	0%		96%	5	6
SRG66 - ARTA		*48%*	3.7	2.0	3.6	5.8	1.6	100%	0%		96%	5	6
SRG69 - Alta Med		*48%*	3.9	2.1	4.8	14.0	2.3	100%	0%		97%	5	6
SRG82 - UCMG		*50%*	5.1	2.4	3.7	9.4	1.4	100%	0%		95%	5	6
Standard			4.0	1.5	6.0	2.5	0.6	75%	5%		75%		6
Average		49%	4.1	2.0	4.1	10.1	1.8	100%	0%		96%	5	

[1]Must meet all standards
ER Gap Scores are informational only for SRG Health Networks
HMO/PHC must meet 6 to avoid a CAP
SRG must meet 5 to avoid a cap

Table D

OneCare
CY 2023 Annual

	Completeness		Accuracy		Timeliness		
	PMPY		Rejected- Records		Encounter Timeliness		
	Overall Encounters	E&M Visits	Prof	Fac		Total	Goal
HMO15 - Heritage	26.6	10.0	0%	0%	94%	4	4
HMO16 - Monarch	24.1	7.6	0%	0%	94%	4	4
HMO17- Prospect	22.4	7.4	0%	0%	97%	4	4
PHC58 - AMVI	15.3	5.0	0%	0%	96%	2	4
PMG21 - Family Choice	16.0	6.3	0%	0%	97%	3	4
PMG52 - Talbert	22.0	6.5	0%	0%	97%	4	4
PMG64 - Noble	19.0	6.2	0%	0%	95%	3	4
PMG66 - Arta	19.0	7.6	0%	0%	97%	3	4
PMG69 - Alta Med	27.0	7.3	0%	0%	97%	4	4
PMG82 - UCMG	17.0	6.5	0%	1%	97%	3	4
Standard	20.0	6.0	5%	5%	90%		4
Average	20.8	7.0	0.0	0.0	96%	3.4	

PMG must meet 3 to avoid CAP

Quantitative Analysis:

For Table A:

- Health Maintenance Organizations (HMOs) and Physician-Hospital Consortia (PHCs) met seven of eight measures
- Children's Hospital of Orange County (CHOC) met five of six measures
- Shared Risk Groups (SRGs) met five of six measures

- The 6.0 Evaluation and Management (E&M) Per Member Per Year (PMPY) standard for the members in the aged aid category challenges most networks
- Telehealth Services are included as part of the E&M PMPY Calculations
- No CAPS are issued for Semiannual Reports, per policy

For Table B:
- Networks met all measures
- Networks met three of four measures
- One network met two of four measures
- Telehealth Services are included as part of the E&M PMPY Calculations
- No CAPS are issued for Semiannual Reports, per policy

For Table C:
- HMOs and PHCs met at least six of eight measures
- CHOC met six of six measures
- SRGs met five of six measures
- The 6.0 E&M PMPY standard for the members in the aged aid category challenges most networks
- Telehealth services are included as part of the E&M PMPY Calculations

Table D:
- Five networks met all measures
- Networks met three of four measures
- One network met two of four measures
- Telehealth Services are included as part of the E&M PMPY Calculations

Identified Barriers:	Identified Opportunities for Improvement:
• One health network for OneCare did not meet the minimum number of measures	• Encounters are working with this health newtork to identify reasons

Conclusion: The majority of health networks are meeting the reporting standards.

Activities/Interventions to continue/add next year:

- Scorecard will be changing for 2025 to report encounter timeliness and rejection rates only

4.2 Population Health Management

4.2.1 2024 CalOptima Health Membership (Risk Stratification)

Business Owner: Katie Balderas

Support Staff: Barbara Kidder/Hannah Kim

Description:

At least annually, 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 such as program access and eligibility for specific services.

CalOptima Health divides its member population into 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
- Chronic Condition Management
- Complex Care Management
- Enhanced Care Management

CalOptima Health's Enterprise Analytics (EA) developed internal SQL queries to calculate each sub-population. This monthly identification and stratification process leverages paid claims, encounters, utilization, authorizations, pharmacy records and lab data. Members are stratified based on severity of condition, comorbidities and utilization characteristics. Practitioners are updated annually on the risk level of their members and may be informed more frequently when significant changes in utilization characteristics occur.

Further details of CalOptima Health Membership Segmentation and Risk Stratification can be found in Appendix B: 2024 CalOptima Health Membership (Risk Stratification)

4.2.2 Population Health Management Strategy with Population Need Assessment (PNA)
Business Owner: Katie Balderas
Support Staff: Barbara Kidder/ Janette Valladolid/ Maria Nguyen
Work Plan Goal/Objective: Implement PHM Strategy and complete the Evaluation of the 2024 PHM Strategy
Goal Met: ☒ Yes ☐ No ☐ Partial
Executive summary: The PHM Strategy outlines CalOptima Health's cohesive plan of action to address the needs of members across the continuum of care. CalOptima Health's PHM Strategy addresses the following areas of focus: 1. Keeping members healthy 2. Managing members with emerging risks 3. Member safety 4. Managing members with multiple chronic conditions CalOptima Health's Population Needs Assessment (PNA) summarizes the results of an annual assessment of a variety of data. The PNA is used to review the characteristics and needs of our agency's member population and relevant focus populations to support data-driven planning and decision-making. This report specifically focuses on CalOptima Health's: • Overall member population, including member's physical, behavioral and social health needs • Children and adolescent members ages 2–19 years old • Members with disabilities • Disparities among members based on their racial and ethnic identity • Disparities among members with limited English proficiency • Relevant focus populations, including pregnant members and members experiencing homelessness Key findings from the PNA are used to inform the PHM Strategy and Workplan, which aim to address gaps in member care through intervention strategies and quality initiatives. A majority of the goals within the PHM Strategy and Workplan are on pace to be met pending MY2024 final rates to be released. A

subgoal under the Street Medicine Program is not being met based on the lack of affordable housing opportunities for unhoused residents of Orange County.

Full details of the 2024 PHM Strategy Evaluation can be found in Appendix C: 2024 Population Health Management Impact Report.

4.2.3 Initial Health Appointment	
Business Owner: Katie Balderas	Department: Equity and Community Health
Support Staff: Anna Safari/Stephanie Johnson	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No

Work Plan Goal/Objective:

- Increase rate of Initial Health Appointments for new members, increase primary care utilization for unengaged members.

The program aims to strengthen primary care and promote prevention and wellness for all CalOptima Health members. As of January 2023, DHCS notified that primary care visits and screenings will be proxy measures for IHA completion. Therefore, primary efforts were made to increase overall Initial Health Appointment (IHA) completion rates. To reach this goal, the following initiatives were arranged:

1. Increase communication and provide training to health networks and CHCN providers.
2. Enhance member outreach efforts by conducting outreach to all newly enrolled members in the following methods: Interactive Voice Response (IVR) calls, Medi-Cal member newsletters, Medi-Cal New Member Handbook, New Member Packet and IHA Member Outreach Script for Member-facing staff
3. Improve oversight of the IHA processes:
   a. Health Networks (including CHCN): Effective in 2024, CalOptima Health's key performance indicator (KPI) for the IHA is benchmarked at 50% for all health networks. CalOptima Health will meet regularly with the health networks to monitor IHA performance and inform them of updates and their IHA completion performance rates.
   b. CHCN Providers: CalOptima Health has incorporated a Chart Review Pilot process for CHCN providers to enhance monitoring of IHA compliance. This process involves a detailed review of member medical records to verify that IHAs are completed accurately and in a timely manner. By analyzing documentation in patient charts, CHCN providers can ensure compliance with IHA requirements, identify areas needing improvement and support quality care standards. This initiative aims to improve the overall IHA completion rates and quality compliance to support providers in meeting established key performance indicators, contributing to more effective member engagement and health outcomes.

Goal Met: ☐ Yes ☒ No ☐ Partial

Work Plan Planned Activities:
Assess and report the following activities:

- Increase health network and provider communications, trainings and resources
- Expand oversight of provider IHA completion
- Increase member outreach efforts
- Other planned activities
  1. Data and Reports
  2. Oversight and Monitoring
  3. Member Outreach
  4. Health Network Education and Engagement
  5. Provider Training and Resources

Status: ☐ Completed ☒ Ongoing

Background:
DHCS requires that all newly enrolled members be offered and provided access to an IHA within the first 120 days of their enrollment date. The IHA is a comprehensive assessment completed during the member's first visit with their selected or assigned PCP. The IHA must be provided in a way that is culturally and linguistically appropriate for the member. For members under the age of 21, the IHA should be offered within 120 days following the date of enrollment or within the most recent Bright Futures periodicity timelines established by the American Academy of Pediatrics for ages 2 and younger, whichever is less. The IHA encompasses gathering the member's physical and behavioral health history, identifying risks, assessing the need for preventive screenings or services and health education, and establishing a diagnosis and treatment plan for any identified diseases.

Methodology:
CalOptima Health uses claims and encounters data and quality measures

1. Claims and Encounters for IHA Completion:
The IHA Performance Report continuously extracts and processes claims data to track the completion of IHA for eligible members. The report aligns claims data with members' enrollment dates and filters for specific billing codes to confirm an IHA has been completed. This data is aggregated and integrated into the Delegation Oversight Committee (DOC) Dashboard monthly. The DOC Dashboard is leveraged to track IHA completion rates across health networks. In 2023, CalOptima Health increased the IHA KPI benchmark for all health networks from 17% to 50%. This increase aligns with DHCS standards to ensure improved access to comprehensive preventive care for Medi-Cal members. Furthermore, these adjustments aim to address gaps in care by holding health networks accountable for prioritizing IHA completion, which plays a foundational role in improving health outcomes and reducing disparities. Additionally, the DOC Dashboard is used to share IHA performance rates with health networks, so they are aware of their compliance with this measure.

2. Quality Measures for IHA Proxy:
CalOptima Health leverages MCAS and HEDIS measures specific to adult preventive visits and infant/child/adolescent well-being visits as a proxy for IHA completion. MY2024 Prospective Rate Report for CalOptima Health Medi-Cal (P4V) is produced by CalOptima Health's Quality Analytics for each health network and CHCN, demonstrating monthly quality measure performance metrics. The Prospective Rate Report demonstrates health network performance on the quality measures used as a proxy for IHA completion. IHA completion is tied to quality and compliance utilizing the MCAS measures that help track preventive care and overall member engagement. This information is shared with each HN at their respective bimonthly Quality Update Meeting.

- 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 to 15 Months — Six or More Well-Child Visits
- Well-Child Visits in the First 30 Months of Life — 15 to 30 Months — Two or More Well-Child Visits
- Chlamydia Screening in Women
- Breast Cancer Screening
- Cervical Cancer Screening
- Adults' Access to Preventive/Ambulatory Health Services

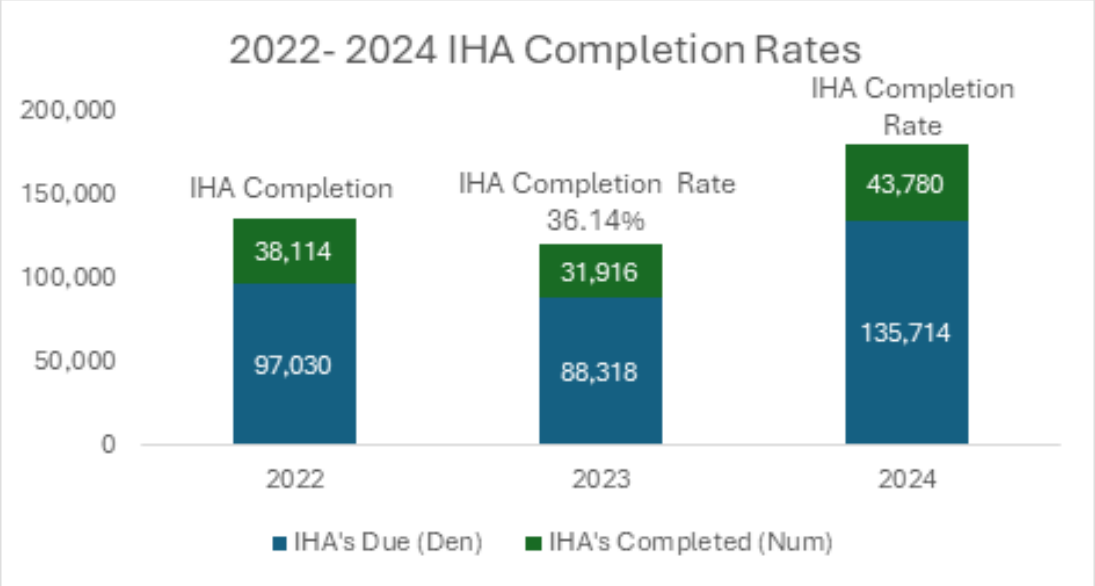
Actions/Interventions Implemented in 2024:

Quarter 1:	• Joint Operation Meetings (JOM) Presentations: JOM ongoing monthly presentations are provided to all health networks in efforts to offer IHA updates, performance rates and reminders. IHA was presented at six JOMs in Quarter 1. • CHCN Virtual Learn: Ongoing quarterly presentations are provided to CHCN to offer IHA updates, performance and reminders. Presentation at Q1 CHCN Virtual Learn Meeting held on February 29, 2024. • Provider Newsletter: Monthly CalOptima Health updates to providers. IHA updates are shared in the March Provider Newsletter. • 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 week of February 12–16, 2024. • QIHEC: Meeting with CalOptima Health leaders to provide direction and oversight of quality improvement processes related to regulatory requirements. IHA updates shared on February 13, 2024. • 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. • Community Health Centers Monthly Forum: A monthly meeting to collaborate and provide important updates from CalOptima Health. IHA updates shared on February 29, 2024. • Implement Quarterly IHA Chart Review Audit Pilot for CHCN providers.
Quarter 2:	• Quality Update Meetings: Bimonthly quality presentations are to all health networks in an effort to offer IHA updates, performance rates and reminders. IHA was presented to all health networks in May. • CHCN Virtual Learn: IHA updates shared at Q2 CHCN Virtual Learn Meeting held on July 8, 2024. • Provider Newsletter: IHA updates shared in the May and June provider newsletters. • Provider Onboarding: Training 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 • Health Network Collaborative Quality Forum: Quarterly meeting held with all health networks to provide updates on various quality measures. IHA updates were presented on April 11, 20 24. • Health Network Forum: Quarterly meeting held for purposes of planning, collaboration and providing updates. IHA updates presented on April 18, 2024. • QIHEC: IHA updates shared on June 11, 2024. • PHMC: IHA updates shared at meeting held on May 16, 2024. • Quarterly IHA Chart Review Audit Pilot for CHCN providers.
Quarter 3:	• Quality Update Meetings: IHA was presented to all health networks in July and September. • PHMC: Shared IHA updates on May 16, 2024. • Health Network Collaborative Quality Forum: IHA updates shared on April 10, 2024. • Health Network Newsletter: Notification to promote IHA CME sent newsletter for week of August 5–9, 2024.

	• 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. Webinar held on August 14, 2024. • CHCN Virtual Learn: IHA updates shared at Q3 CHCN Virtual Learn Meeting held on September 25, 2024. • QIHEC: IHA updates shared on August 13, 20224. • PHMC: IHA updates shared at meeting held on August 15, 2024. • Quarterly IHA Chart Review Audit Pilot for CHCN providers.
Quarter 4:	• Quality Update Meetings: IHA was presented to all health networks in November. • CHCN Virtual Learn: IHA updates shared at Q4 CHCN Virtual Learn Meeting held on December 5, 2024. • Health Network Forum: IHA updates presented on November 21, 2024. • QIHEC: IHA updates shared on November 5, 2024. • PHMC: IHA updates shared at meeting held on November 21, 2024. • QAC: IHA updates shared at meeting held on October 9, 2024. • Quarterly IHA Chart Review Audit Pilot for CHCN providers.

Program Results:

Chart A: 2022-2024 IHA Completion Rates: Three consecutive annual trends of IHA compliance rates



* Please note data was generated on 12/5/2024 from IHA Core Report CC0163B. IHA completion rates are retrieved from claims data and require at least 3 months to be retrieved after the reporting period to account for any claims data lag; data pulled for 2024 is preliminary.

Table A: 2024 IHA Completion Performance: Quarterly Rates for All Ages vs. Members ≤18 Months Compared to 50% KPI Benchmark

2024 IHA Performance												
	Num	***Den***	**Qtr. 1**	***Num***	***Den***	**Qtr. 2**	***Num***	***Den***	***Qtr. 3***	***Num***	***Den***	***Qtr. 4***
All Ages	*6300*	*14929*	**42.2%**	*17359*	*60153*	**28.86%**	10669	27985	**38.12%**	6001	16541	**36.28%**
≤ 18 months	*1471*	*2003*	**73.4%**	*1687*	*2408*	**70.06%**	1810	2645	**68.43%**	1191	2146	**55.50%**

** Please note data was generated on 12/4/2024 from IHA Core Report CC0163, and Quarter 4 data is trending. IHA completion rates are retrieved from claims data and require at least three months to be retrieved after reporting period to account for any claims data lag.*

Table B: 2022–2024 IHA Completion Rates: Annual rates for IHA completion over three consecutive years

	2022–2024 IHA Completion Rates		
	2022	*2023*	*2024*
IHAs Due (Denominator)	97,030	88,318	135,714
IHAs Completed (Numerator)	38,114	31,916	43,780
IHA Completion Rate	38.12%	36.14%	32.25%

** Please note data was generated on 12/5/2024 from IHA Core 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 claims data lag; data pulled for 2024 is preliminary.*

Table C: 2024 IHA Completion Rates by Health Network: Quarterly Performance Against 50% KPI Benchmark

2024 IHA Performance				
	Quarter 1	*Quarter 2*	*Quarter 3*	*Quarter 4*
CalOptima Health Community Network (CHCN)	48.71%	40.96%	51.02%	46.76%
CalOptima Health Direct (CHD)	92.43%	58.75%	57.80%	57.33%
Alta Med	29.32%	23.30%	28.07%	26.15%
AMVI	27.01%	20.52%	29.56%	25.12%
CHOC	66.67%	57.51%	61.21%	54.97%
Family Choice	31.68%	20.08%	28.67%	25.25%
HPN-Regal	21.67%	17.88%	23.37%	17.20%
Noble	21.08%	13.72%	22.37%	19.94%
Optum	30.61%	19.97%	30.85%	25.41%
Prospect	26.86%	20.90%	28.43%	23.35%
United Care	27.46%	21.06%	29.02%	27.36%

** Please note data was generated on 12/4/2024 from IHA Core Report CC0163, and Quarter 4 data is trending. IHA completion rates are retrieved from claims data and require at least three months to be retrieved after reporting period to account for any claims data lag.*

Table D: 2024 IHA Chart Review Pilot Compliance: Gaps by Component

IHA Component	Compliant %	Num/Den
Timely- 120 Days	84.59%	302/357
Outreach Attempts (3), When No IHA Completed	5.74%	7/122
All Components Covered:		
Physical Health History	96.64%	345/357
Mental Health History	90.76%	324/357
Physical Exam	95.24%	340/357
Identification of Risks	96.36%	344/357
Diagnosis	96.92%	346/357
Plan for Treatment	97.20%	347/357
Preventive Services	97.76%	349/357
Health Education	93.00%	332/357
Additional Components (Ages 6-72 Months)		
Anticipatory Guidance on Harms of Blood Lead Exposure	68.18%	15/22
BLL Testing	50.00%	11/22
IHA Completed by PCP Type	100%	350/350

** Please note that data was generated on 12/5/2024 from IHA Chart Review tracking. IHA compliance is preliminary as the ECH team continues to conduct ongoing IHA Chart Reviews.*

Quantitative Analysis:
A collective review of IHA performance among completion and compliance rates provides a comprehensive review that accounts for the quantity of IHAs due and completed that are being validated through claims data. The IHA Chart Review process checks for compliance with IHA requirements, encompassing quality of care.

In 2024, the ECH Department introduced the IHA Chart Review Audit Pilot for CHCN providers. This process is key in the oversight of compliance with IHA requirements. It allows CalOptima Health to effectively monitor provider performance by identifying those who fall below the 90% compliance threshold and enables detailed insight into documentation and delivery of care gaps. The 2024 IHA compliance rates are reflected in Table D, which shows gaps in documentation by component for completed chart reviews. Overall, providers who completed IHAs scored fairly high in completing the IHA components but fell short in blood lead measures for children. Furthermore, for IHAs that were not completed, providers reviewed did not have sufficient documentation of outreach attempts to schedule members for their IHA visit.

Table C shows the health network IHA performance by quarter. In 2024, the IHA completion rates among health networks showed varied performance, with the top three performing networks—CalOptima Health Direct (CHD), CHOC, and CalOptima Community Network (CHCN)—meeting or exceeding the 50% KPI benchmark. CHD led with an impressive 92.43% completion rate in Q4, consistently exceeding the benchmark throughout the year, while CHOC and CHCN demonstrated significant improvement, achieving 66.67% and 51.02% in Q4. However, most other networks, including AltaMed, AMVI, and Optum, fell short of the goal, with marginal improvements and rates below 32%. In 2024, the Medi-Cal Expansion significantly increased Medi-Cal enrollment by broadening eligibility, resulting in a surge of new members requiring an IHA, reflected in quarter 2 and even into quarter 3, when these IHAs were due. The Medi-Cal expansion significantly increased the number of members requiring an IHA due to a surge in enrollment that allowed more individuals (specifically low-income adults without dependent children) to qualify for coverage, which directly led to an increase in the denominator in compliance calculations, necessitating robust strategies to track and manage appointments. The increase in newly enrolled members is evident in Chart A, where the number of IHAs due rose significantly from 88,318 in 2023 to 135,714 in 2024, indicating a 54% rise. Despite a decrease in IHA overall completion rate from 36.14% to 32.26% in 2024, the number of IHAs completed increased by 11,864 from 2023 to 2024, highlighting an improvement in absolute completions amidst the surge in demand. This reflects the challenges in scaling resources and operational capacity to meet the growing demand. The sharp rise in the denominator significantly outpaced the growth in numerators, underscoring the need for process enhancements and greater provider engagement to sustain compliance and performance amidst rising member volumes.

Furthermore, Table A indicates the rise in adult enrollment into Medi-Cal through the Medi-Cal expansion, when observing the variation in denominator values: 14,929 in quarter 1; 60,153 in quarter 2; 27,985 in quarter 3; and 16, 541 in quarter 4. Quarter 2 showed significant delays in completing IHAs due to the overflow from quarter 1 enrollments due to the growing demands from expanding the Medi-Cal member base. These operational delays led to the lowest performance rates during 2024. Interventions to improve communication with health networks and providers were implemented to address the concerns with low rates. As communication increased and Medi-Cal expansion stabilized, the rates in quarter 3 started to recover. By the end of quarter 3, 2024, 34,328 IHAs had been completed compared to the 31,916 IHAs completed over the full year for 2023.

Identified Barriers:	Identified Opportunities for Improvement:
Operational Barriers • Medi-Cal Expansion: Increased Medi-Cal enrollment in early 2024, which led to a surge in IHAs due in Q2 and Q3 • Leveraging reports and data produced by other teams within CalOptima Health for IHA performance • Outdated member contact information • IHA Reports: Methodology does not account for members who may not have had continuous enrollment or disenrolled prior to 120 days and are therefore considered exempt from IHA completion, which can be inflating the denominator and ultimately bringing the overall completion rate down • Lack of staff with scope of competency skills dedicated to IHA process and oversight Health Network Barriers • Unclear Accountability Structure: An unclear network structure made it difficult for ECH to hold health networks accountable for meeting IHA benchmarks • Lack of responsiveness to Delegation Oversight Dashboard Response (DODR) form. • High staff turnover required ongoing training of new staff Provider Barriers • Access to Provider Portal: unaware of how to access IHA reports • Non-responsive clinics • Data format variability • Clinic staffing shortages	Operational • Building stronger working collaborations with Quality Improvement and Delegation Oversight departments • IHA Reports: Make enhancements to methodology for IHA reports used to report IHA completion rates so members who are exempted from IHA completion are not included in the data, leading to more accurate data to report • Hire dedicated IHA team Health Network • DO assigned representatives to oversee network IHA performance oversight and remediation efforts to support and hold networks accountable; Delegation Oversight Dashboard Response Forms presented to all health networks to fill out and return to CalOptima Health so we can track their efforts for improvement on IHA performance • In 2025, DO will be working with ECH to begin issuing CAPs to health networks who are not making efforts to improve performance rates • Elicit CHCN CEO supper and intervention Provider • Direct outreach efforts via in-person site visits • Targeted staff training on the submission of chart review records through the secured file transmission protocol (SFTP) • Initiated virtual chart review audits • Granting appropriate extensions for record submission

Conclusion:

The findings of this report reveal the progressive achievements and areas for improvement in the IHA program. While the overall completion rates decreased to 32.26% in 2024 due to the surge in newly enrolled Medi-Cal members, the number of IHAs completed increased by 11,864 from 2023 to 2024, signifying progress amidst the rising demand for IHAs. Additionally, the 2024 data highlight the variability in IHA completion rates across health networks, with only a few networks meeting or exceeding the increased KPI benchmark of 50%. While some networks, such as CHOD and CHOC, demonstrated strong performance and effective strategies for handling the surge in IHAs, most networks underperformed, indicating challenges in addressing barriers. The program's success is evident in networks that implemented robust workflows, member engagement strategies and provider support, which could serve as a model for underperforming networks. This mixed performance suggests that while the program has made progress in aligning with DHCS standards and improving IHA completion, it is not yet universally successful across all networks.

Overall, the program successfully expands access to preventative care and improves IHA compliance through the IHA Chart Review process. The collaboration between ECH and DO is pivotal in ensuring health networks meet IHA completion and compliance standards. Through this partnership, DO leverages performance monitoring tools, such as the DOC Dashboard, and issues remediation efforts.
Activities/Interventions to continue/add next year:
• All activities listed under the "Actions/Interventions Implemented in 2024" section will continue in 2025. • CAP implementation processes will begin for health networks not meeting the KPI metric threshold for IHA performance, and for CHCN providers that do not pass their IHA Chart Review audits per the written process.

4.2.4 Special Needs Plan (SNP) Model of Care (MOC)

4.2.4.1 OneCare Model of Care: Health Risk Assessment (HRAs)	
Author: Sherry Hickman	Department: Case Management
Responsible Party(ies): Hannah Kim, Megan Dankmyer	
Products: ☐ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: • Percentage of Members reached and willing to complete HRA: Goal 100% of DHCS adjusted scoring	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: • Ongoing monitoring of initial HRA completion for achieving three Stars.	
Status: ☐ Completed ☒ Ongoing	
Background: 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 a collection of HRA <365 days from the prior HRA. Data from initial and annual HRA collection is reported to both DHCS and CMS.	
Methodology: HRA1: Members must have a qualifying outreach that occurs within the first 90 days of eligibility. Qualify outreach: Members who decline to participate, members who are unable to be contacted after a minimum of three telephonic attempts on different days or members who complete an assessment. Methodology: CMS qualifying HRA: The initial HRA must be collected within 90 days of eligibility, and there must be less than 365 days between HRAs on an annual basis.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Utilize newly developed monthly reporting to validate and oversee outreach and completion of HRA1 per regulatory guidance. • As of March 31, 2024, 22% of HRAs completed to date for measure year 2024.
Quarter 2:	• Q1 HRA1 DHCS adjusted score: Members reached and willing to complete HRA is 100% • CMS 2 Star Rating achieved on June 30, 2024, with 41% of HRAs completed. • Usher text messaging reminders for members who were UTC and due in April • OC HRA incentive flyer finalized, approved and mailed to 1,000 reset members. • Usher online HRA distributed to team members to begin utilization • Usher pilot launched to complete HRA through Short Message Service (SMS)

	• HRA flyer mailed to 1,000 reset members • Continue to use monthly reporting to validate and oversee outreach and completion of HRA1
Quarter 3:	• Q2 HRA1 DHCS adjusted score: Members reached and willing to complete HRA is 100% • CMS increased cut points for Star Measure on HRA completion by 4% • Continue to use monthly reporting to validate and oversee outreach and completion of HRA1
Quarter 4:	• Q3 HRA1 DHCS adjusted score: Members reached and willing to complete HRA is 100% • Additional reminders in October and November to initial and annual members due for HRA who did not respond after four or more call attempts via texting. • Staff volunteered at community event to complete HRAs in person. • Achieved 62% HRA completion on October 23, 2024 which equates to a CMS 3 Star rating. • CareNet outreach to members with no HRA in 2023 or 2024.

Program Results:

Table A

Reporting Period 2024	*Members Newly Enrolled*	*Members Who Declined*	*Members Who Were UTC*	*% Members Who Were UTC*	*Members Who Completed HRA*	*% Members Who Completed HRA*	*Members reached, Willing & Completed HRA*
Quarter 1	652	15	77	12%	559	86%	100%
Quarter 2	732	40	68	9%	624	85%	100%
Quarter 3	845	15	110	13%	720	85%	100%
Quarter 4*	*NA	*NA	*NA	*NA	*NA	*NA	*NA

HRA1 Members with Health Risk Assessment completed within 90 days of enrollment as reported to DHCS.

*Quarter 4 in process and not yet finalized at time of submission.

Table B

Reporting Period 2023	*Members Newly Enrolled*	*Members Who Declined*	*Members Who Were UTC*	*% Members Who Were UTC*	*Members Who Completed HRA*	*% Members Who Completed HRA*	*Members reached, Willing & Completed HRA*
Quarter 1	952	93	252	26%	605	64%	100%
Quarter 2	879	45	159	18%	675	77%	100%
Quarter 3	814	28	149	18%	637	78%	100%
Quarter 4	678	22	97	14%	559	82%	100%

HRA1 Members with Health Risk Assessment completed within 90 days of enrollment as reported to DHCS

Table C

SNP Care Management Measure	*Percent of Qualifying HRAs collected*	*Star Rating*
2021 Measurement Year	36%	One
2022 Measurement Year	35%	One
2023 Measurement Year	52%	Two
2024 Measurement Year (in process)	64% as of 12/5/2024	Three

CMS HRA Star Rating.

Quantitative Analysis:

- HRA outreach and collection meet program objectives.
- HRA1 results for UTC and Completed HRA are stable for 2024 (Table A).
- When HRA1 is compared with 2023 HRA1 reporting (Table B) there is a decrease in members who are UTC and increase in members who completed the HRA.
- Table C shows CMS ratings for the past four measurement years demonstrating significant increase in volume of qualifying HRAs collected.

Identified Barriers:	Identified Opportunities for Improvement:
• Members who are UTC despite numerous attempts to reach.	• Decrease the percentage of members who are UTC

Conclusion: The process for HRA outreach and collection is successful and demonstrates improvement from prior year results. This improvement contributes to the CMS Star Ratings.

Activities/Interventions to continue/add next year:

- Continue: Monitoring of HRA1 completion for DHCS quarterly reporting
- Continue: HRA outreach by external vendor, CareNet
- Continue: HRA outreach through Usher using SMS

- Continue: Member incentive for HRA completion
- Continue: Monitor percentage of HRA Completion for CMS Star ratings
- Add: Evaluation of race and ethnicity in the UTC population for identification of disparity.
- Add: Report on HRA2 DHCS 2024 annual reporting in Quarter 1 2025

4.2.4.2 OneCare Model of Care Interdisciplinary Care Team (ICT) and Individual Care Plan (ICP)	
Author: Sherry Hickman	Department: Case Management
Responsible Party(ies): Hannah Kim, Megan Dankmyer	
Products: ☐ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: • Percentage of Members with ICP: Goal 100% of DHCS adjusted scoring for members reached and willing to complete a care plan. • Percentage of Members with ICT: Goal 100%	
Goal Met: ☐ Yes ☐ No ☒ Partial	
Work Plan Planned Activities: • Assess and report the following activities: o Utilize newly developed monthly reporting to validate and oversee outreach and completion of ICP per regulatory guidance. o Develop communication process with networks for tracking outreach and completion to meet benchmarks. o Creation and implementation of the oversight audit tool. o Updated oversight process implementation and monitoring.	
Status: ☐ Completed ☒ Ongoing	
Background: 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 with prioritization of goals and target dates. Attention is paid to needs identified in the HRA and by the ICT. The member's care plan is updated at least annually and when there is a change in health status. Data for the initial and annual ICP development is reported to DHCS.	
Methodology ICP1: Members must have qualifying outreach for purposes of developing the ICP. Members may decline to participate or may be considered as UTC if at least three attempts are made within 90 days of eligibility. Data on ICP1 is reported to DHCS quarterly.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Core Report CC0258 in phase II Jiva Remediation for ICT/ICP data. • Communications to health networks in January, February and March on ICP development status for newly effective members. • Addition of annual ICP development status on the March file. • Communication included identification of members who were also ECM-Like. • Ongoing quarterly audits of delegated health networks.
Quarter 2:	• Core Report CC0258 continues in phase II Jiva Remediation for ICT/ICP/HRA data. • Q1 ICP1 DHCS quarterly reported adjusted score: Members reached and willing to complete ICP is 64% • ICT rates pending Jiva Phase II remediation • Communications to CHCN and health networks in April and May on ICP development status for newly effective members Q1 and Q2 • Addition of annual ICP development status on April and May file • Communication of ECM-like eligibility and members missing face-to-face interaction

	• Ongoing quarterly audits of delegated health networks • Creation and implementation of the oversight audit tool.
Quarter 3:	• CC0258 partially remediated • Q2 ICP1 DHCS quarterly reported adjusted score: Members reached and willing to complete ICP is 91% • ICT reporting pending Jiva remediation and development of SNPE reporting • Ongoing monthly communications to CHCN and health networks for ICP1 development status for newly effective member • Continue to provide feedback on annual ICP development and missing face-to-face interactions. • Audit tool under review for updates • Ongoing quarterly audits
Quarter 4:	• CC0258 partially remediated and will resume per JIVA remediation priorities • Q3 ICP2 DHCS quarterly reported adjusted score 98% • ICT-pending Jiva remediation and development of SNPE reporting. • MOC tracking file revision in development to add additional ICT Metrics • ICP dashboard created by EA for CM implementation in monthly communication

Program Results:

Table A

Reporting Period 2024	*Members Newly Enrolled*	*Members Who Declined*	*Members Who Were UTC*	*% Members Who Were UTC*	*Members Who Completed Care Plan*	*% Members Who Completed Care Plan*	*Members reached, Willing & Completed care plan*
Quarter 1	652	163	261	40%	147	23%	64%
Quarter 2	732	200	310	42%	203	28%	91%
Quarter 3	845	228	382	45%	231	27%	98%
Quarter 4*	*NA	*NA	*NA	*NA	*NA	*NA	*NA

ICP1 Members with Individual Care Plan completed within 90 days of enrollment as reported to DHCS.

**Quarter 4 in process and not yet finalized.*

Table B

Reporting Period 2023	*Members Newly Enrolled*	*Members Who Declined*	*Members Who Were UTC*	*% Members Who Were UTC*	*Members Who Completed Care Plan*	*% Members Who Completed Care Plan*	*Members reached, Willing & Completed Care Plan*
Quarter 1	952	99	133	14%	206	43%	56%
Quarter 2	879	82	178	20%	371	54%	76%
Quarter 3	814	124	185	23%	471	46%	73%
Quarter 4	678	147	228	34%	406	30%	68%

ICP1 Members with Individual Care Plan completed within 90 days of enrollment as reported to DHCS.

Quantitative Analysis:

- DHCS ICP1 adjusted quarterly completion rate did not meet goal for Q1 and Q2 (Table A).
- Goal was within benchmark for Q3 with 98% of members having ICP completed within 90 days.
- When ICP1 for 2024 is compared to ICP1 2023 there is significant movement in percentage of members reached and willing to participate in ICP development.

Identified Barriers:	Identified Opportunities for Improvement:
• Members who are UTC despite outreach attempts.	• Interventions to reduce UTC rates

Conclusion: Results for DHCS reporting on ICP1 demonstrate improvement. Consistent communication to the delegated networks that identify gaps or care plans coming due contributes to this improvement. There is an opportunity to evaluate interventions that may lower the UTC rates.

Activities/Interventions to continue/add next year:

- Continue: Monitoring of ICP1 completion for DHCS quarterly reporting using MOC tracking file, Core CC0258 and ICP Dashboard
- Continue: Communications to CHCN/HN for ICP status for both initial and annual care plans
- Continue: Identification of members who are missing face-to-face interactions in the past 12 months
- Continue: Quarterly audits of delegated health networks.
- Add: Implement revision of MOC tracking for ICT monitoring
- Add: Share UTC trends for 2024 with CHCN/HN
- Add: Report on ICP2 DHCS 2024 annual reporting in Quarter 1 2025

4.3 Keeping Members Healthy

4.3.1 Health Education Services	
Business Owner: Thanh Mai/Katie Balderas	Department: Equity and Community Health
Support Staff: Michael Molina/Anna Safari	
Work Plan Element: Implement Health Education Program	
Products: ☐ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No

Work Plan Goal/Objective:

- Increase member participation in health education services

- Establish new partnerships for class locations to increase Shape Your Life (SYL) Program participation by 50% from Q2 to Q4
- By December 31st, 2024, at least 40% of the SYL participants who completed the pre- and post-assessment will increase their knowledge of basic nutrition and healthy lifestyle.

Goal Met: ☒ Yes ☐ No ☐ Partial

Work Plan Planned Activities:

1) Evaluation of current utilization of health education services
2) Maintain business for current programs and support for the community
3) Improve the process of handling member and provider requests

Status: ☐ Completed ☒ Ongoing

Background:

Health Education programs and services are tailored to member needs with a “no wrong door” approach for accessing services. While the majority of health education referrals are sent by PCPs, many members also self-refer to services seeking support to make healthy lifestyle changes. Many members choose to receive telephonic health education services provided by trained health educators. Once a member is assigned to a team member, they will participate in assessments, individualized coaching and education, including receiving personalized health education materials by mail. Additionally, Shape Your Life (SYL) is a weight management program provided by the ECH department designed for children ages 5–18 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, customized based on location and audience needs. SYL classes are open to the community and are provided in English, Spanish and Vietnamese.

Methodology:

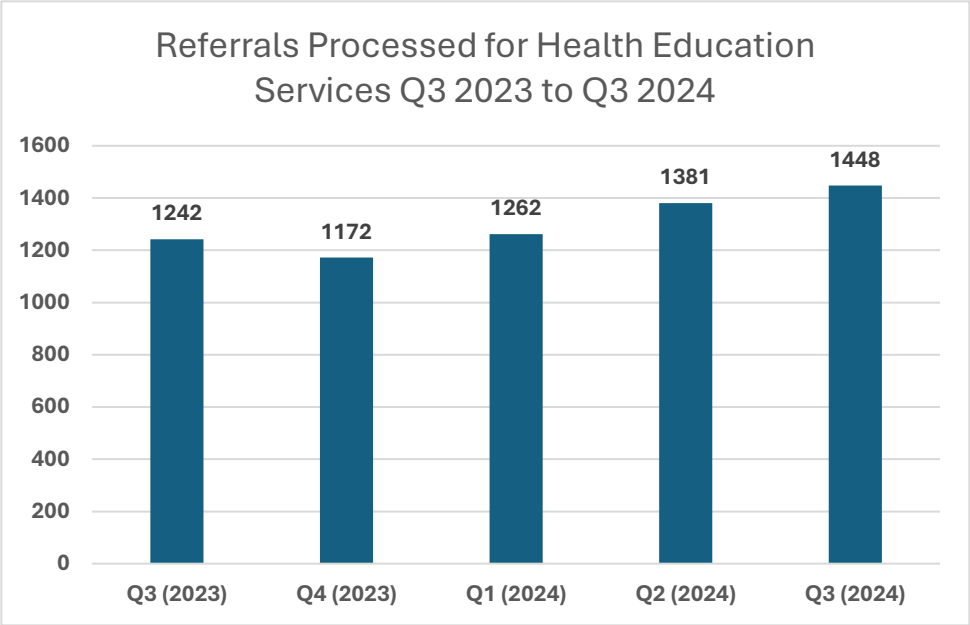
1. Referrals for health education services are received by email, fax and phone from providers, caregivers, community partners, health networks, CM department and members directly. The ECH department programs provide for the identification, assessment, stratification and implementation of appropriate interventions for all members, focusing on health conditions, including chronic diseases. Programs and materials use educational strategies and methods suitable for members, families and caregivers to make informed health decisions or modify health behaviors across the lifespan.
2. Shape Your Life measures the participant’s knowledge of the class topic in an assessment of pre and post-multiple-choice questions (before and after the lesson). The assessments are implemented in both in-person and virtual classes, in the participant’s primary language. Numerator = SYL participant who completed the pre and post-assessment with a gain. Denominator = SYL participant who completed the pre and post-assessment with the exclusion of those who scored 100% on both pre and post-assessment.

Actions/Interventions Implemented in 2024:

Quarter 1:	• Health and wellness services were promoted at all continuing education training sessions in 2024, along with reminders on how and where to send member referrals. • 1,242 referrals were processed for health education services. This was on track with similar referral counts for Q1 2023. Most incoming referrals were for weight management, but hypertension continued to be one of the top conditions. • SYL class attendance was 50 in 2023 Q1, compared to 183 attendees in 2024 Q1. This includes 60 virtual and eight in-person classes. • Promoted community classes using a standalone class flier and explored schools for further collaboration at new locations and for new topics.

	• Explored available services and blood pressure monitor utilization in relation to hypertension diagnoses, to identify gaps in services for members. • Worked on implementing a member self-referral form for health and wellness services. • Promoted Shape Your Life through Health Network Provider Relations department monthly emails to contracted providers and provider networks.
Quarter 2:	• 1,381 referrals were processed for health education services. • 67 SYL classes were completed with 568 participants. This includes 33 virtual and 34 in-person classes. • Virtual SYL classes were piloted two times a day on Tuesday, Wednesday and Thursday in English and Spanish. • The first Vietnamese in-person SYL class was implemented at a community center in Westminster. • The draft electronic member self-referral form was tested with participants attending virtual SYL classes. The form continues to be reviewed with the purpose of improving the member's self-referral experience.
Quarter 3:	• 1,448 referrals were processed for health education services. 48 SYL classes were completed with 540 attendees. This included 24 virtual and 24 in-person classes. • Based on SYL virtual class pilot results, virtual class options were reduced to two evening classes once a week in English and Spanish. • Work to implement an electronic referral form on the organization's website has been paused as the organization is prioritizing a complete website re-design, anticipated to launch in March 2025.
Quarter 4:	• 1,224 referrals were processed for health education services. • 14 virtual SYL classes were provided to 90 attendees.
Program Results:	

Chart A



Referral sources: Provider, Pharmacy, Member/Family/Caregiver, Health Network, Customer Service and Case Management

Chart B

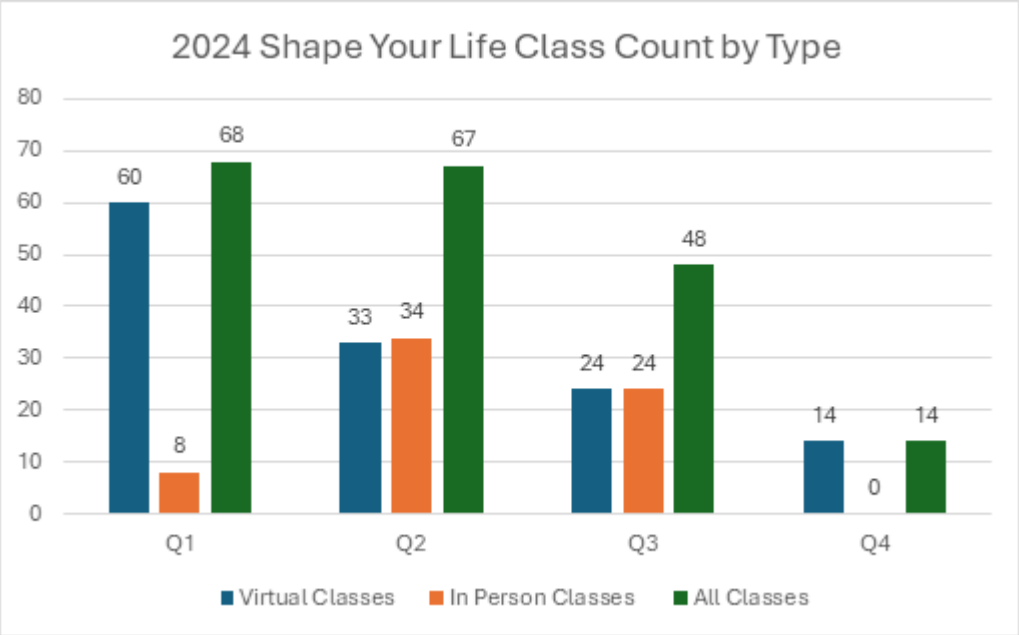
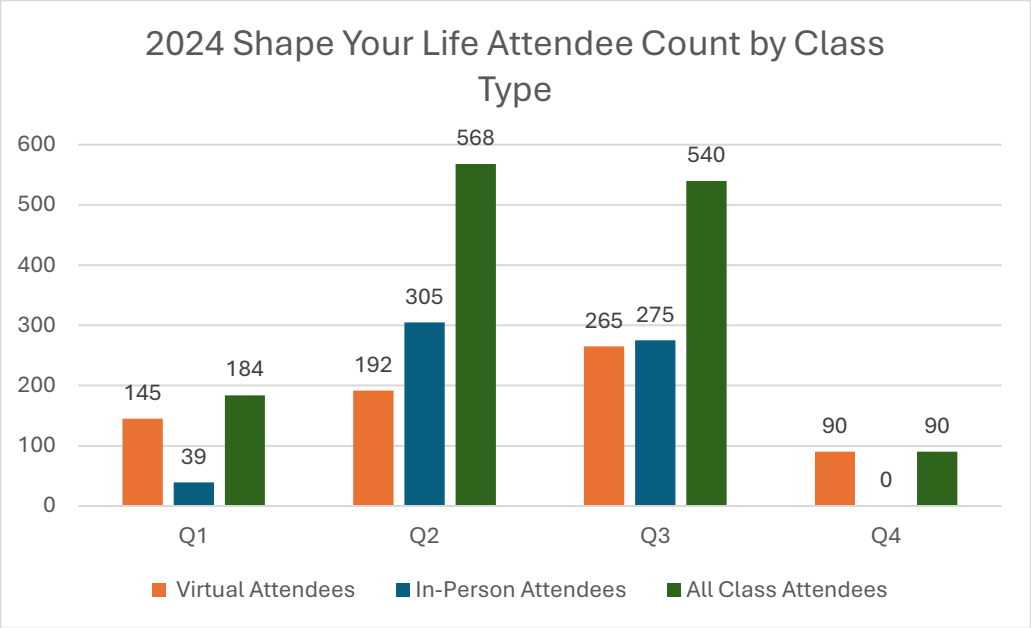


Chart C



2024 SYL Pre and Post Assessment Results by Quarter

	Child Assessment	Adult Assessment	Combined
Q1	20% (1 out of 5)	64.8% (46 out of 71)	61.8% (47 out of 76)
Q2	50.9% (56 out of 110)	54.7% (93 out of 170)	53.2% (149 out of 280)
Q3	29.7% (19 out of 64)	39.4% (63 out of 160)	34.2% (82 out of 240)
Q4	0% (0 out of 3)	62.1% (23 out of 37)	57.5% (23 out of 40)
Total (Q1-Q4)	41.7% (76 out of 182)	51.3% (225 out of 438)	**47.3%** (301 out of 636)

Quantitative Analysis:

Both program goals were met.

- Referrals for health education services steadily increased from Q1 to Q3, at a rate not previously seen. Traditionally, referrals were highest in Q1, decreasing throughout the year.
- In 2024, 47% of SYL participants who completed the pre and post assessment increased their knowledge on basic nutrition and healthy lifestyle. Results exceeded the goal.
- New partnerships for class locations were achieved, increasing from two community partners in 2023 to six community partners in 2024.
- The goal to achieve 50% increase in participation from Q2 to Q4 was also met due to the pilot and implementation of weekly virtual classes. Attendance increased by 209% from Q1 to Q2. Looking only at in-person classes, this goal was also met, with the highest participation in Q2.

Identified Barriers:	Identified Opportunities for Improvement:
• Administratively, CalOptima Health implemented a new medical management system that did not align with established customized reports for referral counts, which delayed assessments and required staff to manually track referrals. • Translation of SYL class materials, based on staff and attendee feedback, was identified as a minor challenge in gathering correct pre- and post-assessment responses. • Participants' comprehension of how to take and understand the assessment was identified as a challenge.	• Improvement areas for the SYL pre and post assessment included: 1) Emphasizing information from the assessment during class, 2) Providing pre-assessment after the group checked in to allow more time for completion and 3) Dedicating time to explicitly instructing members where to navigate the poll questions and encouraging them to submit their responses. • Offer more classes in Vietnamese to additional locations or more often.
Conclusion: The referral data indicates that health education efforts at provider and community awareness campaigns have paid off, increasing member participation in health education programming using new and existing service options. In addition, virtual classes had a higher attendance compared to in-person classes, which was expected for a population that often faces challenges with transportation and childcare. The SYL class data conveys that the program curriculum and components address relevant issues that match attendee priorities. In addition, the delivery of these educational sessions is conducted in a manner that is conducive for increasing knowledge on basic nutrition and healthy lifestyle strategies. The use of formative evaluation among class facilitators and support staff was an important process step, to quickly address barriers for meeting the program goal.	
Activities/Interventions to continue/add next year:	
• The SYL in-person class locations for 2025 have increased to 10, six of which are new. • Identify priority chronic conditions using CalOptima Health claims and encounter data to expand class topics for general audiences. • Implement a weight management presentation for general adult audiences emphasizing chronic condition prevention.	

4.3.2 Adult Wellness

4.3.2.1 Adult Preventive Screenings (CCS, BCS, COL)	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Melissa Morales/ Kelli Glynn	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: CCS: MC 59.85% BCS-E: MC 62.67% OC 71% COL: OC 71%	
Goal Met: ☐ Yes ☒ No ☐ Partial	
Work Plan Planned Activities: Assess and report the following activities:	

- Targeted member engagement and outreach campaigns in coordination with health network partners.
- Strategic Quality Initiatives Intervention Plan — Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.

Status: ☐ Completed ☒ Ongoing

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 for American women, while cervical cancer is one of the most common causes of cancer death for 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.

U.S. Preventive Services Task Force (USPSTF) has recommended screening for cervical, breast and colorectal cancers. Cancer screening tests can help 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 performance measures for HEDIS. Cervical Cancer Screening and Breast Cancer Screening are part of DHCS' MCAS for annual reporting by Medi-Cal managed care health plans. These measures are held to the MPL established by NCQA Quality Compass Medicaid 50th percentile. Breast Cancer Screening and Colorectal Cancer Screening measures are part of the CMS 5-Star quality rating system.

Methodology: Followed the HEDIS data collection methodology.

Goal methodology for MY2023 is based on the current reported performance and most current available benchmark. The Medi-Cal goal setting for MY2023 is based on the MY2021 reported performance results compared to the national percentile from the MY2021 NCQA Quality Compass. If the current reported rate reached the NCQA Quality Compass percentile, the goal was set to the next percentile. The OneCare goal setting for MY2023 is based on the MY2021 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.

Goal methodology for MY2024 is set based on the current reported performance and most current available benchmark. The Medi-Cal goal setting for MY2024 is based on the 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. The OneCare goal setting for MY2024 is based on the MY2022 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.

For health disparity analysis, the data is pulled from the member enrollment file. The data is uploaded to the NCQA certified HEDIS software for rate calculation. The stratified rates are rolled up by denominator and numerator based on the rate/ethnicity, language or gender information uploaded. Disparity analysis was conducted for CCS, BCS and COL measures based on the HEDIS September MY2024 top 10 race/ethnicity administrative data by denominator.

Medi-Cal Results:

Table A

Table below reviews the Medi-Cal final rates for HEDIS MY2023 and goals for MY2023.

Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Me/Not Met
CCS	Cervical Cancer Screening	62.28%	57.73%	58.31%	62.53%	☐ Yes ☒ No
BCS	Breast Cancer Screening	57.64%	57.81%	58.39%	61.27%	☐ Yes ☒ No

Table B

Table below reviews the Medi-Cal final rates for HEDIS MY2023 and goals for MY2023.

Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Me/Not Met
CCS	Cervical Cancer Screening	62.28%	57.73%	58.31%	62.53%	☐ Yes ☒ No
BCS	Breast Cancer Screening	57.64%	57.81%	58.39%	61.27%	☐ Yes ☒ No

Table C

Table below reviews the Medi-Cal final rates for HEDIS MY2023 and goals for MY2023.

Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Me/Not Met
CCS	Cervical Cancer Screening	62.28%	57.73%	58.31%	62.53%	☐ Yes ☒ No
BCS	Breast Cancer Screening	57.64%	57.81%	58.39%	61.27%	☐ Yes ☒ No

Table D

Table below reviews the Medi-Cal rates for September HEDIS MY2023-MY2024 and goals for MY2024.

Acronym	Measure	MY 2023 Sept Medi-Cal Rate	MY 2024 Sept Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Me/Not Met
CCS	Cervical Cancer Screening	50.33%	45.81%	59.85%	☐ Yes ☒ No
BCS	Breast Cancer Screening	51.72%	53.44%	62.67%	☐ Yes ☒ No

OneCare Results:

Table E

Table below reviews the OneCare final rate for HEDIS MY2023 and goals for MY2023.

Acronym	Measure	MY 2021 OneCare Rate	MY 2022 OneCare Rate	MY 2023 OneCare Rate	MY 2023 OneCare Goal	MY 2023 Goal Me/Not Met
BCS	Breast Cancer Screening	66.17%	65.20%	66.88%	70%	☐ Yes ☒ No
COL	Colorectal Cancer Screening	62.34%	64.23%	66.84%	71%	☐ Yes ☒ No

Table F

Table below reviews the OneCare rates for September HEDIS MY2023-MY2024 and goals for MY2024.

Acronym	Measure	MY 2023 Sept OneCare Rate	MY 2024 Sept OneCare Rate	MY 2024 OneCare Goal	MY 2024 Goal Me/Not Met
BCS	Breast Cancer Screening	60.48%	63.80%	71%	☐ Yes ☒ No
COL	Colorectal Cancer Screening	57.77%	60.89%	71%	☐ Yes ☒ No

Table G

Table below reviews September MY2024 Cervical Cancer Screening by Race/Ethnicity Based on Administrative Data.

Admin	**Race/Ethnicity**									
HEDIS Sept MY2024	*Hispanic*	*White*	*Vietnamese*	*No response, client declined to state*	*Other*	*Korean*	*Black*	*Filipino*	*Chinese*	*Asian or Pacific Islander*
Numerator	42345	12772	14650	5943	9089	1701	1223	1215	973	795
Denominator	99823	32891	25169	18164	17954	4582	3158	3041	2861	2041
Rate	42.42 %	38.83 %	58.21 %	32.72 %	50.62 %	37.12 %	38.73 %	39.95 %	34.01 %	38.95 %

Table caption: Table displays the top 10 ethnicities with the highest denominator based on total HEDIS Medi-Cal population.

Table H

Table below reviews September MY2024 Breast Cancer Screening by Race/Ethnicity Based on Administrative Data.

Admin	**Race/Ethnicity**									
HEDIS Sept MY2024	*Hispanic*	*Vietnamese*	*White*	*Other*	*No response, client declined to state*	*Korean*	*Filipino*	*Chinese*	*Asian or Pacific Islander*	*Black*
Numerator	16591	8162	4948	3418	2381	921	785	562	466	353
Denominator	30979	13784	12480	6706	5942	2106	1566	1476	1012	917
Rate	53.56 %	59.21 %	39.65 %	50.97 %	40.07 %	43.73 %	50.13 %	38.08 %	46.05 %	38.50 %

Table caption: Table displays the top 10 ethnicities with the highest denominator based on total HEDIS Medi-Cal and OneCare population combined.

Table I

Table below reviews September MY2024 Colorectal Cancer Screening by Race/Ethnicity Based on Administrative Data.

Admin	**Race/Ethnicity**									
HEDIS Sept MY2024	*Hispanic*	*White*	*Vietnamese*	*Other*	*No response, client declined to state*	*Korean*	*Filipino*	*Chinese*	*Black*	*Asian or Pacific Islander*
Numerator	27661	10791	14915	6439	4495	1694	1269	1115	838	867
Denominator	79844	33025	30484	16017	15932	4693	3275	3084	2670	2395
Rate	34.64 %	32.68 %	48.93 %	40.20 %	28.21 %	36.10 %	38.75 %	36.15 %	31.39 %	36.20 %

Table caption: Table displays the top 10 ethnicities with the highest denominator based on total HEDIS Medi-Cal and OneCare population combined.

Actions/Interventions Implemented in 2024:

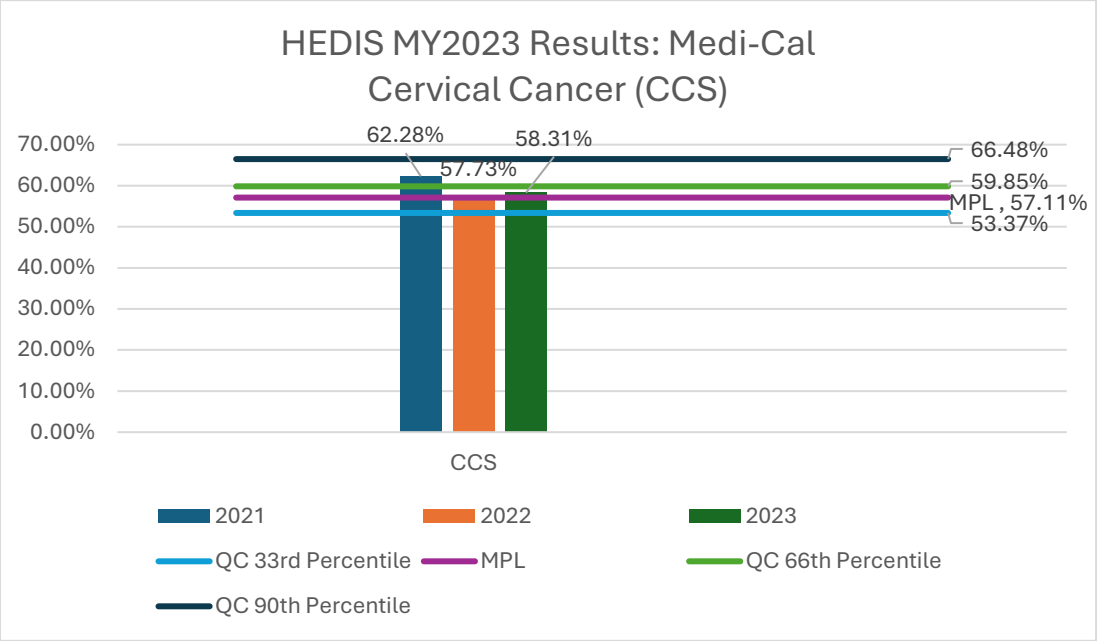
Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Member Health Reward	☒ MC ☒ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	CCS BCS COL
2. Member Mailing	☒ MC ☒ OC	☐ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☒ Completed ☐ On-going ☐ Incomplete	CCS BCS COL
3. IVR	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☒ Completed ☐ On-going ☐ Incomplete	CCS BCS COL
4. Text Messaging	☒ MC ☒ OC	☐ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☐ On-going ☐ Incomplete	CCS BCS COL
5. Telephonic Outreach	☒ MC ☒ OC	☐ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	CCS BCS COL
6. Standing Orders Program	☒ MC ☒ OC	☐ Q1 ☐ Q2 ☐ Q3 ☒ Q4	☒ Member ☒ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	BCS COL
7. Gap-in-Care Reporting	☒ MC ☒ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	CCS BCS COL
8. Specialty Collaboration with Gastroenterology	☐ MC ☒ OC	☐ Q1 ☐ Q2 ☒ Q3 ☒ Q4	☒ Member ☒ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	COL
9. Cologuard	☒ MC ☒ OC	☐ Q1 ☐ Q2 ☐ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	COL

MC = Medi-Cal; OC= OneCare

Results:

Chart A

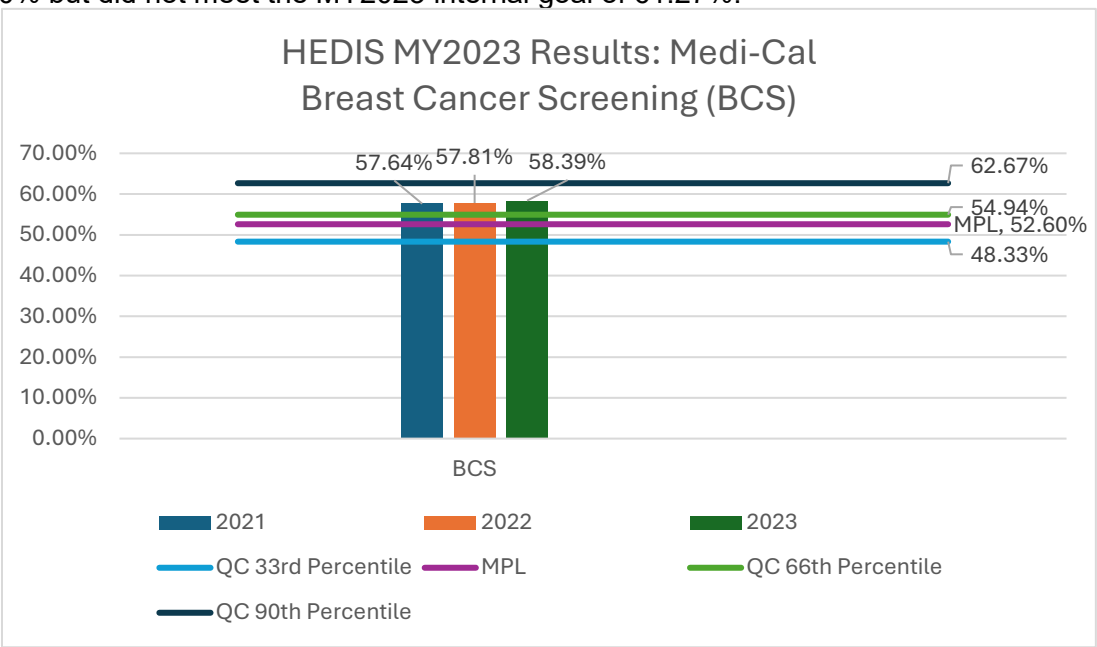
- CalOptima Health's HEDIS MY2023 CCS hybrid rate for Medi-Cal was 58.31% and met the MPL of 57.11% but did not meet the MY2023 internal goal of 62.53%.



Per HEDIS 2022 Quality Compass Percentile

Chart B

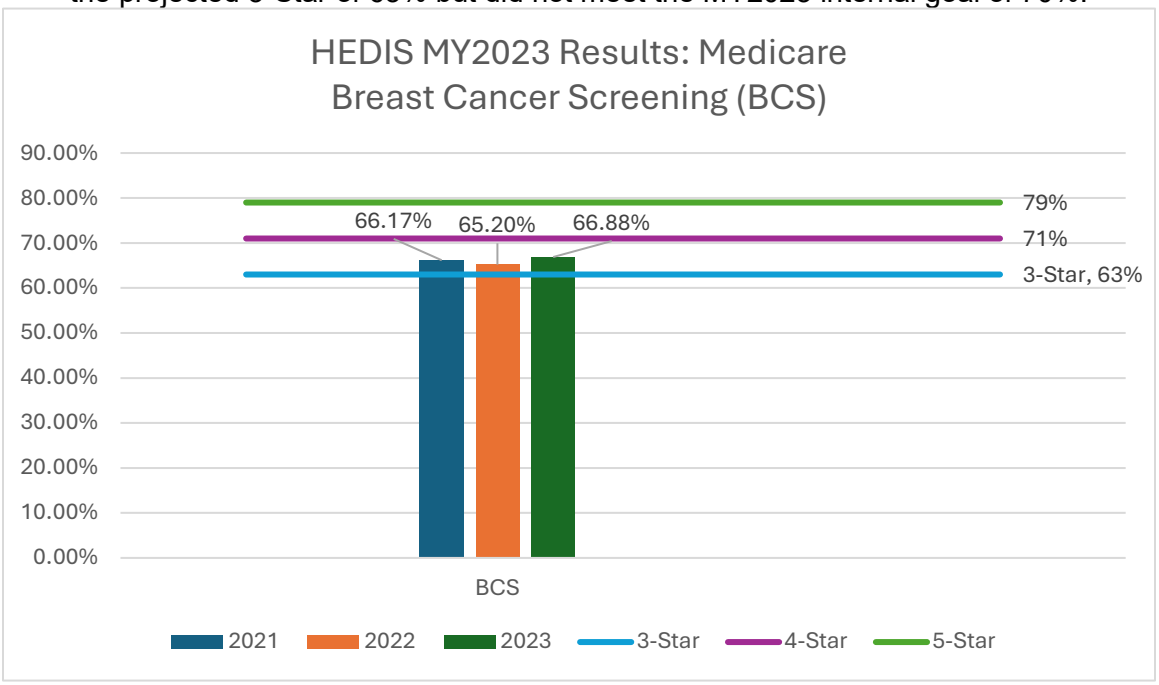
- CalOptima Health HEDIS MY2023 BCS rate for Medi-Cal was 58.39% and met the MPL of 52.60% but did not meet the MY2023 internal goal of 61.27%.



Per HEDIS 2022 Quality Compass Percentile

Chart C

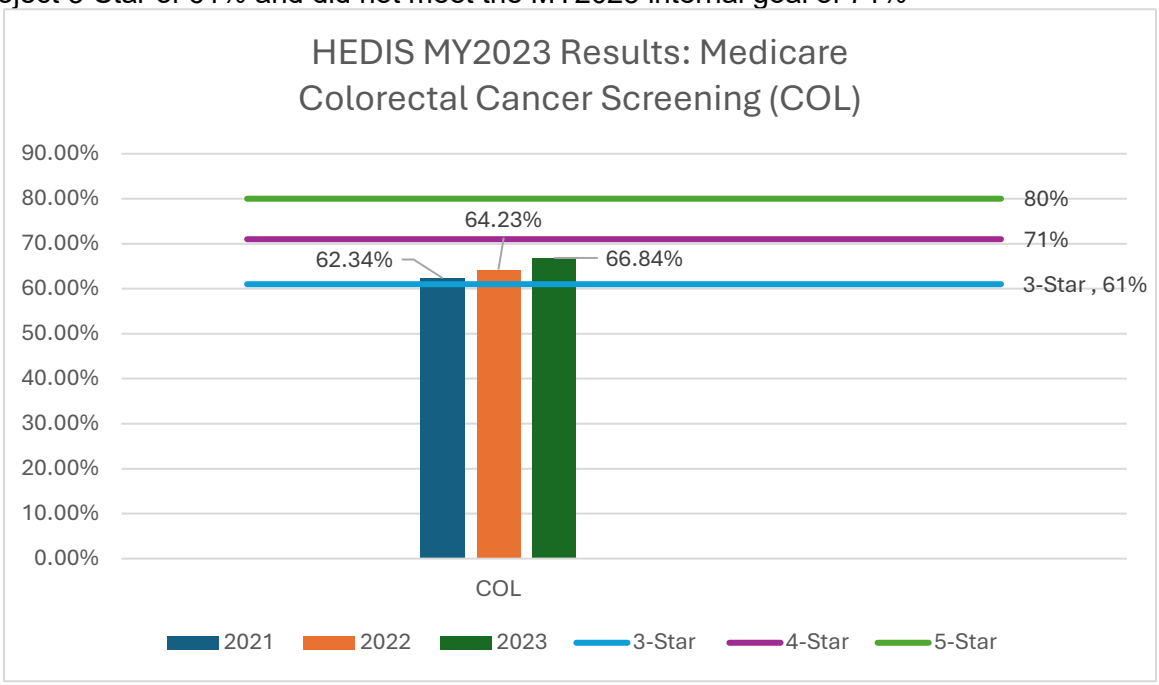
- CalOptima Health's HEDIS MY2023 BCS administrative rate for OneCare was 66.88% and met the projected 3-Star of 63% but did not meet the MY2023 internal goal of 70%.



CMS 2024 Stars Benchmarks

Chart D

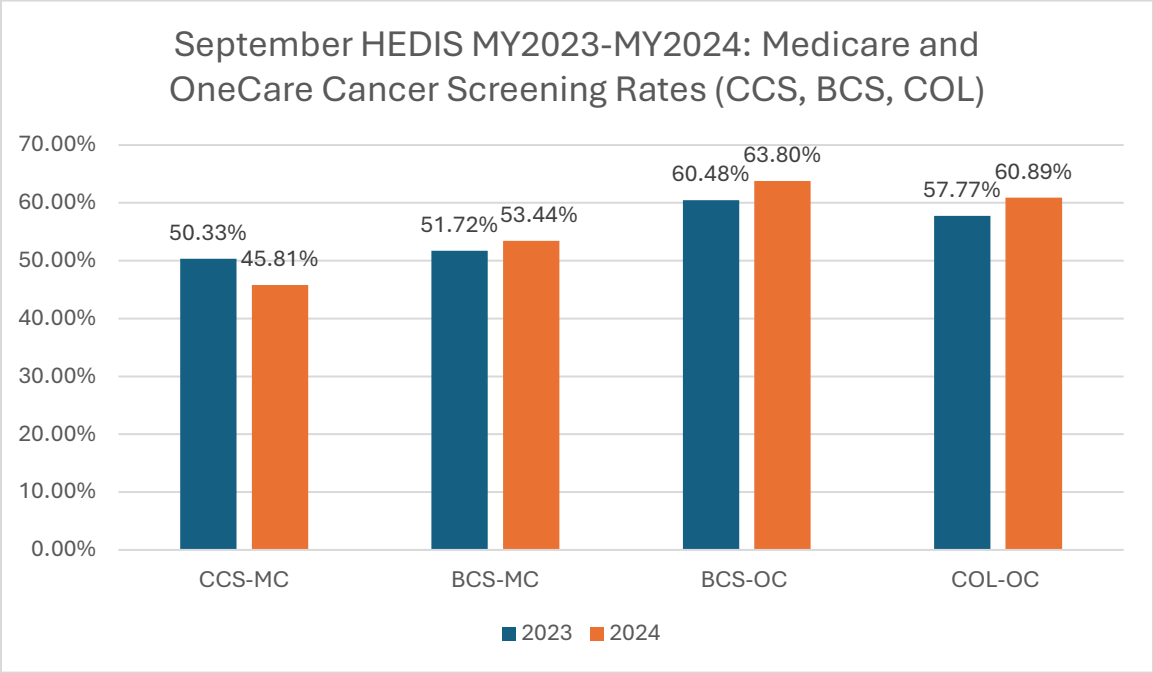
- CalOptima Health's HEDIS MY2023 COL hybrid rate for OneCare was 66.84% and met the project 3-Star of 61% and did not meet the MY2023 internal goal of 71%



CMS 2024 Stars Benchmarks

Chart E

- CalOptima Health Cancer screening rates for September HEDIS MY2023–2024 for Medi-Cal and OneCare



Claims/encounters processed through September 2024

Quantitative Analysis:
Comparing CalOptima Health Medi-Cal cancer screening prospective rates for September HEDIS MY2023-MY2024. The rates are based on the administrative data and represent the claims/encounters process through the month of September for each respective year.

- Cervical Cancer Screening (CCS): As of September 2024, the CCS prospective rate was 45.81%, which is lower than the September 2023 prospective rate of 50.33% by 4.52 percentage points.
- Breast Cancer Screening (BCS-MC): As of September 2024, the BCS prospective rate was 53.44%, which is higher than the September 2023 prospective rate of 51.72% by 1.72 percentage points.
- Breast Cancer Screening (BCS-OC): As of September 2024, the BCS prospective rate was 63.80%, which is higher than the September 2023 prospective rate of 60.48% by 3.32 percentage points.
- Colorectal Cancer Screening (COL-OC): As of September 2024, the COL prospective rate was 60.89%, which is higher than the September 2023 prospective rate of 57.77% by 3.12 percentage points.

Disparity Analysis:
CCS: When looking at the top three race/ethnicity groups by denominator count, the Vietnamese group had the highest rate, at 58.21%, while the group identified as White had the lowest rate, at 38.83%.

BCS-MC, OC: When looking at the top three race/ethnicity groups by denominator count, the Vietnamese group had the highest rate at 53.56%. While the group identified as White had the lowest rate at 39.65%.

COL-MC, OC: When looking at the top three race/ethnicity groups by denominator count, the Vietnamese group had the highest rate at 48.93%, while the group identified as White had the lowest rate at 32.68%.

Identified Barriers:	Identified Opportunities for Improvement:
• Members did not visit their PCP during MY2024, 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 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 shortages, resulting in long wait times. • Due to data lag of approximately 90 days, the September 2024 prospective rate may not provide the most accurate rate of completion of cancer screening measures. • Hybrid measures like Cervical Cancer Screening for Medi-Cal require medical record review; therefore, the actual final rate for MY2024 may be higher.	• Data optimization • Provider and health network quality committee meetings provide input on quality-related opportunities, helping identify barriers, develop and implement effective approaches • Develop member journey campaigns with new text messaging vendor to diminish member outreach abrasion. • Member outreach specific to factors such as age. • Internal member-facing departments will remind members of gaps in care during calls. • Educate eligible members of direct access to imaging centers and gastroenterology specialists that no referral is needed. • Engagement with specialists, such as OB/GYNs

Conclusion:
Although we did not meet the internal CalOptima Health goal, we did reach MPL for Medi-Cal measures and 3-Star for OneCare Measures. On October 2024, the 2025 Star ratings were published, and for OneCare, BCS and COL reached 3-Star. CalOptima Health will retain CCS, BCS and COL measures on the 2025 QI Work Plan and continue to focus on preventative care screenings to address expected dips in utilization by conducting multicomponent interventions (mailers, automated calls and text messaging, e-mail) to increase demand for cancer screenings.

Activities/interventions to continue/add next year:

- Continue health rewards for eligible CalOptima Health members for CCS, BCS and COL measures. In anticipation of the COL measure possibly being held to the MPL for MCAS, CalOptima Health expanded health reward offering to include COL member health reward for eligible Medi-Cal members. Will continue to increase participation in the program and motivate members to schedule and complete cancer screenings.
- The hybrid CCS measure reached MPL in MY2023 by a small margin. The new national benchmark was released in September 2024 and the MPL has increased from 57.11% to 57.18%. Opportunity remains to increase the CCS measure. MCAS announced that they are removing the hybrid reporting method for CCS and transitioning to Electronic Clinical Data Systems (ECDS) reporting in MY2025, which may have an impact on MCAS reporting in 2026. Accordingly, in MY2025, CalOptima Health will explore EMR integration with high-volume providers.
- In MY2024, CalOptima Health removed the prior authorization for OneCare colorectal cancer screening. Will expand removal of prior authorization for breast cancer screening.

- In MY2024, CalOptima Health awarded ~$2.1 million dollars in quality improvement grants to health network partners and CHCN providers. Many of the grant programs will focus on the CCS, BCS and COL measures.
- In MY2024, CareNet conducted live agent calls to members with multiple gaps in care. In MY2025, internal member-facing staff will have access to Decision Point to remind members of cancer screenings that they are due for at the point of member contact.
- Cancer screening measures are part of the CalOptima Health Comprehensive Community Cancer Screening Program and grant funding has been dispersed to organizations to work towards increasing awareness and access to cancer screening.
- In MY2025, CalOptima Health will increase breast cancer screening access by offering mobile mammography.
- Staff will use disparity analysis to develop interventions to target higher-risk members with health inequities caused by race/ethnicity.

4.3.2.2 CalOptima Health Comprehensive Community Cancer Screening Program	
Business Owner: Dr. Richard Pitts	Department: Medical Management
Support Staff: Joanne Ku	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: • Increase capacity and access to cancer screening for breast, colorectal, cervical and lung cancer.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: Assess and report the following: • Establish the Comprehensive Community Cancer Screening and Support grants program • Work with a vendor to develop a comprehensive awareness and education campaign for members	
Status: ☐ Completed ☒ Ongoing	
Background: On December 1, 2022, the Board of Directors approved $50.1 million to support the CalOptima Health Comprehensive Cancer Screening and Support Program. The goal of this large-scale initiative is to increase cancer screening rates for breast, cervical, colon and lung cancers in order to improve the health and well-being of members in Orange County.	
Methodology: For the awareness and education campaign, Maricich (contracted vendor) used the following metrics to assess digital performance: education, impressions/views, appointments and click-through rate (CTR)/web engagement. For community grants, there is no data collected at this time, as the first progress report is due December 31, 2024.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Developed a competitive grant program to support activities that increase early detection and decrease late-stage discovery. We released a notice of funding opportunity in February 2024 and received grant applications from 22 organizations. We anticipate grant implementation of selected grantees will begin in July 2024, pending Board approval in June 2024. • Launched the awareness and education campaign with a marketing firm. Discovery phase took place from January to March, with 15 discovery sessions that included internal and external stakeholder input from community-based organizations (CBOs), health networks and providers.
Quarter 2:	• Reviewed, scored and selected 15 grant proposals for Board approval recommendation. Timeline for Board approval moved from June to August 2024.

	• Insight from the stakeholder sessions informed campaign strategy and approach, and staff is currently engaged with marketing firm in the development of creative concepts.
Quarter 3:	• Board approved 15 grant proposals from 13 organizations on August 1, 2024. • Executed all grant agreements in early September 2024. Completed the first grant payment. • Currently engaged in weekly meetings with mPulse to develop and refine Short Message Service (SMS) content, with the goal of improving member engagement and scheduling of screening appointments.
Quarter 4:	• Held the grantees' kickoff meeting on October 2, 2024. • Hosted a virtual webinar to provide reporting instructions on November 8, 2024 • Met with individual grantees (ACS, TFG) to provide support. • Submitted SMS contents to DHCS for approval. • Worked on an RFP for a research and evaluation initiative.

Program Results:

Awareness and Education Campaign:
Timeframe: August 2024–October 2024

- 16.6 million campaign digital ad impressions to date
- 0.28% CTR digital channels
- 8.2 million digital added value impressions to date
- 784K completed video views (video assets launched in October)
- 46K digital clicks to landing page

Community Grants:

- Received 22 grant applications.
- Awarded 15 grants to 13 organizations, with two organizations receiving multiple grants

Quantitative Analysis: No quantitative analysis is available yet as we are still in the early phase of the program. The first progress report from the grantees is due December 31, 2024.

Identified Barriers:	Identified Opportunities for Improvement:
• Due to a change in project management leadership, several critical operational requirements were delayed, including the Business Associate Agreement (BAA), external data exchange request form, grant amendment process and overlapping member lists for grantees' outreach activities.	• Consider a whiteboard session to strategize and plan oversight of all program components.

Conclusion: As we kicked off 2024 with a successful launch, awarding the first round of grants and launching a digital media campaign, we've set a strong foundation for this important initiative. It was inspiring to see all grantees come together, fostering collaboration and synergy.

Activities/Interventions to continue/add next year:

- Continue quarterly grantee meetings
- Produce a high-impact report that analyzes data to inform future strategies
- Launch the research and evaluation RFP
- Develop more concrete plans for the OC3 Collaborative and Member Journey Interventions initiatives.

4.3.3 Maternal Health

4.3.3.1 Prenatal and Postpartum Care (PPC)	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Kelli Glynn/Leslie Vasquez	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: TOPC: 91.89%, PPC: 84.18%	
Goal Met: ☐ Yes ☒ No ☐ Partial	
Work Plan Planned Activities: 1. Targeted member engagement and outreach campaigns via collaboration with health networks and utilizing multiple communication channels 2. Expansion of Bright Steps 3. Collaborative member engagement events with community-based partners 4. Expansion of member engagement through direct services such as the doula benefit and educational classes The planned activities/initiatives outlined in the section below are reflective of the Work Plan's activities.	
Status: ☐ Completed ☒ Ongoing	
Background: Joint guidelines published by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) recommend a prenatal visit in the first trimester for all birthing persons. ACOG also recommends that all birthing persons have a comprehensive postpartum visit which provides an opportunity to address physical, mental and emotional health early on, followed by ongoing care as needed Prenatal and Postpartum Care (PPC) is a hybrid quality performance measure for HEDIS and is part of the DHCS MCAS that is held to a minimum performance level established by NCQA. HEDIS plays a critical role in supporting maternal health by assessing the quality and timeliness of care provided to birthing persons before and after childbirth. PPC has two components that assess the following for deliveries on or between October 8 of the year prior to October 7 of the current measurement year: 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. PPC: The percentage of deliveries that received a postpartum care visit on or between seven and 84 days (one–12 weeks) after delivery.	
Methodology: CalOptima Health follows the HEDIS data collection methodology to assess performance with prenatal and postpartum care. The methodology for the MY2023 goal is based on the MY2021 reported performance results compared to the MY2021 NCQA Quality Compass national percentile (benchmark). If the performance rate meets the NCQA Quality Compass benchmark, CalOptima Health will set its goal to the next NCQA percentile to encourage continued performance improvement. However, if the measure rate falls below the 50th percentile, then CalOptima Health sets the 50th percentile as the organizational goal. NCQA stratified select measures like PPC for race and ethnicity to support the identification of disparities amongst the patient population. Race and ethnicity data for MY2023 reflect these	

stratification requirements. PPC data was stratified by race and ethnicity and compared to the overall PCC rate to identify any disparities.

Medi-Cal Results: The table below indicates the final Medi-Cal rates for HEDIS MY2023 and how the rate fares against the goal set for MY2023.

Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Me/Not Met
TOPC (hybrid)	PPC: Timeliness of Prenatal Care	91.0%	88.10%	88.10%	91.89%	☐ Yes ☒ No
PPC (hybrid)	PPC: Postpartum Care	81.60%	81.2%	80.00%	84.18%	☐ Yes ☒ No

In MY2023, TOPC did not meet the MY2023 organizational goal; however, TOPC met the NQCA Quality Compass benchmark of 84.23%. Similarly, PPC did not meet the desired MY2023 organizational goal. PPC did meet the NQCA Quality Compass benchmark of 78.1% for MY2023.

Actions/Interventions Implemented in 2024:

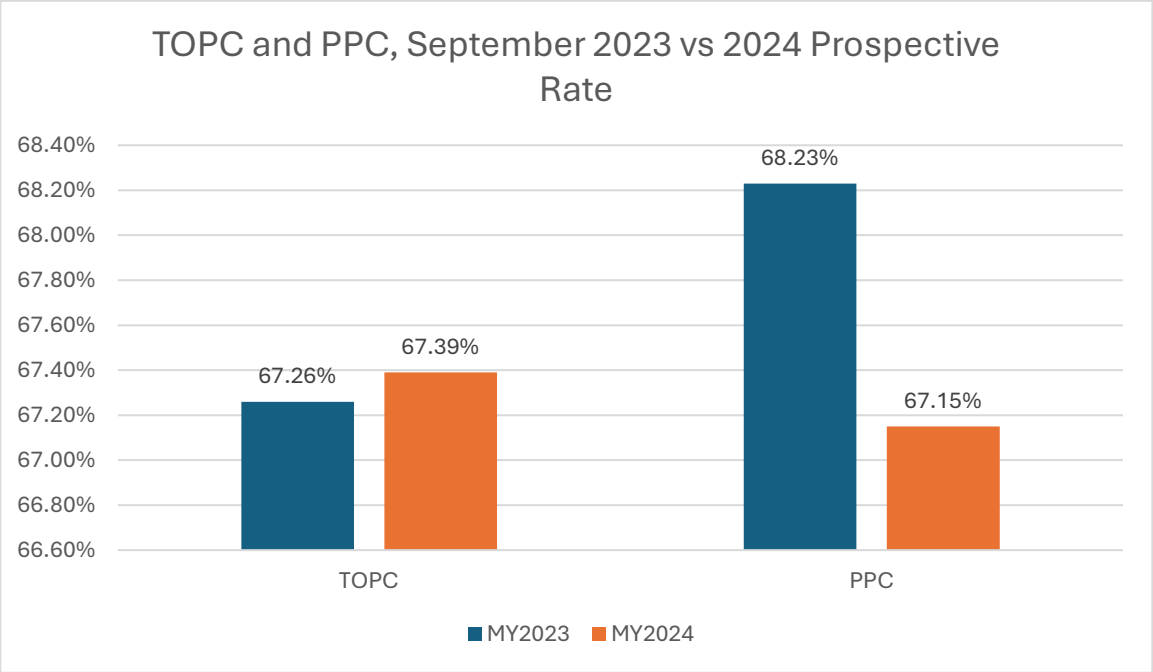
Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Postpartum health reward	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	PPC
2. Bright Steps Program — CalOptima Health's maternal health program provides nutrition, health education, psychosocial support and resource referrals to members during and for one year post-pregnancy.	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	TOPC PPC
3. Paid Digital and Social Media Ads — Provide education regarding the importance of prenatal and postpartum care Ads were in English, Spanish, and Vietnamese and targeted lower performing zip codes across those member languages.	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	TOPC PPC
4. PBS TV ad for maternal health	☐ MC ☐ OC	☐ Q1 ☒ Q2 ☒ Q3 ☐ Q4	☒ Member ☐ Provider ☐ Health Network ☒ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	TOPC PPC
5. Member newsletter	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☒ Q3 ☐ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☒ Completed ☐ On-going ☐ Incomplete	TOPC PPC
6. Provider education — Provider education efforts include presenting on the PPC measure and coding requirements.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☒ Health Network ☒ Community ☐ Data ☐ Other	☒ Completed ☐ On-going ☐ Incomplete	TOPC PPC
7. Postpartum care reminder call campaign	☒☒ MC ☐☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☒☒ Completed ☐☐ On-going ☐☐ Incomplete	PPC

8. Planned: Provider education The development of a coding guide to support practitioners who conduct bundled coding is planned for Q4 to support increased data capture for the PPC measure.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☒ Q4	☐ Member ☒ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☐ On-going ☒ Incomplete	TOPC PPC
9. P4V program	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☐ Member ☒ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☐☒ On-going ☐ Incomplete	TOPC PPC
10. Planned: Report development utilizing available admit, discharge transfer (ADT) data to support the early identification of members that delivered for postpartum education	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☐ Provider ☐ Health Network ☐ Community ☒ Data ☐ Other	☐ Completed ☐ On-going ☐☒ Incomplete	PPC

MC = Medi-Cal
OC= OneCare

Results:

Chart A. MY2023 and MY2024 September Prospective Rate for TOPC and PPC



Prospective rate (PR) methodology includes continuous enrollment criteria. PPC and TOPC are hybrid measures. Prospective rates are solely based on administrative data and are not final.

- TOPC performance in September 2024 is performing relatively similar to September 2023. The increase in the rate for 2024 is not statistically significant.
- PPC is performing 1.08% lower in September 2024 compared to September 2023.

Table A. MY2023 Timeliness of Prenatal Care Rates by NCQA Ethnicity

NCQA Ethnicity	**Hispanic/Latino**	**Unknown**	*Total*
Numerator	4,256	2,500	6,756
Denominator	5,190	3,214	8,404
Rate	82.00%	77.78%	80.39%

Table A displays timeliness of prenatal care rates per NCQA ethnicity specifications. The rates displayed are based on administrative data and do not reflect the final HEDIS rate. Comparisons were made against the total rate of 80.39%. Members that identify as Hispanic/Latino have a higher compliance rate (82.00%) than members whose ethnicity is unknown (77.78%).

Table B. MY2023 Timeliness of Prenatal Care Rates by NCQA Race

NCQA Race	Unknown	Other	White	Asian	Black	Native Hawaiian and Other Pacific Islander	American Indian and Alaskan Native	Total
Numerator	4,713	718	621	575	106	13	10	6,756
Denominator	5,762	890	827	754	140	21	10	8,404
Rate	81.79%	80.67%	75.09%	76.26%	75.71%	61.90%	100%	80.39%

Table B displays Timeliness of Prenatal Care rates per NCQA race specifications. The rates displayed are based on administrative data and do not reflect the final HEDIS rate. See Quantitative Analysis.

Table C. MY2023 Postpartum Care Rates by NCQA Ethnicity

NCQA Ethnicity	*Hispanic/Latino*	*Unknown*	*Total*
Numerator	3,928	2,311	6,239
Denominator	5,190	3,214	8,404
Rate	75.68%	71.90%	74.24%

Table C displays postpartum care rates per NCQA ethnicity specifications. The rates displayed are based on administrative data and do not reflect the final HEDIS rate. Comparisons were made against the total rate 74.24%. Similar to TOPC, the group with the unknown ethnicity performed lower than both the Hispanic/Latino group and the overall total rate.

Table D. MY2023 Postpartum Care Rates by NCQA Race

NCQA Race	Unknown	Other	White	Asian	Black	Native Hawaiian and Other Pacific Islander	American Indian and Alaskan Native	Total
Numerator	4,338	664	549	572	100	10	6	6,239
Denominator	5,762	890	827	754	140	21	10	8,404
Rate	75.29%	74.61%	66.38%	75.86%	71.43%	47.62%	60%	74.24%

Table D displays Postpartum Care rates per NCQA race specifications. The rates displayed are based on administrative data and do not reflect the final HEDIS rate. See Quantitative Analysis.

Quantitative Analysis:

- When assessing final rates (hybrid) for both TOPC and PPC, there has been no significant improvement in performance between MY2021 and MY2023.
- Tables A and B showcase race and ethnicity data, respectively, per NCQA specifications for TOPC. When assessing for race, a large portion of the population was identified as Unknown. Native

Hawaiian and Other Pacific Islander represent the smallest ethnic group, however their TOPC rate was the lowest at 61.90% when compared to the overall total rate of 80.39%.

- Timeliness of Prenatal Care performance was assessed among racial groups with 100 or more members. Data stratified by racial groups were then compared to the overall rate for PPC Two additional racial groups that performed lower than the total rate (overall population) were White and Black, 75.09% and 75.71%, respectively, indicating an opportunity for targeted initiatives.
- Tables C and D showcase race and ethnicity data, respectively, per NCQA specifications for PPC. When assessing for race, a large portion of the population was identified as Unknown. The following three racial groups performed the lowest for PPC: White (66.38%), American Indian and Alaskan Native (60%) followed by Native Hawaiian and Other Pacific Islander (47.62%), American Indian and Alaskan Native (60%), followed by White (66.38%) when compared to the overall rate of 74.24%. This represents opportunities for targeted initiatives for these three groups.
- Across all racial groups, performance with postpartum care was lower compared to prenatal care. This represents opportunities for the health plan to explore the implementation of culturally appropriate messages in the prenatal period to support postpartum care as well as logistical issues (e.g., transportation) that may impede timely postpartum care.

Identified Barriers:	Identified Opportunities for Improvement:
• Delays of claims and encounter data present challenges for the timely identification of a delivery, which impacts the modalities in which CalOptima Health can leverage communication to outreach to members, support care coordination and reminders for care. • Prenatal and postpartum care have varying coding practices. Bundled billing practices, in particular, can present challenges when the appropriate codes are not utilized, thus affecting the identification of care issued to members. • CalOptima Health serves a diverse population. Cultural factors may contribute to gaps related to prenatal and postpartum care. Cultural factors may impact the timeline for which members seek timely prenatal care. Cultural practices and observations after delivery may impact the timeliness in which members seek the completion of a postpartum visit. Member perception as it relates to the value and importance of timely prenatal and postpartum care may impact member practices.	• Report development utilizing ADT data to support early identification for postpartum care. • Development of a guide for practitioners practicing bundled billing for maternal care. • Continue a multi-modal approach for members when issuing education about the importance of timely care. Outreach efforts should be representative of the various groups.

Conclusion:

A comprehensive strategy is needed to address the following:

- Proactive member outreach — Leverage data (e.g., claims, prescriptions) to trigger early member identification and engagement
- Provider education and training — Ongoing messaging and support to reduce disparities in maternal care, education on coding practices and cultural sensitivity
- Culturally tailored approach — Design campaigns that acknowledge cultural practices surrounding pregnancy and postpartum care
- Enhanced partnerships — CBOs can provide insight into barriers or facilitators of health that managed care plans may not have insight on.

Activities/interventions to continue/add next year:

- Continue the postpartum health reward and implement a broader promotion strategy
- Continue to promote postpartum care during the prenatal period and assess for barriers prior to delivery
- Targeted member outreach via various modalities: mailing, text, IVR calls
- Enhanced partnership with CBOs
- Continue to partner with health networks to identify providers to partner with for efforts that improve care delivery or reduce member barriers to care
- Develop initiatives (e.g., culturally appropriate material) aimed at reducing disparities amongst lower performing racial groups for improved TOPC and PPC performance.

4.3.3.2 Maternal Health Programs (Bright Steps and Perinatal Support Services)	
Business Owner: Katie Balderas	Department: Equity & Community Health
Support Staff: Ann Mino	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: The Bright Steps Program did not have an assigned goal but was used as an activity for all maternal health goals.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: 1) Provide prenatal and postpartum education to participating members. 2) Continue the expansion of the Bright Steps Program through community partnerships, provider/health network partnerships and member engagement. 3) Continue the expansion of the Bright Steps Program through community partnerships, provider/health network partnerships, the doula benefit and member engagement.	
Status: ☐ Completed ☒ Ongoing	
Background: The Bright Steps Program was initiated in 2018 to support perinatal members with nutrition education, health education, social support and referrals/resources needed to obtain a healthy pregnancy. This telephonic program assesses members on a trimester basis, at postpartum and through the first year after delivery (infant assessments and maternal mental health). Based on members' responses and needs, internal and community referrals and resources are provided to the members. Through its expansion, the Bright Steps Program has implemented and supported community events	
Methodology: Data collected included the number of referrals to the program (pregnancy notification reports, self-referral, health network referrals, etc.). From those referrals, it is determined how many members were assessed, declined participation or were UTC, as well as additional assessments for the infant/postpartum period.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Telephonic outreach to pregnant and postpartum members • Support doula benefit implementation
Quarter 2:	• Telephonic outreach to pregnant and postpartum members • Support doula benefit implementation
Quarter 3:	• Telephonic outreach to pregnant and postpartum members • Support doula benefit implementation • Breastfeeding event
Quarter 4:	• Telephonic outreach to pregnant and postpartum members • Support doula benefit implementation • Clinic day event at UCI Santa Ana

	• Clinic day event at UCI Anaheim

Program Results:

Chart A: Member Outreach (unique)

BSP Unique Member Outreach	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Maternal Members Assessed	471	319	348	283
Member Decline	13	9	4	13
Unable to Contact (UTC)	418	467	425	205
Total Unique Member Outreach	902	795	777	501

Quantitative Analysis:
The objectives/goals were met. The numbers remain steady over the year. Additionally, referrals remain steady over the year as well. While these goals were met, there is a huge opportunity for expansion to serve additional members. Currently, CHCN members are primarily serviced through the Bright Steps Program and self-referring members, but this could be expanded.

Identified Barriers:	Identified Opportunities for Improvement:
• High UTC rate • Identification of pregnant members can be difficult • PNRs can be difficult to get from providers	• Member opt-in program • Improve pregnancy data • Continue to improve access to doulas, community support and care management for perinatal members

Conclusion:
The program is successful. However, there are areas of improvement that should be considered to better support prenatal and postpartum HEDIS rates including appointments, screening and vaccines. Increasing the community and provider-partnered focus had successful outcomes and expansion of those services should be considered.

Activities/Interventions to continue/add next year:

- Community events
- Clinic days/partner with providers
- Expand doula services

4.3.4 Pediatric/Adolescent Wellness

4.3.4.1 Preventive Care (CIS-Combo 10, W30 First 15 and 15-30, IMA-Combo 2, WCV- total)	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Kelli Glynn/Leslie Vasquez	
Work Plan Element: Yes	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: HEDIS MY2024 Goal CIS-Combo 10: 45.26%, IMA-Combo 2: 48.80%, W30-First 15 Months: 58.38%, W30-15 to 30 Months: 71.35%, WCV (Total): 51.78%	
Goal Met: ☐ Yes ☐ No ☒ Partial	
Work Plan Planned Activities: • Targeted member engagement and outreach campaigns in coordination with health network partners.	

• Quality Initiatives Intervention Plan — Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. • Early identification and data gap bridging remediation for early intervention
Status: ☐ Completed ☒ Ongoing
Background: According to the CDC, well-child visits and recommended vaccinations are essential for good health. Well-child visits are essential for tracking growth and development milestones, discussing any concerns about a child's health, and is the time for children to receive scheduled vaccinations to prevent illnesses and receive recommended screenings (e.g., blood lead testing, developmental screenings). 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-Combo2) • Child and Adolescent Well-Care Visits (WCV-Total) These measures are aligned with the DHCS Medi-Cal MCAS and held to the benchmarks established by the NCQA Quality Compass.
Methodology: CalOptima Health follows HEDIS data collection methodology to assess performance with prenatal and postpartum care. The methodology for MY2024 goal is based on the MY2022 reported performance results compared to the MY2022 NCQA Quality Compass national percentile benchmark. If the performance rate meets the NCQA Quality Compass benchmark, CalOptima Health will set its goal to the next NCQA percentile to encourage continued performance improvement. However, if the measure rate falls below the 50th percentile, then CalOptima Health sets the 50th percentile as the organizational goal. For health disparity analysis, the data is pulled from the member enrollment file. The data is uploaded to the NCQA certified HEDIS software for rate calculation. The stratified rates are rolled up by denominator and numerator based on the rate/ethnicity, language or gender information uploaded.
Medi-Cal Results:

Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Met / Not Met
CIS-Combo 10 (hybrid)	Childhood Immunization Status	47.4%	39.4%	36.50%	49.76%	□ Yes ☒ No
IMA-Combo 2 (hybrid)	Immunizations for Adolescents-Combo 2	50.7%	51.8%	47.5%	48.42%	□ Yes ☒ No
W30-First 15 Months (admin)	Well-Child Visits in the First 30 Months of Life	49.3%	55.8%	55.8%	55.72%	☒ Yes □ No
W30-15 to 30 Months (admin)	Well-Child Visits in the First 30 Months of Life	67.3%	71.2%	72.4%	69.84%	☒ Yes □ No
WCV-Total (admin)	Child and Adolescent Well-Care Visits	54.0%	51.5%	53.0%	57.44%	□ Yes ☒ No

The following analysis pertains to the final rate trends from MY2021–MY2023.

- CIS-Combo 10 has steadily declined in performance. While the measure did not meet its organizational goal of 49.7%, it did meet the national benchmark of 30.9%.
- IMA-Combo 2 has a slight increase in MY2022 from MY2021, but rates declined in MY2023 compared to MY2022. While the measure did not meet the organizational goal for MY2023, it surpassed the national benchmark of 34.31% by more than 10%.
- W30-First 15 Months' performance has remained the same between MY2022 and MY2023. For MY2023, the measure met its organizational goal as well as the national benchmark goal of 58.38%.
- W30-15 to 30 Months' performance improved slightly in MY2023, up 1.2% from MY2022. However, this slight increase is not statistically significant. The measure met its organizational goal as well as the national benchmark goal of 66.76% for MY2023.
- WCV-Total rate performance improved slightly in MY2023, up 1.5% from MY2022. The change is not statistically significant. The measure did not meet the organizational goal for MY2023; however, it met the national benchmark goal of 48.07%.

Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Member mailings (e.g., first and second birthday cards, member newsletters)	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☐ On-going ☐ Incomplete	CIS, IMA, W30 WCV
2. Telephonic outreach (vendor-supported pediatric call campaign)	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	CIS IMA W30 WCV
3. Provider education (e.g., pediatric quality measures guide for HEDIS)	☐ MC ☐ OC	☒ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☒ Completed ☐ On-going ☐ Incomplete	CIS IMA W30 WCV
4. Targeted paid ads: digital, social media, radio, TV Ads were available in English, Spanish, and Vietnamese member languages and targeted zip codes that were performing lower than the overall measure rate.	☒ MC ☐ OC	☒ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	CIS IMA W30 WCV
5. Well-Child Visits in the First 30 Months of Life Member Detail Report (monthly) — Reports outline the total number of visits completed along with visit dates.	☒ MC ☐ OC	☒ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	W30
6. Well Child Visit in the First 30 Months of Life Report — Identifying members with one or two visits pending.	☒ MC ☐ OC	☒ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	W30
7. Pediatric text campaigns — Issued to remind members of various period health assessment recommendations.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	CIS IMA W30 WCV
8. P4V Program	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	CIS IMA W30 WCV

9. W30 Performance Improvement Project (PIP) to improve W30 well child visits in the first 15 months for Black children. Please refer to 4.7.1 Performance Improvement Project (PIP) in this evaluation and section 9.1 Evaluate the PIP of the 2024 Culturally and Linguistic Appropriate Services Program Evaluation for more information about this initiative.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☒ Q3 ☐ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	W30

MC = Medi-Cal
OC= OneCare

Results:

Disparity Analysis:

Methodology: Prospective rates with claims/encounters processed through September 2024 were analyzed for current performance by race/ethnicity. CalOptima Health viewed race/ethnic groups with more than 30 members in the denominator and identified the groups with the lowest performance for pediatric immunizations and pediatric well-care visits. For adolescent well-care performance, CalOptima Health analyzed race/ethnic groups with more than 400 members in the denominator and identified the groups with the lowest performance.

Chart A. Pediatric Immunization Rates by Race/Ethnicity, September 2024

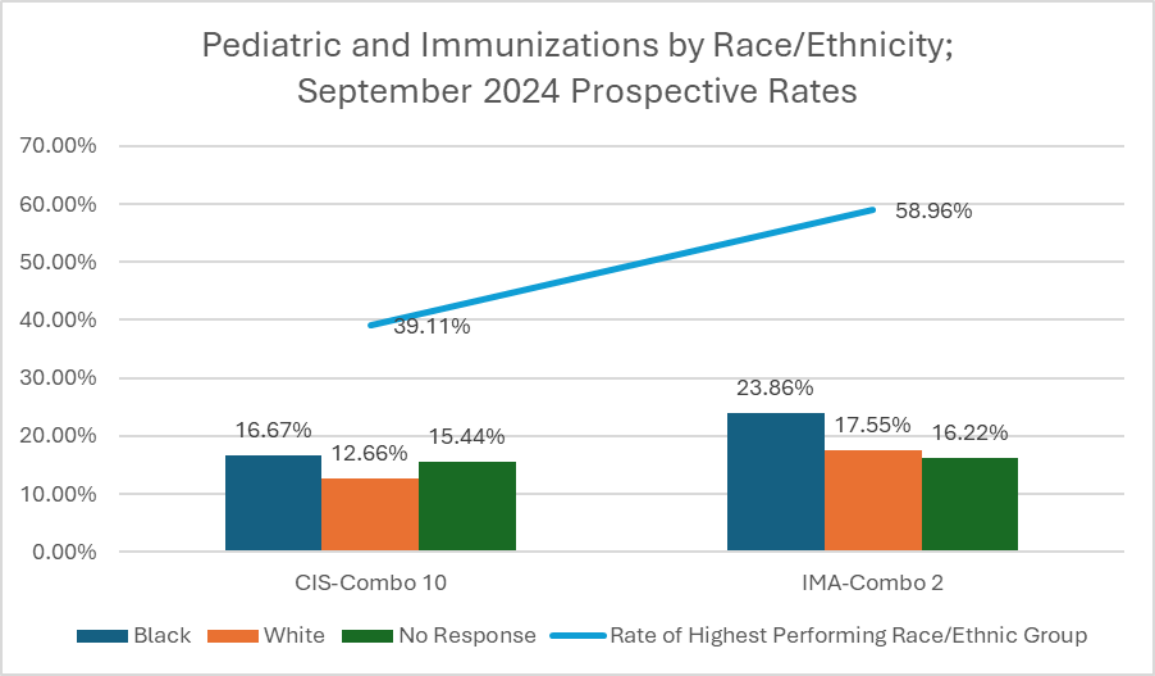


Chart A shows the CIS-Combo 10 and IMA-Combo 2 rates by race/ethnicity for prospective rates through September 2024. For both measures, Black, White and members that identified as “No Response” are performing the lowest across both measures. Vietnamese members are the highest-performing group in both pediatric and adolescent immunizations.

Chart B. Pediatric Well-Child Visits by Race/Ethnicity, September 2024

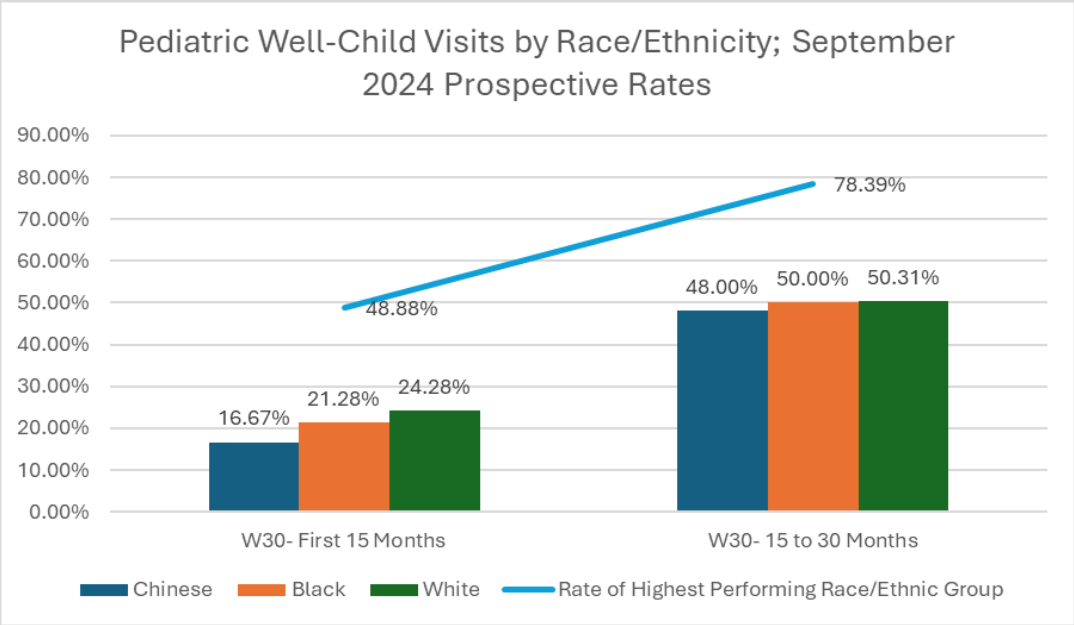


Chart B shows the rates for W30-First 15 Months and W30-15-30 Months by race/ethnicity for prospective rates through September 2024. For both measures, Chinese, Black and white members are performing the lowest across both measures. Vietnamese members are the highest-performing group for pediatric well-child visits.

Chart C. Pediatric Well-Care Visits by Race/Ethnicity, September 2024

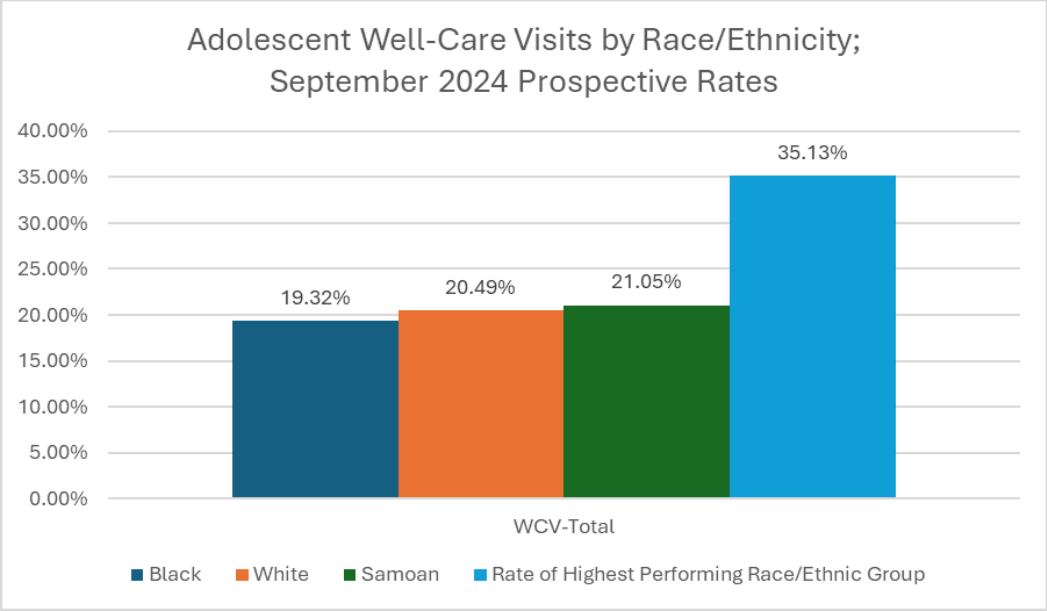


Chart C shows the rates for WCV-Total by race/ethnicity for prospective rates through September 2024. For both measures, Chinese, Black and white members are performing the lowest across both measures. Vietnamese members are the highest-performing group for pediatric well-child visits.

Chart D: MY2023 and MY2024 Pediatric and Adolescent Immunizations

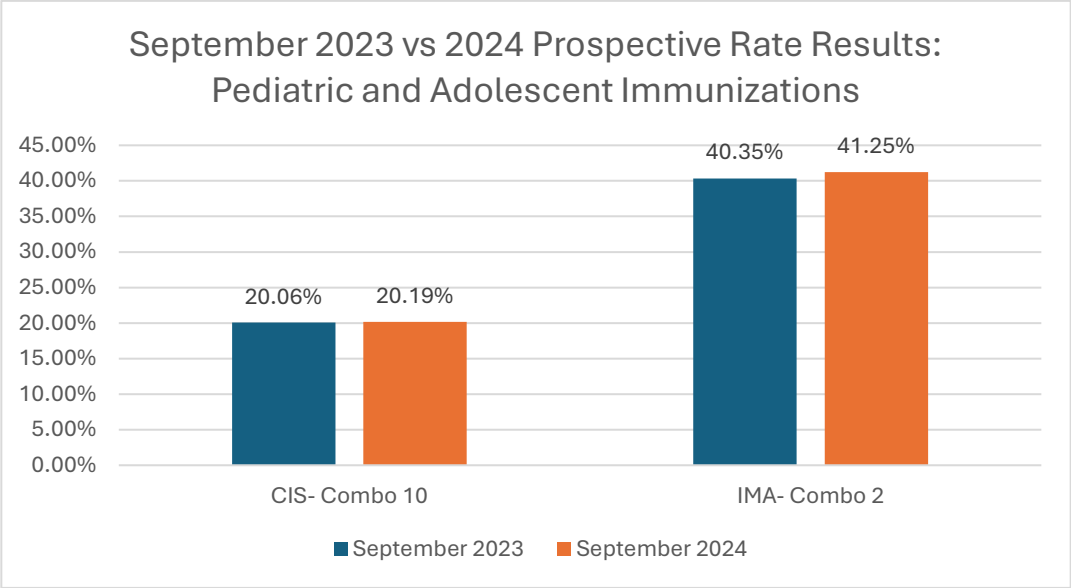
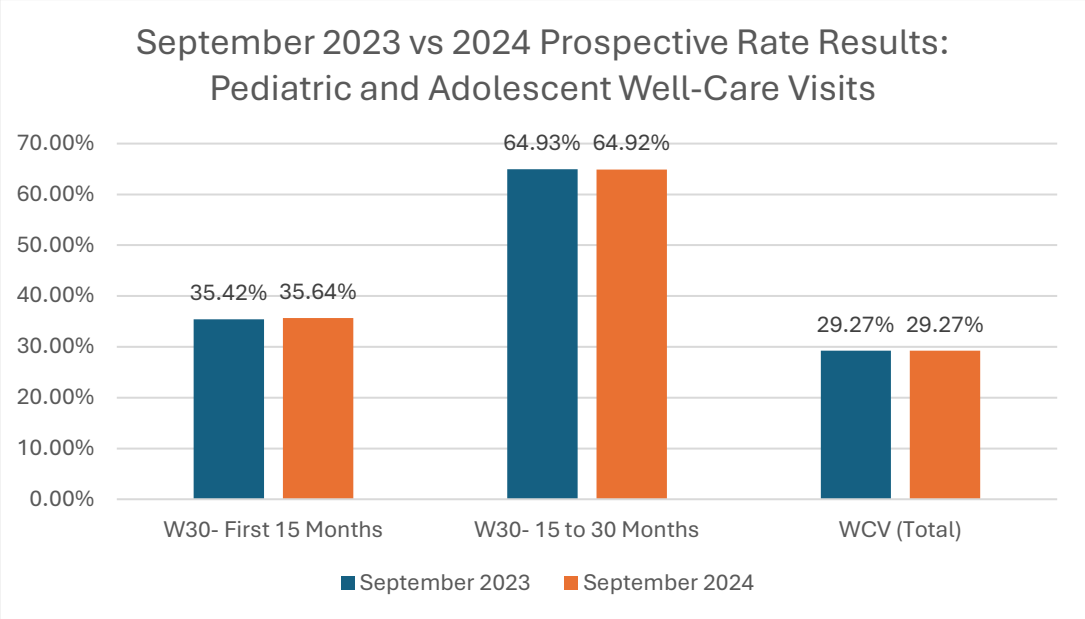


Chart E: MY2023 and MY2024 Pediatric and Adolescent Well-Care Visit Measures



Prospective rate methodology includes continuous enrollment criteria. CIS-Combo 10 and IMA-Combo 2 are hybrid measures, while W30 and WCV are administrative. Prospective rates are based on claims/encounters processed through September. Prospective rates in Chart A and Chart B are

solely based on administrative data and are not final. Charts D and E compare September prospective rates for 2024 to the prospective rate in the previous year.

- Chart D: CIS-Combo 10 performance remains relatively similar to 2023 with no statistically significant improvement. IMA-Combo 2's performance increased slightly from 2023.
- Chart E: W30-First 15 Months of Life and W30-15–30 Months, as well as WCV Total, have not demonstrated any significant improvement in performance, thus indicating opportunities to continue implementing initiatives aimed at improving rates.

Table A

Submeasure	Denominator	Numerator	Administrative Numerator	Supplemental Numerator	Required Exclusions	Rate
Native Hawaiian and Other Pacific Islander Direct	704	247	226	21	0	35.09%
American Indian and Alaska Native Direct	213	75	69	6	0	35.21%
White Direct	32,312	12,419	11,420	999	10	38.43%
Black or African American Direct	4,616	1,872	1,739	133	2	40.55%
Unknown (Ethnicity)	109,890	53,501	50,601	2,900	21	48.69%
Some Other Race Direct	21,381	11,088	10,438	650	1	51.86%
Unknown Race	206,381	112,932	106,327	6,605	24	54.72%
Hispanic or Latino Direct	194,200	107,744	101,541	6,203	23	55.48%
Asian Direct	38,483	22,612	21,923	689	7	58.76%

Quantitative Analysis:
As noted in the Results section above, there has been no significant increase in performance amongst all pediatric and adolescent immunization and well-child/well-care visit rates. CalOptima Health began targeted pediatric text campaigns in 2024 that allow for widespread outreach at the various timeframes for which a periodic health assessment is recommended. CalOptima Health has also refined its methodology with pediatric call campaigns to move away from general vaccination information to now sharing with parents/guardians what specific vaccinations are pending for the members. In addition, the plan has refined its messaging in text messages to speak to more than just vaccines. Often, parents/guardians may attribute well-child visits to just vaccines. However, there are other important screenings and care that are delivered at well-child visits.

Disparity Analysis:
As shown in Table A, the overall total rate for the Child and Adolescent Well-Care Visits (WCV) measure in MY2023 was 53.03%. Using the total rate as a reference point, all ethnic groups except for Hispanic or Latino and Asian performed lower than 53.03%. The compliance rate for all ethnic groups except for Hispanic or Latino and Asian did not meet or exceed the MPL of 48.07%. The highest-performing ethnic group was Asian at 58.76%; the lowest-performing ethnic group was Native

Hawaiian and Other Pacific Islander at 35.09%. In conclusion, CalOptima Health will continue to implement initiatives aimed at improving WCV performance across all ethnic groups.	
Identified Barriers:	Identified Opportunities for Improvement:
• Providers/health networks report that, since COVID-19, they have noted an increased hesitancy with vaccinations. • Telephonic and text campaigns are dependent on having the correct contact information, and often, members opt not to pick up telephonic calls. • Staffing shortages impact appointment availability making it difficult to complete well-child visits and important care (e.g., vaccinations).	• Promote the messaging of HPV vaccination recommendation at an earlier timeframe to support dosage completion. • Limited outreach success with text/calls indicates an opportunity to improve on rapport building with members, tailoring messages so that they meet different parental needs or concerns (e.g., vaccine safety), and leverage data on optimal call times.
Conclusion: • Perceptions are changing around the importance of well-child visits and vaccinations after COVID-19. There is a need to augment messaging in communities about the importance of these visits and address vaccination hesitancy. Messages need to occur through various modalities. • There is a need to continue to connect with health networks, clinics and provider offices to understand their challenges, successes and current process with well-care visits and vaccinations. • Across all pediatric measures, both Black and White race/ethnic groups are the two performing the lowest. CalOptima Health should continue to work with providers and health networks to understand the contributing factors to this performance and tailor initiative to address the varying challenges/concerns with each population.	
Activities/Interventions to continue/add next year:	
CalOptima Health to continue the following efforts: • Connect with health networks, clinics and provider offices to understand their challenges, successes and current process with well-care visits and vaccinations. • Work with providers and health networks to understand best practices that are working to improve the delivery of well-care visits/vaccinations and share these best practices with others. • Promote the CalOptima Health Pediatric HEDIS Guide to support performance and gap closure. • Targeted member engagement and outreach campaigns in coordination with health network partners. ○ Multi-modal efforts: Mail, text, IVR calls, etc. • Early identification and data gap bridging remediation for early intervention and promotion of well-child visits as well as data capture in support of gap closure. • Enhance the promotion of the CalOptima Health Pediatric HEDIS Guide to support performance and gap closure. • Assess the effectiveness of the text campaigns newly implemented in 2024 and revise the member communication strategy as needed. • Continue to leverage race and ethnicity performance data to drive initiatives aimed at reducing disparities in 2023.	

4.3.4.2 Blood Lead Screening	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Kelli Glynn/Leslie Vasquez	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No

Work Plan Goal/Objective:
HEDIS MY2024 Goal: 67.12%;
Improve Lead Screening in Children (LSC) HEDIS measure: 63.99%

Goal Met: ☐ Yes ☒ No ☐ Partial

Work Plan Planned Activities:

- A multi-modal, targeted member approach as well as provider and health network collaborative efforts. Activities will include but not be limited to: IVR calls, texting, mailing, newsletter articles
- Partnership with key local stakeholders (e.g., HCA)

Status: ☐ Completed ☒ Ongoing

Background:
Lead exposure can cause serious health issues, including brain and nervous system damage, and intellectual and behavioral problems. Since children often show no symptoms, lead poisoning may go unrecognized. According to the CDC, there is no safe blood lead level, and screening is the best way to detect exposure. If not caught early, the effects can be permanent.

California regulations recommend that Medi-Cal children be tested for lead at 12 and 24 months and receive catch-up tests if missed. Lead Screening in Children (LSC) is a key quality performance measure for HEDIS and part of the DHCS MCAS, reported annually by Medi-Cal MCPs. Starting in MY2022, MCPs are held to the NCQA Quality Compass Medicaid 50th percentile for LSC. DHCS also issued requirements for MCPs to ensure timely screenings in line with California regulations.

LSC is a hybrid HEDIS and MCAS measure that evaluates the percentage of children who receive a lead test by their second birthday. LSC is a proxy for how well children are being tested for lead in accordance with state regulations.

Methodology:
CalOptima Health follows the HEDIS data collection methodology to assess LSC performance. The methodology for the MY2024 goal is based on the MY2022 reported performance results compared to the MY2022 NCQA Quality Compass national percentile benchmark. If the performance rate meets the NCQA Quality Compass benchmark, CalOptima Health will set its goal to the next NCQA percentile to encourage continued performance improvement. However, if the measure rate falls below the 50th percentile, then CalOptima Health sets the 50th percentile as the organizational goal.

CalOptima Health stratified race and ethnicity for the LSC measure in MY2024 to assess potential disparities. However, this methodology differs from NCQA's approach to race and ethnicity stratification, meaning the identified groups may not align with those in NCQA's stratified data. It's important to note that NCQA does not require race and ethnicity stratification for the LSC measure.

Medi-Cal Results:

Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Met / Not Met
LSC	Lead Screening in Children	64.00%	63.00%	63.8%	63.99%	□ Yes ☒ No

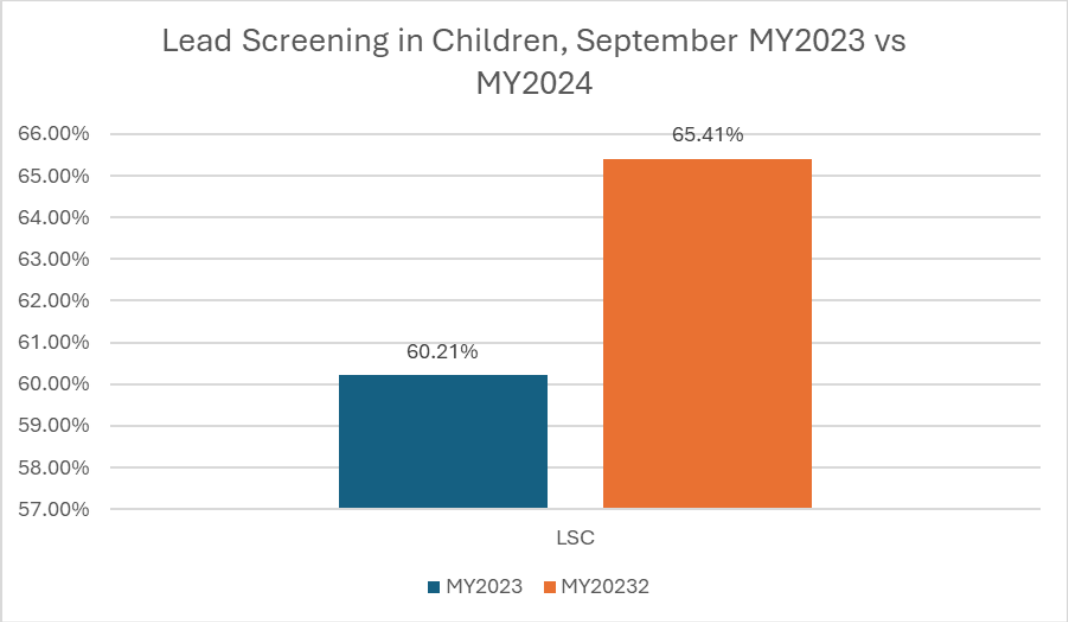
Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Member health reward for blood lead testing at 12 and 24 months of age	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	LSC
2. Texting campaigns — Members are issued general pediatric wellness texts along with blood lead-specific texts.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	LSC
3. Telephonic outreach	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	LSC
4. Blood Lead Screening Reports — Highlights members who are overdue for lead tests at 12 and 24 months of age. Highlights members that will be due for lead testing.	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	LSC
5. Provider education: Various efforts, including presentations, provider continuing education and the Blood Lead Testing Guide. Education offered via fax, email, provider monthly update and provider newsletter.	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	LSC
6. Targeted Paid Ads: Digital, social media, radio	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☒ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	LSC
7. Community partnerships with local health care agency and Childhood Lead Poisoning Prevention Program focused on increasing blood lead testing	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☐ Member ☐ Provider ☐ Health Network ☒ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	LSC
8. Planned: Medical record review process to support monitoring of lead requirements.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☐ On-going ☒ Incomplete	LSC
9. Planned: Point-of-Care Lead Pilot	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☐ On-going ☒ Incomplete	LSC

10. P4V program	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	LSC

MC = Medi-Cal; OC= OneCare

Results:

Chart A. MY2023 and MY2024 September Prospective Rates for LSC



Prospective rate methodology includes continuous enrollment criteria. LSC is a hybrid measure. Prospective rates showcased in Chart A are solely based on administrative data and are not final.

Chart A compares prospective rates; claims/encounters processed through September. LSC performance in September 2024 was much higher than the rate in September 2023 and trending 5% higher. LSC MY2024 rates are not final, however the measure is on pace to meet the established NCQA Quality Compass benchmark.

Table A. MY2024 LSC Administrative Rates by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY2024	**Hispanic**	**No Response**	**Other**	**White**	**Vietnamese**	**Black**	**Chinese**	**Korean**	**Filipino**	**Asian or Pacific Islander**
Numerator	4456	1112	810	405	367	61	46	48	35	36
Denominator	6260	1949	1307	885	496	114	81	80	63	52
Rate	71.18%	57.05%	61.97%	45.76%	73.99%	53.51%	56.79%	60.00%	55.56%	69.23%

Table A displays LSC administrative rates by race/ethnicity. Table A showcases the top 10 race/ethnic groups based on denominator, moving from the highest denominator (right) to lowest (far left).

Quantitative Analysis:

- LSC performance in September 2024 was much higher than the rate in September 2023 and trending 5% higher. LSC MY2024 rates are not final, however, the measure is on pace to meet the established NCQA Quality Compass benchmark.
- When assessing final rates (hybrid) for LSC from MY2021–MY2023, there has been no significant improvement in performance. In MY2022, the performance rate was decreased by 1% when compared to MY2021. In MY2023, the performance rate increased slightly (0.8%) from MY2022. Refer to Medi-Cal Results and Chart A.
- CalOptima Health set its organizational goal based on the MY2022 NCQA Quality Compass benchmark of 63.99%. MY2023 benchmarks were released subsequently, and the 50th percentile was set to 62.79%. CalOptima Health kept the 63.99% goal, which it did not meet. However, it should be noted that CalOptima Health did meet the 50th percentile of 62.79% for MY2023, with a final rate of 63.80%. See Medi-Cal rates above.
- Table A showcases MY2024 data by race and ethnicity data. Hispanic members account for the largest portion of the LSC denominator. When assessing for lead testing by race/ethnicity, the three groups with the lowest performance are as follows: White (45.76%), Black (53.51%) and Filipino (55.56%). Final rates are pending, but based on these trends, these groups may benefit from targeted interventions to support lead testing.

Identified Barriers:	Identified Opportunities for Improvement:
• Lack of parent/guardian awareness related to the importance of lead testing for the identification of lead exposure and potential lead poisoning. • Limited point-of-care lead testing practices • Providers report that there are high costs associated with obtaining point-of-care lead testing machines and lead testing supplies	• Ongoing need to support parental education on lead testing and reducing barriers to care. • CalOptima Health to support a pilot to implement point-of-care testing in select provider offices.

Conclusion:

The latest September 2024 prospective rates showcase a slightly more than 5% increase in lead testing based on the same time last year. This indicates that the combined efforts for lead testing have made a positive impact on LSC performance. Additional activities, such as the medical record review and implementation of the point-of-care lead testing pilot, aim to support further increased rates in LSC performance. Results for these efforts are pending.

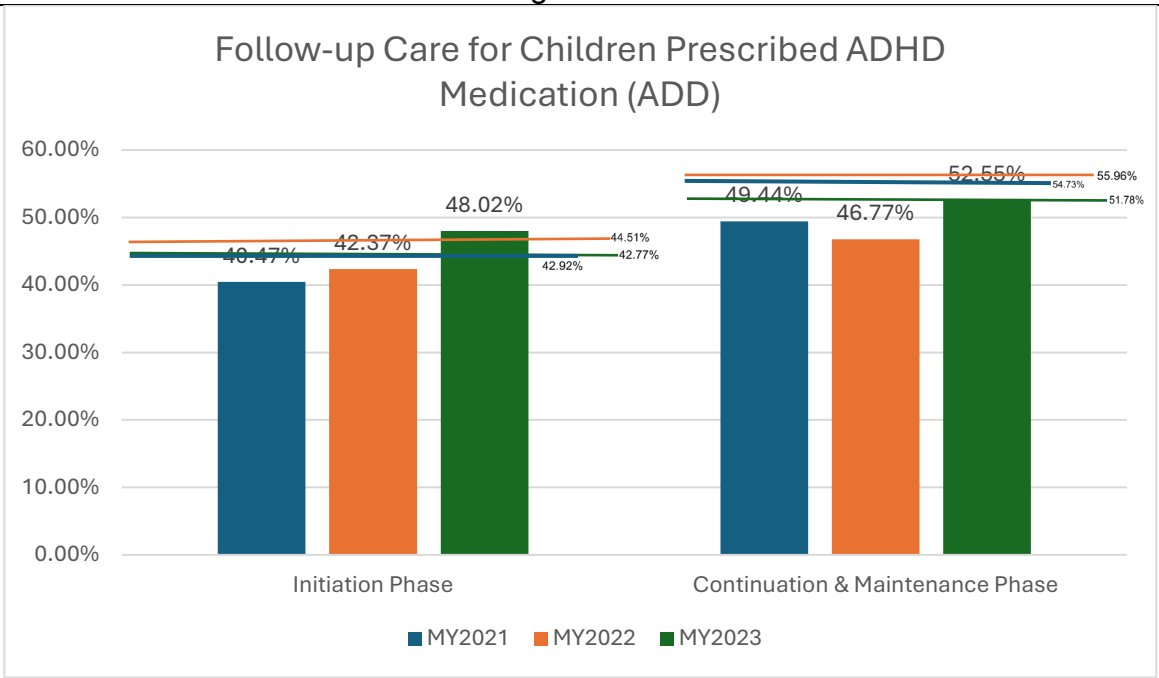
Activities/Interventions to continue/add next year:
• Continue the member health reward to encourage lead testing completion amongst members. • Targeted member outreach via various modalities: mailing, text, IVR calls • Complete the point-of-care lead testing pilot to support increased lead testing rates and reduce barriers for providers seeking to offer point-of-care testing in the office. • Initiate medical record review to assess and monitor provider and health networks for state-issued lead requirements.

4.4 Behavioral Health

4.4.1 Behavioral Health (ADD)	
Author: Valerie Venegas	Department: Behavioral Health Integration (BHI)
Responsible Party(ies): Diane Ramos, Natalie Zavala, Carmen Katsarov	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: MC-Init Phase — 44.22%, MC-Cont Phase — 50.98% Work Plan goal. To increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practices and technological options.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: • Work collaboratively with the Communications department to fax non-compliant providers letter activity (approximately 200 providers) by the fourth quarter. • Participate in provider educational events, related to follow-up visits and best practices. • Continue member outreach to improve appointment follow-up adherence. a. Member newsletter (Fall) b. Monthly member two-way text messaging (approximately 60—100 members) • Member health reward program	
Status: ☐ Completed ☒ Ongoing	
Background: CalOptima Health's program monitors the percentage of children with newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who have at least three follow-up care visits within a 10-month period. The measure focuses on two phases. The Initiation Phase requires that the first follow-up visit occur within 30 days of the initial ADHD medication being dispensed. The Continuation Phase includes those members who remained on medication for at least 210 days and attended at least two additional follow-up visits within nine months following the Initiation Phase.	
Methodology: There are two phases within this measure: The Initiation Phase (one visit within the first 30 days) and The Continuation and Maintenance Phase (two visits in the next nine months for those who remain on the medication). Data is drawn from HEDIS results and health care claims. HEDIS rates are used to establish performance trends.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Created and finalized working collaboratively with QI for the member health reward flyer to distribute to eligible members.

	• Met with ITS to discuss data sourcing automation for the Provider Portal information sharing monthly. • Text messaging outreach to members sent in January and February. • Community clinics/provider education via HCHCN Clinical Quality Champion Meeting on January 31, 2024, and The Coalition of Orange County Community Health Centers and Medical Provider Forum on March 15, 2024, regarding importance of quality measure.
Quarter 2:	• Approved printing vendor for printed flyers to send out member health rewards. • Member health reward approved by DHCS and added to CalOptima Health website for members to access. • Text messaging outreach to members sent May and June.
Quarter 3:	• Monthly text messaging outreach to members sent in July, August and September. • Member health reward flyers mailed to 620 eligible members. • Developed new text message script for member health reward. • ADD data is now available through the Provider Portal. • Presented at The Coalition of Orange County Community Health Center meeting and Medical Provider Forum regarding BH Quality Measures on September 20, 2024.
Quarter 4:	• Monthly text messaging outreach to members sent in October, November and December. • Member health reward flyers mailed to 800 eligible members. • A new text message script for member health reward will be launched in 2025.

Program Results:



HEDIS Final Rates Trend Analysis

Quantitative Analysis:
CalOptima Health's 2023 HEDIS Initiation Phase final rate was 48.02%, which met the intended goal of 42.77%. The 2023 HEDIS Continuation Phase final rate was 52.55%, which also met the intended

goal of 51.78%. The ADD measure has demonstrated an increase in change over the past three years in the trend analysis.	
Identified Barriers:	Identified Opportunities for Improvement:
• Provider letters are faxed to the number on record. We are aware that the fax may not always go to the intended provider to whom the letter was faxed. • Provider availability is still a barrier for members to get an appointment scheduled with the 30-day follow-up requirement.	• While provider engagement was initiated, additional strategies may be necessary to enhance awareness and compliance among providers. Such as uploading data directly to the provider portal. • The BHI quality team will explore opportunities to continue member outreach to identify barriers and assist members.
Conclusion: CalOptima Health has chosen to continue working on improving the number of members who are newly prescribed ADHD medications and have a follow-up visit within 30 days. The BHI quality team will continue to send letters to providers who do not meet the ADD requirements. Text message campaigns will continue to be sent to members as a reminder to follow up with providers after filling out their ADHD medication, and a new text message campaign will be launched to inform members about the member health reward.	
Activities/Interventions to continue/add next year:	
• Continue to send letters to providers who are not meeting the ADD requirements. • Continue to work with text messaging vendor to send text messages to members for follow-up visits. • Send text message campaign of the member health rewards flyer to eligible members.	

4.4.2 Behavioral Health (APM)	
Author: Mary Barranco	Department: Behavioral Health Integration (BHI)
Responsible Party(ies): Diane Ramos, Natalie Zavala, Carmen Katsarov	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Blood Glucose-All Ages: 58.43%, Cholesterol-All Ages: 40.50%, Glucose and Cholesterol Combined-All Ages: 39.01% To improve metabolic monitoring among children and adolescents prescribed antipsychotic medications. Specifically, educating health care providers and members to increase the rates of blood glucose and cholesterol testing.	
Goal Met: ☐ Yes ☐ No ☒ Partial	
Work Plan Planned Activities: • Monthly review of metabolic monitoring data to identify prescribing providers and PCPs for members in need of metabolic monitoring. • Work collaboratively with Provider Relations to conduct monthly face-to-face provider outreach to the top 10 prescribing providers to remind them of best practices for members in need of screening. • Monthly mailing to the next top 50 prescribing providers to remind them of the best practices for members in need of screening. • Send a monthly reminder text message to members (approximately 600 members). • Information sharing via provider portal to PCPs on best practices, with a list of members who need a diabetes screening.	

Status: ☐ Completed ☒ Ongoing	
Background: The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: • The percentage of children and adolescents on antipsychotics who received blood glucose testing. • The percentage of children and adolescents on antipsychotics who received cholesterol testing. • The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.	
Methodology: The data is uploaded to Tableau by CalOptima Health's Quality Analytics team. BHI then downloads the data and filters 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.	
Actions/Interventions Implemented in 2024:	

Quarter 1:	• Worked with Quality Analytics to develop a data report.
	• Drafted the following materials:
	  ○ Text messaging script
	  ○ APM Provider Tip Sheet
	• Community clinics/provider education via HCHCN Clinical Quality Champion Meeting on January 31, 2024, and The Coalition of Orange County Health Centers and Medical Provider Forum on March 15, 2024, regarding the importance of quality measure.

Quarter 2:	• Worked with Quality Analytics/Financial Analysis team to develop a data report.
	• Drafted following materials:
	  ○ Text messaging script (approved by DHCS)
	  ○ APM Provider Tip Sheet

Quarter 3:	• The following materials have been disseminated to providers:
	  ○ Provider Best Practices Letter
	  ○ APM Provider Tip Sheet
	• Collaborated with Provider Relations to conduct in-person provider outreach with top 10 providers monthly.
	• Mailed provider materials (Best Practices Letter and Provider Tip Tool Sheet) to the next top 50 providers monthly.
	• Continued text messaging campaign.
	• Presented at The Coalition of Orange County Community Health Center meeting and Medical Provider Forum regarding BH Quality Measures on September 20, 2024.

Quarter 4:	• Continued text messaging campaign. • Started mailings to providers (letter). • Collaborated with Provider Relations to conduct in-person provider outreach with top 10 providers monthly. • Mailed provider materials (Best Practices Letter and Provider Tip Tool Sheet) to the remaining providers monthly.
Program Results:	

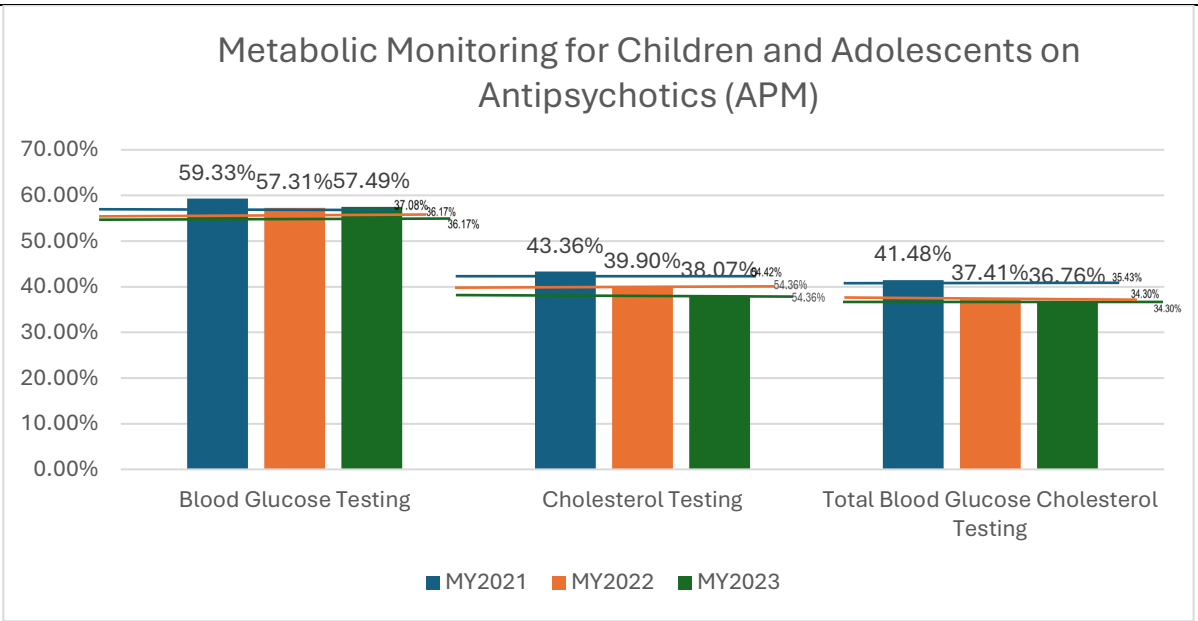


Chart caption: HEDIS Final Rates Trend Analysis

Quantitative Analysis:
Due to outreach efforts, CalOptima Health did meet the goal of 34.30%. The final rate was 36.76% for Total Blood Glucose and Cholesterol Monitoring. The decline from the previous year's rate (38.07%) is due to timely access to data.

Identified Barriers:	Identified Opportunities for Improvement:
• Timely access to data was problematic, affecting our ability to monitor progress effectively. • Identified members prescribed antipsychotic medication still in need of diabetes screening, cholesterol screening, and both cholesterol and diabetes screening test through Tableau Report.	• While provider engagement was initiated, additional strategies may be necessary to enhance awareness and compliance among both providers and members (e.g., uploading data directly to the provider portal).

Conclusion:
While we did not achieve the desired outcome, the insights gained provided a valuable foundation for future improvements. By enhancing data accessibility and continuing to engage both providers and members, we can work towards better outcomes for APM.

Activities/Interventions to continue/add next year:

- Continuing current interventions
  - Maintain existing provider outreach to maintain engagement levels via provider mailings and provider outreach by our Provider Relations department.
  - Text messaging campaigns will continue going out to members.
- Enhance data accessibility
  - Implement the upload of member information to the provider portal, enabling providers with more detailed member information.
- Expand educational efforts
  - Increase the frequency of initiatives targeting both providers and members about the importance of metabolic monitoring.

• Monitor and adjust strategies   ○ Regularly review and adapt outreach strategies based on ongoing data analysis to address identified barriers.

4.4.3 Behavioral Health (AMM)	
Author: Mary Barranco	Department: Behavioral Health Integration (BHI)
Responsible Party(ies): Diane Ramos, Natalie Zavala, Carmen Katsarov	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☒ Yes ☐ No
Work Plan Goal/Objective: Acute Phase — 74.16%, Continuation Phase — 58.06% To improve monitoring of members' adherence to antidepressant medication.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: • Educate providers on the importance of follow-up appointments through outreach to increase follow-up appointments for prescription management associated with the AMM treatment plan. • Educate members on the importance of follow-up appointments through newsletters/outreach to increase follow-up appointments for prescription management associated with AMM treatment plan. • Track number of educational events on depression screening and treatment.	
Status: ☐ Completed ☒ Ongoing	
Background: The percentage of members 18 years of age and older who were treated with antidepressant medication, had a diagnosis of major depression and who remained on an antidepressant medication treatment. Two rates are reported: 1. Effective Acute Phase Treatment: The percentage of members who remained on antidepressant medication for at least 84 days (12 weeks). 2. Effective Continuation Phase Treatment: The percentage of members who remained on antidepressant medication for at least 180 days (six months).	
Methodology: The data is emailed to our program specialist by our Financial Analysis team. We download the data and filter 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.	
Actions/Interventions Implemented in 2024:	

Quarter 1:	• Worked with Quality Analytics to develop a data report.
	• Drafted the following materials:
	  ○ Text messaging script
	  ○ AMM Provider Tip Sheet
	• Community clinics/provider education via HCHCN Clinical Quality Champion Meeting on January 31, 2024, and The Coalition of Orange County Health Centers and Medical Provider Forum on March 15, 2024, regarding the importance of quality measure.

Quarter 2:	• Worked with Quality Analytics/Financial Analysis team to develop a data report.
	• Drafted following materials:
	  ○ Text messaging script (approved by DHCS)
	  ○ AMM Provider Tip Sheet

Quarter 3:	• Data report received monthly. • Drafted following materials: ○ AMM Provider Tip Sheet letter submitted for internal review process.

	○ Text message campaign launched. • Presented at The Coalition of Orange County Community Health Center meeting and Medical Provider Forum regarding BH Quality Measures on September 20, 2024.
Quarter 4:	• Continued text messaging campaign. • Continued mailings to providers (provider letter tip sheet).

Program Results:

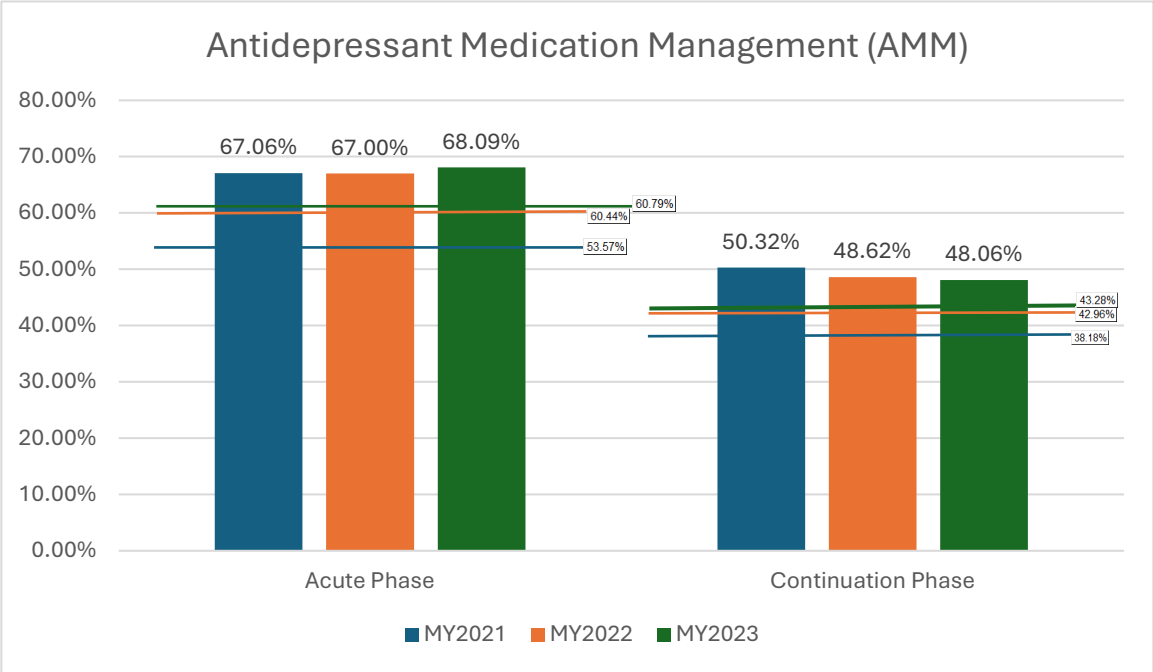


Chart caption: HEDIS Final Rate Trend Analysis

Quantitative Analysis:
The final rate of the Acute Phase was 68.09%, and the final rate of the Continuation Phase was 48.06%; neither goal was met. The decline from the previous year is due to AMM not actively being a monitored measure prior to 2024.

Identified Barriers:	Identified Opportunities for Improvement:
• Data report development • Timely access to data was problematic, affecting our ability to monitor progress effectively.	• While provider engagement was initiated, additional strategies may be necessary to enhance awareness and compliance among both providers and members. Such as uploading data directly to the provider portal.

Conclusion:
For the upcoming year 2025, the BHI quality team will actively monitor AMM to track and trend the eligible member population who are prescribed antidepressant medication.

Activities/Interventions to continue/add next year:

- The following interventions will be disseminated in 2025:
  - The BHI quality team will continue to mail a best practices letter/tool tip sheet to prescribing providers identified.

○ BHI will be working with the Financial Analysis team to further identify data elements needed to address the members' PCPs or prescribing providers for further intervention outreach. ○ In 2025 BHI will work closely with ITS to deliver this member information electronically via the CalOptima Health Provider Portal. The use of modern technology will allow CalOptima Health to deliver this important information and best practices to providers in a timely manner, while streamlining workflows and processes in the BHI Quality Department.

4.4.4 Behavioral Health (SMD)	
Author: Nathalie Pauli	Department: Behavioral Health Integration (BHI)
Responsible Party(ies): Diane Ramos, Natalie Zavala, Carmen Katsarov	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☒ Yes ☐ No
Work Plan Goal/Objective: MC: 76.66% To increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	
Goal Met: ☐ Yes ☒ No ☐ Partial	
Work Plan Planned Activities: • Collaborative meetings between teams to identify best practices to implement • Provider and member education • We have just monitored this measure. No activities have been set. This is the first year of us reporting on this measure in the work plan.	
Status: ☐ Completed ☒ Ongoing	
Background: CalOptima Health's program assesses the percentage of members 18–64 years of age with schizophrenia or schizoaffective disorder and diabetes who completed both a low-density lipoprotein cholesterol (LDL-C; a blood test to assess for risk of cardiovascular events) and a hemoglobin (HbA1C; a plasma glucose concentration [diabetes risk] test) throughout the year. Those who suffer from severe and persistent mental illness (SPMI) are a vulnerable population and are at an increased risk of developing physical health issues. Care coordination between medical and behavioral health care is critical to improving health outcomes. The Diabetes Monitoring for Members with Diabetes and Schizophrenia (SMD) measure allows us to evaluate the prevalence of screening being completed and assess whether opportunities for improvement are needed.	
Methodology: CalOptima Health encourages members with severe mental illness to take part in the laboratory analysis prior to receiving medication remedies. The SMD measure focuses on the percentage of members 18–64 years of age with a diagnosis of schizophrenia or schizoaffective disorder and diabetes who completed both an LDL-C and HbA1C test. Data is drawn from HEDIS results and health care claims. HEDIS rates are used to establish performance trends, and the HEDIS data is reported based on the measurement period.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Monitored measure.
Quarter 2:	• Drafted fall member newsletter for members.
Quarter 3:	• Fall member newsletter approved July 2024 • SMD data available through CalOptima Health Provider Portal on August 15, 2024. • Presented at The Coalition of Orange County Community Health Center meeting and Medical Provider Forum regarding BH Quality Measures on September 20, 2024.

Quarter 4:	• Continued monitoring this measure.
Program Results:	

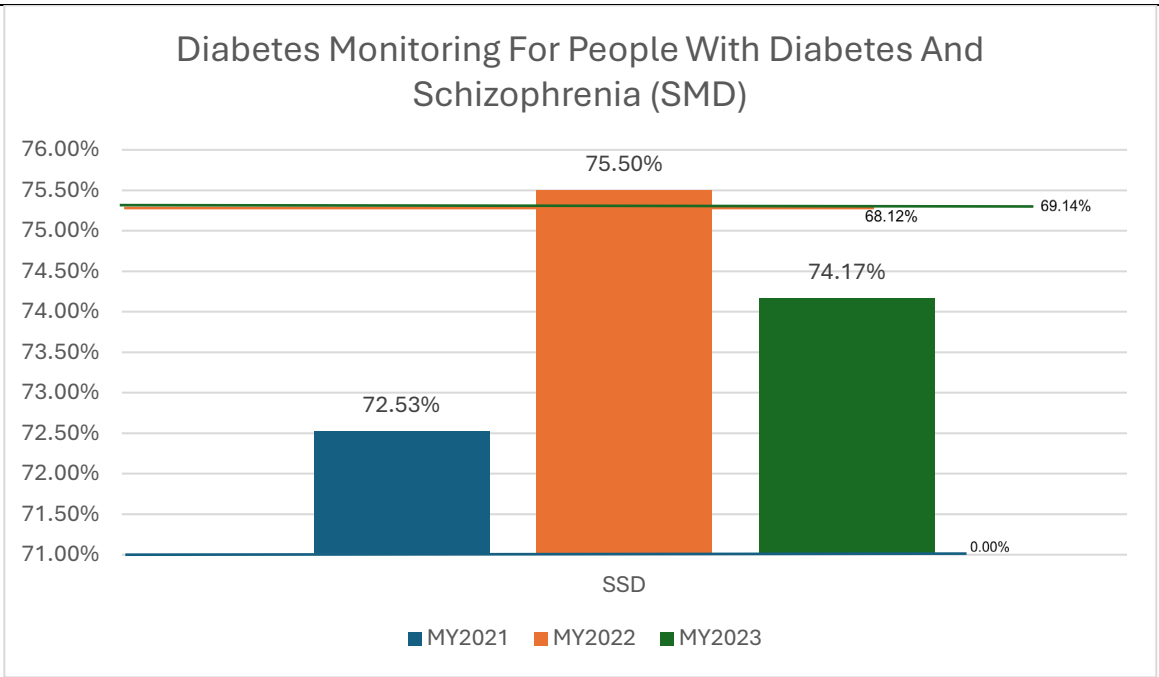


Chart caption: HEDIS Final Rates Trend Analysis

Quantitative Analysis:
CalOptima Health's 2023 SMD Measurement of Effectiveness of Opportunity HEDIS final rate was 74.17% which did not meet the intended goal of 76.66%. The final rate has demonstrated a slight decrease.

Identified Barriers:	Identified Opportunities for Improvement:
• Timely data sharing	• Attend collaborative meetings between teams to identify the best practices to implement. • Attend provider and member education.

Conclusion:
In summary, CalOptima Health did not achieve the SMD Measurement of Effectiveness of Opportunity HEDIS goal of 76.66%. The data did show a slight decline from the year prior and missed the targeted HEDIS goal. The BHI department will continue to monitor this measure.

Activities/Interventions to continue/add next year:

- CalOptima Health will continue to monitor the SMD measure in 2025.

4.4.5 Behavioral Health (FUM)	
Author: Jeni Diaz	Department: Behavioral Health Integration (BHI)
Responsible Party(ies): Diane Ramos, Natalie Zavala, Carmen Katsarov	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: MC 30-Day: 60.08%; 7-day: 40.59%	

To increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	
Goal Met: ☐ Yes ☒ No ☐ Partial	
Work Plan Planned Activities: • Share real-time emergency department (ED) data with our health networks on a secured FTP site. • Participate in provider educational events related to follow-up visits. • Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members to connect with a follow-up after ED visit. • Implement new behavioral health virtual provider visits to increase access to follow-up appointments. • Bi-weekly member text messaging (approximately 500 members). • Member newsletter (spring).	
Status: ☐ Completed ☒ Ongoing	
Background: CalOptima Health's QIHETP program assesses the percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm diagnoses and who had a follow-up visit for mental illness.	
Methodology: Two rates are reported for this measure: The percentage of ED visits for which the member received follow-up care within seven days and 30 days an ED visit. Data is based on measurement year final HEDIS results and behavioral health care claims.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Pulled data for BH data analyst to send out bi-weekly text messages based on real-time ED data. • Development of a pilot project for CHCN members identified who meet FUM criteria. BH telehealth provider to conduct outreach and assist with member linkage for identified FUM members. • Community clinics/provider education via HCHCN Clinical Quality Champion Meeting on January 31, 2024, and The Coalition of Orange County Health Centers and Medical Provider Forum on March 15, 2024, regarding the importance of quality measure. • Collaborated with National Alliance on Mental Illness (NAMI) to share real-time ED data for member outreach.
Quarter 2:	• Continued to pull data for BH data analyst to send out bi-weekly text messages based on real-time ED data. • Continued development of pilot project for CHCN members identified who meet FUM criteria. BH telehealth provider to conduct outreach and assist with member linkage for identified FUM members. • Continued collaboration with NAMI to share real-time ED data for member outreach. • Collaborated with telehealth vendor and internal ITS team to develop implementation plan for member outreach.
Quarter 3:	• Continued bi-weekly text messages to members based on real-time ED data. • Continued sharing ED data with health networks via SFTP and weekly health network communication. • Collaborated with NAMI to share real-time ED data for member outreach/NAMI by Your Side. • Continued to collaborate with telehealth vendor and internal ITS team to develop implementation plan for member outreach.

	• Developed listening sessions for providers to educate/train on how to obtain BH data via CalOptima Health Provider Portal. • Collaborated with the vendor to create an IVR campaign for ED Follow-up. • FUM data became available through provider portal. • Presented at The Coalition of Orange County Community Health Center meeting and Medical Provider Forum regarding BH Quality Measures on September 20, 2024.
Quarter 4:	• Continued bi-weekly text message campaign. • Continued sharing ED data with health networks via SFTP site. • Telehealth vendor began Phase 1 launch (December 3, 2024) of outbound calls to members to schedule follow-up after ED appointments. • Continued collaboration with vendor to create campaign for the IVR calls for ED follow-up. • Educated members on the importance of ED follow-up appointments via fall member newsletter.

Program Results:

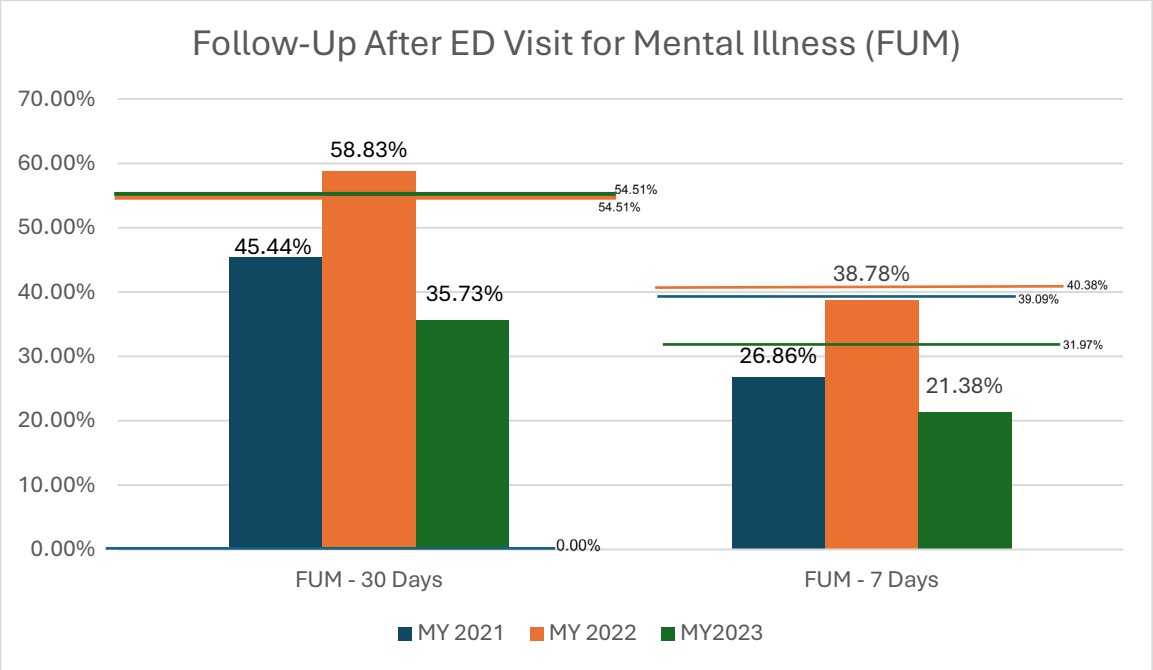


Chart caption: HEDIS Final Rates Trend Analysis

Quantitative Analysis:
The final 30-day rate for MY2023 was 35.73% which did not meet the intended goal of 54.51%. The final seven-day rate for MY2023 was 21.38% which also did not meet the intended goal of 31.97%. The FUM HEDIS measure demonstrated a significant decline in MY2023.

Identified Barriers:	Identified Opportunities for Improvement:
• Not having the bandwidth to outreach to members who fall into the FUM measure daily.	• Use of available technology such as texting and telehealth services may allow better access to follow-up appointments for members as well as new forms of member outreach via IVR and telehealth providers.

• Data collection and data sharing with the HCA has been difficult due to privacy laws.	• Participation with HCA for DHCS initiative to improve follow up after ED visits for mental health (FUM) rates.
Conclusion: Due to the measure not meeting the intended goal, we plan to continue to engage with both providers and members to achieve the desired outcome for FUM and improve data accessibility.	
Activities/Interventions to continue/add next year:	
• IVR calls to members who fall under the FUM measure • BH telehealth vendor will outreach to members from the daily ED data feed • Continue bi-weekly member text messaging • Member outreach with NAMI By Your Side (NBYS) • Regular collaboration meetings between CalOptima Health and HCA.	

4.4.6 Behavioral Health (SSD)	
Author: Nathalie Pauli	Department: Behavioral Health Integration (BHI)
Responsible Party(ies): Diane Ramos, Natalie Zavala, Carmen Katsarov	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: MC: 77.40% To increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	
Goal Met: ☐ Yes ☒ No ☐ Partial	
Work Plan Planned Activities: • Identify members in need of diabetes screening. • Conduct provider outreach, work collaboratively with the communications department to fax best practices and lists of members still in need of screening to prescribing providers and/or PCPs. • Information sharing via provider portal to PCP on best practices, with a list of members who need a diabetes screening. • Send monthly reminder text messages to members (approximately 1,100 members). • Member health reward program.	
Status: ☐ Completed ☒ Ongoing	
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 among 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.	
Methodology: 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 18–64 years of age who fall under the SSD criteria and complete a diabetes screening during the MY. Data is drawn from HEDIS results and health care claims. HEDIS rates are used to establish performance trends; the HEDIS data is reported based on the measurement period.	
Actions/Interventions Implemented in 2024:	

Quarter 1:	• Continued tracking members in need of glucose screening test. • Used provider portal to communicate follow-up best practices and guidelines for follow-up visits. • Continued data pull for text messaging campaign. • Mailed member health rewards flyer to eligible members. • Community clinics/provider education via HCHCN Clinical Quality Champion Meeting on January 31, 2024, and The Coalition of Orange County Health Centers and Medical Provider Forum on March 15, 2024, regarding the importance of quality measure.

Quarter 2:	• Continued tracking members in need of glucose screening test.
	• Used provider portal to communicate follow-up best practices and guidelines for follow-up visits.
	• Continued data pull for text messaging campaign.
	• Mailed member health rewards flyer to eligible members.
	• Mailed to all prescribing providers with the following:
	  ○ Medical Director Letter
	  ○ Provider Tool Tip Sheet

Quarter 3:	• Continued tracking members in need of glucose screening test.
	• Used provider portal to communicate follow-up best practices and guidelines for follow-up visits.
	• Continued data pull for text messaging campaign.
	• Mailed member health rewards flyer to eligible members.
	• Mailed to all prescribing providers with the following:
	  ○ Medical Director Letter
	  ○ Provider Tool Tip Sheet
	  ○ Member Health Reward Flyer
	• Presented at The Coalition of Orange County Community Health Center meeting and Medical Provider Forum regarding BH Quality Measures on September 20, 2024.

Quarter 4:	• Continued tracking members in need of glucose screening test.
	• Continued data pull for text messaging campaign.
	• Mailed member health rewards flyer to eligible members.
	• Mailed to all prescribing providers with the following:
	  ○ Medical Director Letter
	  ○ Provider Tool Tip Sheet
	  ○ Member Health Reward Flyer

Program Results:	

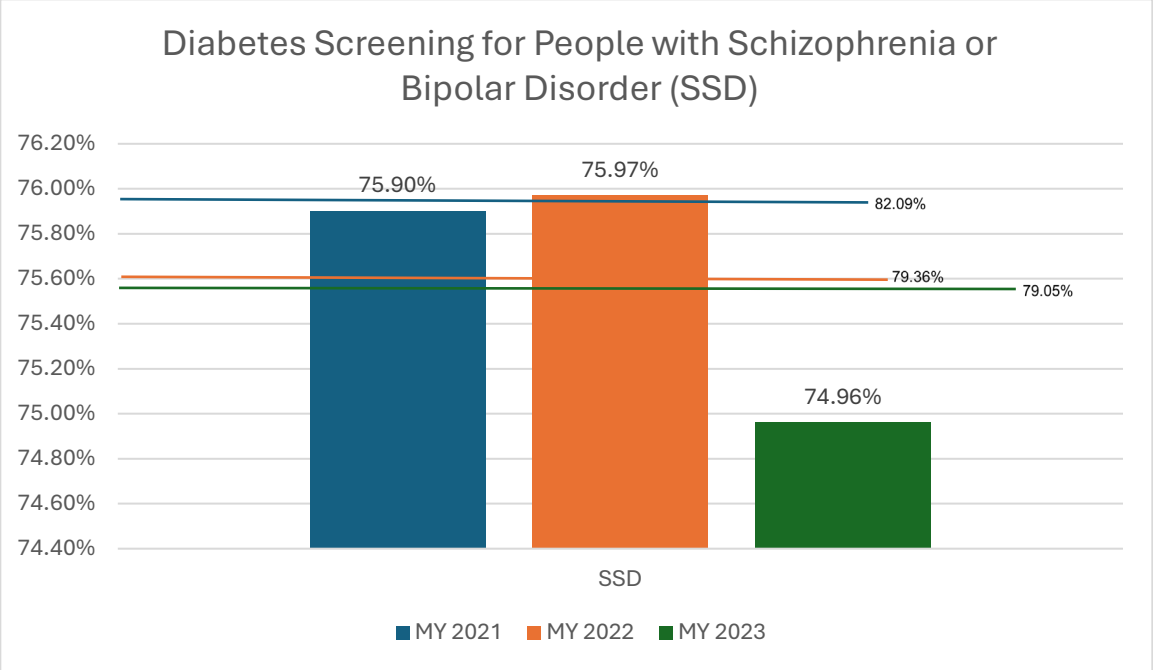


Chart caption: HEDIS Final Rates Trend Analysis

Quantitative Analysis:
CalOptima Health's 2023 SSD Measurement of Effectiveness of Opportunity HEDIS final rate was 74.96%, which did not meet the intended goal of 77.48%. The final rate has demonstrated a slight decrease.

Identified Barriers:	Identified Opportunities for Improvement:

• No first quarter data available from ITS Data Warehouse team.
• Some members with this diagnosis may not see their PCP regularly.
• Some members may refuse to get their lab work completed.
	• Use 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:
	  ○ Medical Director Letter
	  ○ List of members/patients in need of screening
	  ○ Provider Tool Tip Sheet

Conclusion:
In summary, CalOptima Health did not achieve the SSD Measurement of Effectiveness of Opportunity HEDIS goal of 77.48%. The data did show a slight decline from the year prior and missed the targeted HEDIS goal. Based on the provider's feedback, CalOptima Health is aware that some of the members may be having a difficult time getting the lab work completed. The BHI department will continue to monitor this measure and has begun to implement member-focused engagement and incentives to assist and encourage our members to complete the necessary screenings.

Activities/interventions to continue/add next year:

- Continue tracking members in need of glucose screening test.
- Use provider portal to communicate follow-up best practices and guidelines for follow-up visits.
- Continuing data pull for text messaging campaign
- Mail out member health rewards flyers to eligible members.
- Mail out the top 60 providers with the following:
- Medical director letter

○ List of members/patients in need of screening ○ Provider Tool Tip Sheet

4.4.7 Behavioral Health (FUA)	
Author: Valerie Venegas	Department: Behavioral Health Integration (BHI)
Responsible Party(ies): Diane Ramos, Natalie Zavala, Carmen Katsarov	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☒ Yes ☐ No
Work Plan Goal/Objective: MC: 30-days: 36.34%; 7-days: 20.0% To increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	
Goal Met: ☐ Yes ☒ No ☐ Partial	
Work Plan Planned Activities: • Share real-time ED data with our health networks on an SFTP site. • Participate in provider educational events related to follow-up visits. • Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members with a follow-up after ED visit. • Implement new behavioral health virtual provider visits to increase access to follow-up appointments. • Bi-weekly member text messaging (approximately 500 members). • Member newsletter (Spring).	
Status: ☐ Completed ☒ Ongoing	
Background: CalOptima Health's program assesses 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.	
Methodology: Two rates are reported in this program, the percentage of ED visits for which the member received follow-up within 30 days, as well as the percentage of ED visits for which the member received follow-up within seven days. Data is drawn from HEDIS results and health care claims. HEDIS rates are used to establish performance trends.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Shared real-time ED data with our health networks on an SFTP Site. • Met with ITS to discuss data sourcing automation for the provider portal information sharing monthly. • Bi-weekly member text messaging. • Drafted article for Spring member newsletter. • Community clinics/provider education via HCHCN Clinical Quality Champion Meeting on January 31, 2024, and The Coalition of Orange County Health Centers and Medical Provider Forum on March 15, 2024, regarding the importance of quality measure.
Quarter 2:	• Shared real-time ED data with our health networks on an SFTP site. • Bi-weekly member text messaging. • Spring member newsletter (April 2024).
Quarter 3:	• SFTP folders have been established, and BH ED data was sent to health networks daily, as well as weekly reminders in HN communication. • Bi-weekly member text messaging.

	• Article promoting Telemed2U and telehealth services will be included in Fall member newsletter. The article will help with possible provider access issues and increase the likelihood of ED follow-up visits. • Developed IVR calls for ED follow-up. • FUA data became available through provider portal.
Quarter 4:	• SFTP folders have been established and BH ED data is being sent to health networks daily, as well as weekly reminders in HN communication. • Bi-weekly member text messaging. • Finalized IVR script calls for ED follow-up.

Program Results:

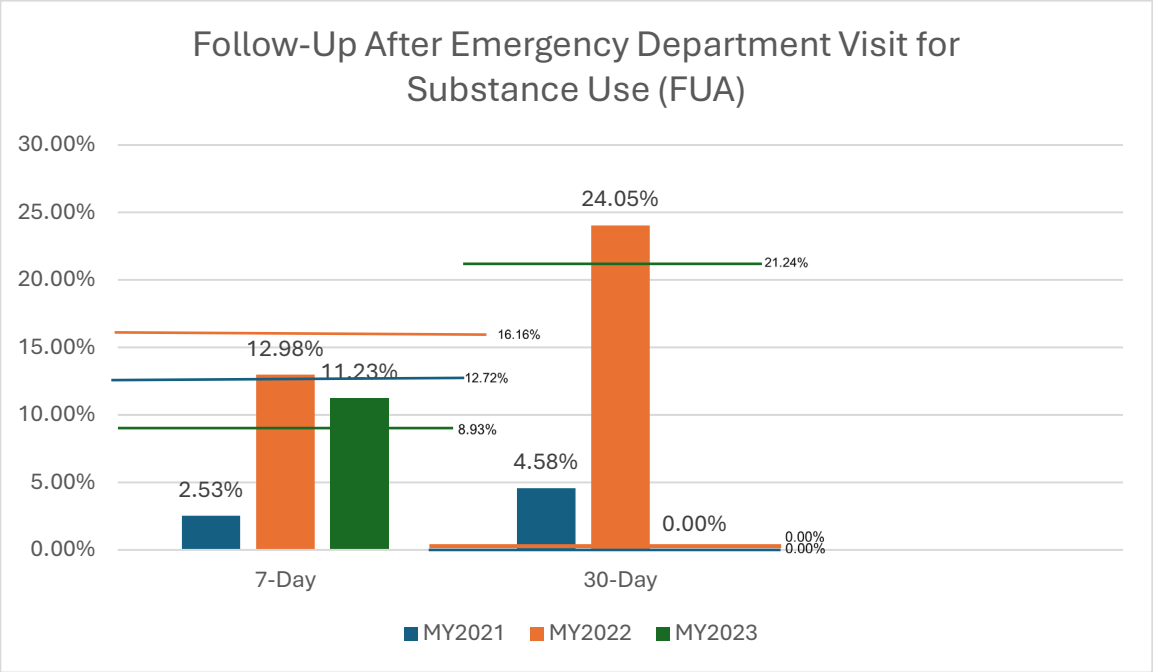


Chart caption: HEDIS Final Rates Trend Analysis

Quantitative Analysis:
CalOptima Health's MY2023 HEDIS final seven-day rate was 11.23% which met the intended goal of 8.93%. The final 30-day rate was 21.41%, which also met the intended goal of 21.24%. The data demonstrates a slight increase in members attending follow-up visits post-ED visits. The pattern appears to be continuing into MY2024.

Identified Barriers:	Identified Opportunities for Improvement:
• Not having the bandwidth to outreach to members who fall into the FUA measure daily. • Data collection and data sharing with the HCA has been difficult.	• Use of available technology such as texting and telehealth services may allow better access to follow-up appointments for members as well as new forms of member outreach via IVR and telehealth providers.

Conclusion:
Due to the measure not meeting the intended goal, we plan to continue to engage with both providers and members to achieve the desired outcome for FUA and improve data accessibility.

Activities/Interventions to continue/add next year:

• IVR calls to members who fall under the FUA measure • BH Telehealth vendor will outreach to members from the daily ED data feed • Continue bi-weekly member text messaging • Member outreach with NAMI By Your Side (NBYS)

4.4.8 Improving Adverse Childhood Experiences (ACES) Screening	
Author: Nathalie Pauli	Department: Behavioral Health Integration (BHI)
Responsible Party(ies): Diane Ramos, Natalie Zavala, Carmen Katsarov	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Improve Adverse Childhood Experiences (ACES) Screening	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: Assess and report on the following activities: • Collaborative meetings between teams to identify best practices to implement • Provider and member education	
Status: ☐ Completed ☒ Ongoing	
Background: CalOptima Health continues to recognize the importance of preventive health care to improve the health and well-being of our members and their families. Research has shown that trauma impacts brain function, coping and patient well-being. DHCS launched a statewide effort starting in January 2020 to screen for childhood trauma and treat the impacts of toxic stress. Adverse Childhood Experiences (ACEs) are potentially traumatic events that occur in childhood (0–17 years). ACEs are linked to chronic health problems, mental illness and substance use disorder problems in adolescence and adulthood. ACEs can also negatively impact education, job opportunities and earning potential. ACEs are costly. In California, ACEs-related health consequences cost an estimated economic burden of $112.5 billion in 2020 alone. CalOptima Health continues to reimburse providers in the amount of $29 for each qualifying ACEs screening, including the requirement for providers to attest to having completed a certified trauma-informed care training program before they could be reimbursed for screenings. This report summarizes our progress on the implementation of the initiative.	
Methodology: CalOptima Health provides comprehensive support on the design and implementation of the ACEs initiative. During an appointment, an age-appropriate ACEs screening tool is administered to parents or caregivers for younger patients and directly to individuals who are adolescents or adults. There are several versions of the qualified screening tool, such as the Pediatric ACEs and Related Life-Events Screener (PEARLS) for members ages 0–19 years old and the Adverse Childhood Experience Questionnaire for members who are 18 years and older. Providers are eligible for reimbursement once per year for children, on a 12-month basis from the date of service, while the screening is reimbursable once in a lifetime for an adult.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Continued collaborative meetings between teams to identify best practices to implement. • Continued provider and member education. • Continued to participate in ACEs-related stakeholder meetings. • Continued to review the quarterly ACES report.
Quarter 2:	• Continued collaborative meetings between teams to identify best practices to implement. • Continued provider and member education.

	• Continued to participate in ACEs-related stakeholder meetings. • Continue to review the quarterly ACES report.
Quarter 3:	• Attended collaborative meetings between teams to identify best practices to implement. • Attended provider and member education. • Participated in ACEs-related stakeholder meetings. • Continued to review the quarterly ACES report.
Quarter 4:	• Attended collaborative meetings between teams to identify best practices to implement. • Attended provider and member education. • Continued to review the quarterly ACES report.

Program Results:

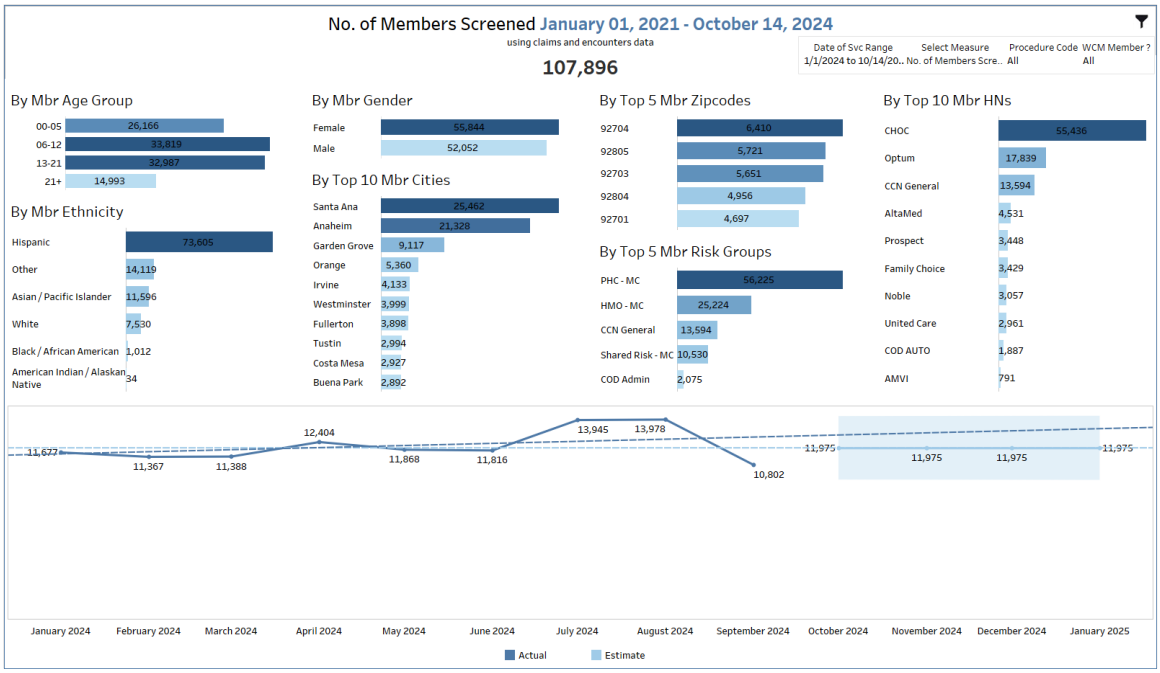


Chart caption: Number of members screened for ACEs

Quantitative Analysis:
CalOptima Health's data analyst calculated and published the rates for the measures in April 2024. The number of completed screenings (68,969) in RY2024 exceeded the goal of 41,793 screenings by 27,176 screenings. Thus, the goal was met. The RY2024 screenings of 68,969 decreased by 3,593 from the RY2023 screenings of 72,562. The RY024 screenings were 5,986 screenings higher than the RY2022 screenings of 62,983.

In addition, the ACEs Aware website displays quarterly ACES data across California. The most current September 2024 data shows Orange County has conducted the most ACEs screenings in CA, with over 42.4% of Medi-Cal members ages 0-20 screened to date.

Identified Barriers:	Identified Opportunities for Improvement:
• Timely data sharing	• CalOptima Health has continued to exceed the goal for the number of completed ACEs screenings.

Conclusion:

In summary, CalOptima Health intervention resulted in an increase in ACEs screenings completed. Our efforts have included the distribution of the ACEs Aware provider toolkit via provider training and our website and offering CME and CE events. Our data continues to show an improvement in the number of ACEs screening in both age groups. ACEs screening will continue to be a high priority for CalOptima Health to continue to improve the healthcare outcomes for our members.
Activities/Interventions to continue/add next year:
• Continue to review the quarterly ACES data and continue to report to QIHEC or other committees as appropriate.

4.4.9 School Based Mental Health Services (SBHIP)	
Business Owner: Diane Ramos, Natalie Zavala, Carmen Katsarov	Department: Behavioral Health Integration (BHI)
Support Staff: Sherie Hopson	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Report on activities to improve access to preventive, early intervention and BH services by school-affiliated BH providers.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: Assess and report on the following Student Behavioral Health Incentive Program (SBHIP) activities: • Implement SBHIP DHCS targeted interventions. • Bi-quarterly reporting to DHCS	
Status: ☐ Completed ☒ Ongoing	
Background: SBHIP was created by state law and managed by DHCS over the program's three-year timeline (January 1, 2022–December 31, 2024). Medi-Cal MCPs across California were eligible for up to $389 million in incentive payments for developing programs that increase access to preventive, early intervention and behavioral health services with school-affiliated behavioral health providers and meeting performance metrics associated with these programs. DHCS has allocated up to $25,459,676 for CalOptima Health as Orange County's MCP.	
Methodology: CalOptima Health SBHIP Partners (CHOC, Hazel Health, Western Youth Services, Orange County Department of Education (OCDE) and all 29 school districts) complete their DHCS-approved targeted interventions and SBHIP board-approved funded program/project by the close of SBHIP December 31, 2024. The targeted interventions are: • Behavior health screenings and referrals • Building stronger partnerships to increase access to Medi-Cal services • Technical assistance support for contracts • IT enhancements for behavioral health services	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• CHOC hired a school transition coordinator and began serving youth in their Mental Health Crisis Clinic' School Reintegration Program. A total of 118 youths from the inpatient psychiatric unit and 11 from the emergency department were served. • CHOC Deaf and Hard of Hearing Mental Health Services psychologist started working with elementary schools on an educational package to help schools educate staff and parents about the mental health needs of deaf/hard of hearing students.

	• CHOC and OCDE completed design walkthroughs for all 10 selected SBHIP-funded WellSpaces. • Hazel Health executed a no-cost memorandum of understanding directly with 20 of the 29 public school districts. Ten school districts launched Hazel Health telehealth services. • Hazel Health executed a CalOptima Health Behavioral Health Master Service Agreement. • CalOptima Health received DHCS approval for four December 2023 Biquarterly Reports.
Quarter 2:	• CHOC served youths in their Mental Health Crisis Clinic' School Reintegration Program, 101 from the inpatient psychiatric unit and 26 from the emergency department. • CHOC SBHIP-funded WellSpaces, the first of 10 installations completed at Marco Forster Middle School in the Capistrano Unified School District. • The Autism Comprehensive Care Program started recruitment for at least six patients to pilot the program. • A total of 16 public school districts launch Hazel Health telehealth services for their students at home or at the student's home. • OCDE: 22 of the 29 public school districts have expanded their behavioral staff, resulting in an overall 17% increase. • CalOptima Health received from DHCS the second of four SBHIP incentive payments for the four December 2023 Biquarterly Reports. • Four June Biquarterly Report submitted to DHCS.
Quarter 3:	• The CHOC School Reintegration program served 149 children hospitalized in their inpatient psychiatric unit and 21 from the emergency department. • CHOC Deaf and Hard of Hearing Mental Health Services' psychologist drafted an educational package to help schools educate staff and parents about the mental health needs of deaf and hard of hearing students. • CHOC SBHIP-funded WellSpaces, eight of 10 have been installed. • CHOC Autism Comprehensive Care Program's curriculum and workflows for referral are finalized. • A total of 19 public school districts have launched Hazel Health telehealth services for their students. Referred students' total count continues to increase monthly. • SBHIP aided in funding OCDE's 2nd Annual Mental Health Summit. The objective was to broaden access to mental health resources such as electronic health record vendors along with vendors representing various behavior screeners for the educators and mental health staff to gain more knowledge about these products. Approximately 400 were in attendance, twice as many as the previous year. • Western Youth Services deployed their on-demand virtual Behavioral Health Curriculum library for the school district staff and began conducting in-person training and post-training consultative support. • CalOptima Health received from DHCS the third of four SBHIP incentive payments for the four June Biquarterly Reports.
Quarter 4:	• Four Project Outcome Reports completed for DHCS SBHIP funding final payment. • SBHIP-funded CHOC's Autism Comprehensive Care Program revised launch date is projected for January 2025. • Eight of 10 SBHIP-funded WellSpace installations completed; the last two projected installation dates are late January/early February 2025.
Quantitative Analysis:	

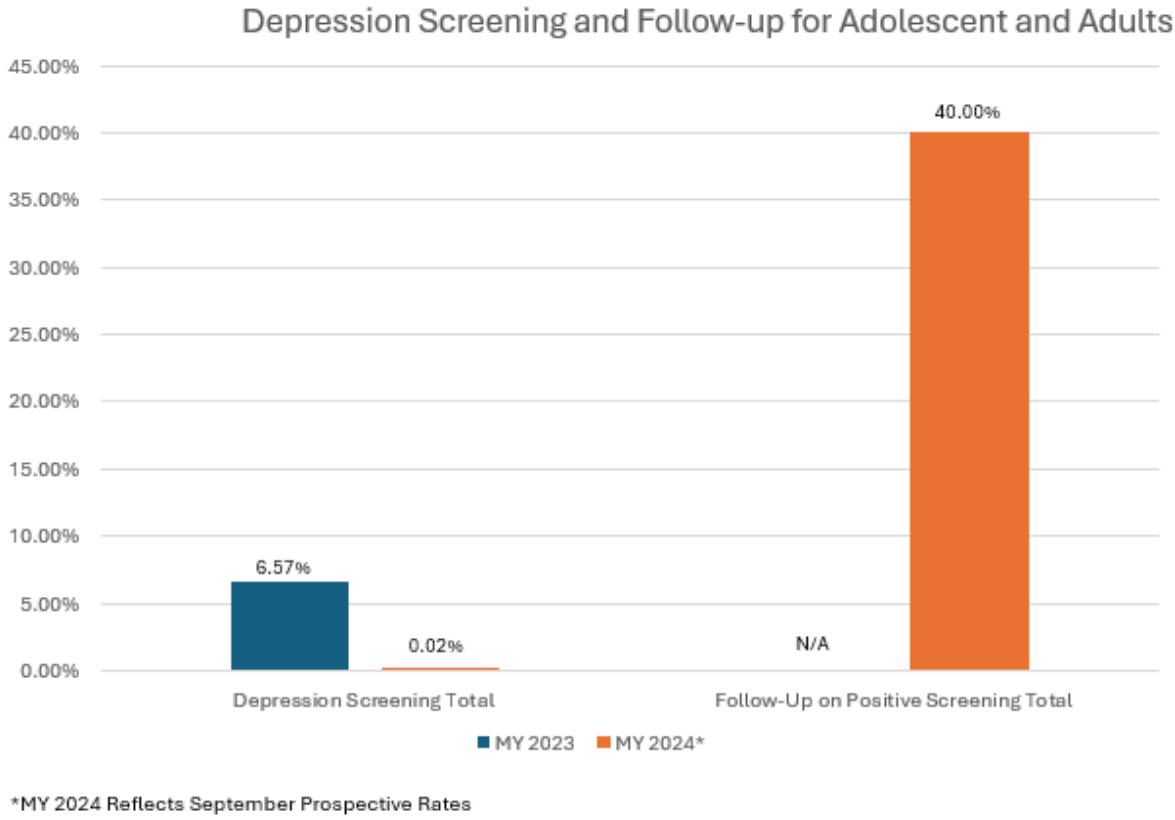
The operational portion of SBHIP is on target to close December 31, 2024. The partnerships developed during SBHIP will remain and regularly scheduled meetings will be established to monitor and report utilization and sustainability.	
Identified Barriers:	Identified Opportunities for Improvement:
• No barriers identified	None
Conclusion: The SBHIP has been successful due to DHCS having approved each bi-quarterly submission; therefore, the funding tied to each submission has been awarded.	
Activities/Interventions to continue/add next year:	
• The operational portion of SBHIP is on target to close December 31, 2024. The partnerships developed during SBHIP will remain and regularly scheduled meetings will be established to monitor and report utilization and sustainability.	

4.4.10 Adolescent Depression Screening	
Business Owner: Natalie Zavala	Department: Behavioral Health Integration
Support Staff: Diane Ramos	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☒ Yes ☐ No
Work Plan Goal/Objective: DSF-E Depression Screening and Follow-up for Adolescent and Adults – Screening: 2.97%	
Goal Met: ☐ Yes ☒ No ☐ Partial	
Work Plan Planned Activities: • Identification and distribution of best practices to health network and provider partners. • Provide health network and provider partners with timely hospital discharge data specific to live deliveries to improve postpartum visit completion. • Targeted member engagement and outreach campaigns in coordination with health network partners. • Provider education (CE/CME) in Q3.	
Status: ☐ Completed ☒ Ongoing	
Background: CalOptima Health monitors the percentage of members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care.	
Methodology: DSF-E has two rates: • Depression Screening — The percentage of members who were screened for clinical depression using a standardized instrument. • Follow-Up on Positive Screen — The percentage of members who received follow-up care within 30 days of a positive depression screen finding.	
Medi-Cal Results:	

Acronym	Measure	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Met / Not Met
DSF-E	Depression Screening and Follow-up for Adolescents and Adults: 12–17	6.80%	N/A	☐ Yes ☐ No ☒ N/A
DSF-E	Depression Screening and Follow-up for Adolescent and Adults: 18–64	5.27%	N/A	☐ Yes ☐ No ☒ N/A
DSF-E	Depression Screening and Follow-up for Adolescents and Adults: 65+	27.01%	N/A	☐ Yes ☐ No ☒ N/A
DSF-E	Depression Screening and Follow-up for Adolescents and Adults: Total	6.57%	N/A	☐ Yes ☐ No ☒ N/A

Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Drafted provider tip sheet; letter submitted for internal review process.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☐ Q4	☐ Member ☒ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☒ Completed ☐ On-going ☐ Incomplete	DSF-E
2. Quality Champions meeting with The Coalition of Orange County Community Health Center presentation on BH Quality Measures on September 20, 2024.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☐ Q4	☐ Member ☐ Provider ☐ Health Network ☒ Community ☐ Data ☐ Other	☒ Completed ☐ On-going ☐ Incomplete	DSF-E
3. Monthly health network communication BH updates.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☐ Q4	☐ Member ☒ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	DSF-E
4. Continued mailings to providers (provider letter tip sheet).	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☒ Q4	☐ Member ☒ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	DSF-E

MC = Medi-Cal; OC= OneCare

Results:
Chart A: MY2023 and MY2024 September Prospective Rate for Depression Screening and Follow-up for Adolescents and Adults  *Chart caption: Chart A displays depression screening rates for 2023 (Final Rates) and September 2024 (Prospective Rates).*
Quantitative Analysis: DSF-E: No Final Rates for Reporting Year 2024

Identified Barriers:	Identified Opportunities for Improvement:
DSF-E: • Data collection was the main barrier. Only supplemental data available.	DSF-E: • The Behavioral Health Quality Improvement Workgroup is exploring ways to obtain additional supplemental data to better capture completed screenings and follow-up visits.

Conclusion:
DSF-E: For 2025, the BHI quality team will be actively monitoring DSF measures to track and trend the eligible member population.
Activities/Interventions to continue/add next year:
DSF-E: The following interventions are planned in 2025: • The BHI quality team will continue to mail a best practices letter/tool tip sheet to identified prescribing providers. • BHI will be working with the appropriate team to identify data elements needed to track depression screening and follow-up care.

4.4.11 Maternal Depression Screening	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Kelli Glynn	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☒ Yes ☐ No
Work Plan Goal/Objective: Medi-Cal only — Meet the following goals For MY2024 HEDIS: • PND-E Prenatal Depression Screening and Follow-up Screening: 8.81% • PDS-E Postpartum Depression Screening and Follow-up: 27.77% Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: 1) Clinic provider days – Collaborative events to support non-compliant members to complete HEDIS measure activities. 2) Complete maternal depression screenings during prenatal and postpartum assessment through the Bright Steps Program 3) Refer members identified at risk through the Bright Steps assessments to BH or provide TeleMed2U information 4) Provide community partners and contracted providers with maternal mental health training	
Status: ☒ Completed ☐ Ongoing	
Background: Perinatal depression encompasses both minor and major depressive episodes that occur during pregnancy and the first 12 months following childbirth. Research shows that depression is a prevalent condition that significantly impacts the well-being and functionality of both birthing persons and their families. A study conducted by Jo, et al., found that the prevalence of depression in pregnant and postpartum persons, ranges from 12 to 15%, with some areas in the United States reporting as high as 20% prevalence. Untreated depression during pregnancy can increase the risk of postpartum depression, suicide and complications to the infant, such as premature birth or low birth weight. Postpartum depression also impairs essential caregiving and disrupts the mother-to-infant bonding, which in turn can lead to long-term developmental issues for the child, issues which can persist well into the adolescent period. Routinely assessing for depression utilizing a standardized tool during the prenatal and postpartum period can identify potential symptoms of depression and allow for early intervention and treatment if needed. The Prenatal and Depression Screening and Follow-up measures are quality performance measures for HEDIS and are part of the reportable DHCS MCAS measures. These measures directly align with DHCS's Population Health Management Bold Goals by focusing proactively on identifying and addressing the mental health needs of birthing persons.	

Prenatal Depression Screening and Follow-up assesses the percentage of deliveries in which birthing persons were screened for clinical depression while pregnant and, if screened positive, received follow-up care.

Postpartum Depression Screening and Follow-up assesses the percentage of deliveries in which members were screened for clinical depression during the postpartum period and, if screened positive, received follow-up care.

Methodology:
CalOptima Health follows the HEDIS data collection methodology to assess performance with prenatal and postpartum depression screening and follow-up. Furthermore, the plan utilizes the previous year's performance and the NCQA Quality Compass benchmarks to set organizational goals. MY2024 is the first year in which rates were introduced for these measures. NCQA established a Medicaid 50th percentile rate for these two measures. However, the measures are not yet associated with an MPL; thus, the 50th percentile rate is a guide to direct CalOptima Health's work.

Medi-Cal Results:
1) Two clinic days were completed (UCI Family Health in Santa Ana and Anaheim). All members that attended these events were screened for prenatal or postpartum depression. A total of 48 members were screened, and six of these members indicated a positive screening for depression. The members who screened positive were provided additional support with an LCSW and provided with follow-up care.
2) CalOptima Health's Bright Steps program screened 316 pregnant members and 350 postpartum members for maternal depression with PHQ-2 and PHQ-9 screeners.
3) CalOptima Health partnered with Postpartum Support International to provide eight training sessions on maternal mental health. The Fall 2024 cohort had 135 registered individuals who serve CalOptima Health members at a range of provider offices, CBOs, hospitals and other agencies.

Acronym	Measure	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Met / Not Met
PND-E	Prenatal Depression Screening and Follow-Up: Depression Screening Total	14.52%	N/A	☐ Yes ☐ No ☒ N/A
PND-E	Prenatal Depression Screening and Follow-Up: Follow-Up on Positive Screening Total	52.8%	N/A	☐ Yes ☐ No ☒ N/A
PDS-E	Postpartum Depression Screening and Follow-up: Depression Screening Total	17.33%	N/A	☐ Yes ☐ No ☒ N/A
PDS-E	Postpartum Depression Screening and Follow-Up: Follow-Up on Positive Screen	56.84%	N/A	☐ Yes ☐ No ☒ N/A

Acronym	Measure	MY 2021 OneCare Rate	MY 2022 OneCare Rate	MY 2023 OneCare Rate	MY 2023 OneCare Goal	MY 2023 Goal Me/Not Met

Actions/Interventions Implemented in 2024:

Efforts to increase maternal depression screening include a collaborative maternal mental health program with HCA, providing the Bright Steps Program for prenatal and postpartum members and their babies through 1 year of age and a Postpartum Member Health Reward.

The Maternal Depression Screening Workgroup, comprised of HCA, CalOptima Health and First Five OC, completed the following activities in 2024:

- Implemented a provider survey to assess barriers to completion of maternal depression screening and follow-up care.
- Facilitation of a Continuing Medical Education/Continuing Education (CME/CE) workshop on July 10, 2024, for physicians and health care professionals titled Maternal Mental Health Conditions, Screenings and Resources.
- The Orange County Perinatal & Infant Mental Health and Substance Use Toolkit was updated and shared online to promote best practices for maternal depression screening and support. Link: https://everyparentoc.org/pimhtoolkit/
- CalOptima Health sponsored 135 participants in the Postpartum Support International Maternal Mental Health Certificate Training Course. Participants include individuals who provide perinatal health services to pregnant and postpartum Medi-Cal members in Orange County, including OB/GYNs, pediatricians, midwives, PCPs, doulas, clinic staff, mental health professionals and paraprofessionals, maternal health educators, etc.

Results:
Both the prenatal and depression screening and follow-up measures are new. There are no benchmark rates set for MY2023, so CalOptima Health is not able to assess progress. Rates for both measures were introduced in MY2024. NCQA set forth a Medicaid 50th percentile for these two measures. CalOptima Health utilized the MY2024 rates set by NCQA as a guide to direct the work; however, there are no performance benchmarks set for both measures.

When CalOptima Health assessed the MY2024 performance against the Medicaid 50th percentile for MY2024, it was evident that the plan met the goal.

Chart A: MY2023 and MY2024 September Prospective Rate for Prenatal and Depression Screening

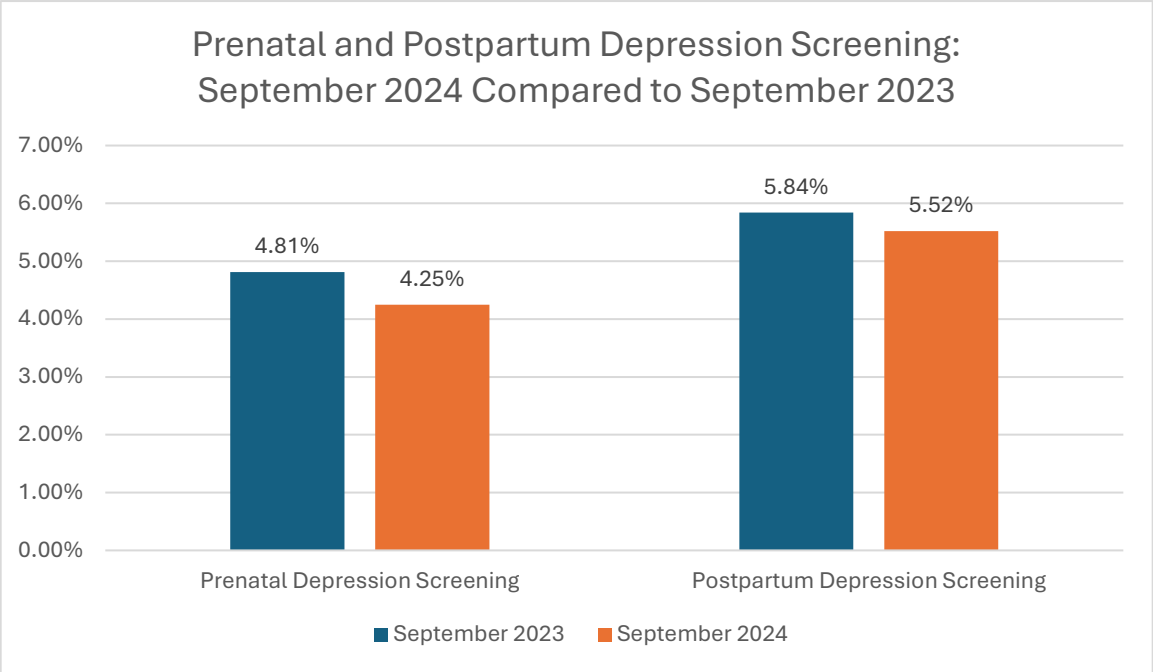


Chart caption: Chart A displays prenatal and postpartum depression screening rates for September 2023 compared to September 2024.

Prospective rate methodology includes continuous enrollment criteria. Prospective rates are solely based on data received and are not final.

Quantitative Analysis:

- Prenatal Depression Screening: When assessing the September 2024 prospective performance rate, the rate dropped less than 1% compared to September 2023. The decrease is not significant, but the plan will continue to monitor.
- Postpartum Depression Screening: When assessing the September 2024 prospective performance rate, the rate dropped less than 1% compared to September 2023. The decrease is not significant, but the plan will continue to monitor.
- Data limitations: For 2023, there were no positive screens identified for prenatal or postpartum care, so CalOptima Health could not draw comparisons between 2024 and the previous year. This is likely due to the challenges associated with obtaining this data.
- Accurate documentation of screenings is critical to assess performance for the delivery of care. For the methodology in which providers document the screening, the data systems can pose barriers to capturing the care that is being delivered. For example, these screenings are often associated with a LOINC code that is not received through the standard claim and encounter process. Consequently, these rates are likely an underestimation of the care that is being delivered. For example, follow-up care may have taken place, but it might not be recorded in a way that can be easily tracked in data systems.

Identified Barriers:	Identified Opportunities for Improvement:
• Low HEDIS rates for maternal depression screening are often due to challenges in data	• Improving HEDIS maternal depression screening rates requires targeted efforts to

collection, reporting and standardization rather than a lack of actual screening. • Many providers perform screenings but fail to document them in a way that is visible for HEDIS reporting, often because of gaps in electronic health record (EHR) systems, incomplete or incorrect coding or the use of non-reportable screening tools. • Workflows and high workloads may deprioritize documentation, while fragmented data systems and lack of integration between behavioral health and medical care further hinder accurate reporting. • Additionally, some patients decline screenings due to stigma or privacy concerns and missed postpartum visits reduce opportunities for screening and documentation.	enhance data accuracy and capture. This includes training providers and clinic staff on proper documentation and coding, optimizing EHR systems to prompt and record screenings, and improving interoperability between medical, behavioral health, and health network systems. • Patient education can help reduce stigma and encourage participation in screening and follow-up for care for those who need additional support.
Conclusion: While the performance rates for prenatal and postpartum depression screenings have remained relatively stable from 2023 to 2024, the absence of positive screens in 2023 and the challenges with documentation make it difficult to definitively determine whether the maternal health program has been entirely successful. We must continue to monitor screening rates and improve data documentation processes to ensure a more accurate assessment of care delivery. Despite these challenges, the program is showing a consistent effort in screening and follow-up, and further improvements are anticipated with continued monitoring and enhancement of data systems. Ultimately, while there have been some minor decreases, these do not significantly impact the overall success of the program at this stage, and steps will be taken to address any gaps identified in future evaluations.	
Activities/Interventions to continue/add next year:	
• Pursue direct EHR integrations with CHCN providers/community clinics to extract depression screening results for care gap closure. • Provide CHCN providers/community clinics with the inbound supplemental data file layout that can be utilized to capture depression screening results. • Provide CHCN providers/community clinics and health network partners with depression screening coding education, such as the utilization of LOINC codes. • Explore the ability to capture depression screenings completed in an inpatient setting via vendor PointClickCare. • Continue to increase provider awareness about maternal depression screenings and resources. • Continue community/clinic-based screening events to meet members where they are.	

4.5 Managing Members with Chronic Conditions

4.5.1 Diabetes Care (HBD, EED)	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Melissa Morales/Kelli Glynn	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No

Work Plan Goal/Objective: EED: MC 66.33% OC 81% HBD: MC 29.44% OC 20%
Goal Met: ☐ Yes ☒ No ☐ Partial
Work Plan Planned Activities: Targeted member engagement and outreach campaigns in coordination with health network partners. Strategic Quality Initiatives Intervention Plan — Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.
Status: ☐ Completed ☒ Ongoing
Background: According to the Centers of Disease Control and Prevention (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 specific treatment plans based on their patients' needs. The following is an evaluation of the diabetes care measure for HEDIS. Hemoglobin A1C Control for Patients with Diabetes – HbA1C Poor Control > 9% (HBD) is part of DHCS MCAS for annual reporting by Medi-Cal MCPs. This measure is held to the MPL established by NCQA Quality Compass Medicaid 50th percentile. HBD and Eye Exam for Patients with Diabetes (EED) measures are part of the CMS 5-Star quality rating system.
Methodology: Followed the HEDIS data collection methodology. Goal methodology for MY2023 is set based on the current reported performance and the most current available benchmark. The Medi-Cal goal setting for MY2023 is based on the MY2021 reported performance results compared to the national percentile from the MY2021 NCQA Quality Compass. If the current reported rate reached the NCQA Quality Compass percentile, the goal was set to the next percentile. The OneCare goal setting for MY2023 is based on the MY2021 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. Goal methodology for MY2024 is set based on the current reported performance and the most current available benchmark. The Medi-Cal goal setting for MY2024 is based on the 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. The OneCare goal setting for MY2024 is based on the MY2022 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. For health disparity analysis, the data is pulled from the member enrollment file. The data is uploaded to the NCQA certified HEDIS software for rate calculation. The stratified rates are rolled up by denominator and numerator based on the rate/ethnicity, language or gender information uploaded.
Medi-Cal Results:

Acronym	Measure	MY2021 Medi-Cal Rate	MY2022 Medi-Cal Rate	MY2023 Medi-Cal Rate	MY2023 Medi-Cal Goal	MY2023 Goal Met/ Not Met
HBD	Hemoglobin A1C Control for Patients with Diabetes — HbA1C Poor Control (>9%)	28.75%	30.41%	29.34%	30.90%	☒ Yes ☐ No
EED	Eye Exam for Patients with Diabetes	65.11%	62.63%	63.52%	63.75%	☐ Yes ☒ No

Acronym	Measure	MY2023 Sept Medi-Cal Rate	MY2024 Sept Medi-Cal Rate	MY2024 Medi-Cal Goal	MY2024 Goal Met / Not Met
HBD	Hemoglobin A1C Control for Patients with Diabetes — HbA1C Poor Control (>9%)	57.05%	56.90%	29.44%	☐ Yes ☒ No
EED	Eye Exam for Patients with Diabetes	44.09%	41.79%	66.33%	☐ Yes ☒ No

HEDIS MY 2023 Rates by Gender for the Hemoglobin A1C Control for Patients with Diabetes Measure (Medi-Cal LOB)

SUBMEASURE_KEY	GENDER_CODE	DENOMINATOR COUNT	NUMERATOR COUNT	RATE
HBA1C8	F	26113	12779	48.94%
HBA1C8	M	20920	9118	43.59%
		47033	21897	46.56%

Analysis

a. As shown in the above table, the overall total rate for the HbA1C Control <8 (HBD) measure in MY2023 was 46.56% (prior to hybrid lift). Using the total rate as a reference point, female members performed higher than male members, with a compliance rate of 48.94% compared to 43.59% respectively. Neither gender met nor exceeded the MPL of 52.31%. In conclusion, CalOptima Health will continue to implement initiatives aimed at improving HBD performance across the entire population.

HEDIS MY 2023 Rates by Language for the Hemoglobin A1C Control for Patients with Diabetes Measure (Medi-Cal LOB)

SUBMEASURE_KEY	SPOKEN LANGUAGE	DENOMINATOR COUNT	NUMERATOR COUNT	RATE
HBA1C8	AltLang - Braille	1	0	0.00%
HBA1C8	American Sign language	13	7	53.85%
HBA1C8	Arabic	539	295	54.73%
HBA1C8	Armenian	4	1	25.00%
HBA1C8	Audio - Arabic	1	1	100.00%
HBA1C8	Audio - English	2	0	0.00%
HBA1C8	Audio - Farsi	1	1	100.00%
HBA1C8	Audio - Vietnamese	1	0	0.00%
HBA1C8	Bengali	31	22	70.97%
HBA1C8	Burmese	5	2	40.00%
HBA1C8	Cambodian	84	51	60.71%
HBA1C8	Cantonese	22	19	86.36%
HBA1C8	Chinese	64	32	50.00%
HBA1C8	Czech	1	0	0.00%
HBA1C8	Egyptian	18	9	50.00%
HBA1C8	English	20939	9433	45.05%
HBA1C8	Estonian	3	3	100.00%
HBA1C8	Farsi	575	342	59.48%
HBA1C8	Finnish	2	1	50.00%
HBA1C8	French	4	3	75.00%
HBA1C8	Greek	2	0	0.00%
HBA1C8	Gujarati	45	23	51.11%
HBA1C8	Hebrew	4	2	50.00%
HBA1C8	Hindi	72	38	52.78%
HBA1C8	Hmong	2	0	0.00%
HBA1C8	Indian	3	2	66.67%
HBA1C8	Indonesian	12	5	41.67%
HBA1C8	Japanese	8	6	75.00%
HBA1C8	Korean	477	294	61.64%
HBA1C8	Lao	14	9	64.29%
HBA1C8	Large Print - Arabic	2	1	50.00%
HBA1C8	Large Print - English	16	10	62.50%
HBA1C8	Large Print - Spanish	10	6	60.00%
HBA1C8	Large Print - Vietnamese	5	3	60.00%
HBA1C8	Maltese	1	0	0.00%

HBA1C8	Mandarin	136	77	56.62%
HBA1C8	Marathi	1	0	0.00%
HBA1C8	Member Declined	4	3	75.00%
HBA1C8	No Valid Data Reported	290	118	40.69%
HBA1C8	Other	39	22	56.41%
HBA1C8	Other Chinese Languages	2	1	50.00%
HBA1C8	Other Non English	36	16	44.44%
HBA1C8	Portuguese	12	6	50.00%
HBA1C8	Punjabi	13	7	53.85%
HBA1C8	Romanian	22	7	31.82%
HBA1C8	Russian	28	17	60.71%
HBA1C8	Samoan	10	4	40.00%
HBA1C8	Sign Language	5	2	40.00%
HBA1C8	South Indian	2	2	100.00%
HBA1C8	Spanish	18184	7922	43.57%
HBA1C8	Swahili	5	4	80.00%
HBA1C8	Tagalog	201	115	57.21%
HBA1C8	Tamil	4	2	50.00%
HBA1C8	Teluga	5	4	80.00%
HBA1C8	Thai	12	3	25.00%
HBA1C8	Turkish	9	4	44.44%
HBA1C8	Ukranian	2	1	50.00%
HBA1C8	Urdu	48	23	47.92%
HBA1C8	Uzbek	3	3	100.00%
HBA1C8	Vietnamese	4977	2913	58.53%
		47033	21897	46.56%

Analysis

b. As shown in the above table, the overall total rate for the HbA1C Control <8 (HBD) measure in MY2023 was 46.56% (prior to hybrid lift). Using the total rate as a reference point, below are some observations:
    a. The largest population is English-speaking members (20,939 out of the total 47,033). As compared to the reference point, English-speaking members perform slightly lower (at 45.05%). English-speaking members did not meet or exceed the MPL of 52.31%.
    b. The second largest population is Spanish-speaking members (18,184 out of the total 47,033). As compared to the reference point, Spanish-speaking members perform lower (at 43.57%). Spanish-speaking members did not meet or exceed the MPL of 52.31%.

c. The third largest population is Vietnamese-speaking members (4,977 out of the total 47,033). As compared to the reference point, Vietnamese-speaking members perform higher (at 58.53%). Vietnamese-speaking members also exceeded the MPL of 52.31%.
d. There are several groups that met or exceeded the MPL of 52.31%, including:
    i. Estonian
    ii. Uzbek
    iii. South Indian
    iv. Cantonese
    v. Swahili
    vi. Teluga
    vii. Japanese
    viii. French
    ix. Bengali
    x. Indian
    xi. Lao
    xii. Korean
    xiii. Cambodian
    xiv. Russian
    xv. Farsi
    xvi. Vietnamese
    xvii. Tagalog
    xviii. Mandarin
    xix. Arabic
    xx. American Sign language
    xxi. Punjabi
    xxii. Hindi
e. There are several groups that did not meet or exceed the MPL of 52.31%, including:
    i. Greek
    ii. Hmong
    iii. AltLang – Braille
    iv. Czech
    v. Maltese
    vi. Marathi
    vii. Thai
    viii. Armenian
    ix. Romanian
    x. Samoan
    xi. Burmese
    xii. Sign Language
    xiii. Indonesian
    xiv. Spanish
    xv. Other Non English
    xvi. Turkish
    xvii. English
    xviii. Urdu
    xix. Chinese

xx. Egyptian
xxi. Portuguese
xxii. Hebrew
xxiii. Tamil
xxiv. Finnish
xxv. Other Chinese Languages
xxvi. Ukranian
xxvii. Gujarati

f. In conclusion, CalOptima Health will continue to implement initiatives aimed at improving HBD performance across the entire population.

OneCare Results:

Acronym	Measure	MY2021 OneCare Rate	MY2022 OneCare Rate	MY2023 OneCare Rate	MY2023 OneCare Goal	MY2023 Goal Met/ Not Met
HBD	Hemoglobin A1C Control for Patients with Diabetes — HbA1C Poor Control (>9%)	19.13%	21.67%	15.30%	17%	☒ Yes ☐ No
EED	Eye Exam for Patients with Diabetes	78.96%	73.33%	75.14%	79%	☐ Yes ☒ No

Acronym	Measure	MY2023 Sept OneCare Rate	MY2024 Sept OneCare Rate	MY2024 OneCare Goal	MY2024 Goal Met/ Not Met
HBD	Hemoglobin A1C Control for Patients with Diabetes — HbA1C Poor Control (>9%)	42.97%	51.45%	20%	☐ Yes ☒ No
EED	Eye Exam for Patients with Diabetes	59.33%	59.48%	81%	☐ Yes ☒ No

Table below reviews September MY2024 Hemoglobin A1C Control for Patients with Diabetes — HbA1C Poor Control (>9%) by race/ethnicity based on administrative data.

Admin	Race/Ethnicity									
HEDIS Sept MY2024	***Hispanic***	***White***	***Vietnamese***	***Other***	***No response, client declined to state***	***Filipino***	***Asian or Pacific Islander***	***Korean***	***Black***	***Asian Indian***
Numerator	17194	3460	3298	2203	2251	606	411	323	427	240
Denominator	28304	6218	5936	4192	3643	1122	741	739	718	460
Rate	60.75%	55.64%	55.56%	52.55%	61.79%	54.01%	55.47%	43.71%	59.47%	52.17%

Table caption: Table displays the top 10 ethnicities with the highest denominator based on total HEDIS Medi-Cal and OneCare population combined.

Table below reviews September MY2024 Eye Exam for Patients with Diabetes by race/ethnicity based on administrative data.

Admin	Race/Ethnicity									
HEDIS Sept MY2024	***Hispanic***	***White***	***Vietnamese***	***No response, client declined to state***	***Other***	***Filipino***	***Asian or Pacific Islander***	***Black***	***Asian Indian***	***Chinese***
Numerator	1046	371	318	215	194	87	42	43	35	24
Denominator	1759	725	492	365	324	150	82	77	50	31
Rate	59.47%	51.17%	64.63%	58.90%	59.88%	58.00%	51.22%	55.84%	70.00%	77.42%

Table caption: Table displays the top 10 ethnicities with the highest denominator based on total HEDIS Medi-Cal and OneCare population combined.

Actions/Interventions Implemented in 2024:

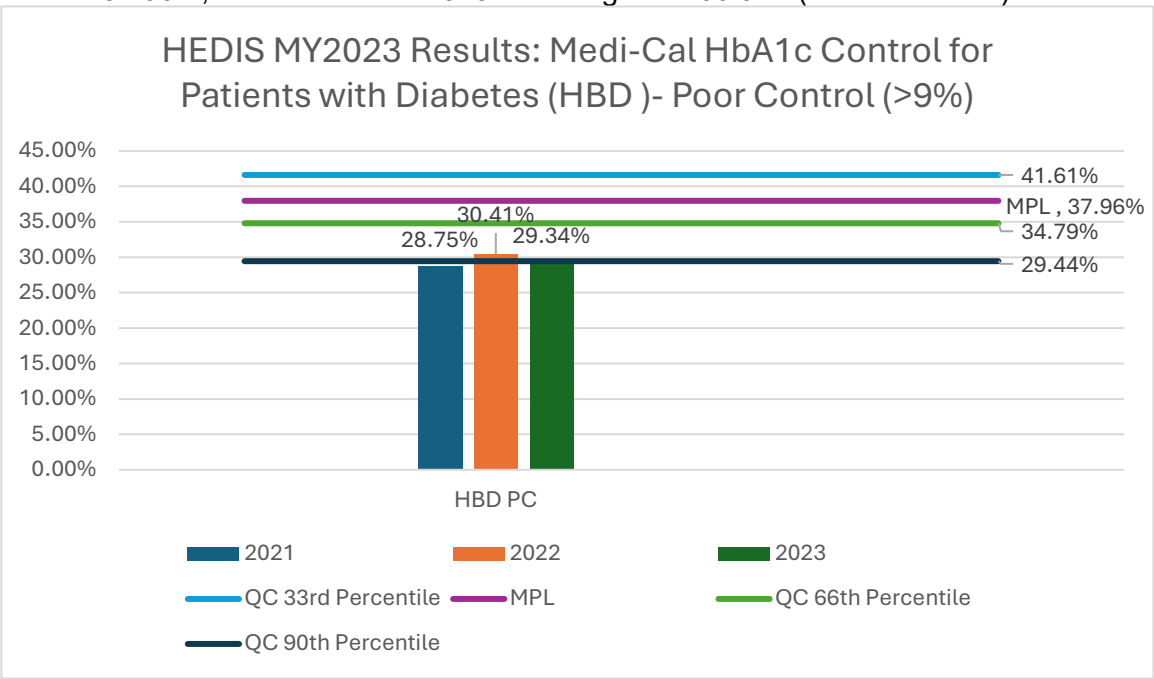
Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Member health reward	☒ MC ☒ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	HBD EED
2. Member mailing	☒ MC ☒ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☒ Completed ☐ On-going ☐ Incomplete	HBD EED
3. Text messaging	☒ MC ☒ OC	☒ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☒ Completed ☐ On-going ☐ Incomplete	HBD EED
4. Telephonic outreach	☐ MC ☒ OC	☐ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	HBD EED
5. VSP vision care data exchange	☒ MC ☒ OC	☐ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☐ Member ☐ Provider ☒ Health Network ☐ Community ☒ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	EED
6. Ophthalmologist provider outreach project	☒ MC ☒ OC	☐ Q1 ☐ Q2 ☐ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	EED
7. Health coach diabetes management program for emerging risk population	☒ MC ☒ OC	☐ Q1 ☐ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data	☐ Completed ☒ On-going ☐ Incomplete	HBD

			☐ Other		

MC = Medi-Cal; OC= OneCare

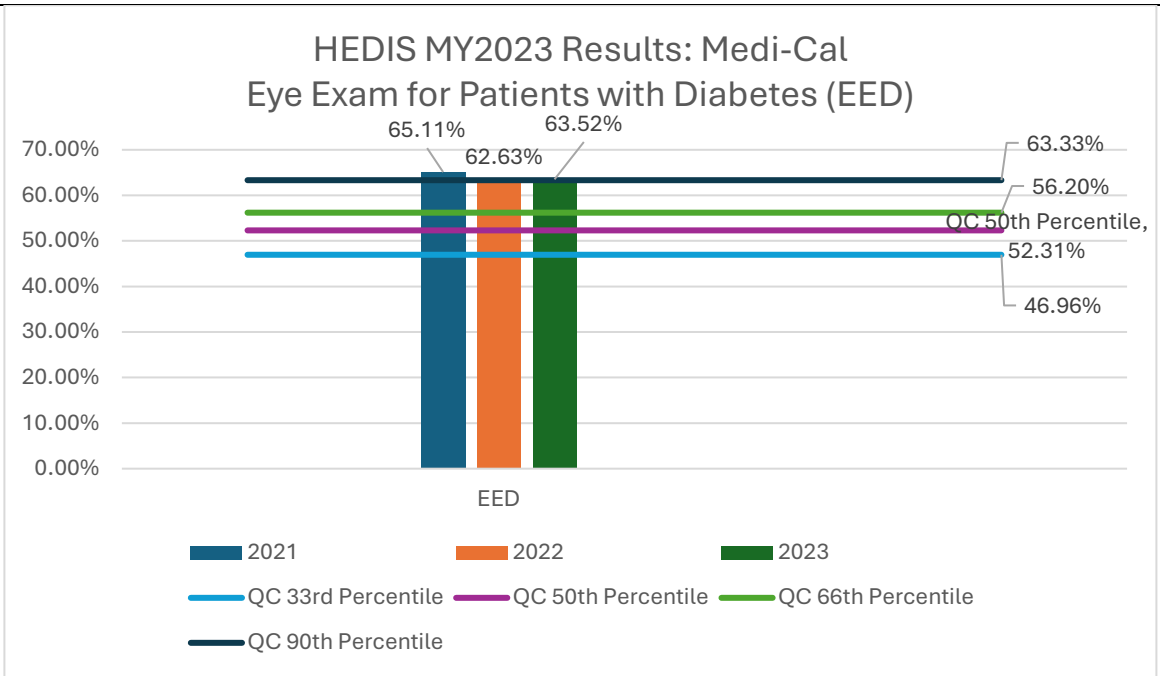
Results:

- CalOptima Health's HEDIS MY2023 HBD hybrid rate for Medi-Cal was 29.34% and met the MPL of 37.96%, and met the MY2023 internal goal of 30.9%. (Lower is better)



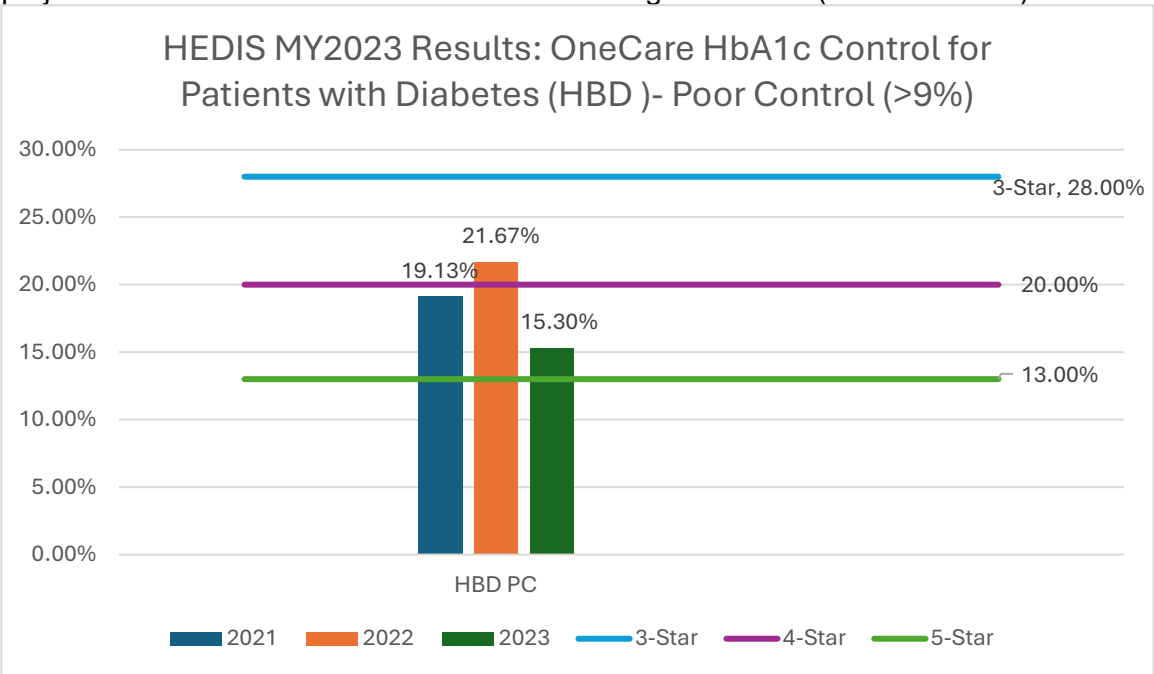
Per HEDIS 2022 Quality Compass Percentile

- CalOptima Health's HEDIS MY2023 EED hybrid rate for Medi-Cal was 63.52% and met 50th percentile of 52.31% but did not meet the MY2023 internal goal of 63.75%.



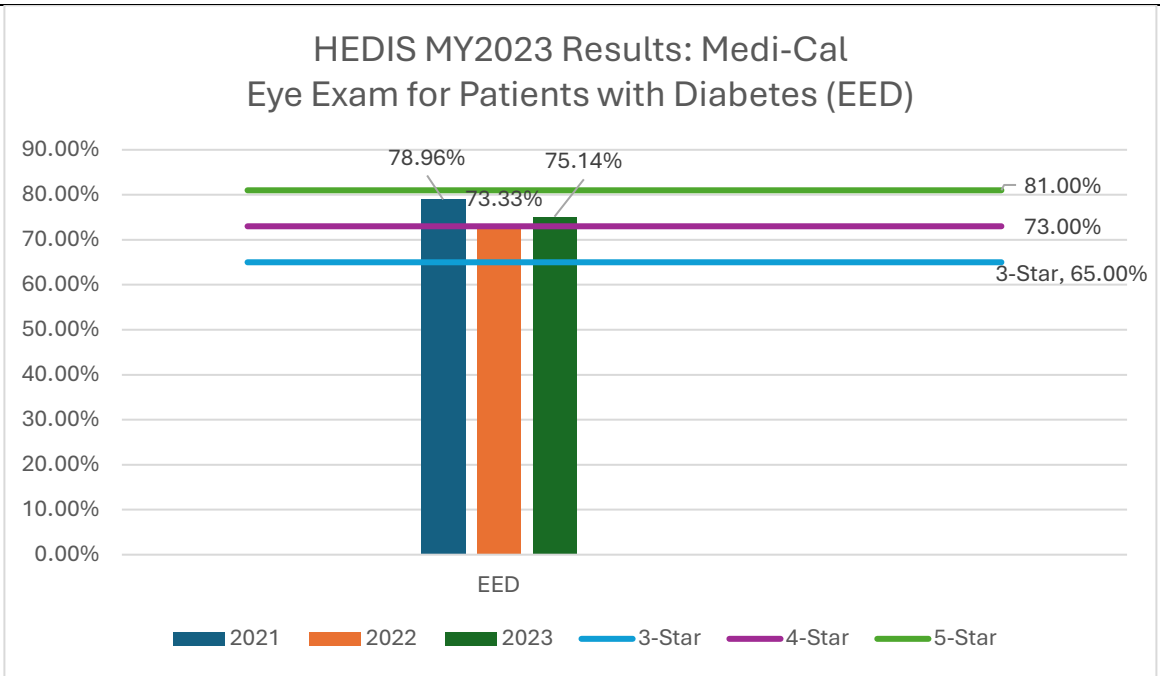
Per HEDIS 2022 Quality Compass Percentile

- CalOptima Health's HEDIS MY2023 hybrid rate for OneCare was 15.30% and met the projected 3-Star of 28% and the MY2023 internal goal of 17%. (Lower is better)



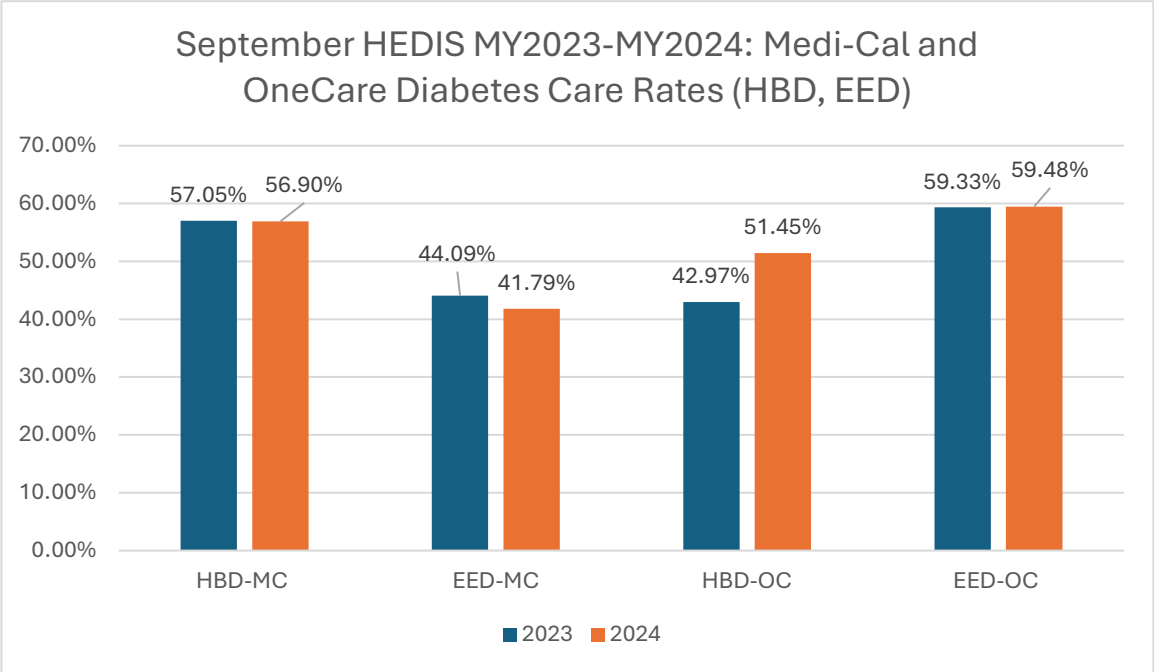
CMS 2024 Benchmarks

- CalOptima Health's HEDIS MY2023 hybrid rate for OneCare was 75.14% and met the projected 3-Star of 65% but did not meet the MY2023 internal goal of 79%.



CMS 2024 Benchmarks

- CalOptima Health diabetes care rates for September HEDIS MY2023–2024 for Medi-Cal and OneCare.



Quantitative Analysis:
Comparing CalOptima Health Medi-Cal diabetes care rates for September HEDIS MY2023–MY2024. The rates are based on the administrative data and represent the claims/encounters process through the month of September for each respective year.

HBD-MC: As of September 2024, the HBD-PC prospective rate was 56.90%, which is lower than the September 2023 prospective rate of 57.05% by 0.15 percentage points (lower is better).

EED-MC: As of September 2024, the EED prospective rate was 41.79%, which is lower than the September 2023 prospective rate of 44.09% by 2.30 percentage points.

HBD-OC: As of September 2024, the HBD-PC prospective rate was 51.45%, which is higher than the September 2023 prospective rate of 42.97% by 8.48 percentage points (lower is better).

EED-OC: As of September 2024, the EED prospective rate was 59.48%, which is higher than the September 2023 prospective rate of 59.33% by 0.15 percentage points.

Disparity Analysis:
Using the total rate as a reference point (58.32%), below are some observations:

Hemoglobin A1c Control for Patients with Diabetes- HbA1c Poor Control (>9%) (HBD-MC, OC): When looking at the top three race/ethnicity groups by denominator count, the Vietnamese group had the lowest rate at 55.56% (lower is better), which is 2.68 percentage points lower than the total rate (58.32%). While the group identified as Hispanic had the highest rate at 60.75%, which is 2.43 percentage points higher than the total rate (58.32%).

Using the total rate as a reference point (58.64%), below are some observations:

Eye Exam for Patients with Diabetes (EED-MC, OC): When looking at the top three race/ethnicity groups by denominator count, the Vietnamese group had the highest rate at 64.63%, which is 5.99 percentage points higher than the total rate (58.64%). While the group identified as White had the lowest rate at 51.17%, which is 7.47 percentage points lower than the total rate (58.64%).

Identified Barriers:	Identified Opportunities for Improvement:
• The ability to reach members (mail, phone, text) creates challenges around providing members with information on diabetes care. • Members did not visit their PCP during MY2024 and did not receive assistance for their diabetes management. • Lack of knowledge of the importance of A1C testing and retinal eye exam. • Appointment access could be limited due to scheduling ability and/or staff shortage, resulting in long waiting times for appointments • Lack of medical release forms between specialist and PCP of diabetic retinal eye exam results. • Lack of data sharing between VSP due to contract restrictions between CalOptima Health and VSP provider network, prohibiting direct data share to any health network and only permitting sharing data via the health plan.	• Data optimization • Provider and health network quality committee meetings provide input on quality-related opportunities, helping identify barriers, develop and implement effective approaches • Develop member journey campaigns with new text messaging vendor to diminish member outreach abrasion • Internal member-facing departments will remind members of gaps in care during calls. • Member outreach specific to factors such as race/ethnicity • Internal member-facing departments will remind members of gaps in care during calls. • Engagement with specialists, such as ophthalmologists for direct member reminder and appointment scheduling

• Due to data lag of approximately 90 days, the September 2024 prospective rate may not provide the most accurate rate of completion of diabetic measures. • Hybrid measures like HBD and EED require medical record review; therefore, the actual final rate for MY2024 may be lower and higher, respectively.	
Conclusion: We did meet the internal CalOptima Health goal for the HBD measure but not for the EED measure. Both HBD and EED measures Medi-Cal MY2023 final rates achieved 90th percentile. In October 2024, the 2025 Star rating was published, and for OneCare, HBD reached a 4-Star while EED reached a 3-Star rating. Because both measures are reported by the hybrid method it is important to continue to monitor these measures. CalOptima Health will retain HBD and EED measures on the 2025 QI Work Plan and continue to focus on diabetic care.	
Activities/Interventions to continue/add next year:	
• Health rewards program will continue for eligible CalOptima Health members for HBD and EED measures. We continue to focus on initiatives to increase participation in the program and motivate members to schedule and complete their screenings. • In MY2024, live agent calls were conducted by CareNet to members who have multiple gaps in care. In MY2025, we will have internal member-facing staff access Decision Point to remind members of cancer screenings that they are due for at the point of member contact. • In MY2024, CalOptima Health awarded ~$2.1 million dollars in quality improvement grants to Health Network partners and CHCN providers. Many of the grant programs will focus on the CCS, BCS and COL measures. • Since HBD and EED perform well historically, CalOptima Health will continue to monitor both HBD and EED measures closely. We will continue with having our members get their tests/labs done by conducting multi-component interventions (mailers, live call outreach, automated calls and text messaging). • Will use disparity analysis to develop interventions to target high-risk members with health inequities caused by race/ethnicity.	

4.5.2 Disease Management Program	
Business Owner: Katie Balderas	Department: Equity and Community Health
Support Staff: Elisa Mora	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Implement Disease Management (DM). The goal of the program is to increase effective self-management of chronic conditions through behavioral change. Through increasing positive disease management behaviors such as medication adherence, self-monitoring and trigger avoidance, the program aims to achieve the following outcomes: • Reduced emergency visits and inpatient hospitalizations due to disease exacerbations • Empowered members who are better equipped to manage their own health • Improved quality of life	

In 2024, the DM program focused on exploring new strategies to increase member engagement and reduce cold calls.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: • Evaluation of current utilization of disease management services • Maintain business for current programs and support for community • Improve process of handling member and provider requests	
Status: ☐ Completed ☒ Ongoing	
Background: CalOptima Health's DM Program promotes self-management for members with low- and moderate-risk chronic conditions through comprehensive assessments, individualized telephonic health and nutritional coaching, and providing resources as needed. The DM Program meets the Basic PHM requirement as defined by the DHCS CalAIM PHM Program, and NCQA standards for health plan accreditation.	
Methodology: A monthly stratification is in place to identify members for the program. Moderate-risk members receive a health coach intervention, and members identified as low-risk receive an educational package through the mail.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Piloted Chronic Kidney Disease (CKD) intervention with selected health coaches focused on 68 CHCN members identified with CKD stage 3 A or B and two chronic conditions (diabetes, hypertension, heart disease) and not seeing a nephrologist. • Developed two-way text campaign on asthma and diabetes to promote PCP engagement and DM program opt-in. Submitted text to DHCS for approval. • Established a new member mailing intervention to provide, providing information on our DM services and condition-specific handouts on asthma and diabetes for low-risk members. This mailing will occur every other month.
Quarter 2:	• A two-way text message campaign focused on members with asthma was implemented on June 19, 2024. In response to the text, 232 members requested a call back from a health coach. • A column was added to the monthly diabetes stratification results identifying members with CKD Stage 3 and 4. • Ongoing monitoring of the bi-monthly new member mailing for low-risk members with asthma and diabetes.
Quarter 3:	• Initiated planning to send the Disease Management Satisfaction Survey. Collaborating with the Usher team to distribute the survey via text message to identified members. • Implemented two-way text message to promote the asthma program and identify members who wished to receive a call from health coach was successful. The enrollment rate significantly increased.
Quarter 4:	• Survey results analyzed • Plan to mail additional 500 surveys due to the low response rate. • Initiated collaboration with Usher to explore other methods for obtaining timely feedback from members. • Collaborated with the credentialing/contracting team to add Yumlish as a web-based provider for the CDC Diabetes Prevention Program (DPP). • Worked towards enhancing the monthly stratification list to include HEDIS measures that members are still missing, enabling health coaches to educate and support members in completing these measures.
Program Results:	

Table A: 2024 Member Satisfaction Survey Results

Question	Satisfaction	Neutral	Dissatisfaction	Goal Met
Q.1 The information I received from my health coach while participating in the program helped me to better manage my health.	97% N=32	3% N=1	0% N=0	Yes
Q.2 My health coach helped me follow my doctor's recommendations.	91% N=30	6% N=2	3% N=1	Yes
Q.3 I was included when making decisions about my care plan.	91% N=30	6% N=2	3% N=1	Yes
Q.4 The information and resources I have received from my health coach have been useful.	97% N=32	0%	3% N=1	Yes
Q.5 My health coach helped me manage my health needs and concerns.	100% N=25	0% N=0	0% N=0	Yes
Q.6 My health coach helped me meet my care plan goals.	100% N=25	0% N=0	0% N=0	Yes
Q.7 I am satisfied with CalOptima's Health Management program.	96% N=24	4% N=1	0% N=0	Yes

Quantitative Analysis:
The goal of achieving 85% satisfaction across all categories was successfully met, as indicated by the survey results. The data suggests that positive interactions with health coaches played a significant role in members' overall satisfaction with CalOptima Health's DM programs. This finding is further supported by numerous positive member comments.

Survey results also indicate that 100% of members felt that their health coach effectively helped them manage their health needs, address concerns and achieve care plan goals. This data suggests strong effectiveness of health coach involvement, contributing to positive health outcomes and member satisfaction.

This year, a new question was added to assess member preferences for engaging with health coaches. The results revealed the following preferences:

- 76% of members prefer phone calls as their primary method of communication
- 20% prefer in-person interactions
- 4% favor video sessions
- 0% prefer group classes

These results suggest a strong preference for phone calls, which may inform future program delivery strategies.

The response rate to the DM Satisfaction Survey this year was 4.3%, which is lower than previous years, which could limit the representativeness of the feedback. In response, we plan to mail 500 additional surveys to a diverse group of members, which will help us increase the response rate and obtain more comprehensive data to better evaluate the program.	
Identified Barriers:	Identified Opportunities for Improvement:
• Low response rate when using only two-way text message to collect feedback from members. • Lengthy process for requesting changes to the survey	• Use multiple feedback collection methods: Offer various options for collecting feedback from members, including two-way text messaging, mail and QR codes. • Expand language options: Provide additional language options to ensure broader accessibility and inclusivity. • Survey timing improvement: Explore the possibility of launching the survey immediately after an intervention, instead of conducting it once a year.
Conclusion: While the data shows that members are highly satisfied with the DM program, a higher response rate would provide more comprehensive data, allowing for a better evaluation of the program.	
Activities/Interventions to continue/add next year:	
• Mail additional 500 surveys to increase response rate • Translate the survey into all CalOptima Health threshold languages • Collaborate with Usher to develop a platform that allows staff to launch the survey to members immediately after intervention	

4.6 Care Management Programs	
Author: Sherry Hickman	Department: Case Management
Responsible Party(ies): Hannah Kim, Megan Dankmyer	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Report on key activities of Case Management (CM) program, analysis compared to goal and improvement efforts	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: Report on the following activities: ECM, Complex Case Management (CCM), Basic PHM/CM, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM, and transitional care services (TCS)	
Status: ☐ Completed ☒ Ongoing	
Background: The CM programs encompass members at different levels of risk and acuity: Basic Care Management (BCM), Care Coordination (CC), CCM and ECM. Members in CM programs may experience a critical event or diagnosis that requires extensive use of resources and/or have a need for help in navigating the appropriate delivery of care and services. TCS support 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.	
Methodology: Monitoring of CCM enrollment month over month through Core CC0251. Members must be enrolled for a minimum of one day. Monitoring of members enrolled in ECM who have a lead care manager (LCM) identified on SafetyNet Connect portal.	
Actions/Interventions Implemented in 2024:	

Quarter 1:	• Developed process for ECM LCM to communicate TCS activity. • Reviewed NCQA Element E, Factors 1–5, with health networks • Monthly real-time reviews of delegated health networks per NCQA requirements • Case Management Quarterly Audit for SPD/WCM MOC for delegated health networks. • Instituted multi-department EPSDT workgroup in Q2 • Worked with IT to develop reports for analyzing outcomes on TCS response.
Quarter 2:	• CalAIM ECM provider report documenting LCM in SafetyNet Connect showed improvement from 3% to 44%. This ensures the LCM is notified of any admissions. The expectation moving forward is to have ECM providers continue to document accurately. • NCQA Accreditation Audit passed with a score of 100% • Continued Monthly NCQA file audit for CHCN and health networks. • CM's quarterly audit for MOC for delegated health networks. • The multi-department workgroup was implemented to discuss EPSDT requirements meetings on May 21, 2024, and July 1, 2024. • Health network training on EPSDT on April 18, 2024 • Analysis with IT support for TCS response pending Phase II Jiva remediation • Shared of TCS qualifying discharge events with ECM providers to track successful outreach
Quarter 3:	• Audit tool created by SafetyNet Connect for ECM providers to validate that their enrolled members have LCM identified. • Continued communication to ECM providers for TCS outcomes for enrolled high-risk members. • Continued monthly NCQA file audits for CHCN and HN members open to CCM level of care. • Continued quarterly audits of delegated health networks for MOC oversight. • Continued discussion in workgroup to obtain data and operationalize oversight for EPSDT.
Quarter 4:	• LCM is identified in 61% of ECM enrolled members as of October 21, 2024 • Continued communication to ECM providers for TCS outcomes for enrolled high-risk members. • Continued monthly NCQA file audits for CHCN and HN members open to CCM level of care. • Continued quarterly audits of delegated health networks for MOC oversight. • Continued discussion in workgroup to obtain data and operationalize oversight.
Program Results:	
Table A	

Health Network	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	Oct	Nov
CHCN	54	54	47	53	17	88	141	138	139	164	123
Prospect	46	42	34	29	31	33	29	43	42	38	48
AltaMed	0	0	15	15	26	30	40	34	27	35	27
UCMG	17	15	12	15	20	17	13	16	17	20	25
AMVI	11	9	9	13	12	9	8	7	8	8	7
CHOC	8	6	7	7	7	5	4	4	4	3	2
Regal	1	1	1	3	3	3	2	2	1	1	1
Noble	0	0	1	1	1	3	5	6	3	3	3
Family Choice	1	1	2	0	0	0	0	0	0	2	2
Optum	0	0	0	0	0	0	0	0	0	0	0

Table caption: Members open to CCM month over month in 2024 based on health network assignment. CCM enrollment is reported to DHCS monthly. December data is not yet reported.

Chart A

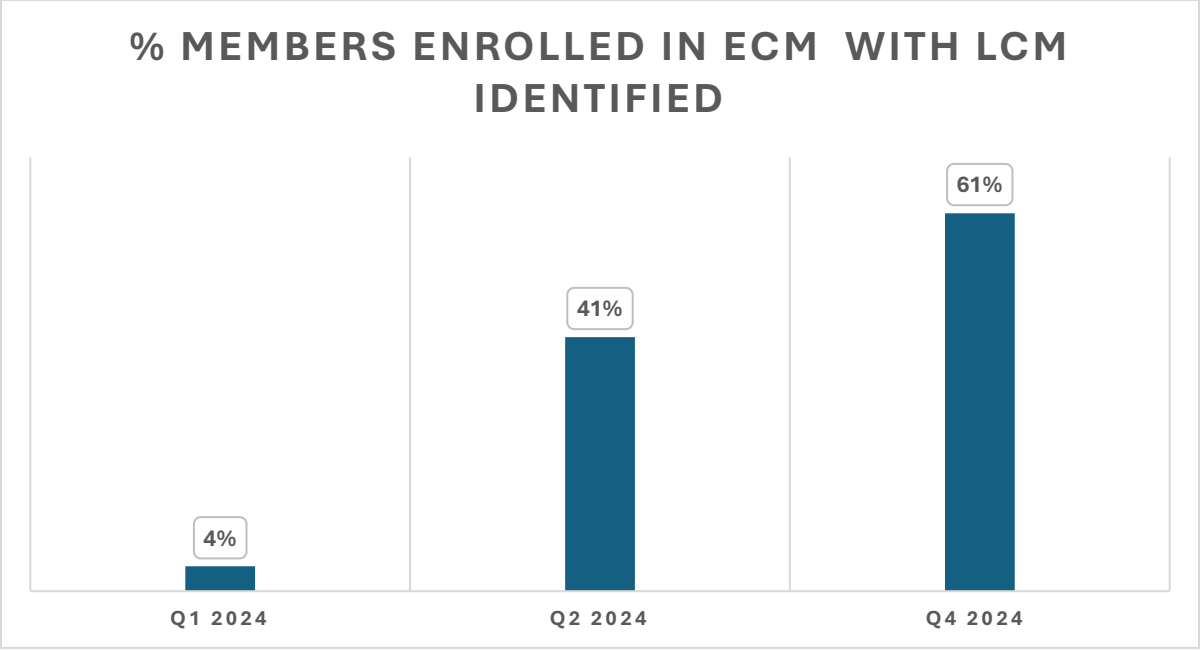


Table caption: Members enrolled in ECM who have LCM identified in SafetyNet Portal.

Quantitative Analysis: Overall, CCM enrollment increased from January 2024 to October 2024. The increase is not evenly distributed with growth and is seen primarily in two of the delegated health

networks: CHCN and AltaMed (Table A). There is improvement in the percentage of members who have their LCM identified in SafetyNet Connect (Chart A).	
Identified Barriers:	Identified Opportunities for Improvement:
• Consistent identification of LCM for members enrolled in ECM in SafetyNet Connect	• Increase number of members open to CCM.
Conclusion: Multiple care management programs will continue to support members and explore opportunities for improvement.	
Activities/Interventions to continue/add next year:	
• Continue communication to ECM providers for TCS outcomes for enrolled high-risk members. • Continue monthly NCQA file audits for CHCN and HN members open to CCM level of care. • Continue quarterly audits of delegated health networks for MOC oversight. • Continued discussion in workgroup to obtain data and operationalize oversight • Add: ECM opportunity to be identified through the ECM Clinical Oversight Sub-work group	

4.7. Improvement Projects

4.7.1 Performance Improvement Project (PIP)	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Leslie Vasquez/Kelly Glynn	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Meet and exceed goals set forth on all improvement projects. Increase well-child visit appointments for African American members (0–15 months) from 41.90% to 55.78% by December 31, 2024. This target was set for MY2024, however, the PIP timeframe spans from 2023 to 2026.	
Goal Met: ☐ Yes ☒ No ☐ Partial	
Work Plan Planned Activities: Action: Improve well-child visit rates in the first 30 months of life for African American child members. MY2024 PIP activities consisted of a telephonic outreach campaign to the parents/guardians of African American child members turning 15 months of age in the measurement year. The telephonic outreach campaign aimed to provide the following: 1. Education on well-child visits 2. Reminders to complete well-child visits 3. Appointment coordination for well-child visits 4. Data gathering on barriers and facilitators to well-child visits	
Status: ☐ Completed ☒ Ongoing	
Background: The California 2020 Health Disparities Report identified disparities for most of the indicators of the Children's Health domain. Per this report, the African American group fared lower than other groups across all six key indicators. The PIP aims to reduce the racial/ethnic disparities in W30-6 visits in support of the statewide goals. In alignment with the recommendations in the Health Equity Framework, this PIP will involve the African American population, the group most affected by health care disparities,	

through a survey call campaign to understand firsthand the experiences with well-child visits and the barriers to and facilitators for attending well-child visits.

Well-child visits are the foundation of pediatric health promotion and disease prevention. These visits are intrinsically linked to the key indicators in the Children's Health domain. Accordingly, improving the W30-6 measure rate has the potential to improve member health status among these key indicators. Insight into the barriers to attending well-child visits has the potential to identify key areas that may improve member satisfaction across health care services.

PIP intends to address the following barriers to well-child visits:

- Parent/guardian gaps in knowledge as it relates to the purpose and value of well-child visits.
- Lack of reminders for parents/guardians to complete well-child visits.
- Lack of available resources for health networks to coordinate well-child visit appointments with a primary care provider for African American child members

Methodology:
CalOptima Health followed HEDIS data collection methodology for the W30 — First 15 Months (noncontinuous enrollment). CalOptima Health then identified child members identified as African American to monitor for rates.

Medi-Cal Results:

Chart A. Rates for W30 — First 15 Months

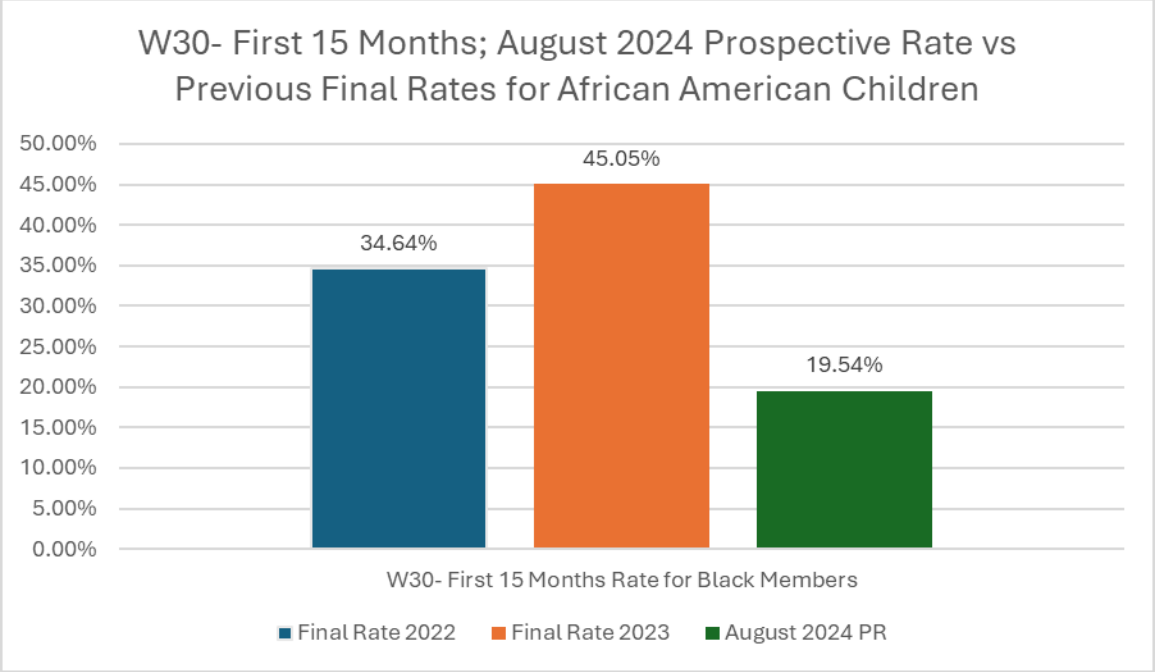


Chart A shows the final MY2022 and MY2023 W30 — First 15 Months rates for African American child members compared to the most recent 2024 prospective rate. The performance improvement project is set for 2023 to 2026. As part of the process, the MY2022 rate (34.64%) was used to confirm the population of interest — African American children — that would be targeted for the project. The chart demonstrates an increase in rates for MY2023 compared to

MY2022. Final MY2024 rates are pending; however, the rate (19.54%) of claims/encounters processed through August 2024 is shown.

Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Status	Measure(s) (Acronym)
1. Telephonic outreach campaign — Two calls were provided to each of the 85 members.	☒ MC ☐ OC	☐ Completed ☐ On-going ☐ Incomplete	W30 (First 15 Months)
2. Email campaign — To members with an email who were not successfully outreached via the telephonic campaign.	☒ MC ☐ OC	☒ Completed ☐ On-going ☐ Incomplete	W30 (First 15 Months)
3. Pediatric text campaign	☒ MC ☐ OC	☐ Completed ☒ On-going ☐ Incomplete	W30 (First 15 Months)

MC = Medi-Cal; OC= OneCare

Quantitative Analysis:

- For the 2024 calendar year, 85 African American members were identified as needing to complete six or more well-child visits by 15 months of age. Staff successfully contacted 34 (40%) of parents/guardians, providing reminders to complete well-child visits and addressing gaps in knowledge related to the importance and value of well-child visits.
- As part of the attempt to increase contact with members, letters were issued to the 51 parents/guardians who could not be contacted telephonically.
- Appointment coordination was offered to all 34 parents/guardians of child members who were successfully outreached. All 34 parents/guardians declined appointment coordination and refused support with appointment coordination for future well-child visits. This refusal may be driven by many reasons, including long call wait times, lack of urgency and competing priorities at the time in which the parent was called. based on feedback gained from the call campaign.

Identified Barriers:	Identified Opportunities for Improvement:
• Member contact information — Member contact lists contain outdated or incorrect information, contributing to a high rate of unsuccessful outreach. Other issues included the inability to leave voicemails or parent/guardian refusal to take the call. • As part of an attempt to increase contact with members, letters were issued to the 51 parents/guardians who could not be contacted telephonically. Parents or guardians did not respond to the letter.	• Opportunities to improve member contact information to maximize outreach. • Opportunities to partner with health networks to support care coordination for child members.

Conclusion:

• There is an opportunity to continue to inform members about the importance and cadence of well-child visits and what makes each of these visits unique to support adherence. Education about these visits should begin as early as possible including prenatal and postpartum timeframe. • There is an opportunity for PCPs to revise their workflows to allow for the scheduling of the next visit prior to the family leaving the existing visit. • Members feel that they benefit when their child's assigned PCP has appointment availability that fits the parents' schedules. PCP offices should continue to implement reminders for these visits. • There are opportunities to increase awareness of the Medi-Cal transportation benefit as well as inform parents of who the child's PCP is.
Activities/Interventions to continue/add next year:
• Efforts to include improved coordination with health networks to delivery care for African American child members.

4.7.2 Chronic Care Improvement Program (CCIP)	
Author: Mike Wilson	Department: Quality Analytics
Responsible Party(ies): Melissa Morales/Kelly Glynn	
Products: ☐ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Meet and exceed goals set forth on all improvement projects. By December 31, 2024, 5% of members identified as emerging risk* and who participated in the program will lower their HbA1C to less than 8.0%.	
Goal Met: ☐ Yes ☐ No ☒ Partial	
Work Plan Planned Activities: Conduct quarterly/annual oversight of specific goals for OneCare CCIP (January 2023–December 2025): CCIP Study — Comprehensive Diabetes Monitoring and Management	
Status: ☐ Completed ☒ Ongoing	
Background: CMS requires all Medicare Advantage (MA) and Special Needs Plans (SNP) to conduct a 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 the improvement of care and health outcomes for members with chronic conditions. For this three-year CCIP program beginning in 2023 and ending in December 2025, CalOptima Health has chosen to focus on diabetes as the target condition with a focus on increasing diabetes management. The target population for the CCIP interventions is OneCare members identified with diabetes (type 1 and 2). CalOptima Health chose to focus on members who fall in the category of "emerging risk" (A1C levels 8.0%–9.0%) as the target condition for this CCIP. Emerging risk is defined by members that were previously controlled <8.0% A1C level but had a recent A1C level result of 8.0% to 9.0%. These members were selected due to a higher chance of improving A1C results when targeting members with A1C results between 8.0% and 9.0% than members with an A1C >9.0% result.	
Methodology: • Two-year look back period for member's A1C results (2022–2023) and current measurement years. • Quality Analytics generated A1C report and identified members that were below 8.0%, 8.0% to 9.0% and above 9.0%. Also included was whether the A1C result decreased, increased, remained the same or no prior result was available. • Quality improvement specialist filtered list for target population: Members between 8.0% and 9.0% with an increase in A1C result.	

- Worked with Diabetes Management Program to finalize outreach list. Outreach included members who were part of the “emerging risk” category and the Diabetes Management stratification to keep outreach list manageable.
- Health coaches outreached to “emerging risk” members.
- Track outreach completion by using Jiva activity report.
- Data refresh occurs on a quarterly basis.

Actions/Interventions Implemented in 2024:

Quarter 1:	• Finalize “emerging risk” report.
Quarter 2:	• Telephonic outreach by health educators
Quarter 3:	• Telephonic outreach by health educators
Quarter 4:	• Telephonic outreach by health educators

Program Results:

OneCare Outreach Results

Date	Emerging Risk List OneCare Members	Outreach Members	Outreach Rate
June 2024	28	3	10.7%
September 2024	97	113	85.8%

Table caption: Members that were outreached were those identified as “emerging risk” and were part of the Diabetes Management Program stratification.

Quantitative Analysis: For data report created in June 2024, health coaches attempted to call 10.7% of call list. For data report created in September 2024, health coaches attempted to call 85.8% of the call list. The CCIP goal has not been met since the program has an end date of December 31, 2025. CalOptima Health will evaluate whether the member was reached and accepted help for diabetes management. Also, will continue to track A1C values for members identified as “emerging risk” and participated in health coaching.

Identified Barriers:	Identified Opportunities for Improvement:
• Delay due to the transition to CalOptima Health’s new managed care system (Jiva), which created the need to update emerging risk methodology. • Data issue A1C values were missing, which may have affected emerging risk assignment. • Outreach list included members that were already assigned to case management, so they were not outreached. • Unable to contact “emerging risk” category members.	• Work with Case Management department on members who are outreached by case managers but have been identified as emerging risk. • Update emerging risk report with Diabetes Management Program report to make identification and assignment more efficient.

Conclusion: Will need additional time to obtain more recent A1C results and health coaching activity.

Activities/Interventions to continue/add next year:

- Identify barriers at the end of the intervention period for telephonic outreach by health educators and case managers.
- Evaluate member outreach and A1C trend.

4.7.3 BH Performance Improvement Project (PIP)	
Business Owner: Diane Ramos, Natalie Zavala, Carmen Katsarov	Department: Behavioral Health Integration (BHI)
Support Staff: Jeni Diaz	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☒ Yes ☐ No
Work Plan Goal/Objective: Meet and exceed goals set forth on all improvement projects.	
Goal Met: ☐ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: Non-Clinical PIP: Improve the percentage of members enrolled in CM, CHCN, CCM or ECM within 14 days of an ED visit where the member was diagnosed with SMH/SUD.	
Status: ☐ Completed ☒ Ongoing	
Background: Improve the percentage of CHCN/COD Medi-Cal-only members enrolled in CM, CCM or ECM, within 14 days of a provider (ED) visit where the member was diagnosed with SMH/SUD.	
Methodology: Internal report was developed to identify members who enroll in CM, CCM or ECM after being diagnosed with SMH/SUD at ED visit.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Conducted quarterly/annual oversight of MC Non-Clinical PIP (January 2023–December 2025). • Baseline Measurement Period: January 1, 2023–December 31, 2023 • Remeasurement 1 Period: January 1, 2024–December 31, 2024 • Remeasurement 2 Period: January 1, 2025–December 31, 2025 • Continued to develop an internal report to identify baseline data for members who enroll in CM, CCM or ECM after being diagnosed with SMH/SUD at ED visit. • Conducted collaboration meetings with internal business units to identify process and reporting specifications.
Quarter 2:	• Continued collaboration meetings with internal business units to identify process and reporting specifications. • Reviewed and analyzed report produced to verify data integrity.
Quarter 3:	• Continued collaboration meetings with internal business units to identify process and reporting specifications. • Reviewed and analyzed report produced to verify data integrity. • September 29, 2024–2025 nonclinical initial PIP validation submission. • October 31, 2024 reviewed feedback and suggestions from HSAG of nonclinical initial PIP validation.
Quarter 4:	• November 27, 2024 resubmission of the nonclinical PIP validation. • Continued collaboration meetings with internal business units to identify process and reporting specifications. • Reviewed and analyzed report produced to verify data integrity. • CalOptima Health telehealth provider began member outreach (December 3, 2024) for members who visited the ED and were diagnosed with SMH/SUD.
Program Results: Results pending, no data from 2024 available currently. Only baseline data from MY2023 is available currently.	
Quantitative Analysis:	

<table>
<tr><td colspan="2">Results pending, no data from 2024 available currently. Only baseline data from MY2023 is available currently.</td></tr>
<tr><td>Identified Barriers:</td><td>Identified Opportunities for Improvement:</td></tr>
<tr><td>Data integrity – Codes identified that should not be included in data set.
Coordinating/engaging internal stakeholder departments due to competing priorities.
Given the diagnosis there is difficulty in connecting with this member population.
Implementation of new CM system February 2024.
PHI data sharing with community partners, for coordination of care and outreach.
Lack of data exchange with the county mental health plan system.</td><td>Monthly collaboration meetings with internal departments to develop workflow for member outreach and engagement. Barriers are identified in these collaboration meetings. The group works to identify and develop solutions to barriers.
Collaboration with county mental health plan to ensure timely data exchange.</td></tr>
<tr><td colspan="2">Conclusion:
Ongoing, too early to determine a conclusion.</td></tr>
<tr><td colspan="2">Activities/Interventions to continue/add next year:</td></tr>
<tr><td colspan="2">Continue to receive daily reports from vendor containing real-time ED data for CHCN and COD members.
Collaborate with telehealth provider and internal ITS team to develop implementation plan for member outreach. Vendor to provide information about case management including ECM and referrals.
Working with CalOptima Health vendor to receive real-time ED data daily for CHCN and COD members.
BHI is in the process of developing a pilot project for CHCN members identified who meet FUM/FUA criteria. Telehealth provider will conduct the outreach to members who meet FUM criteria and assist with linkage. Internal BHI patient care coordinators (PCC) to conduct outreach to members meeting FUA criteria and assist with linkage. Vendor and PCCs will also provide information about case management including ECM and referrals.
Develop outreach and outcome data related to the percentage of members enrolled in CCM and ECM for CHCN members identified who meet FUM/FUA criteria for the duration of each measurement period.
Work in collaboration with the internal privacy department to ensure compliance of data sharing with vendor.</td></tr>
</table>

Section 5: Quality of Service

5.1 Member Experience

5.1.1 Member Experience Survey (CAHPS)	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Carol Matthews/Helen Syn	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Improve CAHPS performance to meet goal.	
Goal Met: ☐ Yes ☐ No ☒ Partial	
Work Plan Planned Activities: Conduct outreach to members in advance of 2024 CAHPS survey, campaign mailings and phone calls to members deemed likely to respond negatively to CAHPS survey, and discussions with health networks regarding CAHPS performance and P4V.	
Status: ☐ Completed ☒ Ongoing	
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 better meeting our members' needs.	
Methodology: CalOptima Health utilizes the CAHPS survey to measure member experience. The CAHPS program is overseen by the U.S. Department of Health and Human Services and the CAHPS 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 Stars ratings for health plans. In addition to the standard CAHPS survey, CalOptima Health annually fields a survey at the contracted health network level. The survey instrument used for the health network survey was an adaptation of the CAHPS 5.1 adult Medicaid core survey that was developed and tested nationally for use in assessing health plan performance. The health network survey instrument used consisted of 43 questions. Most questions addressed the domains of member experience, such as getting needed care, getting care quickly, communicating with doctors, overall satisfaction with health care and overall satisfaction with the health network. The sampling goal was to draw a random sample of 900 members and an oversample of 360 additional members from each of CalOptima Health's 10 health networks. The final selected sample size for the entire CalOptima Health Medi-Cal adult project was 12,600. Selection of cases for analysis surveys was considered complete if respondents did not say 'no" to Q1 (in California, many people covered by Medi-Cal are enrolled in a health plan. In Orange County, CalOptima Health is the Medi-Cal health plan. Are you enrolled in CalOptima Health?) and if they provided a valid response to at least one survey question. Complete interviews were obtained from 1,593 members, and the overall CalOptima Health response rate was 12.7%. Language Analysis Methodology Among Health Network Respondents CalOptima Health's survey vendor uses collected 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; and high education, some college and beyond), ethnicity (Hispanic or Latino and not Hispanic or Latino), language survey was fielded in (English, Spanish, Vietnamese, Chinese, Arabic, Farsi, Korean) and race (White, Black or African American, Asian, American Indian or Alaska native, Native Hawaiian or Pacific Islander, and other).

The disparity analysis was conducted across all health network surveys and all threshold languages. A disparity was recognized when the rate was lower than 5% or more than the CalOptima aggregate health network reference point.

Medi-Cal Results:

Acronym	Adult Measure	MY2021 Medi-Cal Rate	MY2022 Medi-Cal Rate	MY2023 Medi-Cal Rate	MY2023 Medi-Cal Goal	MY2023 Goal Met/Not Met
RHC	Rating of All Health Care	51.9	51.61	55.67	33rd percentile	☒ Yes ☐ No
RPD	Rating of Personal Doctor	63.80	61.71	69.88	33rd percentile	☒ Yes ☐ No
RS	Rating of Specialist	NA	62.50	63.70	33rd percentile	☐ Yes ☒ No
RHP	Rating of Health Plan	56.52	52.34	57.22	33rd percentile	☐ Yes ☒ No
GNC	Getting Needed Care	NA	79.72	76.26	33rd percentile	☐ Yes ☒ No
GCQ	Getting Care Quickly	NA	76.04	75.35	33rd percentile	☐ Yes ☒ No
CS	Customer Service	NA	87.05	87.89	33rd percentile	☒ Yes ☐ No
CC	Coordination of Care	NA	79.55	79.53	33rd percentile	☐ Yes ☒ No
HWDC	How Well Doctors Communicate	89.30	88.10	90.80	33rd percentile	☐ Yes ☒ No

Acronym	Child Measure	MY2021 Medi-Cal Rate	MY2022 Medi-Cal Rate	MY2023 Medi-Cal Rate	MY2023 Medi-Cal Goal	MY2023 Goal Met/Not Met
RHC	Rating of All Health Care	66.10	64.20	67.94	33rd percentile	☒ Yes ☐ No
RPD	Rating of Personal Doctor	79.64	72.27	67.34	33rd percentile	☐ Yes ☒ No
RS	Rating of Specialist	69.05	NA	NA	33rd percentile	☐ Yes ☐ No
RHP	Rating of Health Plan	71.97	66.51	63.61	33rd percentile	☐ Yes ☒ No
GNC	Getting Needed Care	76.90	77.80	75.18	33rd percentile	☐ Yes ☒ No
GCQ	Getting Care Quickly	77.30	82.29	77.81	33rd percentile	☐ Yes ☒ No
CS	Customer Service	88.80	88.08	85.17	33rd percentile	☐ Yes ☒ No
CC	Coordination of Care	78.30	76.42	77.97	33rd percentile	☐ Yes ☒ No
HWDC	How Well Doctors Communicate	89.50	93.99	91.34	33rd percentile	☐ Yes ☒ No

OneCare Results:

Acronym	OneCare Measure	MY2021 OneCare Rate	MY2022 OneCare Rate	MY2023 OneCare Rate	MY2023 OneCare Goal	MY2023 Goal Met/Not Met
RHCQ	Rating of Health Care Quality	83	86	83	4 Star	☐ Yes ☒ No
RHP	Rating of Health Plan	85	86	84	4 Star	☐ Yes ☒ No
RDP	Rating of Drug Plan	87	88	85	4 Star	☐ Yes ☒ No
GNC	Getting Needed Care	77	75	75	3 Star	☐ Yes ☒ No
GCQ	Getting Appointments and Care Quickly	74	73	76	3 Star	☐ Yes ☒ No
CS	Customer Service	87	87	86	3 Star	☐ Yes ☒ No
CC	Care Coordination	82	80	83	3 Star	☐ Yes ☒ No
GNPD	Getting Needed Prescription Drugs	88	88	86	3 Star	☐ Yes ☒ No

Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Conduct outreach to members in advance of the 2024 CAHPS survey.	☐ MC ☒ OC	☒ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☒ Completed ☐ On-going ☐ Incomplete	All
2. Just-in-time mailings and phone calls to members deemed likely to respond negatively to CAHPS survey.	☒ MC ☒ OC	☒ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☒ Completed ☐ On-going ☐ Incomplete	All
3. Discussions with health networks about CAHPS performance and P4V.	☒ MC ☒ OC	☐ Q1 ☒ Q2 ☐ Q3 ☒ Q4	☐ Member ☐ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	All
4. Implement provider training for identified high-priority providers consisting of webinars, practice site training and provider shadow coaching.	☒ MC ☒ OC	☐ Q1 ☐ Q2 ☒ Q3 ☒ Q4	☐ Member ☐ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	All

MC = Medi-Cal; OC= OneCare

Results:

Table A

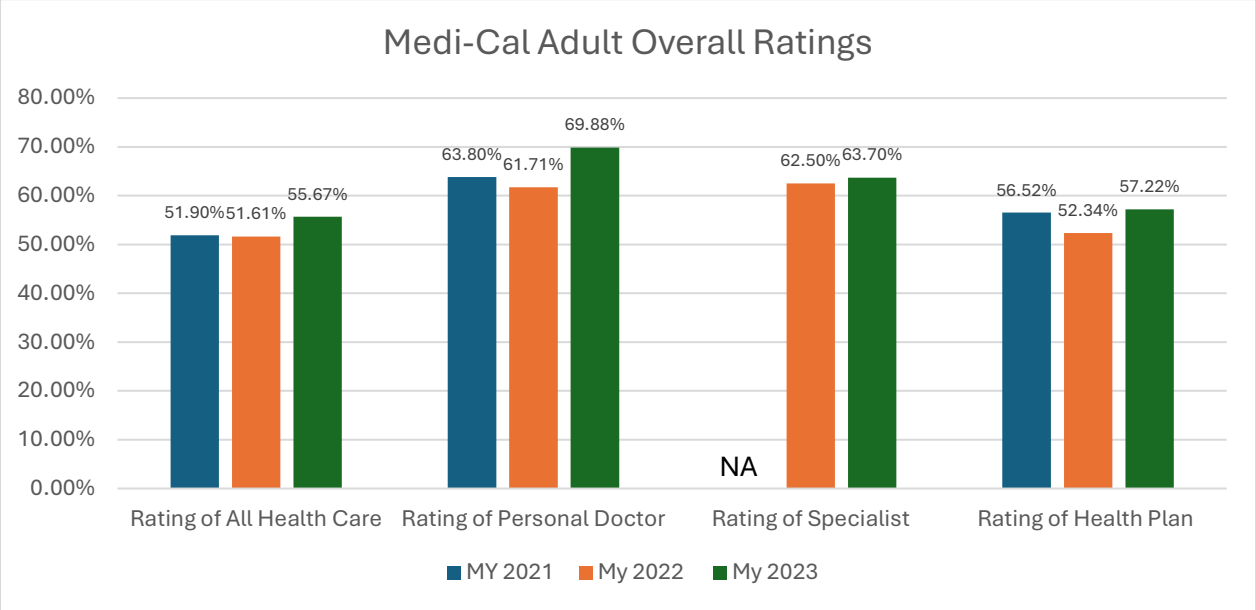


Table B

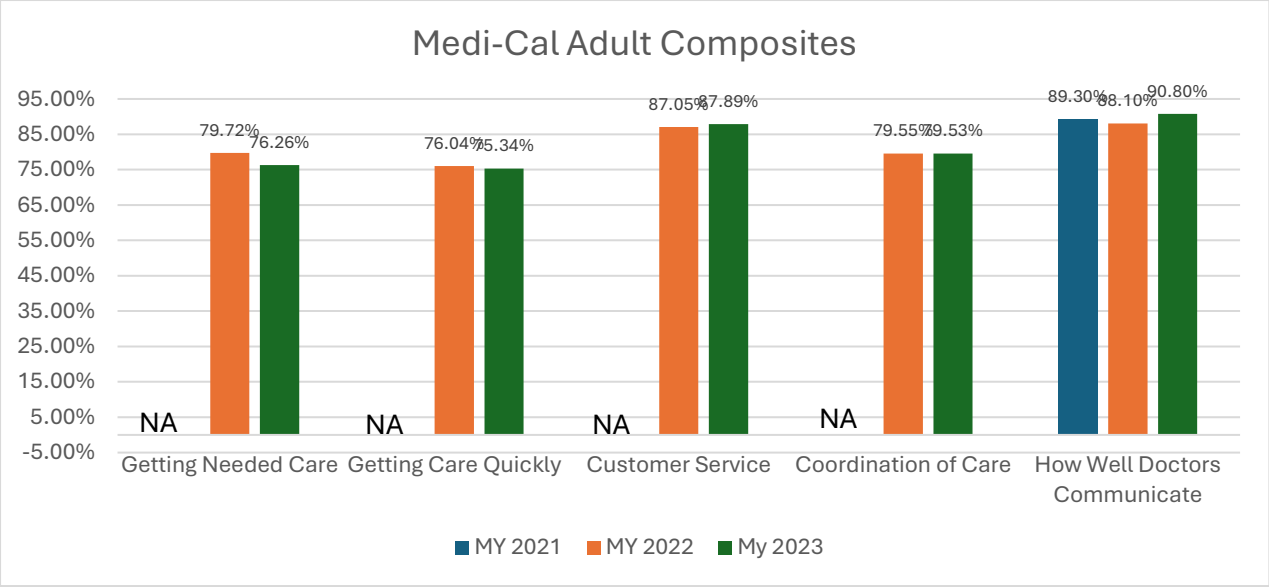


Chart C

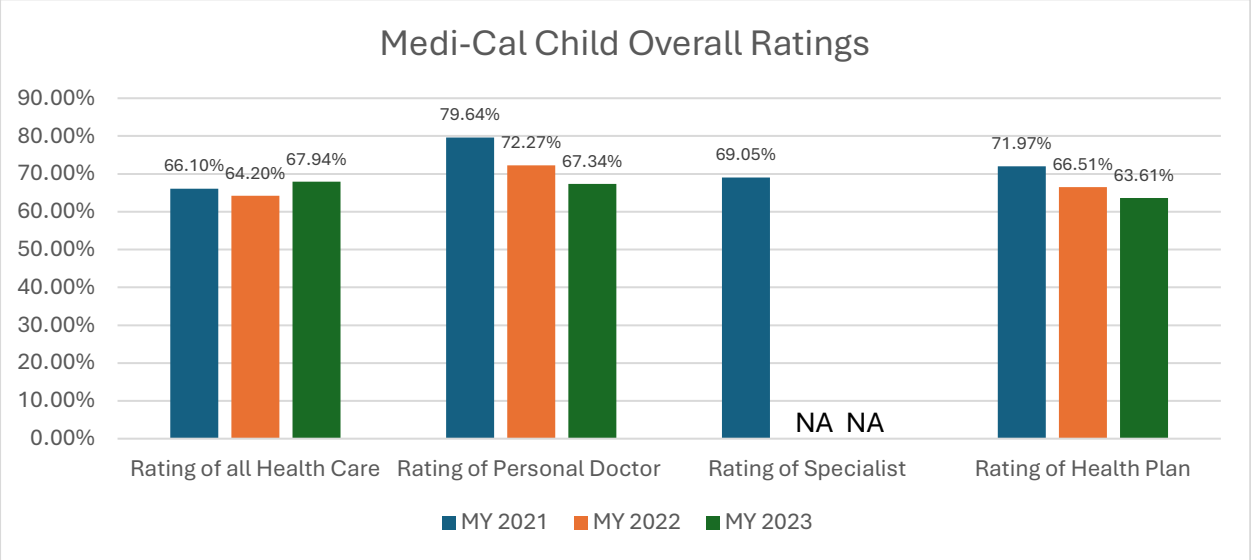
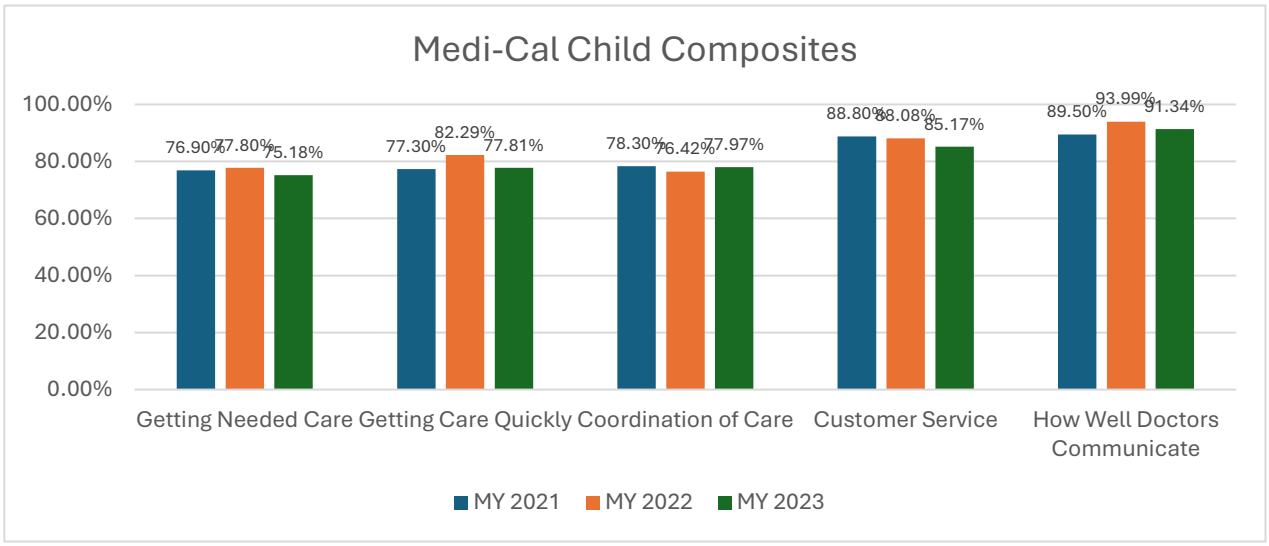


Chart D



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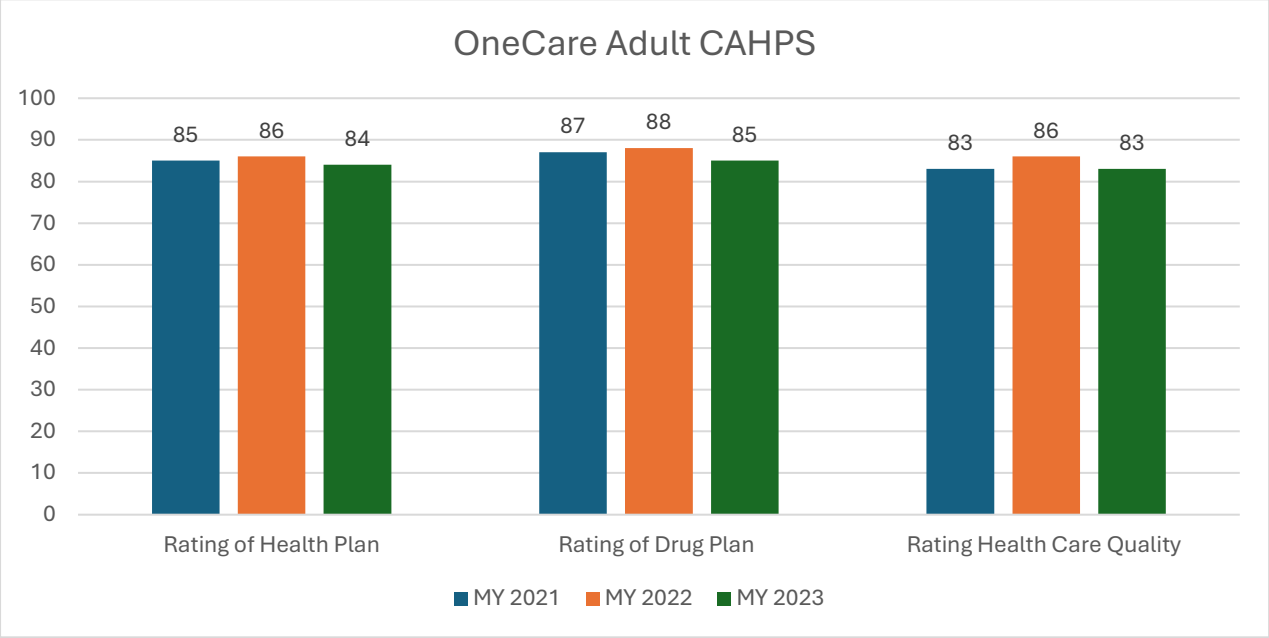
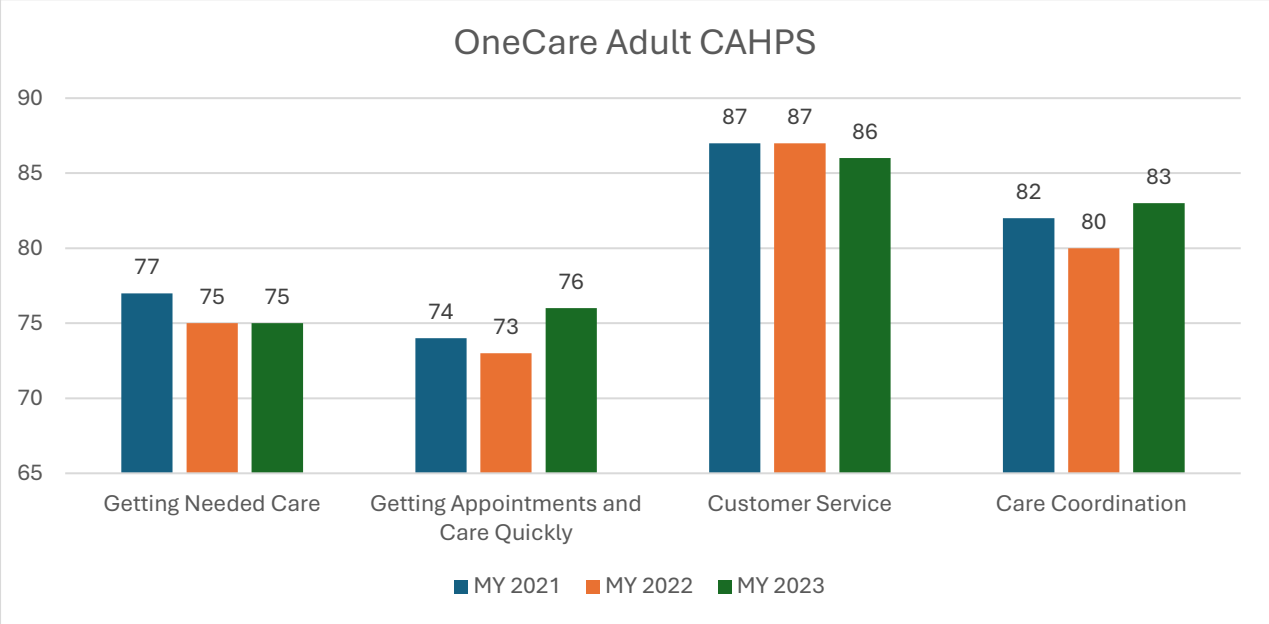


Chart F



*Denotes <11 cases

Adult Overall Ratings	Aggregate Health Network Reference Point	English Survey	Spanish Survey	Vietnamese Survey	Farsi Survey	Korean Survey	Arabic Survey	Chinese Survey
Rating of All Health Care	73.9%	67.8%	82.2%	74.1%	86.7%	75	66.7%*	75%*
Rating of Personal Doctor	84.3%	84.3%	86.1%	82.2%	94.4%	85%	66.7%*	87.5%*
Rating of Specialist	79.5%	75%	91.5%	76.6%	72.7%	57.1%*	50%*	100*
Rating of health Network	75.0%	70.6%	86%	72%	65%	54.2%	60%*	63.5%
Adult Composites								
Getting Needed Care	76.9%	77.6%	82%	70.2%	87.6%	78.1%	58.3%*	53.8%*
Getting Care Quickly	75.2%	75.7%	74.9%	72.8%	94.7%	93.8%	62.5%*	53.6%*
How Well Doctors Communicate	89.4%	93.8%	87.8%	85.2%	94.4%	81.3%	68.8%*	95.8%*
Customer Service	84.8%	87.2%	90.1%	80.3%	88.9%*	71.4%*	66.7%*	66.7%*
Coordination of Care	79.7%	82%	80.2%	74.5%	90%*	71.4%*	100*	75%*

*Denotes <11 cases

Child Overall Ratings	**Aggregate Health Network Reference Point**	**English Survey**	**Spanish Survey**	**Vietnamese Survey**	**Farsi Survey**	**Korean Survey**	**Arabic Survey**	**Chinese Survey**
Rating of All Health Care	79.5%	74.9%	85.2%	78.8%	100%*	85.7%*	83.3%	54.5%
Rating of Personal Doctor	85.7%	86%	90.3%	79.7%	100%*	71.4%	84.6%	71.4%
Rating of Specialist	83.2%	77.9%	95%	78.9%	66.7%*	100%*	50%*	100%*
Rating of Health Network	78.8%	73%	91.5%	70.8%	87.5%*	46.7%	81%	50%
Child Composites								
Getting Needed Care	73.2%	71.9%	78.5%	68%	100%*	100%*	79.2%	57.6%
Getting Care Quickly	80.9%	76.7%	83.7%	82.8%	100%*	78.6%*	77.1%	94.4%*
How Well Doctors Communicate	92.2%	93.7%	92.4%	89.7%	100%*	93.8%*	93.2%	87.5%*
Customer Service	82.5%	88%	87.2%	76.2%	100%*	75%*	90%*	66.7%*
Coordination of Care	74.6%	78.4%	79.8%	63%	50%*	0%*	50%*	0%*

*Denotes <11 cases

One Care Overall Ratings	Aggregate Health Network Reference Point	English Survey	Spanish Survey	Vietnamese Survey	Farsi Survey	Korean Survey	Arabic Survey	Chinese Survey
Rating of All Health Care	79.53 %	75.7%	85.1%	80.7%	55.2%	100%*	75%	75.8%
Rating of Personal Doctor	90.35 %	88.1%	93.1%	91.4%	81.68	100%*	100%	83.3%
Rating of Specialist	85.4%	82.7%	91.2%	85.7%	73.7%	-	75%*	75%
Rating of Health Network	82.94 %	79.4%	90.8%	80.9%	65.4 %	100%*	93.3%	76.7%
Rating of Prescription Drug Plan	88.75 %	87.7%	92.8%	86.7%	96.4%	100%*	92.3%	66.7%
Composites								
Getting Needed Care	81.8%	82.1%	86.6%	77.4%	73%	100%*	87.5%	65.9%
Getting Care Quickly	75.8%	78.3%	72.9%	72.6%	84.1%	100%*	79.7%	83%
How Well Doctors Communicate	93.2%	94.3%	94.4%	90.4%	87.9%	100%*	93.8%	97.2%
Customer Service	84.6%	87.9%	88.6%	77.8%	90.6%	66.7%*	94.4%	70.2%
Care Coordination	86.8%	87.6%	86.6%	86%	86.2%	75%*	91.9%	82.4%
Getting Needed Prescription Drugs	93.7%	94.2%	94%	92.6%	94%	100%*	96.4%	92.3%

*Denotes <11 cases

Quantitative Analysis:
CalOptima Health reviewed all MY2023 CAHPS rates in detail and compared them to the benchmarks. For the health disparity analysis, all stratified rates were compared to the overall or aggregate score (reference point).

- Adult Survey CAHPS Summary:
  - For Medi-Cal adult CAHPS surveys the goal is set at the 33rd NCQA Quality Compass percentile for all measures.
  - CalOptima Health met the goal for the following measures: Rating of all health care, rating of personal doctor and customer service.
  - CalOptima Health did not meet the goal and performed at the 10th percentile for the following measures: Rating of specialist, rating of plan, getting needed care, getting care quickly and how well doctors communicate.
  - CalOptima Health did not meet the goal and performed below the 10th percentile for care coordination.
  - Disparity analysis: The adult health network survey had the following measures 5% or lower than the aggregate score. English: rating of all health care. Vietnamese: getting needed care and coordination of care. Farsi: rating of specialist and rating of health network. Korean: rating of health network, how well doctors communicate and rating of specialist and coordination of care. Rating of specialist and coordination of care had <11 respondents. Arabic: rating of personal doctor, rating of specialist, rating of health network, getting needed care, getting care quickly, how well doctors communicate and customer service (all measures had <11 respondents). Chinese: rating of health network as well as the following measures that were <11 respondents getting needed care, getting care quickly, customer service and coordination of care.
- Child Survey CAHPS Summary:
  - For Medi-Cal child CAHPS surveys the goal is set at the 33rd NCQA Quality Compass percentile for all measures.
  - CalOptima Health met the goal for rating of all health care.
  - CalOptima Health did not meet the goal and performed at the 10th percentile for the following measures: How well doctors communicate, customer service and care coordination.
  - CalOptima Health did not meet the goal and performed below the 10th percentile for the following measures: Rating of personal doctor, rating of plan, getting needed care and getting care quickly.
  - Disparities analysis: The child health network survey had the following measures 5% or lower than the aggregate score: English: rating of specialist and rating of health network. Vietnamese: rating of health network, getting needed care, customer service and coordination of care. Farsi: <11 respondents for care coordination. Korean: rating of personal doctor, rating of health network, and customer service (<11 respondents). Arabic: <11 respondents for rating of specialist and coordination of care. Chinese: rating of all health care, rating of personal doctor, rating of health network, getting needed care and customer service (<11 respondents).
- OneCare Adult Survey CAHPS Summary:
  - For OneCare the goal is set at the CMS 4-star level for the following measures: Rating of health care quality, rating of health plan and rating of drug plan. Getting needed care, getting care quickly, customer service, care coordination and getting needed prescription drugs goals are set at the CMS 3-star level. CalOptima Health did not meet any goals.
  - Rating of health and rating of drug plan performed at the 2-star level.

- Getting needed care, getting appointments and care quickly, rating of health care quality, customer service, care coordination and getting needed prescription drugs performed below the 1-star level.
- Disparity analysis: The OC health network survey had the following measures 5% or lower than the aggregate score: Vietnamese: customer service. Farsi: rating of all health care, rating of personal doctor, rating of specialist, rating of health network, getting needed care, and how well doctors communicate. Korean: customer service and care coordination with <11 respondents. Arabic: rating of specialist with <11 respondents. Chinese: rating of specialist, rating of health network, rating of drug plan, getting needed care and customer service.

- Response rates for all surveys remain stable yet lower than their pre-pandemic years.
- In calendar year 2023, Medi-Cal grievances increased by 8%. Member grievances increased for the following areas from the calendar year 2022:
  - Access: +24%
  - Quality of care: + 25%
  - Quality of service: +11%

There were decreases in the following category:
- Billing: -35%

Due to changes to CalOptima Health's Medicare product line (transitions of OneCare Connect membership to OneCare), grievances trending would not be comparable from 2022 to 2023.

Identified Barriers:	Identified Opportunities for Improvement:

• Lack of organization-wide commitment to improving member experience.
• Low member response rates to surveys.
• Access:
  ○ PCPs have too many members in their panels, resulting in decreased appointment availability for members.
  ○ Specialist access in certain geographic areas is limited.
  ○ Shorter appointment times for members by providers.
	• Adopt an organization-wide commitment to improving member experience, ensuring every department understands its role and impact on member experience.
	• Continue oversampling as appropriate.
	• Encourage providers to expand office capacity by hiring non-physician practitioners.
	• Target contracting with provider types not meeting standards.
	• Network Adequacy and Timely access workgroups to monitor and develop solutions to address and improve network and access gaps.

Conclusion: CalOptima Health improved in some areas of CAHPS performance, but many areas remain low. Delays in implementing member initiatives may have impacted results.

Activities/Interventions to continue/add next year:

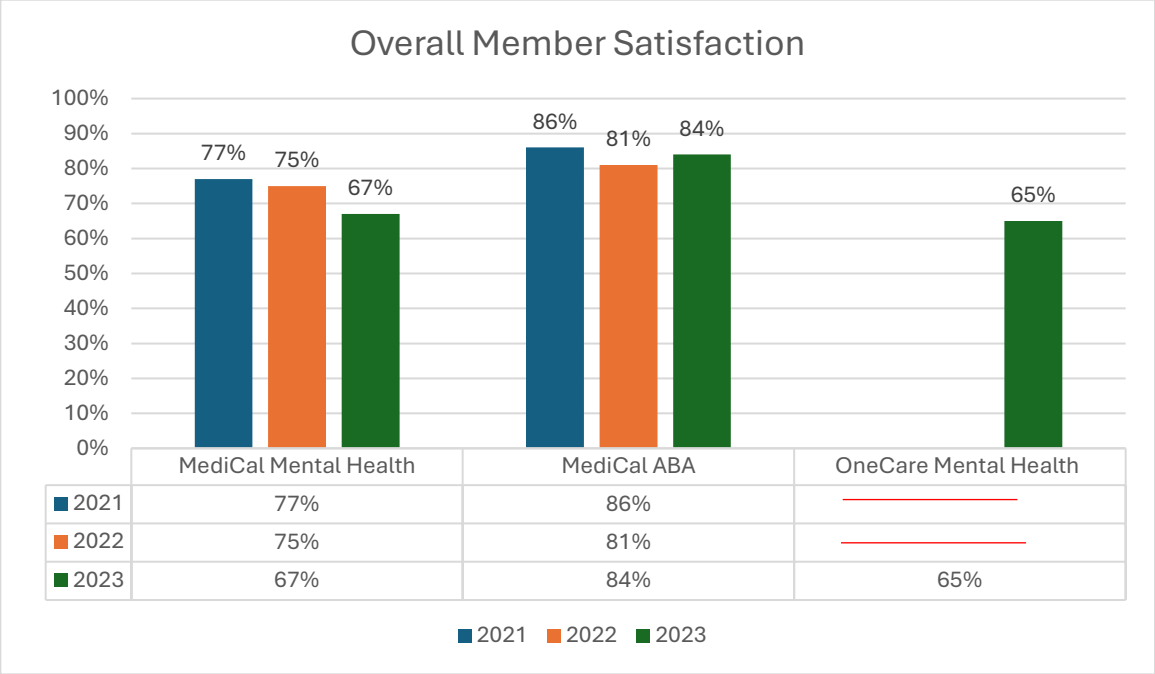
- Conduct member outreach prior to 2025 CAHPS survey fielding.
- Implement member just in time outreach targeted mailings and phone calls to members likely to respond negatively to the CAHPS survey.
- Discuss with health networks CAHPS results, best practices and the P4V program.
- Conduct member focus groups to collect information about issues adversely affecting their member experience.
- Implement listening posts that consist of targeted outreach to members to solicit their input and respond to their needs regarding their health.
- Improve member education regarding the referral process and educate providers about best practices for optimizing the appointment availability and referral process to specialists.

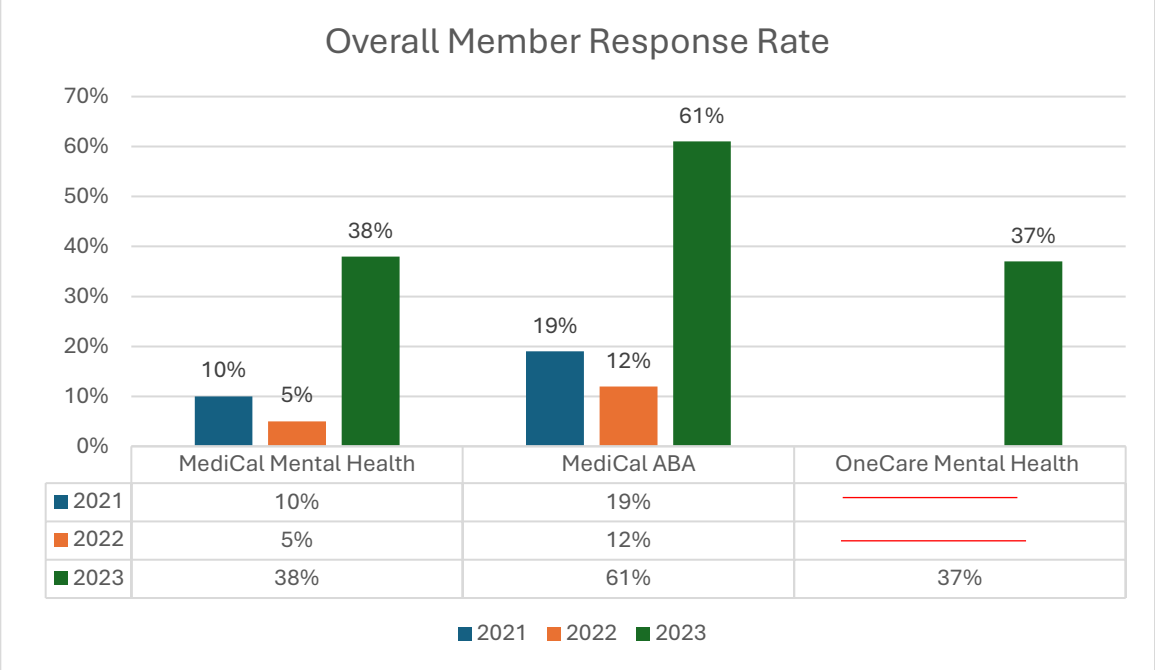
- Implement shadow coaching and office staff and provider training for identified high-volume providers to improve service delivery and member experience in provider offices.
- Distribute provider tips sheets to improve CAHPS scores for Getting Care Quickly and Getting Needed Care.
- Monitor Quality Improvement P4V grants issued to improve member experience.

5.1.2 BH Member Experience	
Business Owner: Diane Ramos, Natalie Zavala, Carmen Katsarov	Department: Behavioral Health Integration (BHI)
Support Staff: Jeni Diaz	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: CalOptima Health has established an overall satisfaction goal of 85%	
Goal Met: ☐ Yes ☒ No ☐ Partial	
Work Plan Planned Activities: Not listed on workplan	
Status: ☒ Completed ☐ Ongoing	
Background: CalOptima Health conducts comprehensive behavioral health surveys and analyses annually to assess member satisfaction regarding BH services. CalOptima Health's BHI department worked internally to conduct the 2024 Behavioral Health Member Experience Surveys. These surveys measured member satisfaction with BH services received in 2023. Two separate surveys were 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 focused on four main areas: telehealth services, access to services, treatment experience and overall experience.	
Methodology: A random sample of 900 members was used to conduct the member survey, which included: • 300 Medi-Cal members who utilized MH services. • 300 OneCare members who utilized MH services. • 300 Medi-Cal members who utilized ABA services. • 2024 was the first time that the Member Experience Survey was conducted telephonically and the first year that OneCare members were included. • Outbound phone Administration. Calls started December 4, 2023 • Data collection end date: March 1, 2024 The BHI Program Specialist team called out to the members and made three attempts to speak with the members and complete the survey. Questions were scored on a five-point Likert scale with options of: Strongly Disagree, Disagree, Neutral, Agree and Strongly Agree. A Not Applicable (NA) optional response was also included apart from the five-point scale. The survey was available to all members in their preferred language via CalOptima Health's telephonic interpreter services.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Reviewed and analyzed data collected.
Quarter 2:	• Presented findings at Behavioral Health Quality Improvement Workgroup (BHQI) to solicit feedback.

	• Discussed the use of different modalities to administer the surveys, as well as using available technology to collect timely results.
Quarter 3:	• Collaborated with the text messaging vendor to develop a text campaign to administer the BH Member Experience survey.
Quarter 4:	• Phase 1 of the text campaign was administered on September 26, 2024. • Phase 2 began November 19, 2024

Program Results:





Quantitative Analysis:

Overall Satisfaction Rates Analysis of 2022 (75%) compared to 2023 (67%) exhibited a decrease in the Medi-Cal MH survey's overall satisfaction rates. The rate dropped by 8%. The OneCare MH survey's overall satisfaction rate for 2023 was 65%. The ABA overall satisfaction rates increased by 3% from 2022 (81%) to 2023 (83%), respectively. Overall Response Rates Analysis of 2022 compared to 2023 exhibited a significant increase in both the Medi-Cal MH and the ABA survey response rates. The Medi-Cal MH response rate increased from 5% in 2022 to 38% in 2023, and the ABA response rate increased from 12% to 61%. The OneCare Mental Health survey response rate for 2023 was 37%.

Identified Barriers:	Identified Opportunities for Improvement:
• Members experiencing survey fatigue. • Invalid phone numbers for members.	• Utilization of different modalities to enhance member engagement.

Conclusion: The change in methodology allowed for more personal interaction with the members. Members were more receptive to completing the survey over the phone than via a mailed survey.
Activities/Interventions to continue/add next year:
• Continue collaboration with text messaging vendor to develop a text campaign to administer the BH Member Experience survey. • Increase the sample size of members.

5.1.3 Customer Service	
Business Owner: Andrew Tse	Department: Customer Service
Support Staff: Mike Erbe	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Implement customer service process and monitor against standards. The telephonic wait time shall not exceed 10 minutes for members to speak with a customer service representative.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: Leverage call back offering for those who do not want to wait in queue Hire additional staff to help with the inbound call volume Partner with various departments to stagger their member engagement campaigns	
Status: ☐ Completed ☒ Ongoing	
Background: Customer Service department providing telephonic assistance to CalOptima Health members.	
Methodology: Inbound call data from contact center system	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Leverage call back offering for those who do not want to wait in queue • Hired additional staff to help with the inbound call volume
Quarter 2:	• Partnered with various departments to stagger their member engagement campaigns

	• Leveraged call back offering for those who do not want to wait in queue • Hired additional staff to help with the inbound call volume
Quarter 3:	• Hired additional staff to help with the inbound call volume • Leveraged call back offering for those who do not want to wait in queue • Partnered with various departments to stagger their member engagement campaigns
Quarter 4:	• Hired additional staff to help with the inbound call volume • Leveraged call back offering for those who do not want to wait in queue • Partnered with various departments to stagger their member engagement campaigns

Program Results:

Average Speed of Answer (Goal: Not to exceed 10 minutes)

Quarter 1	Quarter 2	Quarter 3	Quarter 4
15:15	2:01	1:45	1:35

Quantitative Analysis:
Average speed of answer continues to improve quarter after quarter and the goals were met for quarters 2 and 3.

Identified Barriers:	Identified Opportunities for Improvement:
• For quarter 1, it's typical to experience high call volume. However, the call center received a large spike in call volume that was attributed to additional factors (various transitions involving Optum, Adult Expansion, Kaiser and other departments conducting member engagement campaigns).	• Partnered with various departments to stagger their member engagement campaigns • Hired additional staff to help with the inbound call volume • Offered callback requests within the phone tree (i.e., prevent callers from waiting in the queue for a prolonged time, calling back multiple times)

Conclusion:
On a quarterly basis, the average speed of answer has improved.

Activities/Interventions to continue/add next year:

- Partner with various departments to stagger their member engagement campaigns
- Leverage call back offering for those who do not want to wait in queue
- Perpetual recruiting and hiring additional staff to help with the inbound call volume

5.1.4 GARS	
Business Owner: Heather Sedillo	Department: GARS
Support Staff: Amanda Acosta, Ismael Bustamante, Jamar Phillips	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Implement grievance and appeals and resolution process	
Goal Met: ☐ Yes ☐ No ☒ Partial	
Work Plan Planned Activities: • 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 grievances and appeals	
Status: ☐ Completed ☒ Ongoing	
Background: GARS handles all member and provider complaints and appeals for Medi-Cal and OneCare lines of business.	
Methodology: All Grievances and Appeals received in 2024.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Worked with UM and RAC to improve the process related to integrated benefits for OneCare members. • Worked with BH to identify the issues around an increase in ABA appeals in Q1.
Quarter 2:	• Met with UM/CM to discuss an increase in discharge appeals and grievances. • BH provider training conducted in Q2 related to the appeals increase in Q1. • Partnered with other departments to improve member access to providers.
Quarter 3:	• Partnered with other departments to improve member access to providers. • Hired additional clinical staff.
Quarter 4:	• Clinical Manager was hired. • Continued partnership with other departments to improve member access to providers.
Quantitative Analysis: Grievance increases related to transportation remain our highest volume, under Quality of Service. GARS continues remediations to ensure members have access to their transportation needs.	
Identified Barriers:	Identified Opportunities for Improvement:
• Transportation services	• Workgroup with the transportation vendor, GARS leadership and CalOptima Health Transportation Program manager.
Conclusion: The addition of the GARS tracking and trending reports offers a clearer picture of trending issues and assists the department in determining where to focus for continued process improvement and member satisfaction.	
Activities/Interventions to continue/add next year:	
• Track and trend member and provider grievances and appeals for opportunities for improvement. • Improve the process of handling member and provider grievances and appeals • Maintain business for current programs.	

5.2 Access and Availability

5.2.1 Network Adequacy	
Business Owner: Quynh Nguyen	Department: Provider Data Operations
Support Staff: Cathy Dela Cruz/Tory Vazquez/Jane Flannigan Brown/Mike Wilson	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Increase provider network to meet regulatory access goals	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network	

2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for members

Status: ☐ Completed ☒ Ongoing

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, determining if any gaps exist in a particular HN or with specific practitioner specialties, identifying opportunities for improvement, prioritizing those opportunities, and taking action to improve 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.

Methodology:

CalOptima Health conducted network adequacy gap analysis using the following methodology:

1. CalOptima Health uses the 274 file as the provider network data for network adequacy gap analysis.
2. Provider network data is pulled quarterly to run an analysis for MPTs, network capacity ratio (FTE) and provider-to-member ratio (PMR). This data is 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 Policies: GG.1600 and MA.7007.
3. For the OneCare plan, the minimum number of providers varies per provider type according to CMS annual Health Service Delivery (HSD) reference table.
4. 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 earlier. 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 100% compliance with time and distance standards for primary care and specialist
    b. OneCare: 90% compliance with time and distance standards for primary care and specialist
5. Medi-Cal: Changed the methodology for time/distance from assigned membership to anticipated membership for plan level. No change for the health network level.
6. OneCare: Starting in Q3, changed the methodology for time and distance from anticipated membership to CMS 2025 Beneficiary file to comply with regulations.

Actions/Interventions Implemented in 2024:	
Quarter 1:	• Identified resource constraints and competing priorities as barriers, with the solution of hiring a PM to manage network adequacy
Quarter 2:	• CalOptima Health hired senior program manager dedicated to network adequacy • Established a process for gap closure with health networks not meeting time and distance requirements • Closed CAPS for two health networks with time and distance gaps
Quarter 3:	• Transitioned network adequacy from QA to Provider Data Operations except for timely access

	• Network Adequacy Workgroup conducted two meetings to discuss network adequacy gaps, formulated an action plan to reduce gaps in time and distance and provider-to-member ratio • Provider Data Operations curated leads list to close identified gaps at the plan level and CHCN level • Provider Relations and Contracting collaborated on expanding provider network through new contracts with providers targeted to close identified gaps in Q3 • CalOptima Health worked with HNs to establish alternative access standards and closed four out of six HNs outstanding 2023 SNC CAP for time and distance
Quarter 4:	• Approved alternative access standards request for remaining two HNs, closing out 2023 SNC. • Provider Data Operations curated additional leads list to close identified gaps • Network Adequacy Workgroup continued to work on solutions to reduce gaps, and monitor progress

Program Results:

Medi-Cal: MPT

Standard: Must contract with at least one MPT for FQHC, CNM and LM.

Mandatory Provider type	Q1		Q2		Q3		Q4	
	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met
FQHC	40	Met	47	Met	47	Met	45	Met
CNM	26	Met	4	Met	3	Met	2	Met
LM	0	Not Met	5	Met	6	Met	5	Met

Medi-Cal: Provider to Member Ratios by Specialty Type

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	1:1933	Met	1:1821	Met	1:1801	Met	1:1936	Met
PCP	Internal Medicine	1:2941	Not Met	1:1936	Met	1:1949	Met	1:1918	Met
PCP	Pediatric	1:955	Met	1:978	Met	1:917	Met	1:883	Met
PCP	**Total PCP**	**1:741**	**Met**	**1:768**	**Met**	**1:784**	**Met**	**1:768**	**Met**
Specialist	Cardiology/Interventional Cardiology	1:3224	Met	1:3249	Met	1:2963	Met	1:2955	Met
Specialist	Gastroenterology	1:5756	Not Met	1:5940	Not Met	1:5452	Not Met	1:5182	Not Met
Specialist	General Surgery	1:2251	Met	1:2248	Met	1:2045	Met	1:1983	Met
Specialist	Hematology/Oncology	1:3100	Met	1:3134	Met	1:2908	Met	1:2766	Met
Specialist	Nephrology	1:7462	Met	1:7580	Met	1:6654	Met	1:6879	Met
Specialist	Neurology	1:4658	Met	1:4574	Met	1:4132	Met	1:3946	Met
Specialist	OB/GYN	1:1162	Met	1:1129	Met	1:1098	Met	1:1099	Met
Specialist	Opthalmology	1:4502	Met	1:4398	Met	1:4436	Met	1:4367	Met
Specialist	Orthopedic Surgery	1:6296	Not Met	1:6368	Not Met	1:5993	Not Met	1:5844	Not Met
Specialist	Pulmonology	1:6660	Met	1:6921	Met	1:5378	Met	1:5217	Met

Standards: Provider to Member Ratios

A. PCP-to-member ratio is 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

OneCare: Primary Care Time/Distance Analysis — Non-Compliance County by Zip Code (YoY)

Non-Compliance ZIP Code Count for Contracted PCP				
	Q1	**Q2**	**Q3**	**Q4**

	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met	Count	Met/Not Met
2024	0	Met	0	Met	0	Met		
2023	1	Not Met	1	Not Met	1	Not Met	1	Not Met

OneCare: Specialist Time/Distance Analysis — Non-Compliance County by Zip Code (YoY)

Non-Compliance ZIP Code Count for Contracted Providers								
	Q1 Specialties		**Q2 Specialties**		**Q3 Specialties**		**Q4 Specialties**	
	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met
2024	0	Met	0	Met	0	Met		
2023	8	Not Met	9	Not Met	8	Not Met	8	Not Met
2022	0	Met	0	Met	0	Met	0	Met

OneCare: Facility Time/Distance Analysis — Non-Compliance County by Zip Code (YoY)

Non-Compliance ZIP Code Count for Contracted Providers								
	Q1 Facilities		**Q2 Facilities**		**Q3 Facilities**		**Q4 Facilities**	
	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met	Count	Met/ Not Met
2024	0	Met	0	Met	0	Met		
2023	31	Not Met	29	Not Met	30	Not Met	30	Not Met
2022	0	Met	1	Not Met	1	Not Met	1	Not Met

Quantitative Analysis:

<u>Medi-Cal</u>

- CalOptima Health was compliant with network capacity ratio (FTE), as well as time and distance standards for primary care, specialty care and hospitals.
- 2024 MPT quarterly results show standards met in Q1 were FQHC, Certified Nurse Midwife (CNM). CalOptima Health did not meet standards for Licensed Midwife (LM). However, beginning in Q2 and onward, all standards for MPT were met.
- Provider-to-Member Ratio:
  - Internal medicine did not meet standards in Q1 and became compliant from Q2 onwards.
  - Specialty types gastroenterology and orthopedic surgery are not meeting the standard for ratios. However, the downward trend shows consistent improvement in this metric quarter over quarter.
  - Most ratios are trending downward, signifying less members per provider except for General/Family Medicine and General Surgery which are both trending upward.

<u>OneCare</u>

- Provider-to-member ratios data show OneCare consistently meeting standards. Quarterly data shows an upward trend count overall, indicating that the provider network is expanding. Primary care, ophthalmology and oncology-medical/surgical are the top specialties that experienced the highest increase in provider count from Q1 to Q3. Plastic surgery, neurosurgery, infectious diseases and cardiothoracic surgery, however, all showed a small decrease in provider count.
- In 2023, the time/distance data shows CalOptima Health was non-compliant for all four quarters for PCPs, specialists and facilities. CalOptima Health is now compliant with meeting this standard.

Identified Barriers:	Identified Opportunities for Improvement:
• While CalOptima Health is meeting time and distance standards, our analysis shows South Orange County continues to remain an area where time and distance gaps tend to occur • Contracting and PR are dependent on network adequacy analysis to identify gaps to inform provider network recruitment strategy • Compliance rates in terms of PMR may not be enough to ensure access and availability	• Adding program manager headcount dedicated to managing the network adequacy program will allow the organization better monitoring and reporting capability • CalOptima Health worked on raising rates for Medi-Cal providers, to help incentivize providers to prioritize seeing its members and improve retention. This was implemented July 2024 • Formed a Network Adequacy Workgroup focused on addressing adequacy gaps and ideating solutions to increase and expand provider network

Conclusion:

CalOptima Health's goal to increase the provider network to improve access is ongoing. It has been successful at expanding the provider network in the OneCare program, which can be positively correlated with OneCare now meeting time and distance standards.

CalOptima Health remediated the constraint to monitoring and network adequacy by hiring a senior program manager focused on network adequacy programs. Even though there were challenges, having this resource allowed the transition of this program from QA to Provider Data Operations to be completed.

CalOptima Health changed the methodology for calculating time and distance network adequacy component back to anticipated membership for the plan level for Medi-Cal, and from anticipated membership to using the 2025 Beneficiary File for OneCare, to align with state and federal regulations. In July, CalOptima Health instituted a program-wide provider rate increase for Medi-Cal. This intervention is an opportunity prioritized by CalOptima Health to help incentivize providers to see members and to improve provider retention. CalOptima Health will look to analyze the impact of this solution on network adequacy in the future.
Activities/Interventions to continue/add next year:
CalOptima Health will continue to monitor network adequacy on a quarterly basis by running reports to evaluate whether the plan meets all network adequacy components under Medi-Cal and OneCare. • Continue to conduct gap analysis of our network to identify the areas to target for provider network expansion • Continue conducting outreach and implement recruiting efforts to address network gaps to increase access to members • Take a deeper dive into the data between provider network and membership to better understand the impact of provider recruitment strategy • Continue to conduct Network Adequacy Workgroup to discuss gaps and operationalize solutions

5.2.2 Timely Access Program	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Karen Jenkins/Helen Syn	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Improve timely access compliance with appointment wait times to meet 80% MPL	
Goal Met: ☐ Yes ☐ No ☒ Partial	
Work Plan Planned Activities: • Issue corrective action for areas of non-compliance • Collaborative discussion between CalOptima Health medical directors and providers to develop actions to improve timely access • Continue to educate providers on timely access standards • Develop and/or share tools to assist with improving access to services.	
Status: ☐ Completed ☒ Ongoing	
Background: CalOptima Health contracted with a health care survey vendor to field a telephone survey to our network providers to assess their compliance with CalOptima Health's Timely Access Standards to monitor appointment and telephone wait times. The survey was fielded from September 26, 2023, through December 1, 2023, and utilized a direct survey methodology in which the callers identified themselves as calling on behalf of CalOptima Health to obtain appointment data. Over 2,700 providers were surveyed, including the following provider categories: primary care, OB/GYN, specialty care, non-physician behavioral health care, psychiatric care and ancillary care for both Medi-Cal and OneCare. The minimum performance level is set at 80%.	

Methodology:
The data pull methodology included both census and sampling data. With a few exceptions, census data was used for provider types with universes of less than 100 providers. Sampling was used for provider types with universes of 100 and more and included a pull of a random sample to ensure a minimum of 30 completed surveys. Providers were not called on weekends or holidays, and for each contact, the surveyor made a maximum of three attempts to reach a live person.

The 2023 Timely Access Survey included several changes in its methodology, including the use of a direct script only in lieu of a hybrid (mystery-direct) script. A single script was developed to collect appointment times, and callers followed the script verbatim. The survey was also adjusted to take into consideration the availability of other providers at the same location who could possibly see the patient sooner. The tables below show both compliance rates for illustrative purposes, but when determining compliance CalOptima Health took the highest compliance rate.

In 2023, CMS made moderate changes to the OneCare appointment measures, and therefore, we are reporting them separately from the Medi-Cal population. OneCare changes are as follows:

2022 OneCare	*2023 OneCare*
Primary Care Non-Urgent (10 business days)	Primary Care — Services Not Emergent or Urgently Needed but Requires Medical Attention (Seven business days)
Primary Care Physical Exam (30 calendar days)	Primary Care Routine and Preventive Care (Physical Exam) (30 business days)
Psychiatrist Non-Urgent (15 business days)	Psychiatrist Routine and Preventive Care (30 business days
Non-Physician BH Non-Urgent (10 business days)	Non-Physician BH Routine and Preventive Care (30 business days)

Actions/Interventions Implemented in 2024:	
Quarter 1:	• Continuous contracting efforts to add new providers to the network.
Quarter 2:	• Mailed over 1,400 letters of non-compliance and CAPs to individual providers who did not meet the minimum performance level based on the 2023 Timely Access Survey. Mailing included a copy of CalOptima Health's call script to facilitate appointment scheduling with patients. • Revamped the process for monitoring compliance to facilitate standardization and better monitoring of the non-compliance process, including developing a new CAP evaluation tool (internal use only), updated flow charts, timelines and escalation process. • Developed a RFP for potential new vendor in 2025. • Continuous contracting efforts to add new providers to the network.
Quarter 3:	• CalOptima Health's Provider Relations department and select health networks conducted outreach to providers who were issued a CAP to confirm receipt and address any potential questions and/or concerns provider may have. • Partnered with SullivanLuallin Group to offer a patient experience program to providers, including workshops and provider shadow coaching to educate and facilitate best practices.

	• The contracted vendor fielded an in-office wait time survey to measure office wait time among providers, August through November. • The Access and Availability workgroup began reviewing provider CAP submissions and tagging for escalation for medical director review and potential peer-to-peer meetings. • Continuous contracting efforts to add new providers to the network.
Quarter 4:	• Issued CAPs to HNs not meeting timely access standards in December 2024 • Began scheduling collaborative meetings with CalOptima Health medical directors and select providers for peer-to-peer meetings to develop a plan of action. • CalOptima Health hosted a Timely Access Q&A session for providers to discuss access monitoring, changes for 2024 and 2025, barriers and interventions and next steps. • 2024 Timely Access Survey kick off on October 15th. • Continuous contracting efforts to add new providers to the network.
Program Results:	

Medi-Cal

Appointment Types	2021	2022	2023 Individual Provider	2023 Another Office Provider	Met MPL	Difference (2022 vs highest rate for 2023)
Primary Care Non-Urgent (10 business days)	72%	61%	75%	88%	Met	+27
Primary Care Urgent (48 hours)	63%	59%	60%	75%	Not Met	+16
Primary Care Physical Exam (30 calendar days)	79%	79%	81%	87%	Met	+8
Specialists Non-Urgent (Non-Urgent)	59%	49%	58%	74%	Not Met	+25
Specialists Urgent (96 hours)	64%	55%	47%	59%	Not Met	+4
OB/GYN Non-Urgent (15 business days)	81%	81%	64%	74%	Not Met	-7
OB/GYN Urgent (48 hours)	76%	70%	34%	64%	Not Met	-6
Psychiatrist Non-Urgent (15 business days)	54%	59%	67%	89%	Met	+30
Psychiatrists Urgent (48 hours)	24%	86%	46%	47%	Not Met	-39
Psychiatrists Follow-Up (30 calendar days)	59%	32%	64%	85%	Met	+53
Non-Physician BH Non-Urgent (10 business days)	75%	67%	77%	83%	Met	+16
Non-Physician BH Urgent (48 hours)	57%	69%	44%	70%	Not Met	+1
Non-Physician BH Follow-Up (20 calendar days)	71%	67%	79%	81%	Met	+14
Ancillary Non-Urgent (15 business days)	85%	73%	64%	-	Not Met	-9

OneCare

Appointment Types	2023 Individual Provider	2023 Another Office Provider	Met MPL (Highest rate for 2023)
Primary Care — Services Not Emergent or Urgently Needed but Requires Medical Attention (Seven business days)	66.3%	79.6%	Not Met
Primary Care Routine and Preventive Care - Physical Exam (30 business days)	87.6%	92.8%	Met
Psychiatrist Routine and Preventive Care (30 business days)	91.7%	96.8%	Met
Non-Physician BH Routine and Preventive Care (30 business days)	93.9%	94.7%	Met

Quantitative Analysis:

In 2023, CalOptima Health modified its survey methodology to take into account the availability of other providers who can see the patient sooner at the same location. Therefore, to determine compliance, the highest rate was selected between the provider who was selected to participate in the survey and the availability of the other provider. With this modification, there were some gains in compliance, but overall results show there is still room for improvement for both urgent and routine appointments.

Medi-Cal: Out of the 14 measures for the Medi-Cal program, six met the 80% MPL. This more than doubled in comparison to the previous year. Out of the six standards that were identified as compliant, four are from the Behavioral Health area. No provider types met the Urgent Appointment type category.

OneCare: CMS made significant changes to the OneCare standards, and therefore, the data for OneCare is not trendable. However, findings for 2023 were favorable, as out of the four measures being evaluated, three met the 80% MPL. The one measure that did not meet, Non-Urgent Appointment Services – Not Emergent or Urgently Needed but Requires Medical Attention was very close to meeting the threshold at 79.6%

Identified Barriers:	Identified Opportunities for Improvement:
• Newly contracted providers and staff may not be aware of CalOptima Health Timely Access Standards • PCPs have too many members in their panels. • Closing of panel to potential new patients	• Encourage providers to hire non-physician medical practitioners to expand office capacity • Encourage providers to make appointments more interchangeable to be able to better accommodate patient preference regarding in person vs telehealth appointments.

• Higher rate of rescheduling or cancellation from the provider office resulting in frustration from members • Shorter appointment times with patients • Provider offices that offer both in-person and telehealth appointments, at times may only have telehealth appointment availability, but patients decline because they want in-person. • Network does not have enough contracted specialists in certain areas of the county.	• Target contracting with provider types not meeting standards.
Conclusion: 2023 survey findings indicate that modifications to the survey methodology were positive as compliance rates tended to show an increase from 2022. However, there is still work to be done as many measures remain below the 80% threshold.	
Activities/Interventions to continue/add next year:	
• Field survey earlier in the year to make it more actionable. • Simplify the CAP process, so determination of a CAP can be made over a shorter time frame of one year, instead of three. • Perform interim surveys after main survey fielded to confirm compliance • Utilize provider communication tools such as Provider Update email to educate and reiterate access standards and changes.	

5.2.3 Telephone Access	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Karen Jenkins/Helen Syn	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: 1. Issue corrective action for areas of non-compliance 2. Collaborative discussion between CalOptima Health medical directors and providers to develop actions to improve timely access 3. Continue to educate providers on timely access standards 4. Develop and/or share tools to assist with improving access to services. 5. Meet 80% MPL for all access standards.	
Goal Met: ☐ Yes ☐ No ☒ Partial	
Work Plan Planned Activities:	
Status: ☐ Completed ☒ Ongoing	
Background: CalOptima Health contracted with a health care survey vendor to field a telephone survey to our network providers to assess their compliance with CalOptima Health's Timely Access Standards and to monitor appointment and telephone wait times. The survey was fielded from September 26, 2023, through December 1, 2023, and utilized a direct survey methodology in which the callers identified themselves as calling on behalf of CalOptima Health in order to obtain appointment data. Over 2,700 providers were surveyed, including the following provider categories: primary care, OB/GYN, specialty care, non-physician behavioral health care, psychiatric care and ancillary care for both Medi-Cal and OneCare. The minimum performance level is set at 80%.	
Methodology: The data pull methodology included both census and sampling data. With a few exceptions, census data was used for provider types with universes of less than 100 providers. Sampling was	

used for provider types with universes of 100 and more and included a pull of a random sample to ensure a minimum of 30 completed surveys. Providers were not called on weekends or holidays, and for each contact, the surveyor made a maximum of three attempts to reach a live person.

The 2023 Timely Access Survey included several changes in its methodology, including the use of a direct script only in lieu of a hybrid (mystery-direct) script. A single script was developed to collect appointment times, and callers followed the script verbatim.

Actions/Interventions Implemented in 2024:

Quarter 1:	• None
Quarter 2:	• Mailed over 1,400 letters of non-compliance and CAPs to individual providers who did not meet the MPL based on the 2023 Access survey.
Quarter 3:	• Conducted an interim telephone audit on 738 providers identified as non-compliant for telephone measure Instruct Caller to ER or Dial 911 in Case of Emergency. Results show approximately 67% (511) are now compliant with this measure.
Quarter 4:	• Issued CAPs to HNs not meeting the timely access standards. • CalOptima Health hosted a Timely Access Q&A session for providers to discuss access monitoring, changes for 2024 and 2025, barriers and interventions, and next steps.

Program Results:

CalOptima Health Plan Level

Types	CalOptima Health Plan Level				
	2021	***2022***	***2023***	***Met MPL***	***Difference***
Instructs Caller to ER/911	20.8%	19.7%	62.1%	Not Met	+42.4
Informs Caller of Return Call Time	14.1%	10.8%	20.9%	Not Met	+10.1
Phone Triage Patients within 30 Minutes	95.3%	98.0%	92.0%	Met	-6.0
Callback Time within 24 hours	50.0%	71.4%	68.1%	Not Met	-3.3
Callback Time within 30 minutes	20.6%	14.6%	0%	Not Met	-14.6
Flexibility in Scheduling Members with Disabilities	97.0%	97.8%	95.9%	Met	-1.9

Quantitative Analysis:

2023 Access survey results show telephone access continues to be an area of opportunity. Out of the six measures surveyed, only two met the standards Instructs Caller to ER and Informs Caller of Return Call Time. Both experienced improvement of more than 10 percentage points, but overall failed to meet the threshold.

It is worth noting that the following measures are no longer identified as a regulatory requirement for monitoring in 2024:

- Callback Time within 30 minutes
- Callback Time within 24 hours
- Flexibility in Scheduling Members with Disabilities

Identified Barriers:	Identified Opportunities for Improvement:

• CalOptima Health Provider Directory may not always have current contact information. • Members are unable to reach provider office because the contact information (phone, address) they have is outdated • Provider offices may not be up to date on CalOptima Health's telephone standards • Smaller provider offices may not have phone systems and/or the staff to handle large volumes of calls and/or outgoing voice messages. • Providers are overwhelmed with notices of non-compliance from plans and health networks, and therefore, notices are sometimes unintentionally disregarded	• Educate and collaborate more with provider offices on standards by providing tips and tools on best practices, offer Q&A access call sessions, email/newsletters updates, etc. • Field more interim surveys to enhance monitoring of telephone access
Conclusion: For the three telephone measures that remain in effect for 2024, tighter monitoring is needed for Instructs Caller to ER/911 and Informs Caller of Return Phone Call as both failed to meet the threshold. The addition of interim surveying will facilitate more timely intervention and increased compliance.	
Activities/Interventions to continue/add next year: • Conduct interim surveys to monitor telephone compliance. • Host Q&A Access Call Session at least annually	

5.2.4 Annual Network Certification (ANC)	
Business Owner: Quynh Nguyen	Department: Provider Data Operations
Support Staff: Cathy Dela Cruz/Karen Jenkins	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Comply with Annual Network Certification Requirements	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: Comply with Annual Network Certification requirements. 1. Annual submission of ANC to DHCS with AAS 2. Implement improvement efforts 3. Monitor for improvement	
Status: ☐ Completed ☒ Ongoing	
Background: In April of 2021, DHCS issued APL 21-006, Network Certification Requirements, which established network adequacy standards at the MCP level, a process to assess and certify MCPs for network adequacy at least annually through the ANC process to ensure that each MCP's provider network meets state and federal network adequacy and access requirements. In January of 2023, DHCS issued APL 23-001 Network Certification Requirements to amend and add additional requirements which CalOptima Health codified under policies GG. 7111 and GG.1600. In addition to the annual schedule, network certification will be performed if CalOptima Health's network experiences a change that substantially affects how they service members.	

Methodology:
CalOptima Health complies with ANC using the following methodology:

1. ANC monitors the following for 100% compliance
    a. Mandatory provider type (including cancer center)
    b. Provider-to-member ratio (FTE)
        i. PCP: 1:2,000 ratio
        ii. Physician: 1:1,2000 ratio
    c. Time or distance
    d. Timely access
2. CalOptima Health uses the November 274 and November member data for health network membership to run the analysis for provider-to-member ratio (FTE) compared against the 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 a subcontracted health network is compliant with the standards identified in CalOptima Health Access and Availability Policies: GG.1600
3. 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.

Actions/Interventions Implemented in 2024:	
Quarter 1:	• ANC Phase 2 Submission with AAS completed March 20,2024
Quarter 2:	• Updated ANC policy to ensure adherence with regulations • Quarterly monitoring of ANC requirements and gap analysis
Quarter 3:	• Quarterly monitoring of ANC requirements and gap analysis • Transitioned ANC program from QI to Provider Data Operations department
Quarter 4:	• Quarterly monitoring of ANC requirements and gap analysis • DHCS approved CalOptima Health's AAS request, and CalOptima Health began implementing requirements associated with this approval

Program Results:

Quantitative Analysis: CalOptima Health met requirements for MPT, provider-to-member ratios and time/distance. This is an improvement on MPT, which was not met in 2023. CalOptima Health did not meet requirements for Timely Access

Identified Barriers:	Identified Opportunities for Improvement:
• DHCS uses ArcGIS to run network adequacy for ANC, while CalOptima Health uses Quest, which will result in variance in gap analysis due to the differences in how each software calculates time or distance	• CalOptima Health transitioned ANC program from QI to Provider Data Operations for operational efficiency, consolidating owner of provider data and monitoring/reporting into the same department

Conclusion:
CalOptima Health improved compliance in meeting ANC from 2023 as we are now meeting MPTs.

CalOptima Health examined potentially switching to ArcGIS to run network adequacy, however, we decided not to implement since DHCS does not require MCP's to use the same program. Furthermore, DHCS acknowledges and accepts that there will be a variance in analyses when utilizing two different pieces of geomapping software.

As a result, while our own monitoring and reporting activities show compliance with time and distance requirements, there is a possibility that we will still have gaps due to the difference in geomapping program/methodology that CalOptima Health uses compared to what DHCS uses for ANC.

Activities/Interventions to continue/add next year:

- Continue monitoring ANC component compliance
- Finalize ANC policy

5.2.5 Subcontracted Network Certification (SNC)	
Business Owner: Quynh Nguyen	Department: Provider Data Operations
Support Staff: Cathy Dela Cruz/ Karen Jenkins	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Comply with Subdelegate Network Certification Requirements	
Goal Met: ☒ Yes ☐ No ☐ Partial	

Work Plan Planned Activities:

1. Annual submission of SNC to DHCS with AAS or CAP
2. Monitor for improvement
3. Communicate results and remediation process to HN

Status: ☐ Completed ☒ Ongoing

Background:
On March 20, 2023, DHCS issued APL 23-006 Delegation and Subcontract Network Certification, which established network adequacy standards at the subcontractor and downstream subcontractor level, a process for MCPs to assess and certify subcontractor and downstream subcontractor for network adequacy at least annually through the SNC process to ensure that each subcontractor and downstream subcontractor provider network meets state and federal network adequacy and access requirements.

On May 2024, DHCS approved CalOptima Health's SNC submission and recategorized previously fully delegated CalOptima Health subcontractors as partially delegated, thus removing the MPT element previously included for some health networks, beginning reporting year 2024.

Methodology:
CalOptima Health conducted SNC using the following methodology:

1. CalOptima Health uses the November 274 and November member data for health network membership to run the analysis for provider-to-member ratio (PMR) compared against the 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 a subcontracted health network is compliant with the standards identified in CalOptima Health Access and Availability Policies: GG.1600
2. 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.
3. SNC monitors the following components:
    a. Provider-to-member ratio (FTE)
    b. Time or distance
    c. Timely access

d. Provider directory

Actions/Interventions Implemented in 2024:	
Quarter 1:	• Closed AltaMed and CHOC 2023 time and distance CAPs
Quarter 2:	• Submitted Q2 CAP updates to DHCS • Updated Health Network Certification policy for SNC
Quarter 3:	• Organized focused efforts to help HNs close CAP • Closed Heritage-Regal 2023 time and distance CAP • Developed an alternative access standard process and set up office hours to walk HNs through the process • Closed four 2023 time and distance CAPS through AAS • Submitted Q3 CAP updates to DHCS • Organized a Network Adequacy Workgroup to discuss HN gaps and ideate solutions to increase provider network and access to care
Quarter 4:	• Closed remaining two 2023 issued time and distance CAP through AAS • Submitted Q4 CAP updates to DHCS • Completed SNC Landscape Analysis submission • Completed 2024 SNC analysis for all health networks • Completed 2024 SNC submission for DHCS

Program Results:

SNC Components	Timely Access	Directory Review	Network Capacity/Ratio (FTE)	Time and Distance
Subcontracted Health Network	MY 2023	Q3	Q4	Q4
AltaMed Health Services	Not Met	Met	Met	Not Met
AMVI Care Health Network	Not Met	Met	Met	Not Met
CHOC Physicians Network	Not Met	Met	Met	Not Met
Family Choice Health Services	Not Met	Met	Met	Not Met
Heritage Provider network	Not Met	Met	Met	Not Met
Nobel Mid-Orange County	Not Met	Met	Met	Not Met
OPTUM	Not Met	Met	Met	Not Met
Prospect	Not Met	Met	Met	Not Met
United Care Medical Group	Not Met	Met	Met	Not Met

Quantitative Analysis:

- All health networks are meeting the required provider-to-member ratio for PCP (1:2000) and physician (1:1,200) full-time equivalent
- All health networks are not meeting both timely access and time or distance standards.
- Time or distance gaps per health network are generally decreasing, with Q2 seeing the highest decrease in ZIP codes not meeting standards, except for UCMG, whose gaps increased in Q2 by 53%.

Identified Barriers:	Identified Opportunities for Improvement:

• 2023 was the first year that MCPs had to certify their subcontractors. There was not a process in 2024 to manage the CAPs issued in December 2023. • There was a resource constraint to implementing and executing the follow-up activities needed for monitoring CAPS and HN contracting efforts	• CalOptima Health hired a dedicated senior program manager to manage the network adequacy programs • Facilitated educational meetings with health networks to explain the SNC process and how to formally close CalOptima Health-issued CAPs with each impacted health network impacted • Created a process for issuing alternative access to close CAP • Build a more detailed program plan to improve program transparency
Conclusion: The SNC process is still new, and as a result, many processes are not fully in place, which gave rise to a lot of confusion and lack of understanding of what this program entails and what responsibilities fall under the health networks and why. Health networks issued 2023 time or distance CAPS were inconsistent in meeting CalOptima Health's deadlines for DHCS-mandated quarterly updates. There was a lot of confusion in terms of what was needed and why certain information was requested. Hiring a dedicated program manager at the end of Q2 to manage the program allowed for more communication and transfer of information, giving health networks an available contact person to monitor and provide guidance on the program. As a result, CalOptima Health was able to meet DHCS SNC quarterly update deadlines which showed progression, closing CAPs through contracting and operational efforts, as well as using alternative access standards.	
Activities/Interventions to continue/add next year:	
• Formalize alternative access policy • Finalize policy • Continue to monitor HNs on SNC components quarterly to help them pass requirements for annual certification • Continue to educate health networks on the SNC process • Continue to provide guidance to health networks on how to expand the provider network to address lack of providers identified in quarterly monitoring of network adequacy	

Section 6: Safety of Clinical Care

6.1 Emergency Department Member Support: Emergency Department Diversion Pilot	
Business Owner: Scott Robinson	Department:
Support Staff: Cathy Osborn	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Work Plan Goal/Objective: Emergency Department Diversion Pilot has been implemented. In 2024, we plan to expand a virtual program to additional hospital partners, starting with UCI.	
Goal Met: ☐ Yes ☐ No ☒ Partial	
Work Plan Planned Activities:	
Status: ☐ Completed ☒ Ongoing	
Background: The ED diversion program was developed during 2024 and is planned to launch in January 2025 at the UCI Medical Center Emergency Department. Program Description and Objectives: • Provide care coordination for CalOptima Health members who present in the ED. • Support community access after an ED visit without a hospital stay, prevent future ED visits that could be handled at a lower level of care for better coordinated access, and ensure the member's ambulatory care is in place and SDOH needs are met. • Provide expedited care management between ED and CalOptima Health to promote ambulatory care and connection to appropriate CalOptima Health internal teams and external community supports. • Develop relationships between the ED and CalOptima Health to ensure CalOptima Health members receive the best care in the location of their choice.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Program objectives developed
Quarter 2:	• Planning with CalOptima Health and UCI
Quarter 3:	• Approval of staff job descriptions and hiring
Quarter 4:	• One RN and one social worker hired and trained
Conclusion:	

6.2 Coordination of Care Between Settings: Transitional Care Services (TCS)	
Business Owner: Michelle Evans	Department: Medical Management
Support Staff: Joanne Ku/Mimi Cheung	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: UM/CM/LTC to improve care coordination by 10% from Q4 2023 to December 31, 2024, by increasing successful interactions for TCS for high-risk members within seven days of their discharge by 10%. Monitoring the percentage of acute hospital stay discharges that had follow-up ambulatory visits within seven days post-hospital discharge.	
Goal Met: ☐ Yes ☒ No ☐ Partial	
Work Plan Planned Activities: 1) Use of Usher 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.	
Status: ☐ Completed ☒ Ongoing	
Background: UM/CM/LTC to improve care coordination by increasing successful interactions for members within seven days of their discharge by 10% from Q4 2023 (45.0%) to December 31, 2024.	
Methodology: IPP Appendix B: Technical Specifications and Submission Guidance	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Continued outreaching to TCS high-risk members • Established TCS support line for low-risk members • Developed a TCS support line flyer with CalOptima Health and HN contact information. • Updated report that identifies TCS high-risk members • Updated TCS county in-patient psychiatric hospital process workflow • Explored texting campaign options by leveraging the Usher platform • Developed texting campaign messaging content
Quarter 2:	• Continued outreach to TCS high-risk members • Initiated motivational interview trainings with staff • Hired staff for the TOC outreach to pregnant members who are not enrolled in the Bright Steps program.
Quarter 3:	• Conducted motivational interview trainings • Continued outreach efforts for TOC (non-Bright Steps members receive targeted outreach). • Reviewed DHCS lont resource guide for enhancement opportunities • Developed process for identifying FFS Medicare members in need of TCS • Trained CalAIM ECM provider to document LCMs in CalOptima Health Connect system.
Quarter 4:	• Launched texting campaign using the Usher platform (Q4) • Conducted motivational interview trainings • Continued outreach efforts for TOC (non-Bright Steps members receive targeted outreach).
Program Results:	

CalOptima Health - Ambulatory Follow Up Within 7 Days Post-Discharge by Quarter

Source: CAL_DIM (Claims & Encounters)
Population: All lines of business, all health networks
Denominator: Live discharges
Numerator: Ambulatory follow up with any provider within 7 days post-discharge
Exclusions: OB or pregnancy related inpatient stays, discharges to LTC
*Note: Any data within 12 months of current will likely be incomplete due to claim lag with most recent being most impacted

Year	Quarter	Numerator	Denominator	Rate (%)
2021	Q1	4,703	11,444	41.09577071
	Q2	5,386	13,021	41.36395054
	Q3	5,461	13,744	39.73370198
	Q4	5,235	13,476	38.84683882
		20,785	**51,685**	**40.2147625**
2022	Q1	4,979	12,888	38.63283675
	Q2	5,383	13,638	39.47059686
	Q3	6,028	14,705	40.99285957
	Q4	5,905	14,703	40.16187173
		22,295	**55,934**	**39.85947724**
2023	Q1	6,104	15,294	39.91107624
	Q2	6,371	15,323	41.57801997
	Q3	6,556	15,654	41.88066948
	Q4	6,402	15,645	40.92042186
		25,433	**61,916**	**41.07661994**
2024 (to date)*	Q1	6,355	15,524	40.93661427
	Q2	6,501	15,738	41.30766298
	Q3	6,014	15,130	39.74884336
	Q4 (to date)	1,756	5,076	34.59416864
		20,626	**51,468**	**40.07538665**

Quantitative Analysis:
The internal goal of 45.0% (10% improvement from baseline [Q4 2023]) was not met as the rates remain consistent, ranging from 39% to 41% (Quarters 1–3) this year. The data for Quarter 4 is still pending as data collection is still in progress through the end of this year.

Identified Barriers:

- Provider availability to schedule appointments within seven days of discharge.
- Inability to reach members.

Identified Opportunities for Improvement:

- Research options to improve timely access to providers post-discharge.
- Add more targeted texting campaigns for outreach to members.
- Targeted outreach to hospitals/facilities to discuss ambulatory discharge rates and opportunities for improvement.
- Meet with health network partners in monthly JOMs to go over progress and discuss opportunities for improvement.

Conclusion:

CalOptima Health implemented new activities and interventions this year for TCS. More time is needed to evaluate their effectiveness. The texting campaign, implemented at the end of this year, has resulted in increased member engagement since its launch.

Since the data is consistent within the 39%–41% range for ambulatory follow-up within seven days post-discharge, the team recommends reassessing the goal with further discussion in the TCS workgroup regarding the goal.
Activities/Interventions to continue/add next year: • Evaluate options for enhancements of texting campaigns. • Educate health networks on their performance in HN JOM meetings. • Educate hospital partners on their performance in JOM meetings. • Research options to improve timely access to providers post-discharge.

6.3 Coordination of Care Across Practitioners: Diabetes Eye Care	
Business Owner: Mike Wilson	Department: Quality Analytics
Support Staff: Melissa Morales/Kelli Glynn	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Improve coordination of care, prevention of complications and facilitation of best practice diabetes care management between vision care specialists (VSP) and PCPs	
Goal Met: ☐ Yes ☐ No ☒ Partial	
Work Plan Planned Activities: Collaborative meetings between teams to identify the best practices to implement; provider and member education	
Status: ☐ Completed ☒ Ongoing	
Background: Identified barrier to coordination of care and sharing of data between specialists and PCP for diabetic eye care. No automated process to share claims from VSP with CalOptima Health's contracted health networks. Due to contract restrictions, data exchange is not permitted from VSP as a vendor to contracted health networks. It is only permitted by VSP and CalOptima Health. With the absence of automated data exchange rates reflected could be lower than reality.	
Methodology: VSP and CalOptima Health started development of a HEDIS supplemental report for purpose of distribution by CalOptima Health to share with all contracted health networks. The process to establish an SFTP secure site for data share. VSP provided raw data by line of business, and data file was parsed by delegated health network. Additional report elements were included, and the file was socialized among participating delegated health networks for feedback.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	N/A
Quarter 2:	• Discuss sending VSP quality data to health networks • Held information sessions with health network IT teams and CalOptima Health IT team to discuss file format.
Quarter 3:	• Interested health networks received test files before a production file was created.
Quarter 4:	• Final production files loaded to health networks that approved the test file and would be receiving files monthly.

Program Results:

Table below shows production file pickup by health network.

Health Network	Status Production File Pickup
Altamed Health Services	Yes

Optum Care Network	Yes
Noble Mid-Orange County	Yes
CHOC Health Alliance	Yes
Regal Medical Group	No
Prospect Medical Group	Yes
Family Choice Health Services	Yes

Quantitative Analysis: Automated process to share claims from VSP with CalOptima Health contracted health networks was completed.

Identified Barriers:	Identified Opportunities for Improvement:
• Identifying correct IT staff at the health network level. • Delay in the creation of the test file. • Difficulty for health network to locate the testing SFTP site, which further delayed completion of the production file. • Health network feedback received that there may be duplication in report.	• Resolve the issue of duplicative claims. • Evaluate at health network level the added value of data.

Conclusion: Will need additional time to obtain feedback from health networks on the value of VSP claims data received.

Activities/Interventions to continue/add next year:

- Ensure that all health networks are accessing the production file monthly.
- Evaluate the effectiveness of data sharing.

APPENDIX:

A - 2024 QIHETP Work Plan Q1-Q4
B - 2024 CalOptima Health Membership (Risk Stratification)
C - 2024 Population Health Management Impact Report
D – 2024 Cultural and Linguistically Appropriate Services (CLAS) Evaluation

Submitted and approved by QIHEC: 05/14/2024
Quality Improvement Health Equity Committee Chairperson:

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

Submitted and approved by QAC: 06/12/2024
Board of Directors' Quality Assurance Committee Chairperson:

_____
Trieu Thanh Tran, M.D. Date

2024 QI Work Plan - Q1 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Caution Green - On Target
Program Oversight	2024 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Quality Improvement Health Equity Transformation Program (QIHETP) Description and Annual Work Plan will be adopted on an annual basis; QIHETP-QIHEC-BOD; Annual Work Plan-QIHEC-QAC	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Marsha Choo	Laura Guest	Quality Improvement	X	2024 QIHETP Description and Annual Work Plan was approved by QIHEC on 2/13/24, by QAC on 3/13/24, and by the BOD on 4/4/24.	A copy of the BOD approved 2024 QIHETP and Work Plan will be posted on COH public website.	
Program Oversight	2023 Quality Improvement Program Evaluation	Complete Evaluation 2023 QI Program	~~QIHETP~~ QI Program and Annual Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Marsha Choo	Laura Guest	Quality Improvement	X	Evaluation of 2023 QI Program and Annual Work Plan were approved by QIHEC on 2/13/24; QAC on 3/13/24 and BOD on 4/4/24.	Evaluation of the 2023 QI Program and the four quarters of 2023 Work Plan will be posted on COH public website.	
Program Oversight	2024 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2024 UM and CM Program Description	UM and CM Program will be adopted on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Kelly Giardina	Stacie Oakley	Utilization Management	X	The 2024 Integrated UM & CM Program Description was approved by the Board on 3/13/24.	None at this time	
Program Oversight	2023 Integrated Utilization Management and Case Management Program Evaluation	Complete Evaluation of 2023 UM CM Integrated Program Description	UM Program will be evaluated for effectiveness on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Kelly Giardina	Stacie Oakley	Utilization Management	X	The 2023 Integrated UM & CM Program Description evaluation was drafted & presented to UMC on 1/5/24, presented to QIHEC on 2/13/24 & to the Board on 3/13/24	None at this time	
Program Oversight	Population Health Management (PHM) Strategy	Implement PHM strategy	Conduct the following: Population Needs Assessment (PNA) Risk stratification Screening and Assessment Wellness and prevention	PHMC report to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Katie Balderas	Barbara Kidder/Hannah KimHM/Director of Care Management	Equity and Community Health	X	1) Drafted SOW for Member and Population Health Needs Assessment (**MPHNA)** vendor to better stratify members based on risk and identify opportunities for improvement in access, prevention, and service delivery. 2) In March 2024, CalOptima Health Quality Assurance Committee accepted the **2024 PHM Strategy**, which outlines our efforts for this year. 3) Currently working with department leads throughout the organization to update the **2024 PHM Strategy Workplan** which outlines our PHM programs/initiatives, related activities, and related SMART objectives for the year. 4) Collaborating with Orange County Health Care Agency (OCHCA) and Kaiser Permanente (KP) to co-develop shared SMART Goals for inclusion in the PHM Strategy and identify opportunities to collaborate on the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP).	1) Obtain Board approval in April 2024. MPHNA RFP vendor selection is planned for August 2024. 2-3) 2024 PHM workplan to be finalized and presented to CalOptima Health Board of Directors in April 2024 and PHMC in May 2024 for approval. 4) Will be working to finalize SMART Goals, implementation plans, and the Local Health Department (LHD) + Managed Care Plan (MCP) collaboration worksheet due in August 2024.	
Program Oversight	2024 Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Cultural and Linguistic Services Program Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	X	The 2024 Program and Workplan approval at QAC and BOD was held in order to include Health Equity elements.	Updated the workplan with additional goals related the Health Equity Accreditation and present at the next QAC meeting	
Program Oversight	**Population Health Management (PHM) Committee** - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee activities, findings from data analysis, and recommendations to QIHEC	PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Workplan progress and outcomes. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	PHMC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Barbara Kidder/Hannah Kim	Equity and Community Health	**New**	1.) In February 2024, we created and launched the **PHM Committee** which will oversee PHM activities related to DHCS and NCQA. This committee includes executive representative from across the agency as well as community leaders.	1) Continue to assists this committee by reviewing relevant guidance, agenda setting, and presentation development, and deliverables shared with QIHEC. 2)Finalize approval calendar, charter, and related polices 3) Next PHMC meeting is scheduled for May 2024.	
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 activities, findings from data analysis, and recommendations to QIHEC	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. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Laura Guest	Marsha Choo Rick Quinones Katy Noyes	Quality Improvement	X	Credentialing: CCN Initial Credentialing=59; CCN Recredentialing=119; BH Initial Credentialing=43; BH Recredentialing=25 Seven PQIs were presented to CPRC in Q1. One PQI resulted in a recommendation by CPRC for decredentialing, for which the provider has requested a Fair Hearing. There were no PPCs identified through data mining due to staff limitations, nor were any PPCs reported to CalOptima Health by the hospitals or HNs. There were 5 critical incidents all regarding a COVID-19 outbreak at a CBAS center.	Credentialing: Continue to credentialing and recredentialing of CCN and BH providers. Have contracted with a Credentialing Verification Organization (CVO) to assist with the credentialing of providers. This will ensure compliance and timeliness of the initial credentialing and recredentialing files. We have also hired two Credentialing Auditors to assist with the CVO and delegation oversight for our delegated groups. There are currently 5 physicians undergoing the Fair Hearing process. Claims reports will be mined for PPCs when additional staff are hired and trained trained on the PQI team. Critical incidents will continue to be monitored and reported quarterly to DHCS.	
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 activities, findings from data analysis, and recommendations to QIHEC	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. Trends and results are presented to the committee quarterly. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Tyronda Moses	Heather Sedillo	GARS	X	On 2/14/2024 GARS Comittee met to review Q4 metrics and discussed CY2023 trends in both lines of business and types to include: - Member Grievances - Member Appeals - Provider Disputes - Provider Appeals Discussed the 2 overturned cases by the External Indepdent Reviews - SFH (Medi-Cal) and Maximus (Medicare) Q3 2023 minutes were approved.	GARS Committee is scheduled for May 14 where Q1 trends will be discussed and the remediation activities presented for additional recommendations.	
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 activities, findings from data analysis, and recommendations to QIHEC	The MEMX Subcommittee reviews the annual results of CalOptima Health's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	MemX Committee report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Mike Wilson	Karen Jenkins/Helen Syn	Quality Analytics	X	In Q1, MemX Committee met 3/14/24 and reviewed/discussed the following: •Access to Care Issues •Compliance Rates for BH •Provider Education Opportunities through CHCN Lunch & Learns •Overview of Decision Point's CAHPS Predictive Analytics •Discussion on Outreach Calls	Q2 meeting is scheduled for: 5/22/24	
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 activities, findings from data analysis, and recommendations to QIHEC	UMC reviews medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. 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: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Kelly Giardina	Stacie Oakley	Utilization Management	X	In Q1 2024 UMC held meetings on 1/5/24 and 2/22/24. On 1/5/24 UMC members approved the following items: *11/16/23 meeting minutes *2023 UM Program Evaluation *2024 Integrated UM/CM Program Description *2024 UM Policies & Procedures On 1/26/24 UMC members approved the 2024 hierarchy of UM criteria via an eVote On 2/22/24 the UMC members approved the 1/25/24 meeting minutes.	None at this time	
Program Oversight	**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee activities, findings from data analysis, and recommendations to QIHEC	WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. Pediatric Risk Stratification Process (PRSP) monitoring	WCM CAC report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	T.T. Nguyen, MD/H.Kim	Gloria Garcia	Medical Management	X	WCM CAC met on 2/20/24. They approved the 11/7/23 meeting minutes and submitted a copy to QIHEC. WCM CAC attendees completed annual Conflict of Interest and Confidentiality forms. Regional Center Orange County and Orange County Social Service Agency representatives joined the Commitee. WCM data including BH services was presented and no out of compliance or issues were reported. There are no recomendaions for QIHEC at this time.	The next WCM CAC meeting is scheduled for 5/20/24	
Program Oversight	Care Management Program	Report on key activities of CM program, analysis compared to goal, and improvement efforts	Report on the following activities: Enhanced Care Management (ECM) Complex Case Management (CCM) Basic PHM/CM Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM Transitional care services	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Megan Dankmyer	TBD	Medical Management	**New**	Report on the following activities: Enhanced Care Management (ECM): Develop process for ECM Lead Care Manager to communicate TCS activity. Complex Case Management (CCM): Reviewed with Health Networks NCQA Element E, Factors 1-5. Case Management continues monthly real time reviews of delegated Health Networks per NCQA requirements. Basic PHM/CM: Case Management Quarterly audit for MOC for delegated Health Networks. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM: See Next steps Transitional care services: Work with IT to develop reporting for analyzing outcomes on TCS response.	Report on the following activities: Enhanced Care Management (ECM): 1. Implement process for ECM Lead Care Manager to communicate TCS Activity. Complex Case Management (CCM): 1. Continue real time Monthly NCQA file audits. Basic PHM/CM: Ongoing Case Management Quarterly audit for MOC for delegated Health Networks. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM: Institute multi-department EPSDT workgroup. Transitional care services: 1. Analyze outcomes by Health Network and present in JOMS to track and trend to guide future conversations and interventions. 2. Work with ECM Providers to obtain ECM reporting data for KPI 5	
Program Oversight	Delegation Oversight	Implement annual oversight and performance monitoring for delegated activites.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accredication standard compliance that, at minimum, include comprehensive annual audits.	Report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Monica Herrera	Zulema Gomez John Robertson	Delegation Oversight	**New**	2024 DOAA Findings: - Compliance file review - Credentialing file review - Customer Service file review - Provider Relations file review - Utilization Management file review	Next Steps: A Corrective Action Plan (CAP) is issued for each finding that addresses each deficiency identified. Remediation of the CAP is then implemented based on current CAP policy, HH.2005.	
Program Oversight	Disease Management Program	Implement Disease Management	Report on the following activities: Evaluation of current utilization of disease management services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Elisa Mora	Equity and Community Health	**New**	1) Provided extensive training to staff on the new care management system (Jiva) implemented on 2/1/2024 to ensure smooth implementation and efficient operation. 2) Implemented a Chronic Kidney Disease (CKD) pilot targeting 68 CCN Members with CKD stage 3 A or B and 2 chronic conditions (diabetes, hypertension, heart disease) and not seeing a nephrologist. Staff were able to enroll 7 out 68 members in the program. 3) Developed 2-way text campaign on asthma and diabetes to promote PCP engagement and DM program opt-in. Submitted text to DHCS for approval. 4) Piloted 2-way text as an option for members to complete the Disease Management Satisfaction Surveys. Introducing text message as a survey option improved survey response rates and convenience for members. 5) In February 2024, we resumed the New Member Mailing, providing information on our DM services and condition-specific handouts on asthma and diabetes for low risk members. This mailing will occur every other month. 6) The diabetes monthly stratification criteria were revised to improve high risk member identification. The look back period was shortened and the A1c requirement was dropped to 8% to better identify the emerging risk members. This change could potentially lead to earlier interventions for high-risk members.	1) Continuing to provide ongoing training to staff as the care management system continues to be enhanced for efficiency. 2) Analyzing the results of the CKD pilot to fine-tune the program prior implementation. 3) Launch text campaigns contingent upon DHCS approval. Evaluate effectiveness of text campaigns. 4) Revise stratification criteria for asthma and congestive heart failure.	

2024 QI Work Plan - Q1 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data* *(i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Caution Green - On Target
Program Oversight	Health Education	Implement Health Education Program	Report on the following activities: Evaluation of current utilization of health education services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Anna Safari/Katie Balderas	Thanh Mai Dinh	Equity and Community Health	**New**	1) Evaluation of current utilization of health education services **Goal being met:** During 2024 Q1, 749 referrals were assigned to health education services, very similar count from previouse year as 748 referrals were assigned to health education services during Q1 in 2023. However, during 2024 Q1, there was an increase in community class intake. Class attendance was 50 in 2023 Q1, compared to 183 attendees in 2024 Q1. Classes take more efforts to recruit participants, prepare, and follow up, therefore participation increse is gradual. 2) Maintain business for current programs and support for community **Goal being met:** 68 community classes have been confirmed for 2024, and topics continue to expand. Hypertension education was added to the series in March 2024. Community partners include a collaboration with Northgate Markets offering market tours accompanied by nutrition education. Participating in community collaboration including the Tobacco and Vape Free (TVFREE) Coalition. 3) Improve process of handling member and provider requests **Goal being met:** a. The draft electronic referral form is being reviewed and will be used to help improve member self-referral experience. This is so that members who do not want to call in or providers can directly send referrals to the Health Education team. b. Health and Wellness services are promoted at at all continuing education training in 2024, along with reminders on how and where to send member referrals.	Implementation of an electronic referral form, and continue with the plan as listed. However, with the recent department name/vision change to focus more on Equity and Community Health, it's anticipated that there is will more community engagement efforts and possibly, less one on one coaching approach. Such service will be offered based on providers and members requests.	
Program Oversight	Health Equity	Identify health disparities Increase member screening and access to resources that support the social determinants of health Report on quality improvement efforts to reduce disparities	Assess and report the following activities: 1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	By December 2024 Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Barbara Kidder	Equity and Community Health	x	1) SDOH assessment is being tested for integration to the member portal. SDOH assessment will be built into CalOptima Health's healthcare management system (JIVA) as part of the closed-loop referral integration. 2) Closed-loop referral vendor was selected and contracting process in underway. 3) HL4E certificate programs is ongoing with 59 out of 164 staff having completed the certificate program.	1) Published SDOH assessment in member portal and build the SDOH assessment into JIVA 2) Finalize contract with selected closed-loop referral vendor and integrate into JIVA 3) Continue to encourage staff to complete their mini-credentials to earn their certification. Train the trainer program on the teach-back method is planned for May 2024.	
Program Oversight	Long-Term Support Services (LTSS)	Implement LTSS	Report on the following activities: Evaluation of current utilization of LTSS Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Scott Robinson	Manager of LTSS	Long Term Care	**New**	LTSS remains compliant with all TAT's. LTC, CBAS and MSSP continue to provide timely and efficient member services. 1st quarter FY goal is to review and revise department DTP's to coincide with the Jiva implementation.	Continue everyday LTSS standup meetings with the LTSS Manager and Supervisors to monitor and adjust staffing and caseloads to comply with TAT's.	
Program Oversight	National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by January 1, 2026	1) Implement activites for NCQA Standards compliance for HPA and Health Plan Renewal Submission by April 30, 2024. 2) Develop strategy and workplan for Health Equity Accreditation with 50% document collect for submission.	1) By April 30, 2024 2) By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Veronica Gomez	Marsha Choo	Quality Improvement	X	1. **Health Plan Accreditation:** CalOptima Health is on track to submit for HP re-accreditation which is scheduled for 4/30/24. An additional Program Manager has been hired to help support HP and HE accreditation in preparation for the next HP accreditation. 2. **Health Equity Accreditation:** Consultant completed a review of all the applicable standards.Developed a work plan. Several working sessions have taken place to meet with owners and identify gaps in meeting specific elements. Requested additional Project Management support for Health Equity Accreditation.	**1. HP Accreditation:** An additional Program Manager has been hired to help support HP and HE accreditation in preparation for the next HP accreditation. Virtual File review with NCQA surveyors is scheduled for June 17th-18th, 2024. **2. HEA Accreditation:** 2 project managers will be assigned to support Health Equity Accreditation. CalOptima Health also has an Enterprise Project Management Office with resources to provide additional support, if needed.	
Program Oversight	OneCare STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts.	By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024 Q1: 01/14/2025	Mike Wilson	Kelli Glynn	Quality Improvement	X	MY2024 priority measures identified: OMW, PCR, FMC, CBP, COA (medication review), TRC (average), HbA1c. Stars Steering Committee started in Q1.	Continue with plan as listed	
Program Oversight	Value Based Payment Program	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) Will share HN performance on all P4V HEDIS Measures via prospective rates report each month. 2) Will share hospital quality program performance	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Mike Wilson	Kelli Glynn	Quality Analytics	X	HN performance for all P4V HEDIS measures have been shared continuously on a monthly basis. In addition, high level details for the quality improvement grant process were shared with all HNs during the April HN Quality Forum. NOFO planned for Q3.	Continue with plan as listed	
Program Oversight	Quality Performance Measures: Managed Care Accountability Set (MCAS) STAR measures	Track and report quality performance measures required by regulators	Track rates monthly Share final results with QIHEC annually	Report program update to QIHEC Q2: 05/14/2024 Q3: 08/13/2024 Q4: 11/05/2024 Q1 02/11/2025	Paul Jiang	Terri Wong	Quality Analytics	X	Awaiting for HEDIS results.	HEDIS results will be reported in Q2.	
Program Oversight	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: 1 Implement SBHIP DHCS targeted interventions 2. Bi-quarterly reporting to DHCS	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Sherie Hopson	Behavioral Health Integration	X	1) 1st quarter 2024 SBHIP Progress Reports from CHOC, Hazel Health, WYS, and OCDE reporting implementations are on track. 2) Monitoring SBHIP implementation progress through regularly scheduled OCDE SBHIP Collaborative Meetings and SBHIP Planning Meetings facilitated by BHI. 3) School district contracting Visio workflow finalized for internal departments Contracting, Credentialing, Provider Relations - focused on providing a "concierge service" to help the school district through the process. 4) Reviewed and approved 10 school districts budget plans from detailing their use of SBHIP funds. 5) Received DHCS approval 3/13 for the December 2023 Biquarterly Reports.	1) 2nd quarter 2024 SBHIP Partners Progress Reports receive and review. 2) Coordinate and monitor progress through regularly scheduled meetings with OCDE and SBHIP Partners. 3) Prepare DHCS Biquarterly Reports for June submission. 4) Prepare 2nd SBHIP partner funding distribution/check request process. 5) Review and approve school district budget plan submissions.	
Program Oversight	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	Assess and report the following: 1) Establish the Comprehensive Community Cancer Screening and Support Grants program 2) Work with vendor to develop a comprehensive awareness and education campaign for members.	Report Program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Katie Balderas	Barbara Kidder	Equity and Community Health	X	1) Developed a competitive grant program to support activities that increase early detection and decrease late-stage discovery. We released a noticed of funding opportunity in February 2024 and received grant applications from 22 organizations. We anticipate grant implementation of selected grantees will begin in July 2024, pending Board approval in June 2024. 2) Launched the Awareness and Education Campaign with a marketing firm. Discovery phase took place from January to March with 15 discovery sessions that included internal and external stakeholder input from CBOs, health networks and providers.	1) Currently reviewing applications for selection. Board approval is planned for June 2024. Grant Contracts and go-live planned for July 2024. 2) Present findings from Discovery Phase to leadership and work with Marketing Firm for concept development and strategic recommendations; Test concept/messaging with consumers;	
Quality of Clinical Care	Preventive and Screening Services	Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS) MY 2024 Goals: CCS: MC 59.85% BCS-E: MC 62.67% OC 71% COL: OC 71%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/5/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Quality Analytics	X	1. Member Health Reward: CCS:MC 25; BCS:MC 18; BCS:OC 2. COL:OC 2 2. Text Message Campaign: Jan: CCS 60,762; Feb BCS MC 21,642 OC 596; Mar; COL OC 1256 members 3. Member Health Reward Survey: MC 3,376 OC 2,276 4. Kick off of CCN OC COL GI outreach pilot program. 5. February 2024 Prospective Rate Data: CCS: MC 36.12% BCS: MC 38.81%; BCSL: OC 50%; COL: OC 48%	1. Continue to track CCS, BCS MC OC, COL OC member health reward. 2. Continue member outreach campaigns: mailing, IVR, text and MC/OC live call campaigns. 3. Continue to monitor CCN OC COL GI outreach pilot program. 4. Develop 2 way text message campaigns for each cancer screening measure by line of business.	
Quality of Clinical Care	EPSDT Diagnostic and Treatment Services: ADHD Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare Appropriate Use Of Psychotropic Medications	Follow-Up Care for Children Prescribed ADHD medication (ADD) HEDIS MY2024 Goal: MC - Init Phase - 44.22% MC -Cont Phase - 50.98%	Assess and report the following activities: 1) Work collabortively with the Communications department to Fax blast non-compliant providers letter activity (approx. 200 providers) by second quater. 2) Participate in provider educational events, related to follow-up visits and best practices. 3) Continue member outreach to improve appointment follow up adherence. a. Monthly Telephonic member outreach (approx. 60-100 mbrs) b. Member Newsletter (Fall) c. Monthly Member two-way Text Messaging (approx. 60-100 mbrs) 4) Member Health Reward Program 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Valerie Venegas	Behavioral Health Integration	X	PR HEDIS RATES Q1 (February): Initiation Phase-41.25% Continuation and Maintenance Phase- 51.13% 1) Created and finalized working collaboratively with QI for the Member Health Reward flyer to distribute to eligible members. 2) Met with ITS to discuss data sourcing automation for the Provider Portal information sharing on a monthly basis. 3) Text Messaging outreach to members sent in January and February. 4) Community Clinics/Provider education via HCCN Clinical Quality Champion Meeting on 1/31/24 and Medical Provider Forum - The Coalition of Orange County Community Health Centers on 3/15/24 regarding imortance of quality measure	1) Q2 data will be pulled to initiate fax blast for Provider best practices letter and tip-sheet to non-compliant providers. 2) Member outreach for those who filled an initial ADHD prescription. 3) Mail out Member Health Rewards flyer to eligible members. 4) Continue monthly data pull for text messaging campaign.	
Quality of Clinical Care	Health Equity/Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Prevention Programs For Behavioral Healthcare	Improve Adverse Childhood Experiences (ACES) Screening	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Behavioral Health	**New**	1) ACEs presentation to inform the group of our progress as a Health plan and educate on the importance of this screening given by BHI Executive Director at the BHQI Workgroup Meeting in April.	1) Continue collaborative meetings between teams to identify best practices to implement. 2) Continue Provider and member education. 3) Continue to participate in the ACEs stakeholder meetings.	
Quality of Clinical Care	Mental Health Service: Continuity and Coordination Between Medical Care and Behavioral Healthcare	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS MY2024 Goals: Blood Glucose-All Ages:58.43% Cholesterol-All Ages: 40.50% Glucose and Cholesterol Combined-All Ages: 39.01%	Assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primay Care Providers (PCP) for members in need of merabolic 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 the next top 50 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, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Behavioral Health Integration	X	PR HEDIS RATES Q1 (February) : Blood Glucose all ages: 13.11%, Cholesterol all ages: 5.62%, Glucose & Cholesterol Combined all ages: 5.43% 1) Barriers included: Receiving timely data and accurate information. a)Submeasure names for this measure changed in 2024, causing delay in receiving data. 2) Identified members prescribed antipsychotic medication still in need of diabetes screening, cholesterol screening, and both cholesterol and diabetes screening test through Tableau Report. 3) The following materials have been disseminated to Providers: a) Provider Best Practices Letter. b) APM Provider Tip Sheet. 4) Collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 5) Mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to the next top 50 providers on a monthly basis. 6) Text Messaging Campaign was sent out to members in the month of January. 7) Met with ITS to discuss data sourcing automation for the Provider Portal information sharing on a monthly basis. 8) Community Clinics/Provider education via HCCN Clinical Quality Champion Meeting on 1/31/24 and Medical Provider Forum - The Coalition of Orange County Community Health Centers on 3/15/24 regarding imortance of quality measure.	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Continue data pull for text messaging campaign. 3) Continue mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to the next top 50 providers on a monthly basis. 4) Continue with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis.	
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Appropriate Diagnosis, Treatment And Referral Of Behavioral Disorders Commonly Seen In Primary Care	Antidepressant Medication Management (AMM) HEDIS MY2024 Goal: Acute Phase - 74.16% Continuation Phase - 58.06%	Assess and report the following activities: 1) Educate providers on the importance of follow up appointments through outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 2) Educate members on the importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 3) Track number of educational events on depression screening and treatment.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/052/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Behavioral Health Integration	**New**	PR HEDIS RATES Q1 (February) :Effective Phase Treatment 62.27%, Effective Continuation Phase 36.64% 1) Worked with Quality Analytics to delvelop a data report 2) Drafted the following materials: a)Text Messaging script b)Drafted APM Provider Tip Sheet 3) Community Clinics/Provider education via HCCN Clinical Quality Champion Meeting on 1/31/24 and Medical Provider Forum - The Coalition of Orange County Community Health Centers on 3/15/24 regarding imortance of quality measur	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Submit Text Messaging draft for internal review process. 3)Submit Provider Best Practices Letter for internal review process.	
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Severe And Persistent Mental Illness	Diabetes Monitoring For People With Diabetes And Schizophrenia (SMD) HEDIS MY2024 Goal: 76.66%	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Behavioral Health Integration	**New**	PR HEDIS Rates Q1 (Feb): M/C:18.59% OC: N/A 1) We are monitoring this measure and met our goal last year.	1) Continue to monitor prospective rates on a monthly basis. 2) Continue collaborative meetings between teams to identify best practices to implement.	

2024 QI Work Plan - Q1 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Caution Green - On Target
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Exchange of Information	Follow-Up After Emergency Department Visit for Mental Illness (FUM) HEDIS MY2024 Goal: MC 30-Day: 60.08%; 7-day: 40.59% OC (Medicaid only)	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) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz	Behavioral Health Integration	X	PR HEDIS Rates Q1 (February): 30 day- 17.90%, 7 day- 11.65% 1) The main barrier has been not having the bandwidth for outreach to members that we have been receiving on a daily basis. 2) Working with vendor to create a cohort report of FUM data only. 3) sFTP folders have been established and BH ED data is being sent to Health networks on a daily basis. 4) Bi-weekly Member text messaging. 5) Met with ITS to discuss data sourcing automation for the Provider Portal information sharing on a monthly basis. 6) Community Clinics/Provider education via HCCN Clinical Quality Champion Meeting on 1/31/24 and Medical Provider Forum - The Coalition of Orange County Community Health Centers on 3/15/24 regarding imortance of quality measure. 7) Article emphasizing importance of Follow up appointment after ED visit created and will be included in Spring Member Newsletter (Medi-Cal and OneCare).	1) Pull data for Data Analyst to send out bi-weekly text messages based on real time ED data. 2) BHI is in the process of developing and implementig a Pilot project for CCN members identified who meet FUM criteria. BH Telehealth provider to conduct the outreach and assist with member linakge. 3) Collaborate with NAMI to share real-time ED data for member outreach.	
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Management Of Coexisting Medical And Behavioral Conditions	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) HEDIS 2024 Goal: MC 77.40% OC (Medicaid only)	Assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collabortively 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.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Behavioral Health Integration	X	PR HEDIS Rates Q1 (Feb): MC:23.51% OC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test through Tableau Report. 2) Conducted a text message campaign to reach out to members re: getting their glucose lab screening. 3) Barriers included: Receiving timely data, obtaining the correct contact information for members such as phone numbers. 4) In process of developing new outreach strategies working with internal depts (Case Management) to help reach out to members. 5) Member $25 Reward Program to incentivise members to get glucose screening. 6) Met with ITS to discuss data sourcing automation for the Provider Portal information sharing on a monthly basis. 7) Community Clinics/Provider education via HCCN Clinical Quality Champion Meeting on 1/31/24 and Medical Provider Forum - The Coalition of Orange County Community Health Centers on 3/15/24 regarding imortance of quality measure	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 data pull for text messaging campaign 4) Mail out member health rewards flyer to eligible members.	
Quality of Clinical Care	Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects	Non Clinical PIP:Improve the percentage of members enrolled into care management, Caloptima Helath 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 SMI/SUD.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz/Mary Barranco	Behavioral Health Integration/ Quality Analytics	X	Conduct quarterly/Annual oversight of MC Non Clinical PIPs (Jan 2023 - Dec 2025) Improve the percentage of members enrolled: Baseline Measurement Period: 01/01/23-12/31/23 Remeasurment 1 Period : 01/01/24 -12/31/24 Remeasurment 2 Period : 01/01/25-12/31/25	1) Working with Caloptima Health Vendor to receive Real-Time ED data on a daily basis for CCN and COD members. 2) BHI is in the process of developing a Pilot project for CCN members identified who meet FUM/FUA criteria. Telehealth provider will conduct the outreach to members who meet FUM criteria and assist with linkage. Internal BHI PCC's to conduct outreach to members meeting FUA criteria and assist with linkage. Vendor and PCC's will also provide information about case management including ECM and referrals. 3) Develop outreach and outcome data related to the percentage of members enrolled in CCM and ECM for CCN members identified who meet FUM/FUA criteria for the duration of each measurement period. 4) Work in collabration with internal Privacy dept to ensure compliance of data sharing with vendor.	
Quality of Clinical Care	Substance Use Disorder Services	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) MY2024 Goals: MC: 30-days: 36.34%; 7-days: 20.0%	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) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Valerie Venegas	Behavioral Health Integration	X	PR HEDIS Rates Q1 (February): 30-Day- 17.90%, 7-Day-11.47% 1) Sharing real-time ED data with our Health Networks on a secured FTP Site. 2) Met with ITS to discuss data sourcing automation for the Provider Portal information sharing on a monthly basis 3) Bi-weekly member text messaging 4) Article emphasizing importance of Follow up appointment after ED visit created and will be included in Spring Member Newsletter (Medi-Cal and OneCare). 5) Community Clinics/Provider education via HCCN Clinical Quality Champion Meeting on 1/31/24 and Medical Provider Forum - The Coalition of Orange County Community Health Centers on 3/15/24 regarding imortance of quality measure	1) Data anaylst scrub data for bi-weekly text messaging. 2) BHI is in the process of developing and implementig a Pilot project for CCN members identified who meet FUA criteria.	
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED) MY2024 HEDIS Goals: MC 66.33% OC: 81%;	Assess and report the following activity: 1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	By December 2024 Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Quality Analytics	X	1. Member Health Reward: EED:MC 3 ; EED:OC 1 2. Text Message Campaign: Jan: MC EED 9,903 OC EED 325 members 3. EED VPS mailing for Jan to Mar: 1,443 4. Member Health Reward Survey: MC 3,376 OC 2,276 5. February 2024 Prospective Rate Data: EED:MC 24.7%; EED:OC 37%	1. Continue to track EED MC OC member health reward. 2. Continue member outreach campaigns: mailing, IVR, text and OC live call campaigns. 3.Develop 2 way text message campaigns for diabetes by line of business.	
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better) MY2024 Goals: MC: 29.44%; OC: 20%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts	Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Melissa Morales/Kelli Glynn	Quality Analytics	X	1. Member Health Reward: HBD:MC 4; HBD:OC 2 2. Text Message Campaign: Jan: MC HBD 9,903 OC HBD 325 members 3. Member Health Reward Survey: MC 3,376 OC 2,276 4. February 2024 Prospective Rate Data: HBD PC: MC 91.29%; HBD PC: OC 91%	1. Continue to track HBD MC OC member health reward. 2. Continue member outreach campaigns: mailing, IVR, text and OC live call campaigns. 3.Develop 2 way text message campaigns for diabetes by line of business.	
Quality of Clinical Care	Maternal and Child Health: Prenatal and Postpartum Care Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). HEDIS MY2024 Goal: Postpartum: 82.0% Prenatal: 91.07%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Ann Mino/Mike Wilson	Leslie Vasquez/Kelli Glynn	Equity and Community Health/ Quality Analytics	X	**Community Initiatives:** 1) Digital ads for postpartum ran Jan, Feb & March 2024. 2) Digital promotion of doula benefit March 2024 **Member based initiatives:** 1) Bright Steps Program - - 794 perinatal referrals - 1,201 maternal and infant assessment completed - 204 unique postpartum assessments completed. 2) Postpartum health reward- 32 health rewards issued during Q1 2024. **Performance:** 1) Februrary 2024 HEDIS rate (based on non continuous enrollment): Timeliness of Prenatal Care:66.76% Postpartum Care: 54.60%. Both have not met the MPL.	1) Data - continue to identify mechanisms to access ADT data to be leveraged to support member outreach modalities which include: mailing, text, IVR, and live-call campaigns. 2) Continue member education efforts such as Medi-Cal newsletters. 3) Develop text and email campaign messaging. 4) Continue with provider, clinic and health network education efforts. 5) Continue with partnership with OCHCA in support of maternal mental health.	
Quality of Clinical Care	Blood Lead Screening	HEDIS MY2024 Goal: 67.12%; Improve Lead Screening in Children (LSC) HEDIS measure.	Assess and report the following: Strategic Quality Initiatives Plan to increase lead testing will consist of: 1) A multi-modal, targeted member approach as well as provider and health network collaborative efforts 2) Partnership with key local stakeholders 2024 Member Quality Initiatives will consist of the following but not limited to: - Member health reward and monitoring of impact on LSC HEDIS rate - IVR campaign to - Texting campaign - Mailing campaign - Lead texting campaign for members - Medi-Cal member newsletter article(s) In partnership with the Orange County Health Care Agency, CalOptima Health will co-develop educational toolkit on blood lead testing.	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Leslie Vasquez/Kelli Glynn	Quality Analytics	X	**Provider based initiatives:** 1) Blood Lead Performance Report shared monthly on Jan, Feb, and March 2024 with CCN providers via Provider Portal and health networks via FTP. 2) Sharing of blood lead resources via HN weekly communication in March 2024. **Community Initiatives:** 1) Radio ads ran in Feb & March 2024; PBS TV ad ran Jan & March 2024. **Member based initiatives:** 1) Blood lead education to Bright Steps Program participants at 6 and 12 months old. 2) New scripting in development for lead text campaign to target members turning 12 and 24 months old through new vendor (Ushur). 3) NEW- 12 and 24 month blood lead testing health reward available on website as of March 2024. **Performance:** 1) Preliminary results based on December 2023 prospective rates (continuous enrollment) indicate that the lead screening in children measure met MPL for MY2023. HEDIS results to be reported in Q2. 2) February 2024 HEDIS rate (based on non continuous enrollment): 59.13%. Has not met the MPL: 62.79%	1) Continue with planned targeted member outreach campaigns such as member mailing, text, IVR, and live-call campaigns. 2) Development of 2-way blood lead text message for lead testing at 12 and 24 months of age. 3) Development of email blood lead campaign for lead testing at 12 and 24 months of age. 4) Data- Continue sharing Blood Lead Performance Report with health networks and CCN providers. 5) Continue with provider education efforts. 6) Continue with partnership with OCHCA to increase blood lead testing rates throughout Orange County.	
Quality of Clinical Care	EPSDT/Children's Preventive Services: Pediatric Well-Care Visits and Immunizations	HEDIS **MY2024** Goal CIS-Combo 10: 45.26% IMA-Combo 2: 48.80% W30-First 15 Months: 58.38% W30-15 to 30 Months: 71.35% WCV (Total): 51.78%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Early Identification and Data Gap Bridging Remediation for early intervention.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Michelle Nobe/Kelli Glynn	Quality Analytics	X	1) First and Second Birthday Card mailer for April - June birthdays to 4,961 members. 2) January Text Message Campaigns. W30: 32,911; WCV 3-17: 180,567; WCV 18-21: 73,552 members. 3) W30 Member Detail Report (Dec 2023 PR) shared with health networks via FTP. 4) Based on February 2024 Prospective Rate Data: none of the measures have met goal. CIS-Combo 10: 17.67%; IMA-Combo 2: 34.04%; W30-First 15 Months: 17.49%; W30-15 to 30 Months: 52.64%; WCV (Total): 4.22%.	1) Continue with planned targeted member outreach campaigns such as birthday card mailing, text, IVR, and live-call campaigns. 2) Development of 2-way pediatric wellness text message campaigns specific to each developmental milestone. 3) Ad hoc W30 Noncompliant Member List shared with health networks and clinics who've established supplemental data sharing to close out HEDIS MY2023 efforts. 4) Continue sharing W30 Member Detail Report with health network.	
Quality of Clinical Care	Performance Improvement Projects (PIPs) Medi-Cal	Meet and exceed goals set forth on all improvement projects	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 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Leslie Vasquez/Kelli Glynn	Quality Analytics	X	There were barriers related to the timeliness in which member data was obtained (i.e. 2024 data will not be available until the week of 4/22/2024).		
Quality of Clinical Care	Quality Improvement activities to meet MCAS Minimum Performance Level	Meet and exceed MPL for DHCS MCAS	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits. Perform root cause analysis, strategize and execute planned interventions targeting members, providers and systems.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Michelle Nobe/Kelli Glynn	Quality Analytics	X	W30-2+ PDSA, Cycle 3 was approved (1/21/2024). Findings: members who had 2 successful telephonic outreaches had a comparable W30-2+ compliance rate to those who had 3 successful telephonic outreaches and a birthday card mailing.	Based on the PDSA findings, aiming to conduct at least 2 call campaigns per year to impact the W30 rate. If member is unreachable, send a wellness visit reminder mailer.	
Quality of Clinical Care	Encounter Data Review	Conduct regular review of encounter data submited by health networks	Monitors health network's compliance with performance standards regarding timely submission of complete and accurate encounter data.	Semi-Annual Report to QIHEC Q2: 04/09/2024 Q4: 10/08/2024	Kelly Klipfel	Lorena Dabu	Finance	**New**	Medi-Cal: 1) HMOs and PHCs met 7 of 8 measures 2) CHOC met 5 of 6 measures 3) SRGs met 5 of 6 measures OneCare: 1) 4 networks met all measures 2) 5 networks met 3 of 4 measures 3) 1 network met 2 of 4 measures	None; continue to work with all HNs to ensure complete encounter data submitted	
Quality of Clinical Care	Facility Site Review (including Medical Record Review and Physical Accessibilty Review) Compliance	PCP and High Volume Specialist sites are monitored utilizing the DHCS audit tool and methodology.	Review and report conducted initial reviews for all sites with a PCP or high volume specialists and a review every three years. Tracking and trending of reports are reported quarterly.	Update volume from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025 Compliance details to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Marsha Choo	Katy Noyes	Quality Improvement	**New**	FSR/MRR/PARS, NF and CBAS Oversight A.FSR: Initial FSRs=4; Initial MRRs=6; Periodic FSRs=27; Periodic MRRs=18; On-Site Interims=42; Failed FSRs=2; Failed MRRs=5; CAPs: CE=31; FSR=22; MRR=32 B.PARS: Competed PARS=110 (Basic Access=60 Limited Access=50) C. CBAS: Critical Incidents=6; All Critical Incidents reported were COVID cases. Non-Critical Incidents=12; Falls=7; Completed Audits= 8: CAPs=4; Unannounced Visits=1 NF: 1 Critical Incident was reported in Q1. On-Site Visits=27; Unannounced Visits=1	I. FSR/MRR/PARS, NF and CBAS Oversight **A.** FSR: Continue to audit. Complete Periodic FSR within 36 months from previous audit. Close all issued CAPs by due dates. Currently training an new QI Nurse Specialist-FSR and interviewing for one more position. This will decrease the number of audits assigned to each nurse and increase turn-around-time. **B.** PARS: Continue to complete PARS reviews for PCP, HVS, and Ancillary sites. **C.** CBAS: Continue to complete annual audits and unannounced visits. Remind centers to report critical incidents. **D.** SNF: Two new LVN hires. Working on re-evaluating current processes and procedures.	
Quality of Clinical Care	Potential Quality Issues Review	Referred quality of care grievances and PQIs are reviewed timely	Review and report conducted referred cases are properly reviewed by appropriate clinical staff, cases are leveled according to severity of findings, and recommendations for actions are made, which may include a presentation to the CPRC for peer reviewed.	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Laura Guest	Quality Improvement	**New**	PQI is undergoing a system change which is expected to be implemented in Q2 2024. PQI data is unable to be pulled during this transition period. In Q1, PQI hired one new RN and one LVN is no longer with CalOptima.	PQI anticipates the new system, Jiva, to be implemented in Q2 2024. PQI data will be reported once the system implementation and reporting is completed. PQI anticipates hiring and training a new RN during Q2 2024, as this position is currently under recruitment.	

2024 QI Work Plan - Q1 Update

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Amber - Caution Green - On Target
Quality of Clinical Care	Initial Provider Credentialing	All providers are credentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements and are current within 180 days of review and approval (60 days for BH providers)	Update from CPRC to QIHEC: Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Rick Quinones	Quality Improvement	**New**	Initial BH Credentialing Q1 = 43; Initial CCN Credentialing Q1 =57	Initial credentialing: 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 credentialing.	
Quality of Clinical Care	Provider Re-Credentialing	All providers are re-credentialed according to regulatory requirements	Review and report providers are re-credentialed within 36 months according to regulatory requirements	Update from CPRC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Rick Quinones	Quality Improvement	**New**	BH Recredentialing - Q1 =24; CCN Recredentialing Q1 =115. For Q1 we did not have any recredentialing files out of compliance.	Recredentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the recredentialing of providers. This will ensure that we continue with compliance and timeliness of the recredentialing files.	
Quality of Clinical Care	Chronic Care Improvement Projects (CCIPs) OneCare	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	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 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Quality Analytics	X	1. Member Health Reward: EED:OC 1; HBD PC:OC 2 2. EED VPS mailing for Jan to Mar: 599 members 3. Text Message Campaign: OC HBD/EED 325 members 4. Febnuary 2024 Prospective Rate Data: EED: OC 37%; KED: OC 8.21%; HBD PC: OC 91%; MAD: OC Data Received in May; SUPD: OC Data Received in May	1. Continue to track HBD MC OC member health reward. 2. Continue member outreach campaigns: mailing, IVR, text and OC live call campaigns. 3. Develop 2 way text message campaigns for diabetes by line of business. 4. Begin emerging risk call campaign.	
Quality of Clinical Care	Special Needs Plan (SNP) Model of Care (MOC)	% of Members with Completed HRA: Goal 100% % of Members with ICP: Goal 100% % of Members with ICT: Goal 100%	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implmentation and monitoring.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	S. Hickman/M. Dankmyer/H. Kim	QI Nurse Specialist	Case Management	X	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. Core Report CO2258 in phase II Jiva Remediation for ICT/ICP/HRA data. Q1 DHCS reporting for HRA1 and ICP1 due on 5/30/2024 and data pending validation process. As of 3/31/2024 22% of HRAs completed to date for the year. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. Communications to Health Networks in January, February and March on ICP development status for newly effective members. Addition of annual ICP development status on the March file. Communication included identification of members who were also ECM-Like. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implmentation and monitoring. Ongoing quarterly audits of delegated health networks.	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. Submit Q1 ICP1/HRA2 report by 5/30/2024. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. Continue to communicate monthly to Health Networks on ICP development status for both initial and annual members, ECM-Like eligibility. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implmentation and monitoring. Continue quarterly audits of delgated networks; Implementation audit in development.	
Quality of Service	Improve Network Adequacy: Reducing gaps in provider network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network 2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	1) Quynh Nguyen 2) Tory Vazquez 3) Jane Flannigan Brown	Mahmoud Elaraby Provider Relations	Contracting	X	Resource constraints and competing priorities.	>In the process of transitioning Network Adequacy from QI to Provider Ops team. >In the process of hiring a PM to manage network adequacy. > Contracting and PR dependent on Network Adequacy be completed w/ identified gaps in order to develop provider network recruitment strategy.	
Quality of Service	Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Assess and report the following activities: 1) Issue corrective action for areas of noncompliance 2) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely acces. 3) Continue to educate providers on timely acces standards 4) Develop and/or share tools to assist with improving access to services.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Karen Jenkins/Helen Syn	Quality Analytics	X	Of the eleven Timely Access CAPs issued to HNs in Dec-2023, we have received responses back from eight networks. Of the 117 Timely Access CAPs issued to individual providers, 23 responses received, two termed/terming and one provider passed away.	For CAP responses received, Access workgroup to review and determine next steps. For CAP submissions still outstanding, follow-up and escalate as needed. Planning to field interim access survey in Q2-2023 to re-measure compliance for provider offices who were identified as non-compliant with outgoing telephone message instructing caller to go to ER/call 911 in case of emergency.	
Quality of Service	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Annual submission of SNC to DHCS with AAS or CAP 2) Monitor for Improvement 3) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2024 2) By end of Q2 2024 3) By end of Q3 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Quynh Nguyen/Mike Wilson	Karen Jenkins/Mahmoud Elaraby	Network Operations/Quality Analytics	X	Time or Distance: Geomapping conducted in November 2023 showed that Subcontractor no longer met time or distance standards for the core specialists in a dense county as listed in "CalOptima Health EX.2_supplement Orange" file. Member to Provider Ratios: - Provider network report conducted in November 2023 showed Subcontractor non compliant with provider to member ratios - Kaiser Foundation Health Plan: N/A Subcontractor is no longer in CalOptima Health's Networks effective 1/1/2024 Mandatory Provider Types: Provider network report conducted in November 2023 showed fully delegated Subcontractor (Kaiser Foundation Health Plan) non compliant with MPTs: Federally Quality Health Centers	Time or Distance: - For identified areas of non-compliance CalOptima Health issued a corrective action plan (CAP) to the subcontractor. Subcontractor will attempt to find the specialists within time or distance. - Kaiser: Subcontractor is no longer in CalOptima Health's Networks effective 1/1/2024 - Arta, Monarch & Talbert: are integrated with Optum health network and will be reassessed as part of Optum organization effective 1/1/2024 - Will reassess Subcontractor compliance at next quarterly geomapping analysis Member to Provider Ratios: - CalOptima Health issued corrective action plan for identified areas for non-compliance and will monitor Subcontractor through the corrective action process where they will be required to submit a corrective action plan, carry out that plan and demonstrate progress/improvements - CalOptima Health will reassess Subcontractor on a quarterly basis - Kaiser: Subcontractor is no longer in CalOptima Health's Networks effective 1/1/2024 Mandatory Provider Types: - Kaiser: Subcontractor is no longer in CalOptima Health's Networks effective 1/1/2024	
Quality of Service	Increase primary care utilization	Increase rate of Initial Health Appointments for new members, increase primary care utilization for unengaged members.	Assess and report the following activities: 1) Increase health network and provider communications, trainings, and resources 2). Expand oversight of provider IHA completion 3) Increase member outreach efforts	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Katie Balderas	Anna Safari	Equity and Community Health	X	1) Increase health network and provider communications, trainings, and resources a. Sent communication reminders out to Health Networks and CCN Providers b. Presented Health Networks (HNs) as planned at 5 JOMs, 1 QIHEC Meeting, 1 CCN Virtual Lunch and Learn Meeting, 1 FQ/CC . Provided IHA education at Cancer Screening CME for Providers. c. Incorporating IHA into Provider Toolkit, Created document created for providers with steps on how to access IHA Report and PCP Member Roster on Provider Portal. 2). Expand oversight of provider IHA completion a. Launched IHA Chart Review Audits (CCN) to engage low performing community clinics for IHA Chart Review Audits on at least 30 member files per clinic. b. Reviewing and following up on underperforming HNs; Meetings held with Optum and AltaMed to discuss opportunities to improve performance. c. Established and informed all HNs of the expectation to meet the minimum IHA completion rate of 50%; d. Established a plan for process to visit providers and bring IHA data and related resources to implement in Q2 3) Increase member outreach efforts a. Developing text campaign for new members =IHA: Currently in review with internal team and vendor	1) Increase health network and provider communications, trainings, and resources -Scheduled HN Forum Presentation for Q2 (Goal present twice annually) -IHA Updates will be presented at Health Network Collaborative Quality Forum beginning in April. 2). Expand oversight of provider IHA completion **-IHA Chart Review Audits** (CCN): Staff working with department Medical Director to follow up with non-responsive clinics via clinic executive leadership. - Scheduled meeting with Delegation Oversight during Q2 to agree on the approach for establishing remediation activities (including but not limited to: education, corrective action plans, etc.)	
Quality of Service	Cultural and Linguistics and Language Accessibility	Implement interpreter and translation services	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards Maintain business for current programs Improve process for handling these services	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services		Quarter 1 2024 Assessment C&L assessed the member utilization for interpreter services (in any language) and written translations in CalOptima Health's threshold languages. The assessment concluded that Spanish is the highest utilized LEP language for telephonic and face to face interpreter services as well as written translations. • Telephonic Interpreter Services Spanish 52%; Vietnamese 23%; Farsi: 5%; Arabic 4%; Chinese 4%; Korean 4%; Other 8% • Face to Face Interpreter Services Spanish 35%; Vietnamese 9%; Farsi: 11%; Arabic 14%; Chinese 2%; Korean 14%; American Sign Language 5% Other 9% • Documents Translated Spanish 72%; Vietnamese 8%; Farsi: 6%; Arabic 5%; Chinese 3%; Korean 4% Utilization results aligned with CalOptima's Health membership and therefore C&L findings is goals are being met.	• Continue monitoring CalOptima Health Members' interpreter and translations services needs. • Continue to explore technological improvement opportunities with our contracted Interpreter Services and Translations vendors for all C&L processes and services.	
Quality of Service	Improving Access: Annual Network Certification	Comply with Annual Network Certification requirements	1) Annual submission of ANC to DHCS with AAS 2) Implement improvement efforts 3) Monitor for Improvement	Submission: 1) By June 2024 2) By December 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Quynh Nguyen/Mike Wilson	Mahmoud Elaraby/Johnson Lee	Provider Data Management Services	**New**	Phase 1: ANC Roster provided by DHCS has been completed and submitted for the following: 1-ANC 2023 Cancer Center Validation_CalOptima Health 2-ANC 2023_Exhibit A-3 MPT Validation_CalOptima Health 3-ANC 2023_Exhibit A-5 Hospital Validation_CalOptima Health Phase 2: Time or Distance: CalOptima Health: CalOptima Health did not meet Time or Distance standards for 54 provider type/population combinations in two zip codes (92678 and 92679).	**Phase 1:** ANC Roster provided by DHCS has been completed and submitted for the following: 1) ANC 2023 Cancer Center Validation_CalOptima Health 2) ANC 2023_Exhibit A-3 MPT Validation_CalOptima Health 3) ANC 2023_Exhibit A-5 Hospital Validation_CalOptima Health No further action required **Phase 2:** Time or Distance: CalOptima Health: Based on DHCS' time or distance analysis for this submission, CalOptima Health is submitting AAS requests. CalOptima Health used DHCS Medi-Cal Fee-for-Service Providers to identify the nearest OON providers to meet Time or Distance standards for 54 provider type/population combinations in two zip codes (92678 and 92679).	
Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal	Assess and report the following activities: 1) Conduct outreach to members in advance of 2024 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively. 3) These items also continue to be included in all P4V discussions with HNs.	Update from MemX to QIHEC Q2: 06/11/2024 Q3 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Carol Matthews/Helen Syn	Quality Analytics	X	1) 144,837 mailings were sent to Medi-Cal members and 2,743 were sent to OneCare members 2) Medi-Cal- 90,237 member call attempts were made and 13,933 reached/scheduled callback (18.7%), OneCare-1,498 member call attempts were made and 541 reached (36.1%)	Continue with plan as listed	
Quality of Service	Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process	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	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Tyronda Moses	Heather Sedillo	GARS	**New**	1) provider trends - highest trending provider group are several of the FQHC's - appointment availability, delays in referrals, delays in service, telephone accessibility. 2) transportation trends - NMT, MTM delays and no shows 3) access trend - impacted by the providers who were trending and missed appointments caused by the transportation delays of MTM 4) quality of care - missed appointments No trends identified in member appeals Provider appeals/disputes trends - past timely filing, no authorization on file and underpayment 1 of 16 SFH overturned - Medi-Cal 1 of 40 Maximus overturned - Medicare	The department will continue to perform quarterly and year to date reviews to identify trends. This information will be presented to GARS Committee as opportunities to improve operations across the organization. The department will host the next GARS Committee meeting on May 14.	

Evaluation Category	2024 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2023	Results/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)* Red - At Risk Yellow - Caution Green - On Target	
Quality of Service	Customer Service	Implement customer service and monitor against standards	Track and trend customer service utilization data Comply with regulatory standards Maintain business for current programs Improve process for handling customer service calls	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Andrew Tse	Mike Erbe	Customer Service		DHCS' average speed of answer of not exceeding 10 minutes: Goal was not met (15 min and 15 sec). Internal business goal of abandonment rate not exceeding 5% not met (20.2%). Challenges: call center experienced a large spike in call volume (159,664) due to transitions (Optum consolidation, Adult Expansion, Kaiser) and member engagement campaigns (i.e., text messaging, telephonic surveys).	Continue working with HR to onboard additional staff (permanent vacant positions or temporary staff), maintain the telephonic call back offering, and partner with other departments (QA, Equity and Community Health, etc.) to determine if replacing customer service phone number with member portal features would be a feasible option or containing member engagement interactions within the original mode of engagement (i.e., text messaging).	
Safety of Clinical Care	Coordination of Care: Member movement across settings	Improve care coordination between the hospital and primary care physician (PCP) following patient discharge from an acute care setting	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Stacie Oakley	TBD	Utilization Management	**New**	Refer to the TCS element	Refer to the TCS element	
Safety of Clinical Care	Coordination of Care: Member movement across settings	Improve coordination of care, prevention of complications, and facilitation of best practice diabetes care management between vision care specialists (SPCs) and primary care providers (PCPs)	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Megan Dankmyer	TBD	Medical Management	**New**	MY2022 Eye Exam for Patients with Diabetes is a 62.6% and did not meet the 2023 CalOptima Health goal. November 2023 prospective rates is at 48.68% and below the hybrid goal. Final HEDIS rates for MY2023 is not yet available.	Staff to review the data and determine whether Eye Exam will continue to be the area of focus for monitoring continuity and coordination of care for members moving between practitioners.	
Safety of Clinical Care	Emergency Department Visits	Emergency Department Diversion Pilot Pilot has been implemented. In 2024,plan to expand the program to additional hospital partners.	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	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Scott Robinson	Manager of LTSS	LTSS	X	The program has not been operationalized due to negotiations with UCI regarding the BAA and data useage agreement. New goal is 1st quarter of FY 2024-2025.	Continue to work with CalOptima Health contract department and UCI to monitor progress on executing the agreement.	
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% from Q4 2023 by end of December 31,2024.	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.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Stacie Oakley Hannah Kim Scott Robinson	Joanne Ku	Utilization Management Case Management Long Term Care	X	• Established TCS support line for low-risk members • A TCS support line flyer with CalOptima Health and HN contact information developed • Revised EA's report that identifies TCS high-risk members • Updated TCS County In-patient psychiatric hospital process workflow • Explored a texting campaign leveraging the Usher platform • Developed texting campaign messaging	•Gather data/reports on trends for TCS KPI/IPP measures •Work with ECM Providers to obtain ECM reporting data for KPI 5 •Implement texting campaign using Ushur platform •Update DTPs as appropriate	

Evaluation Category	2024 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/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Caution Green - On Target
Program Oversight	2024 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Quality Improvement Health Equity Transformation Program (QIHETP) Description and Annual Work Plan will be adopted on an annual basis; QIHETP-QIHEC-BOD; Annual Work Plan-QIHEC-QAC	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Marsha Choo	Laura Guest	Quality Improvement	2024 QIHETP Description and Annual Work Plan was first adopted by BOD on 4/4/24. Revisions were made to the QIHETP and Work Plan and was approved by QAC on 6/12/24. 1. Updated QIHETP staffing and resources to reflect current organizational structure and renamed Equity and Community Health Department formaly known as the Population Health Management Department. 2. Updated section in the QIHETP to reflect current operational and workflows. 3. Added Cultural and Linguistic Appropriate Services Program to QIHETP as Appendix D. 4. Added cultural linguistic and health equity goals and planned activities to the QIHETP Annual Work Plan.	The revised 2024 QIHETP Description and Work Plan was submitted for BoD approval at the 8/1/24 meeting.	
Program Oversight	2023 Quality Improvement Program Evaluation	Complete Evaluation 2023 QI Program	Quality Improvement Program and Annual Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Marsha Choo	Laura Guest	Quality Improvement	2023 Quality Improvement Program Evaluation was approved by BoD on 4/5/24.	Goal was completed	
Program Oversight	2024 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2024 UM and CM Program Description	UM and CM Program will be adopted on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Kelly Giardina	Stacie Oakley/Jennifer Harlow	Utilization Management	The 2024 UM and CM Program was presented at the March 2024 BOD and approved	Goal Completed. Next steps not needed.	
Program Oversight	2023 Integrated Utilization Management and Case Management Program Evaluation	Complete Evaluation of 2023 UM CM Integrated Program Description	UM Program will be evaluated for effectiveness on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Kelly Giardina//Jennifer Harlow	Stacie Oakley	Utilization Management	The 2023 UM and CM Program Evaluation was presented at the March 2024 BOD and approved. Based on the approval of the 2023 UM/CM Program Evaluation, the 2024 UM/CM Program was written.	The 2024 UM/Program will be evaluated in Q1 2025.	
Program Oversight	Population Health Management (PHM) Strategy	Implement PHM strategy	Conduct the following: (1) Population Needs Assessment (PNA) (2) Risk stratification (3) Screening and Assessment (4) Wellness and prevention	PHMC report to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Katie Balderas	Barbara Kidder/Hannah KimHM/Director of Care Management	Equity and Community Health	1) PNA: Completed 2024 Population Needs Assessment Report Draft. Engaged with OCHCA to begin implementation of collaborative Community Health Assessment for 2027 and beyond.	1) PNA: Report 2024 PNA Key Findings to MAC, PAC, and PHMC; Publish 2024 PNA to CalOptima Health Website	
Program Oversight	2024 Population Health Management (PHM) Strategy Evaluation	Complete the Evaluation of the 2024 Population Health Managemet (PHM) Strategy	The Population Heath Management (PHM) Strategy will be evaluated for effectiveness on an annual basis.	QIHEC: 11/0520/24 QAC: 12/11/2024 Annual BOD Adoption by January 2025	Katie Balderas	Barbara Kidder/Hannah KimHM/Director of Care Management	Equity and Community Health	DHCS paused reporting on PHM Program Key Performance Indicators (KPIs) until they update technical specifications. Developing shared SMART Goals with OCHCA related to improving outcomes for Maternal Depression and Childhood Blood Lead poisoning.	Evaluation of goals and KPIs to be included in PHM Strategy Evaluation in Q4 2024.	
Program Oversight	2024 Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Cultural and Linguistic Services Program Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	Presented and approved in the June 2024 QAC meeting and set to go for Board approval in July 2024. The workplan was embedded in the QI workplan and also approved in the June 2024 QAC meeting.	Obtain BoD approval in July 2024.	
Program Oversight	2024 Cultural and Linguistic Services Program Evaluation	Complete the Evaluation of the 2024 Cultural and Linguistic Services Program	The Cultural and Linguistic Services Program will be evaluated for effectiveness on an annual basis.	QIHEC: 11/05/2024 QAC: 12/11/2024 Annual BOD Adoption by January 2025	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	No activities in April-June.	Evaluation assessment to begin Q3 or Q4 2024.	
Program Oversight	**Population Health Management (PHM) Committee** - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee activities, findings from data analysis, and recommendations to QIHEC	(1) PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), (2) PHM Strategy activities, and PHM Workplan progress and outcomes. (3) Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	PHMC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Barbara Kidder/Hannah Kim	Equity and Community Health	• Held second quarter PHM Committee Meeting in May 2024 which included both internal CalOptima Health updates on PHM Program and Community Spotlight on CHA/CHIP facilitated by OC HCA. • Provided PHM Committee update for QIHEC in June 2024. • Finalized the approval and reporting calendar, charter, and Policy GG. 1667. • Developed and published PHM Committee SharePoint site to house committee materials	• Continue to assists this committee by reviewing relevant guidance, agenda setting, and presentation development, and deliverables shared with QIHEC. • Next PHM Committee meeting is scheduled for August 2024 • Report committee update to QIHEC in September 2024	
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 activities, findings from data analysis, and recommendations to QIHEC	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. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Laura Guest	Marsha Choo Rick Quinones Katy Noyes	Quality Improvement	There remain five physicians undergoing the Fair Hearing process. Six PQI cases leveled 1, 2 or 3 were presented to CPRC. Two PQIs were brought back to CPRC and the physicians were recommended for an administrative termination. In Q2, 2024, PQI launched a new system to track PQI cases called Jiva. PQI reporting is still being developed, so trends will be reported when the reports are available. We can report that we have 629 open PQI cases. At the end of Q1, we completed the annual audit of contracted hospitals to ensure they have a policy and procedure for ensuring a 72 supply of medications at discharge. 10 hospitals were audited and all were in compliance. There were no new PPCs or OPPCs identifiefd in Q2. Two policies were presented: GG.1650 and GG.1651 with minor changes.	Two of the Fair Hearings are scheduled to commence in Q3, 2024. In Q3, 2024, we aim to have reporting available for PQI developed and be able to report trends for Q1 and Q2. We will continue to monitor claims data for PPCs and OPPCs.	
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 activities, findings from data analysis, and recommendations to QIHEC	The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health netwoks. Trends and results are presented to the committee quarterly. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Tyronda Moses	Heather Sedillo	GARS	GARS Committee met on May 14 to review the trends and actions taken for the trends identified in Q1. During that discussion the following were presented: **Program - Grievances:** Medi-Cal received 3,713 grievances in Q1 and 15,420 appeals/payment disputes = 19,133 OneCare Connect received 2 Grievances in Q1 and 99 appeals/payment disputes = 101 OneCare received 475 grievances in Q1 and 1098 appeals/payment disputes = 20,807 There were no HN over the NCQA threshold Trending Health Networks for MediCal included - CCN at 2.48 per 1000 MM; Heritage at 1.32 per 1000 MM and Optum at 1.31 per 1000 MM Trending Health Networks for OneCare included - Prospect at 7.8 per 1000 MM, Optum at 7.6 MM and CCN at 7.6 MM Top reasons included transportation delays, provider service and CalOptima Services. Both Access to Care and Member Billing both saw a decrease in the volume over Q4. **Appeals:** No trends identified in appeals. Overturn rate in Q1 was 32% and the overturn reasons were consistent with prior quarters - additional records received, medical criteria not applied on the initial review used at the appeal level to support the request and missing information not available at the initial review received at the time of appeal.	The department will continue to perform quarterly reviews to identify trends. This information will be presented to GARS Committee as opportunies to improve operations across the organization. The department will host the next GARS Committee meeting on August 14 to discuss trends identified and any remediation activities found in Q2 2024.	

Evaluation Category	2024 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/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Caution Green - On Target
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 activities, findings from data analysis, and recommendations to QIHEC	The MEMX Subcommittee reviews the annual results of CalOptima Health's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	MemX Committee report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Mike Wilson	~~Karen Jenkins/~~ Carol Matthews/Helen Syn	Quality Analytics	In Q2, MemX Committee met 5/22/24 and reviewed/discussed the following: •Charter review and Committee approved the updates •Created quarterly reporting schedule •Reviewed Behavioral Health Member Experience Survey Results •Timely Access: Appointment Availability and Telephone Access: Reviewed the number of Provider and HN CAPS issued and received and DHCS audit findings. •Network Adequacy: SNC 2023 submitted 1/19/24 and revisions and corrective action plans submitted on 5/3/24. CalOptima's next quarterly update is due 7/1/24. ANC: phase 1 ANC 2023 submitted 2/1/24 and phase 2 ANC 2023 submitted 3/20/24. NAV audit: pre-virutal audit activities completed March-May 2024. CalOptima's virtual audit-7/25/24. •Improve Member Experience: Reviewed current response rates for HN and Plan level CAHPS. •KPI Updates: All KPI's for Customer Service, Health Ed, GARS, UM and CM were presented and are being monitored and addressed in respective committees.	Q3 meeting is scheduled for: 7/16/24	
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 activities, findings from data analysis, and recommendations to QIHEC	UMC reviews medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. 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: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Kelly Giardina//Jennifer Harlow	Stacie Oakley	Utilization Management	Internal and External oversight monitoring established by the Bed Reduction Strategy sub work group and presented for approval at the 5/23/2024 UMC Committee. The goals were approved by the committee. Utilization information will continue to be shared in UMC meetings to monitor these goals going forward. The UMC Committee information was presented to QIHEC at the 6/11/2024 meeting.The Committee information will be presented next in September.	On track - UMC scheduled for 8/22 where information will be reviewed, and next report out scheduled for September QIHEC meeting.	
Program Oversight	**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee activities, findings from data analysis, and recommendations to QIHEC	WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	WCM CAC report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	T.T. Nguyen, MD/H.Kim	Gloria Garcia	Medical Management	WCM CAC met 5/20/2024. They approved the 2/20/2024 meeting minutes and submitted a copy to QIHEC. WCM CAC uninamously voted to keep meeting virtually. The WCM CAC Charter updates were approved. Dr. Wyman Lai CHOC CCS representative resigned from serving on WCM CAC. Dr. James Chu, from CHOC is being considered to replace Dr. Lai. The Committee reviewed WCM data, pediatric quality improvement measures, pediatric CalAIM services.	CalOptima Health staff will continue active monitoring of WCM Health Network adequacy, collaboarte with quality improvement staff on quality improvement strategies. Pediatric Risk Stratification Process (PRSP) monitoring will be reported at the next WCM CAC meeting scheduled for August 20, 2024.	
Program Oversight	Care Management Program	Report on key activities of CM program, analysis compared to goal, and improvement efforts	Report on the following activities: Enhanced Care Management (ECM) Complex Case Management (CCM) Basic PHM/CM Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM Transitional care services	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Megan Dankmyer	TBD	Medical Management	Enhanced Care Management (ECM): a)CalAIM ECM provider report documenting Lead Care Managers in CalOptima Connect showed an improvement from 3% to 44%. This ensures the Lead Care Manager is notified of any admissions. Expectation moving forward is to have ECM Providers continue to document accurately. Complex Case Management (CCM) a) NCQA Accreditation Audit-passed 100% b) Continue Monthly NCQA file audit for CCN and Health Networks. Basic PHM/CM: Case Management's quarterly audit for MOC for delegated Health Networks. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) a) CM: Implemented a multi-department work group to discuss EPSDT requirements meetings on 5/21/2024 and 7/1/2024. b) Health Network training 4/18/2024 on EPSDT. Transitional care services: a) Refer to Row 61 for TCS Updates. b) IT support for reporting to analyze outcomes on TCS response pending Phase II Jiva remediation c) Sharing of TCS qualifying discharge events with ECM providers to track successful outreach	Report on the following activities: Enhanced Care Management (ECM): a) Safety Net Connect to create self-reporting tool for Lead Care Manager to share contact information. Complex Case Management (CCM): a) Continue monthly NCQA file audits for CCN and HN members open to CCM level of care. Basic PHM/CM: Continue quarterly audits of delegated Health Networks for MOC oversight. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM: a) continued workgroup to discuss requirements for EPSDT Transitional care services: a) See Row 61 for TCS updates. b) Outcome analysis of Health Networks for JOMS presentation pending IT support post JIVA Phase II remediation. c) continued requests to ECM providers for information on TCS outreach day 1-7 post qualifying discharge event.	
Program Oversight	Delegation Oversight	Implement annual oversight and performance monitoring for delegated activites.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accredication standard compliance that, at minimum, include comprehensive annual audits.	Report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Monica Herrera	Zulema Gomez John Robertson	Delegation Oversight	Delegate: Family Choice Health Services/Conifer Health Solutions (MSO) (83) Family Choice Medical Group/Conifer Health Solutions (MSO) (21) Area(s) Assessed: Case Management; Claims; Compliance; Credentialing; Customer Service; Provider Network Contracting; Provider Relations; Sub-Contractual; Utilization Management Corrective Action Plan(s) Issued: Claims (Medi-Cal) – Accepted & Closed Compliance, Staff Initial Training (All Lines of Business) - Accepted & Closed Customer Service (All Lines of Business) – Monitoring Utilization Management, Concurrent Review (Medi-Cal) – Monitoring Utilization Management, Expedited & Standard Denials (Medi-Cal) – Monitoring Utilization Management, Physician Administered Drugs (All Lines of Business) – Accepted & Closed Utilization Management, Notice of Medicare Non-Coverage (OneCare) – Accepted & Closed Utilization Management, ODAG Denials (OneCare) – Monitoring Utilization Management, Physician Administered Drugs (All Lines of Business) – Accepted & Closed	Continue to monitor CAPs in "Monitoring" status through acceptance & closure.	
Program Oversight	Disease Management Program	Implement Disease Management	Report on the following activities: Evaluation of current utilization of disease management services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Elisa Mora	Equity and Community Health	1) A 2 way text messages targeting members with asthma was implemented on 6/19/2024. In responding to the text, there were 232 members that requested a call back from a health coach. 2) A column was added to the monthly diabetes stratification results identifying members with Chronic Kidney Disease Stage III and IV. 3) Currently piloting stratification/segmentation data from PointClickCare to identify members with Congestive Heart Failure and from Decision Point Opus to identify members with Asthma for outreach by the health coaches. 4) Monitoring the bi-monthly New Member Mailing for low-risk members with asthma and diabetes taking place since February 2024. 5) Collaboration with CalAIM to refer asthma members to the Asthma Housing Remediation Community Supports program. 6) Process has been established between the CalOptima Health Pharmacy department to conduct the medication therapy management for members receiving health coaching and interventions from Registered Dietitians. 7) CalOptima Health RDs are able to assess and submit their own Medically Tailored Meals referrals for qualifying members.	1. A new risk stratification has been proposed for the chronic condition programs pending approval from the leadership team. 2. Working toward expending the Diabetes Prevention Program services. Currently, working to identify vendors. 3. Plan to initiate Registered Dietitian Member Satisfaction Survey via text message. 4. Plan to create separate condition-specific assessment in Jiva to identify members enrolled by conditions.	
Program Oversight	Health Education	Implement Health Education Program	Report on the following activities: (1) Evaluation of current utilization of health education services (2) Maintain business for current programs and support for community. (3) Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Anna Safari/Katie Balderas	Thanh Mai Dinh	Equity and Community Health	1) Evaluation of current utilization of health education services: -Most incoming referral are for weight control but hypertension continues to be one of the top health conditions. Exploring ways to target members who have high blood pressure, and to include efforts for making the blood pressure monitors more easily accessible as a covered benefit. 2) Maintain business for current programs and support for the community: -Expanded community classes and added ongoing Tuesdays and Thursdays virtual Zoom classes in English and Spanish. 3) Improve the process of handling member and provider requests: -Working on implementing a member self-referral form so that members can direly refer to health and wellness services.	**1)** Exploring available services, blood pressure cuff utilization among members, contracted pharmacies locations and major gaps in services for members with hypertension. **2)** Promoting community classes via a new standalone class flier, and exploring school interests for further collaboration with new community locations and potential new topics. **3)** Seeking member feedback on the draft referral form.	

Evaluation Category	2024 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/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Caution Green - On Target
Program Oversight	Health Equity	Identify health disparities Increase member screening and access to resources that support the social determinants of health Report on quality improvement efforts to reduce disparities	Assess and report the following activities: 1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	By December 2024 Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Katie Balderas	Barbara Kidder	Equity and Community Health	(1) SDOH Member assessment went live in the Member Portal and we continued to build out the assessment for integration into JIVA (2) Fully executed contract with FindHelp as the selected closed-loop referral vendor and working with JIVA for integration (3) HL4E certificate program continues through the end of the year to allow staff to complete their certifications. Currently, 73 out of 164 staff have completed their certification program. Four CalOptima Health staff participated in the Teach-back method Train the Trainer training.	(1) Update SDOH assessment in the Member portal to reflect updates done as part of the SDOH assessment integration into JIVA (2) Continue to work on integration of the closed-loop referral system into JIVA (3) Continue to encourage staff to complete their mini-credentials to earn their certification. Develop a Teach -Back method module to train new member facing staff as part of their onboarding process	
Program Oversight	Long-Term Support Services (LTSS)	95% compliance with TAT	CalAIM Turnaround Time (TAT): Determination completed within 5 business days CBAS Inquiry to Determination (TAT): Determination completed within 30 calendar days CBAS Turnaround Time (TAT): Determination completed within 5 business days LTC Turnaround Time (TAT): Determination completed within 5 business days	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Scott Robinson	Cathy Osborn	Long Term Care	CalAIM TAT: Met - 99.68% CBAS TAT: Met 99.66% CBAS Inquiry to Determination TAT: Met - 100% LTC TAT: Met 99.93%	Continue to monitor TAT.	
Program Oversight	National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by January 1, 2026	1) Implement activites for NCQA Standards compliance for HPA and Health Plan Renewal Submission by April 30, 2024. 2) Develop strategy and workplan for Health Equity Accreditation with 50% document collect for submission.	1) By April 30, 2024 2) By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Veronica Gomez	Marsha Choo	Quality Improvement	1) **HP Accreditation:** Successfully submitted all required documents by the submission deadline of 4/30/2024. Completed Virtual File Review with NCQA Surveyors on UM Appeals, UM Denials (BH, Pharmacy, Credentialing/Recred), and Complex Case Management (CCN and Delegates). We scored 100% on all File review elements. 2) **HE Accreditation**: initial GAP analysis report received on preliminary discovery meetings. Health Equity Workstreams Kick-Off meetings with project managers. Health Equity Guidelines and Elements Training. Currently building systems and processes (workstreams) in preparation for new GAP analysis meetings. 3) **NCQA Consultants:** Contracted with new NCQA Consultants Health Management Associates (HMA) to assist with the initial accreditation of 2025 Health Equity (HE) and 2027 Health Plan (HP) re-accreditation. Preliminary results indicate CalOptima Health met the required points to maintain NCQA HP Accreditation status.	1) **HP Accreditation**: Pending final report and decision letter from NCQA. Quality Improvement (QI) will develop a remediation plan for elements/factors missed. Share CalOptima Health's final HP accreditation results to the Oct QIHEC. 2) **HE Accreditation**: Schedule a meeting with PMs and new consultants for a new GAP Analysis. Submit Application for NCQA HE Survey by 9/2024. 3) **NCQA Consultants:** Kick-off meeting with new NCQA consultants scheduled July 24th.	
Program Oversight	OneCare STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts.	By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/11/2024 Q4: 10/08/2024 Q1: 01/14/2025	Mike Wilson	Kelli Glynn	Quality Improvement	Created monthly workgroups for Operations, Equity and Community Health, Case Management / Utilization Management / Behavioral Health, and Pharmacy. Created process metrics and deliverables for all workgroups. Created glidepaths for all measures with monthly targets to track performance to goal (4 or 5 Stars). Created call scripts and workflow for the Case Management team to begin member outreach for the OMW measure. Ongoing telephonic outreach to members across multiple measures via vendor Carenet. All measures are performing better in 2024 as compared to same time last year except for OMW.	Continue with plan as listed.	
Program Oversight	Value Based Payment Program	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) Will share HN performance on all P4V HEDIS Measures via prospective rates report each month. 2) Will share hospital quality program performance	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Mike Wilson	Kelli Glynn	Quality Analytics	There have been delays in sending monthly HN performance for P4V measures. Quality improvement grant process is on track.	Confer with the HEDIS team re: P4V reporting. Release the Medi-Cal NOFO as planned in Q3, and the OneCare NOFO as planned in Q4.	
Program Oversight	Quality Performance Measures: Managed Care Accountability Set (MCAS) STAR measures	Track and report quality performance measures required by regulators	Track rates monthly Share final results with QIHEC annually	Report program update to QIHEC Q2: 05/14/2024 Q3: 08/13/2024 Q4: 11/05/2024 Q1 02/11/2025	Paul Jiang	Terri Wong	Quality Analytics	HEDIS MY2023 preliminary rates reported to May QIHEC.FUA and FUM measures are below the MPL.	Final rates will be presented to QIHEC in August.	
Program Oversight	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: 1 Implement SBHIP DHCS targeted interventions 2. Bi-quarterly reporting to DHCS	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Sherie Hopson	Behavioral Health Integration	1) SBHIP Partners completed and sent their Q2 progress reports - first of 10 OCDE/CHOC WellSpaces installed; grand opening held on May 3rd at Marco Forster Middle School. 2) SBHIP Partners Meetings include Kaiser; SBHIP Collaboration Meeting with OCDE, and their mental health leaders have been scheduled for 2024-25. 3) Prepared 4 DHCS Biquarterly Reports for June submission. 4) June the 2nd SBHIP payment/check request was completed and issued to CHOC, HAZEL, OCDE, and WYS. 5) Reviewed and approved 14 OCDE school district budget plans. 6) Hazel Health began sending monthly dashboards showing the number of referrals and student visits	1) Individual meetings with CHOC, HAZEL, WYS, and OCDE to review their SBHIP-funded project level of implementation for the remainder of the program. 2) CalOptima Health will be represented at the OCDE Mental Health Summit on August 22. 3) Discuss and confirm the installment dates for the remaining WellSpaces with CHOC. 4) Review the school-based mental health training curriculum with WYS 5) Priority topics selected with OCDE for the SBHIP Collab Meeting (plan for end-of-year accomplishments	
Program Oversight	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	Assess and report the following: 1) Establish the Comprehensive Community Cancer Screening and Support Grants program 2) Work with vendor to develop a comprehensive awareness and education campaign for members.	Report Program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Katie Balderas	Barbara Kidder	Equity and Community Health	1) Reviewed, scored and selected 15 grant proposals for Board approval recommendation. Timeline for Board approval moved from June to August 2024. 2) Insight from the stakeholder sessions informed campaign strategy and approach, and staff is currently engaged with marketing firm in the development of creative concepts.	1) Subject to Board approval and contracting process, implementation of grant activities is expected to commence in September 2024. 2) Campaign soft launch is anticipated for Fall 2024.	
Quality of Clinical Care	Preventive and Screening Services	Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS) MY 2024 Goals: CCS: MC 59.85% BCS-E: MC 62.67% OC 71% COL: OC 71%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/5/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Quality Analytics	1. Member Health Reward:CCS:MC 290; BCS:MC 136; BCS:OC 20; COL: OC 7 2. CCS Mailing: 127,684 members; COL mailing 535 members; Text Campaign: CCS 85014 members; BCS MC 25538 members OC 1455; MC/OC live call campaign 3. Continuation of CCN OC COL GI outreach pilot program 4. Planning Phase for CCN Cologuard Project with Exact Sciences 5. May 2024 Prospective Rate Data: CCS: MC 38.27% BCS: MC 43.75%; BCS: OC 56%; COL: OC 52%	1. Continue to track CCS, BCS MC OC, COL OC member health reward 2. Continue member outreach campaigns: Mailing, IVR, text and MC/OC live call campaigns 3. Continue to monitor CCN OC COL GI outreach pilot program. 4. Kick off CCN Cologuard Project with Exact Sciences	
Quality of Clinical Care	EPSDT Diagnostic and Treatment Services: ADHD Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare Appropriate Use Of Psychotropic Medications	Follow-Up Care for Children Prescribed ADHD medication (ADD) HEDIS MY2024 Goal: MC - Init Phase - 44.22% MC -Cont Phase - 50.98%	Assess and report the following activities: 1) Work collaboratively with the Communications department to Fax blast non-compliant providers letter activity (approx. 200 providers) by second quatre. 2) Participate in provider educational events, related to follow-up visits and best practices. 3) Continue member outreach to improve appointment follow up adherence. a. Monthly Telephonic member outreach (approx. 60-100 mbrs) b. Member Newsletter (Fall) c. Monthly Member two-way Text Messaging (approx. 60-100 mbrs) 4) Member Health Reward Program 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Valerie Venegas	Behavioral Health Integration	PR HEDIS RATES Q2 (May): Initiation Phase-46.50% Continuation and Maintenance Phase- 52.08% 1) Approved for printing vendor for printed flyers to send out for Member Health rewards. 2) Member Health reward approved by DHCS and added to CalOptima Health Website for members to access. 3) Text Messaging outreach to members sent May and June	1) Q3 data will be pulled to initiate fax blast for Non-Compliant Providers Provider best practices letter and tip-sheet to non-compliant providers. 2) Mail out Member Health Rewards flyer to eligible members. 3) Continue monthly data pull for text messaging campaign.	

Evaluation Category	2024 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/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Caution Green - On Target
Quality of Clinical Care	Health Equity/Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Prevention Programs For Behavioral Healthcare	Improve Adverse Childhood Experiences (ACES) Screening	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/052/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Behavioral Health	1) ACEs presentation to inform the group of our progress as a Health plan and educate on the importance of this screening given by BHI Executive Director at the BHQI Workgroup Meeting in April.	1) Continue collaborative meetings between teams to identify best practices to implement. 2) Continue Provider and member education. 3) Continue to participate in the ACEs stakeholder meetings.	
Quality of Clinical Care	Mental Health Service: Continuity and Coordination Between Medical Care and Behavioral Healthcare	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS MY2024 Goals: Blood Glucose-All Ages:58.43% Cholesterol-All Ages: 40.50% Glucose and Cholesterol Combined-All Ages: 39.01%	Assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primay Care Providers (PCP) for members in need of merabolic 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 the next top 50 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, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Behavioral Health Integration	PR HEDIS RATES Q2 (May) : Blood Glucose all ages: 29.61%, Cholesterol all ages: 16.75%, Glucose & Cholesterol Combined all ages: 16.10% 1) Barriers included: Receiving timely data and accurate information. a)Submeasure names for this measure changed in 2024, causing delay in receiving data. 2) Identified members prescribed antipsychotic medication still in need of diabetes screening, cholesterol screening, and both cholesterol and diabetes screening test through Tableau Report. 3) The following materials have been disseminated to Providers: a) Provider Best Practices Letter. b) APM Provider Tip Sheet. 4) Collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 5) Mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to the next top 50 providers on a monthly basis. 6) Text Messaging Campaign	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Continue data pull for text messaging campaign. 3) Continue mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to the next top 50 providers on a monthly basis. 4) Continue with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis.	
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Appropriate Diagnosis, Treatment And Referral Of Behavioral Disorders Commonly Seen In Primary Care	Antidepressant Medication Management (AMM) HEDIS MY2024 Goal: Acute Phase - 74.16% Continuation Phase - 58.06%	Assess and report the following activities: 1) Educate providers on the importance of follow up appointments through outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 2) Educate members on the importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 3) Track number of educational events on depression screening and treatment.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/052/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Mary Barranco	Behavioral Health Integration	PR HEDIS RATES Q2 (May) :Effective acute Phase Treatment: 63.60%, Effective Continuation Phase Treatment: 39.66% 1) Worked with Quality Analytics/Finacial Analysis team to delvelop a data report 2) Drafted following materials: a) Text Messaging script 1. Aproved by DHCS b) Drafted AMM Provider Tip Shee	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Send out Text Messaging campaign. 3) Submit Provider Best Practices Letter for internal review process.	
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare - Severe And Persistent Mental Illness	Diabetes Monitoring For People With Diabetes And Schizophrenia (SMD) HEDIS MY2024 Goal: 76.66%	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Behavioral Health Integration	PR HEDIS Rates Q2 (May): M/C:45.33% OC: N/A 1) We are currently monitoring this measure. 2) Member Fall Newsletter for members.	1) Continue to monitor prospective rates on a monthly basis. 2) Continue collaborative meetings between teams to identify best practices to implement.	
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Exchange of Information	Follow-Up After Emergency Department Visit for Mental Illness (FUM) HEDIS MY2024 Goal: MC 30-Day: 60.08%; 7-day: 40.59% OC (Medicaid only)	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) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz	Behavioral Health Integration	PR HEDIS Rates Q2 (May): 30 day- 22.66%, 7 day- 12.72% 1) The main barrier has been not having the bandwidth for outreach to members that we have been receiving on a daily basis. 2) Working with vendor to create a cohort report of FUM data only. 3) sFTP folders have been established and BH ED data is being sent to Health networks on a daily basis. 4) Bl-weekly Member text messaging. 5) Artcle emphasizing importance of Follow up appointment after ED visit created and will be included in Spring Member Newsletter.	1) Pull data for Data Analyst to send out bi-weekly text messages based on real time ED data. 2) BHI is in the process of developing and implementig a Pilot project for CCN members identified who meet FUM criteria. BH Telehealth provider to conduct the outreach and assist with member linakge. 3) Collaborate with NAMI to share real-time ED data for member outreach. 4) Collaborate with Telemed2U vendor and internal ITS team to develop implementation plan for Member Outreach.	
Quality of Clinical Care	Mental Health Services:Continuity and Coordination Between Medical Care and Behavioral Healthcare- Management Of Coexisting Medical And Behavioral Conditions	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) HEDIS 2024 Goal: MC 77.40% OC (Medicaid only)	Assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collabortively 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.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Nathalie Pauli	Behavioral Health Integration	PR HEDIS Rates Q2 (May): M/C:46.75% OC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test through Tableau Report. 2) Conducted a text message campaign to reach out to members re: getting their glucose lab screening. 3) Barriers included: Receiving timely data, obtaining the correct contact information for members such as phone numbers. 4) Member Health reward approved by DHCS and added to CalOptima Health Website for members to access. 5) Mailed out Member Health reward flyer to eligible members. 6) Met with Quality Analytics Team to discuss data sourcing automation for Tableau on a monthly basis 7) Member Fall Newsletter for members.	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 data pull for text messaging campaign 4) Mail out member health rewards flyer to eligible members. 5) Mail out to top 60 providers with the following: - Medical Director Letter - List of members/patients in need of screening - Provider Tool Tip Sheet	
Quality of Clinical Care	Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects	Non Clinical PIP:Improve the percentage of members enrolled into care management, Caloptima Helath 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 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Jeni Diaz/Mary Barranco	Behavioral Health Integration/ Quality Analytics	Conduct quarterly/Annual oversight of MC Non Clinical PIPs (Jan 2023 - Dec 2025) Improve the percentage of members enrolled: Baseline Measurement Period: 01/01/23-12/31/23 Remeasurment 1 Period : 01/01/24 -12/31/24 Remeasurment 2 Period : 01/01/25-12/31/25	1) Working with Caloptima Health Vendor to receive Real-Time ED data on a daily basis for CCN and COD members. 2) BHI is in the process of developing a Pilot project for CCN members identified who meet FUM/FUA criteria. Telehealth provider will conduct the outreach to members who meet FUM criteria and assist with linkage. Internal BHI PCC's to conduct outreach to members meeting FUA criteria and assist with linkage. Vendor and PCC's will also provide information about case managment including ECM and referrals. 3) Develop outreach and outcome data related to the percentage of members enrolled in CCM and ECM for CCN members identified who meet FUM/FUA criteria for the duration of each measuremnt period. 4) Work in collabration with internal Privacy dept to ensure compliance of data sharing with vendor.	
Quality of Clinical Care	Substance Use Disorder Services	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) MY2024 Goals: MC: 30-days: 36.34%; 7-days: 20.0%	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) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Diane Ramos/ Natalie Zavala/Carmen Katsarov	Valerie Venegas	Behavioral Health Integration	PR HEDIS Rates Q2 (May): 30-Day- 19.29%, 7-Day-9.94% 1) Sharing real-time ED data with our Health Networks on a sFTP Site. 2) Bi-weekly member text messaging 3) Member Newsletter Spring edition	1) Data anaylst scrub data for bi-weekly text messaging. 2) BHI is in the process of developing and implementig a Pilot project for CCN members identified who meet FUA criteria.	

Evaluation Category	2024 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/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED) MY2024 HEDIS Goals: MC 66.33% OC: 81%;	Assess and report the following activity: 1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	By December 2024 Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Quality Analytics	1. Member Health Reward: EED:MC 73; EED:OC 13 2. Text Message Campaign: MC 22254; OC 1190 3. EED VPS mailing for Jan to Jun: MC 3013; OC 988 4. VSP data sharing with HN kickoff 5. February 2024 Prosepctive Rate Data: EED: MC 35.36%; EED: OC 51%	1. Continue to track EED MC OC member health reward. 2. Continue member outreach campaigns: mailing, IVR, text and OC live call campaigns. 3. 2 way text message campaigns for diabetes by line of business 4. Finalize VSP data sharing with HN for production	
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better) MY2024 Goals: MC: 29.44%; OC: 20%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts	Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Melissa Morales/Kelli Glynn	Quality Analytics	1. Member Health Reward: HBD:MC 90; HBD:OC 25 2. Text Message Campaign: MC 22254; OC 1190 3. February 2024 Prosepctive Rate Data: HBD PC: MC 77.34%; HBD PC:76% OC	1. Continue to track HBD MC OC member health reward. 2. Continue member outreach campaigns: mailing, IVR, text and OC live call campaigns. 3. 2 way text message campaigns for diabetes by line of business	
Quality of Clinical Care	Maternal and Child Health: Prenatal and Postpartum Care Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). HEDIS MY2024 Goal: Postpartum: 82.0% Prenatal: 91.07%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Ann Mino/Mike Wilson	Leslie Vasquez/Kelli Glynn	Equity and Community Health/ Quality Analytics	Member Initiatives: - Bright Steps Program - Member Health Reward for postpartum care Community Initiatives - Prenatal social media ads May 2024 Prospective Rate: Timeliness of Prenatal Care: 67.74%, performing slightly lower than this same time last year. Postpartum Care: 63.19% performing slightly higher than this same time last year.	Planned: Maternal health workgroup meeting in Q3. Continue with public awareness and educaiton campaigns (e.g., radio digital, social media).	
Quality of Clinical Care	Maternal and Adolescent Depression Screening	Medi-Cal Only - Meet the following goals For MY2024 HEDIS: DSF-E Depression Screening and Follow-up for Adolescent and Adults - Screening: 2.97% PND-E Prenatal Depression Screening and Follow-up - Screening: 8.81% PDS-E Postpartum Depression Screening and Follow-up: 27.77%	1) Identification and distribution of best practices to health network and provider partners. 2) Provide health network and provider partners with timely hospital discharge data specific to live deliveries to improve postpartum visit completion. 3) Targeted member engagement and outreach campaigns in coordination with health network partners. 4) Provider education (CE/CME) in Q3.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson/Natalie Zavala	Kelli Glynn/Diane Ramos	Operations Management/ Behavioral Health Integration	**Maternal** Timely identification: QA has a maternal health workgroup planned for Q3 to discuss member journey and data management which is inclusive of early identification of members for postpartum visit. Prenatal Depression Screening and Follow Up and Postpartum Depression Screening and Follow Up are new measure that will be held to the MPL beginning MY2025. Prenatal Depression Screening: 6.74% Prenatal Screening Follow Up: 90% Postpartum Depression Screening: 10.35% Postpartum Screening Follow Up: 66%	Planned: Maternal health workgroup meeting in Q3. Fall 2024 Medi-Cal member newsletter article "Let's Talk About Mental Health and Pregnancy"	
Quality of Clinical Care	Blood Lead Screening	HEDIS MY2024 Goal: 67.12%; Improve Lead Screening in Children (LSC) HEDIS measure.	Assess and report the following: Strategic Quality Initiatives Plan to increase lead testing will consist of: 1) A multi-modal, targeted member approach as well as provider and health network collaborative efforts 2) Partnership with key local stakeholders 2024 Member Quality Initiatives will consist of the following but not limited to: - Member health reward and monitoring of impact on LSC HEDIS rate - IVR campaign to - Texting campaign - Mailing campaign - Lead texting campaign for members - Medi-Cal member newsletter article(s) In partnership with the Orange County Health Care Agency, CalOptima Health will co-develop educational toolkit on blood lead testing.	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Leslie Vasquez/Kelli Glynn	Quality Analytics	**Member Facing Initiatives:** - May: Launched an SMS text campaign via mPulse to encourage lead testing. - June: Launched telephonic outreach via CareNet vendor for members that are due for lead testing based on HEDIS and state testing requirements. - June: Launched 2-way SMS via Ushur for multiple pediatric age groups as part of pediatric wellness campaign. - Member health reward for members that test for lead at 12 months and 24 months of age. **Widespread Education Efforts:** May: PBS TV ad and radio ad for blood lead screening **Provider Facing Initiatives:** May: Presented at community health clinic forum on optimizing EMR processes to support state lead requirements. June: Developed provider facing education "Stay Compliant with State-Issued Lead Requirements." June: Email blast to providers who provide care to members ages 0-6. Email blast contained *Stay Compliant with State-Issued Lead Requirements* guide, informed providers of available health rewards including sample form, and attached OC HCA form to order free lead based educational materials for members. HEDIS measure is performing slightly higher than this same time around last year. March 2024 rate: 60.54%, MPL is 62.79%. Measure has not met MPL, therefore highlighted in yellow.	Continue with plan as listed. Planned: - Fax blast to providers to share lead based education - Continue with CareNet member outreach - CE/CME for in support of lead testing	
Quality of Clinical Care	EPSDT/Children's Preventive Services: Pediatric Well-Care Visits and Immunizations	HEDIS **MY2024** Goal CIS-Combo 10: 45.26% IMA-Combo 2: 48.80% W30-First 15 Months: 58.38% W30-15 to 30 Months: 71.35% WCV (Total): 51.78%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Early Identification and Data Gap Bridging Remediation for early intervention.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Michelle Nobe/Kelli Glynn	Quality Analytics	Launched 2-way SMS via Ushur for multiple pediatric age groups (launched on 6/20/24 and outreached to 4,292 members). Presented well-child visit best practices during the June monthly Community Clinic forum. Launched telephonic outreach via vendor Carenet. CIS performance is behind as compared to same time last year; as such, metric listed as yellow - concern. W30 performance is ahead of same time last year.	Continue with plan as listed and explore provider-facing education around parent declination for vaccines and parent-facing education around the importance of preventive care / well-child visits.	
Quality of Clinical Care	Quality Improvement activities to meet MCAS Minimum Performance Level	Meet and exceed MPL for DHCS MCAS	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits. Perform root cause analysis, strategize and execute planned interventions targeting members, providers and systems.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Michelle Nobe/Kelli Glynn	Quality Analytics	Launched 2-way SMS via Ushur for multiple pediatric age groups (launched on 6/20/24 and outreached to 4,292 members). Presented well-child visit best practices during the June monthly Community Clinic forum. Launched telephonic outreach via vendor Carenet.	Continue with plan as listed and explore parent-facing education around the importance of preventive care / well-child visits.	
Quality of Clinical Care	Encounter Data Review	Conduct regular review of encounter data submited by health networks	Monitors health network's compliance with performance standards regarding timely submission of complete and accurate encounter data.	Semi-Annual Report to QIHEC Q2: 04/09/2024 Q4: 10/08/2024	Kelly Klipfel	Lorena Dabu	Finance	No activities in April-June	N/A	
Quality of Clinical Care	Facility Site Review (including Medical Record Review and Physical Accessibiltiy Review) Compliance	PCP and High Volume Specialist sites are monitored utilizing the DHCS audit tool and methodology.	Review and report conducted initial reviews for all sites with a PCP or high volume specialists and a review every three years. Tracking and trending of reports are reported quarterly.	Update volume from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025 Compliance details to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Marsha Choo	Katy Noyes	Quality Improvement	FSR/MRR/PARS, NF and CBAS Oversight A. FSR: Initial FSRs=18; Initial MRRs=13; Periodic FSRs=61; Periodic MRRs=66; On-Site Interims=19; Failed FSRs=3; Failed MRRs=13 CAPs: CE=39; FSR=54; MRR=64; 60 Periodic FSRs completed before 36 month due date. B. PARS Competed PARS=114 (Basic Access=49/43% Limited Access=65/57%) C. CBAS: Critical Incidents=23; 22 Critical Incidents reported were COVID cases. Non-Critical Incidents=14; Falls=3; Completed Audits=10: CAPs=; Unannounced Visits=0 D. NF: Critical Incidents=1; On-Site Visits=8; Unannounced Visits=2	Continue with plan as listed.	

Evaluation Category	2024 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/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Caution Green - On Target
Quality of Clinical Care	Potential Quality Issues Review	Referred quality of care grievances and PQIs are reviewed timely	Review and report conducted referred cases are properly reviewed by appropriate clinical staff, cases are leveled according to severity of findings, and recommendations for actions are made, which may include a presentation to the CPRC for peer reviewed.	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Laura Guest	Quality Improvement	There remain five physicians undergoing the Fair Hearing process. Six PQI cases leveled 1, 2 or 3 were presented to CPRC. Two PQIs were brought back to CPRC and the physicians were recommended for an administrative termination. In Q2, 2024, PQI launched a new system to track PQI cases called Jiva. PQI reporting is still being developed, so trends will be reported when the reports are available. We can report that we have 629 open PQI cases.	Two of the Fair Hearings are scheduled to commence in Q3, 2024. In Q3, 2024, we hope to have reporting available for PQI developed and be able to report trends for Q1 and Q2. An open position for a RN for PQI has been recruited and the individual is expected to begin in early Q3.	
Quality of Clinical Care	Initial Provider Credentialing	All providers are credentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements and are current within 180 days of review and approval (60 days for BH providers)	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Rick Quinones	Quality Improvement	Initial BH Credentialing Q2 = 71; Initial CCN Credentialing Q2 = 59. For Q2 we did not have any initial credentialing files out of compliance.	Initial credentialing: 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 credentialling.	
Quality of Clinical Care	Provider Re-Credentialing	All providers are re-credentialed according to regulatory requirements	Review and report providers are re-credentialed within 36 months according to regulatory requirements	Update from CPRC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Marsha Choo	Rick Quinones	Quality Improvement	BH Recredentialing - Q2 =23; CCN Recredentialing Q2 =99. For Q2 we did not have any recredentialing files out of compliance.	Recredentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the recredentialing of providers. This will ensure that we continue with compliance and timeliness of the recredentialling files.	
Quality of Clinical Care	Chronic Care Improvement Projects (CCIPs) OneCare	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	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 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Melissa Morales/Kelli Glynn	Quality Analytics	1. Health Coaches began calls from emerging risk call list.	1. Continue calls and refresh data. 2. Review completed assessment.	
Quality of Clinical Care	Special Needs Plan (SNP) Model of Care (MOC)	% of Members with Completed HRA: Goal 100% % of Members with ICP: Goal 100% % of Members with ICT: Goal 100%	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implmentation and monitoring.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	S. Hickman/M. Dankmyer/H. Kim	QI Nurse Specialist	Case Management	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. a) Core Report CC0258 continues in phase II Jiva Remediation for ICT/ICP/HRA data. b) Q1 DHCS reporting for HRA1 and ICP1 submitted to DHCS reflecting for HRA1 members who were reached and willing to complete HRA at 100%; for ICP1 members who were reached and willing to complete ICP at 64%. c) as 6/30/2024 41% of HRAs comleted to date achieving two star rating d) ICT rates pending Jiva Phase II remediation 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. a) Communications to CCN and Health Networks in April and May on ICP development status for newly effective members Q1 and Q2. b) Addition of annual ICP development status on April and May file. c) Communication of ECM-Like eligibility and members missing face-to-face interaction 3) Creation and implementation of the Oversight audit tool. a) Ongoing quarterly audits of delegated health networks.	Assess and report the following activities: 1)Continu to use monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. a) Core Report CC0258 remediation should be completed by 8/30/2024 b) Q2 DHCS reporting for HRA1 and ICP1 will be submitted by 8/30/2024. CM will share adjusted score for both HRA1 and HRA2 of members who were reached and willing to complete HRA and ICP. c) Share % of HRAs completed to date per HRA Star Dashboard. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. a) Continue communications to CCN and Health Networks for ICP1 development status for newly effective members Q2 and Q3. b) Continue to provide feedback on annual ICP development and missing face-to-face interactions. 3) Creation and implementation of the Oversight audit tool. a) Ongoing quarterly audits of delegated health networks.	

Evaluation Category	2024 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/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Caution Green - On Target
Quality of Service	Improve Network Adequacy: Reducing gaps in provider network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network 2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	1) Mike Wilson 1)Quynh Nguyen 2) Tory Vazquez 3) Jane Flannigan Brown	Mahmoud Elaraby Provider Relations	Contracting	1. Hlred PM 2. Established process for gap closure with Health Networks not meeting time and distance requirements 3. Closed CAPS for 2 health networks with Time and Distance gaps Transition - QI finalizizing transition plan	>Finalize transition plan, develop priorities of transition > Implement processes for network adequacy programs > Set up network adequacy workgroups to review gaps and trends	
Quality of Service	Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Assess and report the following activities: 1) Issue corrective action for areas of noncompliance 2) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely acces. 3) Continue to educate providers on timely acces standards 4) Develop and/or share tools to assist with improving access to services.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Karen Jenkins/Helen Syn	Quality Analytics	2023 CAP Responses: •In Q2, Timely Access workgroup/subgroup reviewed 8 (out of 11) HN CAP responses received. •Of the 117 Timely Access CAPs issued to individual providers, a total of 71 responses received by Q2, two termed and one provider passed away. June 2024, mailed approx 1400 non-compliance letters to individual providers based on the 2023 Access Survey (9/26-12/1/2023). •Education letters: 1034 •Warning letters: 281 **•Escalation/CAP letters: 110** RFP in the works for potential new vendor in 2025 and process will include additional surveying of those initially found non-compliant with annual survey. In June 2024, CareNet conducted an interim audit on providers who were identified as non-compliant with the 2022 survey results for telephone measure "instruct caller to dial 911 or go to nearest ER" to identify current status. Directors and Timely Access workgroup in the process of developing workflows and additional tools to facilitate standardization and better monitoring of the non-compliance and corrective action process.	For the three HN CAP responses not received, in the process of scheduling a meeting in July to discuss further with Optum. Issue HN Level CAPs in Q3 or Q4. Prep for fielding 2024 Timely Access Survey with a September target date Prep for fielding an In-Office wait Time Survey	
Quality of Service	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Annual submission of SNC to DHCS with AAS or CAP 2) Monitor for Improvement 3) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2024 2) By end of Q2 2024 3) By end of Q3 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Quynh Nguyen/Mike Wilson	Karen Jenkins/Mahmoud Elaraby/Catherine de la Cruz	Network Operations/Quality Analytics	SNC Report Q2 2024: May 274 File. Submitted quarterly CAP status and reviewed 7 of 7 updates from HNs. Optum integration decreased HN updates requested by 2. One HN closed their CAP (Regal). Six remain with open CAPS. 1.Time/Distance: In compliance with the regulatory guidelines specified in APL 23-006, Assigned membership methodology to pull the report form May 274 file. For plan level 2 zip codes did not meet for PCP Adult and Pediatric Core Specialty, and for Specialists Gastroenterology and Orthopedic surgery. Meetings with HNs to review gaps and discuss options for gap closures. For HN level: PCP (Internal Meds) è AltaMed and CHOC_OB/Gyn: AltaMed_Ophthalmology: AltaMed and Optum_Hematology & Oncology: AMVI, Noble, Optum_Neurology: AMVI_Pulmonology: AMVI, UCMG_Gastro: Optum_Orthopedic Surgery: Regal & Optum AMVI then Noble have the greatest number of non-compliance zip codes. The specialties with the most non-compliance zip codes are: Physical Med and Rehab then Endocrinology 2.Out-of-Network (OON): using MCPD - OON Data Q1 2024 submissions to DHCS: 99 total requested for OON referral requests, 3.Network Capacity and Ratios were met. 4. PCP Overcapacity: For Q2 2024, we reopened the panel for 7 provider and closed one panel for Dr. Mobarak and send a notification letter as certified mail. 5.Timely Access: The 2023 Timely Access Survey was fielded September 26 through December 1, 2023, and letters of non-compliance and Corrective Action Plans will be mailed to individual providers in late June or early July 2024. 6.California Children's Services (CCS) Program/Whole Child Model (WCM: 0 deficiencies. Plan Statewide Level - all specialties met. All networks confirmed as met, with exception of UCMG, although AMVI showed non-compliant for 6 specialties, CalOptima H ealth is in receipt of a HN Agreement between AMVI and CHOC.		
Quality of Service	Increase primary care utilization	Increase rate of Initial Health Appointments for new members, increase primary care utilization for unengaged members.	Assess and report the following activities: 1) Increase health network and provider communications, trainings, and resources 2). Expand oversight of provider IHA completion 3) Increase member outreach efforts	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Katie Balderas	Anna Safari	Equity and Community Health	1) Increase health network and provider communications, trainings, and resources Goal being met, see below. a. HN and Provider Communications/Presentations: -Provider Monthly Newsletter: Send messaging out at least once per quarter; messaging sent in April and June. -Health Network Communication/ Presentations: Began meeting with each HN via Health Network Quality Update Meetings starting in May; Further follow-up Meetings began with HNs individually to discuss CAP process which includes the Delegation Oversight Dashboard Response Form; Meeting Presentations and individual follow up meetings replaced email communication in HN Weekly Update. b. Training/Presentations with IHA Updates: -Planning for a provider CME in August 2024. -Provider toolkit that includes the IHA is in progress. 2). Expand oversight of provider IHA completion: Goal being met, see below. a. Continue to audit CHCN clinics. b. Continuing to inform all HNs of the expectation to meet the minimum IHA completion rate of 50%; Still in discussion with management regarding the approach for establishing Corrective Action Plan. c. Provider office visits (CHCN): Established and implemented a process to visit providers and bring IHA data (or give staff presentations) and related resources. 3) Increase member outreach efforts: Goal being met, see below. a. Developing text campaign for new members +IHA: Message currently in review with internal team and vendor for DHCS submission preparation. b. Continuing IVR campaign twice monthly to new members. c. Message to new members on the IHA continues to be sent out in the new member handbook and in the Medi-Cal newsletter.	1) Continue collaboration with HNs and providers via Presentations and Newsletter updates. 2) Continue chart review efforts and provider office visits. 3) Continue identifying new members monthly and sending targeted messages via text, IVR and mailings.	
Quality of Service	Improving Access: Annual Network Certification	Comply with Annual Network Certification requirements	1) Annual submission of ANC to DHCS with AAS 2) Implement improvement efforts 3) Monitor for Improvement	Submission: 1) By June 2024 2) By December 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Quynh Nguyen/Mike Wilson	Mahmoud Elaraby/Johnson Lee	Provider Data Management Services	All ANC Phase 2 Time and Distance submissions were completed in March 2024, including Mandatory Provider Types Roster, P&Ps, MPT and Facility Validation supporting documentation, , Alternative Access Standard Analysis,	Ongoing monitoring in transition to PDMS.	
Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal	Assess and report the following activities: 1) Conduct outreach to members in advance of 2024 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively. 3) These items also continue to be included in all P4V discussions with HNs.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Mike Wilson	Carol Matthews/Helen Syn	Quality Analytics	1. 217,988 members were outreached to through live calls, text messaging and mailings for both lines of business. 2. CalOptima's Just In Time campaign used live calls and text messaging to reach members that were likely to respond negatively. 13,239 live calls and 57,169 text messages were sent to members in both lines of business. 3. CAHPS continues to be part of the P4V for the HN. Final CAHPS reports have not been received. Distribution to health networks is pending final reports due in July.	1. Closed 2. Closed 3. Share HNQR with the HN when available	
Quality of Service	Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process	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	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Tyronda Moses	Heather Sedillo	GARS	GARS identified and reported a non-compliance issue to the Committee regarding untimely Discrimination cases submitted to DHCS. Regulation APL21-004 requires that the named discrimination grievance coordinator properly investigates and responds to all complaints within 30 days of receipt. Additionally, within ***10 calendar days*** of mailing the discrimination grievance resoluion letter to a member, CalOptima Health must submit a copy to DHCS. CalOptima Health did not consistently submit within 10 days. Root cause: lack of reporting. Remediation: documented a process to be followed in Jiva that provides the ability to track not only the date of closure but also the date of submission to DHCS.	GARS will continue to identify and report any Compliance Issues to QIHEC related to either the GARS process, internal departments, providers and/or Health Networks at least quarterly. This report will include any remdiation activities if applicable.	
Quality of Service	Customer Service	Implement customer service process and monitor against standards	Track and trend customer service utilization data Comply with regulatory standards Maintain business for current programs Improve process for handling customer service calls	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Andrew Tse	Mike Erbe	Customer Service	Customer Service ran KPI data and reported results to QIHEC. DHCS' average speed of answer of not exceeding 10 minutes: Goal was met (2 min and 1 sec). Internal business goal of abandonment rate not exceeding 5% met (exactly 5% for Q2). Accomplishments: Hired additional staff, various departments staggered member engagement campaigns, leveraging call back capabilities for inbound calling members opting in.	Continue working with HR to onboard additional staff (permanent vacant positions or temporary staff), maintain the telephonic call back offering, and partner with other departments (QA, Equity and Community Health, etc.) to stagger their member engagement campaigns (i.e., text messaging).	

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Quality of Service	Medi-Cal Customer Service Performance Improvement Project	To meet Medi-Cal Customer Service KPIs by December 31, 2024: Internal call abandonment rate of 5% or lower, DHCS' 10 minutes average speed of answer	1) Partnering with HR to onboard more permanent and temporary staff to service inbound calls. 2) Interacting with various departments involved with member engagement campaigns and determine if they're able to update instructions for targeted members (i.e., instead of calling customer service, have them utilize the member portal).	Report progress to QIHEC quarterly: ~~Q2 2024 Update (08/13/2024)~~ ~~Q3 2024 Update (11/05/2024)~~ Q3 2024 Update (07/09/2024) ~~Q4 2024 Update (02/11/2025)~~ Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Andrew Tse	Mike Erbe	Customer Service	Customer Service ran KPI data and reported results to QIHEC. DHCS' average speed of answer of not exceeding 10 minutes: Goal was met (2 min and 1 sec). Internal business goal of abandonment rate not exceeding 5% met (exactly 5% for Q2). Accomplishments: Hired additional staff, various departments staggered member engagement campaigns, leveraging call back capabilities for inbound calling members opting in.	Continue working with HR to onboard additional staff (permanent vacant positions or temporary staff), maintain the telephonic call back offering, and partner with other departments (QA, Equity and Community Health, etc.) to stagger their member engagement campaigns (i.e., text messaging).	
Safety of Clinical Care	Coordination of Care: Member movement across pracitioners	Improve coordination of care, prevention of complications, and facilitation of best practice diabetes care management between vision care specialists (SPCs) and primary care providers (PCPs)	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement: 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Megan Dankmyer/Katie Balderas/Kelli Glynn	TBD	Medical Management	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement a) Work-Plan goal revised on May 9 for multi-department approach between CM, PHM, QA, and other departments as indicated. b) Inter-department training not previously reported by PHM for CM department on 3/27/2024: Health Education Materials and Chronic Conditions Coaching TipsElisa Mora, MPH, RD, Manager, Chronic Conditions, PHM Noushin Dehbozorgi, MSN, PHN,RN,CCM, Health Coach, PHMPHM 2) Provider and member education a) existing information on CalOptima Website for both Provider and Member under Health and Wellness with links to Diabetes Management resources in video, download, or print format with language preference b) existing Health Education materials for members on sharepoint that Case Managers can print and mail.	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement a. Meeting on 7/8 between Claims, UM, and QA to discuss authorization requirement for diabetic eye exam and feasibility for this potential barrier to be eliminated. 2) Provider and member education a. Continue with existing Health Educational resources on Sharepoint and CalOptima Website. b. Member and Provider education in the event changes to authorization process are implemented.	
Safety of Clinical Care	Emergency Department Member Support	Emergency Department Diversion Pilot has been implemented. In 2024 plan to expand a virtual program to additional hospital partners starting with UCI.	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	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Scott Robinson	Cathy Osborn	LTSS	Establishing the virtual program has not been accomplished due to the inability to execute a data usage agreement.	Two staff members (MSW & RN) were approved in the 2024/2025 budget to be embedded in the UCI emergency department. Currently in the process of developing job descriptions to begin recruitment. The plan is to have UCI ED embedded staff in place by the end of September 2024.	
Safety of Clinical Care	Coordination of Care: Member movement across settings - 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% from Q4 2023 by end of December 31,2024.	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.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Stacie Oakley Hannah Kim Scott Robinson	Joanne Ku	Utilization Management Case Management Long Term Care	•IPP 4.3 report (percentage of members who had ambulatory visits within 7 days post hospital discharge) – Enterprise Analytics updated report with the correct technical specifications. It helps monitor the effectiveness of TCS (mirror the state's monitoring approach). •CalAIM ECM provider report documenting Lead Care Managers in CalOptima Connect showed an improvement from 3% to 44%. This ensures the Lead Care Manager is notified of any admissions. Expectation moving forward is to have ECM Providers continue to document accurately.	•Develop a texting campaign leveraging the Usher platform •Develop report for FFS Medicare members •Develop process and desktop procedure outreaching to pregnant members (TCS high-risk) not enrolled in the Bright Steps program. •Continue motivational interviewing trainings (started in June).	
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 41.90% to 55.78% by 12/31/2024.	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 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Mike Wilson	Leslie Vasquez/Kelli Glynn	Quality Analytics	1. 85 African American members were identified for outreach. 34 parents/guardians were successfully outreached to. Members that were unsuccessfully reached via telephone were sent an unable to contact letter advising of attempt to reach and encouraged a call back to CalOptima Health. 2. Out of the 51 unsuccessful members, 10 were identified as having a email and CalOptima Health provided outreach to encourage reaching out to provider to make well-child visit. Out of the 10 emails, we encountered an error with one email and did not receive a response from the 9 other members outreached to. **Barriers:** Within the organization there was a data transition that contributed to delays in the identification of members in the population of focus. Data for member outreach was not available until April 2024 which resulted in delayed outreach. Barriers to member outreach: Various members has incorrect contact information. **Findings:** Final summary pending. Findings suggest that in scenarios where members were successfully outreached, many children had a well-child visit scheduled or one that was recently completed. When offered assistance to schedule future well-child visits, parents declined. Data suggests that parents are unaware of how often well-child visits should take place during the first few years of life.	Submission of results in September 2024. Quality Analytics team will utilize survey findings to inform interventions for 2025.	
Cultural and Linguistic Appropriate Services	Cultural and Linguistics and Language Accessibility	Enhance interpreter and translation services	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards, including Member Material requirements Intitiate Request for Proposal (RFP) to add and/or replace the translation and interpreter services vendors to improve the member experience.	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	The Request for Proposal (RFP) Scope of Work draft has been completed and currently under review by Vendor Management.	>Finalize Scope of Work and submit RFP bid. *The RFP's Scope of Work (SOW) is currently being reviewed by Vendor Management.*	
Cultural and Linguistic Appropriate Services	Maternity Care for Black and Native American Persons	1) PPC Postpartum: Increase timely PPC postpartum appointments for CalOptima's Black members from 67.48% to 74.74% and Native Americans from 44.44 to 63.22% by 12/31/24. 2) PPC Prenatal: Increase timely PPC prenatal appointments for CalOptima's Black members from 53.77 to 72.37% and Native Americans from 27.78% to 59.43% by 12/31/24.	Assess and report the following activities: 1) Determine the primary drivers to noncompliance via member outreach and literature review 2) Targeted member engagement and outreach campaigns in coordination with health network partners 3) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 4) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 5) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 6) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Ann Mino/Mike Wilson	Leslie Vasquez/Kelli Glynn	Equity and Community Health	Data as of May 2024: PPC - Postparum Care: - 63.19% compliance rate for the entire population - 46.27% compliance rate for the Black population - 45.45% compliance rate for the Native American population PPC - Timeliness of Prenatal Care: - 67.74% compliance rate for the entire population - 55.22% compliance rate for the Black population - 63.64% compliance rate for the Native American population	Planned: Continue with public awareness and educaiton campaigns (e.g., radio digital, social media). Contiue to develop identification of eligible members to enroll with CalAIM providers. Continue to build doula provider network to ensure person-centered, culturally competent care that supports the racial, ethnic, linguistic and cultural diversity of members	
Cultural and Linguistic Appropriate Services	Data Collection on Member Demographic Information	Implement a process to collect member SOGI data by December 1st, 2024.	1) Develop and implement a survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age). 2) Update CalOptima Health's Core eligibility system to store SOGI data. 3) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks. 4) Develop and implement a survey via the Member Portal, mail to new members adn other methods. 5) Share member demographic information with practitioners.	Report progress to QIHEC quarterly: ~~Q2 2024 Update (08/13/2024)~~ Q2 2024 Update (07/09/2024) ~~Q3 2024 Update (11/05/2024)~~ Q3 2024 Update (10/08/2024) ~~Q4 2024 Update (02/11/2025)~~ Q4 2024 Update 01/14/2025)	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	•The SOGI survey was submitted to Compliance and to The Department of Managed Health Services (DHCS) for review. •The survey has been approved by DHCS and translated in CalOptima Health's threshold languages. •The survey has been submitted to ITS to start the process of implementing into the Member Portal. •Facets Core system where data will be stored has been updated with the capabilities to store SOGI data that is collected from members.	•ITS to complete upload survey to the Member Portal. •Work with Communications to create a new member mailing packet for mailing to new CalOptima members (over the age of 18 years of age) •ITS to upgrade XXI in Facets for the survey to upload properly to prepare for the integration of the survey.	

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Cultural and Linguistic Appropriate Services	Data Collection on Practitioner Demographic Information	Implement a process to collect practitioner race/ethnicity/languages (REL) data by December 31, 2024.	1) Develop and implement a survey to collect practitioner REL data 2) Enter REL data into provider data system and ensure ability to retrieve and utilize for CLAS improvement. 3) Complete an analysis of the provider network capacity to meet language needs of the CalOptima Health membership. 4) Assess the provider network's capacity to meeting CalOptima Health's culturally diverse member needs. 5) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Quynh Nguyen	Johnson Lee	Provider Data Management Services	1. Meetings scheduled to plan 2. Develop plan for key activities 3. Identified stakeholders 4. Completed analysis of requirements	1. Set up indicators in Facets 2. Identify methods for collecting data 3. Survey and collect data 4. Enter data in FACETS 5. Set up on going process for collecting information	
Cultural and Linguistic Appropriate Services	Experience with Language Services	Evaluate language services experience from member and staff	1) Develop and implement a survey to evaluate the effectiveness related to cultural and lingustic services. 2) Analyze data and identify opportunities for improvement.	Report progress to QIHEC quarterly: ~~Q2 2024 Update (08/13/2024)~~ Q2 2024 Update (07/09/2024) ~~Q3 2024 Update (11/05/2024)~~ Q3 2024 Update (10/08/2024) ~~Q4 2024 Update (02/11/2025)~~ Q4 2024 Update 01/14/2025)	Albert Cardenas	Carlos Soto	Cultural and Linguistic Services	•Draft language experience Surveys for both members and staff has been completed and has been distributed to Health Equity workgroup for review and feedback. •C&L met with contracted vendors and internal workgroups on best approach to implement the member and staff survey •C&L met with contracted vendors and confirmed vendors, currently, cannot support CalOptima with conducting a member survey.	•Complete the review of draft surveys with internal workgroups. •Send draft surveys to consultants for review and feedback •Explore other options for conducting the survey including texting campaigns and live outreach.	

2024 QI Work Plan – Q3 Update

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Program Oversight	2024 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Quality Improvement Health Equity Transformation Program (QIHETP) Description and Annual Work Plan will be adopted on an annual basis; QIHETP-QIHEC-BOD; Annual Work Plan-QIHEC-QAC	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	The revised 2024 CalOptima Health Quality Improvement and Health Equity Transformation Program and Work Plan was approved by BoD on 8/1/2024 and a copy was posted on CalOptima Health's public website.	Staff will draft timeline and collaborate with QI business owners to write the 2025 QIHETP Description and Work Plan.	
Program Oversight	2023 Quality Improvement Program Evaluation	Complete Evaluation 2023 QI Program	Quality Improvement Program and Annual Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	Goal was completed 5/5/2024.	No next step.	
Program Oversight	2024 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2024 UM and CM Program Description	UM and CM Program will be adopted on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	ED of Clinical Operations	Director of UM	Utilization Management	2024 Integrated Utilization Management (UM) and Case Management (CM) Program Description completed on time and received approval from BOD.	Continue with the plan as defined for 2025.	
Program Oversight	2023 Integrated Utilization Management and Case Management Program Evaluation	Complete Evaluation of 2023 UM CM Integrated Program Description	UM Program will be evaluated for effectiveness on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	ED of Clinical Operations	Director of UM	Utilization Management	2024 Program Evaluation completed on time and received approval from BOD.	Continue with the plan as defined for 2025.	
Program Oversight	Population Health Management (PHM) Strategy	Implement PHM strategy	Conduct the following: (1) Population Needs Assessment (PNA) (2) Risk stratification (3) Screening and Assessment (4) Wellness and prevention	PHMC report to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Director of Equity and Community Health	Manager of PHM/Director of Care Management	Equity and Community Health	(1) Presented 2024 PNA finding to CHA/CHIP Steering Committee for recommendations; Revised 2024 PNA according to CHA/CHIP Steering Committee feedback; finalized collaborative blood lead and maternal health SMART goals with OC HCA (3) Working to update risk stratification based on HIF-MET (4) Exploring vendor platforms for member wellness and prevention health appraisals.	(1) PNA: Report 2024 PNA Key Findings to MAC, PAC, and PHMC; Publish 2024 PNA to CalOptima Health Website 4) Review vendor options for member wellness and prevention health appraisals.	
Program Oversight	2024 Population Health Management (PHM) Strategy Evaluation	Complete the Evaluation of the 2024 Population Health Managemet (PHM) Strategy	The Population Heath Management (PHM) Strategy will be evaluated for effectiveness on an annual basis.	QIHEC: 11/0520/24 QAC: 12/11/2024 Annual BOD Adoption by January 2025	Director of Equity and Community Health	Manager of PHM/Director of Care Management	Equity and Community Health	▪Equity and Community Health has met with Quality Improvement to plan for the PHM Strategy Evaluation; ▪Quarterly PHM Workplan monitoring	▪Quarterly PHM Workplan monitoring ▪Finalize template PHM Strategy Evaluation	
Program Oversight	2024 Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Cultural and Linguistic Services Program Work Plan will be evaluated for	QIHEC: 02/13/2024 QAC: 03/13/2024	Manager of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	The 2024 Program and Workplan apporval at QAC and BOD was held in order to include Health Equity elements.	Annual BOD Adoption by April 3 2025	

			effectiveness on an annual basis	Annual BOD Adoption by April 2024						
Program Oversight	2024 Cultural and Linguistic Services Program Evaluation	Complete the Evaluation of the 2024 Cultural and Linguistic Services Program	The Cultural and Linguistic Services Program will be evaluated for effectiveness on an annual basis.	QIHEC: ~~11/05/2024~~ 01/14/2025 QAC: ~~12/11/2024~~ 03/12/2025 Annual BOD Adoption by ~~January 2025~~ April 3 2025	Manager of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	The BOD approved the Revised 2024 CalOptima Health 2024 Cultural and Linguistic Services Program Evaluation and Work Plan on August 1, 2024.	Annual BOD Adoption by April 3 2025.	
Program Oversight	**Population Health Management (PHM) Committee** - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee activities, findings from data analysis, and recommendations to QIHEC	(1) PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), (2) PHM Strategy activities, and PHM Workplan progress and outcomes. (3) Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	PHMC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Equity and Community Health	Manager of Equity and Community Health/ Director Case Management	Equity and Community Health	▪ Held third quarter PHM Committee Meeting in August 2024 which included both internal CalOptima Health updates on PHM Program and Community presentation from Second Baptist Church on Health Equity for African American's League (HEAAL) ▪ Provided PHM Committee update for QIHEC in August 2024.	▪ Continue to assists this committee by reviewing relevant guidance, agenda setting, and presentation development, and deliverables shared with QIHEC. ▪ Next PHM Committee meeting is scheduled for November 2024 ▪ Report committee update to QIHEC in November 2024	
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 activities, findings from data analysis, and recommendations to QIHEC	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. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Manager of Quality Improvement	Manager of Quality Improvement	Quality Improvement	Of the five physicians undergoing the Fair Hearing process, three remain in process. The Committee decided to move two physicians to probation for 1 year with requirements. Nine PQIs leveled 1, 2 or 3 were presented to CPRC. PQI trends for 1/1/24-6/30/24 identified an ABA group and a acute care hospital. During this time frame, most quality of care PQIs were categorized as medical care, and most were either mismanaged care or treatment (delay, failure, inappropriate or complications). Five providers were presented for on-going monitoring. Three providers were reviewed for recredentialing. The Committee also voted to recognize the Canadian Boards. There were no physicians reported for failing a FSR or MRR, and there were no PPCs reported.	The Committee will continue to monitor providers through on-going monitoring, credentialing/recredentialing, and PQIs. Policies relevent to these processes will continue to be reviewed by the Committee.	
Program Oversight	**Grievance and Appeals Resolution Services (GARS) Committee** - Conduct oversight of Grievances and Appeals to resolve	Report committee activities, findings from data analysis, and recommendations to QIHEC	The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Grievance and Appeals	Manager of GARS	GARS	GARS Committee met on August 14 to review Q2 metrics for both lines of business and types to include: - Member Grievances and Appeals - CalOptima Health remains compliant with processing timeliness both monthly and quarterly - NCQA GARS Goals are met	GARS Committee is scheduled for November 13 where Q3 trends will be discussed and any remediation activities presented for additional recommendations.	

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	complaints and appeals for members and providers in a timely manner.		providers for CalOptima Health's network and the delegated health netwoks. Trends and results are presented to the committee quarterly. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.					- Grievances are under the DHCS Enterprise Average of 3.1 grievances per 1,000 member months - Q2 MC Grievance Rate per 1000 MM = 1.97, which is an increase over Q1 (1.56) - Q2 OC Grievance Rate per 1000 MM = 11.72, which is down compared to Q1 (13.83) - Q2 MC Appeals Count = 362 with 35% Rate Overturned - Q2 OC Appeals Count = 68 with 41% Rate Overturned - Provider Disputes received in Q2 = 10,577 - Total Claims to Disputes received is 0.5% - 33% of the disputes received were overturned Trends for each type by line of business was discussed. Actions taken to remediate trends were also discussed. Q1 2024 minutes were approved.		
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 activities, findings from data analysis, and recommendations to QIHEC	The MEMX Subcommittee reviews the annual results of CalOptima Health's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	MemX Committee report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	Project Manager Quality Analytics	Quality Analytics	In Q3. Member Experience Committee met on July 16. 2024 and reviewed and discussed the following: timely access: reviewed DHCS wait time results for Q1 2024 and CalOptima's internal timely access survey for 2023, whole child model network adequacy: reviewed results for Q2 2024 for both plan and network level, SNC/ANC: reviewed status of CAP updates due 7/1/2024, NAV audit timeline with confirmed audit date of July 25, 2024, PCP overcapacity including provider panels that need to be re-opened or closed, OneCare data analysis and reporting: with all requirements met, and a CAHPS update: all MC plan and HN reports were received and the final CAP submission by HN received 6/13/24. KPI Reporting: Customer Service reported on call volume, abandonment rate, and average speed of answer. Health Education reported on referral process improvement and collaborations. Utilization Management reported prior auth TAT for routine and urgent referrals 2023-Jan 2024, average TAT for urgent and routine referrals. BH reported on routine authorizations processed within 5 days and appointments offered with a mental health appointment within 10 business days of request.	Next meeting October 15. 2024	
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 activities, findings from data analysis, and recommendations to QIHEC	UMC reviews medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. Committee meets at	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Utilization Management	Manager of UM	Utilization Management	UMC reviewed status update on Goals at Committee meeting August 22, 2024. A summary of this presentation was provided at the September 10th QIHEC Committee meeting. The High Risk Management Workgroup (previously titled Bed Day Reduction Strategy) continues to meet and pursue opportunities to improve member care for high risk members.	Continue with the plan as listed - The High Risk Management Workgroup will continue to pursue opportunities such as explore oversight of ECM Providers, explore expansion of our Nurseline offerings, and continue to develop ER Reduction strategies. Actions and goal outcomes will be reported at UMC	

			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.						November 21,2024. and QIHEC December 10, 2024.	
Program Oversight	**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee activities, findings from data analysis, and recommendations to QIHEC	WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	WCM CAC report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Whole Child Model Medical Director / Director of Case Management	Program Assistant QI	Medical Management	WCM CAC met scheduled for August 20, 2024. Introduced Dr. Chu as formal WCM CAC mebmer however he was not present. CalOptima Health staff will continue active monitoring of WCM Health Network adequacy, review UM, GARS, BH, and CS. CalAIM data was tabled to the next meeting. Committee recommended for WCM CAC members to bring up clinically relevant matters for discussion. For example, orthopedic specialist at Medical Therapy Conference and Medical Therapy Units.	Staff will review 7-day readmission (new request) and criterial for 30-day readmission data and report it to Q4 2024 WCM CAC on 11/X/24.	
Program Oversight	Care Management Program	Report on key activities of CM program, analysis compared to goal, and improvement efforts	Report on the following activities: Enhanced Care Management (ECM) Complex Case Management (CCM) Basic PHM/CM Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM Transitional care services	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Care Management	TBD	Medical Management	Enhanced Care Management (ECM): a) Safety Net Connect created an audit tool for ECM providers to validate that their enrolled members have identifed the Lead Care Manager. b) Ongoing communication to ECM providers for TCS outcomes for enrolled high-risk members. Complex Case Management (CCM): a) Continue monthly NCQA file audits for CCN and HN members open to CCM level of care. Basic PHM/CM: Continue quarterly audits of delegated Health Networks for MOC oversight. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM: a) continued discussion in workgroup to obtain data and operationalize oversight. Transitional care services: a) See TOC/Row 61 for TCS updates.	Enhanced Care Management (ECM): a) Assess if there has been improvement to enrolled members with Lead Care Manager contact information populated. b) Ongoing communication to ECM providers for TCS outcomes for enrolled high-risk members. Complex Case Management (CCM): a) Continue monthly NCQA file audits for CCN and HN members open to CCM level of care. b) Potential Q4 MOC Audit with NCQA consulting vendor Basic PHM/CM: Continue quarterly audits of delegated Health Networks for MOC oversight. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM: a) continued discussion in	

									workgroup to obtain data and operationalize oversight. Transitional care services: a) See TOC/Row 61 for TCS updates.	
Program Oversight	Delegation Oversight	Implement annual oversight and performance monitoring for delegated activites.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accredication standard compliance that, at minimum, include comprehensive annual audits.	Report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Audit and Oversight	Manager of Audit and Oversight (Delegation)/ Manager Delegation Oversight	Delegation Oversight	Delegate: • CHOC Health Alliance/Rady's Children's MSO (20) • AMVI Care Health Network/Prospect MSO (58) Area(s) Assessed: • Case Management; • Claims; Compliance; • Credentialing; • Customer Service; • Provider Network Contracting; • Provider Relations; • Sub-Contractual; • Utilization Management Corrective Action Plan(s) Issued – CHOC Health Alliance/Rady's Children's MSO: • Claims (Medi-Cal) – Accepted & Closed • Credentialing (All Lines of Business) – Accepted & Closed • Customer Service (Medi-Cal) – Accepted & Closed • Provider Relations (All Lines of Business) – Accepted & Closed • Utilization Management, Concurrent Review (Medi-Cal) – Accepted • Utilization Management, Expedited & Standard Denial (Medi-Cal) – Accepted Corrective Action Plan(s) Issued – AMVI Care Health Network/Prospect MSO: • Case Management (Medi-Cal) – Accepted & Closed • Claims (Medi-Cal) – Accepted • Claims, Provider Dispute Resolutions (Medi-Cal) – Not Accepted • Credentialing (All Lines of Business) – Accepted • Provider Relations (All Lines of Business) – Accepted & Closed • Utilization Management, Policy (Medi-Cal) – Accepted & Closed • Utilization Management, Carve Out (Medi-Cal) – Accepted • Utilization Management, Concurrent Review (Medi-Cal) – Accepted • Utilization Management, Expedited & Standard Denial (Medi-Cal) – Accepted • Utilization Management, Non-Emergency Medical Transportations (Medi-Cal) – Accepted • Utilization Management, Physician Administered Drugs (Medi-Cal) – Accepted • Utilization Management, Notice of Medicare Noncoverage (OneCare) – Accepted • Utilization Management, Organizational Determinations (, Appeals, & Grievances) (OneCare)	Continue to monitor CAPs in "Monitoring" status through acceptance & closure.	

								– Accepted & Closed • Utilization Management, Physician Administered Drugs (OneCare) – Accepted		
Program Oversight	Disease Management Program	Implement Disease Management	Report on the following activities: Evaluation of current utilization of disease management services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of PHM	Manager of Equity and Community Health	Equity and Community Health	1) The implementation of the 2-way text message to promote the asthma program and identify members who wished to receive a call from health coach was successful. The enrollment rate significantly increased to 41% compared to just 10% with cold calls. 2) Plan to continue using PointClickCare to identify members with congestive heart failure (CHF) who have recently been discharged from the hospital and have a primary diagnosis of CHF, enabling early intervention. 3) The Chronic Conditions team continues to collaborate with the QA team's emerging risk outreach initiative. Members identified through the monthly diabetes stratification are matched with the emerging risk list and prioritized for outreach. 4) The Disease Management Satisfaction survey will be sent earlier this year. We have initiated collaboration with the Ushur team to distribute the survey via text message to identified members.	1) We initiated collaboration with the Ushur team to develop an ongoing campaign targeting members identified in the monthly asthma and diabetes stratifications. This campaign aims to promote chronic conditions services and identify members interested in receiving a call from a health coach, thereby reducing the need for cold calls. 2) Disease Management Survey will be launched via text message on 10/6. 3) Enhancements to the monthly stratification list will include adding HEDIS measures that members are still missing, enabling health coaches to educate and support members in completing these measures. 4) Currently working on incorporating Zoom option for members who prefer video calls for coaching sessions. 5) Considering developing a live outbound call campaign using Carenet to contact individuals from the stratification list and schedule appointments with health coaches. 6) We are collaborating with the credentialing/contracting team to add Yumlish as a web-based provider for the CDC Diabetes Prevention Program (DPP).	
Program Oversight	Health Education	Implement Health Education Program	Report on the following activities: (1) Evaluation of current utilization of health education services (2) Maintain business for current programs and support for community. (3) Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Equity and Community Health/Manager of Health Education	Manager of Equity and Community Health	Equity and Community Health	1) Evaluation of current utilization of health education services **Goal being met:** During 2024 Q2, 728 referrals were assigned for health education services very close to the number of referrals in Q1, where 749 referrals were assigned to health education services, similar trends were observed during Q1 and Q2 in 2023 with referrals counts in 700s for both quarters. Classes take more effort to recruit participants, prepare and follow up, therefore participation increase is gradual. In Q2 2024, virtual classes were piloted two times a day on Tuesday, Wednesday and Thursday. Based on attendance, virtual classes were reduced to two evening classes once a week in English and Spanish each. Aside from heath education referrals, class participants were 568 in total. This is an increase compared to 183 attendees in Q1 of 2024, and 50 attendees in Q1 of 2023.	Work to implement a services awareness text message and will support the organization-wide referral intake process to help expedite service delivery. With the recent department name/vision change focusing on Equity and Community Health, the department is being restructured with more emphasis on community engagement and yet provide individual interactions for members who choose that option.	

								2) Maintain business for current programs and support for community **Goal being met:** During 2024 Q2, 568 participants attended 67 classes, specifically 33 virtual and 34 in-person classes. Community partners continue to be added for Shape Your Life program expansion. New partners include Prospect Elementary in Orange where 4 parent classes were provided. Collaboration efforts with Northgate Supermarkets during Q2 included 6 market tour events that focused on nutrition education and food demonstrations. Health Education staff continues participating in monthly community collaborations with the Tobacco and Vape Free (TVFREE) Coalition. 3) Improve process of handling member and provider request **Goal being met:** a. The Health Education team developed an electronic referral form that was field tested with participants attending virtual Shape Your Life classes for feedback. The form is on hold for now due an organization-wide approach to referral intake processes. Meanwhile, the team is working on a text message campaign to inform members of available services. b. Health and Wellness services are mentioned in the new member packages and continue to be promoted at all continuing education training sessions in 2024, along with reminders on how and where to send member referrals.		
Program Oversight	Health Equity	Identify health disparities Increase member screening and access to resources that support the social determinants of health Report on quality improvement efforts to reduce disparities	Assess and report the following activities: 1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	By December 2024 Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	1) Updated SDOH member assessment with additional questions and continue to integrate into JIVA 2) Kicked off integration meetings with FindHelp and JIVA and developed training space for staff 3) HL4E certificate program continues through the end of the year to allow staff to complete their certifications. Currently, 74 out of 164 staff have completed their certification program.	(1) Update SDOH Member Assessment in the Member Portal and continue to integrate assessment into JIVA (2) Continue integration of Find Help into JIVA and train staff (3) Continue to encourage staff to complete their mini-credentials to earn their certification. Develop a Teach -Back method module to train new member facing staff as part of their onboarding process	
Program Oversight	Long-Term Support Services (LTSS)	95% compliance with TAT	CalAIM Turnaround Time (TAT): Determination completed within 5 business days CBAS Inquiry to Determination (TAT): Determination completed within 30 calendar days CBAS Turnaround	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of LTSS	Manager of LTSS	Long Term Care	CalAIM TAT: 99.75% (Met) CBAS Inquiry to Determination TAT: 99.63% (Met) CBAS TAT: 99.57% (Met) LTC TAT: 98.99% (Met)	Continue with plan. Monitor daily inventory and TAT.	

			Time (TAT): Determination completed within 5 business days LTC Turnaround Time (TAT): Determination completed within 5 business days							
Program Oversight	National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by January 1, 2026	1) Implement activites for NCQA Standards compliance for HPA and Health Plan Renewal Submission by April 30, 2024. 2) Develop strategy and workplan for Health Equity Accreditation with 50% document collect for submission.	1) By April 30, 2024 2) By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Program Manger of QI	Director of Quality Improvement	Quality Improvement	**HP Accreditation:** 1) CalOptima Health successfully renewed our health plan accreditation status on July 10, 2024, and was awarded Accredited status. 2) Our NCQA Health Plan Rating was updated on September 15, 2024, to a rating of 3.5 stars. 3) NCQA released the 2025 HP Standards, which were shared with internal stakeholders in September 2024. **HE Accreditation:** 1) DHCS will require all health plans to obtain HE accreditation by January 1, 2026 2) CalOptima Health is engaged with NCQA consultants to conduct a readiness assessment and perform a gap analysis 3) Consultants have been providing recommendations and have developed a work plan. 4) CalOptima Health has established a Health Equity committee and five work groups. Status updates are shared with the HE committee, and workstreams 5) meet frequently to provide updates. 6) Submitted NCQA Health Equity pre-application on September 13th, 2024, and were given a survey date of October 7, 2025.	1) **HP Accredittation:** Consultants will perform a Kick-off webinar to go over standards and how to interpret standards in October 2024. A separate training session with stakeholders on analytical reports will be scheduled in October 2024. Consultants will be scheduling file reviews in November 2024. Delegates will be notified in advance of the audits. 2) **Health Equity Accreditation:** Five workgroups continue to work on deliverables needed. Our consultants to perform another GAP analyis to see where we are in 4Q2024.	
Program Oversight	OneCare STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts.	By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/11/2024 Q4: ~~10/08/2024~~ 11/5/2024 Q1: 01/14/2025	Director of Medicare Stars and Quality Initiatives	Manager of QA	Quality Improvement	Continued monthly workgroup meetings for Operations, Equity and Community Health, Case Management, and Pharmacy. Created a revised Star Rating tracker in conjunction with Rex Wallace Consulting; utilizes a '3 Ways to Win' approach and provides goals for each Stars measure. Launched a weekly huddle with the Case Management team to address the OMW measure. Ongoing telephonic outreach to members across multiple measures via vendor Carenet. Provided multiple teams with training on the Decision Point Insights platform.	Continue with plan as listed	
Program Oversight	Value Based Payment Program	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) Will share HN performance on all P4V HEDIS Measures via prospective rates report each month. 2) Will share	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: ~~10/08/2024~~ 11/5/2024 Q1: 01/14/2025	Manager of Quality Analytics	Manager Quality Analytics	Quality Analytics	HN prospective rate reports have been distributed on a monthly basis. Quality update calls with each Health Network continue to be held every other month. The Medi-Cal Quality Improvement Grant awards for Health Networks were announced in September. Seventeen (17) proposals across five (5) Health Network partners were approved (over $1.8 M in funding and support for 16 quality measures).	Continue with plan as listed	

2024 QI Work Plan – Q3 Update

			hospital quality program performance							
Program Oversight	Quality Performance Measures: Managed Care Accountability Set (MCAS) STAR measures	Track and report quality performance measures required by regulators	Track rates monthly Share final results with QIHEC annually	Report program update to QIHEC Q2: 05/14/2024 Q3: 08/13/2024 Q4: 11/05/2024 Q1 02/11/2025	Director of Quality Analytics	Manager Quality Analytics	Quality Analytics	Follow-up after ED visit for mental illness (FUM) and Follow-up after ED visit for alcohol and other drug abuse or depend (FUA) are below 33rd percentile. Have high risk not meet MPL for MY2024. An update will be presented by Mike Wilson from QA team at the 11/5/24 QIHEC.	working with BH team for additional data source	
Program Oversight	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: 1 Implement SBHIP DHCS targeted interventions 2. Bi-quarterly reporting to DHCS	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Director of Behavioral Health Integration	Project Manager BHI	Behavioral Health Integration	1) Full installation of 5 SBHIP-funded WellSpaces completed brings the total to 7 out of 10 installed 2) Hazel Health surpassed 1,000 care inquiry referrals, also the number of students with visits has increased since the start of school. 3) Individual meetings with CHOC, HAZEL, WYS, and OCDE were conducted to review their SBHIP-funded project level of implementation for the remaining time of the program. 4) CalOptima Health co-sponsored and attended the OCDE Mental Health Summit on August 22, over 400 MH school staff attended. 5) Received DHCS approval notice for the June Biquarterly Report.	1) Complete 4 project outcomes reports by 12/31/24, these are the last reports required for the program 2) Work with Contracting to amend the initial OCDE SBHIP MOU - the term is to be extended 3) Discussions with Contracting to continue regarding the development of an agreement for the coordination of care and needed as the final deliverable for one of the project outcome reports 4) Work with internal departments SMEs to fulfill the requirements to support paying the CYBHI fee schedule services through DHCS third-party administrator Carelon Behavioral Health	
Program Oversight	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	Assess and report the following: 1) Establish the Comprehensive Community Cancer Screening and Support Grants program 2) Work with vendor to develop a comprehensive awareness and education campaign for members.	Report Program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Director of Equity and Community Health	Manager of Equity and Community Health	Medical Management	1) Board approved 15 grant proposals from 13 organizations on August 1, 2024 2) Executed all grant agreements in early September 2024. Completed the first grant payment. 3) Held the grantees' kickoff meeting on October 2, 2024. 4) Currently engaged in weekly meetings with mPulse to develop and refine short messaging services (SMS) content, with the goal of improving member engagement and scheduling of screening appointments.	1) Host a virtual webinar to provide reporting instructions. 2) Meet with individual grantees to provide support (if requested). 3) Submit SMS content(s) to DHCS for approval. 4) Finalize the research & evaluation contract with UCI	
Quality of Clinical Care	Preventive and Screening Services	Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS) MY 2024 Goals: CCS: MC 59.85% BCS-E: MC 62.67% OC 71% COL: OC 71%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/5/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Quality Analyst	Quality Analytics	1. Member Health Reward: CCS (MC) - 959; BCS (MC) - 398; BCS (OC) - 135; COL (OC) - 65 2. Mailings: CCS MC 127684; BCS (MC)- 36488; BCS (OC)- 2331 3. CareNet Live Call: CCS (MC)- 30694; BCS (MC)- 25280; BCS (OC)- 1550; COL (OC)- 3081 3. Continuation of CCN OC and MC COL GI outreach pilot program plus elimination of prior authorization for GI screening consult for the OC population 4. Prep for CCN Cologuard launch with Exact Sciences (go live in October) 5. August 2024 Prospective Rate Data: CCS (MC) -	Continue with plan as listed	

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			channel targeted member, provider and health network engagement and collaborative efforts.					41.92%; BCS (MC) - 47.48%; BCS (OC) - 59%; COL (OC) - 56%		
Quality of Clinical Care	EPSDT Diagnostic and Treatment Services: ADHD Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare Appropriate Use Of Psychotropic Medications	Follow-Up Care for Children Prescribed ADHD medication (ADD) HEDIS MY2024 Goal: MC - Init Phase - 44.22% MC -Cont Phase - 50.98%	Assess and report the following activities: 1) Work collaboratively with the Communications department to Fax blast non-compliant providers letter activity (approx. 200 providers) by second quarter. 2) Participate in provider educational events, related to follow-up visits and best practices. 3) Continue member outreach to improve appointment follow up adherence. a. Monthly Telephonic member outreach (approx. 60-100 mbrs) b. Member Newsletter (Fall) c. Monthly Member two-way Text Messaging (approx. 60-100 mbrs) 4) Member Health Reward Program 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (~~11/05/2024~~10/08/2024) Q4 2024 Update (~~02/11/2025~~ 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS RATES Q3 (July): Initiation Phase-46.67% Continuation and Maintenance Phase- 51.04% 1) Monthly text messaging outreach to members.(July, August, September) 2) Member Health Reward flyers mailed to 459 eligible members on 07/15/2024 and 161 eligible members on 09/10/2024. 3) Developed new text message script for Member Health Reward and presented at BHQI Workgroup for approval on 07/18/2024. 4) ADD data is now available through the Provider Portal 08/15/2024. 5) Quality Champions meeting with The Coalition of Orange County Community Health Center presentation on BH Quality Measures on 09/20/2024. 6) Monthly Health Network Communication BH Updates.	1) Q4 data will be pulled to initiate best practices letter and tip-sheet to non-compliant providers through the provider portal. 2) Continue to mail out Member Health Rewards flyer to eligible members. 3) Awaiting for DHCS approval of text message script for Member Health Rewards. 4) Work with text messaging vendor to enter new Member Health Reward campaign on vendor platform. 5) Develop listening sessions with Providers to educate/train on how to obtain BH data.	
Quality of Clinical Care	Health Equity/Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Prevention Programs For Behavioral Healthcare	Improve Adverse Childhood Experiences (ACES) Screening	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (~~11/05/2024~~10/08/2024) Q4 2024 Update	Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	Goals Met. 1) Attended collaborative meetings between teams to identify best practices to implement. (UMC,WCM) 2) BHI continued to monitor monthly ACES report through Tableau.	1) Continue montior ACES tableau report on a monthly basis.	

				(~~02/11/2025~~ 01/14/2025)						
Quality of Clinical Care	Mental Health Service: Continuity and Coordination Between Medical Care and Behavioral Healthcare	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS MY2024 Goals: Blood Glucose-All Ages:58.43% Cholesterol-All Ages: 40.50% Glucose and Cholesterol Combined-All Ages: 39.01%	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 the next top 50 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, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (~~11/05/2024~~10/08/2024) Q4 2024 Update (~~02/11/2025~~ 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS RATES Q3 (Ju;y) : Blood Glucose all ages: 36.18%, Cholesterol all ages: 20.23%, Glucose & Cholesterol Combined all ages: 19.08% 1) Barriers included: Identifying members prescribed antipsychotic medication still in need of diabetes screening, cholesterol screening, and both cholesterol and diabetes screening test through Tableau Report. 2) The following materials have been disseminated to Providers (July, August, September): a) Provider Best Practices Letter. b) APM Provider Tip Sheet. 3) Collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis (July, August, September). 4) Mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to the next top 50 providers on a monthly basis (July, August, September). 5) Text Messaging Campaign (July, August, September). 6) APM data is now abailable through the Provider Portal on 08/15/2024. 7) Quality Champions meeting with The Coalition of Orange County Community Health Center presentation on BH Quality Measures on 09/20/2024. 8) Monthly Health Network Communication BH Updates.	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Continue data pull for text messaging campaign. 3) Continue mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to the next top 50 providers on a monthly basis. 4) Continue with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 5) Schedule listening sessions with Providers to educate/train on how to obtain BH data.	
Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Appropriate Diagnosis, Treatment And Referral Of Behavioral Disorders Commonly Seen In Primary Care	Antidepressant Medication Management (AMM) HEDIS MY2024 Goal: Acute Phase - 74.16% Continuation Phase - 58.06%	Assess and report the following activities: 1) Educate providers on the importance of follow up appointments through outreach to increase follow up appointments for Rx management	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (~~11/05/2024~~10/08/2024) Q4 2024 Update (02/11/2025 01/14/2025)	Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	PR HEDIS RATES Q3 (July) :Effective Acute Phase Treatment: 64.79%, Effective Continuation Phase Treatment: 43.33% 1) Data report received monthly 2) Drafted following materials: a) AMM Provider Tip Sheet letter submitted for internal review process 3) Text message campaign launched (July, August, September). 4) AMM data now available through Provider Portal on 08/15/2024. 5) Quality Champions meeting with The Coalition of	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Continue Text Messaging campaign. 3) Start mailings to providers (letter). 4) Schedule listening sessions with Providers to educate/train on how to obtain BH data.	

			associated with AMM treatment plan. 2) Educate members on the importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 3) Track number of educational events on depression screening and treatment.					Orange County Community Health Center presentation on BH Quality Measures on 09/20/2024. 6) Monthly Health Network Communication BH Updates		
Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Severe And Persistent Mental Illness	Diabetes Monitoring For People With Diabetes And Schizophrenia (SMD) HEDIS MY2024 Goal: 76.66%	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (~~11/05/2024~~10/08/2024) Q4 2024 Update (~~02/11/2025~~ 01/14/2025)	Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	PR HEDIS Rates Q3 (July): M/C:57.74% OC: N/A 1) We are currently monitoring this measure. 2) Member Fall Newsletter approved 07/2024. 3) SMD data now available through Provider Portal on 08/15/2024. 4) Quality Champions meeting with The Coalition of Orange County Community Health Center presentation on BH Quality Measures on 09/20/2024. 5) Monthly Health Network Communication BH Updates.	1) Continue to monitor prospective rates on a monthly basis. 2) Continue collaborative meetings between teams to identify best practices to implement. 3) Schedule listening sessions with Providers to educate/train on how to obtain BH data.	
Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare- Exchange of Information	Follow-Up After Emergency Department Visit for Mental Illness (FUM) HEDIS MY2024 Goal: MC 30-Day: 60.08%; 7-day: 40.59% OC (Medicaid only)	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) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (~~11/05/2024~~10/08/2024) Q4 2024 Update (~~02/11/2025~~ 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS Rates Q3 (July): 30 day- 25.02%, 7 day- 13.98% 1) The main barrier has been not havng the bandwidth for outreach to members from daily vendor ED report. 2) Working with vendor to create a cohort report of FUM data only. 3) sFTP folders have been established and BH ED data is being sent to Health networks on a daily basis as well as weekly reminder in HN communication. 4) Bi-weekly Member text messaging. 5) Article promoting Telemed2U, telehealth services, will be included in Fall member newsletter. Article will help with possible provider access issues and increase likelihood of ED follow up visits. 6) FUM data now available through the Provider Portal. 7) Quality Champions meeting with The Coalition of Orange County Community Health Center presentation on BH Quality Measures on 09/20/2024. 8) Developing IVR calls for ED follow-up. 9) Monthly Health Network Communication BH Updates.	1) Continue bi-weekly text messages based on real time ED data. 2) Continue sharing ED data with HN's via sFTP and weekly HN Communication. 3) Collaborate with NAMI to share real-time ED data for member outreach/NAMI by Your Side. 4) Collaborate with Telemed2U provider and internal ITS team to develop implementation plan for Member Outreach 5) Schedule listening sessions with Providers to educate/train on how to obtain BH data. 6) Work with vendor to create campaign for the IVR calls for ED Follow-up.	

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			Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)							
Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare-Management Of Coexisting Medical And Behavioral Conditions	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) HEDIS 2024 Goal: MC 77.40% OC (Medicaid only)	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.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (~~11/05/2024~~10/08/2024) Q4 2024 Update (~~02/11/2025~~ 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS Rates Q3 (July): M/C:58.40% OC: N/A 1) Identified members prescribed antipsychotic medication still in need of diabetes screening test through Tableau Report in August and September. 2) Conducted a text message campaign to reach out to members re: getting their glucose lab screening (July, August, September). 3) Mailed out Member Health reward flyer to 1,164 eligible members on 08/01/2024, and mailed to 287 providers on 08/01/2024. 4) Continue to collaborate with Quality Analytics Team to retrieve data sourcing automation for Tableau on a monthly basis, confirmed that 1583 members received Member Health reward on 09/16/2024. 5) Member Fall Newsletter approved 07/2024. 6) SSD data now available through Provider Portal on 08/15/2024. 7) Quality Champions meeting with The Coalition of Orange County Community Health Center presentation on BH Quality Measures on 09/20/2024. 8) Monthly Health Network Communication BH Updates.	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 data pull for text messaging campaign 4) Mail out member health rewards flyer to eligible members. 5) Mail out to top 60 providers with the following: a.) Medical Director Letter b.) List of members/patients in need of screening c.) Provider Tool Tip Sheet 6) Schedule listening sessions with Providers to educate/train on how to obtain BH data.	
Quality of Clinical Care	Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects	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 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (~~11/05/2024~~10/08/2024) Q4 2024 Update (~~02/11/2025~~ 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration/ Quality Analytics	Conduct Annual oversight of MC Non Clinical PIPs (Jan 2023 - Dec 2025) Improve the percentage of members enrolled: Baseline Measurement Period: Submitted to DHCS 09/09/2024. Remeasurment 1 Period : 01/01/24 -12/31/24 Remeasurment 2 Period : 01/01/25-12/31/25	1) Receiving daily report from vendor which contains Real-Time ED data for CCN and COD members. 2) Internal report developed that identifies members enrolled in CCM and ECM for CCN who meet FUM/FUA criteria for the duration of each measurement period. 3) Collaborate with telehealth provider, Telemed2U, and internal ITS team to develop implementation plan for Member Outreach. Vendor to provide information about case managment including ECM and referrals	

Quality of Clinical Care	Substance Use Disorder Services	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) MY2024 Goals: MC: 30-days: 36.34%; 7-days: 20.0%	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) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (~~11/05/2024~~10/08/2024) Q4 2024 Update (~~02/11/2025~~ 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS Rates Q3 (July): 30-Day- 21.05%, 7-Day- 11.51% 1) sFTP folders have been established and BH ED data is being sent to Health networks on a daily basis as well as weekly reminder in HN communication. 2) Bi-weekly member text messaging 3) Article promoting Telemed2U, telehealth services, will be included in Fall member newsletter. Article will help with possible provider access issues and increase likelihood of ED follow up visits. 4) Developing IVR calls for ED follow-up. 5) FUA data now available through Provider Portal. 6) Quality Champions meeting with The Coalition of Orange County Community Health Center presentation on BH Quality Measures on 09/20/2024. 7) Monthly Health Network Communication BH Updates.	1) Continue bi-weekly text messages based on real time ED data. 2) Continue sharing ED data with HN's via sFTP and weekly HN Communication. 3) Collaborate with Telemed2U provider and internal ITS team to develop implementation plan for Member Outreach. 4) Work with vendor to create campaign for the IVR calls for ED Follow-up. 5) Schedule listening sessions with Providers to educate/train on how to obtain BH data.	
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED) MY2024 HEDIS Goals: MC 66.33% OC: 81%;	Assess and report the following activity: 1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	By December 2024 Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	1. Member Health Reward: EED (MC) - 185; EED (OC) - 79 2. EED VSP mailing from January to September: MC - 5144; OC - 1449 3. Diabetes mailing September: MC- 30362 OC- 3093 4. CareNet Live Call from June to September: OC-1344 5. VSP data sharing to Health Network partners; multiple Health Networks are now receiving Production data and the remaining ones are completing testing 6. August 2024 Prospective Rate Data: EED (MC) - 40.79%; EED (OC) - 59%	Continue with plan as listed	
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better) MY2024 Goals:	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-	Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	1. Member Health Reward: HBD (MC) - 385; HBD (OC) - 125 2. Diabetes mailing September: MC- 30362 OC- 3093 3. CareNet Live Call from June to September: OC-2048 4. August 2024 Prospective Rate Data: HBD (MC) - 70.37%; HBD (OC) - 67%	Continue with plan as listed	

		MC: 29.44%; OC: 20%	channel targeted member, provider and health network engagement and collaborative efforts							
Quality of Clinical Care	Maternal and Child Health: Prenatal and Postpartum Care Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). HEDIS MY2024 Goal: Postpartum: 82.0% Prenatal: 91.07%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Equity and Community Health/ Quality Analytics	Member initiatives: 1) Bright Steps Program: prenatal and posptartum education to participating members. 2) Ongoing: Postpartum Health Reward for members that complete postpartum care between 1-12 weeks after delivery. 1) August 2024: Maternal Health workgroup meeting to discuss member journey. QA will develop a prenatal and postpartum care journey to support member messaging. 2) Community Clinic Forum presentation to support compliance for providers and clinics that utilized bundled coding practices. Per August 2024 prospective rates, Timeliness of Prenatal Care is performing slightly lower than this time time last year with a rate of 67.26% and Postpartum Cre is performing slightly higher than this time time last year with a rate of 65.83%.	Continue with plan as listed. Postpartum member call campaign planned for Q4 Development of guide for providers that participate in bundled billing for prenatal and postpartum care.	
Quality of Clinical Care	Maternal and Adolescent Depression Screening	Medi-Cal Only - Meet the following goals For MY2024 HEDIS:	1) Identification and distribution of best practices to health	Report progress to QIHEC quarterly: Q2 2024 Update	Director of Operations Management /	Manager of Quality Analytics /	Operations Management/	DSF-E PR HEDIS Rates Q3 (July): Screening Total 0.02%; Follow Up Total 36.36% 1) Data collection is still the main barrier. Currently	DSF-E: Distribute best practice guidelines for follow-up visits to providers and health network.	

		DSF-E Depression Screening and Follow-up for Adolescent and Adults - Screening: 2.97% PND-E Prenatal Depression Screening and Follow-up - Screening: 8.81% PDS-E Postpartum Depression Screening and Follow-up: 27.77%	network and provider partners. 2) Provide health network and provider partners with timely hospital discharge data specific to live deliveries to improve postpartum visit completion. 3) Targeted member engagement and outreach campaigns in coordination with health network partners. 4) Provider education (CE/CME) in Q3.	(08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Behavioral Health Integration	Manager of Behavioral Health Integration	Behavioral Health Integration	capturing information by supplemental data. The Behavioral Health Quality Improvement Workgroup exploring ways to obtain additional supplemental data to better capture completed screenings and follow up visits. 2) Drafted Provider Tip Sheet letter submitted for internal review process. 3) Quality Champions meeting with The Coalition of Orange County Community Health Center presentation on BH Quality Measures on 09/20/2024. 4) Monthly Health Network Communication BH Updates.		
Quality of Clinical Care	Blood Lead Screening	HEDIS MY2024 Goal: 67.12%; Improve Lead Screening in Children (LSC) HEDIS measure.	Assess and report the following: Strategic Quality Initiatives Plan to increase lead testing will consist of: 1) A multi-modal, targeted member approach as well as provider and health network collaborative efforts 2) Partnership with key local stakeholders 2024 Member Quality Initiatives will consist of the following but not limited to: - Member health reward and monitoring of impact on LSC HEDIS rate - IVR campaign to - Texting campaign - Mailing campaign - Lead texting campaign for members - Medi-Cal member newsletter article(s) In partnership with the Orange County Health Care Agency, CalOptima Health	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	Member Initiatives: 1) Ongoing: Blood Lead Health Rewards for testing at 12 and 24 months of age. 2) 2-way SMS campaign via Ushur and in alignement with AAP periodicity schedule for well-child visits. Campaing included reminders for lead testing. 3) Live call campaign via vendor CareNet to educate and encourage lead testing. Monitoring Initiatives: 1) In progress: Development of medical record review process to monitor CalOptima Health providers and the adherence to lead requirements (e.g., testing, follow-up, anticipatory guidance) Provider Initiatives: 1) July 2024: Provider fax campaign to providers assigned to children ages 0-6. Fax campaign provided foces on providing resources related to lead requirements such as anticipatory guidance, patient educational materials, etc. 2) July 2024: Posting of Stay Compliant with State-Issued Lead Requirements on CalOptima Health website. Per August 2024 prospective rates, Lead Screening in Children measure is 65.03% and is on track to meet the 50th percentile.	Continue with plan as listed	

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			will co-develop educational toolkit on blood lead testing.							
Quality of Clinical Care	EPSDT/Children's Preventive Services: Pediatric Well-Care Visits and Immunizations	HEDIS **MY2024** Goal CIS-Combo 10: 45.26% IMA-Combo 2: 48.80% W30-First 15 Months: 58.38% W30-15 to 30 Months: 71.35% WCV (Total): 51.78%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Early Identification and Data Gap Bridging Remediation for early intervention.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	Member Initiatives: 1) 2-way SMS via Ushur for multiple pediatric age groups in place. 2) Ongoing telephonic outreach to pediatric members for multiple measures via Carenet. Provider/HN Initiatives: 1) Detailed W30 reports continue to be distributed regularly. CIS performance continues to trend lower than same point-in-time last year; as such, Carenet was provided with a Q4 focus report of members due for CIS that are still actionable (haven't reached their 2nd birthday yet).	Continue with plan as listed	
Quality of Clinical Care	Quality Improvement activities to meet MCAS Minimum Performance Level	Meet and exceed MPL for DHCS MCAS	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits. Perform root cause analysis, strategize and execute planned interventions targeting members, providers and systems.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	Member Initiatives: 1) 2-way SMS via Ushur for multiple pediatric age groups in place. 2) Ongoing telephonic outreach to pediatric members for multiple measures via Carenet. Provider/HN Initiatives: 1) Detailed W30 reports continue to be distributed regularly.	Continue with plan as listed	
Quality of Clinical Care	Encounter Data Review	Conduct regular review of encounter data	Monitors health network's compliance with	Semi-Annual Report to QIHEC Q2: 04/09/2024	Director of Finance	Manager of Finance	Finance	Medi-Cal: HMOs and PHCs met at least 6 of 8 measures; CHOC met 6 of 6 measures; SRGs met 5 of 6 measures. OneCare: 5 networks met all	Encounters team is working with AMVI to review root causes of low submissions and plans for	

		submitted by health networks	performance standards regarding timely submission of complete and accurate encounter data.	Q4: 10/08/2024 postponed to 11/5/2024				measures; 4 networks met 3 of 4 measures; 1 network met 2 of 4 measures	remediation. They can be subject to a Corrective Action Plan.	
Quality of Clinical Care	Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	PCP and High Volume Specialist sites are monitored utilizing the DHCS audit tool and methodology.	Review and report conducted initial reviews for all sites with a PCP or high volume specialists and a review every three years. Tracking and trending of reports are reported quarterly.	Update volume from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025 Compliance details to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director Quality Improvement	Manager Quality Improvement	Quality Improvement	**FSR/MRR/PARS, Community-based Adult Services (CBAS) and Nursing Facilities (NF) Oversight** **A. FSR**: Initial FSRs=15; Initial MRRs=8; Periodic FSRs=66; Periodic MRRs=76; On-Site Interims=4; Failed FSRs=0 Failed MRRs=12 CAPs: CE=39; FSR=63; MRR=61 **B. PARS**: Completed PARS=110 (Basic Access=44 Limited Access=66 **C. CBAS Oversight:** Critical Incidents=16 (16 COVID cases); Non-Critical Incidents=22; Falls=10; Audits Completed=12; CAPs Issued=8; Unannounced Visits=0 **D. NF Oversight**: Critical Incidents=14; On-Site Visits=12; Unannounced Visits=0	FSR/MRR: In order to avoid, a third subsequent failed audit (FSR and/or MRR) and removal from the CalOptima Heatlh provider network, extensive education and additional resources are being provided to sites with two subsequent FSR and/or MRR failed audits. PARS: Continue with plan, as listed.	
Quality of Clinical Care	Potential Quality Issues Review	Referred quality of care grievances and PQIs are reviewed timely	Review and report conducted referred cases are properly reviewed by appropriate clinical staff, cases are leveled according to severity of findings, and recommendations for actions are made, which may include a presentation to the CPRC for peer reviewed.	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director Quality Improvement	Manager Quality Improvement	Quality Improvement	202 PQIs closed in Q3; 57 (28%) were declined grievances. 36 (18%) were leveled QOC; 166 (82%) QOS. We have 721 PQIs currently open. Nine PQIs leveled 1, 2 or 3 were presented to CPRC. PQI trends for 1/1/24-6/30/24 identified an ABA group and a acute care hospital. During this time frame, most quality of care PQIs were categorized as medical care, and most were either mismanaged care or treatment (delay, failure, inappropriate or complications).	In order to reduce the number of PQIs being opened, we are meeting with departments to find other ways to address issues with providers that are not truly a PQI. One strategy is to develop a Provider Action Workgroup where deparments may bring providers for action. The policy and charter is in developement with a desired completion by Q1 2025.	
Quality of Clinical Care	Initial Provider Credentialing	All providers are credentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements and are current within 180 days of review and approval (60 days for BH providers)	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director Quality Improvement	Manager Quality Improvement	Quality Improvement	Initial BH Credentialing Q3 = 5; Initial CCN Credentialing Q3 = 18	Initial credentialing: 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 credentialling.	
Quality of Clinical Care	Provider Re-Credentialing	All providers are re-credentialed according to regulatory requirements	Review and report providers are re-credentialed within 36 months according to regulatory requirements	Update from CPRC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Quality Improvement	Manager Quality Improvement	Quality Improvement	BH Recredentialing - Q3 = 18; CCN Recredentialing Q13 = 49. For Q3 we did not have any recredentialing files out of compliance	Recredentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the recredentialing of providers. This will ensure that we continue with compliance and	

									timeliness of the recredentialing files.	
Quality of Clinical Care	Chronic Care Improvement Projects (CCIPs) OneCare	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	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 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	1. Member Health Reward: EED (OC) - 79; HBD (OC) - 125 2. EED VSP mailing from January to September: OC - 1449 3. Diabetes mailing September: MC- 30362 OC- 3093 4. CareNet Live Call from June to September: EED (OC)- 1344 HBD (OC)- 2048 5. Emergin Risk (telephonic outreach via Equity and Communiy Helath department staff) 5. August 2024 Prospective Rate Data: EED (OC) - 59%: KED (OC)- 45%; HBD PC (OC)- 67%; MAD (OC)- 93%; SUPD (OC)- 85%	Continue with plan as listed	
Quality of Clinical Care	Special Needs Plan (SNP) Model of Care (MOC)	% of Members with Completed HRA: Goal 100% % of Members with ICP: Goal 100% % of Members with ICT: Goal 100%	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implementation and monitoring.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director Medical Management/Case Management	QI Nurse Specialist	Case Management	1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. a) CC0258 partially remediated; b) CMS raised cut points for Star Measure on HRA completion by 4% and Case Mangement is on track to acheive HRA collection to meet three stars in Q4. c) Q2 HRA1 adjusted score: Members reached and willing to complete HRA is 100% d) Q2 ICP2 adjusted score: Members reached and willing to complete ICP is 91% e) ICT-pending Jiva remediation and development of SNPE reporting. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. a) Ongoing monthly communications to CCN and Health Networks for ICP1 development status for newly effective members. b) Continue to provide feedback on annual ICP development and missing face-to-face interactions. Continue communication process with Network 3) Creation and implementation of the Oversight audit tool. a) Audit tool review for updates.	1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. a) CC0258 partially remediated and will resume per JIVA remediation priorities; b) Ongoing monitoring of initial HRA completion for acheiving three stars. c) Report on Q3 HRA1 adjusted score. d) Report on Q3 ICP2 adjusted score. e) ICT-pending Jiva remediation and development of SNPE reporting. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. a) Ongoing monthly communications to CCN and Health Networks for ICP1 development status for newly	

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									effective members. b) Continue to provide feedback on annual ICP development and missing face-to-face interactions. Continue communication process with Network 3) Creation and implementation of the Oversight audit tool. a) Share Audit tool with Health Network.	
Quality of Service	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 network2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members	Update from MemX to QIHECQ2: 06/11/2024Q3: 09/10/2024Q4: 12/10/2024Q1 03/11/2025	1) Director of Provider Network2) Director of Contracting	Analyst of Quality Analytics	~~Contracting~~/Provider Data Operations	1. Transition from QA to Provider Data Operations completed2. Network Adequacy Workgroup conducted first monthly meeting to discuss network adequacy as a whole, Q3 gaps, and an action plan to reduce gaps specific to PMR on plan level and T&D for CCN HN level3. Provider Data Ops provided leads list to Contracting & PR to help close CCN time and distance gaps4. No HN closed CAP this quarter. Based on continued good faith efforts of HNs to contract providers, COH establish and authorized AAS process to close outstanding CAPs 5. 4 out of 6 HNs closed CAP via AAS (FCHS, Noble, Optum, Prospect). AMVI and UCMG issued Non-Compliance notice for not meeting deadline submission for AAS.	1. Provider Data Ops collaborating with PR to receive needed AAS from AMVI and UCMG2. PR conducting provider outreach based on leads list to gauge contracting interest to close CCN time and distance gap3. Provider Data Ops - Program Mgmt & Analytics working on provider leads list to help close Plan level gaps identified in Q3	
Quality of Service	Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Assess and report the following activities: 1) Issue corrective action for areas of noncompliance 2) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely access. 3) Continue to educate providers on timely access standards 4) Develop and/or share tools to assist with improving access to services.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics / Project Manager of Quality Analytics	Quality Analytics	All eleven HN CAPs issued in December 2023 (2022 Timely Access Survey results) have been closed. In June-2024, 110 CAPs were issued to individual providers based on 2023 Timely Access Survey findings. • As of mid-October, received responses from 65 (59%) of the providers • Review of the responses and validation of compliance for select telephone measures began in September • Timely Access workflows and tools completed. Moving forward will be updated as needed. In June 2024, Carenet conducted an interim telephone audit on 758 providers identified as non-compliant for telephone measure ""instruct caller to ER or Dial 911 in case of an emergency" . Results are as follows and additional follow-up is taking place with those who remain non-compliant: • Non-Compliant: 245 • Compliant: 511 • Unreachable: 2 Carenet is currently fielding an In-Office Wait Time survey to members. Survey started in August and scheduled to conclude in November.	2024 Timely Access Survey scheduled to start October 15. HN Timely Access CAPs to be issued in Q4 based on 2023 Access Survey findings Continue to outreach to non-compliant providers for Timely Access and review responses to CAPs.	
Quality of Service	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Annual submission of SNC to DHCS with AAS or CAP	Submission: 1) By end of January 15, 2024 2) By end of Q2 2024	Director of Provider Network / Director of Medicare Stars	Quality Analyst	~~Network Operations~~ Provider Data Operations/Quality Analytics	Submitted 2023 Quarterly CAP status update - 4 of 6 HNs closed via AAS; AMVI and UCMG still open SNC Report Q3 2024: August 274 file results: communicated to HNs	1. PR reaching out to AMVI and UCMG regarding CAP closure 2. Verify that approved AAS have been posted by HNs to their	

			2) Monitor for Improvement 3) Communicate results and remediation process to HN	3) By end of Q3 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	and Quality Initiatives			-Time/Distance: all HN did not meet. Top 5 gaps were Phys Med/Rehab, Endocrinology, Dermatology, Neurology and HIV/AIDS Specialist/Infectious Diseases. South County remains as the general area where the gaps are occurring - OON: using MCPD-OON Data Q2 2024 submission to DHCS - BH: 16; GC:139 - Network Capacity/Ration (FTE): HNs met standards -PMR: 7 HNs now meet PMR, up 3 from Q2; ongoing gaps are in Orthopedic Surgery, Ophthalmology, and Gastroenterology. AMVI is only 1 unique provider short of meeting requirements under Neurology and Pulmonology; AltaMed's current gap may be due to their provider network beign reloaded - PCP: re-opened 3 panels and no new closures - WCM: Plan level met all specialties. All HNs confirmed met (UCMG & AMVI closed gaps) FINDINGS: Throughout Q3, as health networks worked on closing 2023 SNC CAPs for time and distance, they expanded their provider networks which resulted in an overall decrease of time and distance gaps from Q2 to Q3. The only exception is UCMG which increased in gaps, mostly in Dermatology. Timely Access: All eleven HN CAPs issued in December 2023 (2022 Timely Access Survey results) have been closed.	website by due date of October 30th 3. PR to do recruitment outreach to close CCN time and distance gap 4. Timely Access: HN Timely Access CAPs to be issued in Q4 based on 2023 Access survey findings	
Quality of Service	Increase primary care utilization	Increase rate of Initial Health Appointments for new members, increase primary care utilization for unengaged members.	Assess and report the following activities: 1) Increase health network and provider communications, trainings, and resources 2). Expand oversight of provider IHA completion 3) Increase member outreach efforts	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	<u>1) Increase health network and provider communications, training, and resources</u> a. Communication: Reminder to HNs via HN Weekly Communication to sign up for IHA CME; Most HN updates have been moved over to HN Quality Update Meeting (bimonthly) b. Presentations and Trainings HNs/Providers: 1 HN Collaborative Quality Forum Meeting, 21 HN Quality Update Meetings, 2 QIHEC, 2 CHCN Virtual Meetings, 2 PHMC Meetings, 1 CME, 2 QIHEC Meetings, 1 DOC Meeting c. Provider Toolkit Resource: The document was placed on hold due to the website redesign; Components of the Provider Toolkit document are linked on the website. d. Provider Portal: Promoting IHA Report and Member Roster at HN and provider trainings and presentations. <u>2). Expand oversight of provider IHA completion</u> a. IHA Chart Review Audits: Encountered barriers with communication and responsiveness from PCP offices; escalated communication to Medical Director for Clinic Leadership outreach, office direct calls, and provider office visits b. Provider Office Visits: 7 Provider office visits in addition to Teams meetings with all providers selected for chart review audits for Q3 c. KPI Metric Expectation for HNs: Individually met with all HNs at least once; provided them each with the Delegation Oversight Dashboard Response Form	<u>1) Increase health network and provider communications, training, and resources</u> -Provider Toolkit: Resume development upon COMMS confirmation of the website redesign project completion. -Communication, Presentations and Trainings- HNs/Providers: Continue to present and provide trainings on IHA; HN Forum IHA presentation was rescheduled to Q4 <u>2). Expand oversight of provider IHA completion</u> -IHA Chart Review Audits: Establish an approach to handle providers/clinics that are not responsive to records requests (including but not limited to education, failed chart review, corrective action plan, etc.) -KPI Metric Expectation for HNs: Implement Corrective Action Plans to any Health Network that did not return Delegation Oversight Dashboard Response Forms and to the lowest performing HN(s) -KPI Metric Tracking: Continue	

								to fill out to report back on what actions they are taking to increase rates and track their performance d. KPI Metric Tracking: Tracking HN performance and sharing at HN Quality Update Meetings and during individual HN meetings <u>3) Increase member outreach efforts</u> a. Text Message campaign for new members + IHA: Approved by DHCS on 9/26/2024; translation completion date 10/10/2024. Current Step: The text message is being processed, following the COMMS text message request process, in 7 threshold languages (can take up to 2 months). b. Ongoing IVR Campaign: Sent out twice monthly to new members	tracking HN performance and sharing at HN Quality Update Meetings and during individual HN meetings <u>3) Increase member outreach efforts</u> - Text Message campaign for new members + IHA: Anticipated launch in December. - IVR Campaign: Continue ongoing campaign, twice monthly	
Quality of Service	Improving Access: Annual Network Certification	Comply with Annual Network Certification requirements	1) Annual submission of ANC to DHCS with AAS 2) Implement improvement efforts 3) Monitor for Improvement	Submission: 1) By June 2024 2) By December 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	Quality Analyst for Quality Analytics/ Manager of Provider Data Management Services	Provider Data Operations ~~Management Services~~	1. ANC monitoring has transitioned to Provider Data Operations - Program Management 2. Per Q3 Network Adequacy Report, the plan meets requirements for MPT, capacity/ratio (FTE) and time/distance 3. No update on AAS request submitted in March	1. Prepare requirements for 2024 Annual Networ Certification 2. Update changes to policies and procedures	
Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal	Assess and report the following activities: 1) Conduct outreach to members in advance of 2024 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively. 3) These items also continue to be included in all P4V discussions with HNs.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	QA Project Manager	Quality Analytics	1. Closed 2. Closed 3. Pending receipt of HNQR.	1. Closed 2. Closed 3. Analysis of HNQR when available and identify next steps for low performing Health Networks.	
Quality of Service	Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process	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	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of GARS	Manager of GARS	GARS	Trends identified in <u>Member Appeals</u>: tertiary level of care/specialty care denials and continuity of care - State Fair Hearings: 22 Received (10) Upheld (2) Overturned - COC w/OON Pain Management (12) Dismissed - Maximus: 32 Submitted (27) Upheld (1) Dismissed (4) Overturned - OO Country Reim, COC w/Wound Care Provider, In Home Physical Therapy, COC w/Vascular Surgeon Trends identified in <u>Provider Appeals/Disputes</u>: clinical edits denials, level of payment disputes, failure to obtain authorizations. Additional trends worth noting	The department will continue to perform quarterly and year to date reviews to identify trends. This information will be presented to GARS Committee as opportunities to improve operations across the organization. Next GARS Committee meeting is scheduled for November 13, where Q3 data will be presented.	

			grievance and appeals					were - CalAim Provider Denials due to incorrect billing and Cotiviti Overturns Increased 20% over Q1 Trends identified in Grievances: Authorization Delays, Plan Customer Service, Provider/Staff Attitude, Provider Availability and Transportation.		
Quality of Service	Customer Service	Implement customer service process and monitor against standards	Track and trend customer service utilization data Comply with regulatory standards Maintain business for current programs Improve process for handling customer service calls	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Associate Director of Customer Services	Manager of Customer Service	Customer Service	Customer Service ran KPI data and reported results to QIHEC. DHCS' average speed of answer of not exceeding 10 minutes: Goal was met (1 min and 45 sec). Internal business goal of abandonment rate not exceeding 5% met: Goal was met (4.8%). Accomplishments: Hired additional staff, various departments staggered member engagement campaigns, leveraging call back capabilities for inbound calling members opting in.	Continue with plan	
Quality of Service	Medi-Cal Customer Service Performance Improvement Project	To meet Medi-Cal Customer Service KPIs by December 31, 2024: Internal call abandonment rate of 5% or lower, DHCS' 10 minutes average speed of answer	1) Partnering with HR to onboard more permanent and temporary staff to service inbound calls. 2) Interacting with various departments involved with member engagement campaigns and determine if they're able to update instructions for targeted members (i.e., instead of calling customer service, have them utilize the member portal).	Report progress to QIHEC quarterly: ~~Q2 2024 Update (08/13/2024)~~ ~~Q3 2024 Update (11/05/2024)~~ Q3 2024 Update (07/09/2024) ~~Q4 2024 Update (02/11/2025)~~ Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Associate Director of Customer Services	Manager of Customer Service		Goals met	No further action required.	
Safety of Clinical Care	Coordination of Care: Member movement across practitioners	Improve coordination of care, prevention of complications, and facilitation of best practice diabetes care management between vision care specialists (SPCs) and primary care providers (PCPs)	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement: 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Case Management	TBD	Medical Management	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement: a. Multiple meetings with Claims, UM, PR, Customer Service, and other teams to discuss eliminating prior auth for preventive screenings (including the diabetic eye exam measure). 2) Provider and member education: a. Ongoing production data obtained from VSP and posted to Health Networks: CHOC: posted on 9/5 Noble: posted on 9/5 Prospect: posted on 9/10 b. Ongoing communication to members monthly basis from VSP for those in need of eye exam.	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement: a. Ongoing monthly meetins b. Several eye exam CPT codes to be removed from Prior Authorization list effective 10/1/2024. 2) Provider and member education: a. Ongoing plan to send VSP data to health network partners to close data gaps for the Eye Exam Diabetes measure. b. Ongoing communications to members monthly basis from VSP on need for eye exam.	

Safety of Clinical Care	Emergency Department Member Support	Emergency Department Diversion Pilot has been implemented. In 2024 plan to expand a virtual program to additional hospital partners starting with UCI.	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	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of LTSS	Manager of LTSS	LTSS	No metrics to report, still in development.	Two staff members (MSW & RN) were hired in September and are starting the end of October. They will go through CalOptima Health LTSS and UCI emergency department orientation for approximately 30 - 45 days. After orientation they will be embedded in the UCI ED approximately 80% of their time and remainder working virtually to support members in the ED.	
Safety of Clinical Care	Coordination of Care: Member movement across settings - 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% from Q4 2023 by end of December 31,2024.	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.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of UM, CM and LTSS	Manager of Medical Management	Utilization Management Case Management Long Term Care	1) IPP 4.3 Report (percentage of members who had ambulatory visits within 7 days post hospital discharge) = 40.03% 2) Established reports for FFS Medicare program [Post-discharge Dashboard] 3) Developed a process and procedures for outreaching to pregnant members (TCS high-risk) not enrolled in Bright Steps. Hired a Care Manager to conduct these outreaches [July 2024] 4) Developed the Ushur texting campaigns to promote TCS	1) Launch texting campaign using the Ushur platform (Q4) 2) Continue with motivational interviewing trainings 3) Continue improving outreach efforts for TOC. (Non-Bright Steps members are receiving targeted outreach) 4) Review DHCS LTSS resource guide for enhancement opportunities 5) Develop a process for identifying FFS Medicare members in need of TCS 6) Continue educating CalAIM ECM Provider to documenting Lead Care Managers in CalOptima Connect.	
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 41.90% to 55.78% by 12/31/2024.	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 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Quality Analyst	Quality Analytics	Findings: As part of the parental/guardain reminders, call also assessed for barriers and facilitators to well-child visits. Challenges included limitations with successfully being able to outreach to parents/guardians of child members. Out of 85 members, was only able to successfuly reach 24 members. Key highlights: • Parental knowledge- CalOptima Health assessed for knowledge as it relates to the importance of well-child visits and what should be expected at these visits. 21.18% expressed having knowledge of the importance of the visits and 18.82% did not express having any understanding. Some parents drew on the knowledge from their previous experiences with other children. • Scheduling- When inquired about the scheduling of the next well-child visit, 67.65% (n=23) responded not having a visit scheduled, or being unsure, followed by 32.35% reporting that they had the next well-visit	Utilize findings to develop new intervention for 2025	

								scheduled with the PCP. When attempting to assess for barriers and facilitators, 6 of the 34 parents declined to proceed with the call. The following narrative is based on 28 successful parental interactions. • Barriers to well-child visits- 35.29% (n=12) of parents reported experiencing challenges that impact their ability to attend well-child visits. Factors included: family law where custody for the child varied, scheduling conflicts with parental work schedules or PCP schedule that did not align with the parent's needs, lack of childcare, and lack of transportation. • Facilitators to well-child visits- 32.35% (n=11) reported on various facilitators to attending these visits. PCP availability was mentioned the most, followed by transportation benefit, office reminders to attend, knowing who the child's PCP is. PIP Steps 1-8 submitted in September 2024 with the findings noted above.		
Cultural and Linguistic Appropriate Services	Cultural and Linguistics and Language Accessibility	Enhance interpreter and translation services	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards, including Member Material requirements Initiate Request for Proposal (RFP) to add and/or replace the translation and interpreter services vendors to improve the member experience.	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	The goal for this element has changed. The new approach is to extend the current contracts of the 5 contracted vendors in lieu of going out for Request for Proposal (RFP). To COBAR has been completed and will be presented at the November Board of Directors meeting. If approved, Vendor Management will work on extending the existing contracts.	Pending next steps after the November Board meeting.	
Cultural and Linguistic Appropriate Services	Maternity Care for Black and Native American Persons	1) PPC Postpartum: Increase timely PPC postpartum appointments for CalOptima's Black members from 67.48% to 74.74% and Native Americans from 44.44 to 63.22% by 12/31/24. 2) PPC Prenatal: Increase timely PPC prenatal appointments for CalOptima's Black members from 53.77 to 72.37% and Native	Assess and report the following activities: 1) Determine the primary drivers to noncompliance via member outreach and literature review 2) Targeted member engagement and outreach campaigns in coordination with health network partners 3) Strategic Quality Initiatives Intervention Plan -	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Manager Equity and Community Health/ Director of Operations Management	Program Manager of Quality Analytics/ Manager of Quality Analytics	Equity and Community Health	Development of member messaging for prenatal and postpartum care is still taking place to support the goal of multimodal outreach and targeted engagement.	Continue with plan as listed	

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		Americans from 27.78% to 59.43% by 12/31/24.	Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 4) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 5) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 6) Expand member engagement through direct services such as the Doula benefit and educational classes							
Cultural and Linguistic Appropriate Services	Data Collection on Member Demographic Information	Implement a process to collect member SOGI data by December 1st, 2024.	1) Develop and implement a survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age). 2) Update CalOptima Health's Core eligibility system to store SOGI data. 3) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks.	Report progress to QIHEC quarterly: ~~Q2 2024 Update (08/13/2024)~~ Q2 2024 Update (07/09/2024) ~~Q3 2024 Update (11/05/2024)~~ Q3 2024 Update (10/08/2024) ~~Q4 2024 Update (02/11/2025)~~ Q4 2024 Update 01/14/2025)	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	The SOGI survey been implemented and began mailing in September 2024 to new members 18 years of age and older. The REL/SOGI draft policy has been submitted to the consultants for review. Traget date for submission to the Board is December 2024	Continue to collect member REL/SOGI data Build Core report to capture Race/Ethnicity data in OMB format Submit draft REL/SOGI data collection policy to the Board and DHCS for approval.	

			4) Develop and implement a survey via the Member Portal, mail to new members and other methods. 5) Share member demographic information with practitioners.							
Cultural and Linguistic Appropriate Services	Data Collection on Practitioner Demographic Information	Implement a process to collect practitioner race/ethnicity/languages (REL) data by December 31, 2024.	1) Develop and implement a survey to collect practitioner REL data 2) Enter REL data into provider data system and ensure ability to retrieve and utilize for CLAS improvement. 3) Complete an analysis of the provider network capacity to meet language needs of the CalOptima Health membership. 4) Assess the provider network's capacity to meeting CalOptima Health's culturally diverse member needs. 5) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Provider Data Management Services	Manger Provider Data management System	Provider Data Management Services	1. Set up Facets system to capture data 2. Established data needs and sent out surveys to providers 3. Working with web design team to update provider search tool to reflect information in searches	1. Providers to complete survey and submit to CalOptima 2. Ensure search tool will display information collected 3. Ensure Salesforce system will be configured to store data 4. Establish process for providers to update informaiton via the annual providers attestation process.	
Cultural and Linguistic Appropriate Services	Experience with Language Services	Evaluate language services experience from member and staff	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 quarterly: ~~Q2 2024 Update (08/13/2024)~~ Q2 2024 Update (07/09/2024) ~~Q3 2024 Update (11/05/2024)~~ Q3 2024 Update (10/08/2024) ~~Q4 2024 Update (02/11/2025)~~ Q4 2024 Update 01/14/2025)	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	Member and staff language service experience surveys in development stage: The Staff Language Survey has been finalized, currently with Communications. The survey design and layout is currently in process. The Member Language Survey being finalized and will be forward to Communications for design and layout.	Q3 2024 Update presented QIHEC on 10/08/2024 Q4 2024 Update will be presented QIHEC on 01/14/2025	

2024 QI Work Plan – Q4 Update

Evaluation Category	2024 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/Metrics: Assessments, Findings, and Monitoring of Previous Issues *List any problems in reaching the goal or relevant data (i.e. state if goals were met or not met, include what caused the problem/issue)*	Next Steps Interventions / Follow-up Actions *State what will be done to meet the goal (i.e. continue with plan as listed or modify the plan: add a specific new process, etc.)*	Red - At Risk Yellow - Concern Green - On Target
Program Oversight	2024 Quality Improvement Annual Oversight of Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Quality Improvement Health Equity Transformation Program (QIHETP) Description and Annual Work Plan will be adopted on an annual basis; QIHETP-QIHEC-BOD; Annual Work Plan-QIHEC-QAC	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	2024 QIHETP Description and Annual Work Plan was adopted earlier this year. In Q4 QI staff started evaluation of the 2024 QIHETP and Work Plan.	Write a report on the evaluation of the 2024 QIHETP Description an Work Plan and create the 2025 QIHETP Description and Work Plan.	
Program Oversight	2023 Quality Improvement Program Evaluation	Complete Evaluation 2023 QI Program	Quality Improvement Program and Annual Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	Goal was completed 5/5/2024.	No next step.	
Program Oversight	2024 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2024 UM and CM Program Description	UM and CM Program will be adopted on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	ED of Clinical Operations	Director of UM	Utilization Management	2024 UM / CM Integrated Program Description completed on time and received approved the BOD	Draft the 2025 UM / CM Program Description and present to UMC 1/23/25 for approval	
Program Oversight	2023 Integrated Utilization Management and Case Management Program Evaluation	Complete Evaluation of 2023 UM CM Integrated Program Description	UM Program will be evaluated for effectiveness on an annual basis.	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	ED of Clinical Operations	Director of UM	Utilization Management	2024 Program Evaluation completed on time and received approval from BOD.	Draft the 2024 Program Evaluation and present to UMC 1/23/25 for approval	

2024 QI Work Plan – Q4 Update

Program Oversight	Population Health Management (PHM) Strategy	Implement PHM strategy	Conduct the following: (1) Population Needs Assessment (PNA) (2) Risk stratification (3) Screening and Assessment (4) Wellness and prevention	PHMC report to QIHEC: Q1 03/12/2024 Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024	Director of Equity and Community Health	Manager of PHM/Director of Care Management	Equity and Community Health	Developed the 2025 PHM Strategy and Work Plan (1) 2024 PNA was discussed at MAC/PAC, provided to PHMC and posted to CalOptima Health's website. (2) Continued to work to update risk stratification based on HIF-MET (3) Continued to work to update risk stratification based on HIF-MET (4) Initiated updates to care continuum in partnership with Clinical Operations, including enhancements to wellness and prevention programs for all members. Continued contracting process with WebMD for integration of health education materials into Jiva.	Present to 2025 PHM Strategy and Work Plan to QIHEC, PHMC, QAC and Board (1) 2025 PNA planning, outline and data pull. (2) Starting in 2025, Medical Management leading risk stratification efforts. (3) Care continuum will consider vendors that can support screening and assessment through multimodal channels (4) Contract with WebMD to be executed in Q1 2025. Will request approval for expansion of health ed. materials into website via WebMD's Health Hub product.	On Target
Program Oversight	2024 Population Health Management (PHM) Strategy Evaluation	Complete the Evaluation of the 2024 Population Health Management (PHM) Strategy	The Population Heath Management (PHM) Strategy will be evaluated for effectiveness on an annual basis.	QIHEC: 11/05/24 QAC: 12/11/2024 Annual BOD Adoption by January 2025	Director of Equity and Community Health	Manager of PHM/Director of Care Management	Equity and Community Health	▪Quarterly 2024 PHM Workplan monitoring. • Drafted 2024 PHM Impact (Evaluation) Report.	• Continue quarterly 2025 PHM Workplan monitoring • Present 2024 PHM Impact report QIHEC, PHMC, QAC and Board	On Target
Program Oversight	2024 Cultural and Linguistic Services Program and Work Plan	Obtain Board Approval of 2024 Program and Workplan	Cultural and Linguistic Services Program Work Plan will be evaluated for effectiveness on an annual basis	QIHEC: 02/13/2024 QAC: 03/13/2024 Annual BOD Adoption by April 2024	Manager of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	• Board approval was obtained in Q2. • Workplan status updates and results were presented at the MAC/PAC December meeting. • Worked on 2025 Workplan, added new goals and carried over existing goals that were not completed.	The Cultural and Linguistic Services Program Work Plan will be submitted to the QAC for review and approval and to the Board of Directors in March 2025.	
Program Oversight	2024 Cultural and Linguistic Services Program Evaluation	Complete the Evaluation of the 2024 Cultural and Linguistic Services Program	The Cultural and Linguistic Services Program will be evaluated for effectiveness on an annual basis.	QIHEC: ~~11/05/2024~~ 01/14/2025 QAC: ~~12/11/2024~~ 03/12/2025 Annual BOD Adoption by ~~January 2025~~ April 3 2025	Manager of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	• Evaluation was conducted and completed on 1/19/2025 • Evaluation was submitted for executive review and submitted for consultant review and feedback on 1/20/2025	• Pending executive and consultant feedback. • Submit to the QAC for review in March 2025 and approval and to the Board of Directors in April 2025.	

Program Oversight	**Population Health Management (PHM) Committee** - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee activities, findings from data analysis, and recommendations to QIHEC	(1) PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), (2) PHM Strategy activities, and PHM Workplan progress and outcomes. (3) Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	PHMC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Equity and Community Health	Manager of Equity and Community Health/ Director Case Management	Equity and Community Health	▪ Held fourth quarter PHM Committee Meeting in November 2024 which included both internal CalOptima Health updates on PHM Program and community presentation from the Institute for Healthcare Advancement. ▪ PHMC reviewed and approved 2024 PNA. ▪ Provided PHM Committee update for QIHEC in December 2024.	▪ Continue to assist this committee by reviewing relevant guidance, agenda setting, presentation development, and deliverables shared with QIHEC. ▪ Next PHM Committee meeting is scheduled for February 2025. ▪ Report committee update to QIHEC in March 2025.	
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 activities, findings from data analysis, and recommendations to QIHEC	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. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Manager of Quality Improvement	Manager of Quality Improvement	Quality Improvement	The Committee met on 11/21/24, 12/19/24. Three physicians continue undergoing the Fair Hearing process. Seven PQIs leveled as 1, 2 or 3 were presented to CPRC for leveling and actions. Policies GG.1651, GG.1657, GG.1633, GG.1659, GG.1643, GG.1604 and GG.1607 were approved. Two providers were presented for on-going monitoring. Six providers with issues were presented was presented and approved for recredentialing. Approved the Credentialing Clean List for 09/30/2024, 10/31/2024, 11/14/2024, 11/27/2024. Approved the Practitioner Closure List for 09/30/2024, 10/31/2024, 11/27/2024. The Committee approved the addition of Behavioral Health (BH) qualified physicians who have additional CME in BH to contract in this function. Credentialing, FSR and Incident statistics were presented with no action identified.	The Committee will continue to monitor the provider network through on-going monitoring, credentialing/recredentialing, PQIs and FSR audits. Policies relevant to these processes will continue to be reviewed by the Committee.	

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 activities, findings from data analysis, and recommendations to QIHEC	The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health netwoks. Trends and results are presented to the committee quarterly. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Grievance and Appeals	Manager of GARS	GARS	Q3 GARS Committee was held on 11/13/2024. Q2 committee meeting minutes were approved. Discussions were had around HN delays in authorizations and appointment availability. Grievance trends related to transportation were also presented and discussed.	Continue with plan	
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 activities, findings from data analysis, and recommendations to QIHEC	The MEMX Subcommittee reviews the annual results of CalOptima Health's CAHPS surveys, monitor the provider network including access & availability (CCN & the HNs), review customer service metrics and evaluate complaints, grievances, appeals, authorizations and referrals for the "pain points" in health care that impact our members. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	MemX Committee report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	Project Manager Quality Analytics	Quality Analytics	In Q4 Member Experience Committee held an ad hoc committee meeting on October 9, 2024 to discuss the 2024 CAHPS results and the regular Member Experience Committee meeting was held on October 15, 2024. The following were reviewed and discussed at the ad hoc meeting for CAHPS: plan and HN level results for both Medi-Cal and OneCare. At the regular meeting the following were reviewed and discussed: **Timely Access:** Q2 2024 DHCS wait time results, timely access survey 2023 plan level results fielded by CalOptima for Medi-Cal and OneCare that indicates appointment availability compliance rates for individual provider and compliance rate for another office provider and telephone results for pre-recorded messages, callbacks, telephone triage and flexibility for scheduling members with disabilities. An update to the 2023 provider corrective action letters that were mailed as of 10/1 had a 59% response rates, health networks conducted outreach calls to encourage providers to complete the CAP submission by the due date, validation calls were made to confirm compliance with phone measures and in Sepember 2024 the new Corrective Action Review Checklist tool was	Timely Access: 2024 timely Access survey to start fielding October 15, issue health network CAPs by end of November 2024, and continue to outreach to providers to collect CAP responses. Work with AMVI and UCMG to close SNC time and distance CAP.	

								being utilized. **Network Adequacy: SNC and ANC:** 2023 SNC CAP time and distance: CalOptima authorized Alternative Access Standards (AAS) to close the remaining 6 Health Network CAPs, 4 Health Networks closed CAPs via AAS, AMVI and UCMG remain CAPs remain open. CalOptima submitted 3rd quarter required updates to DHCS on October 1st. 2024 pre-SNC activities began with SNC kickoff in November. **Network Adequacy Validation Audit:** HSAG had a full day audit on July 25 and CalOptima was notified that the audit was formally closed on September 30. Plan specific validation rating determinations will be shared late November 2024. **Medi-Cal Quarterly: Reporting PCP Over Capacity:** CalOptima re-opened 3 PCP panels **Whole Child Model:** Q3 results plan and HN level all specialties and HN met requirement of one for every core specialists at the plan and HN level **OneCare Data Analysis and Reporting:** Except Speech Therapy all specialties met time and distance requirements **CAHPS:** An overview of CAHPs was presented at the October 9, 2024 meeting with the recommendation to establish a workgroup to improve CAHPS scores. **KPI updates: Customer Service Health Education Grievance and Appeals UM Behavioral Health**		

Program Oversight	**Utilization Management Committee (UMC) Oversight -** Conduct internal and external oversight of UM activities to ensure over and underutilization patterns do not adversely impact member's care.	Report committee activities, findings from data analysis, and recommendations to QIHEC	UMC reviews medical necessity, cost-effectiveness of care and services, reviewed utilization patterns, monitored over/under-utilization, and reviewed inter-rater reliability results. The 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: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Utilization Management	Manager of UM	Utilization Management	UMC reviewed status update on Goals at Committee meeting November 21, 2024. A summary of this presentation was provided at the December 10th QIHEC Committee meeting including an update on the mitigation strategies implemented for the Notification Compliance initiative. IRR results for UM and Pharmacy were also presented. The High-Risk Management Workgroup, Over-Under Utilization workgroup, Gender Affirming Care Workgroup, EPSDT, and ECM Clinical Oversight groups continue to meet and pursue opportunities to improve member care.	UMC will convene February 20, 2025, to review data from Q3 2024, P&Ps, and receive updates on current active initiatives. High Risk Workgroup to continue collaboration for ED Diversion program and strategies for utilization of data.	
Program Oversight	**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee activities, findings from data analysis, and recommendations to QIHEC	WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. The committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	WCM CAC report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Whole Child Model Medical Director / Director of Case Management	Program Assistant QI	Medical Management	WCM CAC met 11/12/2024. Approved their 08/20/24 meeting minutes. Discussed how to improve pediatric immunization rates. One strategy is having specialty clinics offering vaccines. Pharmacy who are Vaccine for Children providers can give vaccines. Quality Network Adequacy, Utilization (criteria for 30-day readmission data), Appeals and Grievances, Case Management, Behavioral Health, and Customer Service data were reviewed. Pediatric CalAIM ECM audit starts in 2025. Pharmacy 90-day notification.	WCM CAC will continue meeting quarterly in 2025. Review Whole Child Model data for clinical and behavioral service advice from committee members regarding Whole Child Model operations. Oversight of Annual Pediatric Risk Stratification Process.	

2024 QI Work Plan – Q4 Update

Program Oversight	Care Management Program	Report on key activities of CM program, analysis compared to goal, and improvement efforts	Report on the following activities: Enhanced Care Management (ECM) Complex Case Management (CCM) Basic PHM/CM Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM Transitional care services	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Care Management	TBD	Medical Management	Report on the following activities: Enhanced Care Management (ECM) a) LCM contact information has increased from 41% to 61% in October 2024 Complex Case Management (CCM) a) continue monthly NCQA file audits for CCN and Health network members. b) 11/20/2024 moc-NCQA audit with 100% of points achieved. Basic PHM/CM a) ongoing quarterly audits of delegated health networks for MOC oversight. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) 12/12/2024 Education and review on EPSDT services for Health Networks. Transitional care services: See Items #61	Report on the following activities with revisions for 2025: Enhanced Care Management (ECM) moved to stand-alone category on 2025 with CalAIM as BO. Complex Case Management (CCM) moved to stand alone category on 2025 work plan. a) Continue training and educational opportunities to staff on the 2025 PHM5 Element D and E and complex conditions/situations. b) Ongoing training and support for new and existing staf2f. c) Continue to gather member feedback to improve outcomes. d) Training and Education on member centric care plans. Basic PHM/CM a) Ongoing quarterly audits of delegated health networks for MOC oversight. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM a) ongoing work group discussions for oversight of EPSDT. b) explore potential texting campaigns for overdue services for Vision, Dental, and Hearing. Transitional care services: See Items #61.	

Program Oversight	Delegation Oversight	Implement annual oversight and performance monitoring for delegated activities.	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.	Report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Audit and Oversight	Manager of Audit and Oversight (Delegation)/ Manager Delegation Oversight	Delegation Oversight	Delegate: • Prospect Medical Group (17) • United Care Medical Group (82) • HPN-Regal Medical Group (15) • Noble Mid-Orange County (64) • Optum (16) • AltaMed Health Services, Corp. (69) Area(s) Assessed: • Case Management • Claims • Compliance • Credentialing • Customer Service • Provider Network Contracting • Provider Relations • Sub-Contractual • Utilization Management Corrective Action Plan(s) Issued – Prospect Medical Group: • Case Management (Medi-Cal) – Accepted & Closed • Claims (Medi-Cal) – Accepted & Closed • Claims, Provider Dispute Resolutions (Medi-Cal) – Accepted & Closed • Utilization Management, Policy (Medi-Cal) – Accepted • Utilization Management, Expedited & Standard Denial (Medi-Cal) – Accepted • Utilization Management, Non-Emergency Medical Transportations (Medi-Cal) – Accepted • Utilization Management, Physician Administered Drug (PAD) (Medi-Cal) – Accepted & Closed • Utilization Management, Policy (OneCare) – Accepted • Utilization Management, Carve Out (OneCare) – Accepted • Utilization Management, Organizational Determinations (, Appeals, & Grievances) (OneCare) – Accepted • Utilization Management, Physician Administered Drug	Continue to monitor CAPs in “Monitoring” status through acceptance & closure.	

								(PAD) (OneCare) – Accepted & Closed • Credentialing, Organizational Provider (All Lines of Business) – Accepted • Provider Relations (All Lines of Business) – Accepted & Closed Corrective Action Plan(s) Issued – United Care Medical Group: • Claims, Provider Dispute Resolutions (Medi-Cal) – Accepted & Closed • Utilization Management, Expedited & Standard Denial (Medi-Cal) – Accepted • Utilization Management, Non-Emergency Medical Transportations (Medi-Cal) – Accepted • Utilization Management, Physician Administered Drugs (Medi-Cal) – Accepted & Closed • Utilization Management, Notice of Medicare Noncoverage (OneCare) – Accepted & Closed • Utilization Management, Organizational Determinations (, Appeals, & Grievances) (OneCare) – Accepted • Utilization Management, Physician Administered Drugs (OneCare) – Accepted & Closed • Credentialing, Organizational Provider (All Lines of Business) – Accepted & Closed • Provider Relations, Provider Training (All Lines of Business) – Accepted & Closed Corrective Action Plan(s) Issued – HPN-Regal Medical Group: • Case Management (Medi-Cal) – Accepted • Claims (Medi-Cal) – Accepted • Claims, Provider Dispute Resolutions (Medi-Cal) – Accepted • Customer Service (Medi-Cal) – Accepted & Closed • Utilization Management,		

								Policy (Medi-Cal) – Accepted • Utilization Management, Carve Out (Medi-Cal) – Accepted • Utilization Management, Non-Emergency Medical Transportations (Medi-Cal) – Accepted • Utilization Management, Physician Administered Drugs (Medi-Cal) – Accepted • Utilization Management, Post-Stabilization Authorization (Medi-Cal) – Accepted • Customer Service (OneCare) – Accepted & Closed • Utilization Management, Policy (OneCare) – Accepted • Utilization Management, Carve Out (OneCare) – Accepted • Utilization Management, Post-Stabilization Authorization (OneCare) – Accepted Corrective Action Plan(s) Issued – Noble Mid-Orange County: • Claims (Medi-Cal) – Accepted & Closed • Claims, Provider Dispute Resolutions (Medi-Cal) – Accepted & Closed • Utilization Management, Expedited & Standard Denial (Medi-Cal) – Not Accepted • Utilization Management, Physician Administered Drugs (Medi-Cal) – Not Accepted • Utilization Management, Notice of Medicare Noncoverage (OneCare) – Accepted & Closed • Utilization Management, Physician Administered Drugs (OneCare) – Not Accepted Corrective Action Plan(s) Issued – Optum: • Case Management (Medi-Cal) – Not Accepted • Claims, Provider Dispute Resolutions (Medi-Cal) – Accepted • Utilization Management, Policy (Medi-Cal) – Not Accepted		

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								• Utilization Management, Expedited & Standard Denial (Medi-Cal) – Accepted • Utilization Management, Physician Administered Drugs (Medi-Cal) – Not Accepted • Utilization Management, Organizational Determinations (, Appeals, & Grievances) (OneCare) – Accepted • Utilization Management, Physician Administered Drugs (Medi-Cal) – Not Accepted • Customer Service (OneCare) – Accepted • Credentialing, Organizational Provider (All Lines of Business) – Accepted & Closed Corrective Action Plan(s) Issued – AltaMed Health Services, Corp.: • Claims, Provider Dispute Resolutions (Medi-Cal) – Not Accepted • Utilization Management, Expedited & Standard Denial (Medi-Cal) – Accepted • Utilization Management, Physician Administered Drugs (Medi-Cal) – Not Accepted • Utilization Management, Post-Stabilization Authorization (OneCare) – Accepted • Claims, Provider Dispute Resolutions (OneCare) – Not Accepted • Utilization Management, Policy (OneCare) – Accepted • Utilization Management, Notice of Medicare Noncoverage (OneCare) – Accepted & Closed • Utilization Management, Organizational Determinations (, Appeals, & Grievances) (OneCare) – Not Accepted • Utilization Management, Physician Administered Drugs (OneCare) – Not Accepted • Compliance, Staff Training (All Lines of Business) – Not Accepted • Credentialing, Organizational Provider (All Lines of Business) – Accepted & Closed		

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2024 QI Work Plan – Q4 Update

Program Oversight	Disease Management Program	Implement Disease Management	Report on the following activities: Evaluation of current utilization of disease management services Maintain business for current programs and support for community. Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	1) A DM satisfaction survey was sent in October 2024 to eligible members via two-way text message through USHUR. The goal of achieving 85% satisfaction was met across all 7 categories, with satisfaction rates ranging from 91% to 100%. The data indicates that positive interactions with health coaches significantly contributed to members' overall satisfaction. This is further supported by numerous positive member comments. While the data shows high satisfaction with the DM program, a higher response rate would provide more comprehensive data. In light of this, a decision was made to mail an additional 500 surveys. 2) Exploring and testing strategies for incorporating gaps in care into disease management stratification, including a new report supported by Enterprise Analytics and Decision Point 3) Zoom accounts have been created for all member-facing staff. Training on Zoom and proper Zoom etiquette for staff will be conducted in Q1, prior to implementation. 4)The Yumlish web-based provider for the CDC Diabetes Prevention Program is still under review by credentialing. An application to provide an incentive to members who complete the program will be submitted to DHCS for approval when the program is launched. 5)Ongoing collaboration with CalAIM community services continues to refer eligible members to the asthma remediation program. 6)Enhancements have been made to Jiva to improve the	1) Collaborating with USHUR to develop a weblink that will allow staff to deploy the DM survey via two-way text message after the intervention is completed. Estimated launch date: February 2025. 2) Developing a monthly text campaign for members who meet the medium-risk criteria in the asthma and diabetes stratification. The text will ask if they would like to receive a call from a health coach. This initiative aims to reduce the number of cold calls and instances where members cannot be contacted, while also allowing staff to focus on members who opt into the program. Estimated launch date: March 2025. 3) Working toward the implementation of Yumlish and the creation of an incentive program for members who participate in the program. 4) Collaborating with other teams to create a standing order for blood pressure monitors. This will allow health coaches to request a blood pressure monitor for members with diabetes and hypertension who do not have one at home. This initiative supports the HEDIS measure for blood pressure control in patients with diabetes.	

								identification of engagement rates for members identified as diabetes emerging risk.		

2024 QI Work Plan – Q4 Update

Program Oversight	Health Education	Implement Health Education Program	Report on the following activities: (1) Evaluation of current utilization of health education services (2) Maintain business for current programs and support for community. (3) Improve process of handling member and provider requests.	Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Equity and Community Health/Manager of Health Education	Manager of Equity and Community Health	Equity and Community Health	(1) In prior years, referrals for health education services were highest in Q1 and decreased by Q4, but in 2024, referrals were higher than average. In Q4, there were 1,418 referrals received and assigned, higher than the quarterly average of 1,362 referrals received in Quarters 1-3 of 2024. This may be in response to more members resuming preventive health visits with providers post-COVID and due to increased outreach efforts via text messages or mail campaigns. (2) During Q4 2024, 14 participants attended 2 virtual SYL classes. (3) The team has expanded text message campaigns to inform members about health education services and classes, as well as to encourage new members to see their providers in the first 90 days of enrollment. Health and Wellness services continue to be mentioned in new member packages and at all continuing education training sessions, along with reminders on how and where to send member referrals.	Member self-referrals as well as a list of future ECH community classes are still slated to be available on the new website being implemented March 2025. These new activities are on hold as the Communications team continues the build out.	
Program Oversight	Health Equity	Identify health disparities Increase member screening and access to resources that support the social determinants of health Report on quality improvement efforts to reduce disparities	Assess and report the following activities: 1) Increase members screened for social needs 2) Implement a closed-loop referral system with resources to meet members' social needs. 3) Implement an organizational health literacy (HL4E) project	By December 2024 Update from PHMC to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	(1) Continued working on updates to SDOH Member Assessment in the Member Portal and continue to integrate assessment into JIVA. (2) Continued process to integrate Find Help into JIVA and developed training plan for staff. (3) Completed the HL4E project.	(1) Continue supporting process to update SDOH Member Assessment in Member Portal and collaborate with other departments on integration of member assessment into JIVA. (2) Continue to participate in FindHelp integration workgroup and completion of training plan for staff. (3) No further action as the HL4E project concluded.	

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Program Oversight	Long-Term Support Services (LTSS)	95% compliance with TAT	CalAIM Turnaround Time (TAT): Determination completed within 5 business days CBAS Inquiry to Determination (TAT): Determination completed within 30 calendar days CBAS Turnaround Time (TAT): Determination completed within 5 business days LTC Turnaround Time (TAT): Determination completed within 5 business days	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of LTSS	Manager of LTSS	Long Term Care	CalAIM Turnaround Time (TAT): Routine 65.29%; Expedited 86.49% CBAS Inquiry to Determination (TAT): 100% CBAS Turnaround Time (TAT): 95.76% LTC Turnaround Time (TAT): 97.67%	LTSS approved OT to work on CalAIM authorizations/referrals; Daily authorization assignments to nurses to ensure timely completion; Daily monitoring by LTSS and Executive leadership; Report out to UMC; Collaboration with CalAIM Operations team and executive to improve vendor processes.	
Program Oversight	National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation by January 1, 2026	1) Implement activities for NCQA Standards compliance for HPA and Health Plan Renewal Submission by April 30, 2024. 2) Develop strategy and workplan for Health Equity Accreditation with 50% document collect for submission.	1) By April 30, 2024 2) By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Program Manger of QI	Director of Quality Improvement	Quality Improvement	**HP Accreditation:** 1. NCQA released the 2025 HP Standards to internal stakeholders in September 2024. 2. A kickoff webinar was held to review these standards. 3. A file review audit assessed readiness for Complex Case Management, Utilization Management denials (BH and non-BH), Pharmacy, Appeals, and Credentialing with CCN and delegate files. 4. NCQA Consultants provided training on writing Analytical Reports. **HE Accreditation:** 1. Consultants have made recommendations and created a work plan. 2. CalOptima Health established a Health Equity Committee that receives status updates from five ongoing work groups.	**HP Accreditation:** 1. Executive leadership will receive the file review results at the January 2025 QIHEC meeting, where delegates have also been notified of the audit results. 2. The following items will be reviewed and approved at the January meeting: the 2025 Annual QIHETP, 2025 PHM Strategy, and 2025 CLAS Program. 3. In February 2025, QIHEC will review the 2024 QIHETP Evaluation, 2025 QI Work Plan, 2025 UM/CM Program, and 2024 UM Evaluation. 4. The Quality Improvement (QI) team will create a comprehensive work plan and schedule a kick-off meeting with stakeholders. **Health Equity Accreditation:** Document collection for submission starts in April 7. 2025, with the submission survey date set for October 7, 2025. **Overall Status on Both Accreditations:** Health Equity accreditation is on track, with no identified issues we have a look-back period starting April 7, 2025. The Health Plan Accreditation is also ready for its look-back period beginning April 6, 2025.	

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Program Oversight	OneCare STARs Measures Improvement	Achieve 4 or above	Review and identify STARS measures for focused improvement efforts.	By December 2024 Report program update to QIHEC Q2: 04/09/2024 Q3: 07/11/2024 Q4: ~~10/08/2024~~ 11/5/2024 Q1: 01/14/2025	Director of Medicare Stars and Quality Initiatives	Manager of QA	Quality Improvement	1) Bimonthly working sessions focused on Stars measures improvement with Operations, Equity and Community Health, Case Management, Pharmacy, Utilization Management, Customer Service, Health Network Relations, and GARS. 2) Continued utilization of the Star Rating tracker to communicate performance with each Stars workgroup / measure owner. 3) Continued weekly huddle with the Case Management team to address the OMW measure. Outbound calls to members due for bone density testing. 4) Ongoing telephonic outreach to members across multiple measures via vendor Carenet. 5) Case Management and Equity and Community Health team utilization of the Decision Point Insights platform to discuss open care gaps with members. 6) Launch of a detailed Stars project plan in conjunction with EPMO and Rex Wallace Consulting, coupled with a weekly project update meeting. 7) Launch of Listening Posts member experience surveying via Ushur; collected feedback from members who missed a medication refill, or began a new medication related to the medication adherence measures. 8) Launch of the OneCare Quality Improvement Grant program. Awarded $568,846.92 to 4 Health Networks for quality initiatives that will improve OneCare measure performance.	Continue with plan as listed and implement additional initiatives outlined in QA's 2025 strategic project list	

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Program Oversight	Value Based Payment Program	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) Will share HN performance on all P4V HEDIS Measures via prospective rates report each month. 2) Will share hospital quality program performance	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: ~~10/08/2024~~ 11/5/2024 Q1: 01/14/2025	Manager of Quality Analytics	Manager Quality Analytics	Quality Analytics	Hospital Quality program performance: No additional updates for the Hospital since November. No update to provide at the 1/11/25 QIHEC. Quality update calls with each Health Network continue to be held every other month. The Medi-Cal Quality Improvement Grant awards for Health Networks were announced in September. Seventeen (17) proposals across five (5) Health Network partners were approved (over $1.8 M in funding and support for 16 quality measures). All contracts were executed in Q4 and funds were distributed to Health Networks on 1/13/25.	Continue with plan as listed and implement additional initiatives outlined in QA's 2025 strategic project list	
Program Oversight	Quality Performance Measures: Managed Care Accountability Set (MCAS) STAR measures	Track and report quality performance measures required by regulators	Track rates monthly Share final results with QIHEC annually	Report program update to QIHEC Q2: 05/14/2024 Q3: 08/13/2024 Q4: 11/05/2024 Q1 02/11/2025	Director of Quality Analytics	Manager Quality Analytics	Quality Analytics	Final HEDIS Rates were presented last quarter. Continue analysis to identify opportunities and focus areas for 2025.	Plan and prepare for <Y2024 HEDIS data collection.	

Program Oversight	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 on the following Student Behavioral Health Incentive Program (SBHIP) activities: 1 Implement SBHIP DHCS targeted interventions 2. Bi-quarterly reporting to DHCS	Report program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1 01/14/2025	Director of Behavioral Health Integration	Project Manager BHI	Behavioral Health Integration	1) 4 Project Outcome Reports due 12/31/24: BH Screening and Referrals; Building Stronger Partnerships; IT Support Systems; Technical Assistance for Contracts. 2) OCDE SBHIP MOU amendment executed, CalOptima Health and OCDE will monitor school districts SBHIP budget requests and spend. 3) The DHCS MOU template was sent to OCDE for legal review; the template will be used for the coordination of care and data sharing with the school districts. 4) Internal departments SMEs identified for the Carelon interim payment process; waiting for DHCS to finalize Carelon MOU. 5) 8 of 10 SBHIP-funded Well Spaces were installed in 2024; the remaining two are scheduled for completion in late January/early February 2025. 6) Hazel Health has launched its telehealth platform in 19 out of the 29 school districts.	The incentive earning of the SBHIP initiative ended 12/31/24; all required DHCS reporting is completed; CalOptima Health awaits approval from DHCS for the project outcome reports; the announcement is expected in Q1 2025. SBHIP partners will continue to meet throughout the upcoming months.	

Program Oversight	CalOptima Health Comprehensive Community Cancer Screening Program	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer.	Assess and report the following: 1) Establish the Comprehensive Community Cancer Screening and Support Grants program 2) Work with vendors to develop a comprehensive awareness and education campaign for members.	Report Program update to QIHEC Q2: 04/09/2024 Q3: 07/09/2024 Q4: 10/08/2024 Q1: 01/14/2025	Chief Medical Officer	Sr. Manager of Medical Management	Medical Management	1) Held the grantees' kickoff meeting on October 2, 2024. 2) Hosted a virtual webinar to provide reporting instructions on November 8, 2024 3) Met with individual grantees (ACS, TFG) to provide support. 4) Submitted SMS content(s) to DHCS for approval. 5) Worked on an RFP for a research and evaluation initiative. Barriers/challenges: Due to a change in project management leadership, several critical operational requirements were overlooked (e.g., BAA, data exchange approval process, grant amendment, etc.).Also, senior leadership recommended canceling the bid exception for the Research & Evaluation contract. Focus has shifted to releasing an RFP, which may delay the Research & Eval initiative.	1) Host the 2nd quarterly grantee meeting 2) Establish a robust grant management process 3) Launch the Research & Evaluation RFP 4) Develop more concrete plans for the OC3 Collaborative and Member Journey Interventions initiatives.	

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Quality of Clinical Care	Preventive and Screening Services	Cervical Cancer Screening (CCS), Colorectal Cancer Screening (COL), Breast Cancer Screening (BCS) MY 2024 Goals: CCS: MC 59.85% BCS-E: MC 62.67% OC 71% COL: OC 71%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/5/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Quality Analyst	Quality Analytics	1. Member Health Reward: CCS (MC) - xxx; BCS (MC) - xxx; BCS (OC) - xxx; COL (OC) - xx 2. Mailings: COL (MC)- 21239; COL (OC)- 3908 3. Text Message: CCS (MC)- 73309; BCS (MC)- 21499 4. CareNet Live Call from October to December: CCS (MC)- 13711 ; BCS (MC)- 3839; BCS (OC)- 200; COL (OC)- 463 5. Continuation of CCN OC and MC COL GI outreach pilot program plus elimination of prior authorization for GI screening consult for the OC population 6. CCN Cologuard launched November: Mailing- MC Kits 25746 OC Kits 865; Kits returned by December: MC 2482 OC 119 7. September 2024 Prospective Rate Data: CCS (MC) - 43.16%; BCS (MC) - 49.07%; BCS (OC) - 62%; COL (OC) - 58%	Continue with plan as listed and implement additional initiatives outlined in QA's 2025 strategic project list	

Quality of Clinical Care	EPSDT Diagnostic and Treatment Services: ADHD Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare Appropriate Use Of Psychotropic Medications	Follow-Up Care for Children Prescribed ADHD medication (ADD) HEDIS MY2024 Goal: MC - Init Phase - 44.22% MC -Cont Phase - 50.98%	Assess and report the following activities: 1) Work collaboratively with the Communications department to Fax blast non-compliant providers letter activity (approx. 200 providers) by second quarter. 2) Participate in provider educational events, related to follow-up visits and best practices. 3) Continue member outreach to improve appointment follow up adherence. a. Monthly Telephonic member outreach (approx. 60-100 mbrs) b. Member Newsletter (Fall) c. Monthly Member two-way Text Messaging (approx. 60-100 mbrs) 4) Member Health Reward Program 5) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (~~11/05/2024~~10/08/2024) Q4 2024 Update (~~02/11/2025~~ 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS RATES Q4 (September): Initiation Phase- 47.03% Continuation and Maintenance Phase- 52.08% 1) Monthly text messaging outreach to 125 members.(October, November, December). 2) Member Health Reward flyers mailed to 209 eligible members on 11/14/2024. 3) A new text message script for member Health reward will be launched in Q1 2025. 4) Monthly Health Network Communication BH Updates. 5) Collaborated with Communications to disseminate Best Practice Letter and Tip Sheet via automated process with ITs to 127 non-compliant providers on 12/12/2024.	1) Continue to send letters to providers via automated process with ITs who are not meeting the ADD requirements. 2) Continue to work with text messaging vendor to send text messages to members for follow-up visits. 3) Coordinate text message campaign of the Member Health Rewards flyer to eligible members.	
Quality of Clinical Care	Health Equity/Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Prevention Programs For Behavioral Healthcare	Improve Adverse Childhood Experiences (ACES) Screening	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (~~11/05/2024~~10/08/2024) Q4 2024 Update (~~02/11/2025~~ 01/14/2025)	Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	1) Attended collaborative meetings between teams to identify best practices to implement. 2) Attended provider and member education. 3) Continued to review the quarterly ACES report.	Goal Met	

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Quality of Clinical Care	Mental Health Service: Continuity and Coordination Between Medical Care and Behavioral Healthcare	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) HEDIS MY2024 Goals: Blood Glucose-All Ages:58.43% Cholesterol-All Ages: 40.50% Glucose and Cholesterol Combined-All Ages: 39.01%	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 the next top 50 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, with list of members that need a diabetes screening.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (~~11/05/2024~~10/08/2024) Q4 2024 Update (~~02/11/2025~~ 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS RATES Q4 (September) : Blood Glucose all ages: 44.81%, Cholesterol all ages: 27.04%, Glucose & Cholesterol Combined all ages: 26.05% 1) Barrier: Data report unavailable for the end of the quarter due to new HEDIS software implementation for the Quality Analytics team. 2) The following materials have been disseminated to Providers (October 52 letters, November 110 letters): a) Provider Best Practices Letter. b) APM Provider Tip Sheet. 3) Collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis (October, November). 4) Mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to the next top 50 providers on a monthly basis (October, November). 5) Text Messaging Campaign (October 440 texts, November 428 texts, December texts). 6) Monthly Health Network Communication BH Updates.	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Continue data pull from Tableau for text messaging campaign. 3) Continue mailings of Provider materials (Best Practices letter and Provider tip tool sheet) to providers on a monthly basis. 4) Continue collaboration with Provider Relations to conduct in-person provider outreach with top 10 providers on a monthly basis. 5) Schedule listening sessions with Providers to educate/train on how to obtain BH data using the CalOptima Health Provider Portal.	

Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Appropriate Diagnosis, Treatment And Referral Of Behavioral Disorders Commonly Seen In Primary Care	Antidepressant Medication Management (AMM) HEDIS MY2024 Goal: Acute Phase - 74.16% Continuation Phase - 58.06%	Assess and report the following activities: 1) Educate providers on the importance of follow up appointments through outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 2) Educate members on the importance of follow up appointments through newsletters/outreach to increase follow up appointments for Rx management associated with AMM treatment plan. 3) Track number of educational events on depression screening and treatment.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (~~11/05/2024~~10/08/2024) Q4 2024 Update (~~02/11/2025~~ 01/14/2025)	Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	PR HEDIS RATES Q4 (September) :Effective Acute Phase Treatment: 64.74%, Effective Continuation Phase Treatment: 45.45% 1) Barrier: Data report unavailable for the end of the quarter due to new HEDIS software implementation for the Quality Analytics team. 2) Data report received monthly. 3) AMM Provider Tip Sheet letter completed. 4) The following materials have been disseminated to Providers (October 540 letters, November 962 letters): a) Provider Best Practices Letter. 5) Text Messaging Campaign (October 6,887 texts, November 6,885 texts, December 6, 885 texts). 6) AMM data available through Provider Portal 7) Monthly Health Network Communication BH Updates	1) Use provider portal to communicate follow-up best practice and guidelines for follow-up visits. 2) Continue Text Messaging campaign. 3) Continue mailings to providers (letter). 4) Schedule listening sessions with Providers to educate/train on how to obtain BH data using the CalOptima Health Provider Portal.	
Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare - Severe And Persistent Mental Illness	Diabetes Monitoring For People With Diabetes And Schizophrenia (SMD) HEDIS MY2024 Goal: 76.66%	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (~~11/05/2024~~10/08/2024) Q4 2024 Update (~~02/11/2025~~ 01/14/2025)	Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	PR HEDIS Rates Q4 (September): M/C:68.28% OC: N/A 1) We are currently monitoring this measure. 2) SMD data now available through Provider Portal. 3) Monthly Health Network Communication BH Updates.	1) Continue to monitor prospective rates on a monthly basis. 2) Continue collaborative meetings between teams to identify best practices to implement. 3) Schedule listening sessions with Providers to educate/train on how to obtain BH data using the CalOptima Health Provider Portal.	

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Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare-Exchange of Information	Follow-Up After Emergency Department Visit for Mental Illness (FUM) HEDIS MY2024 Goal: MC 30-Day: 60.08%; 7-day: 40.59% OC (Medicaid only)	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) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (~~11/05/2024~~10/08/2024) Q4 2024 Update (~~02/11/2025~~ 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS Rates Q4 (September): 30 day- 26.98%, 7 day- 14.76% 1) The main barrier has been not having the bandwidth for outreach to members from daily vendor ED report. 2) sFTP folders have been established and BH ED data is being sent to Health networks on a daily basis as well as weekly reminder in HN communication. 3) Bi-weekly Member text messaging. 4) Finalize IVR calls for ED follow-up. 5) Monthly Health Network Communication BH Updates. 6) BH Telehealth vendor began test calls to follow up with FUM members starting in Mid-November. Phase one of outreach began 12/3/2024.	1) Starting January 2025- will begin weekly FUM text messages based on real time ED data. 2) Continue sharing ED data with HN's via sFTP and weekly HN Communication. 3) Collaborate with NAMI to share real-time ED data for member outreach/NAMI by Your Side. 4) BH Telehealh vendor will outreach to members based on daily ED data feed to assist with scheduling Follow up appointments.. 5) IVR calls for members who meet FUM criteria to remind them of the importance of scheduling a follow up appointment after an ED visit.	

Quality of Clinical Care	Mental Health Services: Continuity and Coordination Between Medical Care and Behavioral Healthcare-Management Of Coexisting Medical And Behavioral Conditions	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) HEDIS 2024 Goal: MC 77.40% OC (Medicaid only)	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.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (~~11/05/2024~~10/08/2024) Q4 2024 Update (~~02/11/2025~~ 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS Rates Q4 (September): M/C:68.67% OC: N/A 1) Barrier: Data report unavailable for the end of the quarter due to new HEDIS software implementation for the Quality Analytics team. 2) Conducted a text message campaign to reach out to 1,528 members regarding getting their glucose lab screening (October, November, December). 3) Mailed out Member Health reward flyer to 971 eligible members on 11/14/2024, and mailed to 186 providers on 11/14/2024. 4) Continue to collaborate with Quality Analytics Team to retrieve data sourcing automation for Tableau on a monthly basis, confirmed that 729 Member Health rewards were mailed to members on 10/29/2024 and on 12/3/24, 337 members were mailed the Member Health rewards. 5) Monthly Health Network Communication BH Update completed.	1) Continue tracking members in need of glucose screening test as soon as we are able to receive HEDIS 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 offices with the following: a.) Medical Director Letter b.) List of members/patients in need of screening c.) Provider Tool Tip Sheet 6) Schedule listening sessions with Providers to educate/train on how to obtain BH data using the CalOptima Health Provider Portal.	

Quality of Clinical Care	Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects	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 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (~~11/05/2024~~10/08/2024) Q4 2024 Update (~~02/11/2025~~ 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration/ Quality Analytics	Conduct Annual oversight of MC Non Clinical PIPs (Jan 2023 - Dec 2025) Improve the percentage of members enrolled: Baseline Measurement Period: Submitted to DHCS 09/09/2024. Remeasurement 1 Period : 01/01/24 -12/31/24 Remeasurement 2 Period : 01/01/25-12/31/25	1) Receiving daily report from vendor which contains Real-Time ED data for CCN and COD members. 2) Internal report developed that identifies members enrolled in CCM and ECM for CCN who meet FUM/FUA criteria for the duration of each measurement period. 3) 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	
Quality of Clinical Care	Substance Use Disorder Services	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) MY2024 Goals: MC: 30-days: 36.34%; 7-days: 20.0%	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) Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5) Bi-Weekly Member Text Messaging (approx. 500 mbrs) 6) Member Newsletter (Spring)	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (~~11/05/2024~~10/08/2024) Q4 2024 Update (~~02/11/2025~~ 01/14/2025)	Director of Behavioral Health Integration	BHI Program Specialist	Behavioral Health Integration	PR HEDIS Rates Q4 (September): 30-Day- 21.12%, 7-Day-11.33% 1) Secured FTP folders have been established and BH ED data is being sent to Health Networks daily as well as weekly reminder in HN communication. 2) Bi-weekly member text messaging. 3) Finalize IVR calls for ED follow-up. 4) Monthly Health Network Communication BH Update completed.	1) IVR calls to members who fall under the FUA measure. 2) BH Telehealth vendor will outreach members from the daily ED data feed. 3) Continue weekly member text messaging in 2025. 4) Member outreach with NAMI By Your Side (NBYS).	

2024 QI Work Plan – Q4 Update

Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to Eye Exam for Patients with Diabetes (EED) MY2024 HEDIS Goals: MC 66.33% OC: 81%;	Assess and report the following activity: 1) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	By December 2024 Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	1. Member Health Reward: EED (MC) - xxx; EED (OC) - xx 2. EED VSP mailing from October to December: MC - 4521; OC - 1030 3. CareNet Live Call from October to December: OC- 160 4. VSP data sharing to Health Network partners; multiple Health Networks are now receiving Production data and the remaining ones are completing testing 5. September 2024 Prospective Rate Data: EED (MC) - 40.70%; EED (OC) - 59%	Continue with plan as listed and implement additional initiatives outlined in QA's 2025 strategic project list	
Quality of Clinical Care	Members with Chronic Conditions	Improve HEDIS measures related to HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates % of members with poor A1C control-lower rate is better) MY2024 Goals: MC: 29.44%; OC: 20%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts	Update from PHMC to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	1. Member Health Reward: HBD (MC) - xxx; HBD (OC) - xxx 2. CareNet Live Call fromOctober to December: OC-233 3. August 2024 Prospective Rate Data: HBD (MC) - 58.8%; HBD (OC) - 53%	Continue with plan as listed and implement additional initiatives outlined in QA's 2025 strategic project list	

2024 QI Work Plan – Q4 Update

Quality of Clinical Care	Maternal and Child Health: Prenatal and Postpartum Care Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). HEDIS MY2024 Goal: Postpartum: 82.0% Prenatal: 91.07%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 4) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 5) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Equity and Community Health/ Quality Analytics	Member initiatives: 1) Bright Steps Program: prenatal and postpartum education to participating members. 2) Ongoing: Postpartum Health Reward for members that complete postpartum care between 1-12 weeks after delivery. 1) August 2024: Maternal Health workgroup meeting to discuss member journey. QA will develop a prenatal and postpartum care journey to support member messaging. 2) Community Clinic Forum presentation to support compliance for providers and clinics that utilized bundled coding practices. Per August 2024 prospective rates, Timeliness of Prenatal Care is performing slightly lower than this time last year with a rate of 67.26% and Postpartum Cre is performing slightly higher than this time time last year with a rate of 65.83%.	Continue with plan as listed and implement additional initiatives outlined in QA's 2025 strategic project list	

2024 QI Work Plan – Q4 Update

Quality of Clinical Care	Maternal and Adolescent Depression Screening	Medi-Cal Only - Meet the following goals For MY2024 HEDIS: DSF-E Depression Screening and Follow-up for Adolescent and Adults - Screening: 2.97% PND-E Prenatal Depression Screening and Follow-up - Screening: 8.81% PDS-E Postpartum Depression Screening and Follow-up: 27.77%	1) Identification and distribution of best practices to health network and provider partners. 2) Provide health network and provider partners with timely hospital discharge data specific to live deliveries to improve postpartum visit completion. 3) Targeted member engagement and outreach campaigns in coordination with health network partners. 4) Provider education (CE/CME) in Q3.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Operations Management / Director of Behavioral Health Integration	Manager of Quality Analytics / Manager of Behavioral Health Integration	Operations Management/ Behavioral Health Integration	DSF-E PR HEDIS Rates Q4 (September): Screening Total 0.02%; Follow Up Total 40.00% 1) Data collection is still the main barrier. Currently capturing information by supplemental data. The Behavioral Health Quality Improvement Workgroup exploring ways to obtain additional supplemental data to better capture completed screenings and follow up visits. 2) Monthly Health Network Communication BH Update completed. 3) The following materials have been disseminated to Providers (October 540 letters, November 962 letters): a) Provider Best Practices Letter.	1) Distribute best practice guidelines for follow-up visits to providers and health network. 2) Schedule listening sessions with Providers to educate/train on how to obtain BH data using the CalOptima Health Provider Portal.	

Quality of Clinical Care	Blood Lead Screening	HEDIS MY2024 Goal: 67.12%; Improve Lead Screening in Children (LSC) HEDIS measure.	Assess and report the following: Strategic Quality Initiatives Plan to increase lead testing will consist of: 1) A multi-modal, targeted member approach as well as provider and health network collaborative efforts 2) Partnership with key local stakeholders 2024 Member Quality Initiatives will consist of the following but not limited to: - Member health reward and monitoring of impact on LSC HEDIS rate - IVR campaign to - Texting campaign - Mailing campaign - Lead texting campaign for members - Medi-Cal member newsletter article(s) In partnership with the Orange County Health Care Agency, CalOptima Health will co-develop educational toolkit on blood lead testing.	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	Member Initiatives: 1) Ongoing: Blood Lead Health Rewards for testing at 12 and 24 months of age. 2) 2-way SMS campaign via Ushur and in alignment with AAP periodicity schedule for well-child visits. Campaign included reminders for lead testing. 3) Live call campaign via vendor CareNet to educate and encourage lead testing. Monitoring Initiatives: 1) In progress: Development of medical record review process to monitor CalOptima Health providers and the adherence to lead requirements (e.g., testing, follow-up, anticipatory guidance) Provider Initiatives: 1) July 2024: Provider fax campaign to providers assigned to children ages 0-6. Fax campaign provided focus on providing resources related to lead requirements such as anticipatory guidance, patient educational materials, etc. 2) July 2024: Posting of Stay Compliant with State-Issued Lead Requirements on CalOptima Health website. Per August 2024 prospective rates, Lead Screening in Children measure is 65.03% and is on track to meet the 50th percentile.	Continue with plan as listed	

2024 QI Work Plan – Q4 Update

Quality of Clinical Care	EPSDT/Children's Preventive Services: Pediatric Well-Care Visits and Immunizations	HEDIS **MY2024** Goal CIS-Combo 10: 45.26% IMA-Combo 2: 48.80% W30-First 15 Months: 58.38% W30-15 to 30 Months: 71.35% WCV (Total): 51.78%	Assess and report the following activities: 1) Targeted member engagement and outreach campaigns in coordination with health network partners. 2) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 3) Early Identification and Data Gap Bridging Remediation for early intervention.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	Member Initiatives: 1) 2-way SMS via Ushur for multiple pediatric age groups in place. 2) Ongoing telephonic outreach to pediatric members for multiple measures via Carenet. Provider/HN Initiatives: 1) Detailed W30 reports continue to be distributed regularly. CIS performance continues to trend lower than same point-in-time last year; as such, Carenet was provided with a Q4 focus report of members due for CIS that are still actionable (haven't reached their 2nd birthday yet).	Continue with plan as listed.	
Quality of Clinical Care	Quality Improvement activities to meet MCAS Minimum Performance Level	Meet and exceed MPL for DHCS MCAS	Conduct quarterly/Annual oversight of MCAS Performance Improvement Plan PDSA: Well-Child Visits in the First 30 Months (W30-2+) - To increase the number of Medi-Cal members 15-30 months of age who complete their recommended well-child visits. Perform root cause analysis, strategize and execute planned interventions targeting members, providers and systems.	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	Member Initiatives: 1) 2-way SMS via Ushur for multiple pediatric age groups in place. 2) Ongoing telephonic outreach to pediatric members for multiple measures via Carenet. Provider/HN Initiatives: 1) Detailed W30 reports continue to be distributed regularly. CIS performance continues to trend lower than same point-in-time last year; as such, Carenet was provided with a Q4 focus report of members due for CIS that are still actionable (haven't reached their 2nd birthday yet).	Continue with plan as listed.	
Quality of Clinical Care	Encounter Data Review	Conduct regular review of encounter data submitted by health networks	Monitors health network's compliance with performance standards regarding timely submission of complete and accurate encounter data.	Semi-Annual Report to QIHEC Q2: 04/09/2024 Q4: 10/08/2024 postponed to 11/5/2024	Director of Finance	Manager of Finance	Finance	No efforts in Q4 2024.	Continue to monitor health networks	

Quality of Clinical Care	Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	PCP and High Volume Specialist sites are monitored utilizing the DHCS audit tool and methodology.	Review and report conducted initial reviews for all sites with a PCP or high volume specialists and a review every three years. Tracking and trending of reports are reported quarterly.	Update volume from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025 Compliance details to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (~~02/11/2025~~) 03/11/2025	Director Quality Improvement	Manager Quality Improvement	Quality Improvement	**FSR/MRR/PARS, Community-based Aduit Services (CBAS), and Nursing Facilities (NF) Oversight:** **A. FSR**: Initial FSRs=13; Initial MRRs=14; Periodic FSRs=54; Periodic MRRs=56; On-Site Interims=9; Failed FSRs=3; Failed MRRs=19; CAPs: CE=44; FSR=60; MRR=55 **B. PARS:** Completed PARS=82 Basic Access=26 Limited Access=56 **C. CBAS Oversight**: Critical Incidents=2 (2 COVID cases); Non-Critical=17; Falls=14; Audits Completed=12; CAPs Issued:9; Unannounced Visits=0 **D. NF Oversight:** Critical Incidents=23; On-Site Visits=14; Unannounced Visits=0	**FSR/MRR**: In order to avoid third subsequent failed audits and removal from the CalOptima Health Provider Network, FSR nurses are completing annual audits, extensive education, and additional resources for sites with 2 failed audit scores. **PARS:** Continue with plan, as listed. **CBAS:** Continue with plan, as listed. **NF:** Continue with plan, as listed.	

Quality of Clinical Care	Potential Quality Issues Review	Referred quality of care grievances and PQIs are reviewed timely	Review and report conducted referred cases are properly reviewed by appropriate clinical staff, cases are leveled according to severity of findings, and recommendations for actions are made, which may include a presentation to the CPRC for peer reviewed.	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director Quality Improvement	Manager Quality Improvement	Quality Improvement	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. a) HRA collections at volume to satisfy a 3-star HEDIS rating b) Q3 HRA1 Members reached, willing and completed HRA within 90 days of enrollment 100% c) Q3 ICP1 Member reached, willing and completed ICP within 90 days of enrollment 98% d) Off-cycle MOC submitted in Q4 2024 with minor updates for 2025 approved by CMS pending DHCS approval 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. a) Ongoing monthly communication with Health Networks for ICP1 development b) Monthly communication with Health Netowrks for annual ICP development and missing face-to-face interactions. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implementation and monitoring a) Audit tool revision.	Continue to reduce the overall number of open PQIs. Further develop the Provider Action Workgroup.	
Quality of Clinical Care	Initial Provider Credentialing	All providers are credentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements and are current within 180 days of review and approval (60 days for BH providers)	Update from CPRC to QIHEC Q2: 06/12/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director Quality Improvement	Manager Quality Improvement	Quality Improvement	Initial BH Credentialing Q4 = 108; Initial CCN Credentialing Q4 = 43	Initial credentialing: 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 credentialling.	

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Quality of Clinical Care	Provider Re-Credentialing	All providers are re-credentialed according to regulatory requirements	Review and report providers are re-credentialed within 36 months according to regulatory requirements	Update from CPRC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Quality Improvement	Manager Quality Improvement	Quality Improvement	BH Recredentialing - Q4 = 31; CCN Recredentialing Q4 = 138. For Q4 we did not have any recredentialing files out of compliance	Recredentialing: We have contracted with a Credentialing Verification Organization (CVO) to assist with the recredentialing of providers. This will ensure that we continue with compliance and timeliness of the recredentialing files.	
Quality of Clinical Care	Chronic Care Improvement Projects (CCIPs) OneCare	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals)	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 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	1. Member Health Reward: EED (OC) - xx; HBD (OC) - xxx 2. EED VSP mailing from October to December: OC - 1030 3. CareNet Live Call from October to December: EED (OC)- 160 HBD (OC)- 233 4. Emerging Risk (telephonic outreach via Equity and Communiy Helath department staff) 5. September 2024 Prospective Rate Data: EED (OC) - 59%: KED (OC)- 51%; HBD PC (OC)- 53%; MAD (OC)- 92%; SUPD (OC)- 85%	Continue with plan as listed.	

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Quality of Clinical Care	Special Needs Plan (SNP) Model of Care (MOC)	% of Members with Completed HRA: Goal 100% % of Members with ICP: Goal 100% % of Members with ICT: Goal 100%	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implementation and monitoring.	Report progress to QIHEC Q1 2024 Update (05/13/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (~~02/11/2025~~) 01/14/2025	Director Medical Management/Case Management	QI Nurse Specialist	Case Management	Assess and report the following activities: 1)Utilize newly developed monthly reporting to validate and oversee outreach and completion of both HRA and ICP per regulatory guidance. a) HRA collections at volume to satisfy a 3-star HEDIS rating b) Q3 HRA1 Members reached, willing and completed HRA within 90 days of enrollment 100% c) Q3 ICP1 Member reached, willing and completed ICP within 90 days of enrollment 98% d) Off-cycle MOC submitted in Q4 2024 with minor updates for 2025 approved by CMS pending DHCS approval 2) Develop communication process with Networks for tracking outreach and completion to meet benchmarks. a) Ongoing monthly communication with Health Networks for ICP1 development b) Monthly communication with Health Netowrks for annual ICP development and missing face-to-face interactions. 3) Creation and implementation of the Oversight audit tool. Updated Oversight process implementation and monitoring a) Audit tool revision.	Assess and report the following activities which are revised for 2025. 1)Monthly communication process with Networks on ICP development 2) DHCS HRA1 and ICP1 quarterly reporting Q4 2024 available after 2/2025; 3) HRA Star status updates 4) MOC Updates 5) Face to Face interactions	
Quality of Service	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 network2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members	Update from MemX to QIHECQ2: 06/11/2024Q3: 09/10/2024Q4: 12/10/2024Q1 03/11/2025	1) Director of Provider Network~~2) Director of Contracting~~	Analyst of Quality Analytics	~~Contracting~~/Provider Data Operations	The Network Adequacy Workgroup met to discuss gaps and ideate solutions for implementation. Provider Data Ops curated and provided provider target leads lists to PR and Contracting to close plan level NCQA Provider to Member ratio gaps in LMFT, Orthopedic Surgery and Gastroenterology, which were identified in Q3. CalOptima Health closed out the 2023 SNC via approval of AAS for AMVI and UCMG.	1. PDO to review provider data and curate target lists as needed for rheumatology, neuroloy, urology to address access issues2. PR and contracting to provide update on contracting efforts continue expand provider network for the above and LMFT, gastroenterology and orthopedic surgery, as well as to close CCN time and distance gaps.	

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Quality of Service	Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Assess and report the following activities: 1) Issue corrective action for areas of noncompliance 2) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely access. 3) Continue to educate providers on timely access standards 4) Develop and/or share tools to assist with improving access to services.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics / Project Manager of Quality Analytics	Quality Analytics	• 2024 Timely Access Survey fielding started October 15th and concluded December 6, 2024. • Held a Timely Access Q&A Call for providers to discuss access standards, and changes for 2024 and 2025. Call provided an opportunity for providers to ask questions and collaborate on challenges they may be experiencing and discuss best practices. • Scheduled two peer to peer collaborative calls with network providers and CalOptima Health Medical Director to discuss corrective action plan submission and ways to improve access. • Issued Corrective Action Plan to nine HNs in December based on 2023 Timely Access Survey results for not meeting the minimum performance level of 80%. • Access workgroup continues to review provider CAP responses to close out. o Mailed follow-up letters to several providers who did not submit a response to the original CAP issued in late June.	QC survey reports and data as they come from vendor in Q1 Continue to schedule peer review meetings with select providers and CalOptima Medical Director for CAP review Continue to review CAP submissions Post Timely Access Survey RFP	

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Quality of Service	Improving Access: Subcontracted Network Certification	Comply with Subdelegate Network Certification requirements	1) Annual submission of SNC to DHCS with AAS or CAP 2) Monitor for Improvement 3) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2024 2) By end of Q2 2024 3) By end of Q3 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	Quality Analyst	~~Network Operations~~ Provider Data Operations/Quality Analytics	Submitted Q4 2023 Quarterly CAP status update to DHCS - closed remaining 2023 time and distance CAP open (AMVI, UCMG) - Completed 2024 SNC submission to DHCS using Q4 network adequacy data analysis as follows:N54 -Time/Distance: all HN did not meet. Top 5 gaps were Phys Med/Rehab, Endocrinology, Dermatology, Neurology and HIV/AIDS Specialist/Infectious Diseases. South County remains as the general area where the gaps are occurring. Health Networks in general showed minor improvement in closing gaps from Q3 to Q4. - Network Capacity/Ratio (FTE): HNs met standards -PMR: 8 HNs now meet PMR, up 1 (AMVI) from Q3; ongoing gaps are in Orthopedic Surgery, Ophthalmology, and Gastroenterology. - PCP: 1new closures - WCM: Plan level met all specialties. All HNs confirmed met Timely Access: All eleven HN CAPs issued in December 2023 (2022	1. Issue 2024 SNC time and distance CAPs 2. Q1 network adequacy quarterly analysis 3. QC HNs update on closing issued CAPs 4. PR/Contracting to expand provider network to address access issues	

2024 QI Work Plan – Q4 Update

Quality of Service	Increase primary care utilization	Increase rate of Initial Health Appointments for new members, increase primary care utilization for unengaged members.	Assess and report the following activities: 1) Increase health network and provider communications, training, and resources 2). Expand oversight of provider IHA completion 3) Increase member outreach efforts	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/12/2024) Q4 2024 Update (02/11/2025)	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	1) Increase health network and provider communications, training, and resources a. Communication: Most HN updates have been moved over to HN Quality Update Meeting (bimonthly); IHA updates provided to all HNs in November b. Presentations and Trainings HNs/Providers: 1 HN Forum, 7 HN Quality Update Meetings, 1 QIHEC, 1 CHCN Virtual, 1 PHMC Meetings,1 QIHEC Meetings, 1 DOC Meeting c. Provider Toolkit Resource: The document was placed on hold due to the website redesign; Components of the Provider Toolkit document are linked on the website. d. Provider Portal: Promoting IHA Report and Member Roster at HN/Provider trainings and presentations. 2) Expand oversight of provider IHA completion a. IHA Chart Review Audits: Encountered barriers with communication and responsiveness from PCP offices; escalated communication to Medical Director for Clinic Leadership outreach, office direct calls, and provider office visits b. Provider Office Visits: 11 Provider office site visits in addition to Teams meetings with all providers selected for chart review audits c. KPI Metric Expectation for HNs: Worked with DO to send new Delegation Oversight Dashboard Response Forms to fill out to report back on what actions they are taking to increase rates and track their performance d. KPI Metric Tracking: Tracking HN performance in alignment with the DOC Dashboard and sharing at HN Quality Update Meetings and during individual HN meetings 3) Increase member outreach efforts	Continue the plan listed with the addition of starting the process of implementing Corrective Action Plans for HNs/Providers in 2025. New member text campaign scheduled to launch Q1 2025 as an outreach attempt for IHA completion.	

								a. Text Message campaign for new members + IHA: DHCS approval, translation, and COMMS text message request process completed. Current step: Working with the vendor to finalize the campaign. Expected to launch in quarter 1, 2025. b. Ongoing IVR Campaign: Sent out twice monthly to new members		
Quality of Service	Improving Access: Annual Network Certification	Comply with Annual Network Certification requirements	1) Annual submission of ANC to DHCS with AAS 2) Implement improvement efforts 3) Monitor for Improvement	Submission: 1) By June 2024 2) By December 2024 Update from MemX to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Provider Network / Director of Medicare Stars and Quality Initiatives	Quality Analyst for Quality Analytics/ Manager of Provider Data Management Services	Provider Data Operations ~~Management Services~~	1. Per Q4 Network Adequacy Report, the plan meets DHCS requirements for MPT, capacity/ratio (FTE) and time/distance 2. DHCS approved AAS	1. Work on materials and get approvals to post AAS on COH's website. 2. Review last year's ANC filing to prepare for 2024 filing 3. Quarterly monitoring of ANC requirements and gap analysis	

2024 QI Work Plan – Q4 Update

Quality of Service	Improve Member Experience/CAHPS	Increase CAHPS performance to meet goal	Assess and report the following activities: 1) Conduct outreach to members in advance of 2024 CAHPS survey. 2) Just in Time campaign combines mailers with live call campaigns to members deemed likely to respond negatively. 3) These items also continue to be included in all P4V discussions with HNs.	Update from MemX to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of Medicare Stars and Quality Initiatives	QA Project Manager	Quality Analytics	1. Closed 2. Closed 3. HNQR were sent to all health networks and results discussed at health network Quality meetings.	Convened a smaller workgroup dedicated to member experience improvement. This group meets multiple times per month and works with various impacted business owners in trying to improve member experience. Launched member listening post campaigns that target members based on specific criteria and solicits feedback about the event/process/benefit to improve outcomes	
Quality of Service	Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process	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	GARS Committee Report to QIHEC: Q2 06/11/2024 Q3 09/10/2024 Q4 12/10/2024 Q1 03/11/2025	Director of GARS	Manager of GARS	GARS	Q3 GARS Committee was held on 11/13/2024. Q2 committee meeting minutes were approved. Discussions were had around HN delays in authorizations and appointment availability. Grievance trends related to transportation were also presented and discussed.	Continue with plan.	
Quality of Service	Customer Service	Implement customer service process and monitor against standards	Track and trend customer service utilization data Comply with regulatory standards Maintain business for current programs Improve process for handling customer service calls	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Director of Customer Services	Manager of Customer Service	Customer Service	Customer Service ran KPI data and reported results to QIHEC. DHCS' average speed of answer of not exceeding 10 minutes: Goal was met (1 min and 35 sec). Internal business goal of abandonment rate not exceeding 5% met: Goal was met (4.3%). Accomplishments: Hired additional staff, various departments staggered member engagement campaigns, leveraging call back capabilities for inbound calling members opting in.	Continue with plan	

2024 QI Work Plan – Q4 Update

Quality of Service	Medi-Cal Customer Service Performance Improvement Project	To meet Medi-Cal Customer Service KPIs by December 31, 2024: Internal call abandonment rate of 5% or lower, DHCS' 10 minutes average speed of answer	1) Partnering with HR to onboard more permanent and temporary staff to service inbound calls. 2) Interacting with various departments involved with member engagement campaigns and determine if they're able to update instructions for targeted members (i.e., instead of calling customer service, have them utilize the member portal).	Report progress to QIHEC quarterly: ~~Q2 2024 Update (08/13/2024)~~ ~~Q3 2024 Update (11/05/2024)~~ Q3 2024 Update (07/09/2024) ~~Q4 2024 Update (02/11/2025)~~ Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Director of Customer Services	Manager of Customer Service	Customer Service	Customer Service ran KPI data and reported results to QIHEC. DHCS' average speed of answer of not exceeding 10 minutes: Goal was met (1 min and 35 sec). Internal business goal of abandonment rate not exceeding 5% met: Goal was met (4.3%). Accomplishments: Hired additional staff, various departments staggered member engagement campaigns, leveraging call back capabilities for inbound calling members opting in.	Medi-Cal KPI's were achieved by December 31, 2024. Please retire/close out.	
Safety of Clinical Care	Coordination of Care: Member movement across practitioners	Improve coordination of care, prevention of complications, and facilitation of best practice diabetes care management between vision care specialists (SPCs) and primary care providers (PCPs)	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement: 2) Provider and member education	Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (~~02/11/2025~~ 01/14/2025)	Director of Case Management	TBD	Medical Management	Assess and report the following activities: 1) Collaborative meetings between teams to identify best practices to implement: No meetings Q4, metric is in implementation. 2) Provider and member education a) All health networks are receiving monthly files from VSP except for Heritage-Regal. Heritage-Regal has internal barrier to receipt of file that they are working on. b) Ongoing monthly communication to members from VSP for those in need of eye exam.	Internal call abandonment rate of 5% or lower,	
Safety of Clinical Care	Emergency Department Member Support	Emergency Department Diversion Pilot has been implemented. In 2024 plan to expand a virtual program to additional hospital partners starting with UCI.	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	Update from UMC to QIHEC Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Director of LTSS	Manager of LTSS	LTSS	No metrics to report in Q4 2024. The program is still in development and implementation. The two staff, RN & MSW, have completed training and will start being embedded in the UCI ED the beginning of January 2024.	DHCS' 10 minutes average speed of answer	

Safety of Clinical Care	Coordination of Care: Member movement across settings - 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% from Q4 2023 by end of December 31,2024.	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.	UMC Committee report to QIHEC: Q2: 06/11/2024 Q3: 09/10/2024 Q4: 12/10/2024 Q1 03/11/2025	Sr. Director of UM	Project Manager III, Medical Management	Utilization Management Case Management Long Term Care	Usher texting campaign continues to Medi-Cal CCN members admitted to the hospital based on our ADT data. TCS support line new report for call volume: 31 inbound calls handled. Ongoing audits for completion of outreach for high-risk members in need of TCS- 100% compliance for completed audits.	Further develop Usher texting opportunities through TCS and highrisk workgroups. Further refine NICE phone line reporting to drill down TCS support line specificity for further opportunities. Revision of goal for 2025 based on 2024 data.	
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 41.90% to 55.78% by 12/31/2024.	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 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Medicare Stars and Quality Initiatives	Quality Analyst	Quality Analytics	Findings: As part of the parental/guardian reminders, call also assessed for barriers and facilitators to well child visits. Challenges included limitations with successfully being able to outreach to parents/guardians of child members. Out of 85 members, was only able to successfully reach 24 members. Key highlights: • Parental knowledge- CalOptima Health assessed for knowledge as it relates to the importance of well-child visits and what should be expected at these visits. 21.18% expressed having knowledge of the importance of the visits and 18.82% did not express having any understanding. Some parents drew on the knowledge from their previous experiences with other children. • Scheduling- When inquired about the scheduling of the next well-child visit, 67.65% (n=23) responded not having a visit scheduled, or being unsure, followed by 32.35% reporting that they had the next well-visit scheduled with the PCP. When attempting to assess for barriers and facilitators, 6 of the 34 parents declined to proceed with the call. The following	Working with ECH department to identify CBOs which could assist with increasing performance Continue with calls to gain understanding and educate members Work more closely with HNs to target these members for HN based initiatives	

								narrative is based on 28 successful parental interactions. • Barriers to well-child visits- 35.29% (n=12) of parents reported experiencing challenges that impact their ability to attend well-child visits. Factors included: family law where custody for the child varied, scheduling conflicts with parental work schedules or PCP schedule that did not align with the parent's needs, lack of childcare, and lack of transportation. • Facilitators to well-child visits- 32.35% (n=11) reported on various facilitators to attending these visits. PCP availability was mentioned the most, followed by transportation benefit, office reminders to attend, knowing who the child's PCP is. PIP Steps 1-8 submitted		

Cultural and Linguistic Appropriate Services	Cultural and Linguistics and Language Accessibility	Enhance interpreter and translation services	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards, including Member Material requirements Initiate Request for Proposal (RFP) to add and/or replace the translation and interpreter services vendors to improve the member experience.	Report progress to QIHEC Q2 2024 Update (04/09/2024) Q3 2024 Update (07/09/2024) Q4 2024 Update (10/08/2024) Q1 2025 Update (01/14/2025)	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	During quarter 4, interpreter and translation services utilization data was analyzed, tracked and trends were identified and adjusted when necessary to ensure members received timely and adequate interpreter and translation services. Throughout Q4, all Member Material were translated accurately and on time to comply with regulatory standards. In lieu of a Request for Proposal (RFP), the vendor contracts for all five (5) vendors were extended. During Q4 two out of five contract extensions were completed.	During quarter 4, interpreter and translation services utilization data was analyzed, tracked and trends were identified and adjusted when necessary to ensure members received timely and adequate interpreter and translation services. In Quarters 4 from 2023 and 2024 we processed the following translation requests: • 2023 – 11,889 Translations • 2024 – 19,280 Translations In Quarters 4 from 2023 and 2024 we processed the following Telephonic and Face-to-Face interpreter requests: • 2023 – 255,442 Telephonic interpreter requests • 2024 – 517,623 Telephonic interpreter requests • 2023 – 6,944 Face-to-Face interpreter requests • 2024 – 9,691 Face-to-Face interpreter requests Barriers identified for interpreter services were the shortage/lack of interpreters in various languages such as Khmer/Cambodian. Throughout Q4, all Member Material were translated accurately and on time to comply with regulatory standards. In lieu of a Request for Proposal (RFP), the vendor contracts for all five (5) vendors were extended. During Q4 two out of five contract extensions were completed.	

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Cultural and Linguistic Appropriate Services	Maternity Care for Black and Native American Persons	1) PPC Postpartum: Increase timely PPC postpartum appointments for CalOptima's Black members from 67.48% to 74.74% and Native Americans from 44.44 to 63.22% by 12/31/24. 2) PPC Prenatal: Increase timely PPC prenatal appointments for CalOptima's Black members from 53.77 to 72.37% and Native Americans from 27.78% to 59.43% by 12/31/24.	Assess and report the following activities: 1) Determine the primary drivers to noncompliance via member outreach and literature review 2) Targeted member engagement and outreach campaigns in coordination with health network partners 3) Strategic Quality Initiatives Intervention Plan - Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. 4) Continue expansion of Bright steps comprehensive maternal health program through community partnerships, provider/ health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events 5) Implement Collaborative Member Engagement Event with OC CAP Diaper Bank and other community-based partners 6) Expand member engagement through direct services such as the Doula benefit and educational classes	By December 2024 Report progress to QIHEC Q1 2024 Update (05/14/2024) Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Manager Equity and Community Health/ Director of Operations Management	Program Manager of Quality Analytics/ Manager of Quality Analytics	Equity and Community Health	ECH piloted outreach efforts focused on Black and Native members using the Birth Equity population of focus list. Phone calls and mailings to promote BIH, ECM, and Doula services were provided to 183 members. 13% of members accepted referrals when contacted by phone, 92% of members were mailed materials about the services. Development of member messaging for prenatal and postpartum care is still taking place to support the goal of multimodal outreach and targeted engagement.	Working with ITS to develop reporting that identifies pregnant members earlier to allow for timely prenatal care Identify CBOs which could assist with increased performance and develop enhanced referral systems for ensuring care coordination.	

Cultural and Linguistic Appropriate Services	Data Collection on Member Demographic Information	Implement a process to collect member SOGI data by December 1st, 2024.	1) Develop and implement a survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age). 2) Update CalOptima Health's Core eligibility system to store SOGI data. 3) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks. 4) Develop and implement a survey via the Member Portal, mail to new members and other methods. 5) Share member demographic information with practitioners.	Report progress to QIHEC quarterly: ~~Q2 2024 Update (08/13/2024)~~ Q2 2024 Update (07/09/2024) ~~Q3 2024 Update (11/05/2024)~~ Q3 2024 Update (10/08/2024) ~~Q4 2024 Update (02/11/2025)~~ Q4 2024 Update 01/14/2025)	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	1) The Member's Sexual Orientation and Gender Identity (SOGI) survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age) was sent to members in September 2024. 2) The CalOptima Health's Core eligibility system to store SOGI data is continually being updated. 3) Member demographic information is being shared with practitioners.	1) Member's (SOGI) surveys will continue to be sent to members (18+ years of age) throughout Q1 and Q2 of 2025, to collect the Member's Sexual Orientation and Gender Identity (SOGI) information. 2) The CalOptima Health's Core eligibility system to store SOGI data will continue to be updated, as necessary. 3) Member demographic information will continue to be shared with practitioners.	

Cultural and Linguistic Appropriate Services	Data Collection on Practitioner Demographic Information	Implement a process to collect practitioner race/ethnicity/languages (REL) data by December 31, 2024.	1) Develop and implement a survey to collect practitioner REL data 2) Enter REL data into provider data system and ensure ability to retrieve and utilize for CLAS improvement. 3) Complete an analysis of the provider network capacity to meet language needs of the CalOptima Health membership. 4) Assess the provider network's capacity to meeting CalOptima Health's culturally diverse member needs. 5) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks.	Report progress to QIHEC quarterly: Q2 2024 Update (08/13/2024) Q3 2024 Update (11/05/2024) Q4 2024 Update (02/11/2025)	Director of Provider Data Management Services	Manger Provider Data Management System	Provider Data Management Services	Collecting REL data from healthcare providers was met, as the primary objective was to establish a process for REL data collection, rather than to achieve a specific response rate. The Provider Satisfaction Survey was successfully conducted in mid September 2024 to mid November 2024, and the data was processed and entered inot the database as planned. The Provider Satisfaction Survey was distributed to 2,272 healthcare providers, with 30 responses received, resulting in a response rate of 1.32%. Challenges: The low response rate might be influenced by factors such survey fatigue at the end of the year, the lack of incentives, and the high volume of email communications likely contributed to low engagement and overlooked reminders, impacting the overall response rate.	In 2025, REL questions will be integrated into routine forms such as credentialing and provider demographic forms, instead of being included in the Provider Satisfaction Survey. This adjustment will shift visibility to the beginning of the year, rather than at the end, ensuring higher engagement and more timely responses.	
Cultural and Linguistic Appropriate Services	Experience with Language Services	Evaluate language services experience from member and staff	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 quarterly: ~~Q2 2024 Update (08/13/2024)~~ Q2 2024 Update (07/09/2024) ~~Q3 2024 Update (11/05/2024)~~ Q3 2024 Update (10/08/2024) ~~Q4 2024 Update (02/11/2025)~~ Q4 2024 Update 01/14/2025)	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	Cultural and Linguistic Services have developed a Staff and Member survey to evaluate the effectiveness of language services provided by cultural and linguistic services and vendors. The surveys will be launched in early February 2025. Survey updates will be provided to QIHEC at the Quarterly Update on 02/11/2025.	Staff and Member surveys to evaluate the effectiveness of language services provided by cultural and linguistic services and vendors will continue to be sent to members in 2025. Survey result updates will be provided to QIHEC at the Quarterly Update on 02/11/2025.	

2024 CalOptima Health Membership Risk Stratification

Interventions and Risk Levels	Targeted Intervention	Number of Members	Percentage of Membership
Basic Population Health Management: All members	An array of services that include care coordination, comprehensive wellness programs, and prevention initiatives, all requiring a strong connection to primary care.	916,989	100%
Chronic Condition Management: Medium Risk	Programs focused 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.	45,166*	4.93%
Complex Care Management: High Risk	Care for high-risk patients with complex medical, behavioral, or social needs, including comprehensive assessments, care coordination, and advocacy to ensure effective health management and prevention of poor outcomes.	806	0.09%
Enhanced Care Management: Highest Risk	Enhanced Care Management (ECM) is a Medi-Cal benefit offering 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 social determinants of health. It represents the highest level of care management in Medi-Cal.	47,416**	5.17%

***Chronic Care Management numbers based on CalOptima Health members potentially eligible for services from 01/01/24 to 12/01/24.

****Enhanced Care Management numbers based on CalOptima Health members potentially eligible for services from 01/01/24 to 06/30/24.

Medi-Cal Membership = 916,989 (Membership Data as of January 2024)

CalOptima Health

2024 Population Health Management Impact Report

Report Date: January 2025
Data Date Range: January–December 2024

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2024 Population Health Management Signature Page

Population Health Management Committee Chairperson:

_____ _____

Shilpa Jindani, M.D., FAAFP
Medical Director, Equity and Community Health

Date

Responsible Staff:

Shilpa Jindani, M.D., FAAFP
Medical Director, Equity and Community Health

Katie Balderas, MPH
Director, Equity and Community Health

Table of Contents

Section 1: CalOptima Health Overview

CalOptima Health Overview
CalOptima Health has had the privilege of caring for Orange County residents since 1995. We believe that all 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 providers, community stakeholders and government agencies to achieve our mission and vision.

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

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

Our Values
CalOptima Health honors its "Better. Together." motto by working with members, providers and community stakeholders so we can make things better — for our members and community. We believe that to best serve the people of Orange County, we must continue to lead with Collaboration, Accountability, Respect, Excellence and Stewardship. These are our CARES values, which guide how we build and maintain trust as a public agency, as well as with our members and providers.

Section 2: Introduction

CalOptima Health's annual Population Health Management (PHM) Impact Report measures the effectiveness of the agency's PHM Strategy and Work Plan to address member care needs in the areas of:

- Keeping members healthy
- Managing members with emerging risks
- Increasing patient safety
- Managing multiple chronic conditions

Through this evaluation, CalOptima Health also identifies and addresses opportunities for improvement.

Summary of Results

In 2024, all but one of the programs and initiatives within the 2024 PHM Strategy and Work Plan are on pace to meet established goals pending final rates for measurement year (MY) 2024. One of the three subgoals under the Street Medicine Program is at risk of not being met based on the lack of affordable housing opportunities for unhoused residents of Orange County.

2024 Population Health Management Strategy

Details of CalOptima Health' PHM impact evaluation are captured in this report and the 2024 PHM Work Plan can be found in the report Appendix on page 88.

Section 3: Keeping Members Healthy

CalOptima Health designs programs and initiatives to keep our members healthy by focusing on promoting early detection, fostering healthy habits and supporting preventive care. CalOptima Health offers a range of screenings, wellness assessments and educational resources to empower members to take control of their health. With a focus on prevention, CalOptima Health aims to reduce the risk of chronic conditions and improve long-term well-being among members. The following section evaluates selected programs and initiatives designed to keep members healthy, including child preventive services, maternal health, nutrition and physical activity.

3.1 Blood Lead Testing in Children (12-24 Months)	
Business Owner: Mike Wilson	**Department:** Quality Analytics
Support Staff: Kelli Glynn/Leslie Vasquez	
Products: ☒ Medi-Cal ☐ OneCare	**New Activity:** ☐ Yes ☒ No
Work Plan Goal/Objective: HEDIS MY2024 Goal: 67.12%; Improve Lead Screening in Children (LSC) HEDIS measure: 63.99%	
Goal Met: ☐ Yes ☒ No ☐ Partial	
Work Plan Planned Activities: • A multi-modal, targeted member approach as well as provider and health network collaborative efforts. Activities will include but not be limited to: IVR calls, texting, mailing, newsletter articles • Partnership with key local stakeholders (e.g., HCA)	
Status: ☐ Completed ☒ Ongoing	
Background: Lead exposure can cause serious health issues, including brain and nervous system damage, and intellectual and behavioral problems. Since children often show no symptoms, lead poisoning may go unrecognized. According to the CDC, there is no safe blood lead level, and screening is the best way to detect exposure. If not caught early, the effects can be permanent. California regulations recommend that Medi-Cal children be tested for lead at 12 and 24 months and receive catch-up tests if missed. Lead Screening in Children (LSC) is a key quality performance measure for HEDIS and part of the DHCS MCAS, reported annually by Medi-Cal MCPs. Starting in MY2022, MCPs are held to the NCQA Quality Compass Medicaid 50th percentile for LSC. DHCS also issued requirements for MCPs to ensure timely screenings in line with California regulations. LSC is a hybrid HEDIS and MCAS measure that evaluates the percentage of children who receive a lead test by their second birthday. LSC is a proxy for how well children are being tested for lead in accordance with state regulations.	
Methodology: CalOptima Health follows the HEDIS data collection methodology to assess LSC performance. The methodology for the MY2024 goal is based on the MY2022 reported performance results compared to the MY2022 NCQA Quality Compass national percentile benchmark. If the performance rate meets the NCQA Quality Compass benchmark, CalOptima Health will set its goal to the next NCQA percentile to encourage	

continued performance improvement. However, if the measure rate falls below the 50th percentile, then CalOptima Health sets the 50th percentile as the organizational goal.

CalOptima Health stratified race and ethnicity for the LSC measure in MY2024 to assess potential disparities. However, this methodology differs from NCQA's approach to race and ethnicity stratification, meaning the identified groups may not align with those in NCQA's stratified data. It's important to note that NCQA does not require race and ethnicity stratification for the LSC measure.

Please note 2024 PHM Work Plan goal for Blood Lead Testing in Children was revised. Currently, blood lead testing rates are not available by 12 and 24 months. Therefore, the blood lead screening goals could not be evaluated by 12 and 24 months separately. Instead, the LSC MCAS measure of 50th percentile was used to evaluate performance.

Medi-Cal Results:

Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Met / Not Met
LSC	Lead Screening in Children	64.00%	63.00%	63.8%	63.99%	☐ Yes ☒ No

Actions/Interventions Implemented in 2024:

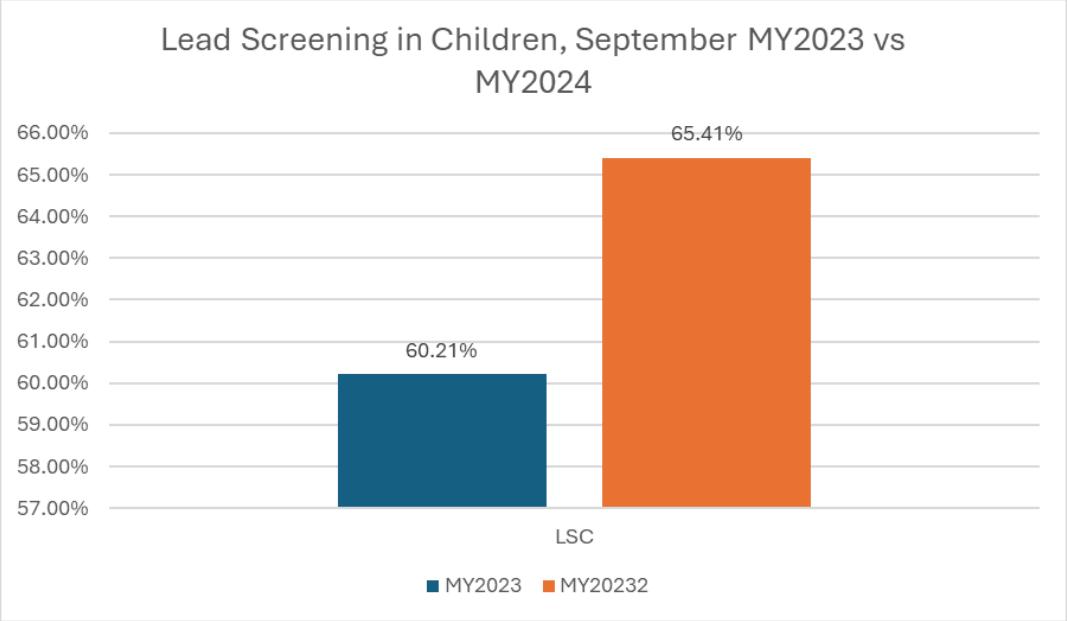
Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Member health reward for blood lead testing at 12 and 24 months of age	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	LSC
2. Texting campaigns — Members are issued general pediatric wellness texts along with blood lead-specific texts.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	LSC
3. Telephonic outreach	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	LSC
4. Blood Lead Screening Reports — Highlights members who are overdue for lead tests at 12 and 24 months of age. Highlights members that will be due for lead testing.	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	LSC
5. Provider education: Various efforts, including presentations, provider continuing education and the Blood Lead Testing Guide. Education offered via fax, email, provider monthly update and provider newsletter.	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	LSC
6. Targeted Paid Ads: Digital, social media, radio	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☒ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	LSC
7. Community partnerships with local health care agency and Childhood Lead Poisoning Prevention Program focused on increasing blood lead testing	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☐ Member ☐ Provider ☐ Health Network ☒ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	LSC
8. Planned: Medical record review process to support monitoring of lead requirements.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☐ Ongoing ☒ Incomplete	LSC

9. Planned: Point-of-Care Lead Pilot	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☐ Ongoing ☒ Incomplete	LSC
10. P4V program	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	LSC

MC = Medi-Cal; OC= OneCare

Results:

Chart A. MY2023 and MY2024 September Prospective Rates for LSC



Prospective rate methodology includes continuous enrollment criteria. LSC is a hybrid measure. Prospective rates showcased in Chart A are solely based on administrative data and are not final.

Chart A compares prospective rates; claims/encounters processed through September. LSC performance in September 2024 was much higher than the rate in September 2023 and trending 5% higher. LSC MY2024 rates are not final, however the measure is on pace to meet the established NCQA Quality Compass benchmark.

Table A. MY2024 LSC Administrative Rates by Race/Ethnicity

Admin	Race/Ethnicity									
HEDIS MY2024	**Hispanic**	**No Response**	**Other**	**White**	**Vietnamese**	**Black**	**Chinese**	**Korean**	**Filipino**	**Asian or Pacific Islander**
Numerator	4456	1112	810	405	367	61	46	48	35	36
Denominator	6260	1949	1307	885	496	114	81	80	63	52
Rate	71.18%	57.05%	61.97%	45.76%	73.99%	53.51%	56.79%	60.00%	55.56%	69.23%

Table A displays LSC administrative rates by race/ethnicity. Table A showcases the top 10 race/ethnic groups based on denominator, moving from the highest denominator (right) to lowest (far left).

Quantitative Analysis:

- LSC performance in September 2024 was much higher than the rate in September 2023 and trending 5% higher. LSC MY2024 rates are not final, however, the measure is on pace to meet the established NCQA Quality Compass benchmark.
- When assessing final rates (hybrid) for LSC from MY2021–MY2023, there has been no significant improvement in performance. In MY2022, the performance rate was decreased by 1% when compared to MY2021. In MY2023, the performance rate increased slightly (0.8%) from MY2022. Refer to Medi-Cal Results and Chart A.
- CalOptima Health set its organizational goal based on the MY2022 NCQA Quality Compass benchmark of 63.99%. MY2023 benchmarks were released subsequently, and the 50th percentile was set to 62.79%. CalOptima Health kept the 63.99% goal, which it did not meet. However, it should be noted that CalOptima Health did meet the 50th percentile of 62.79% for MY2023, with a final rate of 63.80%. See Medi-Cal rates above.
- Table A showcases MY2024 data by race and ethnicity data. Hispanic members account for the largest portion of the LSC denominator. When assessing for lead testing by race/ethnicity, the three groups with the lowest performance are as follows: White (45.76%), Black (53.51%) and Filipino (55.56%). Final rates are pending, but based on these trends, these groups may benefit from targeted interventions to support lead testing.

Identified Barriers:	**Identified Opportunities for Improvement:**
• Lack of parent/guardian awareness related to the importance of lead testing for the identification of lead exposure and potential lead poisoning. • Limited point-of-care lead testing practices • Providers report that there are high costs associated with obtaining point-of-care lead testing machines and lead testing supplies	• Ongoing need to support parental education on lead testing and reducing barriers to care. • CalOptima Health to support a pilot to implement point-of-care testing in select provider offices.

Conclusion:
The latest September 2024 prospective rates showcase a slightly more than 5% increase in lead testing based on the same time last year. This indicates that the combined efforts for lead testing have made a positive impact on LSC performance. Additional activities, such as the medical record review and implementation of the point-of-care lead testing pilot, aim to support further increased rates in LSC performance. Results for these efforts are pending.

Activities/Interventions to continue/add next year:

- Continue the member health reward to encourage lead testing completion amongst members.
- Targeted member outreach via various modalities: mailing, text, IVR calls
- Complete the point-of-care lead testing pilot to support increased lead testing rates and reduce barriers for providers seeking to offer point-of-care testing in the office.
- Initiate medical record review to assess and monitor provider and health networks for state-issued lead requirements.

3.2 Pediatric and Adolescent Wellness (CIS-Combo 10, W30 First 15 and 15-30, IMA-Combo 2, and WCV-Total)	
Business Owner: Mike Wilson	**Department:** Quality Analytics
Support Staff: Kelli Glynn/Leslie Vasquez	
Products: ☒ Medi-Cal ☐ OneCare	**New Activity:** ☐ Yes ☒ No
Work Plan Goal/Objective: HEDIS MY2024 Goal CIS-Combo 10: 45.26%, IMA-Combo 2: 48.80%, W30-First 15 Months: 58.38%, W30-15 to 30 Months: 71.35%, WCV (Total): 51.78%	
Goal Met: ☐ Yes ☐ No ☒ Partial	
Work Plan Planned Activities: • Targeted member engagement and outreach campaigns in coordination with health network partners. • Quality Initiatives Intervention Plan — Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts. • Early identification and data gap bridging remediation for early intervention	
Status: ☐ Completed ☒ Ongoing	
Background: According to the CDC, well-child visits and recommended vaccinations are essential for good health. Well-child visits are essential for tracking growth and development milestones, discussing any concerns about a child's health, and is the time for children to receive scheduled vaccinations to prevent illnesses and receive recommended screenings (e.g., blood lead testing, developmental screenings). 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-Combo2) • Child and Adolescent Well-Care Visits (WCV-Total) These measures are aligned with the DHCS Medi-Cal MCAS and held to the benchmarks established by the NCQA Quality Compass.	
Methodology: CalOptima Health follows HEDIS data collection methodology to assess performance with prenatal and postpartum care. The methodology for MY2024 goal is based on the MY2022 reported performance results compared to the MY2022 NCQA Quality Compass national percentile benchmark. If the performance rate meets the NCQA Quality Compass benchmark, CalOptima Health will set its goal to the next NCQA percentile to encourage continued performance improvement. However, if the measure rate falls below the 50th percentile, then CalOptima Health sets the 50th percentile as the organizational goal.	

For health disparity analysis, the data is pulled from the member enrollment file. The data is uploaded to the NCQA certified HEDIS software for rate calculation. The stratified rates are rolled up by denominator and numerator based on the rate/ethnicity, language or gender information uploaded.

Medi-Cal Results:

Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Met / Not Met
CIS-Combo 10 (hybrid)	Childhood Immunization Status	47.4%	39.4%	36.50%	49.76%	☐ Yes ☒ No
IMA-Combo 2 (hybrid)	Immunizations for Adolescents-Combo 2	50.7%	51.8%	47.5%	48.42%	☐ Yes ☒ No
W30-First 15 Months (admin)	Well-Child Visits in the First 30 Months of Life	49.3%	55.8%	55.8%	55.72%	☒ Yes ☐ No
W30-15 to 30 Months (admin)	Well-Child Visits in the First 30 Months of Life	67.3%	71.2%	72.4%	69.84%	☒ Yes ☐ No
WCV-Total (admin)	Child and Adolescent Well-Care Visits	54.0%	51.5%	53.0%	57.44%	☐ Yes ☒ No

The following analysis pertains to the final rate trends from MY2021–MY2023.

- CIS-Combo 10 has steadily declined in performance. While the measure did not meet its organizational goal of 49.7%, it did meet the national benchmark of 30.9%.
- IMA-Combo 2 has a slight increase in MY2022 from MY2021, but rates declined in MY2023 compared to MY2022. While the measure did not meet the organizational goal for MY2023, it surpassed the national benchmark of 34.31% by more than 10%.
- W30-First 15 Months' performance has remained the same between MY2022 and MY2023. For MY2023, the measure met its organizational goal as well as the national benchmark goal of 58.38%.
- W30-15 to 30 Months' performance improved slightly in MY2023, up 1.2% from MY2022. However, this slight increase is not statistically significant. The measure met its organizational goal as well as the national benchmark goal of 66.76% for MY2023.
- WCV-Total rate performance improved slightly in MY2023, up 1.5% from MY2022. The change is not statistically significant. The measure did not meet the organizational goal for MY2023; however, it met the national benchmark goal of 48.07%.

Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Member mailings (e.g., first and second birthday cards, member newsletters)	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☐ Ongoing ☐ Incomplete	CIS, IMA, W30 WCV
2. Telephonic outreach (vendor-supported pediatric call campaign)	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	CIS IMA W30 WCV
3. Provider education (e.g., pediatric quality measures guide for HEDIS)	☐ MC ☐ OC	☒ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	CIS IMA W30 WCV
4. Targeted paid ads: digital, social media, radio, TV Ads were available in English, Spanish, and Vietnamese member languages and targeted zip codes that were performing lower than the overall measure rate.	☒ MC ☐ OC	☒ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	CIS IMA W30 WCV
5. Well-Child Visits in the First 30 Months of Life Member Detail Report (monthly) — Reports outline the total number of visits completed along with visit dates.	☒ MC ☐ OC	☒ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	W30
6. Well Child Visit in the First 30 Months of Life Report — Identifying members with one or two visits pending.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	W30
7. Pediatric text campaigns — Issued to remind members of various period health assessment recommendations.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	CIS IMA W30 WCV
8. P4V Program	☒ MC ☐ OC	☐ Q1 ☐ Q2	☐ Member ☒ Provider	☐ Completed ☒ Ongoing	CIS IMA W30

		☐ Q3 ☐ Q4	☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Incomplete	WCV
9. W30 Performance Improvement Project (PIP) to improve W30 well child visits in the first 15 months for Black children. Please refer to 4.7.1 Performance Improvement Project (PIP) in this evaluation and section 9.1 Evaluate the PIP of the 2024 Culturally and Linguistic Appropriate Services Program Evaluation for more information about this initiative.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☒ Q3 ☐ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	W30

MC = Medi-Cal
OC= OneCare

Results:

Disparity Analysis:

Methodology: Prospective rates with claims/encounters processed through September 2024 were analyzed for current performance by race/ethnicity. CalOptima Health viewed race/ethnic groups with more than 30 members in the denominator and identified the groups with the lowest performance for pediatric immunizations and pediatric well-care visits. For adolescent well-care performance, CalOptima Health analyzed race/ethnic groups with more than 400 members in the denominator and identified the groups with the lowest performance.

Chart A. Pediatric Immunization Rates by Race/Ethnicity, September 2024

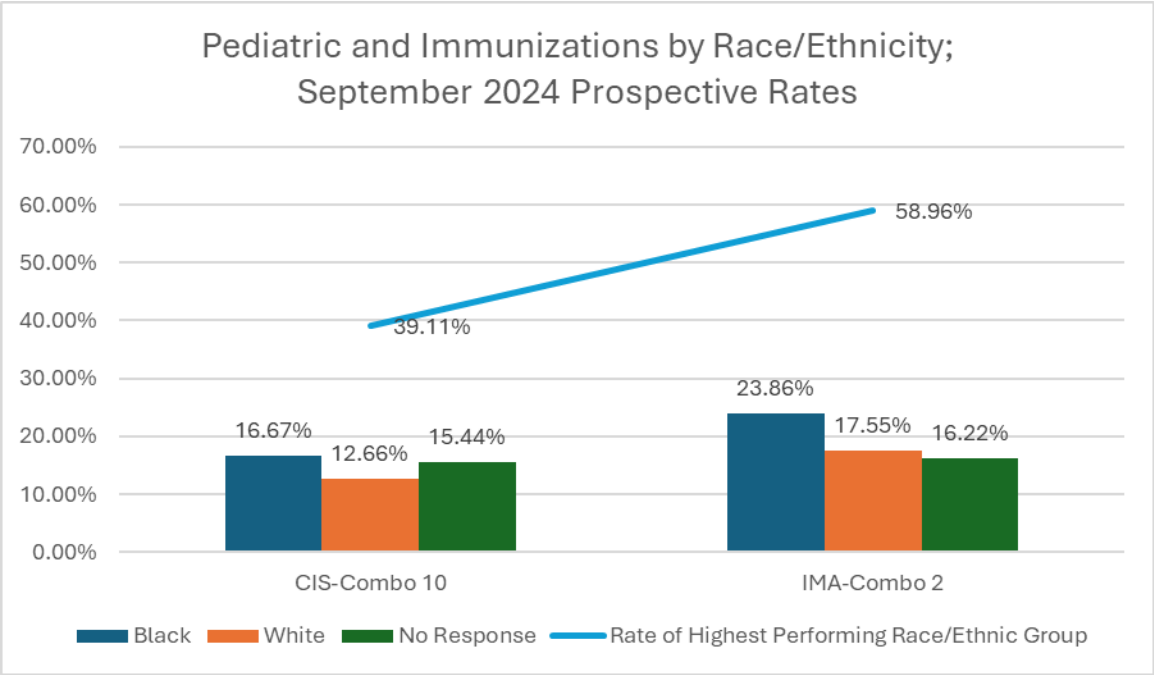


Chart A shows the CIS-Combo 10 and IMA-Combo 2 rates by race/ethnicity for prospective rates through September 2024. For both measures, Black, White and members that identified as “No Response” are performing the lowest across both measures. Vietnamese members are the highest-performing group in both pediatric and adolescent immunizations.

Chart B. Pediatric Well-Child Visits by Race/Ethnicity, September 2024

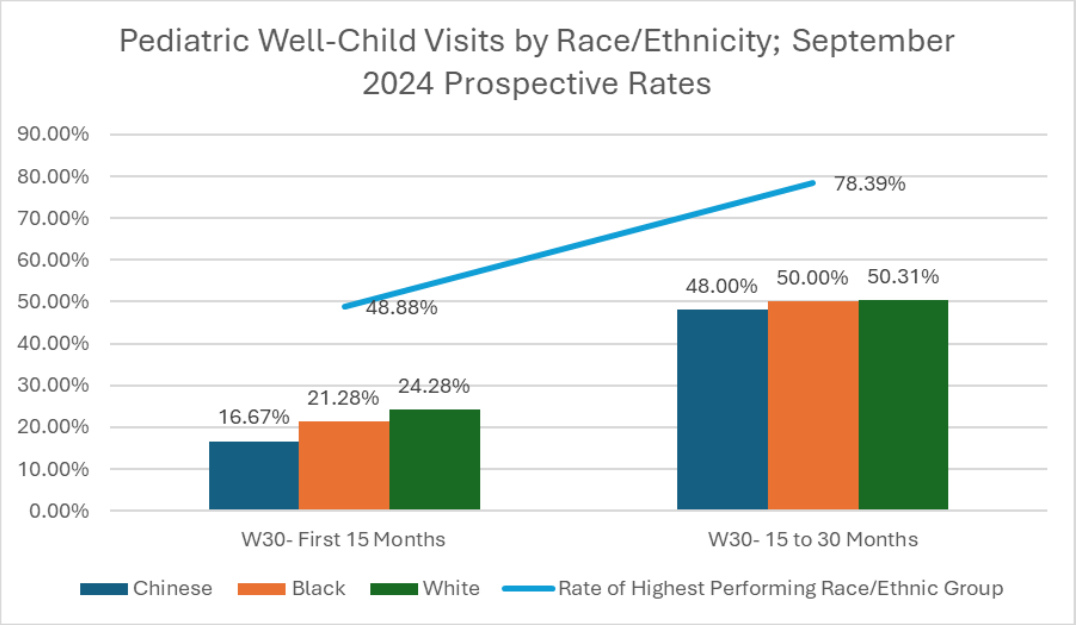


Chart B shows the rates for W30-First 15 Months and W30-15-30 Months by race/ethnicity for prospective rates through September 2024. For both measures, Chinese, Black and white members are performing the lowest across both measures. Vietnamese members are the highest-performing group for pediatric well-child visits.

Chart C. Pediatric Well-Care Visits by Race/Ethnicity, September 2024

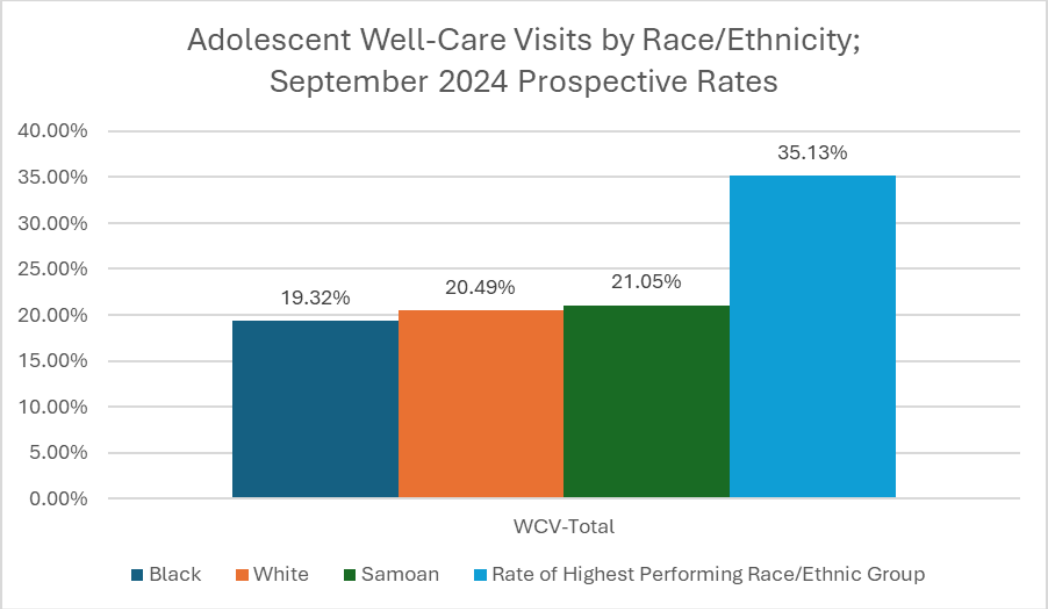


Chart C shows the rates for WCV-Total by race/ethnicity for prospective rates through September 2024. For both measures, Chinese, Black and white members are performing the lowest across both measures. Vietnamese members are the highest-performing group for pediatric well-child visits.

Chart D: MY2023 and MY2024 Pediatric and Adolescent Immunizations

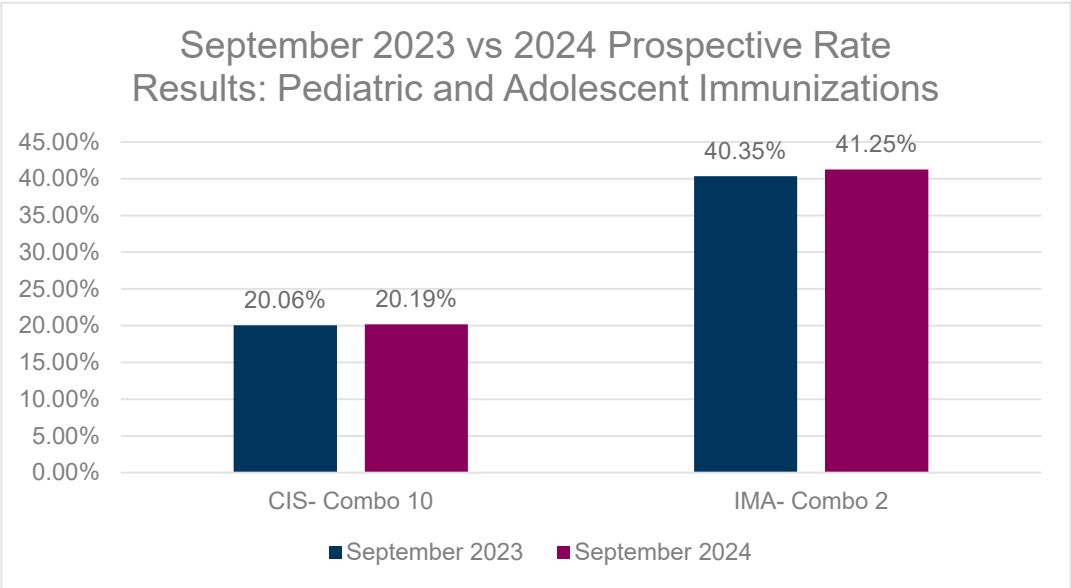
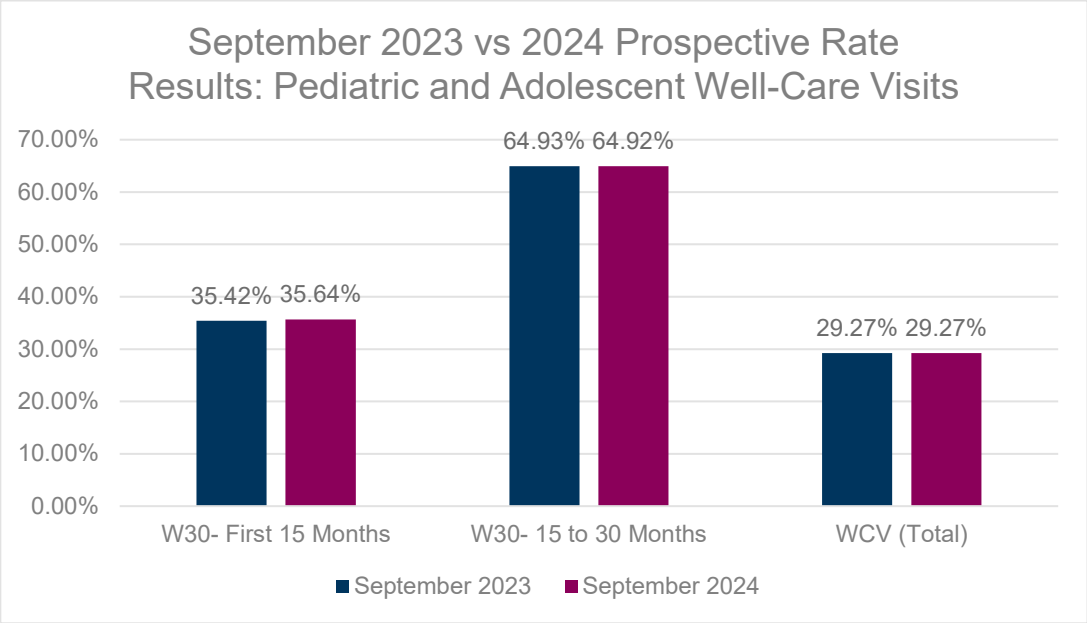


Chart E: MY2023 and MY2024 Pediatric and Adolescent Well-Care Visit Measures



Prospective rate methodology includes continuous enrollment criteria. CIS-Combo 10 and IMA-Combo 2 are hybrid measures, while W30 and WCV are administrative. Prospective rates are based on claims/encounters processed through September. Prospective rates in Chart A and Chart B are solely based on administrative data and are not final. Charts D and E compare September prospective rates for 2024 to the prospective rate in the previous year.

- Chart D: CIS-Combo 10 performance remains relatively similar to 2023 with no statistically significant improvement. IMA-Combo 2's performance increased slightly from 2023.
- Chart E: W30-First 15 Months of Life and W30-15–30 Months, as well as WCV Total, have not demonstrated any significant improvement in performance, thus indicating opportunities to continue implementing initiatives aimed at improving rates.

Table A

Submeasure	Denominator	Numerator	Administrative Numerator	Supplemental Numerator	Required Exclusions	Rate
Native Hawaiian and Other Pacific Islander Direct	704	247	226	21	0	35.09%
American Indian and Alaska Native Direct	213	75	69	6	0	35.21%
White Direct	32,312	12,419	11,420	999	10	38.43%
Black or African American Direct	4,616	1,872	1,739	133	2	40.55%
Unknown (Ethnicity)	109,890	53,501	50,601	2,900	21	48.69%
Some Other Race Direct	21,381	11,088	10,438	650	1	51.86%
Unknown Race	206,381	112,932	106,327	6,605	24	54.72%
Hispanic or Latino Direct	194,200	107,744	101,541	6,203	23	55.48%
Asian Direct	38,483	22,612	21,923	689	7	58.76%

Quantitative Analysis:
As noted in the Results section above, there has been no significant increase in performance amongst all pediatric and adolescent immunization and well-child/well-care visit rates. CalOptima Health began targeted pediatric text campaigns in 2024 that allow for widespread outreach at the various timeframes for which a periodic health assessment is recommended. CalOptima Health has also refined its methodology with pediatric call campaigns to move away from general vaccination information to now sharing with parents/guardians what specific vaccinations are pending for the members. In addition, the plan has refined its messaging in text messages to speak to more than just vaccines. Often, parents/guardians may attribute well-child visits to just vaccines. However, there are other important screenings and care that are delivered at well-child visits.

Disparity Analysis:
As shown in Table A, the overall total rate for the Child and Adolescent Well-Care Visits (WCV) measure in MY2023 was 53.03%. Using the total rate as a reference point, all ethnic groups except for Hispanic or Latino and Asian performed lower than 53.03%. The compliance rate for all ethnic groups except for Hispanic or Latino and Asian did not meet or exceed the MPL of 48.07%. The highest-performing ethnic group was Asian at 58.76%; the lowest-performing ethnic group was Native Hawaiian and Other Pacific Islander at 35.09%. In conclusion, CalOptima Health will continue to implement initiatives aimed at improving WCV performance across all ethnic groups.

Identified Barriers:	Identified Opportunities for Improvement:
• Providers/health networks report that, since COVID-19, they have noted an increased hesitancy with vaccinations. • Telephonic and text campaigns are dependent on having the correct contact information, and often, members opt not to pick up telephonic calls. • Staffing shortages impact appointment availability making it difficult to complete well-child visits and important care (e.g., vaccinations).	• Promote the messaging of HPV vaccination recommendation at an earlier timeframe to support dosage completion. • Limited outreach success with text/calls indicates an opportunity to improve on rapport building with members, tailoring messages so that they meet different parental needs or concerns (e.g., vaccine safety), and leverage data on optimal call times.

Conclusion:

- Perceptions are changing around the importance of well-child visits and vaccinations after COVID-19. There is a need to augment messaging in communities about the importance of these visits and address vaccination hesitancy. Messages need to occur through various modalities.
- There is a need to continue to connect with health networks, clinics and provider offices to understand their challenges, successes and current process with well-care visits and vaccinations.
- Across all pediatric measures, both Black and White race/ethnic groups are the two performing the lowest. CalOptima Health should continue to work with providers and health networks to understand the contributing factors to this performance and tailor initiative to address the varying challenges/concerns with each population.

Activities/Interventions to continue/add next year:

CalOptima Health to continue the following efforts:

- Connect with health networks, clinics and provider offices to understand their challenges, successes and current process with well-care visits and vaccinations.
- Work with providers and health networks to understand best practices that are working to improve the delivery of well-care visits/vaccinations and share these best practices with others.
- Promote the CalOptima Health Pediatric HEDIS Guide to support performance and gap closure.
- Targeted member engagement and outreach campaigns in coordination with health network partners.
    - Multi-modal efforts: Mail, text, IVR calls, etc.
- Early identification and data gap bridging remediation for early intervention and promotion of well-child visits as well as data capture in support of gap closure.
- Enhance the promotion of the CalOptima Health Pediatric HEDIS Guide to support performance and gap closure.
- Assess the effectiveness of the text campaigns newly implemented in 2024 and revise the member communication strategy as needed.
- Continue to leverage race and ethnicity performance data to drive initiatives aimed at reducing disparities in 2023.

3.2.1 Health Disparity Remediation for Well-Child Visits	
Business Owner: Mike Wilson	**Department:** Quality Analytics
Support Staff: Leslie Vasquez/Kelly Glynn	
Products: ☒ Medi-Cal ☐ OneCare	**New Activity:** ☐ Yes ☒ No

Work Plan Goal/Objective:
Meet and exceed goals set forth on all improvement projects.
Increase well-child visit appointments for African American members (0–15 months) from 41.90% to 55.78% by December 31, 2024. This target was set for MY2024, however, the PIP timeframe spans from 2023 to 2026.

Goal Met: ☐ Yes ☒ No ☐ Partial

Work Plan Planned Activities:
Action: Improve well-child visit rates in the first 30 months of life for African American child members.

MY2024 PIP activities consisted of a telephonic outreach campaign to the parents/guardians of African American child members turning 15 months of age in the measurement year. The telephonic outreach campaign aimed to provide the following:

1. Education on well-child visits
2. Reminders to complete well-child visits
3. Appointment coordination for well-child visits
4. Data gathering on barriers and facilitators to well-child visits

Status: ☐ Completed ☒ Ongoing

Background:
The California 2020 Health Disparities Report identified disparities for most of the indicators of the Children's Health domain. Per this report, the African American group fared lower than other groups across all six key indicators.

The PIP aims to reduce the racial/ethnic disparities in W30-6 visits in support of the statewide goals. In alignment with the recommendations in the Health Equity Framework, this PIP will involve the African American population, the group most affected by health care disparities, through a survey call campaign to understand firsthand the experiences with well-child visits and the barriers to and facilitators for attending well-child visits.

Well-child visits are the foundation of pediatric health promotion and disease prevention. These visits are intrinsically linked to the key indicators in the Children's Health domain. Accordingly, improving the W30-6 measure rate has the potential to improve member health status among these key indicators. Insight into the barriers to attending well-child visits has the potential to identify key areas that may improve member satisfaction across health care services.

PIP intends to address the following barriers to well-child visits:

- Parent/guardian gaps in knowledge as it relates to the purpose and value of well-child visits.
- Lack of reminders for parents/guardians to complete well-child visits.
- Lack of available resources for health networks to coordinate well-child visit appointments with a primary care provider for African American child members

Methodology:
CalOptima Health followed HEDIS data collection methodology for the W30 — First 15 Months (noncontinuous enrollment). CalOptima Health then identified child members identified as African American to monitor for rates.

Medi-Cal Results:

Chart A. Rates for W30 — First 15 Months

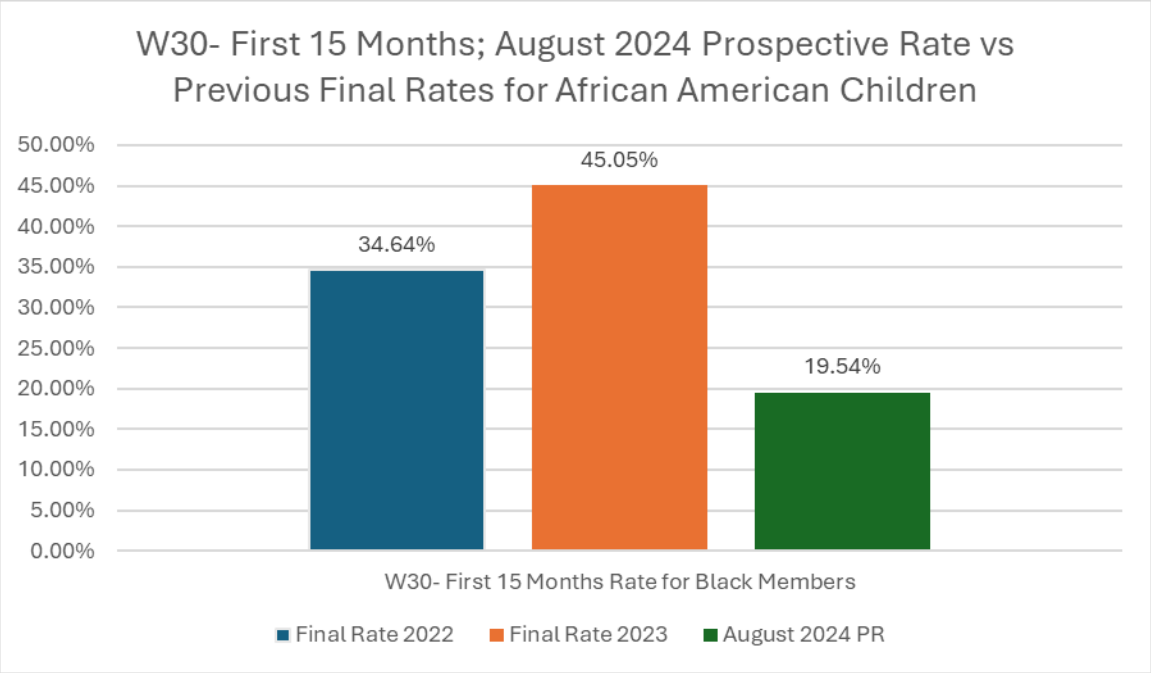


Chart A shows the final MY2022 and MY2023 W30 — First 15 Months rates for African American child members compared to the most recent 2024 prospective rate. The performance improvement project is set for 2023 to 2026. As part of the process, the MY2022 rate (34.64%) was used to confirm the population of interest — African American children — that would be targeted for the project. The chart demonstrates an increase in rates for MY2023 compared to MY2022. Final MY2024 rates are pending; however, the rate (19.54%) of claims/encounters processed through August 2024 is shown.

Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Status	Measure(s) (Acronym)
1. Telephonic outreach campaign — Two calls were provided to each of the 85 members.	☒ MC ☐ OC	☐ Completed ☐ On-going ☐ Incomplete	W30 (First 15 Months)
2. Email campaign — To members with an email who were not successfully outreached via the telephonic campaign.	☒ MC ☐ OC	☒ Completed ☐ On-going ☐ Incomplete	W30 (First 15 Months)
3. Pediatric text campaign	☒ MC ☐ OC	☐ Completed ☒ On-going ☐ Incomplete	W30 (First 15 Months)

MC = Medi-Cal; OC= OneCare

Quantitative Analysis:

- For the 2024 calendar year, 85 African American members were identified as needing to complete six or more well-child visits by 15 months of age. Staff successfully contacted 34 (40%) of parents/guardians, providing reminders to complete well-child visits and addressing gaps in knowledge related to the importance and value of well-child visits.
- As part of the attempt to increase contact with members, letters were issued to the 51 parents/guardians who could not be contacted telephonically.
- Appointment coordination was offered to all 34 parents/guardians of child members who were successfully outreached. All 34 parents/guardians declined appointment coordination and refused support with appointment coordination for future well-child visits. This refusal may be driven by many reasons, including long call wait times, lack of urgency and competing priorities at the time in which the parent was called. based on feedback gained from the call campaign.

Identified Barriers:	Identified Opportunities for Improvement:
• Member contact information — Member contact lists contain outdated or incorrect information, contributing to a high rate of unsuccessful outreach. Other issues included the inability to leave voicemails or parent/guardian refusal to take the call. • As part of an attempt to increase contact with members, letters were issued to the 51 parents/guardians who could not be contacted telephonically.	• Opportunities to improve member contact information to maximize outreach. • Opportunities to partner with health networks to support care coordination for child members.

Parents or guardians did not respond to the letter.	

Conclusion:

- There is an opportunity to continue to inform members about the importance and cadence of well-child visits and what makes each of these visits unique to support adherence. Education about these visits should begin as early as possible including prenatal and postpartum timeframe.
- There is an opportunity for PCPs to revise their workflows to allow for the scheduling of the next visit prior to the family leaving the existing visit.
- Members feel that they benefit when their child's assigned PCP has appointment availability that fits the parents' schedules. PCP offices should continue to implement reminders for these visits.
- There are opportunities to increase awareness of the Medi-Cal transportation benefit as well as inform parents of who the child's PCP is.

Activities/Interventions to continue/add next year:

- Efforts to include improved coordination with health networks to delivery care for African American child members.

3.3 Comprehensive Community Cancer Screening and Support Program (Breast Cancer Pilot)	
Business Owner: Mike Wilson	**Department:** Quality Analytics
Support Staff: Melissa Morales/ Kelli Glynn	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: BCS-E: MC 62.67%	
Goal Met: ☐ Yes ☒ No ☐ Partial	
Work Plan Planned Activities: Assess and report the following activities: • Targeted member engagement and outreach campaigns in coordination with health network partners. • Strategic Quality Initiatives Intervention Plan — Multi-modal, omni-channel targeted member, provider and health network engagement and collaborative efforts.	
Status: ☐ Completed ☒ Ongoing	
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 for American women. U.S. Preventive Services Task Force (USPSTF) has recommended screening for breast cancer. Cancer screening tests can help 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 performance measures for HEDIS. Breast Cancer Screening are part of DHCS' MCAS for annual reporting by Medi-Cal managed care health plans. These measures are held to the MPL established by NCQA Quality Compass Medicaid 50th percentile.	
Methodology: Followed the HEDIS data collection methodology. Goal methodology for MY2023 is based on the current reported performance and most current available benchmark. The Medi-Cal goal setting for MY2023 is based on the MY2021 reported performance results compared to the national percentile from the MY2021 NCQA Quality Compass. If the current reported rate reached the NCQA Quality Compass percentile, the goal was set to the next percentile. Goal methodology for MY2024 is set based on the current reported performance and most current available benchmark. The Medi-Cal goal setting for MY2024 is based on the 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. For health disparity analysis, the data is pulled from the member enrollment file. The data is uploaded to the NCQA certified HEDIS software for rate calculation. The stratified rates are rolled up by denominator and numerator based on the rate/ethnicity, language or gender information uploaded. Disparity analysis was conducted for BCS measures based on the HEDIS September MY2024 top 10 race/ethnicity administrative data by denominator.	

Medi-Cal Results:

Table A

Table below reviews the Medi-Cal final rates for HEDIS MY2023 and goals for MY2023.

Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Me/Not Met
BCS	Breast Cancer Screening	57.64%	57.81%	58.39%	61.27%	☐ Yes ☒ No

Table B

Table below reviews the Medi-Cal rates for September HEDIS MY2023-MY2024 and goals for MY2024.

Acronym	Measure	MY 2023 Sept Medi-Cal Rate	MY 2024 Sept Medi-Cal Rate	MY 2024 Medi-Cal Goal	MY 2024 Goal Me/Not Met
BCS	Breast Cancer Screening	51.72%	53.44%	62.67%	☐ Yes ☒ No

Table C

Table below reviews September MY2024 Breast Cancer Screening by Race/Ethnicity Based on Administrative Data.

Admin	Race/Ethnicity									
HEDIS Sept MY2024	*Hispanic*	*Vietnamese*	*White*	*Other*	*No response, client declined to state*	*Korean*	*Filipino*	*Chinese*	*Asian or Pacific Islander*	*Black*
Numerator	16591	8162	4948	3418	2381	921	785	562	466	353
Denominator	30979	13784	12480	6706	5942	2106	1566	1476	1012	917
Rate	53.56 %	59.21 %	39.65 %	50.97 %	40.07 %	43.73 %	50.13 %	38.08 %	46.05 %	38.50 %

Table caption: Table displays the top 10 ethnicities with the highest denominator based on total HEDIS Medi-Cal and OneCare population combined.

Actions/Interventions Implemented in 2024:

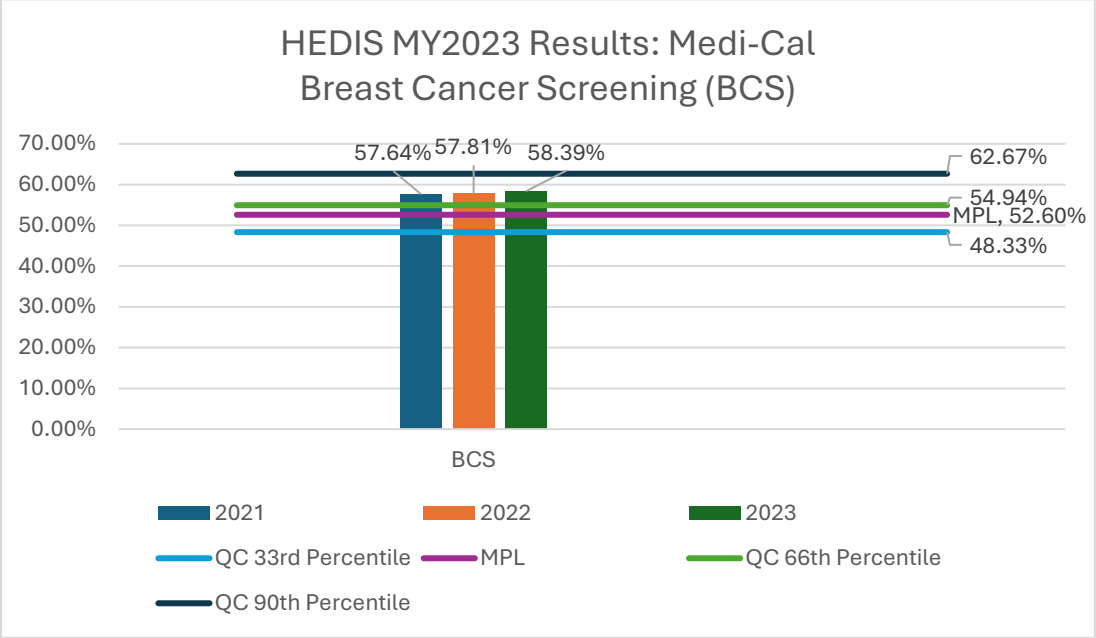
Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
• Member Health Reward	☒ MC ☒ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	BCS
• Member Mailing	☒ MC ☒ OC	☐ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	BCS
• IVR	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete	BCS
• Text Messaging	☒ MC ☒ OC	☐ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☐ Ongoing ☐ Incomplete	BCS
• Telephonic Outreach	☒ MC ☒ OC	☐ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	BCS
• Standing Orders Program	☒ MC ☒ OC	☐ Q1 ☐ Q2 ☐ Q3 ☒ Q4	☒ Member ☒ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ O-going ☐ Incomplete	BCS
• Gap-in-Care Reporting	☒ MC ☒ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete	BCS

MC = Medi-Cal; OC= OneCare

Results:

Chart A

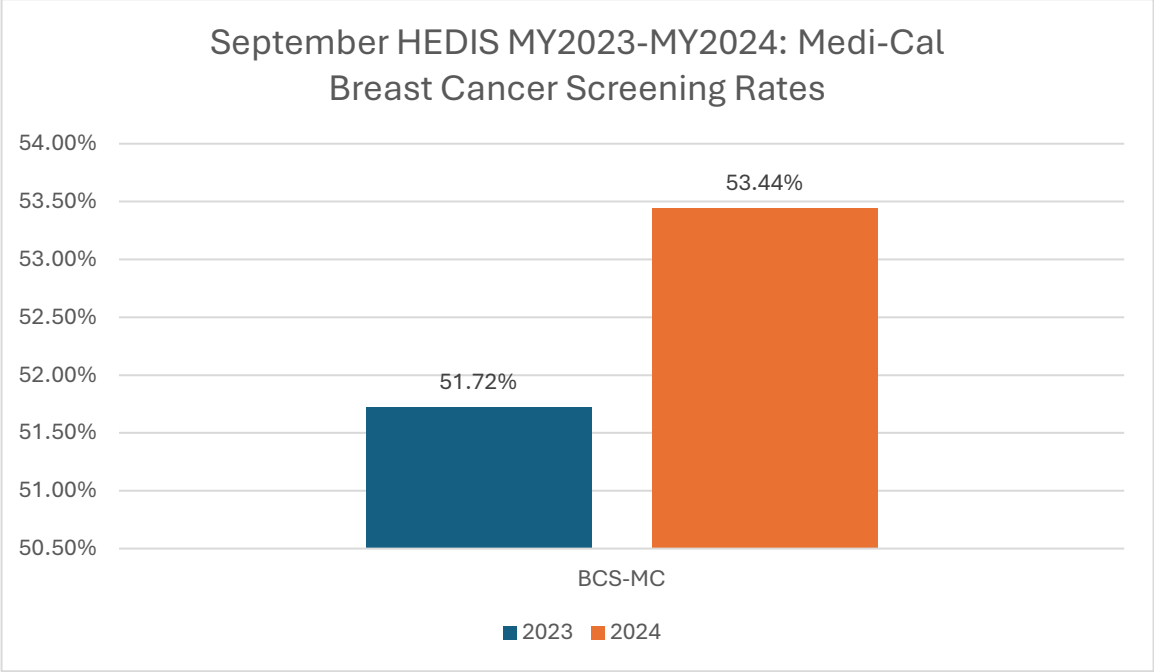
- CalOptima Health HEDIS MY2023 BCS rate for Medi-Cal was 58.39% and met the MPL of 52.60% but did not meet the MY2023 internal goal of 61.27%.



Per HEDIS 2022 Quality Compass Percentile

Chart E

- CalOptima Health BCS rates for September HEDIS MY2023–2024 for Medi-Cal.



Claims/encounters processed through September 2024

Quantitative Analysis:

Comparing CalOptima Health Medi-Cal BCS prospective rates for September HEDIS MY2023-MY2024. The rates are based on the administrative data and represent the claims/encounters process through the month of September for each respective year.

- Breast Cancer Screening (BCS-MC): As of September 2024, the BCS prospective rate was 53.44%, which is higher than the September 2023 prospective rate of 51.72% by 1.72 percentage points.

Disparity Analysis:

BCS-MC, OC: When looking at the top three race/ethnicity groups by denominator count, the Vietnamese group had the highest rate at 53.56%. While the group identified as White had the lowest rate at 39.65%.

Identified Barriers:	Identified Opportunities for Improvement:
• Members did not visit their PCP during MY2024, 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.	• Data optimization • Provider and health network quality committee meetings provide input on quality-related opportunities, helping identify barriers, develop and implement effective approaches

• Members may not be aware of the importance of cancer screening and/or 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 shortages, resulting in long wait times. • Due to data lag of approximately 90 days, the September 2024 prospective rate may not provide the most accurate rate of completion of cancer screening measures. • Hybrid measures like Cervical Cancer Screening for Medi-Cal require medical record review; therefore, the actual final rate for MY2024 may be higher.	• Develop member journey campaigns with new text messaging vendor to diminish member outreach abrasion. • Member outreach specific to factors such as age. • Internal member-facing departments will remind members of gaps in care during calls. • Educate eligible members of direct access to imaging centers and gastroenterology specialists that no referral is needed. • Engagement with specialists, such as OB/GYNs

Conclusion:

Although we did not meet the internal CalOptima Health goal, we did reach MPL for Medi-Cal measures and 3-Star for OneCare Measures. On October 2024, the 2025 Star ratings were published, and for OneCare, BCS and COL reached 3-Star. CalOptima Health will retain CCS, BCS and COL measures on the 2025 QI Work Plan and continue to focus on preventative care screenings to address expected dips in utilization by conducting multicomponent interventions (mailers, automated calls and text messaging, e-mail) to increase demand for cancer screenings.

Activities/interventions to continue/add next year:

- Continue health rewards for eligible CalOptima Health members for CCS, BCS and COL measures. In anticipation of the COL measure possibly being held to the MPL for MCAS, CalOptima Health expanded health reward offering to include COL member health reward for eligible Medi-Cal members. Will continue to increase participation in the program and motivate members to schedule and complete cancer screenings.
- The hybrid CCS measure reached MPL in MY2023 by a small margin. The new national benchmark was released in September 2024 and the MPL has increased from 57.11% to 57.18%. Opportunity remains to increase the CCS measure. MCAS announced that they are removing the hybrid reporting method for CCS and transitioning to Electronic Clinical Data Systems (ECDS) reporting in MY2025, which may have an impact on MCAS reporting in 2026. Accordingly, in MY2025, CalOptima Health will explore EMR integration with high-volume providers.
- In MY2024, CalOptima Health removed the prior authorization for OneCare colorectal cancer screening. Will expand removal of prior authorization for breast cancer screening.
- In MY2024, CalOptima Health awarded ~$2.1 million dollars in quality improvement grants to health network partners and CHCN providers. Many of the grant programs will focus on the CCS, BCS and COL measures.
- In MY2024, CareNet conducted live agent calls to members with multiple gaps in care. In MY2025, internal member-facing staff will have access to Decision Point to remind members of cancer screenings that they are due for at the point of member contact.
- Cancer screening measures are part of the CalOptima Health Comprehensive Community Cancer Screening Program and grant funding has been dispersed to organizations to work towards increasing awareness and access to cancer screening.

- In MY2025, CalOptima Health will increase breast cancer screening access by offering mobile mammography.
- Staff will use disparity analysis to develop interventions to target higher-risk members with health inequities caused by race/ethnicity.

3.4 Maternal Health (TOPC and PPC)	
Business Owner: Mike Wilson	**Department:** Quality Analytics
Support Staff: Kelli Glynn/Leslie Vasquez	
Products: ☒ Medi-Cal ☐ OneCare	**New Activity:** ☐ Yes ☒ No
Work Plan Goal/Objective: TOPC: 91.89%, PPC: 84.18%	
Goal Met: ☐ Yes ☒ No ☐ Partial	

Work Plan Planned Activities:

1. Targeted member engagement and outreach campaigns via collaboration with health networks and utilizing multiple communication channels
2. Expansion of Bright Steps
3. Collaborative member engagement events with community-based partners
4. Expansion of member engagement through direct services such as the doula benefit and educational classes

The planned activities/initiatives outlined in the section below are reflective of the Work Plan's activities.

Status: ☐ Completed ☒ Ongoing

Background:

Joint guidelines published by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) recommend a prenatal visit in the first trimester for all birthing persons. ACOG also recommends that all birthing persons have a comprehensive postpartum visit which provides an opportunity to address physical, mental and emotional health early on, followed by ongoing care as needed

Prenatal and Postpartum Care (PPC) is a hybrid quality performance measure for HEDIS and is part of the DHCS MCAS that is held to a minimum performance level established by NCQA. HEDIS plays a critical role in supporting maternal health by assessing the quality and timeliness of care provided to birthing persons before and after childbirth.

PPC has two components that assess the following for deliveries on or between October 8 of the year prior to October 7 of the current measurement year:
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. PPC: The percentage of deliveries that received a postpartum care visit on or between seven and 84 days (one–12 weeks) after delivery.

Methodology:

CalOptima Health follows the HEDIS data collection methodology to assess performance with prenatal and postpartum care. The methodology for the MY2023 goal is based on the MY2021 reported performance results compared to the MY2021 NCQA Quality Compass national percentile (benchmark). If the performance rate meets the NCQA Quality Compass benchmark, CalOptima Health will set its goal to the next NCQA percentile to encourage continued performance improvement. However, if the measure rate falls below the 50th percentile, then CalOptima Health sets the 50th percentile as the organizational goal.

NCQA stratified select measures like PPC for race and ethnicity to support the identification of disparities amongst the patient population. Race and ethnicity data for MY2023 reflect these stratification requirements. PPC data was stratified by race and ethnicity and compared to the overall PCC rate to identify any disparities.

Medi-Cal Results: The table below indicates the final Medi-Cal rates for HEDIS MY2023 and how the rate fares against the goal set for MY2023.

Acronym	Measure	MY 2021 Medi-Cal Rate	MY 2022 Medi-Cal Rate	MY 2023 Medi-Cal Rate	MY 2023 Medi-Cal Goal	MY 2023 Goal Me/Not Met
TOPC (hybrid)	PPC: Timeliness of Prenatal Care	91.0%	88.10%	88.10%	91.89%	☐ Yes ☒ No
PPC (hybrid)	PPC: Postpartum Care	81.60%	81.2%	80.00%	84.18%	☐ Yes ☒ No

In MY2023, TOPC did not meet the MY2023 organizational goal; however, TOPC met the NQCA Quality Compass benchmark of 84.23%. Similarly, PPC did not meet the desired MY2023 organizational goal. PPC did meet the NQCA Quality Compass benchmark of 78.1% for MY2023.

Actions/Interventions Implemented in 2024:

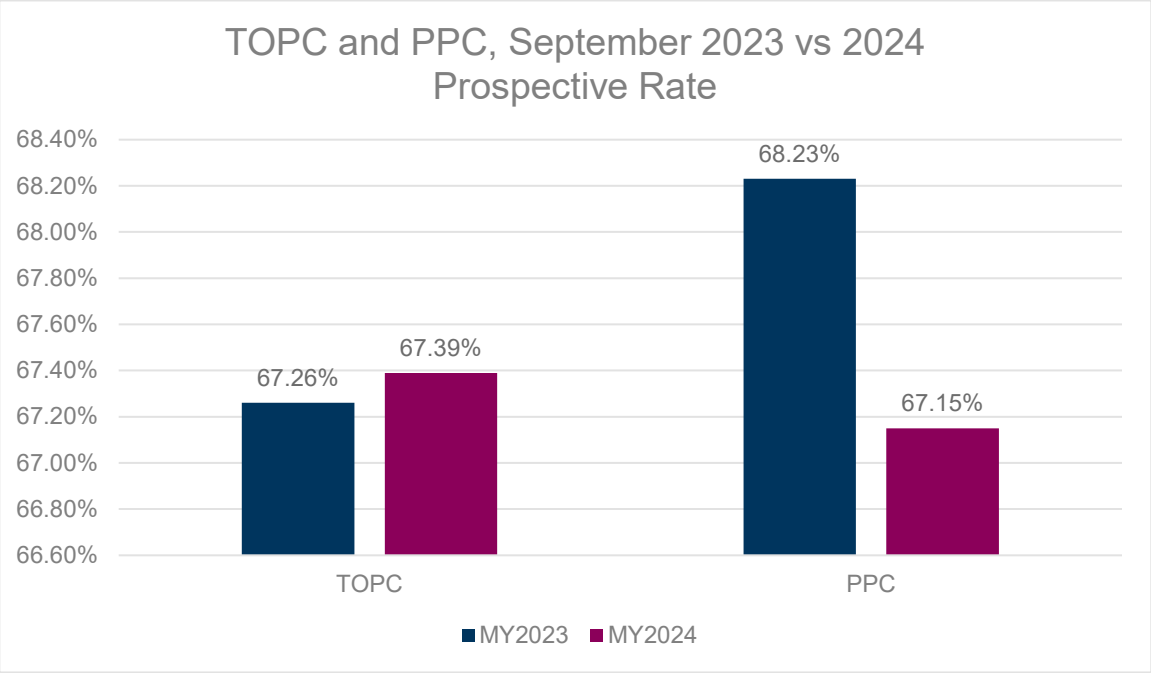
Planned Activities/Interventions	Product	Quarter	Type	Status	Measure(s) (Acronym)
1. Postpartum health reward	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	PPC
2. Bright Steps Program — CalOptima Health's maternal health program provides nutrition, health education, psychosocial support and resource referrals to members during and for one year post-pregnancy.	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	TOPC PPC
3. Paid Digital and Social Media Ads — Provide education regarding the importance of prenatal and postpartum care Ads were in English, Spanish, and Vietnamese and targeted lower performing zip codes across those member languages.	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	TOPC PPC
4. PBS TV ad for maternal health	☐ MC ☐ OC	☐ Q1 ☒ Q2 ☒ Q3 ☐ Q4	☒ Member ☐ Provider ☐ Health Network ☒ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	TOPC PPC
5. Member newsletter	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☒ Q3 ☐ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☒ Completed ☐ On-going ☐ Incomplete	TOPC PPC
6. Provider education — Provider education efforts include presenting on the PPC measure and coding requirements.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☒ Health Network ☒ Community ☐ Data ☐ Other	☒ Completed ☐ On-going ☐ Incomplete	TOPC PPC

7. Postpartum care reminder call campaign	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☒ Completed ☐ On-going ☐ Incomplete	PPC
8. Planned: Provider education The development of a coding guide to support practitioners who conduct bundled coding is planned for Q4 to support increased data capture for the PPC measure.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☒ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☐ On-going ☒ Incomplete	TOPC PPC
9. P4V program	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☐ Member ☒ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	TOPC PPC
10. Planned: Report development utilizing available admit, discharge transfer (ADT) data to support the early identification of members that delivered for postpartum education	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☐ Provider ☐ Health Network ☐ Community ☒ Data ☐ Other	☐ Completed ☒ On-going ☐ Incomplete	PPC

MC = Medi-Cal
OC= OneCare

Results:

Chart A. MY2023 and MY2024 September Prospective Rate for TOPC and PPC



Prospective rate (PR) methodology includes continuous enrollment criteria. PPC and TOPC are hybrid measures. Prospective rates are solely based on administrative data and are not final.

- TOPC performance in September 2024 is performing relatively similar to September 2023. The increase in the rate for 2024 is not statistically significant.
- PPC is performing 1.08% lower in September 2024 compared to September 2023.

Table A. MY2023 Timeliness of Prenatal Care Rates by NCQA Ethnicity

NCQA Ethnicity	**Hispanic/Latino**	**Unknown**	*Total*
Numerator	4,256	2,500	6,756
Denominator	5,190	3,214	8,404
Rate	82.00%	77.78%	80.39%

Table A displays timeliness of prenatal care rates per NCQA ethnicity specifications. The rates displayed are based on administrative data and do not reflect the final HEDIS rate. Comparisons were made against the total rate of 80.39%. Members that identify as Hispanic/Latino have a higher compliance rate (82.00%) than members whose ethnicity is unknown (77.78%).

Table B. MY2023 Timeliness of Prenatal Care Rates by NCQA Race

NCQA Race	Unknown	Other	White	Asian	Black	Native Hawaiian and Other Pacific Islander	American Indian and Alaskan Native	Total
Numerator	4,713	718	621	575	106	13	10	6,756
Denominator	5,762	890	827	754	140	21	10	8,404
Rate	81.79%	80.67%	75.09%	76.26%	75.71%	61.90%	100%	80.39%

Table B displays Timeliness of Prenatal Care rates per NCQA race specifications. The rates displayed are based on administrative data and do not reflect the final HEDIS rate. See Quantitative Analysis.

Table C. MY2023 Postpartum Care Rates by NCQA Ethnicity

NCQA Ethnicity	*Hispanic/Latino*	*Unknown*	*Total*
Numerator	3,928	2,311	6,239
Denominator	5,190	3,214	8,404
Rate	75.68%	71.90%	74.24%

Table C displays postpartum care rates per NCQA ethnicity specifications. The rates displayed are based on administrative data and do not reflect the final HEDIS rate. Comparisons were made against the total rate 74.24%. Similar to TOPC, the group with the unknown ethnicity performed lower than both the Hispanic/Latino group and the overall total rate.

Table D. MY2023 Postpartum Care Rates by NCQA Race

NCQA Race	Unknown	Other	White	Asian	Black	Native Hawaiian and Other Pacific Islander	American Indian and Alaskan Native	Total
Numerator	4,338	664	549	572	100	10	6	6,239
Denominator	5,762	890	827	754	140	21	10	8,404
Rate	75.29%	74.61%	66.38%	75.86%	71.43%	47.62%	60%	74.24%

Table D displays Postpartum Care rates per NCQA race specifications. The rates displayed are based on administrative data and do not reflect the final HEDIS rate. See Quantitative Analysis.

Quantitative Analysis:

- When assessing final rates (hybrid) for both TOPC and PPC, there has been no significant improvement in performance between MY2021 and MY2023.
- Tables A and B showcase race and ethnicity data, respectively, per NCQA specifications for TOPC. When assessing for race, a large portion of the population was identified as Unknown. Native Hawaiian and Other Pacific Islander represent the smallest ethnic group, however their TOPC rate was the lowest at 61.90% when compared to the overall total rate of 80.39%.
- Timeliness of Prenatal Care performance was assessed among racial groups with 100 or more members. Data stratified by racial groups were then compared to the overall rate for PPC Two additional racial groups that performed lower than the total rate (overall population) were White and Black, 75.09% and 75.71%, respectively, indicating an opportunity for targeted initiatives.
- Tables C and D showcase race and ethnicity data, respectively, per NCQA specifications for PPC. When assessing for race, a large portion of the population was identified as Unknown. The following three racial groups performed the lowest for PPC: White (66.38%), American Indian and Alaskan Native (60%) followed by Native Hawaiian and Other Pacific Islander (47.62%), American Indian and Alaskan Native (60%), followed by White (66.38%) when compared to the overall rate of 74.24%. This represents opportunities for targeted initiatives for these three groups.
- Across all racial groups, performance with postpartum care was lower compared to prenatal care. This represents opportunities for the health plan to explore the implementation of culturally appropriate messages in the prenatal period to support postpartum care as well as logistical issues (e.g., transportation) that may impede timely postpartum care.

Identified Barriers:	**Identified Opportunities for Improvement:**
• Delays of claims and encounter data present challenges for the timely identification of a delivery, which impacts the modalities in which CalOptima Health can leverage communication to outreach to members, support care coordination and reminders for care. • Prenatal and postpartum care have varying coding practices. Bundled billing practices, in particular, can present challenges when the appropriate codes are not utilized, thus affecting the identification of care issued to members. • CalOptima Health serves a diverse population. Cultural factors may contribute to gaps related to prenatal and postpartum care. Cultural factors may impact the timeline for which members seek timely prenatal care. Cultural practices and observations after delivery may impact the timeliness in which members seek the completion of a postpartum visit. Member perception as it relates to the value and importance of timely prenatal and postpartum care may impact member practices.	• Report development utilizing ADT data to support early identification for postpartum care. • Development of a guide for practitioners practicing bundled billing for maternal care. • Continue a multi-modal approach for members when issuing education about the importance of timely care. Outreach efforts should be representative of the various groups.

Conclusion:
A comprehensive strategy is needed to address the following:

- Proactive member outreach — Leverage data (e.g., claims, prescriptions) to trigger early member identification and engagement
- Provider education and training — Ongoing messaging and support to reduce disparities in maternal care, education on coding practices and cultural sensitivity
- Culturally tailored approach — Design campaigns that acknowledge cultural practices surrounding pregnancy and postpartum care
- Enhanced partnerships — CBOs can provide insight into barriers or facilitators of health that managed care plans may not have insight on.

Activities/interventions to continue/add next year:

- Continue the postpartum health reward and implement a broader promotion strategy
- Continue to promote postpartum care during the prenatal period and assess for barriers prior to delivery
- Targeted member outreach via various modalities: mailing, text, IVR calls
- Enhanced partnership with CBOs
- Continue to partner with health networks to identify providers to partner with for efforts that improve care delivery or reduce member barriers to care
- Develop initiatives (e.g., culturally appropriate material) aimed at reducing disparities amongst lower performing racial groups for improved TOPC and PPC performance.

3.5 Shape Your Life (SYL)	
Business Owner: Thanh Mai Dinh	**Department:** Equity and Community Health
Support Staff: Michael Molina	
Work Plan Element: Keeping Members Healthy	
Products: ☒ Medi-Cal ☐ OneCare	**New Activity:** ☐ Yes ☒ No
Work Plan Goal/Objective: By December 31, 2024, at least 40% of the SYL participants who completed the pre- and post-assessment will increase their knowledge of basic nutrition and healthy lifestyles.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities (From the QI Work Plan): • Increase class locations with new community partners. • Increase the number of class attendees by 50% from Q2 to Q4. • Increase the number of classes offered.	
Status: ☐ Completed ☒ Ongoing	
Background: CalOptima Health's Equity and Community Health department offers the no-cost Shape Your Life (SYL) weight management program designed for children ages 5–18 years old and their families. Educational classes are open to the community, offered virtually and in person throughout Orange County at partner community centers and schools. Classes are customizable by location and audience needs. Along with the goal of achieving overall health, the program educates participants about healthy food choices, exercise, and how to attain or maintain a healthy weight by balancing healthy habits. SYL includes six classes available in English, Spanish and Vietnamese. Classes are provided as a weekly series, for six consecutive weeks per location. When a class is not offered in the member's primary spoken language, language interpretation is provided as needed.	

Methodology:
SYL measures participants' knowledge on class topics using multiple-choice assessments before and after the lesson. The assessments are implemented in the participant's primary language. SYL program goal calculation was updated in Q2 2024 and current results reflect the revised calculation.

- Numerator = SYL participant who completed the pre- and post-assessment with an increase in knowledge about nutrition and healthy lifestyle.
- Denominator = SYL participant who completed the pre- and post-assessment with the exclusion of those who scored 100% on both pre- and post-assessment.

After each class, participants had the opportunity to voluntarily fill out the SYL class qualitative feedback form about their experience, including the usefulness of class materials, feeling safe asking questions in class, staff knowledge of the topic, the importance of the topic, plans to use something learned in class and feeling connected with others.

Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status
• Implemented in-person and virtual SYL classes for members and families. • Formative evaluation included monthly facilitator meetings to provide feedback and improve member experience in the program, which led to improving and revising lesson plans based on facilitator and member feedback.	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• SYL program goal calculation was updated in Q2 and its current results are reflected in the updated calculation. Numerator = SYL participant who completed the pre- and post-assessment with a gain in class topic knowledge. Denominator = SYL participant who completed the pre- and post- assessment with the exclusion of those who scored 100% on both pre- and post- assessment.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☐ Q3 ☐ Q4	☐ Member ☐ Provider ☐ Health Network ☐ Community ☒ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
• Expanded SYL program to at least four new schools and community partners in Orange County by attending and promoting the program at networking meetings such as Nutrition and Physical Activity Collaborative led by Orange County Health Care Agency and Family and Community Partnership with Orange County Department of Education.	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☐ Q3 ☐ Q4	☐ Member ☐ Provider ☐ Health Network ☒ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• Promoting SYL through Health Network Provider Relations department monthly emails to contracted providers and provider networks.	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☐ Q4	☐ Member ☒ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete

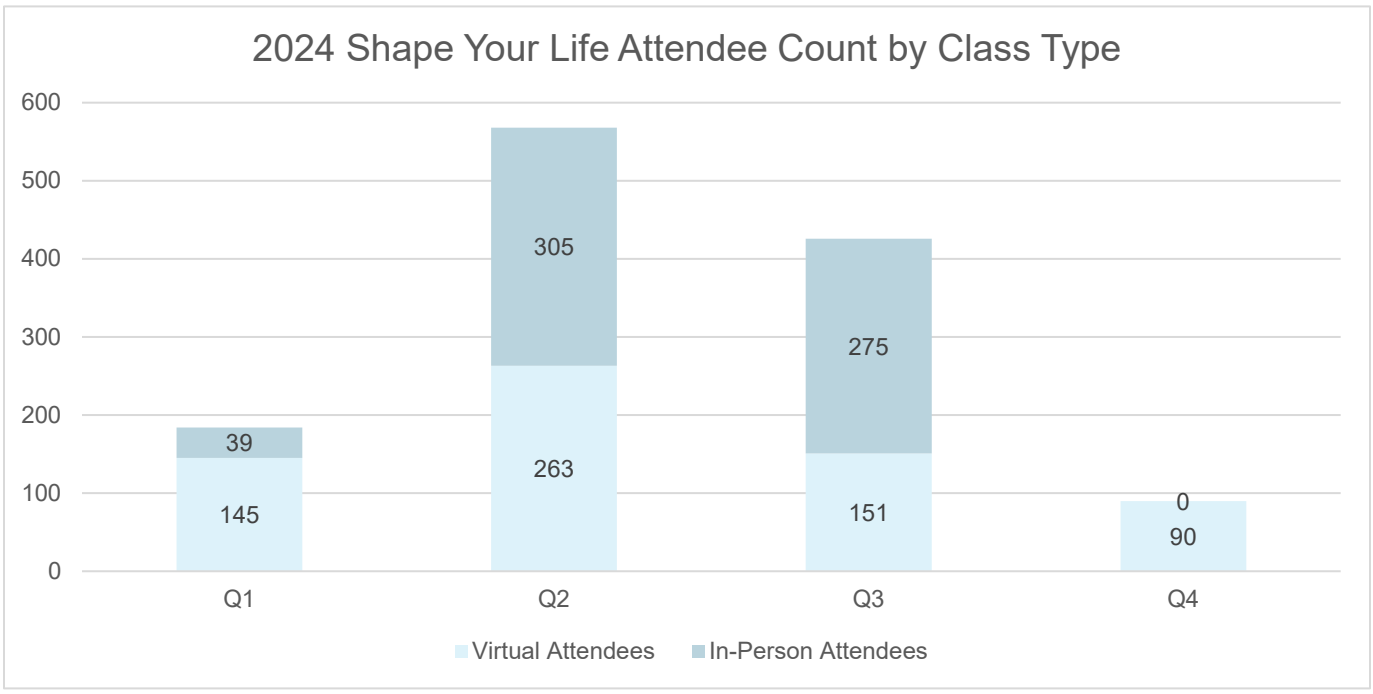
MC = Medi-Cal
OC = OneCare

Quantitative Results:

2024 SYL Pre- and Post-Assessment Results by Quarter

	Child Assessment	Adult Assessment	Combined	Goal Met
Q1	20% (1 out of 5)	64.8% (46 out of 71)	61.8% (47 out of 76)	Yes
Q2	50.9% (56 out of 110)	54.7% (93 out of 170)	53.2% (149 out of 280)	Yes
Q3	29.7% (19 out of 64)	39.4% (63 out of 160)	34.2% (82 out of 240)	No
Q4	0% (0 out of 3)	62.1% (23 out of 37)	57.5% (23 out of 40)	Yes
Total (Q1–Q4)	41.7% (76 out of 182)	51.3% (225 out of 438)	**47.3%** (301 out of 636)	**Yes**

The table above shows the evaluation of the cumulative pre- and post-assessment results by target group for each quarter. The last row represents the overall annual pre- and post-assessment evaluation of the SYL program.



	Q1	Q2	Q3	Q4
Virtual classes	60	33	24	14
In-person classes	8	34	24	0
Total class count	68	67	48	14

Qualitative Results:
Below are the qualitative results from 472 responses collected from the SYL class feedback form in 2024.

In the form of Yes, No or Maybe responses:

- 96% of participants found the materials in class useful.
- 93% of participants felt safe asking questions and sharing ideas.
- 97% of participants believed the staff knew the topics well.
- 95% of participants believed the topics covered in class were important.
- 94% of participants plan to use something learned in the class.
- 79% of participants felt the classes helped them connect with their peers; 15% reported “Maybe.”

Quantitative Analysis:

In 2024, 47% of SYL participants who completed the pre- and post-assessment increased their knowledge of basic nutrition and healthy lifestyle. Results exceeded the goal (i.e., By December 31, 2024, at least 40% of the SYL participants who completed the pre- and post-assessment will increase their knowledge of basic nutrition and healthy lifestyle).

- Although the cumulative results for 2024 by Q3 were above the program goal rate, Q3 results alone during July, August and September decreased. Continuous process improvement was conducted with class facilitators in biweekly meetings to discuss implementation changes.

The SYL program well exceeded the goal of a 50% increase in participation from Q2 to Q4 due to the pilot of virtual class options. Attendance increased by 209% from Q1 to Q2. Looking only at in-person classes, this goal was also met, with the highest participation in Q3.

New partnerships for class locations were achieved, increasing from two community partners in 2023 to six community partners in 2024.

Identified Barriers:	**Identified Opportunities for Improvement:**

• Possible reasons for the lower rate of knowledge gain during Q3:
  ○ Increase of in-person attendees missing part of the assessment due to arriving late or leaving early from class.
  ○ Virtual participants had difficulty navigating and completing the assessment due to limited digital literacy skills.
• Translation of class materials, based on staff and attendee feedback, was identified as a minor challenge in gathering correct pre- and post-assessment responses.
	• Improvement areas for the assessment included:
	  ○ 1) Emphasizing information from the assessment during class.
	  ○ 2) Providing pre-assessment after the group check in to allow more time for completion.
	  ○ 3) Dedicating time to explicitly instruct members how to navigate the poll questions and encourage them to submit their responses.
	• Offer more classes in Vietnamese to additional locations or more often. The first in-person series was very well attended weekly, and more classes were requested by attendees and the community partner who hosted the site.

Conclusion: The data conveys that the program curriculum and components address relevant issues that match attendee priorities. Also, the delivery of these educational sessions is conducted in a manner that is conducive to increasing knowledge on basic nutrition and healthy lifestyle strategies. The use of formative evaluation among class facilitators and support staff was an important process step used to quickly address barriers to meeting program goals. The first Vietnamese in-person SYL class was implemented at a community center in Westminster. Classes were well attended for six consecutive weeks and more classes were requested by attendees and the community partner organization. Virtual SYL classes were piloted in Q1 two times a day on Tuesday, Wednesday and Thursday in English and Spanish. Based on SYL virtual class pilot results, in Q2 virtual class options were reduced to two evening classes once a week in English and Spanish. By doing so, attendees seemed more willing to engage with each other or the facilitator, and to share their own experiences, successes and challenges. In addition, virtual classes had a higher attendance compared with in-person classes, which is likely due to the many families facing challenges with transportation and childcare.
Activities/Interventions to continue/add next year:
• SYL in-person class locations increased from six in 2024 to 10 locations planned in 2025. • Implement a plan to document class participation in the care management system (Jiva). • Based on attendee and staff feedback, lesson plans were revised to enhance common terms and activities, creating a better connection with pre- and post-assessments. • Implement a weight management presentation for general adult audiences emphasizing chronic condition prevention.

Section 4: Emerging Risk

CalOptima Health's emerging risks programs and initiatives are designed to identify, assess and mitigate serious health risks among our members. These programs and initiatives focus on continuous monitoring, cross-disciplinary collaboration and adaptive strategies. Through these efforts, CalOptima Health aims to reduce the risk of chronic condition complications and improve long-term well-being among members. The following section evaluates select programs and initiatives designed to address emerging risks, including the chronic condition and self-management program and behavioral health services.

4.1 Chronic Condition Care and Self- Management Program (HbA1c <8.0%)	
Business Owner: Michael Wilson	**Department:** Quality Analytics
Support Staff: Melissa Morales/Kelly Glynn	
Products: ☐ Medi-Cal ☒ OneCare	**New Activity:** ☐ Yes ☒ No
Work Plan Goal/Objective: Meet and exceed goals set forth on all improvement projects. By December 31, 2024, 5% of members identified as emerging risk* and who participated in the program will lower their HbA1C to less than 8.0%.	
Goal Met: ☐ Yes ☐ No ☒ Partial	
Work Plan Planned Activities: Conduct quarterly/annual oversight of specific goals for OneCare CCIP (January 2023–December 2025): CCIP Study — Comprehensive Diabetes Monitoring and Management	
Status: ☐ Completed ☒ Ongoing	
Background: CMS requires all Medicare Advantage (MA) and Special Needs Plans (SNP) to conduct a 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 the improvement of care and health outcomes for members with chronic conditions. For this three-year CCIP program beginning in 2023 and ending in December 2025, CalOptima Health has chosen to focus on diabetes as the target condition with a focus on increasing diabetes management. The target population for the CCIP interventions is OneCare members identified with diabetes (type 1 and 2). CalOptima Health chose to focus on members who fall in the category of "emerging risk" (A1C levels 8.0%–9.0%) as the target condition for this CCIP. Emerging risk is defined by members that were previously controlled <8.0% A1C level but had a recent A1C level result of 8.0% to 9.0%. These members were selected due to a higher chance of improving A1C results when targeting members with A1C results between 8.0% and 9.0% than members with an A1C >9.0% result.	
Methodology: • Two-year look back period for member's A1C results (2022–2023) and current measurement years. • Quality Analytics generated A1C report and identified members that were below 8.0%, 8.0% to 9.0% and above 9.0%. Also included was whether the A1C result decreased, increased, remained the same or no prior result was available. • Quality improvement specialist filtered list for target population: Members between 8.0% and 9.0% with an increase in A1C result. • Worked with Diabetes Management Program to finalize outreach list. Outreach included members who were part of the "emerging risk" category and the Diabetes Management stratification to keep outreach list manageable. • Health coaches outreached to "emerging risk" members. • Track outreach completion by using Jiva activity report. • Data refresh occurs on a quarterly basis.	

Actions/Interventions Implemented in 2024:	
Quarter 1:	• Finalize "emerging risk" report.
Quarter 2:	• Telephonic outreach by health educators
Quarter 3:	• Telephonic outreach by health educators
Quarter 4:	• Telephonic outreach by health educators

Program Results:

OneCare Outreach Results

Date	Emerging Risk List OneCare Members	Outreach Members	Outreach Rate
June 2024	28	3	10.7%
September 2024	97	113	85.8%

Table caption: Members that were outreached were those identified as "emerging risk" and were part of the Diabetes Management Program stratification-n.

Quantitative Analysis: For data report created in June 2024, health coaches attempted to call 10.7% of call list. For data report created in September 2024, health coaches attempted to call 85.8% of the call list. The CCIP goal has not been met since the program has an end date of December 31, 2025. CalOptima Health will evaluate whether the member was reached and accepted help for diabetes management. Also, will continue to track A1C values for members identified as "emerging risk" and participated in health coaching.

Identified Barriers:	**Identified Opportunities for Improvement:**
• Delay due to the transition to CalOptima Health's new managed care system (Jiva), which created the need to update emerging risk methodology. • Data issue A1C values were missing, which may have affected emerging risk assignment. • Outreach list included members that were already assigned to case management, so they were not outreached. • Unable to contact "emerging risk" category members.	• Work with Case Management department on members who are outreached by case managers but have been identified as emerging risk. • Update emerging risk report with Diabetes Management Program report to make identification and assignment more efficient.

Conclusion: Will need additional time to obtain more recent A1C results and health coaching activity.

Activities/Interventions to continue/add next year:

- Identify barriers at the end of the intervention period for telephonic outreach by health educators and case managers.
- Evaluate member outreach and A1C trend.

4.2 Chronic Condition Program Member Satisfaction	
Business Owner: Elisa Mora	**Department:** Equity and Community Health
Support Staff: Joanna Hoffnagle	
Work Plan Element: Member Satisfaction	
Products: ☒ Medi-Cal ☒ OneCare	**New Activity:** ☐ Yes ☒ No
Work Plan Goal/Objective: CalOptima Health established the goal of 85% member satisfaction with Disease Management (DM) services.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities:	
Status: ☐ Completed ☒ Ongoing	

Background:
CalOptima Health annually evaluates the experiences of members who participate in disease management (DM) services. The Equity and Community Health (ECH) department analyzes data from the DM Member Satisfaction Survey and member complaints to identify opportunities to enhance the member experience.

In 2024, CalOptima Health set a goal of achieving 85% member satisfaction with DM services.

Methodology:
The 2024 DM Satisfaction Survey focused on English and Spanish-speaking members enrolled in a DM program who had completed an initial health coach assessment between February 1, 2024, and September 15, 2024. The survey was sent to 767 members via two-way text message and 33 responses were received, resulting in a response rate of 3.69%.

The survey tool was developed to obtain feedback from members regarding their experience with DM programs including:

1. Overall program satisfaction
2. Helpfulness of program staff
3. Usefulness of the information disseminated
4. Members' ability to adhere to treatment plans
5. Members indicating that the program helped them achieve health goals

This year, a new question was added to obtain feedback from members on their preferred method(s) of receiving health coaching.

Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status
• Ongoing member enrollment to the program and health coaching interventions.	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☐ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• Launched the two-way text message survey. • Identify members for the survey.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☐ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☒ Data ☐ Other	☒ Completed ☐ Ongoing ☐ Incomplete
• Planned to mail 500 additional surveys. • Explored other methods for obtaining timely feedback from members.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☒ Q4	☐ Member ☐ Provider ☐ Health Network ☐ Community ☒ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

Program Results:

Table A: Overall Member Satisfaction With CalOptima Health's DM Programs

Question	Satisfaction	Neutral	Dissatisfaction	Goal Met
Q.1 The information I received from my health coach while participating in the program helped me to better manage my health.	97%	3%	0%	Yes
Q.2 My health coach helped me follow my doctor's recommendations.	91%	6%	3%	Yes
Q.3 I was included when making decisions about my care plan.	91%	6%	3%	Yes
Q.4 The information and resources I have received from my health coach have been useful.	97%	0%	3%	Yes
Q.5 My health coach helped me manage my health needs and concerns.	100%	0%	0%	Yes
Q.6 My health coach helped me meet my care plan goals.	100%	0%	0%	Yes
Q.7 I am satisfied with CalOptima's Health Management program.	96%	4%	0%	Yes

Quantitative Analysis:

As indicated in Table A, the goal of 85% satisfaction was met in all categories. The data suggests that positive interactions with health coaches played a significant role in members' overall satisfaction with CalOptima Health's DM program. Numerous positive member comments further support this finding.

Survey results also indicate that 100% of members felt that their health coach effectively helped them manage their health needs, address concerns and achieve care plan goals. This data suggests strong effectiveness of health coach involvement, contributing to positive health outcomes and member satisfaction.

This year, a new question was added to assess member preferences for engaging with health coaches. The results revealed the following preferences:

- **76%** of participants prefer phone calls as their primary method of communication.
- **20%** of participants prefer in-person interactions.
- **4%** of participants favor video sessions.
- **0%** of participants prefer group classes.

These results suggest a strong preference for phone calls, which will be used to inform future program delivery strategies.

Qualitative Analysis:

As previously mentioned, the DM satisfaction goal of 85% was successfully met across all areas, reflecting overall positive program performance. Additionally, 15 qualitative responses were received, with **100% positive comments** and no negative feedback.

Of the 15 responses, **three were in English (20%)** and **12 were in Spanish (80%)**. This distribution suggests that Spanish-speaking members are more likely to provide qualitative feedback, and it may be beneficial to consider strategies to increase response rates from English-speaking members as well.

The response rate to the DM Satisfaction Survey this year was 3.69**%, which is lower** than in previous years, which may limit the representativeness of the feedback. In response, we plan to mail **500 additional surveys** to a diverse group of members, which will help us increase the response rate and obtain more data to evaluate the program.

Identified Barriers:	Identified Opportunities for Improvement:
• Low response rate when using only two-way text message to collect feedback from members. • Lengthy process for requesting changes to the survey.	• **Use multiple feedback collection methods:** Offer various options for collecting feedback from members, including text messaging (two-way), mail and QR codes. • **Expand language options:** Provide additional language options to ensure broader accessibility and inclusivity. • **Survey timing improvement:** Explore the possibility of launching the survey immediately after an intervention, instead of conducting it once a year.
Conclusion: While the data shows that members are highly satisfied with the DM program, a higher response rate would provide more comprehensive data, allowing for a better evaluation of the program.	
Activities/Interventions to continue/add next year: • Mail an additional 500 surveys to help increase the response rate. • Translate the survey into all CalOptima Health threshold languages. • Develop a platform that allows staff to launch the survey to members after intervention.	

4.3 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA 7-days and 30-days)	
Business Owner: Valerie Venegas	**Department:** Behavioral Health Integration (BHI)
Support Staff: Diane Ramos, Natalie Zavala, Carmen Katsarov	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☒ Yes ☐ No
Work Plan Goal/Objective: MC: 30-days: 36.34%; 7-days: 20.0% To increase chances to meet or exceed HEDIS goals through effective interventions that are aligned with current practice and technological options.	
Goal Met: ☐ Yes ☒ No ☐ Partial	
Work Plan Planned Activities: • Share real-time ED data with our health networks on an SFTP site. • Participate in provider educational events related to follow-up visits. • Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members with a follow-up after ED visit. • Implement new behavioral health virtual provider visits to increase access to follow-up appointments. • Bi-weekly member text messaging (approximately 500 members). • Member newsletter (Spring).	
Status: ☐ Completed ☒ Ongoing	
Background: CalOptima Health's program assesses 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.	
Methodology: Two rates are reported in this program, the percentage of ED visits for which the member received follow-up within 30 days, as well as the percentage of ED visits for which the member received follow-up within seven days. Data is drawn from HEDIS results and health care claims. HEDIS rates are used to establish performance trends.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Shared real-time ED data with our health networks on an SFTP Site. • Met with ITS to discuss data sourcing automation for the provider portal information sharing monthly. • Bi-weekly member text messaging. • Drafted article for Spring member newsletter. • Community clinics/provider education via HCHCN Clinical Quality Champion Meeting on January 31, 2024, and The Coalition of Orange County Health Centers and Medical Provider Forum on March 15, 2024, regarding the importance of quality measure.
Quarter 2:	• Shared real-time ED data with our health networks on an SFTP site. • Bi-weekly member text messaging. • Spring member newsletter (April 2024).
Quarter 3:	• SFTP folders have been established, and BH ED data was sent to health networks daily, as well as weekly reminders in HN communication. • Bi-weekly member text messaging.

	• Article promoting Telemed2U and telehealth services will be included in Fall member newsletter. The article will help with possible provider access issues and increase the likelihood of ED follow-up visits. • Developed IVR calls for ED follow-up. • FUA data became available through provider portal.
Quarter 4:	• SFTP folders have been established and BH ED data is being sent to health networks daily, as well as weekly reminders in HN communication. • Bi-weekly member text messaging. • Finalized IVR script calls for ED follow-up.

Program Results:

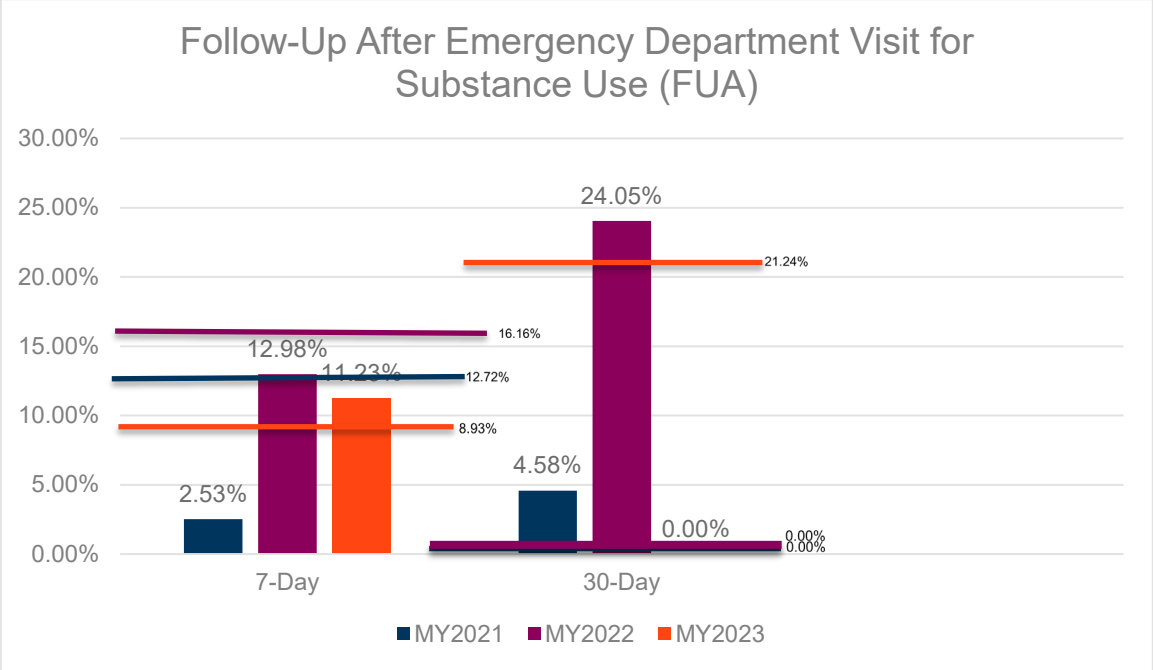


Chart caption: HEDIS Final Rates Trend Analysis

Quantitative Analysis:
CalOptima Health's MY2023 HEDIS final seven-day rate was 11.23% which met the intended goal of 8.93%. The final 30-day rate was 21.41%, which also met the intended goal of 21.24%. The data demonstrates a slight increase in members attending follow-up visits post-ED visits. The pattern appears to be continuing into MY2024.

Identified Barriers:	Identified Opportunities for Improvement:
• Not having the bandwidth to outreach to members who fall into the FUA measure daily. • Data collection and data sharing with the HCA has been difficult.	• Use of available technology such as texting and telehealth services may allow better access to follow-up appointments for members as well as new forms of member outreach via IVR and telehealth providers.

Conclusion: Due to the measure not meeting the intended goal, we plan to continue to engage with both providers and members to achieve the desired outcome for FUA and improve data accessibility.
Activities/Interventions to continue/add next year:
• IVR calls to members who fall under the FUA measure • BH Telehealth vendor will outreach to members from the daily ED data feed • Continue bi-weekly member text messaging • Member outreach with NAMI By Your Side (NBYS)

Section 5: Patient Safety

CalOptima Health's patient safety programs and initiatives are designed to prevent harm and ensure the well-being of patients within health care settings. These programs and initiatives focus on identifying potential risks, fostering a culture of safety and implementing evidence-based practices. Through these efforts, CalOptima Health aims to reduce errors, improve quality of care across settings and enhance patient outcomes. The following section evaluates select programs and initiatives designed to ensure patient safety, including CalAIM Community Supports and Street Medicine.

5.1 CalAIM Community Supports	
Business Owner: Mia Arias	**Department:** CalAIM
Support: N/A	
Work Plan Element: Patient Safety	
Products: ☒ Medi-Cal ☒ OneCare	**New Activity:** ☐ Yes ☒ No
Work Plan Goal/Objective: 90% of members referred to CalAIM Community Supports between July 1–December 31, 2024, will have received at least one Community Support.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: Implement CalAIM Community Supports: 1. Recuperative care (medical respite) 2. Housing transition navigation services 3. Housing deposits 4. Housing tenancy and sustaining services 5. Short-term post-hospitalization housing 6. Day habilitation programs 7. Sobering centers 8. Medically tailored meals/medically supportive food 9. Personal care and homemaker services 10. Respite services 11. Nursing facility transition/diversion to assisted living facilities 12. Community transition services/nursing facility transition to a home 13. Environmental accessibility adaptations (home modifications) 14. Asthma remediation	
Status: ☐ Completed ☒ Ongoing	
Background: California Advancing and Innovating Medi-Cal (CalAIM) is a five-year initiative by DHCS to improve the quality of life and health outcomes of the Medi-Cal population by addressing social drivers of health and breaking down barriers to access care. Community Supports are a core component of CalAIM.	
Methodology: Population of focus includes eligible CalOptima Health members referred to CalAIM Community Supports. • Numerator: Eligible CalOptima Health members who qualify for CalAIM Community Supports (CCS) between July 1–December 31, 2024, and received at least one CCS. • Denominator: Eligible CalOptima Health members referred to CCS* between July 1– December 31, 2024. To qualify for CalAIM Community Supports the member must be an eligible CalOptima Health member and referred or self-referred to CCS. Eligibility criteria for each CCS varies and are listed on the referral form.	

Results:

Measure	MY 2024 Q1 Rate	MY 2024 Q2 Rate	MY 2024 Q3 Rate	MY 2024 Q4 Rate	MY 2024 Goal Met/ Not Met
Percentage of members who were referred to CalAIM Community Supports and received at least one Community Support.	90%	92%	94%	Pending	☒ Yes ☐ No

Rationale for Trending: This is a new measure, and there is no trending data available.

Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status
• Recuperative care (medical respite) • Housing transition navigation services • Housing deposits • Housing tenancy and sustaining services • Short-term post-hospitalization housing • Day habilitation programs • Sobering centers • Medically tailored meals/medically supportive food • Personal care and homemaker services • Respite services • Nursing facility transition/diversion to assisted living facilities • Community transition services/nursing facility transition to a home • Environmental accessibility adaptations (home modifications) • Asthma remediation	☒ MC ☒ OC	☒ Q1 ☒ Q2 ☒ Q3 ☒ Q4	☒ Member ☐ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal
OC = OneCare

<table>
<tr><td colspan="2">Quantitative Analysis:
The CalAIM Community Supports goal (i.e., 90% of members who were referred to CalAIM Community Supports between July 1–December 31, 2024, will have received at least one Community Support) is on track to meet set goal, as indicated in the results section. The data shows that the rate of members receiving at least one CalAIM Community Support has steadily increased over the first three quarters of 2024. Please note that the implementation of CalAIM Community Support Services is still in progress and final results will be available in the first quarter of 2025.</td></tr>
<tr><td>Identified Barriers:
None. CalAIM Community Supports continue to be successful in reaching this goal. One critical reason for this success is the diverse network of community-based organizations contracted to provide services in the communities where members live. Currently, there are more than 120 organizations providing one or more Community Supports to eligible CalOptima Health members.</td><td>Identified Opportunities for Improvement:
None.</td></tr>
<tr><td colspan="2">Conclusion:
Based on the data above, the CalAIM Community Supports goal is on track to be met. Furthermore, the data conveys that the program interventions are addressing social drivers of health, which can help reduce barriers to health care access.</td></tr>
<tr><td colspan="2">Activities/Interventions to continue/add next year:
CalOptima Health will continue to support our contracted providers by offering ongoing training via the CalAIM Academy, which provides an annual schedule of monthly training.
CalOptima Health will continue to reach out to community-based providers to educate them on the Community Supports available to members to help facilitate connection to services.</td></tr>
</table>

5.2 Street Medicine (Active PCP)	
Business Owner: Nicole Garcia	**Department:** CalAIM
Support Staff: McKenzie Rodriguez	
Work Plan Element: Patient Safety	
Products: ☒ Medi-Cal ☐ OneCare	**New Activity:** ☐ Yes ☒ No
Work Plan Goal/Objective: By December 2024, connect 80% of unhoused participating members to an active Primary Care Physician (PCP).	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activity (From the PHM Work Plan): • Utilize a scheduling system for planning service delivery. • Complete care scheduling and delivery. • Utilize releases of information when a member has an active primary care provider (PCP) to increase collaboration and communication. • Offer all members the opportunity to utilize the Street Medicine Provider as their PCP.	
Status: ☐ Completed ☒ Ongoing	
Background: CalOptima Health's Street Medicine Program model is implemented by a contracted medical and social service provider who is responsible for identifying and managing the comprehensive needs of Orange County's unhoused individuals and families through whole-person care approaches and addressing social drivers of health. The service delivery process is efficiently managed through a well-organized scheduling system, ensuring timely care scheduling and consistent service delivery. All enrolled members are presented with the opportunity to select the Street Medicine Provider as their PCP, offering a flexible and accessible option for ongoing health care management. This approach promotes streamlined services and improved health outcomes. Enrolled members also have the option to select their own PCP, separate from the Street Medicine Provider. In this case, to enhance collaboration and communication, releases of information are utilized to facilitate better coordination of care.	

Methodology:
The population of focus includes members who are experiencing homelessness.

Numerator: Eligible CalOptima Health members who are experiencing homelessness, opted into the Street Medicine program, and are not assigned to a PCP.

Denominator: Members who are eligible for CalOptima Health services self-report experiencing homelessness to Street Medicine Team that is canvassing in designated geographic locations within Orange County during the measurement period (January 1–December 31, 2024).

Results:

Measure	Q1 2024 Medi-Cal Rate	Q2 2024 Medi-Cal Rate	Q3 2024 Medi-Cal Rate	Q4 2024 Medi-Cal Rate	MY 2024 Goal Me/Not Met
Unhoused participating members were connected to an active Primary Care Physician (PCP).	84%	93%	83%	Pending	☒ Yes ☐ No

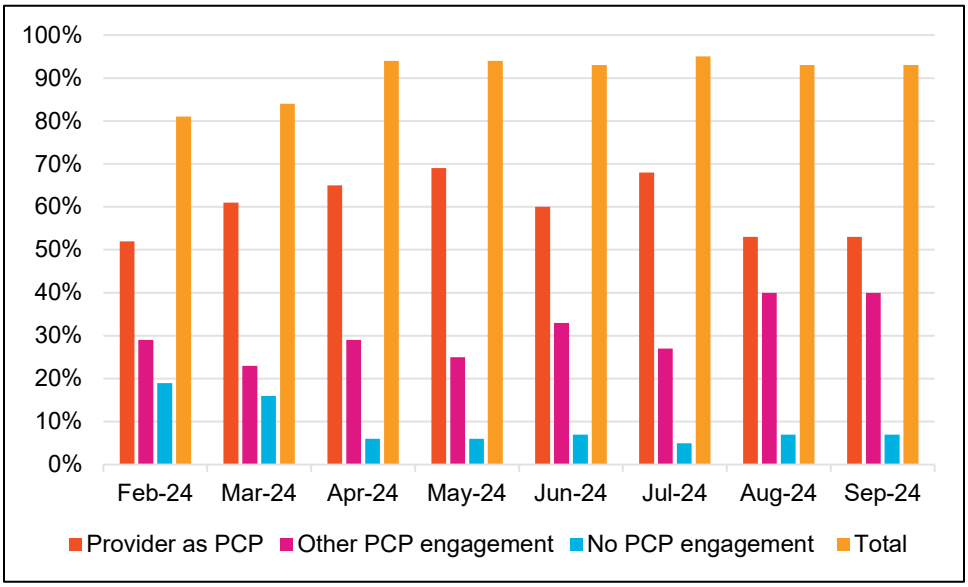
Rationale for Trending: This is a new measure, and there is no trending data available.

Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status
• Utilize a scheduling system for planning service delivery. • Complete care scheduling and delivery. • Utilize releases of information when member has an active PCP to increase collaboration and communication. • Offe all members the opportunity to utilize the Street Medicine Provider as their PCP.	☒ MC ☐ OC	☒Q1 ☒ Q2 ☒ Q3 ☐ Q4	☒ Member ☒ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal
OC = OneCare

2024 Unhoused Member Connected to a Medical Home



Source: Street Medicine Providers, Accessed November 2024

Quantitative Analysis: From Q1 to Q3, there was a steady increase in connecting members to a medical home. Members were successfully linked to a PCP to address and manage their health care needs.

Identified Barriers:	**Identified Opportunities for Improvement:**
• None. The Street Medicine providers are building a rapport with members and ensuring active PCP engagement.	• None.

Conclusion:
The Street Medicine Active PCP goal (i.e., By December 2024, connect 80% of unhoused participating members to an active PCP) is on track to be met, as indicated in the results section. Furthermore, the data above indicates that the program effectively connects members to a PCP. Please note that the implementation of Street Medicine Program interventions is still in progress, and final results will be available in the first quarter of 2025.

Activities/Interventions to continue/add next year:

- Continue to offer members who are unhoused a Street Medicine PCP.

5.2.1 Street Medicine (CalAIM ECM and Housing Navigation)	
Business Owner: Nicole Garcia	**Department**: CalAIM
Support Staff: McKenzie Rodriguez	
Work Plan Element: Patient Safety	
Products: ☒ Medi-Cal ☐ OneCare	**New Activity:** ☐ Yes ☒ No
Work Plan Goal/Objective: By December 2024, connect 90% of unhoused participating members with CalAIM ECM and Housing Navigation.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities (From the QI Work Plan): • Making attempts to engage with members weekly. • Providing Enhanced Care Management (ECM) and/or Housing Navigation and face-to-face appointments every other week. • Completing care scheduling and delivery. • Documenting all encounters. • Connecting and providing supportive services.	
Status: ☐ Completed ☒ Ongoing	
Background: CalOptima Health's Street Medicine Program model is implemented by a contracted medical and social service provider who is responsible for identifying and managing the comprehensive needs of Orange County's unhoused individuals and families through whole-person care approaches and addressing social drivers of health. Efforts are made to engage with members on a weekly basis, ensuring consistent communication and support. Every other week, face-to-face appointments are provided for ECM and Housing Navigation, addressing members' immediate needs and fostering stronger relationships. Care scheduling and delivery are carefully coordinated to ensure timely and efficient services, with all encounters thoroughly documented to maintain accurate records. Additionally, members are connected to a wide range of supportive services, reinforcing the overall care plan that contributes to long-term well-being.	

Methodology:
The population of focus includes members who are experiencing homelessness.

Numerator: Eligible CalOptima Health members who are experiencing homelessness, opted into the Street Medicine Program, and are not enrolled in CalAIM ECM or Housing Navigation.

Denominator: Members who are eligible for CalOptima Health services self-report experiencing homelessness to the Street Medicine Team that is canvassing in designated geographic locations within Orange County during the measurement period (January 1–December 31, 2024).

Results:

Measure	Q1 2024 Medi-Cal Rate	Q2 2024 Medi-Cal Rate	Q3 2024 Medi-Cal Rate	Q4 2024 Medi-Cal Goal	MY 2024 Goal Me/Not Met
Unhoused participating members who were connected with CalAIM ECM and Housing Navigation.	93%	93%	95%	Pending	☒ Yes ☐ No

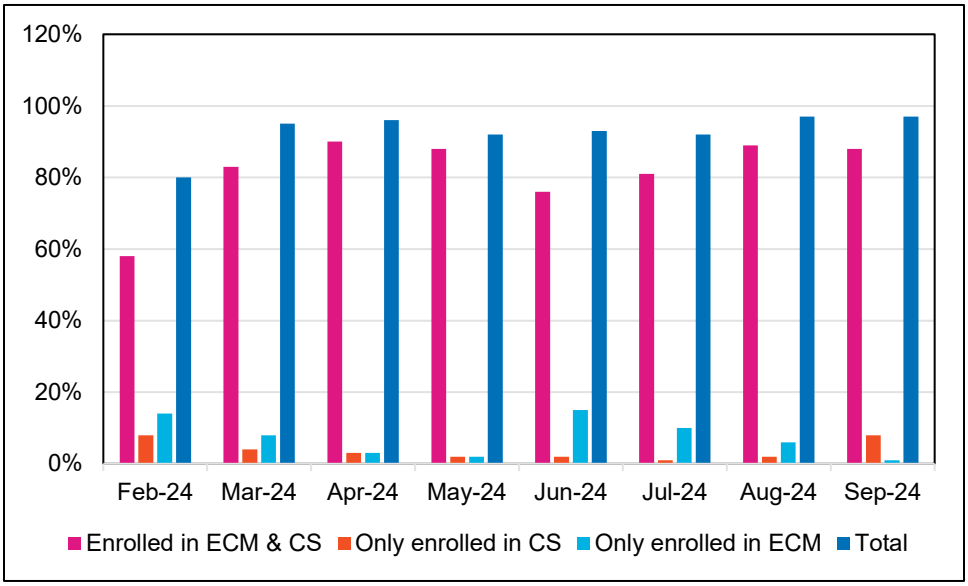
Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status
• Making attempts to engage with members weekly. • Providing ECM and/or Housing Navigation appointments face to face at least every other week. • Completing care scheduling and delivery. • Documenting all encounters. • Connecting and providing supportive services.	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☐ Q4	☒ Member ☒ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal

OC = OneCare

2024 Unhoused Members Enrolled in ECM and/or Community Supports



Source: Street Medicine Providers, Accessed November 2024

Quantitative Analysis:

From Q1 to Q3, there was a steady increase in enrolling members to CalAIM services. Members were successfully enrolled in CalAIM services to address and manage their medical and social needs.

Conclusion:

The Street Medicine Program (CalAIM ECM and Housing Navigation) goal (i.e., By December 2024, connect 90% of unhoused participating members with CalAIM ECM and Housing Navigation) is on track to be met, as indicated in the results section. Furthermore, the data shows that the program has been successful in enrolling members into CalAIM ECM and Housing Navigation services, as the enrollment trend steadily increased over the course of the year. Please note that the implementation of the Street Medicine Program interventions is still in progress, and final results will be available in the first quarter of 2025.

Identified Barriers:	**Identified Opportunities for Improvement:**
• None. Street Medicine providers enrolled members into CalAIM services quickly and consistently.	• None.

Activities/Interventions to continue/add next year:

- Street Medicine providers will continue to offer CalAIM ECM and Housing Navigation services to all enrolled members.

5.2.2 Street Medicine (Shelter or Housing Options)	
Business Owner: Nicole Garcia	**Department:** CalAIM
Support Staff: McKenzie Rodriguez	
Work Plan Element: Patient Safety	
Products: ☒ Medi-Cal ☐ OneCare	**New Activity:** ☐ Yes ☒ No
Work Plan Goal/Objective: By December 2024, connect 20% of unhoused participating members to a shelter or other housing option.	
Goal Met: ☐ Yes ☒ No ☐ Partial	
Work Plan Planned Activities (From the PHM Work Plan): • Outreach to and engage unsheltered individuals. • Provide Enhanced Care Management (ECM) and/or Housing Navigation services. • Enter members into the Coordinated Entry System. • Connect individuals to local shelters. • Work with members on completing housing documentation.	
Status: ☐ Completed ☒ Ongoing	
Background: CalOptima Health's Street Medicine Program model is implemented by a contracted medical and social service provider who is responsible for identifying and managing the comprehensive needs of Orange County's unhoused individuals and families through whole-person care approaches and addressing social drivers of health. Providing crucial support through ECM and Housing Navigation, the Street Medicine Coordination Care Teams focus on housing their unsheltered members. After individualized assessment, housing plans are completed, and interventions are carried out. This could include entering members into the Bed Reservation System, making direct links to shelter and/or entering members into the Coordinated Entry System to streamline access to housing resources. Additionally, services include assisting individuals in completing necessary housing documentation, helping to remove barriers and moving them closer to securing stable, permanent housing. This comprehensive approach aims to address both the immediate and long-term needs of unsheltered individuals, fostering a pathway to stability, safety and well-being.	

Methodology:
The population of focus includes members who are experiencing homelessness.

Numerator: Eligible CalOptima Health members who are experiencing homelessness, opted into the Street Medicine Program, and are not connected to a shelter or other housing option.

Denominator: Members who are eligible for CalOptima Health services self-report experiencing homelessness to the Street Medicine Team that is canvassing in designated geographic locations within Orange County during the measurement period (January 1–December 31, 2024).

Results:

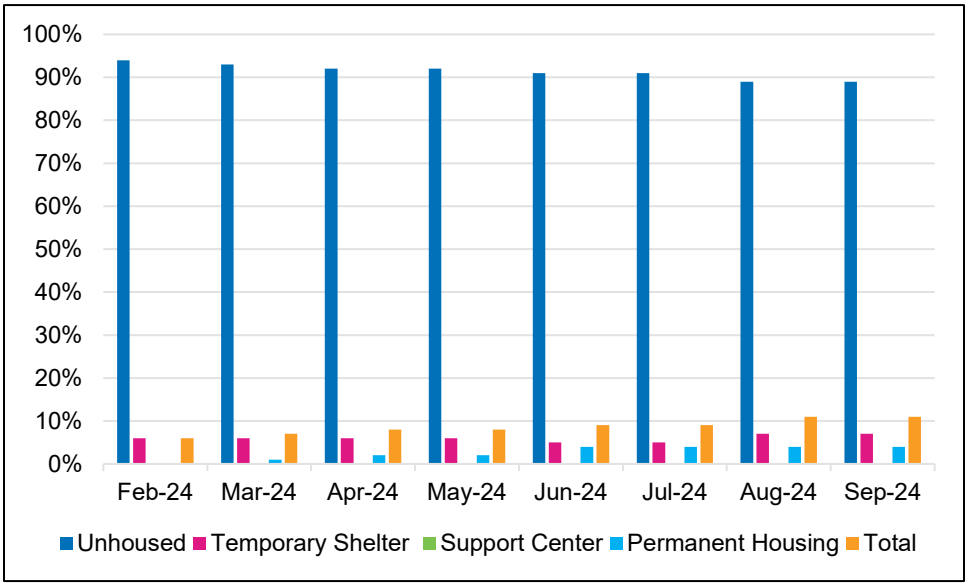
Measure	Q1 2024 Medi-Cal Rate	Q2 2024 Medi-Cal Rate	Q3 2024 Medi-Cal Rate	Q4 2024 Medi-Cal Goal	MY 2024 Goal Me/Not Met
Unhoused participating members were connected to a shelter or another housing option.	8%	9%	10%	Pending	☐ Yes ☒ No

Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status
• Outreach to and engage unsheltered individuals. • Provide ECM and/or Housing Navigation. • Enter members into the Coordinated Entry System. • Connect individuals to local shelters. • Work with members on completing housing documentation.	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☐ Q4	☒ Member ☒ Provider ☐ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal
OC = OneCare

2024 Housing Status



Source: Street Medicine Providers, Accessed November 2024

Quantitative Analysis:

From Q1 to Q3 there was a slight increase in the number of members who were linked to housing over time.

Conclusion:

The Street Medicine Program (Shelter/Housing) goal (i.e., By December 2024, connect 20% of unhoused participating members to a shelter or other housing option) is not on track to be met, as indicated in the results section. The data highlights a significant barrier in securing housing placements for members. However, there was a slight increase in the number of members who were successfully connected to housing. Please note that the implementation of Street Medicine Program interventions are still in progress, and final results will be available in the first quarter of 2025.

Identified Barriers:

- There are simply not enough housing opportunities for the unsheltered residents of Orange County.
- Additionally, while members may be in the Coordinated Entry System (CES) or Shelter Bed Reservation System, there is no guarantee of a match.

Identified Opportunities for Improvement:

- Street Medicine providers will continue to use and stay educated on CES and the Bed Reservation System.
- Street Medicine providers will stay up to date on housing opportunities in their geographic locations.

Activities/Interventions to continue/add next year:

- Street Medicine providers will continue to offer and provide Housing Navigation to all members.
- Street Medicine providers will continue to use the CES and Bed Reservation System.

- Lastly, Street Medicine providers will work directly with CalOptima Health and the cities in which they operate to be aware of all housing opportunities.

Section 6: Managing Multiple Chronic Conditions

CalOptima Health's program for managing members' multiple chronic conditions provides coordinated, comprehensive care for members living with more than one long-term health issue. The program aims to improve quality of life, reduce complications and prevent hospitalizations by integrating care across medical, behavioral and social domains. By tailoring treatment plans to each patient's unique needs and promoting proactive health management, this program helps members better manage chronic conditions, enhance overall well-being and navigate the complexities of living with multiple health challenges. Effective condition management relies on a collaborative approach, involving health care providers, patients and caregivers to optimize outcomes. The following section evaluates CalOptima Health's Complex Case Management (CCM) program.

6.1 Complex Case Management (Monthly Auditing)	
Business Owner: Hannah Kim	**Department:** Case Management
Support Staff: Diana Tep	
Work Plan Element: Managing Members with Multiple Chronic Conditions	
Products: ☒ Medi-Cal ☐ OneCare	**New Activity:** ☐ Yes ☒ No
Work Plan Goal/Objective: Ensure provision of Complex Case Management (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, 2024.	
Goal Met: ☐ Yes ☐ No ☒ Partial	

Work Plan Planned Activiti (From the PHM Work Plan):
Conduct quarterly/annual oversight:

- Provided CCM updates to Population Health Management Committee (PHMC) on a quarterly basis.
- Provide ongoing training on CCM topics for new and current staff, including the CalOptima Health Community Network (CHCN) and other health networks.
- Review the National Committee for Quality Assurance (NCQA) standards with the health networks during the Clinical Operations biweekly meeting and encourage questions to ensure understanding and promote compliance with the standards.
- Train and educate individual case managers as requested.
- Meet with Quality Improvement (QI) nurses and Case Management (CM) leadership to review NCQA audit feedback to enhance NCQA CCM trainings.
- Participate in a mock audit with consultants to ensure compliance with the NCQA standards.
- Developed and refined training materials based on identified needs.
- Provide Motivational Interviewing (MI) training to Medi-Cal teams to promote member engagement and improve outcomes.

Status: ☐ Completed ☒ Ongoing

Background:
CCM 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.

Methodology:
The population of focus includes members with the most complex health care needs. The most frequently managed conditions, diseases or high-risk groups include but are not limited to: spinal injuries, transplants, cancer (with additional complex conditions), serious trauma, AIDS, multiple chronic illnesses, chronic illnesses that result in high utilization, children and adolescents with special health care needs, serious and persistent mental illness with complex medical illness, and/or members with a medical condition and complex social situation that affects the medical management of the members' care and requires extensive use of resources.

Case Management reviews five files or 5% of members for each health network that is enrolled in CCM for 60 days or longer.

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.

Results: Results:

Measure	Q1 2024 Medi-Cal Rate	Q2 2024 Medi-Cal Rate	Q3 2024 Medi-Cal Rate	Q4 2024 Medi-Cal Goal	MY 2024 Goal Me/Not Met
Review of five files or 5% of files for each health network resulting in a minimum score of 90%.	2 health networks received a score of 90%	4 health networks received a score of 90%	6 health networks received a score of 90%	Pending	☐ Yes ☒ No

Planned Activities/Interventions	Product	Quarter	Type	Status
• Ongoing training of new and current staff including health networks. • Reviewed NCQA standards with the health networks during the Clinical Ops biweekly meeting and encouraged questions to ensure understanding and promote compliance with the standards on 1/25/2024, 2/8/2024, and 3/7/2024. • Training and education were provided to individual case managers as requested. • Results provided for informational purposes to the PHMC in February 2024.	☒ MC ☐ OC	☒ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☐ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• Training and education were provided to individual case managers as requested. • Training for CHCN was completed in April and May 2024. • Training and education on member-centric care plans were provided to individual case managers as requested. • Results provided for informational purposes to the PHMC in May 2024.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☐ Q3 ☐ Q4	☐ Member ☐ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• Training and education were provided to individual case managers as requested. • Meeting was held with QI nurses and CM leadership to review NCQA audit feedback from the consultant/auditors on 8/23/2024 to enhance NCQA CCM trainings. • In-person training provided to Medi-Cal CHCN Case Management team on 9/17/2024. • MI training provided to Medi-Cal teams on 7/9/2024, 7/10/2024 and 8/21/2024 to promote member engagement and improve outcomes. • Scheduled training on NCQA PHM5 D and E in November 2024.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☐ Q4	☐ Member ☐ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

• Scheduled mock audit with Health Management Associate consultants on 11/20/2024. • Results provided for informational purposes to the PHMC in August 2024.				
• Results are provided on a quarterly basis for informational purposes to the PHMC in November 2024.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☒ Q4	☐ Member ☒ Provider ☐ Health Network ☒ Community ☐ Data ☒ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal
OC = OneCare

Results:

Chart A: Complex Case Management Scores for 2024

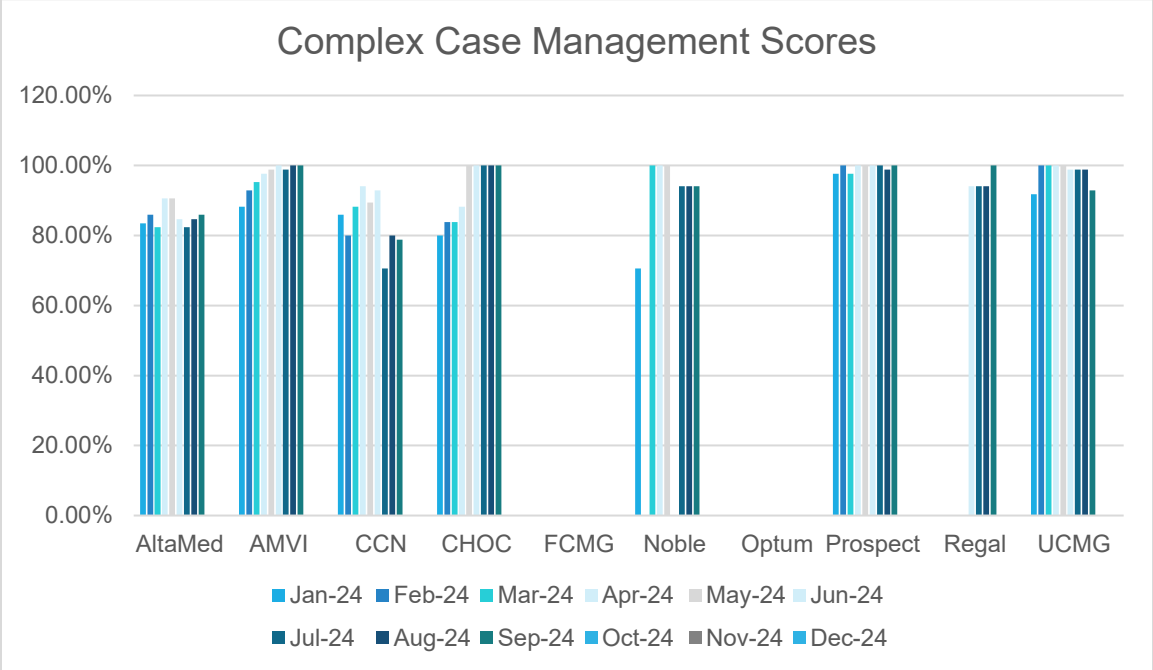


Chart A displays the average audited score for each health network that reported files during the given month. Note that Optum and Family Choice Medical Group (FCMG) did not identify any cases during this period.

Table A: Complex Case Management Scores for Each Health Network in 2024

	Jan	Feb	Mar	Apri	May	Jun	July	Aug	Sep	Oct	Nov	Dec
AltaMed	84%	86%	82%	91%	91%	85%	82%	85%	86%			
AMVI	88%	93%	95%	98%	99%	100%	99%	100%	100%			
CHCN	86%	80%	88%	94%	89%	93%	71%	80%	79%			
CHOC	80%	84%	84%	88%	100%	100%	100%	100%	100%			
FCMG	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a			
Noble	71%	n/a	100%	100%	100%	n/a	94%	94%	94%			
Optum	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a			
Prospect	98%	100%	98%	100%	100%	100%	100%	99%	100%			
Regal	n/a	n/a	n/a	n/a	n/a	94%	94%	94%	100%			
UCMG	92%	100%	100%	100%	100%	99%	99%	99%	93%			

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.

Cases are reviewed monthly for CalOptima Health members who are open to CCM for 60 days or longer. Five or 5% of cases are reviewed from each health network. There are a total of 10 health networks.

Q1: The files reviewed did not meet a minimum score of 90%. Eight out of 10 health networks had files to review. FCMG and Optum did not participate as they did not identify any CCM cases. Out of the 8 health networks, only Prospect and UCMG scored 90% and above through Q1.

Q2: Eight out of 10 health networks had files to review. FCMG and Optum did not participate as they did not identify any CCM cases. AltaMed, CHOC and CHCN did not meet the benchmark of 90%.

Q3: Eight out of 10 health networks had files to review. FCMG and Optum did not participate as they did not identify any CCM cases. AltaMed and CHCN did not meet the benchmark of 90%.

Quantitative Analysis:

The goal of 90% for each health network was not met for Q1–Q3 2024.

Qualitative Analysis:

The benchmark minimum of 90% for each health network was not met due to the challenges associated with training needs for managing CCM members. This led to lower scores at the beginning of the year as staff adapted to the updated processes. With ongoing training and support, consistent progress has been seen. By Q3, the majority of the health networks achieved the benchmark, with only two health networks falling short.

Identified Barriers: • Staff turnover led to the need for more training. • Fortwo health networks, training and adjustment time were needed for staff to transition to the new medical management system. The new assessment is significantly longer and more complex, making it challenging for staff to navigate and adapt efficiently. • Implementing consultants' guidance enhanced the process, and staff had a short period of time to adapt to the new process.	**Identified Opportunities for Improvement:** • Increase engagement with complex cases. • Provide training in groups and individualized settings to reinforce learning. • Offer ongoing training and support for new and existing staff. • Regularly track performance.

Conclusion:

Based on the data, six of the eight health networks that participated in CCM met the goal and achieved a minimum score of 90%. Please note that the implementation of CCM program interventions is still in progress, and final results will be available in the first quarter of 2025.

Activities/Interventions to continue/add next year:

- Continue training and educational opportunities for staff on the 2025 PHM5 Element D and E and complex conditions and situations.

6.1.1 Complex Case Management (Member Satisfactions)	
Business Owner: Hannah Kim	**Department:** Case Management
Support Staff: Diana Tep	
Work Plan Element: Managing Members with Multiple Chronic Conditions	

Products: ☒ Medi-Cal ☐ OneCare	**New Activity:** ☐ Yes ☒ No
Work Plan Goal/Objective: Obtain 85% member satisfaction in the Complex Case Management (CCM) program by December 31, 2024.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities (From the PHM Work Plan): Conduct quarterly/annual oversight: • Provide CCM updates to PHMC on a quarterly basis. • Host member satisfaction meetings with QI nurse and CM leadership team to improve member participation/engagement in survey. • Provide Member Satisfaction Survey outreach training for staff to curate details regarding scoring reasons. • Share Member Satisfaction Survey results at CM department Clinical Operations meetings to identify areas for improvement and highlight successes. • Share Member Satisfaction scores with the CHCN and delegates to help identify strengths and areas for improvement to enhance the quality of care and member outcomes. • Provide MI training to Medi-Cal teams to promote member engagement and improve outcomes.	
Status: ☐ Completed ☒ Ongoing	
Background: CCM 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.	

Methodology:

The population of focus includes members with the most complex health care needs. The most frequently managed conditions, diseases or high-risk groups include but are not limited to: Spinal injuries, transplants, cancer (with additional complex conditions), serious trauma, AIDS, multiple chronic illnesses, chronic illnesses that result in high utilization, children and adolescents with special health care needs, serious and persistent mental illness with complex medical illness, and/or members with a medical condition and complex social situation that affects the medical management of the members' care and requires extensive use of resources.

▪**Numerator:** Members enrolled for 60 days or longer, completed satisfaction survey, and whose results show satisfaction* with the program.

**The survey tool utilizes a rating scale of options for six questions. For five of the six questions, satisfaction is defined by selecting one of the following responses, Very Helpful, Helpful, Very Beneficial, Beneficial. For the sixth question, a response of "yes" defines satisfaction.*

▪**Denominator:** Members eligible with Medi-Cal line of business, enrolled in CCM for 60 days who successfully completed a satisfaction survey after the case is opened, annually and upon case closure during the measurement year. The denominator excludes blanks or "not applicable" responses.

Results:

Measure	Q1 2024 Medi-Cal Rate	Q2 2024 Medi-Cal Rate	Q3 2024 Medi-Cal Rate	Q4 2024 Medi-Cal Goal	MY 2024 Goal Me/Not Met
85% member satisfaction in CCM program.	83%	91%	91%	Pending	☐ Yes ☒ No

Planned Activities/Interventions	Product	Quarter	Type	Status
• Additional Member Satisfaction Survey outreach training for staff to curate details regarding scoring reasons. • Member Satisfaction Survey scores shared with the CHCN and the delegates to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care and member outcomes. • Member satisfaction meeting held with QI nurse and CM leadership team on 1/9/2024 and 2/8/2024. • Results are provided for informational purposes to the PHMC in February 2024.	☒ MC ☐ OC	☒ Q1 ☐ Q2 ☐ Q3 ☐ Q4	☐ Member ☐ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• Member satisfaction meeting held with QI nurse and CM leadership on 5/12/2024 to review results and improve member participation/engagement in survey. • Member Satisfaction Survey scores shared with the CHCN and the delegates to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care and member outcomes. • Results are provided for informational purposes to the PHMC in May 2024.	☒ MC ☐ OC	☐ Q1 ☒ Q2 ☐ Q3 ☐ Q4	☐ Member ☐ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

• Member Satisfaction Survey results shared during CM department meeting on 7/25/2024 and at the Clinical Operations meeting on 8/8/2024 to identify areas for improvement and highlight successes. • Member satisfaction meeting held with QI nurse and CM leadership team on 07/3/2024 and 9/3/2024 to review results and improve member participation/engagement in survey. • Motivational Interviewing (MI) training provided to Medi-Cal teams on 7/9/2024, 7/10/2024 and 8/21/2024 to promote member engagement and improve outcomes. • Results are provided for informational purposes to the PHMC in August 2024.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☐ Q4	☐ Member ☐ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• Results are provided on a quarterly basis for informational purposes to the PHMC in November 2024.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☒ Q4	☐ Member ☐ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

Chart A: Member Experience Satisfaction Survey Average Results January–September 2024

Chart A is the average total score for the member satisfaction survey. Q1 did not meet the 85% benchmark at 83%, Q2 and Q3 met at 91%.

Table A: Member Experience Satisfaction Survey Results January–March 2024

Q1 2024	Member Satisfaction Surveys Completed	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
	3	3	2	2	2	3	3
		100%	67%	67%	67%	100%	100%

In Q1, three members were surveyed regarding their satisfaction with the CCM program, which had an impact on the overall score due to a smaller denominator. CM supports members with medical questions, educational materials and community resources, but did not meet the benchmark of 85% contributing to an average satisfaction score of 83%.

Table B: Member Experience Satisfaction Survey Results April–June 2024

Q2 2024	Member Satisfaction Surveys Completed	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
	22	20	20	19	20	21	20
		91%	91%	86%	91%	95%	91%

In Q2, there was a significant improvement in the number of members who participated in the survey. A total of 22 members were surveyed, and all questions met the 85% benchmark contributing to an average score of 91%.

Table C: Member Experience Satisfaction Survey Results July–September 2024

Q3 2024	Member Satisfaction Surveys Completed	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
	34	29	34	30	33	29	30
		85%	100%	88%	97%	85%	88%

In Q3, more member satisfaction surveys were completed showing increased engagement in the cCCM program. All surveyed questions met the 85% benchmark, leading to an average score of 91%.

Quantitative Analysis:
The goal of 85% was not met in Q1. However, it was met in Q2 and Q3.

Qualitative Analysis:

In Q1, we did not achieve the 85% member satisfaction benchmark. The feedback indicated gaps in the effectiveness of educational materials, helpfulness of the case manager with medical questions, and community resources. In Q2 and Q3, the benchmark was successfully met, demonstrating significant improvement. Progress shows that the training, sharing the satisfaction scores and meetings to improve outcomes were effective. Please note that the implementation of CCM program interventions is still in progress, and final results will be available in the first quarter of 2025.

Identified Barriers:	**Identified Opportunities for Improvement:**
Staff turnover led to the need for more training.	• Improve case manager engagement with members regarding understanding of mailed resources. • Provide ongoing training and support for new and existing staff.

	• Regularly track performance.
Conclusion: Based on the data, this goal is projected to met.	
Activities/Interventions to continue/add next year: • Member satisfaction scores will be shared with the CHCN and the delegates to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care and member outcomes. • Continue to gather member feedback to improve outcomes.	

6.1.2 Complex Case Management (Care Plans)	
Business Owner: Hannah Kim	**Department:** Case Management
Support Staff: Diana Tep	
Work Plan Element: Managing Members with Multiple Chronic Conditions	

Products: ☒ Medi-Cal ☐ OneCare	**New Activity:** ☐ Yes ☒ No
Work Plan Goal/Objective: 85% of members surveyed who participated in Complex Case Management (CCM) between January 1–December 31, 2024, will report that the case management process helped them meet their care plan goals.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities (From the PHM Work Plan): Conduct quarterly/annual oversight: • Provided CCM updates to PHMC on a quarterly basis. • Provide training and educational materials on member-centric care plans to CHCN CM teams, health network CM teams, and individual case managers as requested. • Provide MI training to Medi-Cal teams to promote member engagement and improve outcomes.	
Status: ☐ Completed ☒ Ongoing	
Background: CCM 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.	
Methodology: The population of focus includes members with the most complex health care needs. The mMost frequently managed conditions, diseases or high-risk groups include but are not limited to: Spinal injuries, transplants, cancer (with additional complex conditions), serious trauma, AIDS, multiple chronic illnesses, chronic illnesses that result in high utilization, children and adolescents with special health care needs, serious and persistent mental illness with complex medical illness, and/or members with a medical condition and complex social situation that affects the medical management of the members' care and requires extensive use of resources. ▪Numerator: Members enrolled for 60 days or longer, completed question 13 (How helpful was the case management process in helping you to meet your care plan goals?) in the satisfaction survey, and whose results show satisfaction* with the program. ** The survey tool utilizes a rating scale of options for questions related to developing and helping with care plan goals. Satisfaction is defined by selecting one of the following responses, Very Helpful, Helpful.* ▪Denominator: Members eligible with Medi-Cal line of business, enrolled in CCM for 60 days who successfully completed a satisfaction survey after the case is opened, annually or upon case closure during the measurement year. The denominator excludes blanks or "not applicable" responses.	

Results:

Measure	Q1 2024 Medi-Cal Rate	Q2 2024 Medi-Cal Rate	Q3 2024 Medi-Cal Rate	Q4 2024 Medi-Cal Goal	MY 2024 Goal Me/Not Met
85% of members will report that the case management process helped them meet their care plan goals.	67%	95%	91%	Pending	☐ Yes ☐ No

Actions/Interventions Implemented in 2024:

Planned Activities/Interventions	Product	Quarter	Type	Status
• Training and education on member-centric care plans provided to individual case managers as requested. • Training and educational materials on member-centric care plans provided to CHCN CM teams, health network CM teams, and individual case managers as requested. • Results are provided for informational purposes to the PHMC in February and May 2024.	☒ MC ☐ OC	☒ Q1 ☒ Q2 ☒ Q3 ☐ Q4	☐ Member ☐ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• MI training provided to Medi-Cal teams on 7/9/2024, 7/10/2024, 8/21/2024 and 10/30/2024 to promote member engagement and improve outcomes. • Results are provided for informational purposes to the PHMC in August 2024.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☒ Q3 ☐ Q4	☐ Member ☐ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete
• Results are provided for informational purposes to the PHMC in November 2024.	☒ MC ☐ OC	☐ Q1 ☐ Q2 ☐ Q3 ☒ Q4	☐ Member ☐ Provider ☒ Health Network ☐ Community ☐ Data ☐ Other	☐ Completed ☒ Ongoing ☐ Incomplete

MC = Medi-Cal
OC = OneCare

Quantitative Analysis:
The goal of 85% was met in Q2 and Q3; however, the goal was not met in Q1.

Qualitative Analysis:
In Q1, we did not meet the 85% benchmark for members reporting that the case management process helped with their care plans. However, scores improved in Q2 and Q3, meeting the benchmark in both quarters. This increase demonstrates progress in addressing the members' needs and improving their outcomes with care plans. Please note that the implementation of CCM program interventions is still in progress, and final results will be available in the first quarter of 2025.

Identified Barriers:	**Identified Opportunities for Improvement:**
• Staff turnover led to the need for more training.	• Provide ongoing training and support for new and existing staff. • Regularly track performance.

Conclusion:
Based on the data this goal is projected to meet.

Activities/Interventions to continue/add next year:
- Training and educational opportunities to work collaboratively with members.
- Continue to gather member feedback to improve outcomes.

Area of Focus	Program/ Initiative	Department	Description	Population of Focus	SMART Objective(s)	Red - At Risk Yellow - Concern Green - On Target
Keeping Members Healthy	**Blood Lead Testing in Children**	Quality Analytics	In babies and young children, whose brains are still developing, even a small amount of lead can cause learning disabilities and behavioral problems. CalOptima Health works with providers and members to ensure that all young children are tested for lead at appropriate age intervals.	Members that are 12 and 24 months and due for a blood lead test. ***Blood Lead Testing at 12 Months of Age:*** *· Numerator: Medi-Cal members who completed a one lead capillary or venous blood test within 6 months (before or after) their first birthday.* *· Denominator: Medi-Cal members who turn 12 months old during the measurement year. Child member must be continuously enrolled for 12 months (6 months before and 6 months after the first birthday with no more than one gap in enrollment during the 12-month period where the gap is no longer than one month.* ***Blood Lead Testing at 24 Months of Age:*** *· Numerator: Medi-Cal members who complete one lead capillary or venous blood test within 6 months (before or after) their second birthday.* *· Denominator: Medi-Cal members who turn 24 months old during the measurement year. Child member must be continuously enrolled for 12 months (6 months before and 6 months after the 2nd birthday with no more than one gap in enrollment during the 12-month period where the gap is no longer than one month.*	1. Increase the rate for blood lead testing in children (12 Months) from 56.03% to 59.03% by December 31st, 2024. 2. Increase the rate for blood lead testing in children (24 Months) from 47.44% to 52.44% by December 31st, 2024.	ON TARGET
	Health Disparity Remediation for Well- Child Visits	Quality Analytics	CalOptima Health aims to reduce the racial/ethnic disparities in well child visits in support of the statewide goals. Well-child visits are the foundation of pediatric health promotion and disease prevention. These visits are intrinsically linked to the key indicators in the Children's Health domain. Accordingly, improving the W30-6 measure rate among African American child members has the potential to improve their overall health status.	African American child members who are turning 15 months old during the measurement year, between January 1 and December 31. · ***Numerator:*** *African American Medi-Cal members who complete six or more well-child visits (Well-Care Value Set) on different dates of service on or before their 15-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.* · ***Denominator:*** *African American Medi-Cal members who turn 15 months old during the measurement year.*	~~1. PIP AIM Statement: Do targeted interventions increase the percentage of African American children 15 months of age that had size or more well-child visits during the measurement year.~~ **REVISED:** 1. Increase well-child visit appointments for Black/African American members (0-15 months) from 41.90% to 55.78% by December 31st, 2024.	ON TARGET
	Well-Child Visits	Quality Analytics	Well-child visits are important during the early months of a child's life to assess growth, development and identify and address any concerns early. CalOptima Health promotes preventive care for its youngest members to help them live long, happy and healthy lives.	Members 0-14 months and members 15-30 months due for a well-child visit. ***W30 (First 15 Months)*** · ***Numerator:*** *Medi-Cal members who complete six or more well-child visits (Well-Care Value Set) on different dates of service on or before their 15-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.* · ***Denominator:*** *Medi-Cal members who turn 15 months old during the measurement year.* ***W30 (15-30 Months)*** · ***Numerator:*** *Medi-Cal members who complete two or more well-child visits (Well-Care Value Set) on different dates of service between their 15-month birthday plus 1 day and their 30-month birthday. The well-child visit must occur with a PCP, but the PCP does not have to be the practitioner assigned to the child.* · ***Denominator:*** *Medi-Cal members who turn 30 months old during the measurement year.*	1. Increase the rate for well-child visits (W30 - 0 to 14 Months) to meet the 50th percentile benchmark of 58.38% by December 31st, 2024. 2. Increase the rate for well-child visits (W30 - 15 to 30 Months) to meet the 75th percentile benchmark of 71.35% by December 31st, 2024.	ON TARGET
	Childhood Immunizations	Quality Analytics	Childhood vaccinations are a safe and effective way to protect children from a variety of serious or potentially fatal diseases. CalOptima Health works to promote immunizations and ensure that children are healthy, growing and ready to learn.	Child members due for Combo 10 and adolescent members due Combo 2. ***CIS (Combo-10)*** · ***Numerator:*** *Medi-Cal members who completed four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.* · ***Denominator:*** *Medi-Cal members who turn 2 years of age during the measurement year.* ***IMA (Combo-2)*** · ***Numerator:*** *Medi-Cal members who completed one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.* · ***Denominator:*** *Medi-Cal members who turn 13 years of age during the measurement year.*	1. Increase the CIS-Combo 10 rate to meet the 90th percentile benchmark of 45.26% by December 31st, 2024. 2. Maintain the IMA-Combo 2 rate at quality compass 90% benchmark for MY 2024.	ON TARGET
	Comprehensive Community Cancer Screening and Support Program	Medical Management & Quality Analytics	CalOptima Health partnered with external stakeholders in the fight against cancer to launch this program. Together, we aim to decrease late-stage breast, cervical, colorectal and lung cancer diagnoses through early screening.	Members between the ages of 50–74 due for mammogram. · ***Numerator:*** *Medi-Cal members who are women 50-74 years of age who complete at least one mammogram (Mammography Value Set) during the measurement period.* · ***Denominator:*** *Medi-Cal members who are women 52–74 years of age by the end of the measurement period.* *Measurement period: anytime on or between October 1 two years prior to the measurement year and December 31 of the measurement year.*	1. Increase the BCS rate from 57.81% to 61.27% by December 31st, 2023.	ON TARGET
	Maternal Health	Equity and Community Health & Quality Analytics	CalOptima Health's prenatal and postpartum care program aims to inform and provide resources to pregnant members to help them have a healthy pregnancy, delivery and baby.	Members who are expecting or recently delivered. · ***Numerator:*** *◦PPC-Prenatal - Medi-Cal member who had a prenatal visit during the first trimester or 42 days within enrollment.* *◦ PPC-Postnatal - Medi-Cal member who had a postpartum visit on or between 7 and 84 days after delivery.* · ***Denominator:*** *Medi-Cal members who delivered a live birth within the measurement year.*	1. Increase the Prenatal Care Services (PPC-Pre) rate from 88.08% to 91.89% by December 31st, 2024. 2. Increase the Postpartum Care Services (PPC-Post) rate from 81.15% to 84.18% by December 31st, 2024.	ON TARGET

Area of Focus	Program/ Initiative	Department	Description	Population of Focus	SMART Objective(s)	Red - At Risk Yellow - Concern Green - On Target
	Shape Your Life	Equity and Community Health	CalOptima Health offers no-cost, in-person and virtual group classes for children ages 5 to 18 and their families. Topics include healthy eating, physical activity and other ways to build healthy habits.	Children ages 5-18 and/or their families. · **Numerator:** The number of SYL participants who completed the pre and post assessments on basic nutrition and healthy lifestyle topics and showed an increase in knowledge on these topics during the measurement year. **Basic nutrition and healthy lifestyle knowledge are assessed via in-class survey. The survey tool used contains multiple choice and open-ended questions on basic nutrition and healthy lifestyle topics taught during SYL classes. Correct responses are an indicator of basic nutrition and healthy lifestyle knowledge.* · **Denominator:** The number of SYL participants that completed the SYL pre and post assessments during the measurement year.	1. By December 31st, 2024, at least 40% of the SYL participants who completed the pre and post assessment will increase their knowledge on basic nutrition and healthy lifestyle.	ON TARGET
Emerging Risk	**Chronic Condition Care and Self-Management Program**	Equity and Community Health & Quality Analytics	CalOptima Health's programs promotes self-management skills for people with chronic conditions to enable them to manage their health on a day-to-day basis and to take an active role in their health care.	Members with diabetes that are at risk of HbA1c poor control. · ***Numerator:*** *Medi-Cal Members 18-75 years of age with diabetes (types 1 and 2) who participated in the Chronic Conditions Care and Self-Management Program and lowered their HbA1c to less than 8% during the measurement year.* · ***Denominator:*** *Medi-Cal Members 18-75 years of age with diabetes (types 1 and 2) with a result of HbA1c 8.0% to HbA1c 9.0% who were previously in good control (HbA1c less than 8.0%) in previous 12 months.*	1. By December 31st, 2024, 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.* 2. Maintain the HBD-HbA1c Poor Control (>9.0%)** at 75th percentile (33.45%) by December 31st, 2023. ***Lower rates is better*	ON TARGET
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	Behavioral Health Integration	CalOptima Health's program assesses the percentage of emergency department (ED) visits for members aged 13 and older with a principal diagnosis of alcohol and other drug abuse or dependence to ensure our members receive appropriate follow-up care.	Members 13 years and older as of the ED visit for substance use. · ***Numerators:*** ◦*7-Day Follow-Up - A follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.* ◦*30-Day Follow-Up - A follow-up visit or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit.* · ***Denominator:*** *Medi-Cal members ages 13 and older who had emergency department (ED) visits with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up during the measurement period.*	1. Increase the FUA (7-days) rates from 11.47% to 20.0% by December 31st, 2024. 2. Increase the FUA (30-days) rates form 17.90% to 36.34% by December 31st, 2024.	ON TARGET
Patient Safety	**CalAIM Community Supports**	CalAIM	California Advancing and Innovating Medi-Cal (CalAIM) is a five-year initiative by the DHCS to improve the quality of life and health outcomes of the Medi-Cal population by addressing social drivers of health and breaking down barriers in accessing care. Community Supports are a core component of CalAIM.	Eligible CalOptima Health Members that are referred to CalAIM Community Supports. · ***Numerator:*** *Eligible CalOptima Health members who qualify for CalAIM Community Supports (CCS) between January 1st - December 31st, 2024 and received at least one CCS.* · ***Denominator:*** *Eligible CalOptima Health members referred to CCS* between January 1st - December 31st, 2024.* *To qualify for CalAIM Community the member must be eligible for CalOptima Health and referred or self-referred to CCS. Eligibility criteria for each CSS varies and listed on the referral form.*	1. 90% of members that were referred to CalAIM Community Supports between July 1st - December 31st, 2024 will have received at least one Community Support.	ON TARGET
	Street Medicine Program	CalAIM	CalOptima Health's Street Medicine Program model is implemented by a contracted medical and social service provider who is responsible for identifying and managing the comprehensive needs of Orange County's un-housed individuals and families through whole person care approaches and addressing social drivers of health.	Members that are experiencing homelessness. ***Numerator:*** *Eligible CalOptima Health members who are experiencing homelessness*, opted into the Street Medicine program, and:* *· assigned to a Medical Home.* *· received CalAIM ECM or at least one Community Support; OR* *· referred to a shelter or other housing option.* ***Denominator:*** *Members eligible for CalOptima Health who are experiencing homelessness* during the measurement period.* **Members that are eligible for CalOptima Health services self-report experiencing homelessness to Street Medicine Team canvassing in designated geographic locations within Orange County during the measurement period.*	1. By December 2024, connect 80% of unhoused participating members to an active Primary Care Physician (PCP). 2. By December 2024, connect 90% of unhoused participating members with CalAIM ECM and Housing Navigation. 3. By December 2024, connect 20% of unhoused participating members to a shelter or other housing option.	CONCERN (Specific to Goal #3)

Area of Focus	Program/ Initiative	Department	Description	Population of Focus	SMART Objective(s)	Red - At Risk Yellow - Concern Green - On Target
Managing Multiple Chronic Conditions	**Complex Case Management Program**	Case Management	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.	Members with the most complex health care needs. Most frequently managed conditions, diseases or high-risk groups (including, but not limited to): Spinal injuries, transplants, cancer (with additional complex condition, serious trauma, AIDS, multiple chronic illnesses, chronic illnesses that result in high utilization, children and adolescents with special health care needs, serious and persistent mental illness with complex medical illness, and/or members with a medical condition and complex social situation that affects the medical management of the members' care and requires extensive use of resources. · ***Numerator:*** *Members enrolled for 60 days or longer, complete satisfaction survey, and who's results show satisfaction* with the program.* ** The survey tool utilizes a rating scale of options for six questions. For five of the six questions, satisfaction is defined by selecting one of the following responses, Very Helpful, Helpful, Very Beneficial, Beneficial. For the sixth question a response of "yes" defines satisfaction.* · ***Denominator:*** *Members eligible with Medi-Cal line of business, enrolled in CCM for 60 days who successfully completed a satisfaction survey after the case is opened, annually and upon case closure during the measurement year. The denominator excludes blanks or "not applicable" responses.*	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, 2024. 2. Obtain 85% member satisfaction in CCM program by December 31st, 2024. 3. 85% of members surveyed who participated in CCM between January 1, 2024-December 31, 2024, will report that the case management process helped them meet their care plan goals.	ON TARGET

2024 CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) PROGRAM EVALUATION

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2024 CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) 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:

_____ _____

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

Board of Directors Chair:

_____ _____

Isabel Becerra **Date**

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Our Values
Who We Serve
Our Commitment to Culturally and Linguistically Appropriate Services (CLAS)

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Section 1: CalOptima Health Overview

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

Our Values
Collaboration. **A**ccountability. **R**espect. **E**xcellence. **S**tewardship. CalOptima Health abides by our core values (CARES) in working to meet members' needs and partnering with Orange County providers who deliver access to quality care. Living our values ensures CalOptima Health builds and maintains trust as a public agency and with our members and providers.

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.

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. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has developed a Cultural and Linguistic Services Program, a program that is a part of the Quality Improvement and Health Equity Transformation Program (QIHETP) that integrates culturally and linguistically appropriate services at all levels of the operation.

Section 2: Executive Summary

2.1 2024 Achievements

Authors: Albert Cardenas and Carlos Soto

Summary of 2024 Achievements

In 2024, the following achievements were accomplished by Cultural & Linguistic Services (C&L):

CLAS Goals:

- Implemented a process to collect, store and retrieve member Race, Ethnicity and Language/Sexual Orientation Gender Identity (REL/SOGI) data.
- Implemented a process to collect, store and retrieve practitioner race/ethnicity/languages (REL) data.
- Created surveys to evaluate the language services experience of CalOptima Health members and staff (Implementation set for Q1 2025).
- Increased well-child visit appointments for Black/African American members (0–15 months).
- Increased timely postpartum appointments for CalOptima Health Black and Native American members.
- Improved practitioner support in providing language services.

C&L Department:

- Added a department supervisor to assist with the oversight of the daily operations of all C&L department activities, based on the increased utilization of translation and interpreter services and health equity deliverables.
- Streamlined the Pharmacy Care Plan process to reduce the translation turnaround times from 40 days to 10 days. This previously involved an extensive timeframe, approximately 40-day turnaround (20 days for the translation phase and 20 days for the review). As a result, the Care Plan timeline was reduced to a 10-day turnaround time.
- Created a new SharePoint worklog for the Spanish team. Spanish translations represent 67% of all translations. The new SharePoint worklog enhances the routine and expedited assignment process. This tool enables translators to receive their assignments more efficiently and provides clear guidance on task ownership. In addition, this new log helps the team quickly identify unassigned work to ensure timely deliveries to our internal clients.
- Streamlined the Alternative Format Selection (AFS) process for the Notice of Action (NOA) AFS requests. AFS materials include Braille, Audio/Data files and Large Print materials. This improved the production process of AFS (related NOAs), reducing it from 5 to 10 business days per request to 2 to 3 business days per request.

2.2 Review of 2024 CLAS Goals

Authors: Albert Cardenas and Carlos Soto

2024 CLAS goals and achievements:

1. Implement a process to collect, store and retrieve member REL/SOGI data.
    - Developed member surveys
    - Updated systems to support the collection of REL/SOGI data
    - Added member survey to the Member Portal
    - Developed member mailing packets
    - Launched mailing of surveys in September 2024 to new members 18+ years of age
    - Launched survey in the Member Portal in December 2024

2. Implement a process to collect, store and retrieve practitioner race/ethnicity/languages.
    - Developed provider satisfaction survey
    - Launched survey in September 2024
    - Store provider responses in CalOptima Health care system

3. Implement a process to survey and evaluate the language services experiences of CalOptima Health members and staff.
    - Developed member and staff surveys
    - Launch of surveys targeted for Q1 2025

4. Increase well-child visit appointments for Black/African American members (0–15 months).
    - Conducted focused outreach and assessed parental knowledge of the importance of well-child visits and what should be expected at these visits
    - CalOptima Health staff provided education, assisted with scheduling well-child visits and offered care coordination
    - CalOptima Health staff identified barriers and will use findings to develop new interventions for 2025
5. Increase in timely prenatal and postpartum appointments for CalOptima Health Black and Native American members.
    - Conducted focused outreach to offer doula, Enhanced Care Management and black infant health services
6. Improve practitioner support in providing language services.
    - Made members' language preference available to providers in the CalOptima Health Provider Portal
    - Informed providers of members' language preferences during customer service interactions
    - Evaluated CalOptima Health's contracted health networks Cultural and Linguistics process to ensure members' language needs are being met

2.3 Recommendations for 2025

Authors: Albert Cardenas and Carlos Soto

Recommendations for 2025 CLAS goals:

1. Expand the threshold languages to include Russian to meet requirements established by the California Department of Health Care Services (DHCS).
2. 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.
3. Increase the collection of race/ethnicity/languages (REL) data by 10% through focused outreach and education, ensuring better representation and inclusion of providers.
4. Increase the collection of SOGI data through focused outreach and education.
5. Implement and train CalOptima Health and health network staff on Diversity, Equity and Inclusion (DEI) training, ensuring compliance with DHCS All Plan Letter (APL) 24-016.

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2.4 Recommended Priority Areas and Goals for 2025

Authors: Albert Cardenas and Carlos Soto

Recommended goals for 2025:

1. Expand the threshold languages to include Russian to meet requirements established by the California Department of Health Care Services (DHCS).
2. Launch a language services experience survey for members and staff and aim to collect feedback from at least 10% of members and 80% of staff using surveys. Analyze the results to identify improvements to language services.
3. Increase the collection race/ethnicity/language (REL) data by 10% through focused outreach and education, ensuring better representation and inclusion of providers.
4. Increase the collection of sexual orientation gender identity (SOGI) data by 10% through focused outreach and education, ensuring better representation and inclusion of members.
5. 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, by December 31, 2025.

Section 3: Program Structure

3.1 CLAS Program Documents	
Authors: Albert Cardenas and Carlos Soto	Department: Customer Service/Cultural and Linguistic Services
Responsible Party(ies): Albert Cardenas/Carlos Soto	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☒ Yes ☐ No
Work Plan Goal/Objective: Complete documents and obtain Board of Directors Approval of 2024 Program and Work Plan	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: CLAS Program Description and Work Plan will be completed, reviewed and approved by the following committees in Q1 2024, and by their appropriate subcommittee, where applicable. o QIHEC: 02/13/2024 o QAC: 03/13/2024 o Annual BOD Adoption by April 2024	
Status: ☐ Completed ☒ Ongoing	
Background: To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has developed a CLAS Program, which is part of the Quality Improvement and Health Equity Transformation Program (QIHETP) that integrates culturally and linguistically appropriate services at all levels of the 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.	
Methodology: The CLAS Program guides the development and implementation of an annual CLAS Work Plan, which includes but is not limited to documentation for the following: • 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	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• None
Quarter 2:	• Staff worked with other departments to draft the CLAS Program Description and identify CLAS items to be included in the overall QIHETP Work Plan
Quarter 3:	• The revised 2024 CalOptima Health QIHETP Program and Work Plan to include CLAS and the documents were approved by BOD on 8/1/2024 and a copy was posted on CalOptima Health's public website.
Quarter 4:	• Staff developed a draft of the 2024 CLAS Evaluation, and the 2025 QIHETP and Work Plan, including CLAS, will be approved in Q1 2025.
Program Results: Overall, the CLAS Program successfully yielded positive results.	
Identified Barriers:	Identified Opportunities for Improvement:
• These are new documents for CalOptima Health, so it took staff time to draft the materials	• Schedule a meeting earlier in the year to review the goals and priorities for the next year.

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• As there were new elements added to the overall work plan, it took some time to identify the lead or main business owners for each element.	

Conclusion:
- The CLAS Program was drafted, presented and approved.

Activities/Interventions to continue/add next year:
- C&L staff to collaborate with staff in Quality Analytics and other business areas in September to begin developing goals and priorities for the next year.

3.2 CLAS Reporting Structure and Community and Member Engagement

Author: Albert Cardenas	Department: Customer Service/Cultural & Linguistic Services

Support Staff: Carlos Soto

Background:
CalOptima Health is committed to member-focused care through member and community engagement. C&L seeks guidance from the Member Advisory Committee (MAC), the Provider Advisory Committee (PAC) and the Quality Improvement Health Equity Committee (QIHEC).

Activities from the CLAS Program and Work Plan are reported quarterly to the QIHEC. Staff will present CLAS activities implemented for the quarter, findings, barriers and any need to conduct corrective action or remediation.

CalOptima Health engages members through MAC to seek input, advice and guidance related to Cultural and Linguistic and 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 about CalOptima Health programs and services as a liaison on items of interest to the provider community. The PAC meets along 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.

In addition to the MAC and PAC, CalOptima Health also seeks input, advice and guidance related to Cultural and Linguistic and 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.

Actions/Interventions Implemented in 2024:	
Quarter 1:	• None
Quarter 2:	• None
Quarter 3:	• CLAS activities were reported to QIHEC each quarter
Quarter 4:	• A summary of the 2024 CLAS Program goals was presented at the December MAC and PAC meeting, and committee members provided feedback • Requested MAC/PAC standing agenda items to ensure CLAS and quality items are presented to our advisory boards for feedback.

Analysis:
The reporting structure was successful. Staff were able to report to QIHEC quarterly on all CLAS activities and obtained feedback and guidance from the QIHEC. The QIHEC was able to provide guidance on the following activities:
- DEI survey to staff and committee members.

- Language to include in the surveys to encourage a response to providing SOGI data.

Identified Barriers:	Identified Opportunities for Improvement:
• MAC and PAC meetings have a full agenda. It is difficult to obtain dedicated time on the agenda to have a deeper discussion and solicit feedback at these meetings.	• Quality Improvement reserved space in the MAC and PAC meeting agenda for C&L and Customer Service to present. • Going forward C&L and/or Customer Service will ensure they are added to the MAC and PAC agenda.

Conclusion:
CalOptima Health staff presented the CLAS Program updates at the December 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 2024 CLAS Program and 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.

Staff asked the committees for feedback and recommendations to increase response rates. Committee members provided valuable feedback, including working with First 5 Orange County, which has a Black infant health program, and UCI's Black Pearl Program, which is focused on increasing the number of Black, Indigenous, and People of Color (BIPOC) doulas in the community. Committee members also suggested CalOptima Health, partner with FQHCs as they also collect the same member demographic data CalOptima Health is attempting to collect.

Activities/Interventions to continue/add next year:

- CalOptima Health will continue to engage members and providers through the MAC and PAC to seek input, advice and guidance related to CLAS goals and objectives.

3.3 CLAS Monitoring Progress

Author: Albert Cardenas	Department: Customer Service/Cultural & Linguistic Services

Support Staff: Carlos Soto

Bbackground:
To ensure that the CLAS Program meets the needs of our diverse member population, CalOptima Health continuously monitors the progress of CLAS goals. At least quarterly, dedicated staff from C&L, in collaboration with multidisciplinary work teams throughout the agency, collect and track indicators and activities specific to CLAS goals, outcomes and outputs. CalOptima Health staff prepares quarterly findings and identifies potential risks to share with CalOptima Health leadership at QIHEC meetings. CalOptima Health's QIHEC reviews, offers feedback and approves quarterly CLAS monitoring reports. QIHEC summarizes the CLAS monitoring reports and shares them with CalOptima Health's Board of Directors Quality Assurance Committee (QAC).

Methodology:
CalOptima Health staff followed the 2024 Health Equity Standards and Guidelines when implementing the CLAS Program goals and monitored progress against CLAS goals. Quarterly, dedicated staff from C&L, in collaboration with multidisciplinary work teams throughout the agency, collect and track indicators and activities specific to CLAS goals, outcomes and outputs.

Actions/Interventions Implemented in 2024:

Quarter 1:	• Work began on the development of the CLAS Program and goals.
Quarter 2:	• Monitored the completion of surveys for the collection of member REL/SOGI data and collection of practitioner REL data. • Monitored the updates to CalOptima Health systems to ensure the capacity to store member REL/SOGI. • Reported progress to the QIHEC.
Quarter 3:	• Monitored the implementation of the mailing of the REL/SOGI surveys to new members 18 years of age and older. • Quality Analytics team worked on CLAS goal: Increase well-child visit appointments for Black/African American members (0–15 months). • Provider Data Management team implemented the collection of practitioner race/ethnicity/languages (REL) data. • Equity and Community Health worked on CLAS goal: Maternity Care of Black and Native American Persons. • Reported progress to the QIHEC.
Quarter 4:	• Created the survey to be used to evaluate the effectiveness related to cultural and linguistic services. • Implemented the process of collecting REL/SOGI data via the Member Portal. • Reported progress to the QIHEC.

Program Results:

Analysis:
CalOptima Health will continue to monitor progress against CLAS goals. Quarterly, dedicated staff from C&L, in collaboration with multidisciplinary work teams throughout the agency, collect and track indicators and activities specific to CLAS goals, outcomes and outputs.

Identified Barriers:	Identified Opportunities for Improvement:
• SOGI surveys have a 5% return rate. Practitioner REL surveys had only a 1% return rate. • The member and staff surveys are being reviewed and designed. • During the outreach efforts conducted by CalOptima staff, parents provided feedback on barriers to well-child visits which included conflicts	• Explore other methods of collecting member SOGI data, including community events, collaborating with contracted providers and direct member interaction. Also, explore other methods of collecting practitioner race/ethnicity data, including during new provider onboarding.

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with parental work schedules, PCP schedules not aligning with parents' needs, lack of childcare and lack of transportation.	• From the results of the survey, enhance interpreter and translation services by tracking and trending the utilization. • Utilize well-child visit findings to develop new interventions for 2025.
Conclusion: Overall, the monitoring of CLAS was successful as all but one goal was completed. CalOptima Health will continue to monitor progress against the CLAS goals to ensure timely progress and completion.	
Activities/Interventions to continue/add next year:	
In 2025, C&L will continue to monitor progress against CLAS goals by: • Continuing to send surveys to collect the members' SOGI information to members 18 years of age and older. • Implement a language services experience survey for members and staff and aim to collect feedback, analyze the results and identify improvement opportunities to language services.	

3.4 Assessment of CLAS Staff and Resources

Author: Albert Cardenas	Department: Customer Service/Cultural & Linguistic Services

Support Staff: Carlos Soto

Bbackground:
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 translations, interpreter and alternative format services. Throughout 2024, CalOptima Health's Human Resources department worked with the business areas to fill vacant and needed positions to support the CLAS Program, including adding a C&L supervisor, a Sr. Director of Equity and Community Health and Director of Customer Service.

In addition to supporting CLAS, CalOptima Health has developed workgroups to focus on different CLAS priorities. Each workstream is comprised of staff from different functional departments to ensure the items listed on the CLAS work plan are implemented.

Workstream 1: Organizational Readiness
Workstream 2: REL/SOGI Data
Workstream 3: Access and Availability of Language Services
Workstream 4: Practitioner Network Cultural Responsiveness
Workstream 5: Reducing Health Care Disparities with CLAS

Actions/Interventions Implemented in 2024:	
Quarter 1:	• None
Quarter 2:	• Recruited one (1) temp staff position to support C&L staff.
Quarter 3:	• Hired a C&L Supervisor.
Quarter 4:	• Hired a Sr. Director of Equity and Community Health. • Renewed the contracts of CalOptima Health's translations and interpreter services vendors.

Analysis:
CalOptima Health added several positions that support CLAS throughout the organization, providing adequate staffing and resources to meet members' needs.

Identified Barriers:	Identified Opportunities for Improvement:
• Ensuring we had adequate staffing to provide effective communication for LEP members. • Needed a department supervisor to assist the department manager with the oversight of the department. • C&L needed a coordinator to help coordinate translation and interpreter requests.	• The C&L manager, supervisor and staff continue to ensure effective communication is conveyed to members, in their language, as part of the CalOptima Health CLAS Program. • Hired a department supervisor. • Hired a full-time coordinator to assist with the coordination and vending of incoming translation and interpreter requests. • Cross-trained several members of the C&L staff to process interpreter requests and help with the influx of interpreter requests.

Conclusion:
This goal has been met, as CalOptima Health ensures sufficient CLAS staff and resources are available to effectively provide culturally and linguistically appropriate services to members.

Activities/Interventions to continue/add next year:

- 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.

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3.5 Review of System Resources

Author: Albert Cardenas	Department: Customer Service/Cultural & Linguistic Services

Support Staff: Carlos Soto

Background:
To ensure effective communication regarding treatment and to try and avoid language barriers, CalOptima Health has resources to ensure there are adequate systems 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.
- The NICE CXone (NICE) Contact Center phone system was implemented in Q4 2024. The system includes telephone interactions and call routing, Interactive Voice Response, callback option, Workforce Management (planning, scheduling, productivity), Quality Management Assurance (recording, evaluations) and Feedback Management (member surveys).
- 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).

These systems play a crucial role in staff providing culturally and linguistically appropriate services to CalOptima Health members and contracted providers.

In addition, in Q4 2024, CalOptima Health started implementing a Customer Relationship Management (CRM) System. This system will seamlessly integrate with existing systems (NICE CXone, Facets, Jiva, Salesforce Provider Network Management) to enable efficient data management, automate processes, and provide CalOptima Health staff with the tools and resources to deliver exceptional customer service to both members and providers. The anticipated launch date for the CRM system is Q3 2025.

Actions/Interventions Implemented in 2024:	
Quarter 1:	• 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).
Quarter 2:	• Enhanced Facets to support the collection and storage of REL/SOGI data.
Quarter 3:	• Submitted request to ITS to enhance the Member Portal to implement the SOGI survey.
Quarter 4:	• Transitioned from Avaya phone system to NICE CXone Contact Center system. • Implemented the SOGI surveys in the Member Portal. • Began CRM implementation project.

Analysis:
CalOptima Health has sufficient system resources to support the CLAS Program.

Identified Barriers:	Identified Opportunities for Improvement:
• Jiva reports still needed to be developed after go-live to produce appropriately formatted member documents for translations. • Jiva required updates to store member pronouns (HE2 requirement). • Facets had limitations in storing SOGI data.	• Collaborated with the Jiva team and Utilization Management/Case Management to develop workarounds until the formatting issue with Jiva is corrected. • Collaborated with ITS and Jiva team to update Jiva to store member pronouns.

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• The member portal required an update to upload the member SOGI survey.	• Collaborate with ITS to enhance Facets to store SOGI data. • Collaborated with ITS to update the Member Portal to make the SOGI survey available to members.
Conclusion: With the system updates completed in 2024 and updates scheduled for 2025, CalOptima Health has the necessary system resources to support the CLAS Program.	
Activities/Interventions to continue/add next year:	
• Continue to work with vendors and ITS to improve the current process. • Continue to work with the CRM implementation team to ensure the successful launch of the CRM system in Q3 2025.	

3.6 Overall Assessment of CLAS Program Structure	
Author: Albert Cardenas	Department: Customer Service/Cultural & Linguistic Services

Program Results:
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, medical history and health education, CalOptima Health developed a Cultural and Linguistic Services Program, a program that is a part of the Quality Improvement and Health Equity Transformation Program (QIHETP) that integrates culturally and linguistically appropriate services at all levels of the 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.

CalOptima Health is committed to member-focused care through member and community engagement. CalOptima Health intends to engage members through the Member Advisory Committee (MAC) and seek input and advice related to the Cultural and Linguistic and Health Equity goals.

In addition to engaging MAC members, CalOptima Health intends to gather member input through community focus groups, meetings and/or surveys. For example, it will implement a health equity and cultural needs member survey that will be distributed to new members during the monthly New Member Orientation Meetings.

Along with the MAC, QIHEC provides advice and recommendations regarding CalOptima Health programs and services. The QIHEC reports annually directly to CalOptima Health's Board of Directors.

The following are the goals of the QIHEC/CLAS Program:

1. Implement a process to collect, store and retrieve member SOGI data.
2. Evaluate the language services experience of members and staff.
3. Implement a process to collect, store and retrieve practitioner REL data.
4. Improve practitioner support in providing language services.

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

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

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

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

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

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

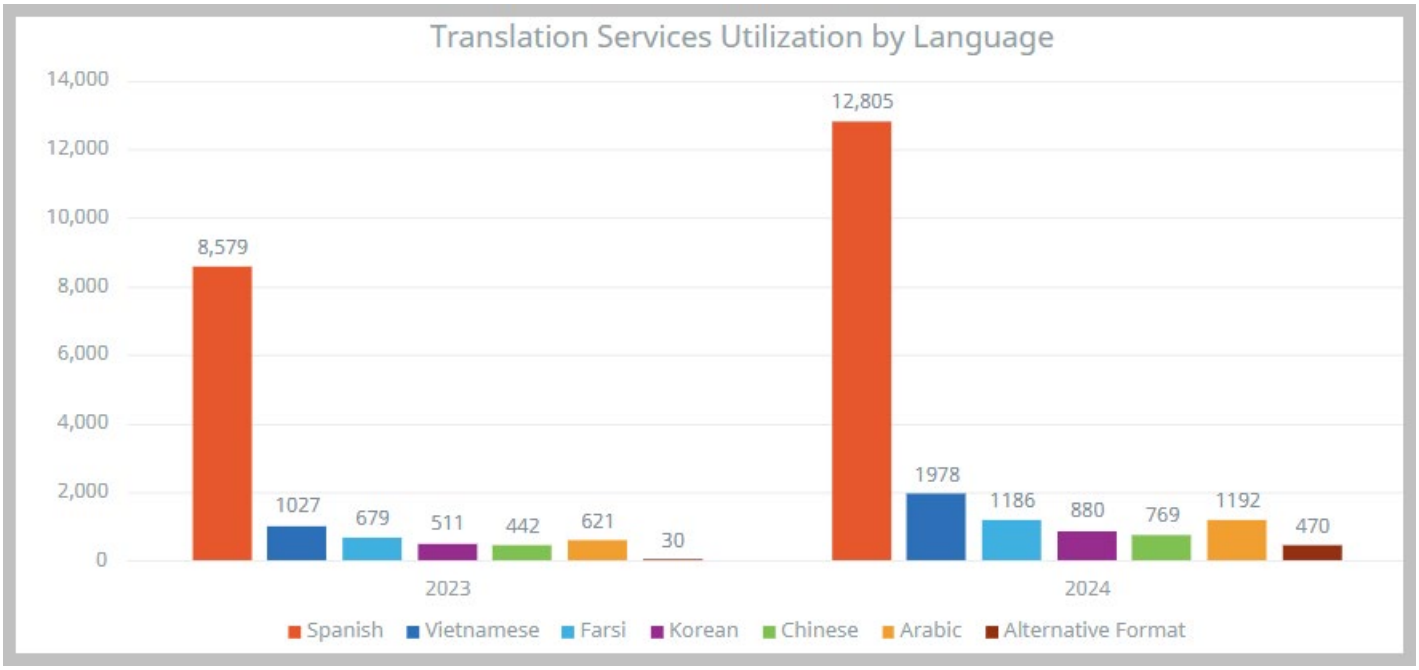
- CalOptima Health will continue to ensure we provide culturally and linguistically appropriate services to members, with effective communication.
- CalOptima Health added staff and system resources during 2024 and implemented several surveys as part of the program. At the end of 2024, the CLAS program was appropriate and there is no plan to further restructure it in 2025.

Section 4: Language Services

4.1 Translation Services	
Author: Carlos Soto/Albert Cardenas	Department: Cultural & Linguistic Services
Support Staff: Angelica Acosta (Dept. Sup.); C&L Translation Staff	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Monitor translation services utilization	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: • Track and trend interpreter and translation services utilization data and analysis for language needs • Comply with regulatory standards, including Member Material requirements • Maintain business for current programs • Improve the process for handling these services	
Status: ☐ Completed ☒ Ongoing	
Background: As a health care organization in the diverse community of Orange County, CalOptima Health recognizes that language misunderstandings and a lack of cultural awareness can sometimes negatively affect clear communication during care delivery. CalOptima Health's C&L department ensures that all members have access to translation services in CalOptima Health's threshold languages.	
Methodology: CalOptima Health's Cultural and Linguistics (C&L) department receives translation requests from members via CalOptima Health staff through an internal intake system named K2. C&L staff process the requests and translates member-facing materials in CalOptima Health's threshold languages, which are Arabic, Chinese, Farsi, Korean, Spanish and Vietnamese.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• C&L reviewed more than 1,500 pages of translated templates for the Jiva implementation throughout February 2024. • As a result of the new format, C&L extended the previous 5-day Care Plans turnaround timeline to a 10-day turnaround timeline for all Care Plan translations. The new timeline helped with the translation schedule. • C&L streamlined the Alternative Format Selection (Braille, Audio/Data files & Large Print materials) for the Notice of Action (NOA) process.
Quarter 2:	• Staff have been cross trained to process NOA translations to help cover the coordination process of NOAs to support the C&L coordinator. • A new SharePoint work log was created for the Spanish team to distribute the workload among the Spanish translators. • A temporary staff member was hired to assist with the coordination and processing of NOA translations.
Quarter 3:	• The C&L Coordinator was promoted to supervisor to help with the department oversight. • C&L leaders opened recruitment for a full-time coordinator. • C&L staff updated all Annual Notice of Change (ANOC) materials that were mailed to members. • C&L management established a workflow for the C&L team to vend out all overflow translation requests in order to accommodate the translations of all ANOC materials in-house. • A process was established for the C&L staff to assist with coordination and vending of NOA translations and other translation requests.

Quarter 4:	• A full-time coordinator was hired to assist with the translation coordination and vending of NOA and other incoming translation requests. • C&L streamlined the process with Pharmacy Management team to translate Care Plans. • C&L is processing a translated answer key for Case Management for HRA surveys. • C&L staff translated approximately five documents for Liberty Dental, in CalOptima Health threshold languages.

Program Results:



This slide shows a 2023–24 comparison of pages translated into CalOptima Health threshold languages, Arabic, Chinese, Farsi, Korean, Spanish and Vietnamese. Spanish and Vietnamese have the highest utilization.

Analysis:

- All goals and objectives were met in 2024.
- Spanish had the highest increase in utilization followed by Vietnamese.
- All other languages also show an increase in utilization.
- There was a 38% increase in utilization in 2024 compared with 2023.

Identified Barriers: Although C&L encountered the following challenges, all goals and/or objectives were met.	Identified Opportunities for Improvement:
• C&L reviewed more than 1,500 pages of translated templates for the Jiva implementation, which caused delays in the translation process. • Once JIVA went live, Case Management and Pharmacy Management Care Plans had a new format, which caused delays with translation. • C&L assisted CalOptima Health's contracted vendor with the review of member facing translated documents processed by the contracted vendor's translation vendor. • C&L experienced an influx of translation requests, which consequently led to hiring a department	• Hired a department supervisor. • Hired a full-time coordinator to assist with coordination and vending of NOA and other incoming translation requests. • Streamlined the process with Pharmacy Management team to translate Care Plans. • C&L is processing a translated answer key for Case Management for HRA surveys • With Case Management's approval, C&L extended the 5-day Care Plans turnaround timeline to a 10-day turnaround timeline for all Care Plan translations. The new timeline helped with translation schedule.

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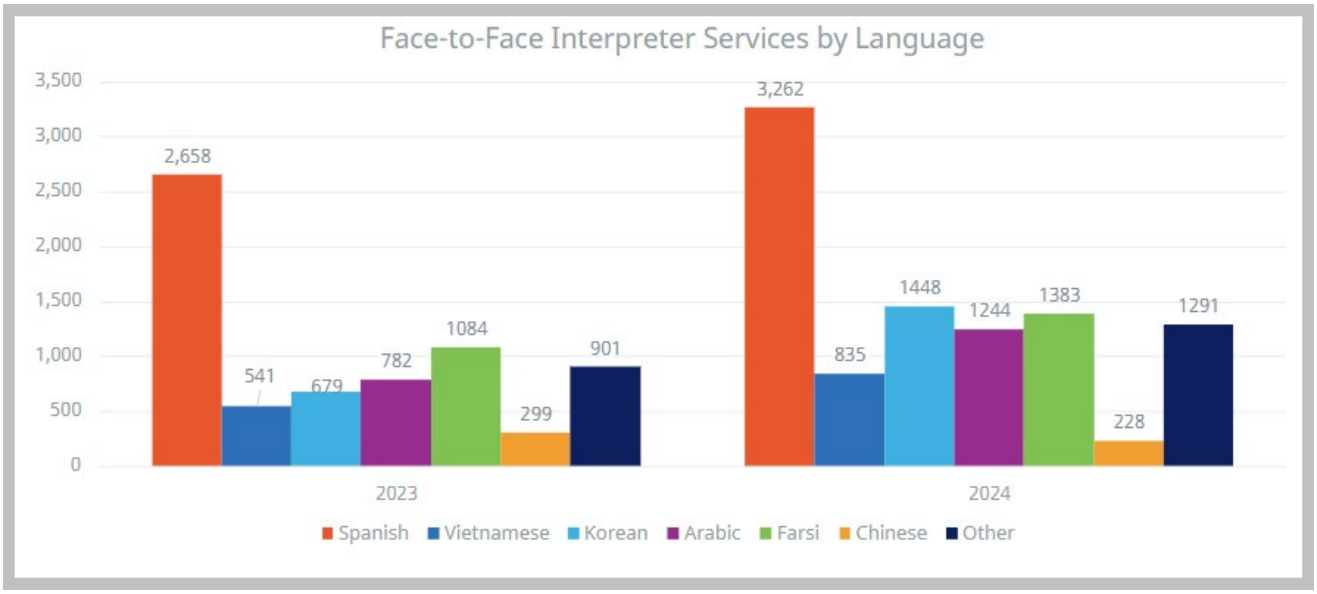
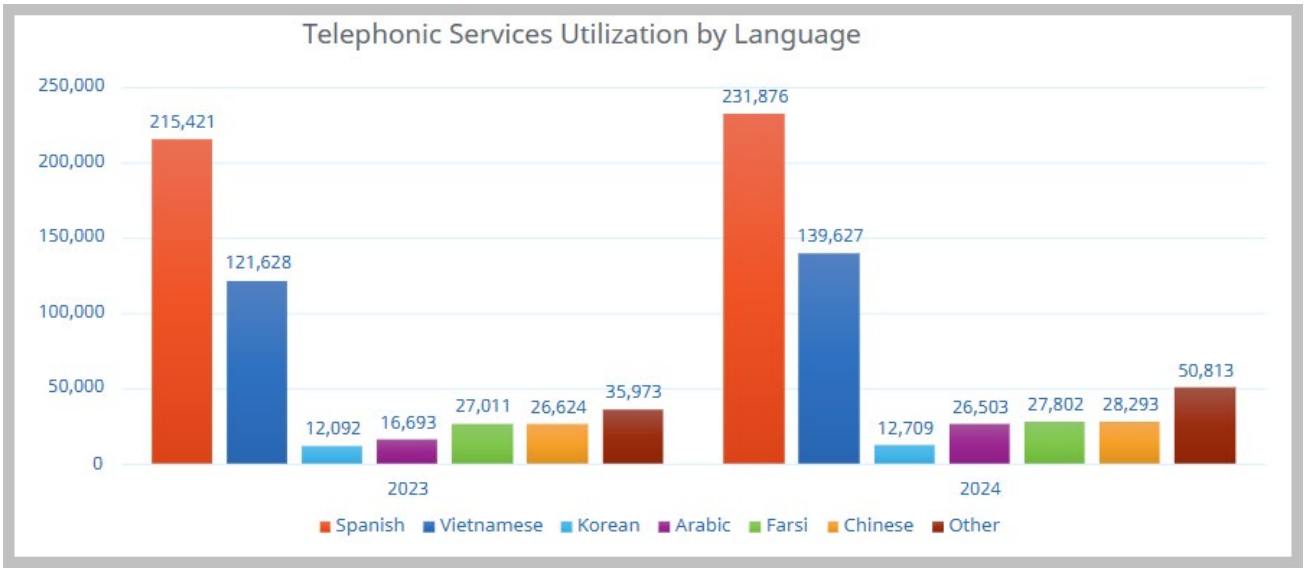
supervisor and a full-time coordinator to assist with the coordination and vending of the incoming translation workload.	• A new SharePoint work log was created for the Spanish team to distribute the workload amongst the Spanish translators. • Streamlined the Alternative Format Selection (Braille, Audio/Data files & Large Print materials) for the NOA process. • In 2025, C&L will establish a process to assist the Medicare Program Development department with a transcreation process.
Conclusion: The increase in utilization indicates there is increased member awareness of the availability of translations/interpreter services. CalOptima Health's C&L department will continue to ensure all members have access to translation services related to health care in CalOptima Health's threshold languages.	
Activities/Interventions to continue/add next year:	
• Continue to provide accessibility to translation services. • Implement new processes to make improvements and assist with the translation workflow for C&L.	

4.2 Interpreter Services	
Author: Carlos Soto/Albert Cardenas	Department: Cultural & Linguistic Services
Support Staff: Angelica Acosta (Dept. Sup.); C&L Interpreter Coordination Staff	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Monitor interpreter services utilization	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: • Track and trend interpreter and translation services utilization data and analysis for language needs. • Comply with regulatory standards, including Member Material requirements. • Maintain business for current programs. • Improve the process for handling these services.	
Status: ☐ Completed ☒ Ongoing	
Background: CalOptima Health recognizes that language misunderstandings and lack of cultural awareness can sometimes negatively affect communication during the process of receiving care. 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 access to interpretation services related to receiving health care in any language and American Sign Language.	
Methodology: To ensure members communicate clearly with CalOptima Health and health care providers in their preferred language, CalOptima Health's C&L staff assist members in obtaining an interpreter in their preferred language for their health care-related appointments. Interpreter requests from members via CalOptima Health staff are submitted through internal intake systems, K2 and Facets. CalOptima Health's C&L services staff book interpreters for members in any language, including American Sign Language.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Created a new vendor process for TeleMed2U, who will be submitting interpreter requests via email. • Beginning January 2025, C&L will begin booking interpreter requests for OC Liberty Dental members for face-to-face appointments.
Quarter 2:	• The C&L team received access to the interpreting vendor portals and began using the vendor for the overflow telephonic, face-to-face and VRI interpreter requests.

Quarter 3:	• Due to the influx of interpreter requests, existing C&L staff were cross trained to assist with the coordination of interpreter request processing.
Quarter 4:	• Created an internal process for C&L staff to submit issue notifications on behalf of members when grievances are brought to our attention. • Developed new Health Equity-related surveys to request feedback from members and CalOptima Health staff regarding their satisfaction with language access. The surveys will be launched in 2025.

Program Results:





The charts show the 2023–24 comparison of face-to-face (in-person) and telephonic utilization interpreter services. CalOptima Health threshold languages, Arabic, Chinese, Farsi, Korean, Spanish and Vietnamese, are the most used languages. Spanish and Vietnamese have the highest utilization.

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Analysis:

- All goals and objectives were met in 2024.
- Spanish had the highest increase in utilization followed by Vietnamese.
- All other languages also show an increase in utilization.
- There was a 28% increase in face-to-face interpreter services in 2024 compared with 2023.
- There was a12% increase in telephonic interpreter services in 2024 compared with 2023.

Identified Barriers:	Identified Opportunities for Improvement:
• Ensuring we were able to provide language interpreters in any language. • On occasion, we had trouble accessing Cambodian interpreters.	• We had discussions with our contracted vendors to ensure they can provide language interpreters in any language. • A couple of our contracted vendors onboarded more Cambodian interpreters to ensure this language will be properly covered going forward.

Conclusion:
The increase in utilization indicates there is increased awareness of the availability of interpreter services. CalOptima Health's C&L department will continue to ensure all members have access to interpreter services related to health care in CalOptima Health's threshold languages.

Activities/Interventions to continue/add next year:

- Continue to provide accessibility to different language interpreters for interpreter service requests.
- Implement new cross-training processes for C&L staff to coordinate interpreter requests.
- Hire an interpreter request coordinator to assist C&L staff in coordinating and booking interpreter requests.
  Monitor utilization and resources to ensure members are provided with timely language services.

4.3 Experience with Language Services Survey

Author: Albert Cardenas	Department: Cultural & Linguistic Services
Support Staff: Carlos Soto	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No

Work Plan Goal/Objective:

- Evaluate the language services experience of members and staff

Goal Met: ☐ Yes ☐ No ☒ Partial

Work Plan Planned 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.

Status: ☐ Completed ☒ Ongoing

Background:
The CLAS surveys were drafted and will be administered to CalOptima Health members and staff.

- A member survey will be mailed to all CalOptima Health members to assess members' satisfaction with language access.
- CalOptima Health staff will receive a staff survey to evaluate members' satisfaction with language access.

Methodology:
The CLAS surveys will be conducted with CalOptima Health members and staff, as per the following:

- A member survey will be mailed to all CalOptima Health members.
- A staff survey will be sent to CalOptima Health staff through an internal process or email.

Actions/Interventions Implemented in 2024:

Quarter 1:	• None
Quarter 2:	• None
Quarter 3:	• Surveys drafted, reviewed and approved by contracted consultants.

Quarter 4:	• The staff survey is currently being reviewed through the Member Material Approval Process (MMA) and DHCS. Once approved, it will be sent to the Communications department to be designed by CalOptima Health graphic designers. • The member survey is currently being designed by CalOptima Health designers in the Communications department. • Both surveys will be sent out in early 2025.

Program Results:

Analysis:
- This goal was not completed in 2024 and will carry over to the 2025 goals. Once the surveys are launched in Q1 2025, analysis will be conducted.

Identified Barriers:	Identified Opportunities for Improvement:
• No barriers identified	• To be determined

Conclusion:
The conclusion will be summarized and added to this section once the survey responses are received.

Activities/Interventions to continue/add next year:
- Implement surveys in Q1 2025.
- Collect and analyze data.

Section 5: Data Collection and Analysis

5.1 Collecting CLAS Member Data	
Author: Albert Cardenas	Department: Cultural & Linguistic Services
Support Staff: Anita Garcia	
Work Plan Element: Data Collection on Member Demographic Information	
Products: ☐ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☐ No
Work Plan Goal/Objective: Implement a process to collect member SOGI data by December 1, 2024.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: 1) Develop and implement a survey to collect the member's SOGI information from members (18+ years of age). 2) Update CalOptima Health's Core eligibility system to store SOGI data. 4) Develop and implement a survey via the Member Portal, mail to new members and other methods. 5) Collect (REL data 6) Share member demographic information with practitioners.	
Status: ☐ Completed ☒ Ongoing	
Background: The collection of SOGI data is a National Committee for Quality Assurance (NCQA) Health Equity Accreditation requirement and was implemented in Q3 2024.	
Methodology: CalOptima Health staff followed the 2024 NCQA Health Equity Accreditation Standards and Guidelines when implementing the CLAS Program goals and monitored progress against CLAS goals. Quarterly, dedicated staff from C&L, in collaboration with multidisciplinary work teams throughout the organization, collect and track indicators and activities specific to CLAS goals, outcomes and outputs.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• The HE2 workgroup began the development of a survey to collect SOGI data.
Quarter 2:	• Received approval of SOGI survey from DHCS. • Updated CalOptima Health's Core eligibility system to store SOGI data. • Developed member mailing (survey) packets.
Quarter 3:	• Implemented the mailing of the SOGI survey to new CalOptima Health members (18+ years of age).
Quarter 4:	• Implemented the SOGI survey in the Member Portal.
Program Results:	
Successfully implemented the process of collecting SOGI data.	
Analysis: CalOptima Health collects REL data via the state daily/monthly eligibility files, through member surveys, and member interaction with CalOptima Health staff. CalOptima Health meets the NCQA Health Equity requirement of 80% for REL data. CalOptima Health shares REL data with practitioners via the Provider Portal and the daily eligibility files sent to the contracted health networks. There is currently no NCQA Health Equity Accreditation percentage requirement for SOGI data. Analysis is pending.	
Identified Barriers:	Identified Opportunities for Improvement:

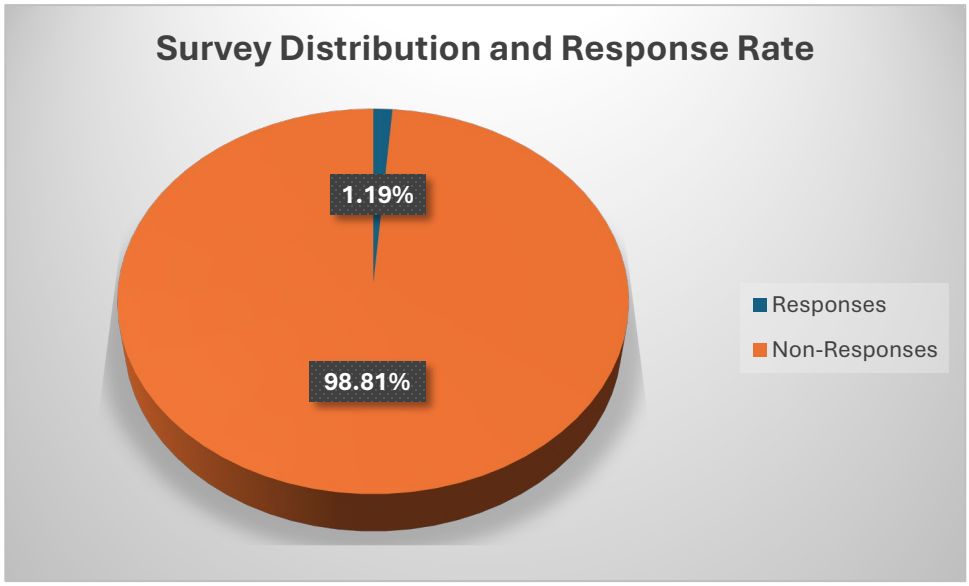
• Low response rate from members (5%).	• Expand the survey collection efforts by including existing members. • Adding additional methods such as texting campaigns and through customer service member interactions.
Conclusion: Although the implementation of collecting SOGI data was successful, the return rate is low, so additional efforts will be made in 2025 to increase it.	
Activities/Interventions to continue/add next year:	
• Expand the collection efforts of SOGI data. • Explore other methods of collecting SOGI data.	

5.2 Collecting CLAS Provider Data

Author: Quynh Nguyen	Department: Provider Data Operations
Support Staff: Linda Huynh	
Work Plan Element: Data Collection on Practitioner Demographic Information	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☒ Yes ☐ No
Work Plan Goal/Objective: Implement a process to collect practitioner REL data by December 31, 2024.	
Goal Met: ☐ Yes ☐ No ☒ Partial	
Work Plan Planned Activities: 1) Develop and implement a survey to collect practitioner REL data. 2) Enter REL data into the provider data system and ensure the ability to retrieve and utilize it for CLAS improvement. 3) Complete an analysis of the provider network capacity to meet language needs of the CalOptima Health membership. 4) Assess the provider network's capacity to meet CalOptima Health's culturally diverse member needs. 5) Collaborate with other participating CalOptima Health departments to share SOGI data with the health networks.	
Status: ☐ Completed ☒ Ongoing	
Background: The initiative seeks to enhance CalOptima Health's ability to address the cultural and linguistic needs of its diverse membership by the collection efforts of race/ethnicity and language data from providers. Implementation will occur through ongoing updates to provider forms, including the Provider Satisfaction Survey.	
Methodology: CalOptima Health conducted a Provider Satisfaction Survey to assess provider experiences, including questions related to REL. The survey was distributed to 2,272 health care providers via e-mail. A total of 30 responses were received, 27 responded to the REL questions resulting in a response rate of 1.19%. The survey was designed to gather feedback on various aspects of provider satisfaction, including the REL questions. Once the data was gathered, Provider Relations sent it to Provider Data Operations, where the information was added to the system (Facets).	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• N/A
Quarter 2:	•
Quarter 3:	• Provider Satisfaction Survey questions to include REL questions. • The survey was sent to providers via email. Reminders were sent every two weeks. A Provider Relations Representative reached out to providers to administer the survey through email/telephone interactions and during office visits. Additional efforts were made to collect survey responses during CCN Lunch & Learn in September. Provider Data Management Service coordinators entered REL data into the provider data system (Facets).
Quarter 4:	• Email reminders were sent to providers every two weeks. Provider Relations Representatives reminded providers about the survey through email/telephone interactions

	and during office visits. Additional efforts were made during CCN Lunch & Learn in October and November Provider Update alerts. Provider Data Management Service coordinators entered REL data into the provider data system (Facets). Provider Satisfaction Survey initiative completed 11/15/2024.

Program Results:



Provider Satisfaction Survey: 98.81% Non-Responses and 1.19% Responses

Quantitative Analysis:
Since the survey focuses on provider satisfaction and includes REL-related questions, satisfaction levels or metrics would typically be compared to past surveys. However, no historical data or baseline is provided, so only the response rate of 1.19% can be evaluated. Given that this is generally considered very low, it's likely that the response rate has decreased compared with previous efforts with higher engagement. While the data was collected and processed, the low response rate raises concerns about its representativeness and actionability, potentially limiting its value for drawing meaningful conclusions.

Identified Barriers:	Identified Opportunities for Improvement:
• • Providers' offices likely had competing priorities during the survey period, which may have impacted on their capacity and willingness to participate in non-urgent surveys. • The survey included over 20 questions, which may have been seen as time-consuming or burdensome. • Providers' offices may have been overwhelmed by multiple feedback requests from various organizations, leading to fatigue and lower response rates. • Lack of Incentive for survey completion.	• Offering a shorter, more focused survey could lead to better engagement, especially if it's framed as quick and easy to complete. • Offering incentives, such as professional development credits or public recognition, may encourage providers to take the time to participate. • To increase provider participation, incorporate key questions into standard forms or other mandatory reporting documents. This integration could be done as part of regular credentialing or quality reporting processes, ensuring higher response rates with minimal disruption to providers' workflow.

Conclusion:
The Provider Satisfaction Survey conducted by CalOptima Health, with a response rate of 1.19%, highlights key challenges, such as survey length and competing demands on providers' time. These challenges offer clear opportunities to improve data collection efforts in the future. By shortening the survey, and using multiple communication channels, CalOptima Health can increase participation rates. Additionally, integrating REL

questions into annual forms or other reporting processes can streamline data collection and reduce provider burden.
Activities/Interventions to continue/add next year:
• Adjust Timing: Conduct the survey earlier in the year, avoiding the busy end-of-year period, to reduce provider fatigue and ensure more timely responses. • Shorten Survey Length: Streamline the survey to focus on key areas only, such as REL, to make it more manageable and less time-consuming for providers. • Incentives and Recognition: Introduce incentives such as gift cards, professional development credits or public recognition to motivate providers to complete the survey. Clear communication about how feedback will be used to make improvements could also encourage participation. • Integrate Questions into Forms: Include key survey questions, especially those related to REL, within required attestation forms or other routine reporting processes as an example. This will streamline data collection and reduce provider burden.

Section 6: Trainings

6.1 Cultural Competency and Training	
Author: Carlos Soto	Department: Cultural & Linguistic Services
Support Staff: Carlos Soto	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Goal/Objective: • Conduct a cultural competency training	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: • Conduct cultural competency training in 2024	
Status: ☐ Completed ☒ Ongoing	
Background: Cultural Competency: The NET1A Report C&L outlines Cultural Competency details. Training: C&L currently presents a cultural and linguistic overview during the monthly Bootcamp training. C&L also provides in-service training to staff at different CalOptima Health departments. 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.	
Methodology: HR conducts cultural competency training for the entire CalOptima Health staff. Provider Relations department conducts provider office staff training. Training: Bootcamp training is done monthly, as requested by Human Resources. The Bootcamp presentations are rotated among the C&L manager and C&L staff. C&L conducts in-service training for CalOptima Health staff with different CalOptima Health departments, as requested.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Held three Bootcamp presentations and two in-service trainings. • Cultural Competency training for CalOptima Health staff and provider office staff
Quarter 2:	• Held three Bootcamp presentations. • Cultural Competency training for CalOptima Health staff and provider office staff
Quarter 3:	• Held three Bootcamp presentations. • Cultural Competency training for CalOptima Health staff and provider office staff
Quarter 4:	• Held two Bootcamp presentations. • Cultural Competency training for CalOptima Health staff and provider office staff
Program Results:	

Quantitative Analysis:
 	
• The NET1A Report includes information on Cultural Competency trainings completed in 2024 by CalOptima Health staff and providers.
• Bootcamp training courses were completed every quarter in 2024, as scheduled by Human Resources.
• The C&L manager lead two in-service training courses for CalOptima Health Customer Service staff at the beginning of 2024.
• Cultural Competency training completed in 2024:
  ○ CalOptima Health Employees: 1,742
  ○ Provider Office Staff: 9,724	

Identified Barriers:	Identified Opportunities for Improvement:

• None.	• Continue C&L services bootcamp trainings.. • Continue in-service trainings for CalOptma Health Customer Service staff and other departments

Conclusion:
- Monthly Bootcamp training courses and in-service training courses for CalOptima Health Customer Service staff were completed in 2024.
- Cultural Competency training throughout the year for new and existing CalOptima Health staff and provider office staff.

Activities/Interventions to continue/add next year:
- Continue to present at Bootcamp training courses and in-service training courses for CalOptima Health Customer Service staff in 2025.
- Diversity Equity and Inclusion (DEI) training.
- Cultural Competency Training for CalOptima Health staff and office provider staff.

6.2 Diversity, Equity and Inclusion Training

Author: Dr. Michaell Rose	Department: Equity and Community Health
Support Staff: Greta Rice; Adriana Ramos	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☒ Yes ☐ No
Work Plan Goal/Objective: *DHCS mandated training from APL24-016*	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: Creation of staff and provider DEI training and submission to DHCS.	
Status: ☐ Completed ☒ Ongoing	

Background: DHCS has a vision to advance health equity for Medi-Cal members. The managed care plan (MCP) DEI training program will support creating a better relationship and connectivity with diverse MCP members across populations disadvantaged by the system. Additionally, trainings can create an inclusive environment within the MCP organization and externally with health network providers and other community-based contractors and staff, thereby improving members' outcomes by enhancing access to care, reducing health disparities and improving overall quality of care.

Methodology:
Medi-Cal MCPs are required to develop a DEI training program encompassing the requirements in APL 24-016 that will be launched to staff and providers in 2025.
Chief Health Equity Officer created a DEI Training policy based on the APL requirements that was approved at the December 2024 Board meeting..

Actions/Interventions Implemented in 2024:

Quarter 1:	• Released RFP for a vendor to develop the DEI Training Program.
Quarter 2:	• Contracted with vendor; gathered staff, provider and community feedback.
Quarter 3:	• Developed the DEI Training Program.
Quarter 4:	• Finalized the DEI Training Program and submitted to DHCS.

Program Results:
- No data since the DEI Training Program will be launched to staff and providers in 2025.

Identified Barriers:	Identified Opportunities for Improvement:
• None	• None

Conclusion
No data is available at this time.

Activities/Interventions to continue/add next year:
- Incorporate DHCS feedback, pilot DEI Training Program and launch official training.

Section 7: Promotion of Diversity

7.1 Staff, Leadership and Committee Hiring and Recruiting Practices	
Author: Michael Coringrato/Marsha Choo	Department: Human Resources/Quality Improvement
Support Staff: Ravi Hayashida/Glora Garcia	
Products: ☐ Medi-Cal ☐ OneCare	New Activity: ☒ Yes ☐ No
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	
Work Plan Planned Activities: Develop and launch surveys of all CalOptima Health staff and QIHEC participants to determine perceptions of current DEI support environment within the organization. Surveys will be sent to more than 1,600 people. The expected response rate is unknown. Subsequently, data will be used to determine the effectiveness of activities developed to improve identified opportunities.	
Status: ☐ Completed ☒ Ongoing	
Background: CalOptima Health is seeking NCQA Health Plan Accreditation, as required by DHCS. The organization also recognizes the opportunity to identify where the DEI environment in the workplace is healthy and where it can be improved. The HE1 workgroup has met since May 2024 to identify current policies and procedures relating to overall Hiring and Recruiting practices that support the DEI work environment. Further, the workgroup is developing surveys to gather data from internal staff and leadership, as well as participants within CalOptima Health's QIHEC committees and sub-committees. This is a first-of-its-kind survey that is scheduled to launch in Q4 2024. The HE1 workgroup plans to collect and analyze the data in January 2025 to determine areas of opportunity and develop action plans to seek improvement where applicable.	
Methodology: 1) The workgroup analyzed statements and results from the 2024 Great Places to Work Survey. Initial analysis and feedback from a consultant for NCQA Health Equity Accreditation determined the statements were too broad to create actionable items to address perceptions relating to the DEI environment. 2) The consultant provided example questions that the workgroup customized for CalOptima Health staff and committee participants. 3) The survey was split into two sections: Perceptions of DEI environment and Demographics. 4) The survey was hosted on HR Survey Monkey and the team is using Survey Monkey analytics to collect data and reports. 5) Communication plan includes Chief-level review, announcements via All Staff meeting, email and internal meeting announcements 6) Staff/Leadership survey was sent to about 1,600 employees; Committee survey was sent to 149 participants 7) The Survey period was between Monday December 16, 2024, and Friday January 10th, 2025. Holidays were considered while setting this response period. 8) NCQA target response rate is not specified, but the best practice is to seek at least 15%. Staff/Leadership Survey response reached about a 38% Response Rate; Committee Survey attained 34% Response Rate.	
Actions/Interventions Implemented in 2024:	
Quarter 1:	• Organization identified stakeholders for executing the project to achieve NCQA Health Equity Accreditation.
Quarter 2:	• Workgroups held kickoff meetings. • HE1 workgroup met to identify relevant policies and available data.
Quarter 3:	• HE1 workgroup analyzed Best Places to Work survey statements and results. • Obtained survey question examples from the consultant. • Drafted surveys and conducted multiple reviews. • Surveys focused on staff/leadership and committees. Determined Governance Body survey may be subject to exemption.

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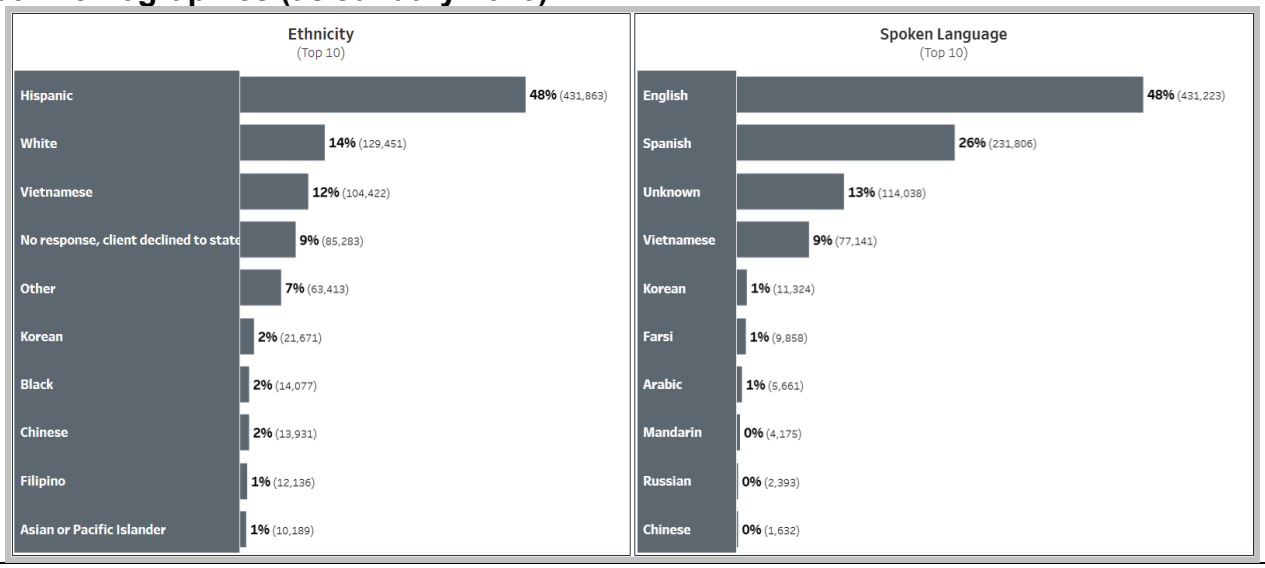
<table>
<tr><td>Quarter 4:</td><td>• Legal review
• Chief-level review and feedback
• Communications review completed December 12, 2024
• Communication to Committees of the upcoming survey
• Surveys were launched December 16, 2024.</td></tr>
<tr><td colspan="2">Program Results:</td></tr>
<tr><td colspan="2">Quantitative Analysis:
• 621 Staff / Leadership responses; 50 Committee responses.
• Analysis completion not expected until February 2025</td></tr>
<tr><td>Identified Barriers:
•
• None at this time.</td><td>Identified Opportunities for Improvement:
• Final results and analysis not expected until February 2025
• Preliminary analysis indicates possible communications opportunities
• Maintain roster of committee participants
• Establish and maintain annual process</td></tr>
<tr><td colspan="2">Conclusion: Staff were successful in fielding the survey. Response rate is encouraging. Further data analysis is needed to clearly identify opportunities for improvement.</td></tr>
<tr><td colspan="2">Activities/Interventions to continue/add next year:</td></tr>
<tr><td colspan="2">• Data analysis of survey data collected.
• Identify opportunities for DEI improvement.</td></tr>
</table>

Section 8: Practitioner Network Cultural Responsiveness

8.1 Member Demographics	
Author: Carlos Soto, Albert Cardenas	Department: Customer Service/Cultural & Linguistic Services
Support Staff:	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: • Implement a process to collect member SOGI data by December 31, 2024.	
Goal Met: ☒ Yes ☐ No ☐ Partial	
Work Plan Planned Activities: 1) Develop and implement a survey to collect the member's SOGI information from members (18+ years of age). 2) Update CalOptima Health's Core eligibility system to store SOGI data. 3) Collaborate with other participating CalOptima Health departments to share SOGI data with the health networks. 4) Develop and implement a survey to distribute during the monthly New Member Orientation sessions. 5) Collect REL data. 6) Share member demographic information with practitioners.	
Status: ☐ Completed ☒ Ongoing	
Background: CalOptima Health staff followed the 2024 Health Equity Standards and Guidelines when implementing the CLAS Program goals and monitored progress against CLAS goals. Quarterly, dedicated staff from C&L, in collaboration with multidisciplinary work teams throughout the organization, collect and track indicators and activities specific to CLAS goals, outcomes and outputs. **Member Demographics (as January 2025)**  	

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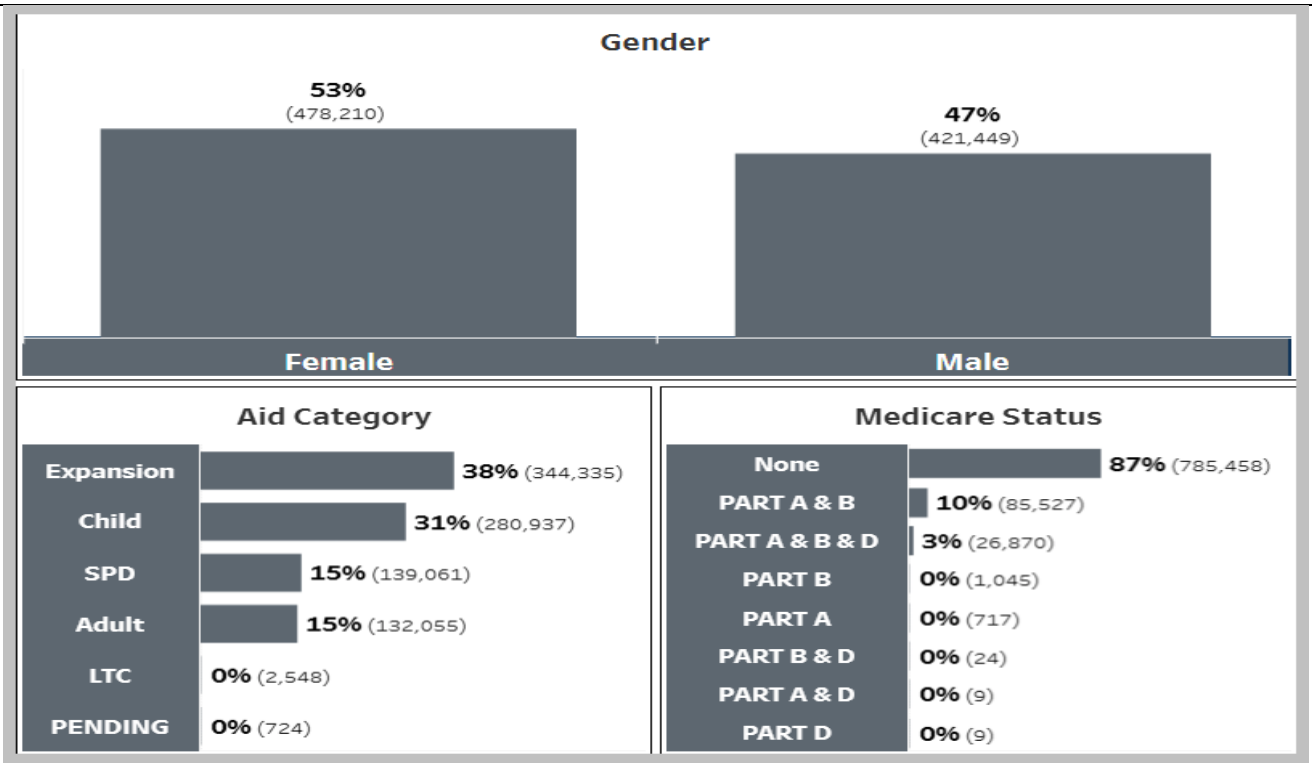

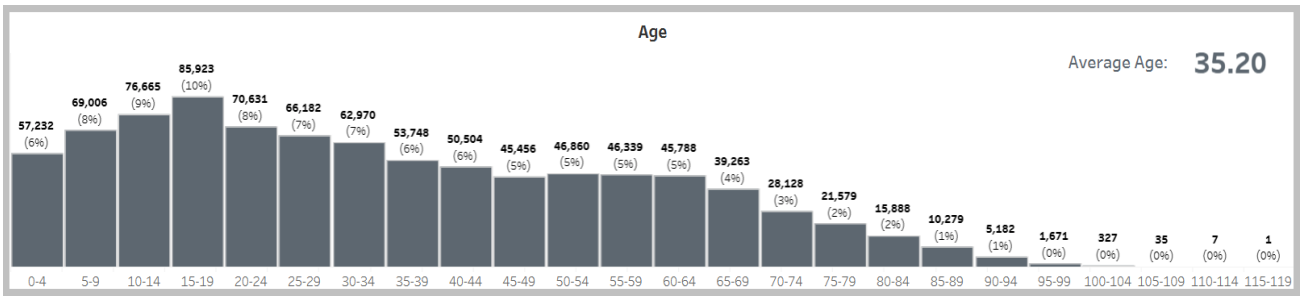

Actions/Interventions Implemented in 2024:	
Quarter 1:	• HE2 workgroup began development of survey to collect SOGI data. • Collection of REL data via the state daily/monthly eligibility files, through member surveys and member interaction with CalOptima Health staff.
Quarter 2:	• Received approval of SOGI survey from DHCS. • Updated CalOptima Health's Core eligibility system to store SOGI data. • Developed member mailing (survey) packets.
Quarter 3:	• Implemented the mailing of the SOGI survey to new CalOptima Health members (18+ years of age). • Collection of REL data via the state daily/monthly eligibility files, through member surveys and member interaction with CalOptima Health staff.
Quarter 4:	• Implemented the SOGI survey in the Member Portal. • Collection of REL data via the state daily/monthly eligibility files, through member surveys, and member interaction with CalOptima Health staff.

Analysis:
CalOptima Health collects REL information via the state daily/monthly eligibility files, through member surveys and member interaction with CalOptima Health staff. CalOptima Health meets the Health Equity requirement of 80% for REL data.
CalOptima shares REL data with practitioners via the Provider Portal and the daily eligibility files sent to the contracted health networks.

There is currently no Health Equity percentage requirement for SOGI data.

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Identified Barriers:	Identified Opportunities for Improvement:
• Low response rate from members (5%).	• Expand the survey collection efforts by including existing members. • Adding additional methods such as texting campaigns and through customer service member interactions.
Conclusion: Although the implementation of collecting SOGI data was successful, the return rate is low, so additional efforts will be made in 2025 to increase member response.	
Activities/Interventions to continue/add next year:	
• Expand the collection efforts of SOGI data. • Explore other methods of collecting SOGI data.	

8.2 Enhancing Network Responsiveness

Author: Carlos Soto	Department: Cultural & Linguistic Services
Support Staff: Carlos Soto	
Products: ☒ Medi-Cal ☒ OneCare	New Activity: ☐ Yes ☒ No

Work Plan Goal/Objective:
- Analyze CalOptima Health's provider network and its ability to address members' cultural and linguistic needs.

Goal Met: ☒ Yes ☐ No ☐ Partial

Work Plan Planned Activities:
- Conduct an analysis on CalOptima Health's provider network and their ability to address members' cultural and linguistic needs.

Status: ☐ Completed ☒ Ongoing

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

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

Membership Data (as of January 2025)

Methodology:
CalOptima Health provides the Medi-Cal, OneCare and PACE programs and collaborates with partnering Orange County providers who assist in delivering access to quality care, treatment, diagnoses and medical history in the member's language.

Actions/Interventions Implemented in 2024:

Quarter 1:	• CalOptima Health continues to collaborate with partnering Orange County providers in assisting and delivering access to quality care, treatment, diagnoses and medical history for members in the member's language.
Quarter 2:	• CalOptima Health continues to collaborate with partnering Orange County providers in assisting and delivering access to quality care, treatment, diagnoses and medical history for members in the member's language. • C&L staff held meetings with health networks' Cultural & Linguistics departments to review their process to ensure the health networks have the staff and resources to address members' cultural and linguistic needs. • Provider Relations staff developed a provider satisfaction survey to collect practitioner REL data.
Quarter 3:	• CalOptima Health continues to collaborate with partnering Orange County providers in assisting and delivering access to quality care, treatment, diagnoses and medical history for members in the member's language. • C&L staff held meetings with health networks' Cultural & Linguistics departments to review their process to ensure the health networks have the staff and resources to address members' cultural and linguistic needs. • Provider Relations staff launched the provider satisfaction survey.
Quarter 4:	• CalOptima Health continues to collaborate with partnering Orange County providers in assisting and delivering access to quality care, treatment, diagnoses and medical history for members in the member's language.

Analysis:

The C&L review of the health networks' C&L policies shows the networks have an established C&L process to address members' cultural and linguistic needs.

Identified Barriers:	Identified Opportunities for Improvement:
• Ensuring members had access to their health networks. • Ensure provider availability. • Ensure language interpreters assisted members in their language. • Low practitioner response rate to the provider satisfaction survey	• Continue to ensure providers are available for members. • Continue to ensure language interpreters are booked and attend members' appointments to help members in their language.

Conclusion:
The program appears to be successful, according to actions and interventions Implemented.

Activities/Interventions to continue/add next year:

- Continue to ensure members have access to their providers.
- Continue to ensure providers are available for members.
- Continue to ensure language interpreters are booked and attend members' appointments to help members in their language.
- Explore other methods to increase provider response rate.

Section 9: CLAS Improvement and Reduction in Health Care Inequities

9.1 Evaluate the PIP	
Author: Leslie Vasquez	Department: Quality Analytics
Support Staff: Kelli Glynn	
Work Plan Element: Performance Improvement Projects (PIPs) Medi-Cal	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☐ Yes ☒ No
Work Plan Goal/Objective: Increase well-child visit appointments for African American members (0–15 months) from 41.90% to 55.78% by 12/31/2024.	
Goal Met: ☐ Yes ☐ No ☒ Partial- 2024 final rates are still pending to confirm if goal was met	
Work Plan Planned Activities (From the QI Work Plan): Conduct quarterly/annual oversight of Medi-Cal PIPs (January 2023–December 2025): 1) Clinical PIP – Increasing W30 6+ measure rate among African American Population	
Status: ☐ Completed ☒ Ongoing	

Background:

The California 2020 Health Disparities Report identified disparities for most of the indicators of the Children's Health domain. Per this report, the Black/African American group fared lower than other groups across all six key indicators.

The PIP aims to reduce the racial/ethnic disparities in W30-6+ visits in support of the statewide goals. In alignment with the recommendations in the Health Equity Framework, this PIP will involve the African American population, the group most affected by health care disparities, through a survey call campaign to understand firsthand the experiences with well-child visits, the barriers and facilitators to attending well-child visits.

Well-child visits are the foundation of pediatric health promotion and disease prevention. These visits are intrinsically linked to the key indicators in the Children's Health domain. Accordingly, improving the W30-6 measure rate has the potential to improve member health status among these key indicators. Insight into the barriers to attending well-child visits has the potential to identify key areas that may improve member satisfaction across health care services.

PIP intends to address the following barriers to well-child visits:

- 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 primary care provider for African American child members

Methodology:

CalOptima Health followed HEDIS data collection methodology for the W30 – First 15 Months (non-continuous enrollment). CalOptima Health then identified child members identified as African American to monitor for rates.

Medi-Cal Results:

Chart A. Rates for W30- First 15 Months

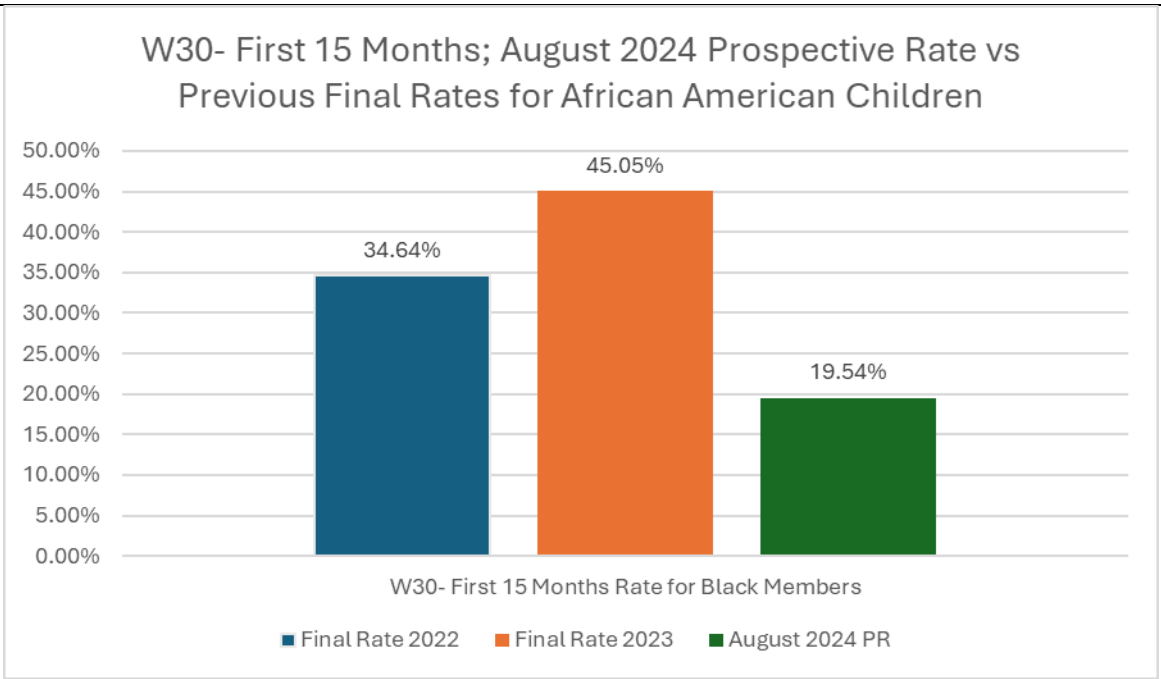

Chart A shows the final MY 2022 and MY 2023 W30-First 15 Months rates for African American child members compared with the most recent 2024 prospective rate. The performance improvement project is set for 2023–2026. As part of the process, the MY 2022 rate (34.64%) was used to confirm the population of interest — African American children — that would be targeted for the project. The chart demonstrates an increase in rates for MY 2023 compared with MY 2022. Final MY 2024 rates are pending; however, the rate (19.54%) of claims/encounters processed through August 2024 is shown.

Actions/Interventions Implemented in 2024:

Results:

- Final MY 2024 rates are pending; however, the rate (19.54%) of claims/encounters processed through August 2024 is shown in Chart A. Chart A depicts an increase in the W30 rate in MY2023, up from MY2022.

Quantitative Analysis:

- For the 2024 calendar year, 85 African American members were identified as needing to complete six or more well-child visits by 15 months of age. Staff successfully contacted 34 (40%) of parents/guardians, providing reminders to complete well-child visits and addressed gaps in knowledge about the importance and value of well-child visits.
- In an attempt to increase contact with members, letters were issued to the 51 parents/guardians who were unsuccessfully contacted telephonically.
- Appointment coordination was offered to all 34 parents/guardians of child members who were successfully reached. All 34 parents/guardians declined appointment coordination and refused support with appointment coordination for future well-child visits. This refusal may be driven by many reasons, including long call wait times, lack of urgency and competing priorities at the time the parent was called.
- 2024 rates have not been finalized; therefore, CalOptima cannot fully assess for the goal met.

Identified Barriers:	Identified Opportunities for Improvement:
• **Member Contact Information:** Member contact lists contain outdated or incorrect information, contributing to a high rate of unsuccessful outreach. Other issues include	• Opportunities to improve member contact information to maximize outreach. • Opportunities to partner with health networks to support care coordination for child members.

the inability to leave voicemails or parent/guardian refusal to take calls. • **Refusal or Low Parental Engagement**: As part of an attempt to increase contact with members, letters were issued to the 51 parents/guardians who were unsuccessfully contacted telephonically. Parents/guardians did not respond to the letter that was issued after unsuccessful telephonic outreach. This may be due to the plan's business hours that do not align with the parent's needs, privacy concerns, lack of time, demanding jobs, responsibilities or other commitments, lack of urgency, previous negative experiences or lack of trust between the plan and the child's family.	

Conclusion:

- There is an opportunity to continue to inform members about the importance and cadence of well-child visits and what makes each of these visits unique to support adherence. Education about these visits should begin as early as possible during the prenatal and postpartum timeframe.
- There is an opportunity for PCPs to revise their workflows to allow for the scheduling of the next well-child visit prior to the family leaving the existing visit.
- Members feel that they benefit when their child's assigned PCP has appointment availability that fits the parent's schedules. PCP offices should continue to implement reminders for these visits.
- There are opportunities to increase awareness of the Medi-Cal transportation benefit as well as inform parents of who the child's PCP is.

Activities/Interventions to continue/add next year:

- Efforts to include improved coordination with health networks to deliver care for African American child members.

9.2 PPC for Black and Native American

Author: Leslie Vasquez/Katie Balderas	Department: Quality Analytics
Support Staff: Kelli Glynn	
Work Plan Element: Maternity Care for Black and Native American Persons	
Products: ☒ Medi-Cal ☐ OneCare	New Activity: ☒ Yes ☐ No

Work Plan Goal/Objective:
1) PPC Postpartum: Increase timely PPC postpartum appointments for CalOptima Health's Black members from 67.48% to 74.74% and Native Americans from 44.44% to 63.22% by 12/31/24.
2) PPC Prenatal: Increase timely PPC prenatal appointments for CalOptima Health's Black members from 53.77% to 72.37% and Native Americans from 27.78% to 59.43% by 12/31/24.

Goal Met: ☐ Yes ☐ No ☒ Partial

Work Plan Planned Activities (From the QI Work Plan):
Assess and report on the following activities:
1) Determine the primary drivers of noncompliance via member outreach and literature review.
2) Targeted member engagement and outreach campaigns in coordination with health network partners.
3) Strategic Quality Initiatives Intervention Plan: Multimodal, omni-channel targeted member, provider and health network engagement and collaborative efforts.
4) Continue expansion of Bright Steps comprehensive maternal health program through community partnerships, provider/health network partnerships, and member engagement. Examples: WIC Coordination, Diaper Bank Events
5) Implement Collaborative Member Engagement Event with CAP OC Diaper Bank and other community-based partners.

6) Expand member engagement through direct services such as the doula benefit and educational classes.

Status: ☐ Completed ☒ Ongoing

Background:
In alignment with DHCS' 2025 Bold Goals for maternal health, this focus area aims to improve timely prenatal and postpartum care for CalOptima Health's Black and Native American members. The initiative seeks to increase prenatal and postpartum care appointment adherence through targeted outreach, member engagement and enhanced provider partnerships. Key strategies include identifying barriers to care, implementing data-driven interventions, expanding community-based programs such as the Bright Steps maternal health program, and leveraging benefits like doulas and educational services. Collaborative efforts with community organizations, including WIC and diaper bank events, are central to achieving equitable maternal health outcomes.

Methodology:
CalOptima Health follows the HEDIS data collection methodology to identify members that are part of the prenatal and postpartum care measure denominator. CalOptima Health proceeds to stratify the data by race/ethnicity to identify performance for Black and Native American members.

Actions/Interventions Implemented in 2024:
Given that this was a new goal for the CLAS Program in 2024, many of the efforts were focused on laying the foundation for collaboration and process improvements. Activities completed in 2024 include:

- Review and analysis of Birth Equity Population of Focus, which includes Black and Native American Pregnant Persons
- Collaboration and relationship-building with local partners and providers, including the Orange County Health Care Agency, First Five Orange County, Orange County's new Black Infant Health (BIH) Program (led by Breastfeed LA), Black PEARL (Promoting Equity, Anti-Racism, and Love), Model for Systemic Integration of Community Maternal Support Services (COMSS), MOMS Orange County, and others.
- Piloted a focused outreach call and mailing campaign to promote Enhanced Care Management (ECM), doula and BIH services (as appropriate) to members in the population of focus.

Results:

The outreach campaign piloted in Q4 2024 focused on Black and Native American members identified in the ECM Birth Equity Population of Focus. Members were called and offered information about ECM, doula services and the BIH program.

Intervention	Numerator	Denominator	Percent
Telephonic outreach to promote ECM, doula and BIH	24	183	13%
Member mailed materials on ECM, doula and BIH	169	183	92%

Identified Barriers:	Identified Opportunities for Improvement:
• Many members cannot be contacted over the phone or by mail due to a lack of updated contact information/addresses in the system or because they are not available to answer the phone. • Many services that are culturally tailored for Black and Native members, including doula, ECM and BIH, are newer. The provider network and programming are still in the process of being developed.	• Develop multimodal outreach strategies for the population(s) of focus, including text, email, community events, group classes and social media. • Continue to participate in the Orange County Perinatal Council's workgroup on health equity to engage with partners around program enhancements and foster stronger relationships and coordination for members.

Conclusion: Because efforts to pilot interventions were started in Q4 2024, additional work is needed to determine the success of various outreach efforts.

Activities/Interventions to continue/add next year:

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- Ensure a strong continuum of culturally relevant care for Black and Native members through continued collaboration with CalAIM providers to support provision of ECM, and Doulas and referrals to community organizations such as BIH
- Focused maternal health community events to meet members where they are and foster connection

2025 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

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

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2025 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:

_____ _____

Isabel Becerra **Date**

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CalOptima Health Overview

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

Our Mission

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

Our Vision

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

Our Values

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

Our Strategic Plan

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

The five Strategic Priorities and Objectives are:

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

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

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

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

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

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

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

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

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

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

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

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

Quality Strategy Goals

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

Quality Strategy Guiding Principles

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

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

Bold Goals: 50x2025:

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

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

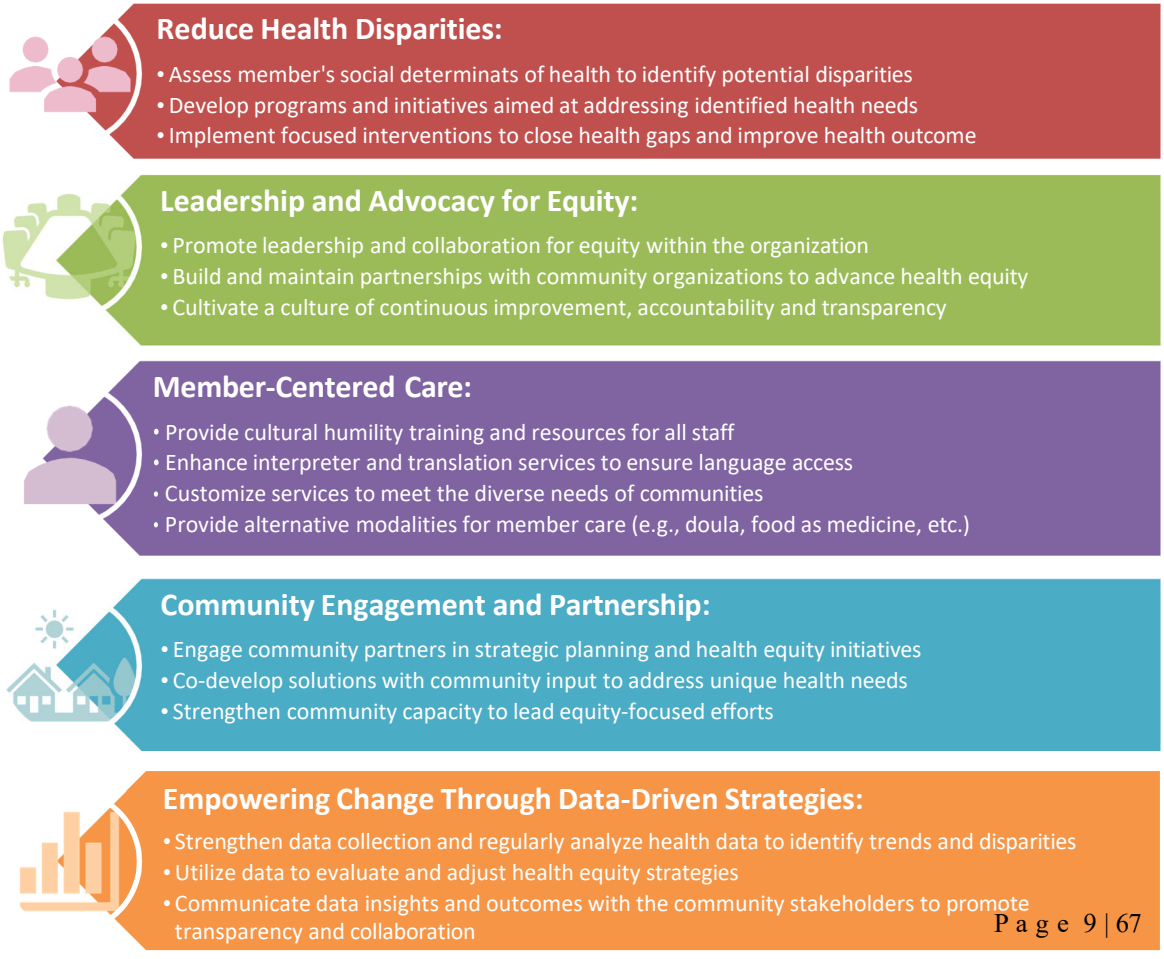
- Data collection and stratification
- Workforce diversity and cultural responsiveness
- Reducing health care disparities

Health Equity Framework

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

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

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



Program Structure

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

Medi-Cal

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

Scope of Services

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

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

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

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

Members With Special Health Care Needs

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

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

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

Medi-Cal Managed Long-Term Services and Supports

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

These integrated LTSS benefits include the following programs:

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

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

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

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

OneCare (HMO D-SNP)

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

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

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

Scope of Services

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

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

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

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

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

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

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

8. Hospital care and emergency services

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

Provider Partners

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

CalOptima Health Direct (COD)

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

CalOptima Health Direct-Administrative (COD-A)

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

CalOptima Health Community Network (CHCN)

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

CalOptima Health Contracted Health Networks

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

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

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

CalOptima Health contracts with the following:

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

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

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

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

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

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

Membership Demographics

Membership Data* (as of October 31, 2024)

Total CalOptima Health Membership

910,063

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

*Based on unaudited financial report and includes prior period adjustment

Membership Demographics (as of October 31, 2024)

Member Age		Language Preference		Medi-Cal Aid Category	
0 to 5	8%	English	54%	Temporary Assistance for Needy Families	37%
6 to 18	23%	Spanish	31%	Expansion	38%
19 to 44	35%	Vietnamese	10%	Optional Targeted Low-Income Children	8%
45 to 64	20%	Other	2%	Seniors	11%

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

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

Quality Improvement and Health Equity Transformation Program (QIHETP)

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

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

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

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

Quality Improvement and Health Equity Transformation Program (QIHETP) Purpose

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Authority and Accountability

Board of Directors

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

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

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

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

Board of Directors' Quality Assurance Committee

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

Member Advisory Committee

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

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

The MAC membership includes representatives from the following constituencies:

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

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

Provider Advisory Committee

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

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

Whole-Child Model Family Advisory Committee

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

The WCM FAC includes the following 11 voting seats:

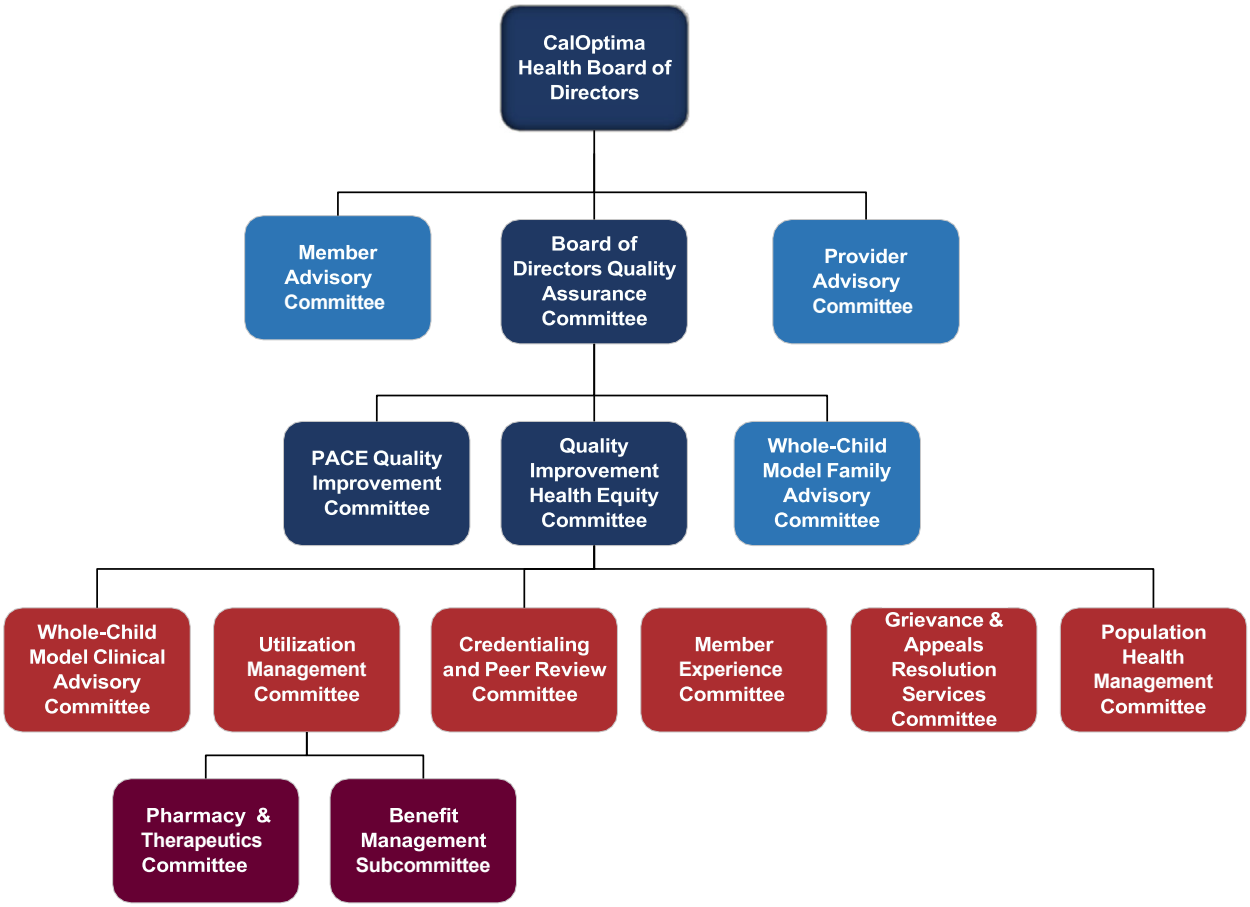
- Family representatives (nine seats)
    - Authorized representatives, which includes parents, foster parents and caregivers of a CalOptima Health member who is a current recipient of CCS services; or
    - CalOptima Health members ages 18–21 who are current recipients of CCS services; or
    - Current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

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

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

Quality Improvement and Health Equity Transformation Program Committee Structure

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



Quality Improvement Health Equity Committee (QIHEC)

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

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

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

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

Responsibilities of the QIHEC include:

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

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

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

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

Voting Members

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

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

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

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

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

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

Quorum

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

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

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

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

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

Minutes of the QIHEC and Subcommittees

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

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

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

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

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

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

Credentialing and Peer Review Committee (CPRC)

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

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

Utilization Management Committee (UMC)

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

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

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

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

Pharmacy & Therapeutics Committee (P&T)

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

Benefit Management Subcommittee (BMSC)

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

Whole-Child Model Clinical Advisory Committee (WCM CAC)

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

Member Experience Committee (MEMX)

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

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

Grievance and Appeals Resolution Services (GARS) Committee

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

Population Health Management Committee (PHMC)

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

Confidentiality

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

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

Conflicts of Interest

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

2025 Quality Improvement and Health Equity Priority Areas and Goals

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

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

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

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

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

Quality Improvement and Health Equity Transformation Program Work Plan

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

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

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

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

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

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

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

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

Quality Improvement and Health Equity Projects

QIHE Project Selection and Focus Areas

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

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

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

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

- Access to and provision of preventive services

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

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

QIHE Project Measurement Methodology

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

QI Projects shall include the following:

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

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

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

Plan 1) Identify opportunities for improvement
2) Define baseline

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

Do 5) Communicate change plan
6) Implement change plan

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

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

Types of QIHE Projects

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

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

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

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

Improvement Standards

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

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

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

Documentation of QIHE Projects

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

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

Communication of QIHE Activities

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

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

Quality Improvement and Health Equity Program Evaluation

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

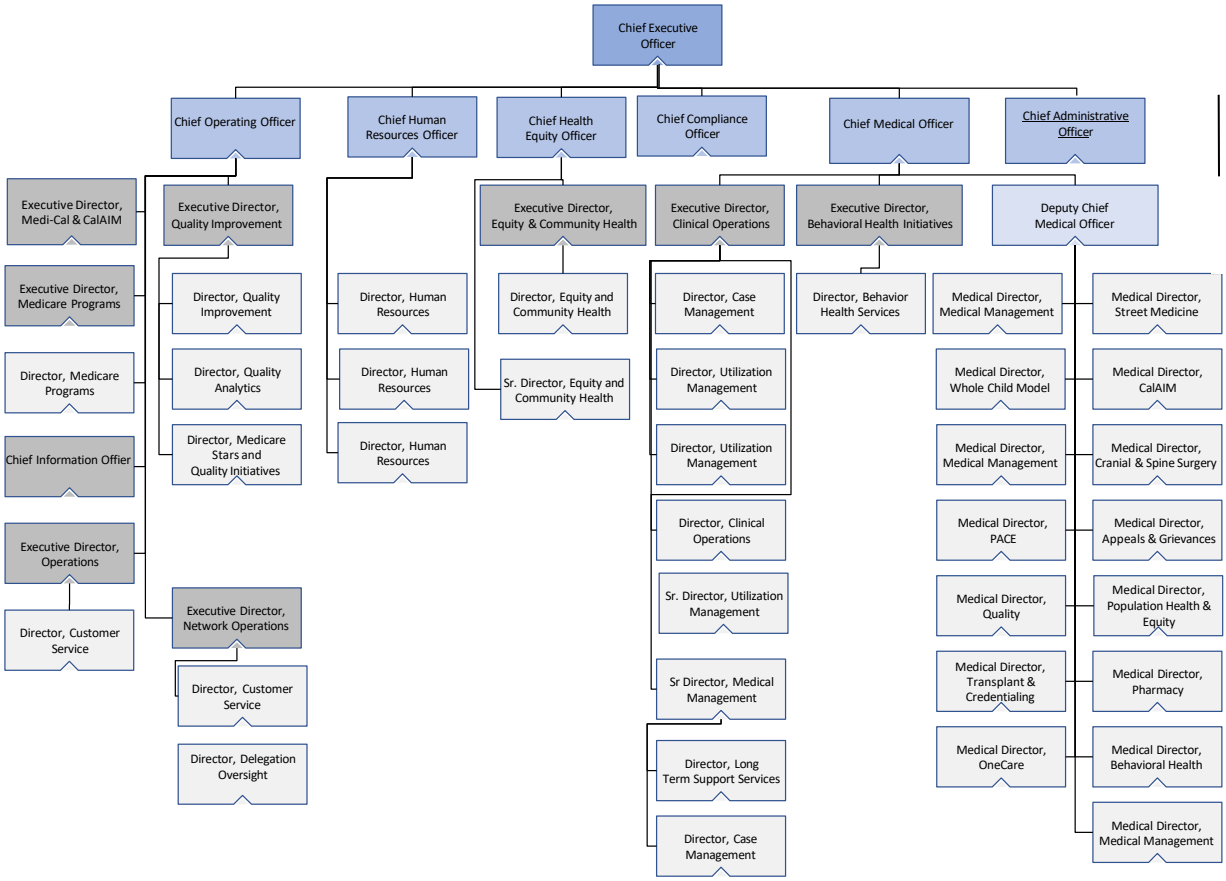
- A description of completed and ongoing QIHE activities that address the quality and safety of clinical care and quality of services, including the achievement or progress toward goals, as outlined in the QIHETP Work Plan, and identification of opportunities for improvement.
- Trending of measures to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

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

Quality Improvement and Health Equity Transformation Program Organizational Structure

Quality Program Organizational Chart — Diagram

As of December 2024



Rev. 3/12/2025

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

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Quality Improvement and Health Equity Transformation Program Organizational Structure

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Quality Improvement and Health Equity Program Resources

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

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

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

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

The following positions report to the Director, Quality Improvement:

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

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

The following positions report to the Director, Quality Analytics:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Staff Orientation, Training and Education

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

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

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

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

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

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

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

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

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

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

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

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

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

Administrative oversight:

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

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

Quality Improvement

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

QI department activities include:

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

Peer Review Process for Potential Quality Issues

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

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

Comprehensive Credentialing Program

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

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

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

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

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

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

Facility Site Review, Medical Record and Physical Accessibility Review

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

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

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

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

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

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

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

Medical Record Documentation

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

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

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

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

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

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

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

National Committee for Quality Assurance (NCQA) Accreditation

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

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

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

Quality Analytics

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

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

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

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

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

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

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

Quality Performance Measures

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

OneCare STARs Measures Improvement

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

Medi-Cal Managed Care Accountability Set MCAS

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

Value-Based Payment Program

CalOptima Health's Value-Based Payment Performance Program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health networks, including CHCN, and delegated health networks' PCPs are eligible to participate in the Value-Based Payment Programs. CalOptima Health has adopted the Integrated Healthcare Association (IHA) pay-for-performance methodology to assess performance. Performance measures are aligned with the DHCS MCAS for Medi-Cal and a subset of CMS Star measures for OneCare.

Five-Year Hospital Quality Program 2023–2027

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

Population Health Management

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

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

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

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

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

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

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

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

Health Education and Promotion

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

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

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

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

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

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

Managing Members With Emerging Risk

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

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

Disease Management Program

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

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

Care Coordination and Care Management

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

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

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

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

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

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

Interdisciplinary Care Team (ICT)

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

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

Individual Care Plan (ICP)

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

Whole-Child Model (WCM)

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

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

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

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

The MOC goals are:

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

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

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

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

Behavioral Health Integration (BHI)

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

Medi-Cal Behavioral Health (BH)

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

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

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

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

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

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

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

OneCare Behavioral Health

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

Utilization Management (UM)

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

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

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

Patient Safety Program

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

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

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

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

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

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

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

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

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

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

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

Encounter Data Review

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

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

Member Experience

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

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

Grievance and Appeals

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

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

Access to Care

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

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

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

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

Availability of Practitioners

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

Appointment Access

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

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

Telephone Access

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

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

Cultural and Linguistic Services Program

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

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

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

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

Objectives for serving a culturally and linguistically diverse membership include:

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

Serving a culturally and linguistically diverse membership includes:

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

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

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

Delegated And Non-Delegated Activities

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

Delegation Oversight

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

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

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

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

- Claims, Credentialing, Customer Service and Utilization Management.

Non-Delegated Activities

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

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

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

APPENDIX:

A – 2025 QIHETP WORK PLAN

B – 2025 POPULATION HEALTH MANAGEMENT STRATEGY AND WORK PLAN

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

D – 2025 CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES PROGRAM DESCRIPTION

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ABBREVIATIONS

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

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

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

I. PROGRAM OVERSIGHT

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

II. QUALITY OF CLINICAL CARE: Quality Management and Oversight

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

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

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

Jose Mayorga, M.D. Date

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
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

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
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

TOC	Evaluation Category	Domain	2025 QIHETP Work Plan Element Description	Goal(s)	Planned Activities	Specific date of completion for each activity (i.e. MM/DD/YYYY)	Responsible Business owner	Support Staff	Department	Continue Monitoring from 2024	Results for the Quarter	Findings	Interventions /Activities Implemented	Barriers	Next Steps /Follow-up Actions	Red - At Risk Yellow - Concern Green - On Target
1	Program Oversight		2025 Quality Improvement Health Equity and Transformation Program (QIHETP) Description and Annual Work Plan	Obtain Board Approval of 2025 QIHETP Description and Workplan by April 30, 2025	QIHETP Description and Annual Work Plan will be adopted on an annual basis; QIHEC-QAC-BOD Development of the QIHETP Work Plan will include a review of the following: 1. Comprehensive Quality Strategy Report 2. Technical Report 3. Health Disparities Report 4. Preventive Services Report 5. Focus Studies 6. Encounter Data Validation Report	QIHEC: 01/14/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Quality Improvement	Program Specialist of Quality Improvement	Quality Improvement	X						
2	Program Oversight		2024 QIHETP Description and Work Plan Evaluation	Complete Evaluation of the 2024 QIHETP Description and Work Plan by April 30, 2025	2024 QIHETP Description and Work Plan will be evaluated for effectiveness on an annual basis; QIHEC-QAC-BOD. 2025 QIHETP Evaluation will be drafted in Q4 of 2025	QIHEC: 02/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Quality Improvement	Program Specialist of Quality Improvement	Quality Improvement	X						

					and approved in Q1 2026.											
3	Program Oversight		2025 Integrated Utilization Management (UM) and Case Management (CM) Program Description	Obtain Board Approval of 2025 Integrated UM and CM Program Description by April 30, 2025	Integrated UM and CM Program will be adopted on an annual basis; UMC-QIHEC-QAC-BOD	UMC: 01/23/2025 QIHEC: 2/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Executive Director of Clinical Operations	Director of Utilization Management	Utilization Management	X						
4	Program Oversight		2024 Integrated UM CM Program Evaluation	Complete Evaluation of 2024 Integrated UM CM Program Description by April 30, 2025	Integrated UM CM Program Description will be evaluated for effectiveness on an annual basis; UMC-QIHEC-QAC-BOD 2025 UM CM Program Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	UMC: 01/23/2025 QIHEC: 2/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Executive Director of Clinical Operations/Director Case Management	Director of Utilization Management	Utilization Management	X						

5	Program Oversight	PHM	2025 Population Health Management (PHM) Strategy and PHM Work Plan	Obtain Board Approval of 2025 PHM Strategy and PHM Work Plan by April 30, 2025	PHM Strategy will be adopted on an annual basis; PHMC-QIHEC-QAC-BOD	QIHEC: 01/14/2025 PHMC: 02/20/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	X					
6	Program Oversight	PHM	2024 PHM Strategy Evaluation	Complete the Evaluation of the 2024 PHM Strategy by April 30, 2025	PHM Strategy will be evaluated for effectiveness on an annual basis (PHMC-QIHEC-QAC-BOD) and will include the following: 1. Develop collaborative evaluation process 2. Facilitate development of the evaluation process 3. Produce evaluation 4. Present evaluation to the appropriate governing committees 2025 PHM Strategy Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	QIHEC: 02/11/2025 PHMC: 02/20/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	X					

7	Program Oversight	CLAS	2025 Cultural and Linguistic Accessibility Services (CLAS) Program	Obtain Board Approval of 2025 CLAS Program by April 30, 2025	CLAS Program will be adopted on an annual basis; QIHEC-QAC-BOD	QIHEC: 01/14/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Customer Service	Manager of Cultural and Linguistics	Customer Service/Cultural and Linguistic Services	X						
8	Program Oversight	CLAS	2024 CLAS Program Evaluation	Complete the Evaluation of the 2024 CLAS Program by April 30, 2025	The CLAS Program will be evaluated for effectiveness on an annual basis; QIHEC-QAC-BOD 2025 CLAS Program Evaluation will be drafted in Q4 of 2025 and approved in Q1 2026.	QIHEC: 02/11/2025 QAC: 03/12/2025 BOD: 4/3/2025 Annual BOD adoption by end of April 2025	Director of Customer Service	Manager of Cultural and Linguistics	Customer Service/Cultural and Linguistic Services	X						
9	Program Oversight	PHM	**Population Health Management Committee (PHMC)** - Oversight of population health management activities to improve population health outcomes and advance health equity.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. PHMC reviews, assesses, and approves the Population Needs Assessment (PNA), PHM Strategy activities, and PHM Workplan progress and outcomes. 2. Provide overall direction for the continuous improvement process and oversee that activities are consistent with CalOptima	PHMC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/9/2025 Q4 12/9/2025	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	X						

					Health's PHM strategic goals and priorities. 3. Facilitate quarterly meetings 4. Report PHMC activities to the QIHEC quarterly.											
10	Program Oversight		**Credentialing Peer Review Committee (CPRC) Oversight** - Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review to ensure quality of care delivered to members	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. Review of Initial and Recredentialing applications approved and denied; Facility Site Review (including Medical Record Review (MRR) and Physical Accessibility Reviews (PARS)); Quality of Care cases leveled by committee, critical incidence reports and provider preventable conditions. 2. Committee meets at least 8 times a year, maintains and approve minutes, and reports to the QIHEC quarterly.	CPRC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Manager of Quality Improvement	Manager of Quality Improvement	Quality Improvement	X						

11	Program Oversight		**Grievance and Appeals Resolution Services (GARS) Committee -** Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. The GARS Committee reviews the Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health networks. 2. Trends and results are presented by product time to the committee quarterly. 3. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	GARS Committee Report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Associate Director of Grievance and Appeals	Manager of Grievance and Appeals	GARS	X						
12	Program Oversight		**Member Experience (MEMX) Committee Oversight -** Oversight of Member Experience activities to improve quality of service, member experience and access to care.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. The MEMX Committee reviews the annual results of CalOptima Health's CAHPS surveys, monitors the provider network including access and availability (CCN and the HNs), reviews customer	MemX Committee report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Project Manager Quality Analytics / Manage of Quality Analytics	Quality Analytics	X						

					service metrics and evaluates complaints, grievances, appeals, authorizations and referrals for the “pain points” in health care that impact our members. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.											
13	Program Oversight		**Utilization Management Committee (UMC) Oversight -** Conduct internal and external oversight of UM activities to ensure over and under utilization patterns do not adversely impact member's care.	Report committee key findings/updates, activities, and recommendations to QIHEC:	Conduct and report on the following activities: 1. UMC reviews medical necessity, cost-effectiveness of care and services, reviews utilization patterns, monitors over/under-utilization, and reviews inter-rater reliability results. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly. P&T and BMSC reports to the UMC, and minutes are	UMC Committee report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Executive Director of Clinical Operations/Director Case Management	Director of Utilization Management	Utilization Management	X						

					submitted to UMC quarterly.											
14	Program Oversight		**Whole Child Model - Clinical Advisory Committee (WCM CAC)**- Ensures clinical and behavior health services for children with California Children Services (CCS) eligible conditions are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Report committee key findings/updates, activities, and recommendations to QIHEC including the Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3)	Conduct and report on the following activities: 1. WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations. 2. Committee meets at least quarterly, maintains and approve minutes, and reports to the QIHEC quarterly.	WCM CAC report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Medical Director of Whole Child Model / Director of Case Management	Program Specialist of Quality Improvement	Medical Management	X						

15	Program Oversight	PHM	Care Management (CM) Program	Report on key activities of CM program, analyze CM data compared to goal, and improvement efforts.	Report on the following activities: 1. Basic PHM/CM2. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) CM	Report to PHMCQ1: 02/20/25Q2: 05/15/25Q3: 08/21/25Q4: 11/20/25	Director of Medical Management (Case Management)	Quality Improvement Nurse	Medical Management	X						
16	Program Oversight	PHM	Complex Case Management Program	Implement Complex Case Management Program and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: (1) Ensure provision of CCM services resulting in optimal care coordination as evidenced through monthly auditing of 5 files or 5% of files for each health network resulting in a minimum score of 90% through December 31, 2025. (2) Obtain 85% member satisfaction in CCM program by December 31st, 2025. (3) 85% of members surveyed who participated in CCM between January 1, 2024-December 31, 2025, will report that the case management process helped them meet their care plan goals.	Conduct and report on the following activities: 1. Continue training and educational opportunities to staff on the 2025 PHM5 Element D and E and complex conditions/situations (Goal 1) 2. Member Satisfaction scores will be shared with the CCN and the delegates to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care, member outcomes, and improve the member experience of CM programs (Goal 2) 3. Ongoing training and support for new and existing staff. (Goal 2)	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Medical Management (Case Management)	Nurse Specialist of Utilization Management	Case Management	X						

					4. Continue to gather member feedback to improve outcomes. (Goal 3) 5. Training and Education on member centric care plans. (Goal 3)											
17	Program Oversight	PHM	Population Health Management (PHM) Strategy and Program	Implement initiatives for the 2025 PHM program starting January 1, 2025.	Conduct and report the following activities: 1. Population Needs Assessment (PNA) 2. Develop and implement a PHM Work Plan and includes the following: a. Risk stratification b. Screening and Assessment c. Wellness and prevention 3. Collect quarterly progress reports from PHM Work Plan implementation owners	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Equity and Community Health	Manager of Population Health Management/ Sr. Director Medical Management	Equity and Community Health	X						

18	Program Oversight	PHM	Disease Management Program	Implement 2025 Disease Management Program and report key findings and/or activities, analyze barriers, and improvement efforts and meet the following goal: 1. By December 31, 2025, 85% of members who participate in Disease Management program from January 1 – December 31, 2025 will report satisfaction	Conduct and report on the following activities: 1. Evaluation of current utilization of disease management services 2. Enhance identification of gaps in care to better promote quality care across all Disease Management interventions. 3. Use multimodal methods of outreach to identify members in need of Disease Management services and reduce cold calls. 4. Integrate new methods to measure and improve member satisfaction.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	X						
19	Program Oversight	PHM	Health Education	Implement interventions for the 2025 Health Education program and report key findings and/or activities, analyze barriers, and improvement efforts. 2025 Health Education program focuses on promoting early detection, fostering healthy habits, and empowering members to be proactive with preventive care.	Conduct and report on the following activities: 1. Evaluation of current utilization of health education services 2. Enhance methods for outreaching, promoting, and enrolling members in Health Education	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	X						

					services and classes (e.g. text message outreach, member self-referral, etc.) 3. Expand health education offerings in various community classes and events (e.g. clinic days, virtual and in-person classes, etc.) and tech-based modalities (app/web-based services).											
20	Program Oversight	PHM	CalAIM Community Supports and Enhance Care Management (ECM)	Implement CalAIM and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: 1. By December 31, 2025, enhance community support services (e.g., housing transition navigation services, housing deposits, and housing tenancy and sustaining services) to achieve optimal care coordination, as demonstrated by auditing the performance of 10 providers. 2. Increase number of members authorized for ECM services by 10%, from 2,500 to 2,842 by December 31, 2025.	Community Supports Activities: 1. Conduct housing transition navigation services audits. 2. Conduct housing deposits audits. 3. Conduct housing tenancy and sustaining services audits. ECM Activity: Track ECM outreach, authorizations and services.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Medi-Cal and CalAIM	Director of Medi-Cal and CalAIM	Medi-Cal and CalAIM	X							

21	Program Oversight	PHM	Street Medicine Program	Implement Street Medicine Program and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: (1) By December 31, 2025, connect 80% of unhoused participating members to an active Primary Care Physician (PCP). (2) By December 31, 2025, connect 90% of unhoused participating members with CalAIM ECM and Housing Navigation. (3) By December 31, 2025, connect 20% of unhoused participating members to a shelter or other housing option.	Conduct and report on the following activities: Goal 1: ▪ Offer all members the opportunity to utilize the Street Medicine Provider as their PCP. ▪ Utilize Releases of Information when member has active PCP to increase collaboration and communication. ▪ Support member with PCP change, as needed. ▪ Care scheduling and delivery. Goal 2: ▪ Make attempts to engage with members weekly. ▪ Provide ECM and/or Housing Navigation appointments face to face at least every other week. ▪ Care scheduling and delivery. ▪ Document all encounters. Goal 3: ▪ Outreach to and engage unsheltered individuals ▪ Provide ECM	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director, CalAIM Community Outreach	None	Medi-Cal and CalAIM	New						

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

22	Program Oversight		Long-Term Support Services (LTSS)	Implement LTSS Program and meet the 95% compliance with the following TATs: (1) CalAIM Turnaround Time (TAT): Determination completed within 5 business days (2) CBAS Inquiry to Determination (TAT): Determination completed within 30 calendar days (3) CBAS Turnaround Time (TAT): Determination completed within 5 business days (4) LTC Turnaround Time (TAT): Determination completed within 5 business days	Assess and report the following activities: 1. Evaluation of current utilization of LTSS 2. Maintain business for current programs and support for community 3. Improve process of handling member and provider requests 4. Meet goal/TATs	Report to UMC Q1: 02/20/2025 Q2: 05/22/2025 Q3: 08/22/2025 Q4:11/20/2025	Director of Long Term Support Services	Manager of Long Term Support Services	Long Term Support Services	X						
23	Program Oversight		Delegation Oversight	Implement annual oversight and performance monitoring for delegated activities and report key findings and/or activities, analyze barriers, and improvement efforts.	Report on the following activities: Implementation of annual delegation oversight activities; monitoring of delegates for regulatory and accreditation standard compliance that, at minimum, include comprehensive annual audits and corrective actions.	Report to QIHEC: Q1 03/11/2025 Q2 06/10/2025 Q3 09/9/2025 Q4 12/9/2025	Director of Delegation Oversight	Manager of Delegation Oversight	Delegation Oversight	X						

24	Program Oversight		National Committee for Quality Assurance (NCQA) Accreditation	CalOptima Health must have full NCQA Health Plan (HP) Accreditation and NCQA Health Equity (HE) Accreditation by January 1, 2026	1. Implement activities for NCQA Standards compliance for HP and HP Renewal Submission by April 6, 2027. 2. Implement activities for NCQA Standards compliance for Initial HE Accreditation Survey and submit requirement documents to NCQA by October 7, 2025.	1) By December 31, 2025 2) By October 7, 2025 Report program update to QIHEC Q1:01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director Quality Improvement	Program Manager of Quality Improvement (NCQA)	Quality Improvement	X						
25	Program Oversight		Quality Performance Improvement: Managed Care Accountability Set (MCAS) OneCare STAR measures DHCS Quality Withhold Health Plan Accreditation (QI3) Health Plan Rating	Track and report quality performance measures required by regulators against the following goals: (1) Achieve 50th percentile MPL or above (2) Achieve 4 Stars or above (3) Achieve 100% of withhold (4) Achieve 3 or higher (5) Achieve 5.0	1. Track rates monthly 2. Share final results with QIHEC annually 3. Review and identify measures for focused improvement efforts after each monthly refresh	By December 2025 Report program update to QIHEC Q1: 01/14/2025 Q2: 05/13/2025 Q3: 07/08/2025 Q4: 11/04/2025	Director of Quality Analytics/Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X						

26	Program Oversight		Value Based Payment Program	Implement a value-based payment program and report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants- HN P4V-Hospital Quality	Assess and report the following activities: 1. Share HN performance on all P4V HEDIS measures via prospective rates report each month. 2. Share hospital quality program performance3. Develop monthly P4V report to show HNs the estimated amount of P4V dollars based on current performance	Report program update to QIHEC Q1: 01/14/2025 Q2: 05/13/2025 Q3: 07/08/2025 Q4: 11/04/2025	Executive Director of Quality Improvement	Director of Quality Analytics	Quality Analytics	X						
27	Quality of Clinical Care		Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	Monitor PCP, High Volume Specialist and ancillary sites utilizing the DHCS audit tool and methodology and report any findings, barriers and improvement efforts.	Review and report initial and periodic reviews conducted for PCP, high volume specialists and ancillary sites and ensure periodic reviews are conducted every three years. Tracking and trending of reports are reported quarterly.	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director of Quality Improvement	Manager of Quality Improvement	Quality Improvement	X						

28	Quality of Clinical Care		Potential Quality Issues Review	PQIs are reviewed timely to ensure care and services provided fall within the range of professionally recognized standards of health care.	Review and report quality-of-care cases for peer review (CPRC), determine appropriate severity level and make recommendations for actions based on findings.	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Quality Improvement	Manager of Quality Improvement	Quality Improvement	X						
29	Quality of Clinical Care		Provider Credentialing and Recredentialing	All providers are credentialed and recredentialed according to regulatory requirements	Review and report providers are credentialed according to regulatory requirements: • No more than 180 days between verification and approval • Providers are recredentialed within 36 months	Report to CPRC Q1:02/27/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Quality Improvement	Manager of Quality Improvement	Quality Improvement	X						
30	Quality of Clinical Care		Special Needs Plan (SNP) Model of Care (MOC)	Increase the number of members completing an HRA, and ICP and ICT to meet the following goal: Percent of Members with Completed HRA: Goal 100% Percent of Members with ICP: Goal 100% Percent of Members with ICT: Goal 100%	Assess and report the following activities: 1. Monthly communication process with Networks on ICP development 2. DHCS HRA1 and ICP1 Quarterly reporting 3. HRA Star status 4. MOC Updates 5. Face to Face interactions	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Medical Management	QI Nurse Specialist	Medical Management	X						

31	Quality of Clinical Care	PHM - LSC	Pediatric and Adolescent Wellness: EPSDT/Children's Preventive and Screening Services	Childhood Immunization Status (CIS) MC Combo 10: 42.34% Increase from 36.50% to 42.34% by 12/31/2025. Immunizations for Adolescents (IMA) MC Combo 2: Increase from 47.45% to 48.66% by 12/31/2025. Well-Child Visits in the First 30 Months of Life (W30) MC First 15 Months: Increase from 58.92% to 63.38% by 12/31/2025. MC 15 to 30 Months: Increase from 72.44% to 73.09% by 12/31/2025. Child and Adolescent Well-Care Visits (WCV) MC Total: Increase from 53.03% to 55.29% by 12/31/2025. Lead Screening in Children (LSC) MC LSC: Increase from 63.75% to 63.84% by 12/31/2025.	Goal not met - W30. Continue to assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored and age-appropriate messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs (e.g. provide insight into CIS Combo 10 status for each vaccine) 4. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone) 5. For CIS Combo 10, identify members missing only the first Hep B vaccine and complete chart chase efforts year-round	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/14/2025 Q3: 08/12/2025 Q3: 11/04/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics	Quality Analytics	Continue to Monitor W30 Not Met						

					6. Begin prospective outreach to members that will age into the measure for the following year (i.e. message 1 year old members to ensure compliance with recommended vaccine schedule thus far) 7. Create educational materials for addressing vaccine hesitancy and distribute to providers and members 8. Drive provider participation in the Standing Orders Program to place lab orders for blood lead testing 9. Provide point-of-care lead testing equipment and supplies to providers via the Quality Improvement Grant Program 10. Early Identification and Data Gap Bridging Remediation for early intervention											

32	Quality of Clinical Care		Adult Wellness: Preventive and Screening Services	Cervical Cancer Screening (CCS) MC: Increase from 58.31% to 60.10% by 12/31/2025. Colorectal Cancer Screening (COL) OC: Increase from 66.84% to 70.33% by 12/31/2025. Breast Cancer Screening (BCS-E) MC: Increase from 58.39% to 59.51 % by 12/31/2025. OC: Increase from 66.88% to 75.00 % by 12/31/2025. Immunization Status - Flu, Pneu, Tdap, Zoster MC Flu Total: Increase from 22.19% to 26.40% by 12/31/2025. OC Flu Total: Increase from 47.17% to 49.12% by 12/31/2025. MC Pneumococcal 66+: Increase from 38.18% to 38.73% by 12/31/2025. OC Pneumococcal 66+: Increase from 44.96% to 56.76% by 12/31/2025. MC Tdap Total: Increase from 25.43% to 33.40% by 12/31/2025. OC Tdap Total: Increase from 24.57% to 31.56% by 12/31/2025. MC Zoster Total: Increase from 17.52% to 20.56% by 12/31/2025. OC Zoster Total: Increase from 23.62% to 40.94% by 12/31/2025.	Assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs 4. Provide facility listings for services completed outside the PCP office setting, such as diagnostic sites for mammography 5.Provide mobile mammography services in collaboration with other departments, Health Network partners, and CHCN providers 6. Provide at-home Cologuard testing for Colorectal Cancer Screening	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Quality Analyst of Quality Analytics / Manager of Quality Analytics	Quality Analytics	New							

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

33	Quality of Clinical Care		CalOptima Health Comprehensive Community Cancer Screening Program (CCCSP)	Increase capacity and access to cancer screening for breast, colorectal, cervical, and lung cancer report key findings and/or activities, analyze barriers, and improvement efforts.	Assess and report the following: 1. Establish the Comprehensive Community Cancer Screening and Support Grants program and monitor Grantees' progress to measure impact 2. Develop and implement a comprehensive plan for other initiatives under CCCSP.	Report Program update to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Chief Medical Officer	Manager of Medical Management	Medical Management	X						

34	Quality of Clinical Care	CoC - PPC	Maternal and Child Health: Prenatal and Postpartum Services	Timeliness of Prenatal Care and Postpartum Care (PHM Strategy). MC Prenatal: Increase from 88.08% to 88.58% by 12/31/2025. MC Postpartum: Increase from 80.00% to 80.23% by 12/31/2025.	Assess and report the following activities: 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Implement a comprehensive outreach strategy utilizing multiple modalities timed with the member meeting denominator-qualifying criteria 4. Launch an interdepartmental maternal health workgroup focused on improving outcomes and addressing disparities 5. Provide bundled code education to high volume providers 6. Create a comprehensive dashboard / report that refreshes weekly to ensure timely member identification	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics	Quality Analytics	X						

					and intervention 7. Collaborate with OBGYN specialty groups to perform member outreach and schedule services 8. Expand on collaborative efforts with community-based organizations, providers, and health networks.											

35	Quality of Clinical Care	PHM	Maternal and Child Health: Prenatal and Postpartum Depression Screening	Prenatal Depression Screening and Follow-Up (PND-E) MC Screening: Increase from 14.52% to 16.03% by 12/31/2025. MC Follow-up: Increase from 52.80% to 53.33% by 12/31/2025. Postpartum Depression Screening and Follow-Up (PDS-E) MC Screening: Increase from 17.33% to 29.84% by 12/31/2025. MC Follow-up: Increase from 56.84% to 61.70% by 12/31/2025.	PND-E & PDS-E Activities: 1. Provider maternal mental health training 2. Enhance CalOptima Health Maternal Depression Program and support referral to Behavior Health Integration when screened at risk. 3. Conduct or promote depression screening at community events.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director Equity and Community Health	Manager of Equity and Community Health/Manager of Behavioral Health Integration	Equity and Community Health	X					
36	Cultural and Linguistic Appropriate Services	PHMCLAS HE	Maternity Care for Black Members	Medi-Cal 1. Increase timeliness of prenatal care (TOPC) for CalOptima's Black members from 75.71% to 84.55% by December 31, 2025. 2. Increase postpartum care (PPC) for CalOptima's Black members from 71.43% to 80.23% by December 31, 2025.	Assess and report the following activities:1. Connect members to doula, Enhanced Care Management (ECM) services, and Black Infant Health (BIH) programs. 2. Implement community and clinic events that focus on improving prenatal and postpartum appointments. 3. Explore digital methods of providing perinatal assessments, education, and resource navigation for	Report progress to QIHECQ1: 02/11/2025Q2: 05/13/2025Q3: 08/12/2025Q4: 11/20/2025	Director of Medicare Stars and Quality Initiatives	Manager of Quality Analytics/Manager of CalAIM/Director of Equity and Community Health	Equity and Community Health/ Cal AIM/Quality Analytics	X					

					pregnant and postpartum members.											

37	Quality of Clinical Care	PHM CoC-EED	Chronic Conditions: Members with Diabetes	Eye Exam for Patients with Diabetes (EED) MC EED 64.06% Increase from 63.52% to 64.06% by 12/31/2025. OC: EED 77.00%; Increase from 75.14% to 77.00% by 12/31/2025. HbA1c Control for Patients with Diabetes (HBD): HbA1c Poor Control (this measure evaluates Percentage of members with poor A1C control-lower rate is better) (>9.0%) MC HBD: Decrease from 29.34% to 27.01% by 12/31/2025. OC HBD: 10.00% decrease from 15.30% to 10.00% by 12/31/2025.	Assess and report the following activities (Quality Analytics): 1. Determine primary drivers to noncompliance and segment members into targeted groups 2. Develop culturally tailored messaging to improve engagement 3. Update outreach materials to include personalized content based on individual health needs 4. Explore at-home testing for HBD via lab vendor 5. Implement a comprehensive outreach strategy utilizing multiple modalities (e.g. mail, SMS, IVR, email, telephone) 6. Drive provider participation in the Standing Orders program to place A1c lab orders on behalf of physicians 7. Collaborate with OPH and	By December 2025 Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Quality Analytics (Medicare Stars and Quality Initiatives)/Director of Equity and Community Health	Manager of Quality Analytics	Equity and Community Health and Quality Analytics	X						

					OPT providers on member outreach and scheduling of services for EED 8 Regularly review members with evidence of A1c testing but no result and address via supplemental data capture 9. Partner with VSP to educate providers on EED CPT II code submission to capture testing results 10. Explore offering EED testing at community based events Assess and report the following activities: 1. Enhance Diabetes Education: Launch virtual and group education classes to improve member engagement by FY 2025. 2. Leverage Technology: Use digital apps and web-based tools to support diabetes prevention, management, and interactive											

					engagement. 3. Strengthen Support Services: Link members to medically tailored meals, health coaching nutrition services, community/clinic events.											

38	Quality of Clinical Care	PHM CLAS HE	Chronic Conditions: Members with Heart Health (Hypertension)	Controlling High Blood Pressure (CBP) MC CBP: Maintain the 90th percentile (72.75%) or higher by December 31, 2025. OC CBP: Increase from 74.87% to 80.00% by 12/31/2025. Controlling High Blood Pressure (CBP) - CLAS and Health Disparity for Medi-Cal 1. Increase CBP rate among Black and African American Medi-Cal members from 39.21% to 64.48% by 12/31/2025. 2. Increase CBP rate among Black and African American Medicare members from 47.24% to 77% by 12/31/2025. 3. Increase CBP rate among Korean speaking Medi-Cal members from 24.87% to 64.48% by 12/31/2025. 4. Increase CBP rate among Vietnamese speaking Medicare members from 50.56% to 77% by12/31/2025.	Assess and report the following activities: 1. Expand Hypertension Program to offer both virtual and in-person Hypertension Education.	Report to PHMC: Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Equity and Community Health	Manager of Equity and Community Health	Equity and Community Health	New						
39	Quality of Clinical Care		Chronic Conditions: Osteoporosis	Osteoporosis Management in Women Who Had a Fracture (OMW) OC Total: Increase from 34.67% to 39.00% by 12/31/2025.	1. Case management to collaborate with Quality to identify members who need follow-up. 2. Quality to outreach to noncompliant members via SMS, mail, and/or telephone. 3. Quality to pursue at-home DEXA testing via vendor. 4. Quality to provide timely notifications to	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Sr. Director Medical Management/Manager of Quality Analytics	Quality Improvement Nurse/Program Manager Quality Analytics	Medical Management (Case Management) /Quality Analytics	New						

					the member's PCP via fax. 5. Quality to explore collaboration with the Pharmacy team to provide education on the importance of taking a medication to treat osteoporosis (e.g. bisphosphonate). 6. Quality and Case Management coordinate to provide more timely data and insight to the member's compliance deadline date to Health Network partners.											
40	Quality of Clinical Care	CoC - FMC	Chronic Conditions: Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions	Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC) OC Total: Increase from 51.27% to 53.00% by 12/31/2025.	1. Review and update the Key Events for Emergency Visits 2. Continue to share Emergency Visits with Health Networks through Key Event reporting.	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director Medical Management	Quality Improvement Nurse	Case Management	New						

41	Quality of Clinical Care		Behavioral Health Services: Child and Adolescent Health on Antipsychotics	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) MC Glucose and Cholesterol Combined-All Ages: Increase from 36.76% to 41.41% by December 31, 2025.	Goal not met. Continue to assess and report the following activities: 1) Monthly review of metabolic monitoring data to identify prescribing providers and Primary Care Providers (PCP) for members in need of metabolic monitoring. 2) Work collaboratively with provider relations to conduct monthly face to face provider outreach to the top 10 prescribing providers to remind of best practices for members in need of screening. 3) Monthly mailing to prescribing providers to remind of best practices for members in need of screening. 4) Send monthly reminder text message to members (approx 600 mbrs). 5) Information sharing via provider portal	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	Continue to Monitor APM Not Met						

					to PCP on best practices.											
42	Quality of Clinical Care	PHM	Behavioral Health Services: Depression	Antidepressant Medication Management (AMM) MC Acute Phase - 63.35% Increase from 68.06% to 68.35% by December 31, 2025. MC Continuation Phase - Increase from 48.06% to 48.16% by December 31, 2025. OC Acute Phase - 63.35% Increase from 75.52% to 78.39% by December 31, 2025. OC Continuation Phase - Increase from 60.77% to 62.58% by December 31, 2025. Depression Screening and Follow-up for Adolescents and Adults (DSF-E) MC Screening Total: Increase from 6.57% to 16.22% by December 31, 2025. OC Screening Total: Maintain the 90th percentile (54.28%) or higher by December 31, 2025.	AMM Goal not met. Continue to assess and report the following activities: 1) Educate providers on the importance of medication adherence through outreach. 2) Educate members on the importance of medication adherence through newsletters/outreach. 3) Track number of educational events on depression treatment adherence. DSF-E Goal not met.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	Continue to Monitor AMM and DSF-E Not Met						

					Continue to assess and report the following activities: 1) Educate providers on the importance of screenings and follow-up care after positive screenings. 2) Educate members on the importance of screenings through newsletters/outreach and increase follow up appointments after positive screenings.											

43	Quality of Clinical Care	CoC-SSD	Behavioral Health Services: Schizophrenia	Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) MC SSD: Increase from 74.96% to 79.51% by 12/31/2025. Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) MC: Increase from 70.19% to 74.83% by 12/31/2025. OC: Increase from 77.37% to 77.93% by 12/31/2025.	SSD Goal not met. Continue to assess and report the following activities: 1) Identify members in need of diabetes screening. 2) Conduct provider outreach, work collaboratively with the communications department to fax blast best practice and provide list of members still in need of screening to prescribing providers and/or Primary Care Physician (PCP). 3) Information sharing via provider portal to PCP on best practices, with list of members that need a diabetes screening. 4) Send monthly reminder text message to members (approx 1100 mbrs) 5) Member Health Reward Program. SAA Assess and report the following activities:	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	Continue to Monitor SSD Not Met						

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

44	Quality of Clinical Care	PHMCoC -FUM; FUA; FUI	Behavioral Health Services: Care Coordination and Follow-up Care	Follow-Up After Emergency Department Visit for Mental Illness (FUM) MC 30-Day: Increase from 35.76% to 53.82% by 12/31/2025. MC 7-day: Increase from 21.38% to 33.01% by 12/31/2025. Follow-Up After Emergency Department Visit for Substance Use (FUA) MC 30-Day: Increase from 21.12% to 36.18% by 12/31/2025. MC 7-Day: Increase from 11.23% to 18.76% by 12/31/2025. Follow-up After High-Intensity Care for Substance Use Disorder (FUI) MC 30-Day: Increase from 20.25% to 44.53% by 12/31/2025. MC 7-Day: Increase from 7.99% to 26.90% by 12/31/2025.	FUM Goal not met. Continue to assess and report the following activities: 1. Share real-time ED data with our health networks on a secured FTP site. 2. Participate in provider educational events related to follow-up visits. 3. Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4. Bi-Weekly Member Text Messaging (approx. 500 mbrs) 5. IVR calls to members who fall under the FUM measure FUA Goal not met. Continue to assess and report the following activities: 1. IVR calls to members who fall under the FUA measure 2. Continue weekly member text messaging.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	Continue to Monitor FUA and FUM Not Met: New: FUI						

					3. Share FUA data with providers through the Provider Portal. 4. Sharing FUA data with Health Networks via sFTP. FUI: This measure was added for monitoring purposes. Opportunities for improvement and/or interventions will be considered upon the ability to obtain data from the Orange County Health Care Agency.											

45	Quality of Clinical Care	CoC - APP	Behavioral Health Services: Medication Management	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) MC Total: Increase from 28.95% to 54.55% by 12/31/2025. Pharmacotherapy for Opioid Use Disorder (POD) MC Total: 21.36% Increase from 7.79% to 21.36% by 12/31/2025.	Assess and report on the following activities: 1) Educate providers on measure and best practice guidelines.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Manager of Behavioral Health Integration	Behavioral Health Integration	New						
46	Quality of Clinical Care		Behavioral Health Services: School-Based Services Mental Health Services	Report on activities to improve access to preventive, early intervention, and BH services by school-affiliated BH providers.	Assess and report the following Student Behavioral Health Incentive Program (SBHIP) activities/school base mental health services 1 . SBHIP Program Outcome Reporting 2. DHCS CYBHI multi-Payer Fee Schedule	Report program update to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Project Manager of Behavioral Health Integration	Behavioral Health Integration	Changed						

47	Quality of Clinical Care		Medication Management	Appropriate Testing for Pharyngitis (CWP) MC Total: Increase from 43.66% to 76.71% by 12/31/2025. OC Total: Increase from 15.77% to 72.50% by 12/31/2025. Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) MC Total: Increase from 47.55% to 56.73% by 12/31/2025. OC Total: Increase from 68.97% to 47.50% by 12/31/2025.	1) Identify top 5-10 providers that prescribed antibiotics to members and provide targeted provider education via provider updates/provider newsletter. 2) Provide members with general education on antibiotic avoidance.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Medicare Stars and Quality Initiatives	Program Manager of Quality Analytics	Quality Analytics	New						
48	Quality of Clinical Care		Medication Adherence	Improve medication adherence for Cholesterol (Statins), Hypertension (RAS Antagonists) and Diabetes	1) Member IVR, member education, provider education, PDC report to Health Networks.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Pharmacy Management	Manager of Pharmacy Management	Pharmacy Management	New						
49	Cultural and Linguistic Appropriate Services	CLAS HE	Performance Improvement Projects (PIPs) Medi-Cal	Increase well-child visit appointments for Black/African American members (0-15 months) from (final rate TBD) to 55.78% by 12/31/2025.	Conduct quarterly/Annual oversight of MC PIPs (Jan 2023 - Dec 2025): 1) Clinical PIP – Increasing W30 6+ measure rate among Black/African American Population	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics / Manager of Quality Analytics	Quality Analytics	X						

50	Quality of Clinical Care		Performance Improvement Projects (PIPs) Medi-Cal BH	Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) FUM and FUA for complex case management.	Non Clinical PIP: Improve the percentage of members enrolled into care management, CalOptima Health community network (CCN) members, complex care management (CCM), or enhanced care management (ECM), within 14-days of a ED visit where the member was diagnosed with SMH/SUD.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Manager, Director and Executive Director of Behavioral Health Integration	Program Specialist of Behavioral Health Integration	Behavioral Health Integration/ Quality Analytics	X						
51	Quality of Clinical Care		Chronic Care Improvement Projects (CCIPs) OneCare: Diabetes Emerging Risk	By December 31, 2025, 5% of members identified as emerging risk* and who participated in program will lower HbA1c to less than 8.0%. *Emerging risk is defined as members with a result of A1C 8.0% to A1C 9.0% who were previously in good control A1C less than 8.0% in previous 12 months.	Conduct quarterly/Annual oversight of specific goals for OneCare CCIP (Jan 2023 - Dec 2025): CCIP Study - Comprehensive Diabetes Monitoring and Management Measures: Diabetes Care Eye Exam Diabetes Care Kidney Disease Monitoring Diabetes Care Blood Sugar Controlled Medication Adherence for Diabetes Medications Statin Use in	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics	Quality Analytics	X						

					Persons with Diabetes											
52	Quality of Service: Access		Improve Network Adequacy: Reducing Gaps In Provider Network	Increase provider network to meet regulatory access goals	Assess and report the following activities: 1) Conduct gap analysis of our network to identify opportunities with providers and expand provider network 2) Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/21/2025	Director of Provider Operations	Sr. Program Manager, Provider Operations	Provider Data Operations	X						

53	Quality of Service: Access		Improve Timely Access: Appointment Availability/Telephone Access	Improve Timely Access compliance with Appointment Wait Times to meet 80% MPL	Goal not met. Continue to assess and report the following activities: 1) Conduct an evaluation of appointment and telephone access 2) Issue corrective action for areas of noncompliance 3) Collaborative discussion between CalOptima Health Medical Directors and providers to develop actions to improve timely access. 4) Continue to educate providers on timely access standards 5) Develop and/or share tools to assist with improving access to services.	Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/21/2025	Director of Quality Analytics (Medicare Stars and Quality Initiatives)	Manager of Quality Analytics / Project Manager of Quality Analytics	Quality Analytics	Continue to Monitor Goals Not Met						

54	Quality of Service: Access		Network Adequacy Regulatory Submission and Audits	Comply with regulatory requirements • Annual Network Certification (ANC) • Subdelegate Network Certification (SNC) • Network Adequacy Validation (NAV) Audit	1) Annual participation of ANC, SNC and NAV to DHCS with AAS or CAP 2) Implement improvement efforts 3) Monitor for Improvement 4) Communicate results and remediation process to HN	Submission: 1) By end of January 15, 2025 2) By end of Q2 2025 3) By end of Q3 2025 Report to MemX Q1: 01/28/2025 Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/21/2025	Director of Provider Operations	Sr. Program Manager, Provider Operations	Provider Data Operations	X						
55	Quality of Service: Access	PHM	Increase Primary Care Utilization - Initial Health Appointment	Increase the IHA completion rate for all new Medi-Cal members from 33% to 50% by December 31, 2025.	Assess and report the following activities: 1) Enhance methods of informing members of the importance of IHA and preventive screenings. 2) Collaborate with delegation oversight to improve IHA compliance by Health Network. 3) Provider and HN education to support new member screening for SDOH screening	Report to PHMC Q1: 02/20/25 Q2: 05/15/25 Q3: 08/21/25 Q4: 11/20/25	Director of Equity and Community Health	Manager of Equity and Community Health/Program Manager Equity and Community Health	Equity and Community Health	X						

					within 120 days.											

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

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

57	Quality of Service: Member Experience		Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process and report key findings and/or activities, analyze barriers, and improvement efforts. Maintain the grievance and appeals and resolution process while meeting all regulatory requirements for timely processing of appeals and grievances at a target goal of 95%.	Track and trend member and provider grievances and appeals for opportunities for improvement. Maintain business for current programs. Improve process of handling member and provider grievance and appeals Identify trends in grievances quarterly to address member needs and systemic issues within the Plan. Utilize feedback provided in our quarterly GARS Committee Meetings to improve overall member experience and plan operations.	GARS Committee Report to QIHEC: Q1 03/11/2025 Q2: 06/10/2025 Q3 09/09/2025 Q4 12/09/2025	Director of Grievance and Appeals	Manager of Grievance and Appeals	GARS	X						

58	Quality of Service: Member Experience		Customer Service Call Center	Implement customer service process and monitor against the following standards: OC Call Center Abandonment Rate 5% or lower OC Call Center Average Speed of Answer 2 minutes or lower MC Call Center Average Speed of Answer 10 minutes or lower Report key findings and/or activities, analyze barriers, and improvement efforts.	Track and trend customer service call center data Comply with regulatory standards Improve process for handling customer service calls	Report progress to QIHEC Q1: 01/14/2025 Report to MemX Q2: 04/15/2025 Q3: 07/15/2025 Q4: 10/21/2025	Director of Customer Services	Manager of Customer Service	Customer Service	X						
59	Safety of Clinical Care		Plan All Cause Readmission	Plan All-Cause Readmissions 18-64 (PCR) MC: Decrease from 0.8983 to 0.8937 by 12/31/2025. OC: Decrease from 10.00% to 8.00% by 12/31/2025.	1. Collaborate with Quality /Data analytics to identify top 5-10 readmission DX – consider adding in top 5-10 member readmission data for targeted education and outreach for member/provider. 2. review of ambulatory Follow up within 7 days of DC for HN and discharging facilities. 3. Provider education for E/M's post discharge	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/04/2025	Director Medical Management	None	Case Management	New						

					appt's within 7 days: 99495 and 99496. 3. Collaborate with other departments (UM/CM/TCS) for targeted outreach for member outreach for											
60	Safety of Clinical Care		Emergency Department Member Support	Launch the Emergency Department (ED) Program in 2025 and track utilization of services and report key findings and/or activities, analyze barriers, and improvement efforts.	Assess and report the following activities: 1) Promoting communication and member access across all CalOptima Networks 2) Increase CalAIM Community Supports Referrals 3) Increase PCP follow-up visit within 30 days of an ED visit 4) Decrease inappropriate ED Utilization	Report to UMC Q1: 03/11/2025 Q2: 06/10/2025 Q3: 09/09/2025 Q4: 12/09/2025	Director of Long Term Support Services	Manager of Long Term Support Services	Long Term Support Services	Changed						

61	Safety of Clinical Care		Transitional Care Services (TCS)	UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% by end of December 31,2025. [New goal will be established Q1 2025]	1) Use of Ushur platform to outreach to members post discharge. 2) Implementation of TCS support line. 3) Ongoing audits for completion of outreach for High-Risk Members in need of TCS. 4) Ongoing monthly validation process for Health Network TCS files used for oversight and DHCS reporting.	Report to UMC Q1: 03/11/2025 Q2: 06/10/2025 Q3: 09/09/2025 Q4: 12/09/2025	Sr. Director of Utilization Management	Project Manager, Medical Management	Utilization Management	X						
62	Cultural and Linguistic Appropriate Services	CLAS	Language Services: Cultural and Linguistics and Language Accessibility	Implement interpreter and translation services and report key findings and/or activities, analyze barriers, and improvement. For translation services, by August 1st, 2025, CalOptima Health will expand the threshold languages to include Russian to meet requirements established by the California Department of Health Care Services (DHCS).	Track and trend interpreter and translation services utilization data and analysis for language needs. Comply with regulatory standards, including Member Material requirements Launch Russian as new threshold language.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	X						

63	Cultural and Linguistic Appropriate Services	CLAS	Network Cultural Responsiveness: Data Collection on Member Demographic Information	By Dec. 31st, 2025, CalOptima Health will increase the collection of sexual orientation gender identify (SOGI) data by 10% through focused outreach and education, ensuring better representation and inclusion of members.	1) Field a survey to collect the Member's Sexual Orientation and Gender Identity (SOGI) information from members (18+ years of age). 2) Collaborate with other participating CalOptima Health departments, to share SOGI data with the Health Networks. 3) Develop and implement a survey via the Member Portal, mail to new members and other methods. 4) Share member demographic information with practitioners.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	X						

64	Cultural and Linguistic Appropriate Services	CLAS	Network Cultural Responsiveness: Data Collection on Practitioner Demographic Information	By Dec. 31st, 2025, CalOptima Health will increase the collection of race/ethnicity/languages (REL) data by 10% through focused outreach and education, ensuring better representation and inclusion of providers.	1) Add REL questions to routine forms, including credentialing, provider relations LOI, and provider demographic forms. 2) Enter REL data into the provider data system to ensure it can be retrieved and used for CLAS improvement. 3) Share data on the provider network's capacity to meet the language needs of CalOptima Health members. 4) Assess the provider network's ability to meet CalOptima Health's culturally diverse member needs. 5) Collaborate with other CalOptima Health departments to share SOGI data with Health Networks.	Report progress to QIHEC Q1: 02/11/2025 Q2: 05/13/2025 Q3: 08/12/2025 Q4: 11/20/2025	Director of Provider Operations	Program Manger Provider Data Operations	Provider Data Management Services	X						

65	Cultural and Linguistic Appropriate Services	CLAS	Experience with Language Services	Evaluate language services experience from member and staff by implementing at language services survey to member and staff by March 31, 2025. By Dec. 31st, 2025, CalOptima Health will evaluate language services experience by collecting feedback from at least 10% of members and 80% of staff using surveys and will analyze the results to identify improvements to language services.	Goal not met. Continue to assess and report the following activities: 1) Develop and implement a survey to evaluate the effectiveness related to cultural and linguistic services. 2) Analyze data and identify opportunities for improvement.	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Director of Customer Service	Manager of Cultural and Linguistics	Cultural and Linguistic Services	Continue to Monitor Goals Not Met						
66	Cultural and Linguistic Appropriate Services	CLAS	Network Cultural Responsiveness: Diversity, Equity and Inclusion Training	By Dec. 31st, 2025, CalOptima Health will implement and train 90% of staff, health networks, and providers on Diversity, Equity and Inclusion (DEI) training, ensuring compliance with DHCS All Plan Letter (APL) 24-016.	1. Develop a DEI Training and launch training by July 31, 2025	Report progress to QIHEC Q1: 01/14/2025 Q2: 04/08/2025 Q3: 07/08/2025 Q4: 10/07/2025	Chief Health Equity Officer	Manager Human Resources and Provider Relations	HR and Provider Relations	New						

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

2025
POPULATION HEALTH MANAGEMENT (PHM)
STRATEGY & WORK PLAN

Responsible Staff:

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INTRODUCTION

Organization Overview

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

Our Mission

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

Our Vision

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

Strategy Purpose

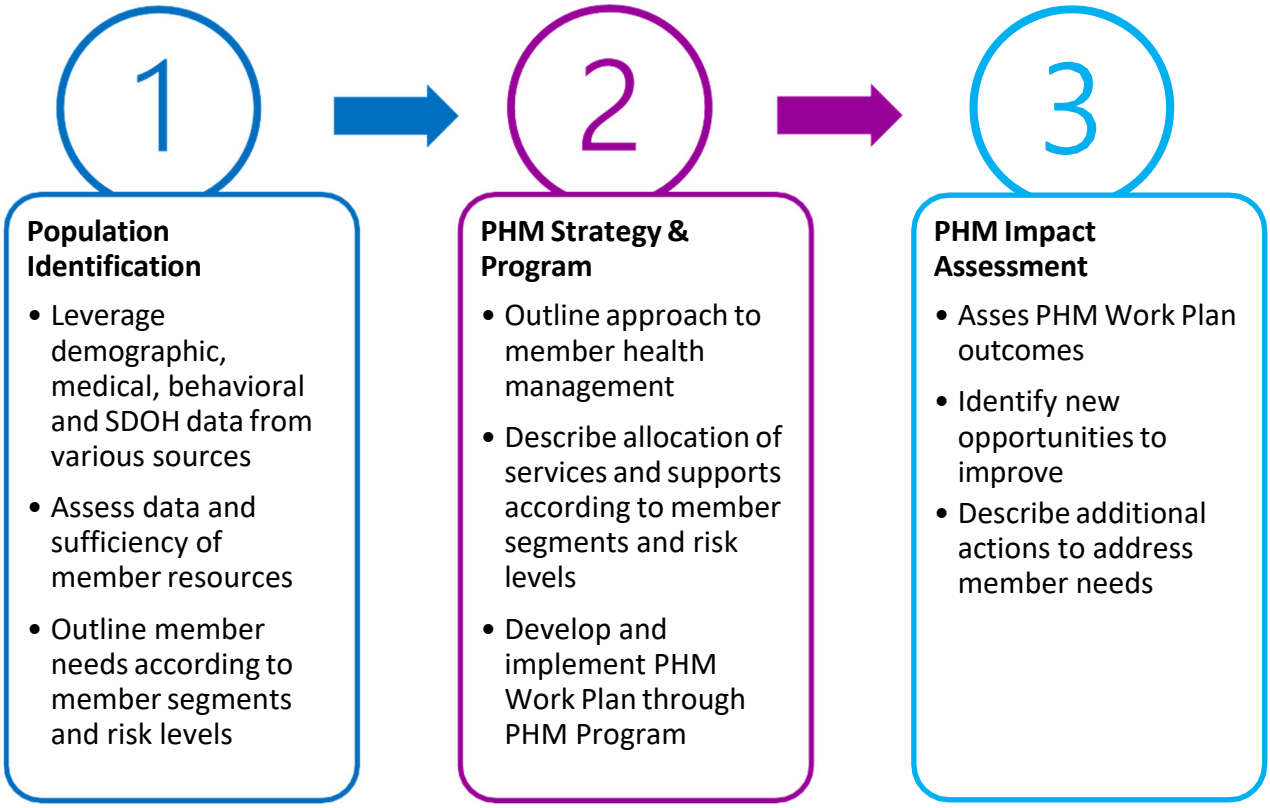
The PHM Strategy outlines CalOptima Health's cohesive plan of action to address the needs of our members across the continuum of care. Through the PHM Strategy and our commitment to health equity, CalOptima Health also incorporates an upstream approach to address social determinants of health (SDOH)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

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

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

Strategic Management

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



Population Identification

Population Needs Assessment

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

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

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

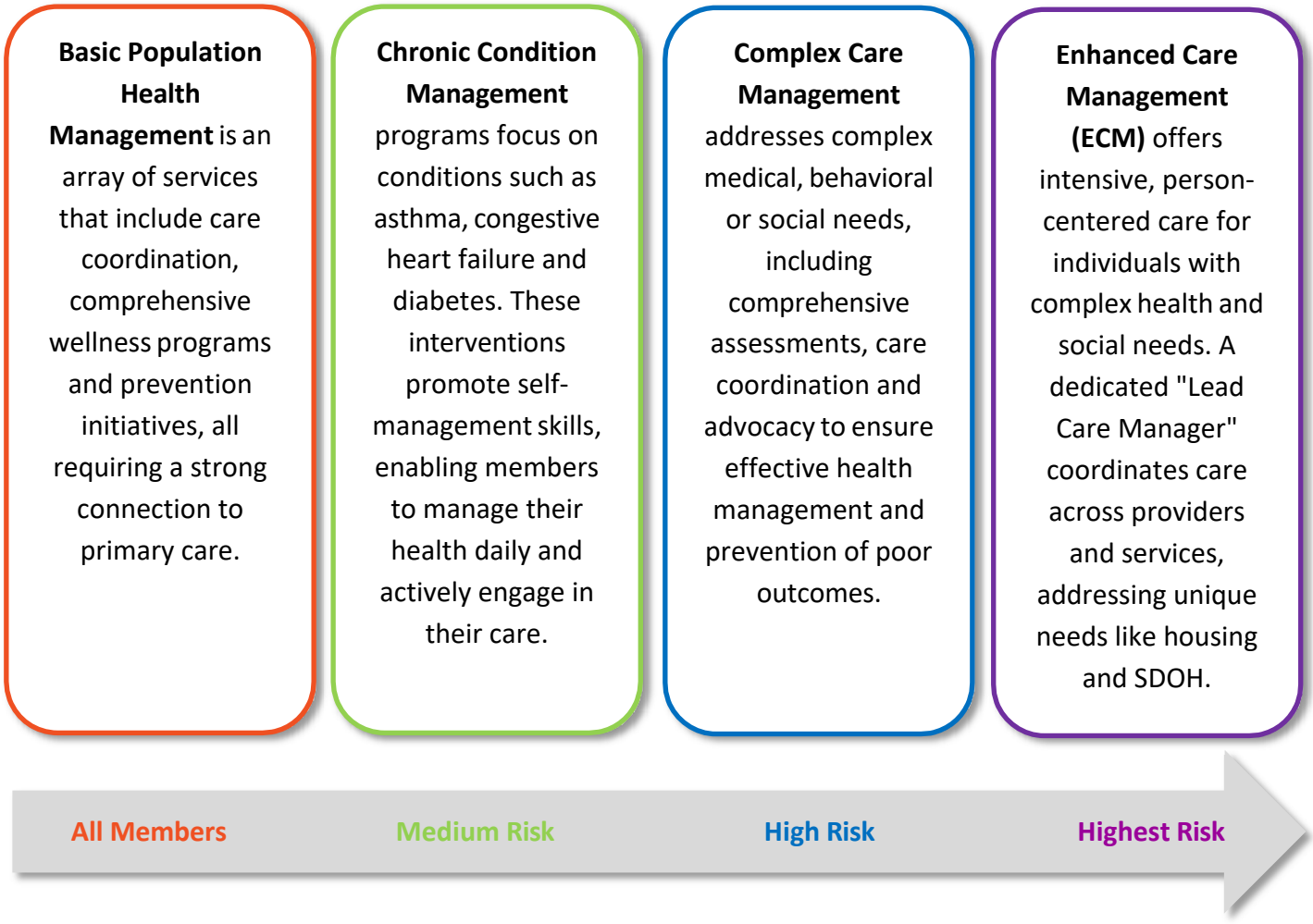
Population Segmentation and Care Coordination

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

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

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

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



PHM Strategy and Program

PHM Work Plan

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

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

Keeping Members Healthy

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

Managing Emerging Risk

- Chronic Condition Care and Self-Management Program

Increasing Patient Safety

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

Managing Multiple Chronic Conditions

- Complex Care Management Program

Providing Advance Care Support

- Enhanced Care Management

PHM Program

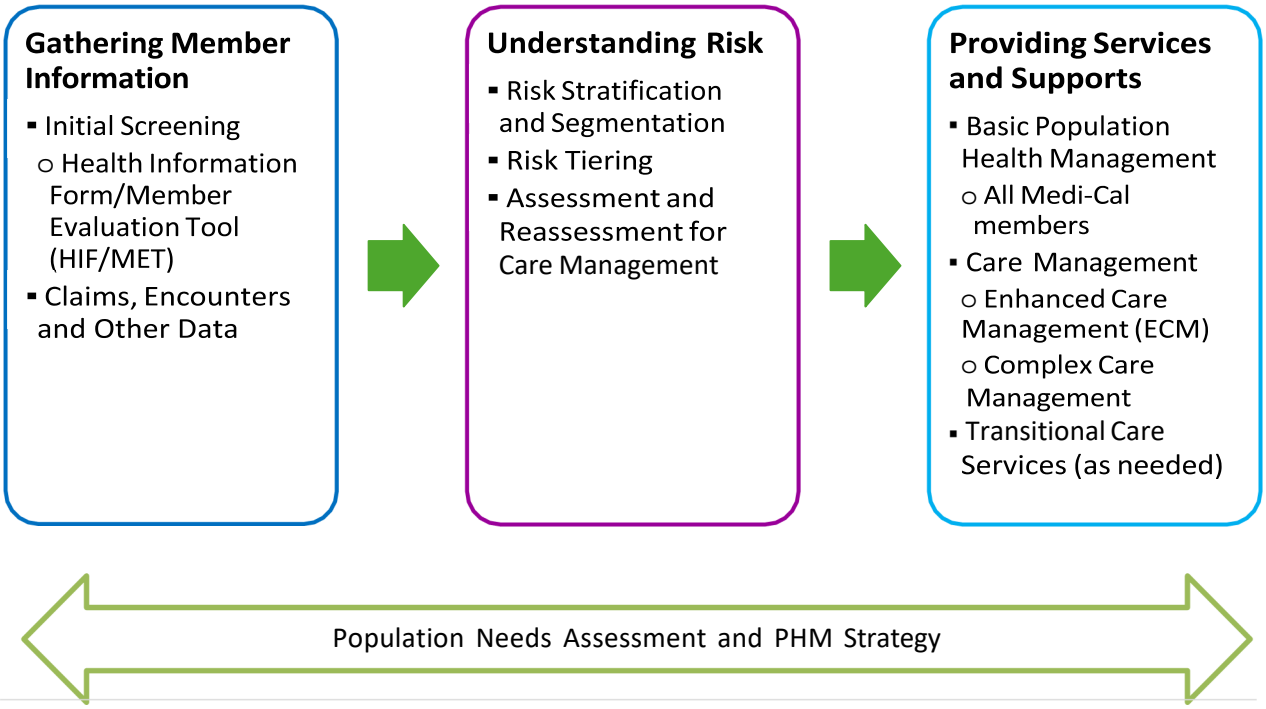
The PHM Strategy guides CalOptima Health's PHM Program. Our PHM Program and related services are developed by a multidisciplinary team of health professionals, community partners and stakeholders. Together, we ensure that our PHM Program is committed to health equity, member involvement and accountability.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

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

PHM Framework

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

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



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PHM Program Coordination

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

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

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

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

Informing Members About PHM Programs

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

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

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

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

PHM Impact Assessment

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

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

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

PROMOTING HEALTH EQUITY

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

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

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

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

Social Determinants of Health (SDOH)

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

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

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

- Condition prevalence
- Hospital readmissions

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

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

ACTIVITIES AND RESOURCES

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

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

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

DELIVERY SYSTEM SUPPORTS

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

Information Sharing

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

Shared Decision-Making Aids

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

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

Transformation Support

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

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

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

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

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

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

Pay for Value (P4V)

CalOptima Health's Pay for Value (P4V) program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health networks and CalOptima Health Community Network (CHCN) primary care providers are eligible to participate in the P4V programs.

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

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

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

PHM Structure

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

Team Roles and Responsibilities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PHM Oversight

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

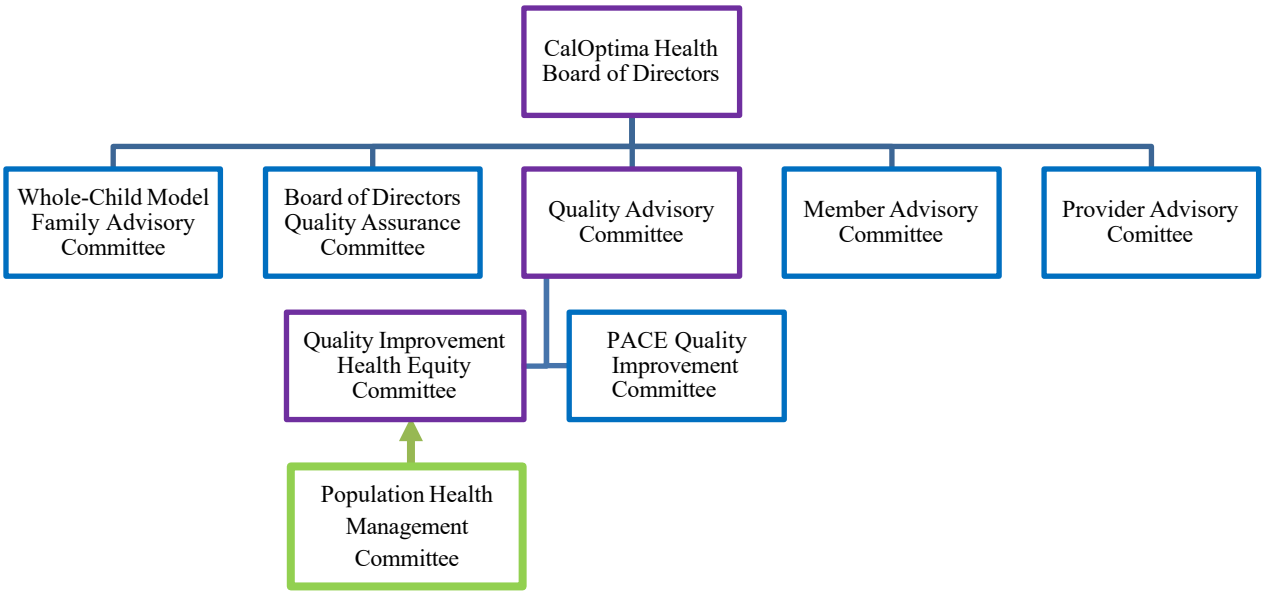
PHM Oversight Responsibilities

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

Committee Approval Descriptions

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

PHM Oversight Structure



Population Health Management Committee (PHMC)

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

Quality Improvement Health Equity Committee (QIHEC)

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

Board of Directors' Quality Assurance Committee (QAC)

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

CalOptima Health Board of Directors

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

2025 Population Health Management Work Plan

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

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

#	Area of Focus/ Evaluation Category	Program/ Initiative Description	Summary	SMART Objective(s)	Anticipated Completion Date	Population(s) of Focus	Planned Activities for 2025	Responsible Business Owner	Department	Oversight Reporting	Continue Monitoring from 2024	Results for the Quarter	Interventions/ Activities Implemented	Barriers	Next Steps/ Follow-Up Actions	Red- At Risk Yellow- Concern Green-On Target
			efforts, CalOptima Health aims to reduce the risk of chronic conditions complications and improve long-term well-being among members	satisfaction with program.		receive a package through the mail with information about the condition and on how to access health education services.	outreach, member self-referral, etc.) 2. Expand health education offerings in various community classes and events (e.g. clinic days, virtual and in-person classes, etc.) and tech-based modalities (app/web-based services).									
6	Program Oversight	Health Education	The Health Education program promotes early detection, fosters healthy habits, and supports preventive care. With a focus of prevention, CalOptima Health aims to reduce the risk of chronic conditions and improve long-term well-being among members.	By January 1, 2025, implement interventions for the 2025 Health Education program focused on promoting early detection, building fostering healthy habits, and empowering members to be proactive with preventive care.	Report progress to PHMC : • Q1: 02/20/25 • Q2: 05/15/25 • Q3: 08/21/25 • Q4: 11/20/25	Members with no to low risk.	1. Enhance methods for outreaching, promoting, and enrolling members in Health Education services and classes (e.g. text message outreach, member self-referral, etc.) 2. Expand health education offerings in various community classes and events (e.g. clinic days, virtual and in-person classes, etc.) and tech-based modalities (app/web-based services).	Director of Equity and Community Health & Manager of Equity and Community Health	Equity and Community Health	PHMC	X					
7	Quality of Service	Increase primary care utilization - Initial Health Appointment (IHA)	CalOptima Health ensures provision of an IHA. An IHA at a minimum must include: • History of the member's physical and mental health; • Identification of risks;	Increase the IHA completion rate for all new Medi-Cal members from 33% to 50% by December 31, 2025.	Report progress to PHMC : • Q1: 02/20/25 • Q2: 05/15/25 • Q3: 08/21/25 • Q4: 11/20/25	All new CalOptima Health members.	1. Enhance methods of informing members of the importance of IHA and preventive screenings. 2. Collaborate with delegation oversight to improve IHA	Senior Manager of Equity and Community Health & Program Manager of Equity and Community Health	Equity and Community Health	PHMC	X					

#	Area of Focus/ Evaluation Category	Program/ Initiative Description	Summary	SMART Objective(s)	Anticipated Completion Date	Population(s) of Focus	Planned Activities for 2025	Responsible Business Owner	Department	Oversight Reporting	Continue Monitoring from 2024	Results for the Quarter	Interventions/ Activities Implemented	Barriers	Next Steps/ Follow-Up Actions	Red- At Risk Yellow- Concern Green-On Target
			• Assessment of need for preventive screens or services and health education; • Physical examination; and • Diagnosis and plan for treatment of any diseases* **Unless the member's primary care provider (PCP) determines that the member's medical record contains complete information, updated within the previous 12 months, consistent with the assessment requirements.*				compliance by Health Network. 3. Provider and HN education to support new member screening for SDOH screening within 120 days.									
8	Cultural and Linguistic Appropriate Services	Birth Equity: Maternity Care for Black Members	CalOptima Health's Birth Equity initiative aims to improve birth outcomes by ensuring that all members have optimal birth conditions and addressing racial and asocial inequalities in birth outcomes.	1. Increase timeliness of prenatal care (TOPC) for CalOptima's Black members from 75.71% to 84.55% by December 31, 2025. 2. Increase postpartum care (PPC) for CalOptima's Black members from 71.43% to 80.23% by December 31, 2025.	Report progress to QIHEC : • Q1: 02/11/25 • Q2: 05/13/25 • Q3: 08/12/25 • Q4: 11/11/25	Pregnant members who are Black and Native American.	*Objectives 1 -2:* 1. Connect members to doula, Enhanced Care Management (ECM) services, and Black Infant Health (BIH) programs. 2. Implement community and clinic events that focus on improving prenatal and postpartum appointments. 3. Explore digital methods of providing perinatal assessments, education, and resource navigation for pregnant and postpartum members.	Manager of Quality Analytics & Program Manager of Quality Analytics	Quality Analytics	QIHEC	X					

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

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						complete one lead capillary or venous blood test within 6 months (before or after) their second birthday. - Denominator: Medi-Cal members who turn 24 months old during the measurement year. Child member must be continuously enrolled for 12 months (6 months before and 6 months after the 2nd birthday with no more than one gap in enrollment during the 12-month period where the gap is no longer than one month.										
10	Keeping Members Healthy	Maternal Health	The Maternal Health program aims to inform and provide resources to pregnant members to help them have a healthy pregnancy, delivery and baby.	1. Increase the Prenatal Depression Screening (PND-E) rate from 14.52% to 16.03% by December 31, 2025. 2. Increase the Prenatal Depression Screening (PND-E) follow-up rate on positive screening from 52.80% to 53.33% by December 31, 2025.	Report progress to PHMC : •Q1: 02/20/25 •Q2: 05/15/25 •Q3: 08/21/25 •Q4: 11/20/25	Members who are expecting or recently delivered. PND-E (Prenatal) Numerators: 1. Depression Screening - Deliveries in which members had a documented result for depression screening, using an age-appropriate standardized screening	*Objectives 1 -4:* 1. Provider maternal mental health training. 2. Enhance CalOptima Health Maternal Depression Program and support referral to Behavior Health Integration when screened at risk. 3. Conduct depression screenings at community events with a target population of maternal and	Director of Equity and Community Health & Senior Manager of Equity and Community Health	Equity and Community Health & Quality Analytics	PHMC	X					

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

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

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			change and self-management.	47.24% to 77% by December 31, 2025. 3. Increase CBP rate among Korean speaking Medi-Cal members from 24.87% to 64.48% by December 31, 2025. 4. Increase CBP rate among Vietnamese speaking Medicare members from 50.56% to 77% by December 31, 2025.		DHCS to receive a blood pressure monitor based on their health conditions and has not received one.										
12	Emerging Risk	Chronic Condition Care and Self-Management Program	Chronic Condition Care and Self-Management program promotes self-management skills for people with chronic conditions to enable them to manage their health on a day-to-day basis and to take an active role in their health care.	By December 31, 2025, 5% of members identified as emerging risk* and who participated in program will lower HbA1c to less than 8.0%. **Emerging risk is defined as members with a result of A1C 8.0% to A1C 9.0% who were previously in good control A1C less than 8.0% in previous 12 months.*	Report progress to PHMC : • Q1: 02/20/25 • Q2: 05/15/25 • Q3: 08/21/25 • Q4: 11/20/25	Members with diabetes that are at risk of HbA1c poor control. • Numerator: Medi-Cal Members 18-75 years of age with diabetes (types 1 and 2) who participated in the Chronic Conditions Care and Self-Management Program and lowered their HbA1c to less than 8% during the measurement year. • Denominator : Medi-Cal Members 18-75 years of age with diabetes (types 1 and 2) with a result of HbA1c 8.0%	1. Enhance Diabetes Education: Launch virtual and group education classes to improve member engagement by FY 2025. 2. Leverage Technology: Use digital apps and web-based tools to support diabetes prevention, management, and interactive engagement. 3. Strengthen Support Services: Link members to medically tailored meals, health coaching nutrition services, community/clinic events.	Manager of Quality Analytics, Quality Improvement Specialist & Manager of Equity and Community Health	Quality Analytics & Equity and Community Health	PHMC	X					

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						to HbA1c 9.0% who were previously in good control (HbA1c less than 8.0%) in previous 12 months.										
13	Emerging Risk	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	The FUA program assesses the percentage of emergency department (ED) visits for members aged 13 and older with a principal diagnosis of alcohol and other drug abuse or dependence to ensure our members receive appropriate follow-up care.	1. Increase the FUA (7-days) rates from 11.23% to 18.76% by December 31, 2025. 2. Increase the FUA (30-days) rates from 21.12% to 36.18% by December 31, 2025.	Report progress to QIHEC : ▪Q1: 02/11/25 ▪Q2: 05/13/25 ▪Q3: 08/12/25 ▪Q4: 11/11/25	Members 13 years and older as of the ED visit for substance use. ▪Numerators: ▫7-Day Follow-Up - A follow-up visit or a pharmacotherapy dispensing event within 7 days after the ED visit (8 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit. ▫30-Day Follow-Up - A follow-up visit or a pharmacotherapy dispensing event within 30 days after the ED visit (31 total days). Include visits and pharmacotherapy events that occur on the date of the ED visit. ▪Denominator: Medi-Cal members ages 13 and	*Objectives 1 -2:* 1. Share real-time ED data with our health networks on a secured FTP site. 2. Participate in provider educational events related to follow-up visits. 3. Utilize CalOptima Health NAMI Field Based Mentor Grant to assist members connection to a follow-up after ED visit. 4. Implement new behavioral health virtual provider visit for increase access to follow-up appointments. 5. Bi-Weekly Member Text Messaging (approx. 500 members) 6. Member Newsletter (Spring)	Director of Behavioral Health Integration & Senior Manager of Behavioral Health Integration	Behavioral Health Integration	QIHEC	X					

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						older who had emergency department (ED) visits with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up during the measurement period.										
14	Patient Safety	CalAIM Community Supports	California Advancing and Innovating Medi-Cal (CalAIM) is a 5-year initiative by the DHCS to improve the quality of life and health outcomes of the Medi-Cal population by addressing social drivers of health and breaking down barriers in accessing care. Community Supports are a core component of CalAIM.	By December 31, 2025, enhance community support services (e.g., housing transition navigation services, housing deposits, and housing tenancy and sustaining services) to achieve optimal care coordination, as demonstrated by auditing the performance of 10 providers.	Report progress to PHMC : ▪ Q1: 02/20/25 ▪ Q2: 05/15/25 ▪ Q3: 08/21/25 ▪ Q4: 11/20/25	Eligible CalOptima Health Members that are referred to CalAIM Community Supports. ▪ Numerator: Eligible CalOptima Health members who qualify for CalAIM Community Supports (CCS) between January 1st - December 31st, 2025 and received at least one CCS. ▪ Denominator: Eligible CalOptima Health members referred to CCS* between January 1st - December 31st, 2025. To qualify for CalAIM Community	1. Conduct housing transition navigation services audits. 2. Conduct housing deposits audits. 3. Conduct housing tenancy and sustaining services audits.	Director of Medi-Cal & CalAIM	CalAIM	PHMC	X					

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						the member must be eligible for CalOptima Health and referred or self-referred to CCS. Eligibility criteria for each CSS varies and listed on the referral form.										
15	Patient Safety	Street Medicine Program	CalOptima Health's Street Medicine Program model is implemented by a contracted medical and social service provider who is responsible for identifying and managing the comprehensive needs of Orange County's un-housed individuals and families through whole person care approaches and addressing social drivers of health.	1. By December 31, 2025, connect 80% of unhoused participating members to an active Primary Care Physician (PCP). 2. By December 31, 2025, connect 90% of unhoused participating members with CalAIM ECM and Housing Navigation. 3. By December 31, 2025, connect 20% of unhoused participating members to a shelter or other housing option.	Report progress to PHMC : • Q1: 02/20/25 • Q2: 05/15/25 • Q3: 08/21/25 • Q4: 11/20/25	Members that are experiencing homelessness Numerator: Eligible CalOptima Health members who are experiencing homelessness *, opted into the Street Medicine program, and: - assigned to a Medical Home; - received CalAIM ECM or at least one Community Support; OR - referred to a shelter or other housing option. Denominator: Members eligible for CalOptima Health who are experiencing homelessness * during the measurement period. *Members that are eligible for CalOptima Health	*Objective 1:* 1. Offer all members the opportunity to utilize the Street Medicine Provider as their PCP. 2. Utilize Releases of Information when member has active PCP to increase collaboration and communication. 3. Support member with PCP change, as needed. 4. Care scheduling and delivery. *Objective 2:* 1. Make attempts to engage with members weekly. 2. Provide ECM and/or Housing Navigation appointments face to face at least every other week. 3. Care scheduling and delivery. 4. Document all encounters. *Objective 3:* 1, Outreach to and engage unsheltered	Director of Medi-Cal & CalAIM	CalAIM	PHMC	X					

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						services self-report experiencing homelessness to Street Medicine Team canvassing in designated geographic locations within Orange County during the measurement period.	individuals 2. Provide ECM and/or Housing Navigation 3. Enter members in to the Coordinated Entry System 4. Connect individuals to local shelters 5. Work with members on completing housing documentation									
16	Managing Multiple Chronic Conditions	Complex Case Management Program	Complex Case Management is the coordination of care and services provided to a Member who has experienced a critical event, or diagnosis that requires the extensive use of resources, and who needs assistance in facilitating the appropriate delivery of care and services.	1. Ensure provision of CCM services resulting in optimal care coordination as evidenced through monthly auditing of 5 files or 5% of files for each health network resulting in a minimum score of 90% through December 31, 2025. 2. Obtain 85% member satisfaction in CCM program by December 31, 2025. 3. 85% of members surveyed who participated in CCM between January 1, 2024– December 31, 2025, will report that the case management process helped them meet their care plan goals.	Report progress to PHMC : • Q1: 02/20/25 • Q2: 05/15/25 • Q3: 08/21/25 • Q4: 11/20/25	Members with the most complex health care needs. Most frequently managed conditions, diseases or high-risk groups (including, but not limited to): Spinal injuries, transplants, cancer (with additional complex condition, serious trauma, AIDS, multiple chronic illnesses, chronic illnesses that result in high utilization, children and adolescents with special health care needs, serious and persistent mental illness with complex medical illness, and/or members with a medical condition and	*Objective 1:* 1. Continue training and educational opportunities to staff on the 2025 PHM5 Element D and E and complex conditions/ situations. *Objective 2:* 1. Member Satisfaction scores will be shared with the CCN and the delegates to provide valuable insight to help identify strengths and areas for improvement to enhance the quality of care and member outcomes or and improve the member experience in CM programs. 2. Ongoing training and support for new and existing staff *Objective 3:* 1. Continue to gather member feedback to improve outcomes.	Director of Case Management & Quality Improvement Nurse Specialist	Case Management	PHMC	X					

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

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

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

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

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

MY2025 Medi-Cal Pay for Value (P4V)

The Medi-Cal P4V program incentivizes performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) that are included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL). The Medi-Cal P4V programs also incentives for Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the Medi-Cal P4V program.

Recommended for MY2025 Medi-Cal P4V

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

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

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

- Utilize both the child and adult CAHPS results, proportional to the age distribution of the assigned member population. For example, if a HN's membership is 30% children ages 0 to 18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.

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

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

OneCare Pay for Value Program (P4V)

The OneCare P4V program focuses on areas with the greatest opportunity for improvement and incentivizes performance on select Centers for Medicare and Medicaid Services (CMS) Star Part C and Part D measures. Measures are developed from industry standards including HEDIS, CAHPS member experience, and Pharmacy Quality Alliance. Health networks (HNs) and CalOptima Health Community Network (CCN) primary care physicians (PCPs) are eligible to participate in the OneCare P4V program.

Recommended for MY 2024 OneCare P4V

Alignment with the CMS Star program and the following components:

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

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

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

3. Program funding of $20 PMPM

2025 Culturally and Linguistically Appropriate Services (CLAS) Program Description

Table of Contents

CalOptima Health Overview

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

Our Mission

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

Our Vision

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

Who We Serve

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

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

Membership Demographics

Membership Data (as of 10/31/2024)

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

Member Demographics (as of 10/31/2024)

Member Age

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

Language Preference

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

Medi-Cal Aid Category

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

Our Commitment to Culturally and Linguistically Appropriate Services (CLAS)

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

Objectives for culturally and linguistically diverse membership include:

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

Authority and Accountability

Board of Directors

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

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

Board of Directors' Quality Assurance Committee

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

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

Member Advisory Committee

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

The MAC membership includes representatives from the following constituencies:

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

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

Provider Advisory Committee

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

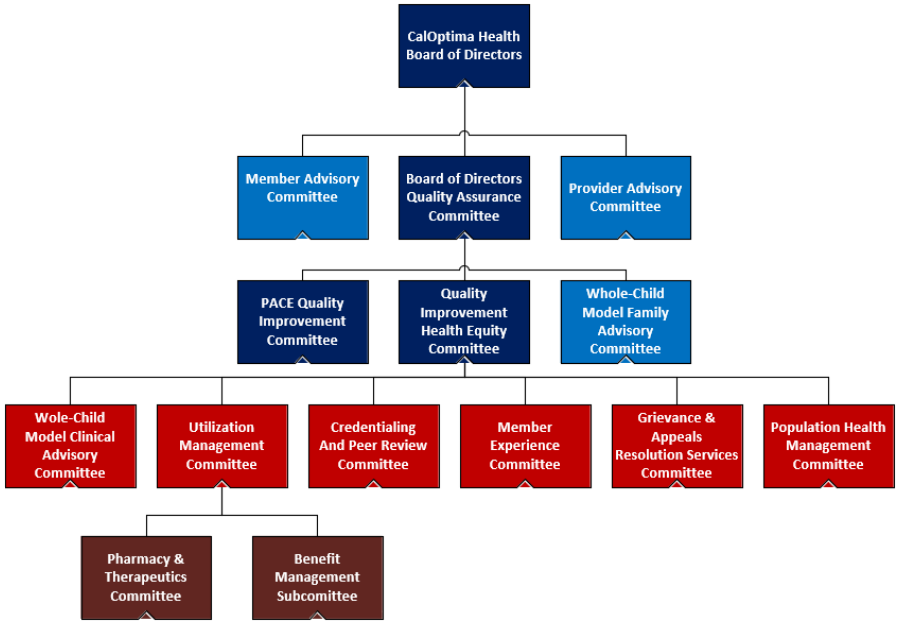
members. The PAC has 15 members, 14 of whom serve three-year terms with two consecutive term limits, along with a representative of Orange County Health Care Agency, which maintains a standing seat. PAC meetings are open to the public. The 15 seats include:

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

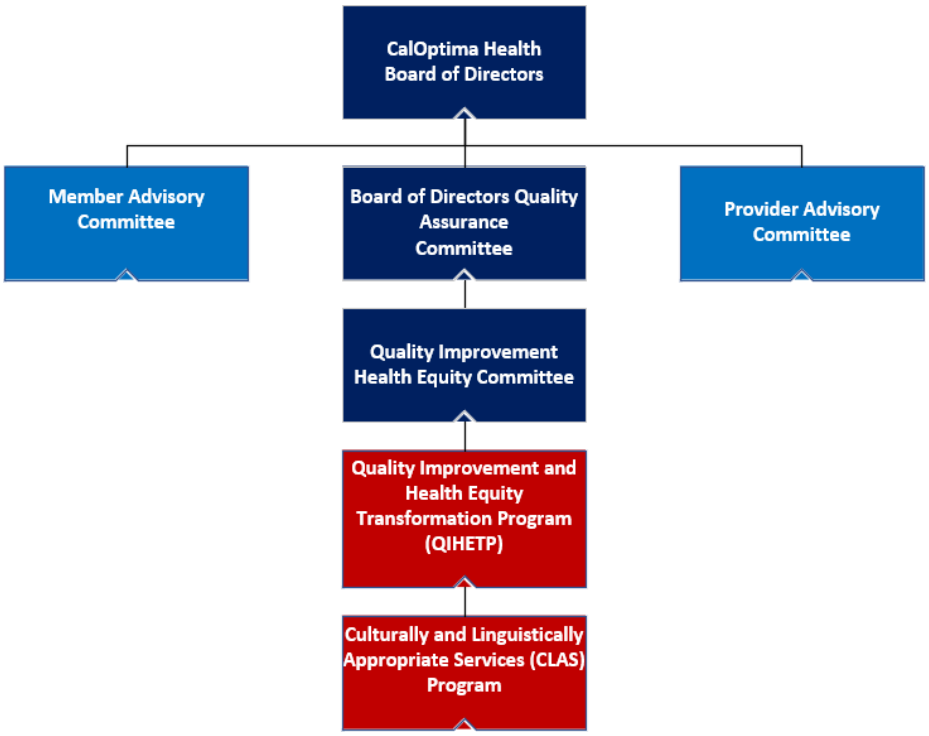
Quality Improvement Health Equity Committee (QIHEC)

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

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



CLAS Reporting Structure



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

Community and Member Engagement

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

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

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

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

Goals

The following are the 2025 goals for the CLAS Program:

1. By August 1st, 2025, CalOptima Health will expand the threshold languages to include Russian to meet requirements established by the California Department of Health Care Services (DHCS).
2. By March 31st, 2025, CalOptima Health will launch a language services experience survey for members and staff and aim to collect feedback from at least 10% of members and 80% of staff using surveys and will analyze the results to identify improvements to language services.
3. By Dec. 31st, 2025, CalOptima Health will increase the collection race/ethnicity/language (REL) by 10% through focused outreach and education, ensuring better representation and inclusion of providers.
4. By Dec. 31st, 2025, CalOptima Health will increase the collection of sexual orientation gender identify (SOGI) data by 10% through focused outreach and education, ensuring better representation and inclusion of members.
5. By Dec. 31st, 2025, CalOptima Health will implement and train 90% of staff, health networks, and providers on Diversity, Equity and Inclusion (DEI) training, ensuring compliance with DHCS All Plan Letter (APL) 24-016.

CLAS Workplan

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

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

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

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

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

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

CLAS Monitoring Progress

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

CLAS Evaluation

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

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

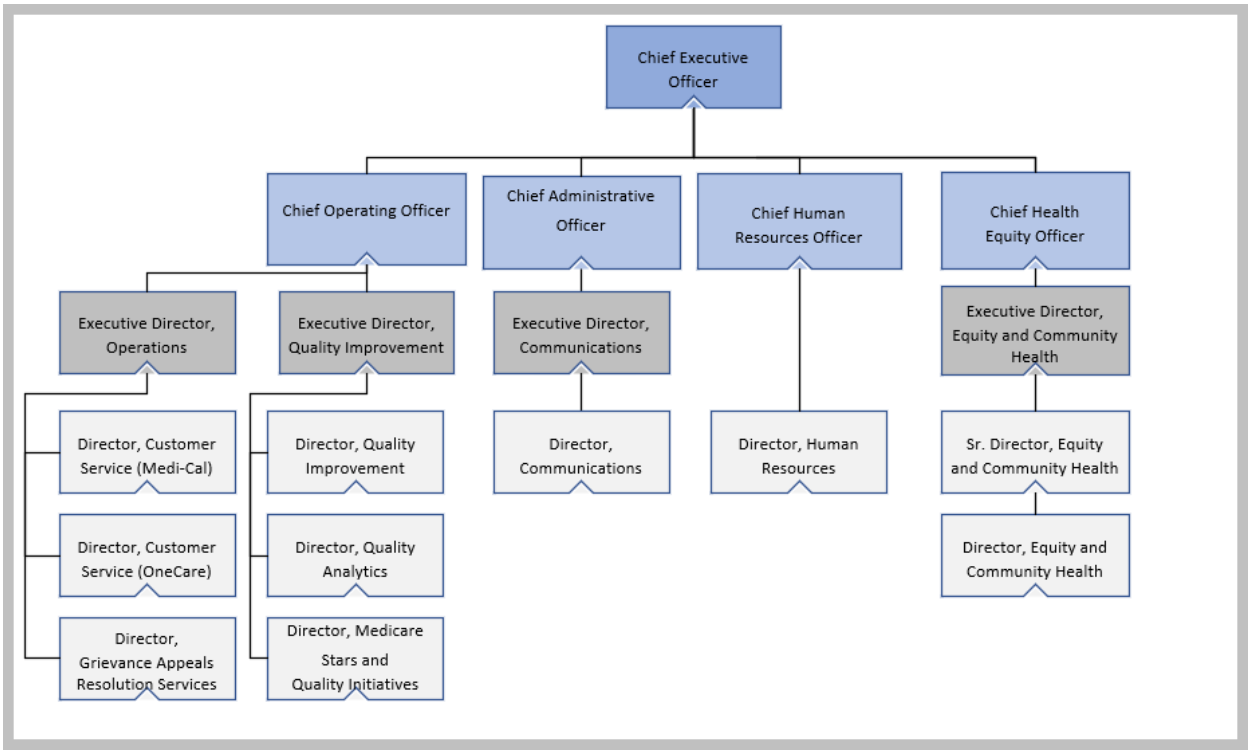
barrier analyses, to prepare for new interventions.
- An evaluation of the effectiveness of CLAS activities, including QIPs, PIPs and PDSAs.
- An evaluation of the effectiveness of member experience surveys related to cultural and linguistic services.
- A report to the QIHEC and QAC summarizing all CLAS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

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

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

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

Cultural & Linguistic Services Organizational Chart Structure



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Language Services

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

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

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

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

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

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

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

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

Cultural & Linguistic Services Language Competency Testing

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

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

Cultural Competency and Training

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

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

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

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

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

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

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

Promotion of Diversity, Equity and Inclusion

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

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

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

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

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

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

Data Collect and Analysis

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

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

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

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

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

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

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

CalOptima Health

2024 Quality Improvement and Health Equity Program Evaluation

Quality Assurance Committee Meeting

March 12, 2025

Linda Lee, Executive Director Quality Improvement

Our Mission

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

Our Vision

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

2024 Quality Improvement and Health Equity Transformation Program (QIHETP) Evaluation

2024 Program Achievements

- **April 2024:** CalOptima Health approved nearly $25 million in workforce education grants to seven institutions in Orange County.
- **June 2024:** CalOptima Health approved an investment of $526.2 million to increase rates paid to network providers in Orange County.
- **August 2024:** CalOptima Health held its largest community event ever, the Back-to-School Health and Wellness Fair.
- **August 2024:** CalOptima Health launched its second Street Medicine Program in Costa Mesa in partnership with Celebrating Life Community Health Center. The following month, the CalOptima Health Street Medicine Program began in Anaheim.
- **December 2024:** CalOptima Health partnered with Illumination Foundation, an Orange County-based nonprofit, to open the nation's first recuperative care center to serve medically vulnerable children and families experiencing homelessness.

Review of 2024 Priority and Goals

Priority Goals	Evaluation
Close racial/ethnic disparities in well-child visits and immunizations by 50%	• CalOptima Health focused on increasing well-child visit appointments for African American members (0-15 months) from 41.90% to 55.78% by 12/31/2024. • Conducted outreach to 85 members through telephone, email and text and reached 40% (34) of members outreached. • Rate improved from the previous year, but the was goal not met.
Close maternity care disparity for Black and Native American persons by 50%	• CalOptima Health focused on increasing prenatal and postpartum appointments for African and Native American* members. • Goal to increase timely PPC postpartum appointments for CalOptima Health's Black members from 67.48% to 74.74% • Conducted member outreach and promotion of the Bright Steps Program. • Goal set for this initiative was met for the African American population.
Exceed the 50th percentile for all children's preventive care measures	• For MY2023, CalOptima Health met or exceeded the 50th for all children's preventive measures and goal was met.

*Native American denominator too low to calculate a statistically significant rate.

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Review of 2024 Priority Goals

Priority Goals	Accomplishments
Improve maternal and adolescent depression screening by 50%	• Maternal depression screening rate increased from 8.73% in MY 2022 to 14.52% in MY2023, with a 5.79% increase in material screening. Goal Met. • Adolescent depression screening rate increased from 1.98% in MY2022 for both adolescents and adults to 6.57% in MY2023 for only adolescents. Goal Met.
Improve follow-up care for mental health and substance abuse disorder by 50%	• Follow-up care for mental health within 30 days after an emergency room visit decreased from 58.83% in MY 2022 to 35.73% in MY2023. Goal Not Met. • Follow-up care for substance abuse within 30 days after an emergency room visit decreased from 24.05% in MY 2022 to 21.41% in MY2023. Goal Not Met.

Medi-Cal: Exceed the minimum performance levels (MPLs) for MCAS	• Did not meet the minimum performance levels (MPL) for the following MCAS measures:
	  • Follow-up After ED visit for Alcohol and Other Drug Dependence within 30 days (FUA) and
	  • Follow-up After ED visit for Mental Illness within 30 days (FUM)

OneCare: Attain a Four-Star Rating for Medicare	• CMS Star-Rating at 2.5 for MY 2023 – Goal Not Met

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2024 QI Evaluation Highlights: Program Structure and Oversight

- The QIHEC met 12 times in 2024
  - Six (6) subcommittees met at least quarterly in 2024
    - Population Health Management Committee launched in 2024
- Expanded the Comprehensive Community Cancer Screening Program to include a grants program.
- Launched the Student Behavioral Health Incentive Program (SBHIP)
- Expanded the Street Medicine Program to additional cities
- Developed, approved and implemented a new Cultural and Linguistically Appropriate Services Program
- Launched activities to prepare for the NCQA Health Equity Accreditation Survey scheduled for October 7, 2025.
- Launched a Star Executive Steering Committee to focus on Stars measure improvement

2024 QIHETP Evaluation Highlights: Quality of Clinical Care and Performance Outcomes

- Medi-Cal
  - NCQA[1] Health Plan Rating
    - Prevention and Equity: 4 Stars
    - Treatment: 3 Stars
  - CalOptima Health met 16 of the 18 MCAS[2] measures held to the MPL[3]
    - Measures that did not meet MPL:
      - Follow-up After ED visit for Alcohol and Other Drug Dependence within 30 days (FUA) didn't meet MPL
      - Follow-up After ED visit for Mental Illness within 30 days (FUM) didn't meet MPL

1. NCQA - National Committee for Quality Assurance
2. MCAS – Medi-Cal Managed Care Accountability Set; goal is 50th percentile
3. MPL – Minimum Performance Level

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2024 QIHETP Evaluation Highlights: Quality of Care and Performance Outcomes

- OneCare
  - 14 of the 18 Star measures achieved a 3.0 Star or higher rating
  - The following measures reported a 2.0 Star rating
    - Osteoporosis Management in Women who had a Fracture (OMW)
    - Transitions of Care (TRC)
    - Follow-Up after ED Visit for People with Multiple High-Risk Chronic Conditions

2024 QIHETP Evaluation Highlights: Quality of Service and Member Experience

- Member Experience (CAHPS[1]) Surveys were fielded at both the plan and network level in 2024
  - NCQA[2] Health Plan Rating for Patient Experience at 2.5-Stars (Medi-Cal)
  - CMS Star Rating (OneCare)
    - Rating of Health Plan at 2-Stars
    - Rating of Health Care Quality 1-Stars
- CalOptima Health submitted all deliverables to DHCS 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. CAHPS - Consumer Assessment of Healthcare Providers and Systems
2. NCQA - National Committee for Quality Assurance
3. CMS – Centers for Medicare and Medicaid

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2024 QIHETP Evaluation Highlights: Safety of Clinical Care

- Transitions of Care (TCS) Program Case Management continues to outreach to TCS High Risk members to ensure member needs are met post-hospitalization.
- VSP data shared with health networks to improve coordination of care for members with diabetes.
- The Emergency Department Diversion Program was in development throughout 2024 and is scheduled to launch in January 2025 at the UCI Medical Center Emergency Department

2024 QIHETP Evaluation: New Recommendations for 2025

- Implement a Diversity, Equity and Inclusion Training Program for staff, our health networks and our network providers that includes sensitivity, diversity, cultural competency and cultural humility, and health equity training programs.
- Leverage technology and automation to streamline quality operations, enhance productivity.

CalOptima Health

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2025 Quality Improvement and Health Equity Transformation Program (QIHETP) Description and Work Plan

Quality Assurance Committee Meeting

March 12, 2025

Linda Lee, Executive Director Quality Improvement

Our Mission

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

Our Vision

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

2025 QIHETP Priority Areas and Goals

Priority Areas	Goals
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 ○ Attain NCQA Health Equity Accreditation

2025 Work Plan contains specific SMARTs goals aligned with these priority and goals

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2025 QIHETP Description: Revision Highlights

- Updated the priority areas and goals for 2025
- Revised scope of services for OneCare to include OneCare Complete and OneCare Flex Plus
- Updated QIHEC's responsibilities to oversee the following:
  - CLAS Program
  - Diversity, Equity and Inclusion (DEI) Training Program
- Updated sections in the QIHETP to reflect current operational processes and workflows
  - Member Experience – Behavioral Health Member Experience Survey

2025 QIHETP Description: Revision Highlights

- Updated the QIHE Program Staffing and Resources to reflect current organizational structure
  - Added Chief Administrative Officer
  - Added Senior Director, Equity and Community Health
- Removed programs that sunset in 2024
- Updated sections in the QIHETP to reflect current operational processes and workflows
- 2025 Workplan
  - Grouped measures under a focus area
  - Added measures below goal for: MCAS, Star Ratings, NCQA Accreditation Health Plan Ratings, NCQA Health Plan Continuity of Care focus, and Quality Withhold.
  - Minor edits were made to the assignments since the document were released
  - Added support staff for 2 elements

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2025 QIHETP Work Plan Updates: Program Oversight

Change	Programs/Initiatives
Added	• Complex Case Management Program (new to overall workplan, was in the PHM Strategy) • CalAIM Community Supports and Enhance Care Management (ECM) • Street Medicine Program
Changed	• OneCare Stars and Quality Performance – combined and expanded to incorporate all quality programs • School-Based Services Mental Health Services – program has evolved, and item moved to Quality of Clinical Care • Comprehensive Cancer Screening Program – moved to Quality of Clinical Care
Removed	• Health Equity (now embedded throughout the entire work plan)

2025 QIHETP Work Plan Updates : Quality of Clinical Care

Change	Programs/Initiatives
Add	• Follow-up After High-Intensity Care for Substance Use Disorder (FUI) • Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) • Controlling High Blood Pressure (CBP) Health Disparity • Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC) • Osteoporosis Management in Women Who Had a Fracture (OMW) • Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics (APP) • Pharmacotherapy for Opioid Use Disorder (POD) • Appropriate Testing for Pharyngitis (CWP) • Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) • Adult Immunization Status • Medication Adherence
Change	• Coordination of Care: Member movement across practitioners – monitored by other continuity of care measures in the work plan
Remove	• Improve Adverse Childhood Experiences (ACES) Screening • Follow-Up Care for Children Prescribed ADHD medication (ADD) • Encounter Data Review

2025 QIHETP Work Plan Updates : Quality of Service, Safety of Clinical Care and CLAS

Change	Programs/Initiatives
Add	• Plan All Cause Readmission
Change	• Emergency Department (ED) Program (formerly the ED Diversion Pilot) • Data Collection on Member and Practitioner Demographic Information (goal changed from implementation to increase data collection rates)
Remove	• None

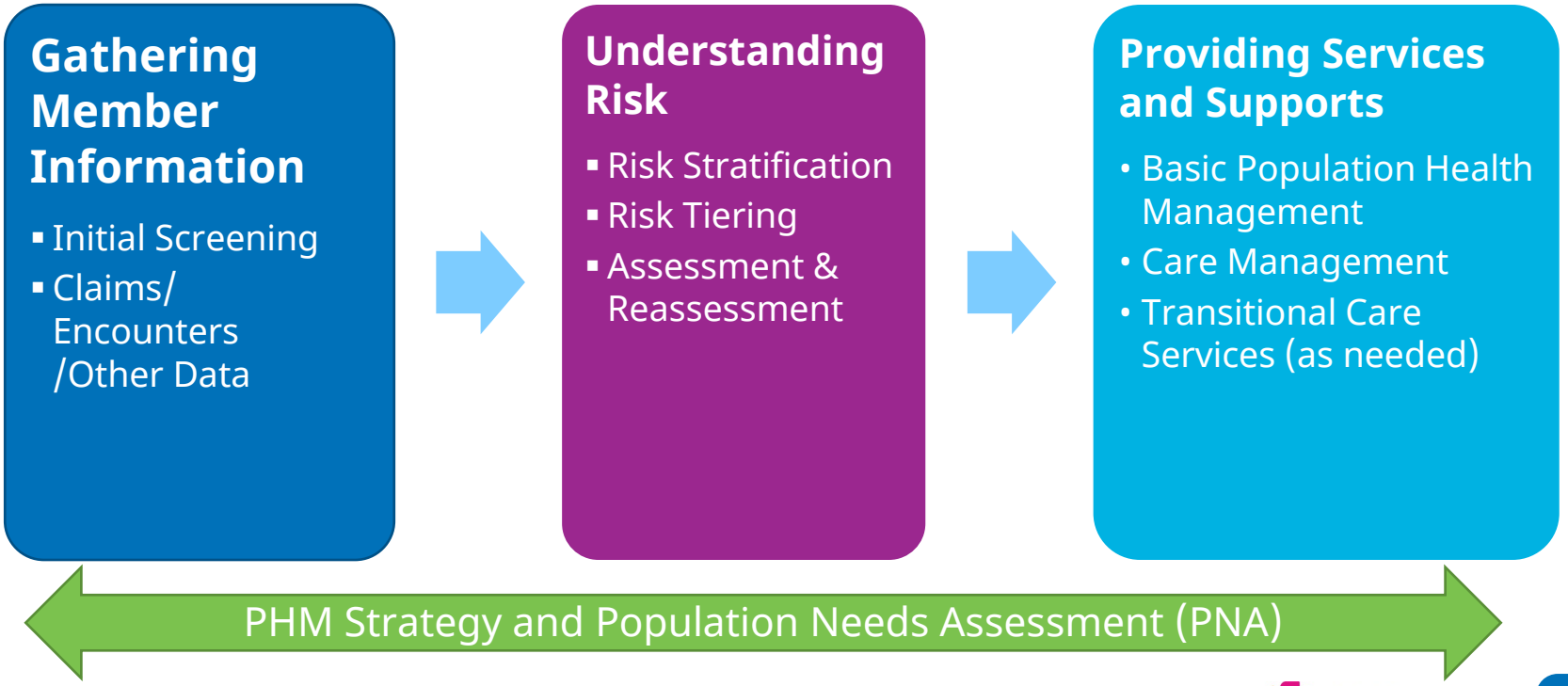
2025 Population Health Management Strategy and Work Plan

Marie Jeannis, Executive Director,
Equity and Community Health

CalAIM PHM Program

The PHM Program is a statewide initiative designed to ensure all members have access to a comprehensive set of services based on their needs and preferences, across the continuum of care*.

PHM Framework



*Source: Department of Health Care Services (DHCS) Population Health Management (PHM) Policy Guide, May 2024

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PHM Strategy

- Comprehensive action plan that describes CalOptima Health's approach to meeting members' needs
  - Annual assessment of member needs and characteristics
  - Five areas of focus
  - Aligns with National Committee for Quality Assurance (NCQA) PHM guidelines.

PHM Workplan and Oversight

- PHM Work Plan describes activities to support the PHM Strategy
  - Aligns with both DHCS and NCQA requirements
- Population Health Management Committee (PHMC)
  - Provides overall direction for continuous process improvement and oversight of the PHM Program
  - Ensures PHM activities are consistent with CalOptima Health's strategic goals and priorities
  - Monitors compliance with regulatory requirements
- PHM Impact Report
  - Annual evaluation of PHM Strategy and workplan activities

2024 PHM Impact Report

2024 PHM Impact Report Overview

- On an annual basis, CalOptima Health assesses the effectiveness of its PHM Strategy which includes:
  - Achievements from the previous year
  - Program structure
  - Responsibility and success of PHM Strategy
  - Identification of new initiatives
- Results of the PHM Impact analysis used to identify opportunities for improvement and targeted interventions

2024 Program Achievements

- **February 2024**: Established PHMC
- **April 2024**: Aligned Equity and Community Health* department under the Chief Health Equity Officer and established a Community Impact Team
- **May 2024:** Completed Organizational Health Literacy (OHL) Assessment for Equity Infrastructure
- **September 2024:** Sponsored 125 community-based partners for the Maternal Mental Health Certificate Training course
- **October 2024**: Developed Diversity, Equity, Inclusion and Belonging training approved by DHCS
- **November 2024:** Launched two health and wellness pilot events (Clinic Days) in collaboration with UCI**

*Formerly Population Health Management Department

**University of California Irvine Family Health Centers

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CalOptima Health

Review of 2024 Areas of Focus

Focus Area	Priority Goals	Evaluation
Keeping Members Healthy	40% of participants will improve basic nutrition knowledge based on pre and post assessment*	• Exceeded goal – 47% of participants in the SYL* program who completed the pre- and post-assessment will increase their knowledge of basic nutrition and healthy lifestyle • Implemented the first Vietnamese in-person Shape Your Life (SYL) class in Westminster. • Expanded SYL program to six (6) locations throughout Orange County
Emerging Risk	Lower hemoglobin A1C rate to 8% for members with diabetes identified as emerging risk**	• Goal partially met - additional time required to review definition of emerging risk and analyze impact of health coaching
Patient Safety	Provide at least one service to 90% of members referred to CalAIM Community Support	• Exceed goal – 94% of members received at least one CalAIM Community Support

*Weigh management program for children ages 5-18 and their families
**Emerging risk is defined by members that were previously controlled <8.0% A1C level but had a recent A1C level result of 8.0% to 9.0%

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Review of 2024 Areas of Focus

Focus Area	Priority Goals	Evaluation
Patient Safety	Connect 80% of unhoused participating members to an active Primary Care Physician (PCP)	• Exceeded goal – 83% of unhoused participating members connected to PCP • Expanded Street Medicine programs in Costa Mesa with Celebrating Life Community Health Center and Anaheim with Healthcare in Action.
Patient Safety	Enroll 90% of unhoused participating members with CalAIM Enhanced Care Management (ECM) and Housing Navigation	• Exceeded goal - 95% of unhoused participating members were enrolled into offered services. • Offered services included: Face to Face appointments, care scheduling, connecting and providing supportive services.
Managing members with Multiple Chronic Conditions (CCM)	Quarterly HN CCN file audit: • Audit 5% of Health Network files (minimum of 5) • Achieve score of 90%	• Goal partially met – 6 of 8 networks achieved minimum audit score of 90%

*Emergency Department

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2025 PHM Strategy and Work Plan

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2025 PHM Strategy Areas of Focus and Goals

Priority Areas	Goals
Keeping Members Healthy	○ Increase Controlling Blood Pressure (CBP) rate to 50th percentile for Black/African American, Korean, and Vietnamese members
Emerging Risk	○ Lower HbA1c to less than 8.0% in members identified as emerging risk* and who participated in program
Patient Safety	○ Audit performance of 10 community support providers to review care coordination effectiveness ○ Connect 80% of unhoused participating members to an active Primary Care Physician (PCP) ○ Enroll 90% of unhoused participating members into CalAIM Enhanced Care Management (ECM) and Housing Navigation
Managing Multiple Chronic Conditions	○ Quarterly HN CCN file audit: • Audit 5% of Health Network files (minimum of 5) • Achieve score of 90%
Advanced Care Support	○ Increase number of members authorized for ECM services by 10%

2025 PHM Strategy Revision Highlights

- Updated areas of focus to include Enhanced Care Management (ECM) under Advance Care Support
- Revised department name and included roles (e.g., Senior Director of Equity and Community Health)
- Added Program Oversight, Quality of Service and Cultural and Linguistic Appropriate Services as new PHM Workplan Categories

2025 PHM Strategy Work Plan Updates

Change	Programs/Initiatives
Added	• Workplan sections for Program Oversight, Quality of Service and Cultural and Linguistic Appropriate Services • Controlling Blood Pressure (Hypertension) • Area of Focus – to include Advance Care Support • Increase number of members authorized for ECM services by10%
Changed	• Population Health Management department name updated to Equity and Community Health • PHMC Structure to add Chief Medical Officer (CMO) as voting member
Removed	• Health Equity (now embedded throughout the entire work plan) • Shape Your Life as workplan goal

Culturally and Linguistically Appropriate Services (CLAS) Program

Ladan Khamseh, Executive Director Operations

2024 Culturally and Linguistically Appropriate Services (CLAS) Evaluation

- The 2024 CLAS evaluation provides an overview of all the activities conducted by CalOptima Health staff. It outlines the successes, challenges and opportunities for improvement.
- The CLAS evaluation includes:
  - Program Structure
  - Language Services
  - Data Collection and Analysis
  - Trainings
  - Promotion of Diversity
  - Practitioner Network Cultural Responsiveness
  - CLAS Improvement and Reduction in Health Care Inequities

2024 Culturally and Linguistically Appropriate Services (CLAS) Evaluation

- Overall, the 2024 CLAS Program was successful and yielded positive results.
  - Successfully implemented 5 of 6 2024 Work Plan CLAS goals.
  - CLAS updates reported to QIHEC quarterly on all CLAS activities and obtained feedback and guidance from the QIHEC.
  - The 2024 CLAS Program goals and results were presented at the December MAC/PAC meeting, and committee members provided feedback.
  - Assessment of staff and resources was conducted to ensure sufficient support for CLAS activities. Human Resources worked with the business areas to fill vacant and needed positions to support the Program.
  - Monitored language services utilization to ensure members had access to language services during healthcare encounters.

2024 CLAS Evaluation: New Work Plan Goals for 2025

- The 2025 Work Plan will carry over goals implemented in 2024 including building on the process of improving the collection of Sexual Orientation, Gender Identify, and member data. Collection of Race, Ethnicity and language data from CalOptima Health practitioners.
- The Work Plan will include two new goals:
  - Expand CalOptima Health's threshold languages to include Russian to meet requirements established by the California Department of Health Care Services (DHCS).
  - Implement and educate CalOptima Health and health network staff on Diversity, Equity and Inclusion (DEI) training, ensuring compliance with DHCS requirements.

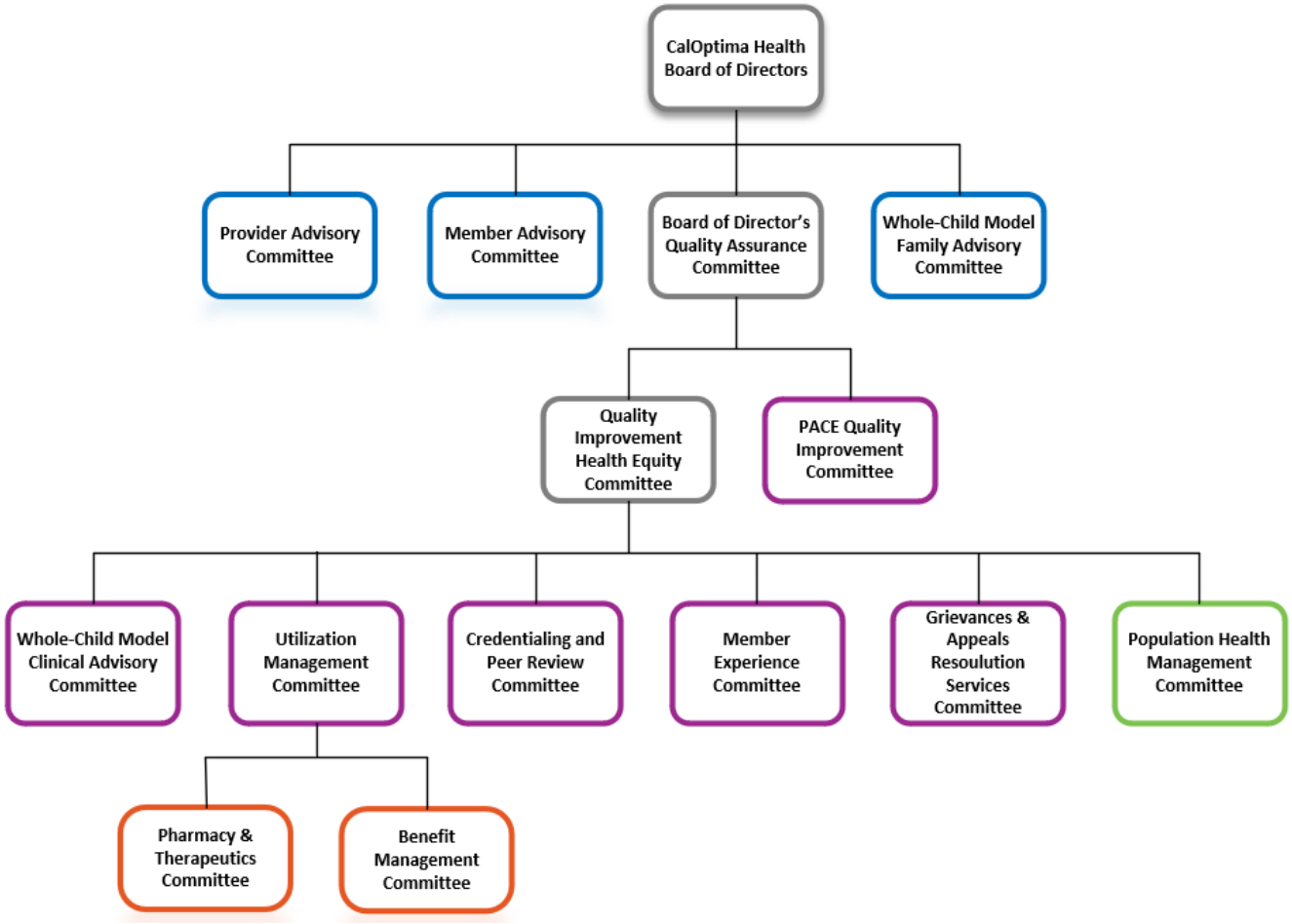
2025 CLAS Program Description

The 2025 CLAS Program revisions and updates include:

- Member demographics
  - Updates to CalOptima Health membership by age, language, and aid codes
- CLAS and Cultural and Linguistics reporting structure
  - Updates to new organization chart positions
- Member and Provider Advisory Committees (MAC & PAC)
  - Revisions to better define MAC & PAC membership/representation and responsibilities
- 2025 CLAS Workplan
  - Updates to Goals and objectives
- Data Collection and Analysis
  - Revisions to better define collection and analysis process

Appendix

PHM Committee Organizational Structure



Eleven (11) internal executive staff and three (3) external partners who represent:

- Community-based organizations
- Health Network medical directors
- Orange County Health Care Agency

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CalOptima Health Board Action Agenda Referral

Action To Be Taken April 3, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

4. Approve the 2024 CalOptima Health Utilization Management Program Evaluation and the 2025 CalOptima Health Integrated Utilization Management/Case Management Program Description

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, Medical Management, (714) 246-8491
Kelly Giardina, MSG, CCM, Executive Director, Utilization Management, (657) 900-1013

Recommended Actions

1. Approve the Annual 2024 CalOptima Health Utilization Management Program Evaluation, and
2. Approve the updates to the Annual 2025 CalOptima Health Integrated Utilization Management and Case Management Program Description.

Background

CalOptima Health's Utilization Management (UM) Program describes how medically necessary and quality health care services are delivered to members in a coordinated, comprehensive, and culturally competent manner. The program ensures that medical decision making is not influenced by financial considerations, does not reward practitioners or other individuals for issuing denials of coverage, and does not encourage decisions that result in underutilization.

CalOptima Health's UM Program is reviewed and evaluated annually and approved by the Board of Directors. The UM Program defines the structure within which UM activities are conducted and establishes processes for systematically coordinating, managing, and monitoring these processes to achieve positive member outcomes.

CalOptima Health's UM Program achievements in 2024 include:

- Enhanced reporting and workflows to prioritize treatment authorization and inventory oversight to continue to exceed required turnaround times;
- Provider portal enhancements to increase automation and capabilities;
- Design, configuration, and implementation in February 2024 of a new clinical documentation platform, Jiva;
- Continuity of care protocol refinements;
- Transplant and transitional care services program enhancements;
- Launch of the following care coordination workgroups: Over/Under Utilization; Early and Periodic Screening, Diagnostic and Treatment (EPSDT); Case Management; and High-Risk Management;
- Identified over and under-utilization metrics to be standardly reviewed and monitored internally and across Health Networks and CalOptima Health Community Networks;
- Updated the UM hierarchical criteria for Medi-Cal and OneCare to include additional clinical guidelines;
- Launch of pediatric facility rounds;

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- Continued weekly support with University of California, San Diego Transplant Center of Excellence;
- Removal of preventive and screening prior authorization requirements for OneCare;
- Refinement of pediatric reviews to ensure inclusion of EPSDT criteria;
- Refinement of post stabilization authorization workflows and processes; and
- Refinement of gender affirming care reviews.

Discussion

CalOptima Health's 2025 Integrated UM and Case Management (CM) Program Description includes the following departments: quality, pharmacy, population health management, and behavioral health. The program description is designed to ensure that all regulatory requirements and National Committee for Quality Assurance (NCQA) accreditation standards are met in a consistent manner across all lines of business and are aligned with health network and strategic organizational changes.

The key revisions to the Annual 2025 Integrated UM and CM Program Description include but are not limited to the following areas:

- Updates to Clinical Operations / Medical Management 2025 priorities and objectives;
- Adoption of a formal Emergency Department Diversion Program;
- Enhancements to oversight of Health Network affiliation and provider network data;
- Behavioral Health programmatic enhancements;
- Updates to CalOptima Health team and UM Leadership;
- Department name change from Population Health Management to Equity and Community Health;
- Multipurpose Senior Services Program expansion of available care slots;
- Continued refinement to physician led workgroups: UM Workgroup; High-Risk Management Workgroup; Over/Under Utilization Workgroup; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Workgroup; and Enhanced Case Management Clinical Oversight Workgroup;
- Updates to hierarchy of clinical criteria;
- Program enhancements to Transitional Care Services;
- OneCare program implementation of Palliative Care Services; and
- UM Committee updates.

The purpose of the 2025 Integrated UM and CM Program Description is to define the oversight and delivery of CalOptima Health's structure, clinical processes, and programmatic approach. 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.

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The changes to CalOptima Health's Integrated UM and CM Program Description reflect current clinical operations and are necessary to meet the requirements specified by the Centers of Medicare and Medicaid Services, 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) 2024-25 Operating Budget and separate Board actions. Staff will include updated expenditures for the period of July 1, 2025, through December 31, 2025, in the FY 2025-26 Operating Budget.

Concurrence

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

Attachments

1. 2024 UM Program Evaluation
2. 2025 UM/CM Integrated Program Description (Redline version)
3. 2025 UM/CM Integrated Program Description (Clean version)
4. Annual Review: 2024 UM Program Evaluation and 2025 UM/CM Integrated Program Description (PowerPoint)

/s/ Michael Hunn *03/27/2025*
Authorized Signature **Date**

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2023~~3~~4 CalOptima Health Utilization Management Program Evaluation

Executive Summary

The 2023~~3~~4 Utilization Management (UM) Program description defines and outlines CalOptima Health's clinical activities to provide optimal utilization and quality health care services that are delivered compassionately at the right time and in the appropriate setting.

CalOptima Health evaluates the UM ~~p~~Program structure, scope, processes, and information sources used to determine utilization trends, medical necessity, and benefit coverage determinations. This evaluation of UM activity 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 2023~~3~~4 UM program evaluation is Q4'2022~~3~~ through the end of Q~~3~~4'2023~~3~~4.

CalOptima Health implemented a new clinical platform system in February 2024. This change led to variations in the layout of the data in new reports compared to previous versions. CalOptima Health wants to highlight this potential difference to ensure clarity and transparency in our reporting process.

Program Structure and Process

The UM ~~p~~Program was enhanced throughout 2023~~3~~4 to ensure member needs were addressed, while maintaining compliance with regulatory and accreditation standards. Although the staffing model for the UM nursing and non-clinical ~~Teams~~ teams making UM determinations did not change during the 2023~~3~~4 reporting period, a Senior UM Manager and Senior Director, Medical Management Hospital/Facility Liaison joined the Utilization Management Department. ~~the Medical Director Team was enhanced with additional physician reviewers and targeted specialties.~~ CalOptima Health also implemented multiple process improvements throughout the year to address operational and clinical

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enhancements. These included but not limited to the following:

- Improved workflows and oversight to prioritize aging inventory to exceed regulatory turnaround time compliance.
- Continued refinement of inpatient (adult) facility clinical rounds to conduct peer to peer and complex discharge planning and support needs.
- Launch of pediatric inpatient focused on long lengths of stay (NICU and PICU) and coordination of CCS eligibility and needs with the implementation of pediatric facility clinical rounds.
- Report development to align with the new clinical platform system to ~~i~~improve~~d~~ access to real time reporting and tools to ensure compliance of ~~address~~ authorization requests.
- Enhanced provider portal automation and capabilities.
- ~~Developed referral business rules for UM clinical staff to apply hierarchical criteria and to only approve where appropriate without Medical Director review.~~
- Enhancement to referral intelligence rules.
- Refinement to the PSA protocols including "secret shopper" oversight of timeliness response.
- Refinement of the custom DME workflow process for gained efficiencies for clinical and non-clinical teams.
- Enhancement of transitions of care services (TCS) through alignment and collaboration with UM. Added additional clinical roles and dedicated Medical Director.
- Removed preventative and screening prior authorization requirements for OneCare.
- Temporary coverage for all vacant roles to minimize the impact of staffing fluctuations.
- Enhanced ~~Implemented~~ transitions of care to include a touch to all post discharge members ensuring discharge needs such as, physician follow up care and ancillary services are met.
- ~~Refinement of bed days goals.~~Refinement ~~of bed days for~~ short stay (one day) reviews (i.e.,chest pain, abdominal pian, UTI, etc) for potentially avoidable admissions and member care of a lower level of care.
- Continue to refine all pediatric reviews to ensure inclusion of EPSDT criteria including denial auditing to validate compliance with APL 23-005.
- Re-education and auditing enhancements to ensure ongoing compliance with gender affirming care and services in compliance with APLs and updated WPATH protocols.
- Successful transition of Kaiser delegated Health Network to Kaiser Health Plan entity.
- Successful planning and execution of contract terminations and contract changes to large hospital entities in Orange County with minimal disruption to members and providers at the point of service.
- Established a formal pipeline for process improvement through twice a week interdisciplinary clinical leadership meetings, UM and CM Workgroup, physician led sub workgroups and Medical Director direct initiative assignment.
- ~~Established a Brain/Spine/Pain Workgroup.~~
- Enhanced the continuity of care process.
- Continued weekly program support with the UCSD Transplant Center of Excellence (COE), ~~Enhanced the t~~Transplant Team including surgeons, Case Managers, Social Workers, and Discharge Planners~~program to include expansion of COE to UCSD and fully coordinated inpatient rounds, lodging and meal assistance to family members/caretakers of transplant members.~~, UCSD COE presented programmatic outcomes to CalOptima Health's Health

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Network Clinical Forum meeting.

- Design review, and configuration, and implement of the new medical management platform with for implementation in February 2024.

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Program Structure

During 202443, CalOptima Health added one five additional Medical Directors to the UM Program to continue to address clinical complexities, over and underutilization patterns and Utilization Management oversight of CalOptima Health's delegated entities, and the need for additional specialty programs and interventions.

The following specialties and Medical Directors with robust experience in key areas were added to the full-time Medical Director team within the UM Program:

- Internal Medicine with Stars and HEDIS quality measures experience and expertise
- Emergency Medicine with trauma experience to oversee the CalOptima Health Street Medicine program
- Child and adolescent psychiatry and pharmacy
- Internal Medicine with utilization and quality management experience
- Family Medicine with addiction and correctional health certification.

In addition to the above Medical Directors, CalOptima Health added a Chief Equity Officer to focus on areas to include but not limited to, public and mental health focusing on health equity.

Information sources as well as staff assigned activities used to determine benefit coverage and medical necessity remained current and appropriate, in addition the current UM structure supports CalOptima Health's UM functions. Medical Necessity coverage tools and hierarchical protocols are reviewed and approved annually at the UMC

Program Scope Impact

Program Scope impact areas include but were not limited to:

- Continued refinement of CalAIM services,
- established Launching of Medical Director--led sub workgroups, established
- Formal KPI utilization/ benchmarks for over and underutilization including for Health Networks
- .-Refinement of EPSDT review and protocols.
- Transition to vendor broker NEMT services and refinement of broker oversight.
- Addition of a inEstablished a dedicated inpatient liaison senior leader role to oversee facility partner operations and transitional care protocols.

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Effective January 1, 2022, DCHS mandated Medi-Cal retail pharmacy and pharmacy grievances be carved out of managed care health plans and on January 1, 2022, Magellan Rx began managing the pharmacy benefit for CalOptima Health. CalOptima Health continues to manage the Medicare outpatient pharmacy benefit and grievances

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~~as well as physician-administered drug (PAD) benefits. The current UM structure is effective in supporting the required CalOptima Health UM functions based on 2023 data and analysis. Throughout 2023 DHCS continued to focus on population health management initiatives targeting transitional care support and Medi-Cal CalAIM community supports/ECM. CalOptima Health operationalized all 14 community supports and continues to increase network of community-based ECM providers based on members needs and preferences.~~

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PROJECTS, PROGRAMS AND INITIATIVES

A. Utilization Management

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Oversight of prior authorization (PA) inventory continued to be part of the overall UM Program to improve average turnaround time ~~to~~ decision making ~~aligned~~ aligned with CalOptima Health's strategic vision for same day treatment authorizations.

Initiatives implemented or enhanced to support the UM Program include but ~~is~~are not limited to:

- Enhanced the UM Leadership daily morning touchpoint to review the outstanding pending inventory including an upcoming 10-day forecast.
- Hospital partner engagement to gain EMR access for CalOptima Health staff to send timely discharge summaries and medication reconciliation to the PCP to incorporate in the member outpatient chart.
- Enhanced the High-Risk Management Sub Workgroup ~~Created a~~ (formerly called the Bed Day Reduction Strategy Sub Workgroup) ~~to be led by CalOptima Health Medical Directors with the participation of UM and CM staff~~ to ensure the healthcare needs of the member is met through the inpatient admission. ~~This Workgroup will analyze bed day data identifying opportunities for improvement and the development of interventions to reduce over utilization of inpatient services thus decreasing admits/1000 and ALOS.~~

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- ~~Created an Inpatient Utilization Strategy Sub Workgroup to identify members at risk for a readmission and the development and implementation for focused and targeted support.~~
- ~~Enhanced post discharge process to include but not limited to, coach members to convene a telehealth PCP or specialty follow-up within 30 days post discharge and coordinated communication will treating providers.~~
- ~~Enhanced Transitional Care Services (TCS) to include a TCS High Risk flag as identified by DHCS, UM and CM staff outreach to all discharged members to ensure receipt of post hospital care needs are met and the member has a scheduled appointment with their PCP, and development of a member resource letter to provide members with a single point of contact for navigation assistance through transitions of care.~~
- Refinement of enhanced ~~t~~Transitional ~~c~~Care ~~s~~Services (TCS) for member outreach with admission to a facility supporting increased member engagement in TCS services.
- Implement and explore opportunities for texting campaign for members admitted identifying TCS support line for assistance. Continue to refine and enhance texting campaign to include ~~member~~members seen in the ED~~emergency department~~ as well as those at high risk for readmission.
- Refinement of ~~facilty~~facility rounds to include TCS staff supporting real-time discharge

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planning activities with transitions of care.

- ~~Enhanced the PCP Discharge Notice faxed to the PCP. This notice includes the hospital Discharge Summary and Medication Reconciliation list and reminds providers to file in the members outpatient medical chart.~~
- Review Admit Discharge and Transfer (ADT) data file transfers and identify a mechanism for real time PCP admit, discharge, and transfer notification.

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UM Medical Directors

The UM Medical Director(s) remain ~~ed~~ very engaged in the UM process and provided continuing clinical oversight for the administration of the UM Program. This oversight and support included but were~~is~~ 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 ~~The~~ UM Medical Directors (including Behavioral Health and Pharmacy) 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 Sub~~C~~committee 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 Sub~~C~~committee ~~continues~~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 all 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 ~~is~~are not limited to, providing input to key UM performance indicators, measures, goals, protocols, provide input to UM Department policies and procedures, and provides updates and input to the quarterly UMC.

The assigned UM Medical Director responsible for facilitating the High Risk Management ~~Bed Day Reduction Strategy~~ Sub Workgroup ~~and the Inpatient Utilization Strategy Sub Workgroup~~ and lead the Workgroup ~~Teams~~ to review bed day and ED data to identify under and overutilization to develop and implement opportunities for improvement.

The Medical Director team conducted semiweekly facility internal clinical rounds with the nursing team to support complex discharge needs. In addition, during these rounds' meetings, hospital discharge staff were educated on ECM, community supports and integrated case management available to members in weekly hospital partner rounding. The Medical Director team also attended the bi-weekly Clinical Operations Health Network UM CM forum and provided support to include but not limited to; education of regulatory guidance as outlined by new and/or revised APLs and other

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regulatory requirements.

Lastly, the Medical Director team also provided to the CalOptima Health clinical team and external provider education and consultation on specific topics including, but not limited to:

- Coronary Artery Bypass Graft (CABG) Outcome Study
- Ambulatory Bariatric Surgery
- EPSDT Services
- Pediatric ~~tranfers~~transfers to a higher level of care
- CCS NL 08-1024and CCS NL 09-1024
- ~~Genetic testing~~
- Gender Affirming Care and ~~Procedures~~Services
- ~~Management of administrative days~~
- ~~Appropriate Long-Term Acute Care vs. Chronic/Subacute Level of Care (LOC) criteria~~
- ~~Letter of Agreement (LOA) process~~
- ~~Evaluation and Medical Director oversight of the appropriateness of one-day inpatient stays~~
- ~~Management of transplant members~~
- ~~Management of members requiring neuro or spine surgery~~

The assigned 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 are integrated and aligned with the medical program to ensure compliance with UM regulatory and accreditation requirements and to ensure parity in decision-making. The designated BH Medical Director and BH clinical leadership participated in biweekly UM work groups and quarterly Utilization Management Committee (UMC) meetings, and Benefit Management Subcommittee (BMSC) meetings to ensure adequate representation of critical BH topics such as ~~expansion of the autism benefit and~~ development of strategies to address substance use disorder, eating disorders and coordination with the county to serve our shared members during this period.

Authorization Automation Rule Oversight ~~Protocols Pilot~~

The UM team ~~E~~established a formal process to assign a dedicated Medical Director to oversee recommendations from UM Workgroup review and decisioning on updates to referral intelligence rules. ~~During Q2 2022 an auto-authorization pilot project was implemented for the CCN and COD network to deploy automation rules to determine opportunities to auto-authorization or pend for manual review in order to support real-time treatment authorization decisions.~~ This process pilot and final ~~affiliated~~ analysis served to inform ~~continued in 2023.~~UM leadership and Medical Directors ~~continue to~~ review of utilization patterns. Below is ~~YTD 2023 data reported to UMC 2023~~data reflecting October 2023 – September 2024. The total auth volume has increased month-over-month and the percentage of auto-approvals has remained ~~fairly consistent~~consistent throughout ~~2023~~the reporting period.

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Month	Total Auths	% Auto-approved	% Manual Review
Oct-23	27,007	36.4%	63.6%
Nov-23	26,569	36.3%	63.7%
Dec-23	24,755	32.1%	67.9%
Jan-24	26,836	35.1%	64.9%
Feb-24	31,467	34.9%	65.1%
Mar-24	34,050	35.5%	64.5%
Apr-24	34,839	36.1%	63.9%
May-24	36,889	36.6%	63.4%
Jun-24	34,198	36.5%	63.5%
Jul-24	36,238	37.7%	62.3%
Aug-24	37,252	37.2%	62.8%
Sep-24	35,547	35.4%	64.6%

	Total Auths	% Approved	% Manual Review
Jan-23	22,382	37.9%	62.1%
Feb-23	21,565	38.0%	62.0%
Mar-23	27,108	37.3%	62.7%
Apr-23	24,485	36.4%	63.6%
May-23	26,491	36.6%	63.4%
Jun-23	27,208	38.2%	61.8%
Jul-23	24,730	37.3%	62.7%
Aug-23	28,552	35.8%	64.2%
Sep-23	27,277	35.9%	64.1%

Auto Auth Source: CORE Report AutoAuth_Cercon Referral Count (CC0087_GC) data ~~1/1/2023-11/30/2023~~10/2023-1/2024. Enterprise Analytics ad-hoc pull for data 2/2024-9/2024. Data pulled ~~12/13/2023~~1/15/2025

B. 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 to be directly responsible 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.

C. UM Data Management

UM data reporting design is led by the Director of UM and generated by CalOptima Health's Enterprise Analytics (EA) and Information Technology Services (ITS) Department. 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 tracking and trending of metrics for both CalOptima Health and the delegated Health Networks (HNs). Daily inventory reports, notification compliance report ~~-~~and ~~a fax~~fax out denial letter notification report were enhanced throughout 202~~3~~4

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to ensure continued timely processing of treatment authorization requests and provider and member notifications of approvals, denials and modifications. ~~Additional efforts are focused on the development of existing reports from the new medical management system (Jiva) which will be operational in February 2024.~~

Inpatient Bed ~~d~~Day Utilization Performance (excludes Health Network data)

The 202334 goals were set ~~for~~ at a roll up of the TANF, SPD, and LTC ~~a rollup of all~~ Medi-Cal Aid categories. Bed Day data below ~~During 2023 the UMC requested inpatient utilization data to~~ excludes acute rehabilitation and LTAC data and includes maternal health planned birth admissions.

Medi-Cal Expansion

Metric	Goal	2023 Q4	2024 Q1	2024 Q2	2024 Q3
Admits/1000 PTMPY	n/a	107.9	102.2	110.2	107.6
Days/1000 PTMPY	n/a	554.1	545.2	601.2	539.4
ALOS	n/a	5.1	5.3	5.5	5.0
Readmit %	n/a	18.6%	18.1%	17.9%	18.8%

~~Medi-Cal Expansion~~

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	60.2	62.1	105.9	103.5
~~Days/1000 PTMPY~~	~~358~~	~~315.2~~	~~321.4~~	~~553.1~~	~~518.1~~
ALOS	4.3	5.24	5.18	5.22	5.01
Readmit %	25.00%	17.54%	18.85%	18.27%	18.65%

Source: Membership and Utilization Trends Tableau report, Data reflecting Medi-Cal CCN/COD for Q4 ~~2022~~ 2023 – Q3 ~~2023~~2024.

- **Admit/1000 Per Year (PTMPY):** ~~Admits/1000 fell below the goal of 284 in Q4 2022 and 2023 YTD~~ Admits/1000 remained stable between Q4 2023 and Q3 2024 with a slight uptick in Q4 2024.
- **Bed Day/1000 Per Year (PTMPY):** ~~Bed days/100 fell below the goal of 358 in Q4 2022 and 2023 YTD~~ Bed days/1000 remained stable between Q4 2023 and Q3 2024 with a slight uptick in Q2 2024. The Q2 2024 uptick is driven by 3,662 inpatient days.
- **Average Length of Stay (ALOS):** ~~The ALOS for this population remained above the goal of 4.3 in Q4 2022 and 2023 YTD~~ The ALOS remained stable between Q4 2023 and Q3 2024.
- **Readmissions:** ~~Readmits remained below the goal of 25% in Q4 2022 and 2023 YTD~~Readmissions remained stable between Q4 2023 and Q3 2024

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Metric	Goal	2023 Q4	2024 Q1	2024 Q2	2024 Q3
Admits/1000 PTMPY	107.1	147.5 ↑	131.1 ↑	147.1 ↑	152.8 ↑
Days/1000 PTMPY	441.2	434.4 ↓	442.5 ↑	488.4 ↑	466.5 ↑
ALOS	3.7	3.0 ↓	3.4 ↓	3.3 ↓	3.1 ↓
Readmit %	14.7%	13.8% ↓	13.2% ↓	14.9% ↑	11.0% ↓

~~Metric~~ Indicates trend toward goal

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	86.6	78.1	141.2	155.4
~~Days/1000 PTMPY~~	~~358~~	~~274.4~~	~~244.8~~	~~428.9~~	~~479.1~~
ALOS	4.3	3.17	3.14	3.04	3.08
Readmit %	25.00%	12.25%	10.49%	12.36%	13.09%

Source: Membership and Utilization Trends Tableau report, Data reflecting Medi-Cal CCN/COD for Q4 2023 – Q3 2024.

~~Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.~~

- **Admits/1000 Per Year (PTMPY):** ~~Admits/1000 fell below the goal of 284 in Q4 2022 and YTD 2023.~~ Admits/1000 ~~fell~~rose above the goal of 107.1 in Q4 2023 through Q3 2024. The rate of Admits/1000 us driven by the volume of obstetrics including ~~R~~routine delivery, C-Section ~~D~~delivery, ~~A~~antepartum ~~D~~disorders, and ~~P~~post ~~P~~partum. Obstetrics made up between 59.9% - 68.9% of all admits during the reporting period. Month over month the percent of total admits attributed to obstetrics is increasing indicating a decrease in non-obstetrics-related admissions.
- **Bed Days/1000 Per Year (PTMPY):** ~~Bed days fell below the goal of 358 in Q4 2022 and YTD 2023.~~ Bed days ~~fell below~~rose above the goal of 441.2 in ~~Q4 2023 and~~ Q1 2024 ~~and above goal in Q2 2024 ??~~and increased in Q2 2024. Bed ~~D~~days/1000 decreased in Q3 2024 but remains above goal.
- **Average Length of Stay (ALOS):** ~~The ALOS for this population remained below the goal of 4.3 throughout in Q4 2022 and YTD 2023.~~ The ALOS ~~fell below the~~has remained ~~at or~~ below the goal of 3.7 in ~~??~~all reported quarters.
- **Readmissions:** ~~Readmits remained below the goal of 25% in Q4 2022 and YTD 2023.~~ Readmits fell below the goal of 14.7% in ~~??~~Q4 2023 and Q1 2024, ~~but~~ rose to slightly above goal for Q2 2024 before returning below goal in Q3 2024. The Q2 2024 readmit rate is driven by four (4) oncology admits with 100% all readmitted. Overall readmit rate volume is slightly increasing month over month during the reporting period. Total admit volume is also increasing month over month during the reporting period.~~.~~

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TANF Under 18

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	15	13.1	27.5	28
~~Days/1000 PTMPY~~	~~358~~	~~102~~	~~88.9~~	~~319.5~~	~~331~~
ALOS	4.3	6.79	6.79	11.6	11.82
Readmit %	25.00%	2.30%	2.32%	0.00%	0.00%

Metric	Goal	2023 Q4	2024 Q1	2024 Q2	2024 Q3
Admits/1000 PTMPY	13.9	24.5 ↑	28.7 ↑	30.1 ↑	29.1 ↑
Days/1000 PTMPY	193.7	346.8 ↑	369.4 ↑	341.5 ↑	349.3 ↑
ALOS	13.2	14.1 ↑	12.9 ↓	11.4 ↓	12.0 ↓
Readmit %	2.0%	4.0% ↑	2.0% ↓	5.0% ↑	2.9% ↑

Source: Membership and Utilization Trends Tableau report, Data reflecting Medi-Cal CCN/COD for Q4 2023 – Q3 2024.

~~Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.~~

- **Admits/1000 Per Year (PTMPY):** ~~Admits/1000 fell below goal of 284 in Q4 2022 and YTD 2023~~Admits/1000 ~~fell~~rose above goal in all reporting periods. Admits for TANF members age 0-17 were driven by Neonatology with an average of 57.3% of admits during the reporting period attributed to Neonatology.
- **Bed Days/1000 Per Year (PTMPY):** ~~**Bed days/1000 fell below goal of 358 in Q4 2022 and YTD 2023**~~ Bed days/1000 ~~fell~~rose above goal in all reporting periods. The rate was driven by the Neonatology volume with roughly 80.9% of days during the reporting period attributed to Neonatology. This rate has slightly trended down throughout 2024.
-
- Average **Length of Stay (ALOS):** ~~The ALOS remained above goal of 4.3 in Q4 2022 and YTD 2023~~ The ALOS ~~fell~~rose above goal in Q4 2023 and below goal in Q1 2024 through Q3 2024. The increased Q4 2023 rate is due to the high volume of neonatology admissions in October 2024 with 41 total admits and 18 ~~N~~neonatology admits with an overall ALOS of 11.4 and the ALOS for neonatology at 22.9.
-
- **Readmissions**: The fluctuation in the readmit rate is attributed to the low volume of total admits.
  - Readmissions~~t~~ rose above 4% in Q4 driven by the low volume of admits with readmits for key conditions including: General Medicine (20%, driven 1 admit for allergic reaction, drug toxicity and ~~P~~poisoning with 100% readmit) and General Surgery (1 admit for small and large bowel procedures with 100% readmit).
  - Readmits hit goal for Q1 2024 and rose in Q2 2024 driven by low volume of

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Commented [SO1]: @Harlow, Jennifer should this be Q2 2024?

Commented [JH2R1]: Q4, thanks for the catch!

admits for Gastroenterology (1 admit for Disorders of the Alimentary tract with 100% readmit rate) a obstetrics (6 total admits including 2 admits for Antepartum Disorders with 50% readmit rate).

- Q3 2024 readmissions decreased from ~~over~~ Q2 2024 but still was over the 2% target. Q3 2024 readmits is driven by Gastroenterology with 2 admits for appendectomy with 50% readmit rate).~~Readmissions remained below goal of 25% in Q4 2022 and YTD 2023~~

Overall readmission rate is trending down slightly quarter over quarter during the reporting period.

SPD

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	164.6	169.2	271.3	268.6
~~Days/1000 PTMPY~~	~~358~~	~~1063.4~~	~~999~~	~~1577.5~~	~~1540.2~~
ALOS	4.3	6.46	5.85	5.81	5.73
Readmit %	25.00%	21.60%	20.81%	24.64%	24.12%

Metric	Goal	2023 Q4	2024 Q1	2024 Q2	2024 Q3
Admits/1000 PTMPY	n/a	258.7	264.6	261.3	248.0
Days/1000 PTMPY	n/a	1,588.0	1,478.8	1,582.0	1,419.4
ALOS	n/a	6.1	5.6	6.1	5.7
Readmit %	n/a	23.2%	24.5%	21.4%	21.8%

Source: Membership and Utilization Trends Tableau report, Data reflecting Medi-Cal CCN/COD for Q4 2023 – Q3 2024. ~~Data reflecting Q4 2022 – Q3 2023.~~

- **Admits/1000 Per Year (PTMPY):** ~~Admits/1000 fell below goal of 284 in Q4 2022 and YTD 2023.~~ Admits/1000 remained stable between Q4 2023 and Q4 2024 with a slight uptick in Q1 2024.
- **Bed Days/1000 Per Year (PTMPY):** ~~Bed days were above goal of 258 in Q4 2022 and YTD 2023~~ Bed days/1000 fluctuated between Q4 2023 and Q4 2024, decreasing in Q1 2024 before an uptick in Q2 2024 and then a decrease in Q3 2024.
- **Average Length of Stay (ALOS):** ~~The ALOS for this population remained above the goal of 4.3 in Q4 2022 and YTD 2023.~~ The ALOS remained stable for all reporting periods
- **Readmissions:** ~~Readmits remained below the goal of 25% in Q4 2022 and YTD 2023 Q3.~~ Readmissions had an uptick in Q1 2024 before a decline in Q2 2024 and Q3 2024. The uptick in Q1 2024 is driven by a 34.2% readmit rate for oncology, 29.1% readmit rate for nephrology and a 28.6% readmit rate for transplants.

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LTC

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Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	673	495.8	435.2	446.4
~~Days/1000 PTMPY~~	~~358~~	~~4159.3~~	~~3524.3~~	~~2159.5~~	~~2940.9~~
ALOS	4.3	6.18	7.11	4.94	6.59
Readmit %	25.00%	16.28%	23.53%	9.68%	13.79%

Metric	Goal	2023 Q4	2024 Q1	2024 Q2	2024 Q3
Admits/1000 PTMPY	n/a	539.0	552.8	643.4	444.4
Days/1000 PTMPY	n/a	4,553.2	3,101.7	5,356.6	3,818.9
ALOS	n/a	8.5	5.6	8.3	8.6
Readmit %	n/a	30.0%	16.1%	30.3%	15.4%

Source: Membership and Utilization Trends Tableau report, Data reflecting Medi-Cal CCN/COD for Q4 2023 – Q3 2024. ~~Data reflecting Q4 2022 – Q3 2023.~~

- **Admits/1000 Per Year (PTMPY):** ~~Admits/1000 remained above goal of 284 in Q4 2022 and YTD 2023~~ Admits/1000 had an uptick in Q1 2024 and Q2 2024 before a decrease in Q3 2024. The uptick in Q2 2024 is driven by a low volume of admits.
- **Bed Days/1000 Per Year (PTMPY):** ~~Bed days/1000 remained above goal of 358 in Q4 2022 and YTD 2023~~ Bed days/1000 had an uptick in Q2 2024 before a decrease in Q3 2024. The uptick in Q2 2024 is driven by a low volume of admits.
- **Average Length of Stay (ALOS):** ~~The ALOS remained above the goal in Q4 2022 and YTD 2023~~ The ALOS stay had a decrease in Q1 2024 from Q4 2023 before and increase in Q2 2024 and Q3 2024. Q4 2023 is driven by a low volume of admits.
- **Readmissions:** Readmission fluctuated across all quarters in the report period due to low volume of admits. Q4 2023 had a total of 78 admits. Top condition was gastroenterology with 7 admits and 100% readmit rate, followed by Cardiac Services with 13 admits and 50% readmit rate. Q2 2024 had a total of 75 admits. Top condition was Neurology with 1 admit and 100% readmit rate, followed by General Surgery with 6 admits and 40% readmit rate.~~Readmits remained below goal during Q4 2022 and YTD 2023.~~

WCM

Metric	Goal	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Admits/1000 PTMPY	284	221.9	242.9	217	242.8
~~Days/1000 PTMPY~~	~~358~~	~~1424.8~~	~~1726.9~~	~~1291.7~~	~~1273~~
ALOS	4.3	6.42	7.11	5.95	5.24
Readmit %	25.00%	12.91%	13.36%	12.63%	11.99%

Metric	Goal	2023 Q4	2024 Q1	2024 Q2	2024 Q3
Admits/1000 PTMPY	n/a	244.2	257.1	280.6	260.0
Days/1000 PTMPY	n/a	1,706.7	1,928.1	1,677.6	1,369.4
ALOS	n/a	7.0	7.5	6.0	5.3
Readmit %	n/a	15.5%	12.4%	13.8%	10.8%

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 ~~2022~~ 2023 – Q3 ~~2023~~2024.

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- **Admits/1000 Per Year (PTMPY):** ~~Admits/1000 remained below goal of 284 in Q4 2022 and YTD 2023~~ Admits/1000 had an uptick in Q1 2024 and Q2 2024 from Q4 2023.
- **Bed Days/1000 Per Year (PTMPY):** ~~Bed days remained above goal of 358 in Q4 2022 and YTD 2023~~ Bed days had an uptick in Q1 2024 from Q4 2023 before a decrease in Q2 2024 and Q3 2024.
- **Average Length of Stay (ALOS):** ~~The ALOS for this population remained above the goal of 4.3 in Q4 2022 and YTD 2023~~ The ALOS had an uptick in Q1 2024 from Q4 203 before a decrease in Q2 2024 and Q3 2024.
- **Readmissions:** ~~**Readmits remained below the goal of 25% in Q4 2022 and YTD 2023**~~ Readmits fluctuated up and down in each reporting period.
-

Emergency Department Utilization Performance

Medi-Cal Expansion

Metric	Goal	2023 Q4	2024 Q1	2024 Q2	2024 Q3
ED Visits / 1000 PTMPY	n/a	504.0	474.5	500.9	521.2

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits / 1000 PTMPY	492.4	480.6	497.9	495.0

Source: Membership and Utilization Trends Tableau report, Data reflecting Medi-Cal CCN/COD Q4 ~~2022~~ 2023 – Q3 ~~2023~~2024.

~~Medi-Cal Expansion ED utilization remained fairly flat since Q4 2022, however there is a slight uptick in Q2 2023.~~ ED utilization decreased in Q1 2024 from Q4 2023 before an uptick in Q2 2024 and Q3 2024.

TANF 18+

Metric	Goal	2023 Q4	2024 Q1	2024 Q2	2024 Q3
ED Visits / 1000 PTMPY	**459.4**	547.4 ↑	491.9 ↑	540.5 ↑	543.3 ↑

↑↓ Indicates trend toward goal

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits / 1000 PTMPY	549.6	533.9	545.4	550.0

Source: Membership and Utilization Trends Tableau report, Data reflecting Medi-Cal CCN/COD Q4 2023 – Q3 2024.

~~Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.~~

~~Medi-Cal TANF 18+ ED utilization remained fairly flat since Q4 2022 with a slight uptick in Q2 2023 from Q1 2023.~~ Medi-Cal TANF 18+ ED utilization was above goal in Q4 2023 through

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Q3 2024.

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TANF Under 18

Metric	Goal	2023 Q4	2024 Q1	2024 Q2	2024 Q3
ED Visits / 1000 PTMPY	349.1	422.8 ↑	370.5 ↑	353.2 ↑	334.2 ↓

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↑↓ Indicates trend toward goal

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Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits / 1000 PTMPY	459.5	398.3	370.2	333.0

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Source: Membership and Utilization Trends Tableau report, Data reflecting Medi-Cal CCN/COD Q4 2023 – Q3 2024.

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~~Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.~~

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~~Medi-Cal TANF under 18 ED utilization trended downward from Q4 2022.~~ Medi-Cal TANF under the age of 18, ED utilization trended above goal in Q4 2023 through Q2 2024 before trending under goal in Q3 2024.

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Metric	Goal	2023 Q4	2024 Q1	2024 Q2	2024 Q3
ED Visits / 1000 PTMPY	n/a	695.9	731.0	657.8	676.9

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Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits / 1000 PTMPY	644.8	640.5	706.6	748.6

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Source: Membership and Utilization Trends Tableau report, Data reflecting Medi-Cal CCN/COD Q4 2023 – Q3 2024. ~~Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.~~

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~~Medi-Cal SPD ED utilization trended down in Q1 2023 and then had an uptick in Q2 2023.~~ Medi-Cal SPD ED utilization fluctuated up and down between Q4 2023 and Q3 2024 with slight spike in Q1 2024.

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Metric	Goal	2023 Q4	2024 Q1	2024 Q2	2024 Q3
ED Visits / 1000 PTMPY	n/a	581.6	399.2	353.9	197.5

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Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits / 1000 PTMPY	259.2	389.5	342.9	341.0

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Source: Membership and Utilization Trends Tableau report, Data reflecting Medi-Cal CCN/COD Q4 2023 – Q3 2024.

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~~*Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.*~~

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~~Medi-Cal LTC ED utilization had an uptick in Q1 2023 and then trended down in Q2 2023.~~
Med-Cal LTC ED utilization trended down in Q1 2024 through Q3 2024 from Q4 2023.

Whole Child Model (WCM)

Metric	2022 Q4	2023 Q1	2023 Q2	2023 Q3
ED Visits / 1000 PTMPY	656.7	630.05	568.57	576.7

Metric	Goal	2023 Q4	2024 Q1	2024 Q2	2024 Q3
ED Visits / 1000 PTMPY	717.4	661.6 ⬇	642.3 ⬇	611.6 ⬇	550.5 ⬇

↑↓ Indicates trend toward goal

Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2022 – Q3 2023.

~~ED utilization has declined since Q4 2022.~~ WCM ED utilization trended ~~above~~below goal for Q4 2023 through Q3 2024.

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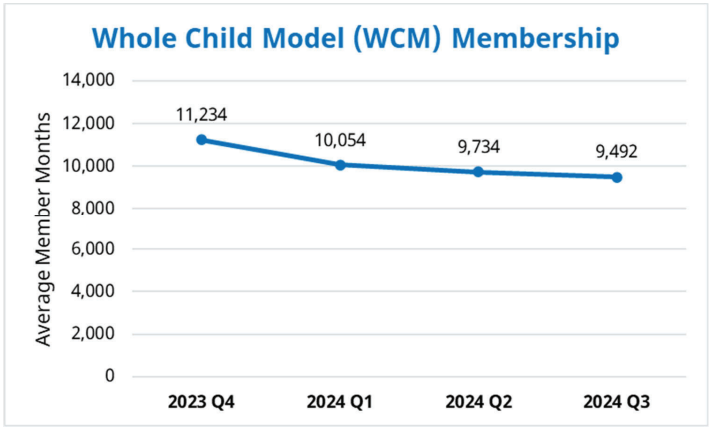
Whole Child Model (WCM)



Source: Membership and Utilization Trends Tableau report. WCM Membership reflecting Q4 2023 – Q3 2024. Data pulled 11/21/2024

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WCM Counts

Reporting Period: November 2024

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
506-Cal Optima-Orange	**8,877**	**109**	**1,081**
CalOptima Community Network	1,108	41	202
HPN - Regal	17	3	3
~~Optum Care Network – Monarch~~	~~849~~	~~15~~	~~147~~
Prospect Medical Group, Inc.	112	2	25
Family Choice Health Network	163	3	32
CHOC Health Alliance	6,126	42	601
AMVI Care Health Network	122	0	21
Noble Mid-Orange County	141	1	19
United Care Medical Group	239	2	31

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2023~~3~~4 CalOptima Health Utilization Management Program Evaluation

Reporting Period: November 2024

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	6,126	42	601
CalOptima Community Network	1,108	41	202
Optum Care Network – Monarch	849	15	147
United Care Medical Group	239	2	31
Family Choice Health Network	163	3	32
Noble Mid-Orange County	141	1	19
AMVI Care Health Network	122	0	21
Prospect Medical Group, Inc.	112	2	25
HPN - Regal	17	3	3
506-Cal Optima-Orange	**8,877**	**109**	**1,081**

WCM counts source: Core Report WCM Member Counts (CC0218). Reporting Period November 2024. Data pulled 11/21/2024

CHOC Health Alliance continues to have the majority of the WCM members with 69% of the WCM membership followed by CalOptima Health's CCN network with 12.5% of the WCM membership.

UTILIZATION STATISTICS

Referrals Processed Q4 2022 - Q3 2023 (CCN/COD)

Year	Quarter	LOB	Prospectve Routine	Prospective Urgent	Retro/ Post Service
2022	Qtr 4	Medi-Cal	25,073	6,576	1,780
		One Care	N/A	N/A	N/A
2023	~~Qtr 1~~	Medi-Cal	28,022	6,935	3,075
		One Care	1,927	368	78
	Qtr 2	Medi-Cal	31,422	8,138	2,760
		One Care	2,972	443	120
	Qtr 3	Medi-Cal	32,427	7,756	3,707
		One Care	3,141	476	146
Grand Total			124,984	30,692	11,666

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20234 CalOptima Health Utilization Management Program Evaluation

Referrals Processed Q4 2023 - Q3 2024 (CCN/COD)

Year	Quarter	LOB	Prospective Routine	Prospective Urgent	Retro/ Post Service
2023	Qtr. 4	Medi-Cal	59,200	11,070	2,462
		One Care	2,987	527	129
2024	January	Medi-Cal	19,753	4,233	947
		One Care	951	200	47
2024	Qtr. 1 (exc. Jan)	Medi-Cal	47,696	12,462	1,885
		One Care	2,693	630	121
	Qtr. 2	Medi-Cal	77,813	20,057	2,636
		One Care	4,116	1,056	194
	Qtr. 3	Medi-Cal	79,732	20,338	3,412
		One Care	4,210	1,075	206
Grand Total			299,151	71,648	12,039

Q4 2023 and Jan 2024 data pulled from prior clinical system. Quarter 1 - 3 2024 pulled from new Clinical System. Q1 2024 data excludes January due to system cutover starting Feb.1.

Referrals Processed Source: Q4 2023 – January 2024 CORE report Authorization Turn Around Summary CC0003A_GC. ~~Data Q42022-Q32023. Data pulled 11/3/2023~~
Q1 2024 (excluding Jan) – Q3 2024 pulled via ad-hoc report from Enterprise Analytics. Data as of 1/15/2024.

Medi-Cal referrals continued to increase across all quarters from Q4 ~~2022~~ 2023 – Q3 ~~2023~~2024, ~~with the exception retrospective referrals in Q2 2022.~~ across all referral types. OneCare referrals had a slight uptick in Q3 2024 from Q2 2024.

~~OneCare was effective January 1, 2023, there was an increase quarter over quarter in 2023~~

Prior Authorization Turn Around Time – Medi-Cal and OneCare

Prior Authorization Turnaround Time Compliance (TAT) Q4 2022 - Q3 2023

Year	Goal	Quarter	LOB	Prospectve Routine	Prospective Urgent	Retro/ Post Service
2022	95%	Qtr 4	Medi-Cal	99.62%	99.71%	100.00%
			One Care	N/A	N/A	N/A
2023	95%	Qtr 1	~~Medi-Cal~~	~~99.67%~~	~~99.67%~~	~~98.86%~~
			One Care	99.43%	100.00%	100.00%
		Qtr 2	Medi-Cal	99.92%	99.90%	99.64%
			One Care	99.83%	98.65%	100.00%
		Qtr 3	Medi-Cal	99.94%	99.86%	100.00%
			One Care	99.97%	100.00%	98.63%

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Prior Authorization Turnaround Time Compliance (TAT) Q4 2023 - Q3 2024						
Year	Goal	Quarter	Month	Prospective Routine	Prospective Urgent	Retro Post Service
2023	95%	Q4	Oct	100.0%	99.8%	100.0%
			Nov	99.8%	99.8%	99.6%
			Dec	99.9%	99.8%	99.8%
2024	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: ~~CORE report~~ Authorization ~~Turn Around Summary (CC0003A_GC) Inventory Tableau~~ Data Q4 ~~2022~~2023-Q3 ~~2023~~2024. Data pulled ~~11/3/2023~~11/20/2024

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Prior authorization turnaround time compliance remained compliant since Q4 202~~3~~. Although turnaround time compliance is trending in the ~~98~~th-95th percentile and above and has continued to meet the quarter over quarter goal of 95%, there was downward trending in February 2024. ~~-~~The start of this downward trend is noted at the time of transition into the new clinical platform system, Jiva. -

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Utilization Statistics - Inpatient Review Turn Around Time – Medi-Cal and OneCare

Inpatient Turnaround Time Compliance (TAT) Q4 2023 - Q3 2024 (CCN/COD)					
Year	Goal	Quarter	Month	Concurrent Review	Retro Post Service
2023	95%	Q4	Oct	99.7%	91.5%
			Nov	98.8%	100.0%
			Dec	98.9%	95.6%
2024	95%	Q1	Jan	99.6%	82.4%
			Feb	89.0%	98.4%
			March	95.7%	92.6%
	95%	Q2	April	92.4%	97.5%
			May	96.8%	93.6%
			June	95.6%	100.0%
	95%	Q3	July	97.7%	97.6%
			Aug	98.3%	98.4%
			Sept	98.7%	99.1%

Inpatient Turnaround Time Compliance (TAT) Q4 2022 - Q3 2023 (CCN/COD)					
Year	Goal	Quarter	LOB	Urgent	Retro/ Post Service
2022	95%	Qtr 4	Medi-Cal	96.47%	84.54%
			One Care	N/A	N/A
2023	95%	Qtr 1	~~Medi-Cal~~	~~98.22%~~	~~84.47%~~
			One Care	99.13%	100.00%
		Qtr 2	Medi-Cal	99.41%	88.62%
			One Care	99.14%	100.00%
		Qtr 3	Medi-Cal	98.68%	85.28%
			One Care	98.55%	90.91%

Source: Authorization ~~Turn Around Summary (CC0003I_GC).Inventory Tableau.~~ Data Q4 ~~2022~~ 2023 – Q3 ~~2023~~2024. Data pulled 11/~~3~~20/~~2023~~2024

~~Medi-Cal and OneCare i~~Inpatient urgent turnaround time compliance remained stable since Q4 202~~2~~3 with the exception of February 2024 during the transition to the new clinical platform system, Jiva.~~-~~ Average turnaround time compliance for retro post service request is 95.5%. ~~An identified delay in UM assignment for retro post services cases surfaced due to pended claims and/or provider dispute resolutions (PDR). UM continues to ensure expedited review and continued process improvements to communicate retro case assignments in real time.~~

Over and Underutilization

In 2023~~3~~4 CalOptima Health continued to enhance over and underutilization identification and monitoring. A dedicated Medical Director is assigned to monitor CalOptima Health utilization patterns including outlier trends compared between Health Networks including the CalOptima

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Health Community Network (CCN) and CalOptima Health Direct (COD) network. Quarterly Health Network clinical discussions continuedwere launched with delegated Health Networks and CalOptima Health staff to include 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 have been identified as indicators for over and underutilization.. Metrics from the following area are included but are not limited to, and are analyzed on an quarterlyannual basis to ensure they are indicative of over and underutilization monitoring.

- 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

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Over and underutilization data analysis was reported by UM leadership during 202334 and reported to UMC, QIHEC and the Quality Assurance Committee (QAC).

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OPERATIONAL PERFORMANCE

Authorization Utilization for Expedited/Urgent, Standard/Routine, and Retrospective Requests — Medical

Summary of Medi-Cal and OneCare rReferral vVolume (Q4 Q1 202223 to Q34Jan 202334)

Referrals Processed		Referrals Processed		Turnaround Time Compliance (TAT)	
Routine	132,456	Faxed	253,775	Routine	99.80%
Urgent	33,768	COLAs	316,094	Urgent	99.77%
Retro	12.843	Auto Auth	129,739	Retro	99.62%
Total	166,237	Total	699,608		

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2023~~3~~4 CalOptima Health Utilization Management Program Evaluation

Referrals Processed	
Routine	82,834
Urgent	16,005
Retro	3,579
Total	102,418

Referrals Processed	
Faxed	74,503
COLAs (Portal)	68,318
Auto Auth	36,849
Total	179,670

Turnaround Time Compliance (TAT)	
Routine	99.9%
Urgent	99.8%
Retro	99.8%

Sources: Q4 2023 and Jan 2024 data pulled from prior clinical system, Authorization Turn Around Summary (CC0003A_GC), UM Incoming Fax Report (CC0195), Cer~~e~~con Referral Count (CC0087), and Auto Authorization Trend Report

Summary of Medi-Cal and OneCare referral volume (Feb 2024 to Q3 2024)

Referrals Processed	
Routine	216,260
Urgent	55,618
Retro	8,454
Total	280,332

Referrals Processed	
Faxed	41,455
COLAs (Portal)	235,094
Auto Auth	101,697
Total	378,246

Turnaround Time Compliance (TAT)	
Routine	99.7%
Urgent	99.6%
Retro	97.8%

Data for Q1 2024 - Q3 2024 provided by ad-hoc report from EA supplied 1/15/2025. Q1 2024 data excludes January due to system cutover starting Feb.1.

Sources: Enterprise Analytics Report ad-hoc data pull provided 1/15/2025. Turnaround Time Compliance (TAT) pulled from Authorization Inventory Jiva Tableau

February 2024 through Q3 2024 ~~Q4 2022 – Q33 2023~~ turnaround met goal of ≥95%.

Authorization Utilization for Expedited/Urgent, Routine, and Retro Requests – Pharmacy

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Pharmacy Authorization Turnaround Time Compliance (TAT) CY Q4 2023 - Q3 2024 (CCN/COD)						
Year	**Goal**	**Quarter**	**Month**	**Standard**	**Urgent**	**Retro**
2023	95%	Q4	Oct	100.0% ↑	99.3% ↑	100.0% ↑
			Nov	100.0% ↑	100.0% ↑	100.0% ↑
			Dec	100.0% ↑	100.0% ↑	100.0% ↑
2024	95%	Q1	Jan	100.0% ↑	100.0% ↑	100.0% ↑
			Feb	100.0% ↑	100.0% ↑	100.0% ↑
			March	100.0% ↑	100.0% ↑	100.0% ↑
	95%	Q2	April	100.0% ↑	99.3% ↑	100.0% ↑
			May	100.0% ↑	100.0% ↑	100.0% ↑
			June	100.0% ↑	100.0% ↑	100.0% ↑
	95%	Q3	July	100.0% ↑	98.2% ↑	100.0% ↑
			Aug	99.6% ↑	100.0% ↑	100.0% ↑
			Sept	100.0% ↑	100.0% ↑	100.0% ↑

Source: Ad-hoc report pulled from Enterprise Analytics dated 1/7/2025

	Turnaround Time Compliance (TAT)
Routine	100%
Urgent	100%
Retro	100%

Pharmacy Turnaround Time Source: CORE report Authorization Turn Around Summary (CC0003A_GC) YTD 2023 (Jan 2023 – October 2023)

Pharmacy has exceeded the goal of 95% for every quarter of the reporting period.~~CY 2023 pharmacy prior authorization turnaround time processing is above goal of 98%.~~

Authorization for Expedited / Urgent / Routine / Retro Requests — LTSS (CBAS, LTC)

LTC Referrals Processed Q4 2022 - Q3 2023			
Year	**Quarter**	**Routine**	**Urgent**
2022	**Qtr 4**	2,606	None to Report
2023	**Qtr 1**	2,877	None to Report
	Qtr 2	4,370	None to Report
	Qtr 3	4,595	None to Report

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LTC Referrals Processed Q4 2023 - Q3 2024				
Year	**Quarter**	**Month**	**Routine**	**Urgent**
2023	**Q4**	**Oct**	763	0
		Nov	868	0
		Dec	709	0
2024	**Q1**	**Jan**	869	0
		Feb	854	0
		March	710	0
	Q2	**April**	711	0
		May	717	0
		June	673	0
	Q3	**July**	689	0
		Aug	881	0
		Sept	738	0

Source: LTC Referrals Processed Source: ~~LTSS;~~ LTSS Authorization Turnaround Detail (LT0027C-GC)

LTC Turnaround Time Compliance (TAT) Q4 2022 - Q3 2023				
Year	**Goal**	**Quarter**	**Routine**	**Urgent**
2022	**95%**	**Qtr 4**	96.76%	None to Report
2023	**95%**	**Qtr 1**	94.10%	None to Report
		Qtr 2	93.25%	None to Report
		Qtr 3	96.90%	None to Report

~~LTC Referrals Processed Q4 2023 - Q3 2024~~				
~~**Year**~~	~~**Quarter**~~	~~**Month**~~	~~**Routine**~~	~~**Expedited**~~
~~**2023**~~	~~**Q4**~~	~~**Oct**~~	~~763~~	~~0~~
		~~**Nov**~~	~~868~~	~~0~~
		~~**Dec**~~	~~709~~	~~0~~
	~~**Q1**~~	~~**Jan**~~	~~869~~	~~0~~
		~~**Feb**~~	~~854~~	~~0~~
		~~**March**~~	~~710~~	~~0~~
	~~**Q2**~~	~~**April**~~	~~711~~	~~0~~

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~~2024~~		~~May~~	~~717~~	~~0~~
		~~June~~	~~673~~	~~0~~
		~~July~~	~~689~~	~~0~~
	~~Q3~~	~~Aug~~	~~881~~	~~0~~
		~~Sept~~	~~738~~	~~0~~

LTC Turnaround Time Compliance (TAT) Q4 2023 - Q3 2024

Year	Goal	Quarter	Routine	Urgent
2023	95%	Q4	99.4% ↑	0
2024	95%	Q1	97.7% ↑	0
	95%	Q2	99.9% ↑	0
	95%	Q3	98.3% ↑	0

LTC Turnaround Time Compliance Source Q4 2024 – 1/31/2024: S Authorization Turnaround Detail (LT0027C-GC)
LTC Turnaround Time Compliance Source 2/1/2024 - Q3 2024: Jiva UM TAT Detail Report

LTC met required turnaround times of 95% or greater during the reporting period: Q4 2023 – Q3 2024.

~~LTSS met required turnaround times (TAT) in Q4 2022.~~

~~TAT fell below the 95% threshold in Q1 2023 and Q2 2023. Based on a root cause analysis, errors were discovered in the Turnaround time report on October 23, 2023. The errors resulted in the mis categorization of pended authorizations as noncompliant. In October of 2023 the 23 authorizations reported as non-compliant were reversed to be compliant. The report was adjusted to correct this issue. Ongoing efforts are taking place to continuously review the non-compliant cases and determine additional root causes. No root~~

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~~causes have been found to impact member care.~~

CBAS TAT Compliance: LTSS Authorization Turnaround Detail (LT0027C_GC)

CBAS Turnaround Time Compliance (TAT) Q1 2023 - Q3 2023				
Year	Goal	Quarter	TAT Compliance	Volume
2023	95%	~~Qtr 1~~	~~51.06%~~	~~1,731~~
		Qtr 2	34.08%	1,815
		Qtr 3	79.72%	2,141

~~CBAS Referrals Processed Q4 2023 - Q3 2024~~				
~~Year~~	~~Quarter~~	~~Month~~	~~Routine~~	~~Expedited~~
~~-~~		~~Oct~~	~~688~~	~~0~~
~~2023~~	~~Q4~~	~~Nov~~	~~654~~	~~0~~
~~-~~		~~Dec~~	~~673~~	~~0~~
~~-~~		~~Jan~~	~~555~~	~~0~~
~~-~~	~~Q1~~	~~Feb~~	~~711~~	~~0~~
~~-~~		~~March~~	~~746~~	~~0~~
~~-~~		~~April~~	~~656~~	~~0~~
~~2024~~	~~Q2~~	~~May~~	~~539~~	~~0~~
~~-~~		~~June~~	~~579~~	~~0~~
~~-~~		~~July~~	~~515~~	~~0~~
~~-~~	~~Q3~~	~~Aug~~	~~640~~	~~0~~
~~-~~		~~Sept~~	~~572~~	~~0~~

CBAS Referrals Processed Q4 2023 - Q3 2024					
Year	Goal	Quarter	Month	Routine	Expedited
2023	95%	Q4	Oct	688	0
			Nov	654	0
			Dec	673	0
2024	95%	Q1	Jan	555	0
			Feb	711	0
			March	746	0
			April	656	0
	95%	Q2	May	539	0
			June	579	0
	95%	Q3	July	515	0

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			Aug	640	0
			Sept	572	0

Source: Q4 2023 – 1/31/2024 LTSS Authorization Turnaround Time Detail report (LT0027C); 2/1/2024 - Q3 2024 Jiva UM TAT Detail Report

CBAS Turnaround Time Compliance (TAT) Q4 2023 - Q3 2024			
Year	Goal	Quarter	TAT Compliance
2023	95%	Q4	79.7%
2024	95%	Q1	99.5%
	95%	Q2	99.6%
	95%	Q3	99.6%

CBAS Turnaround Time Compliance Source Q4 2023 – 1/31/2024: ~~: Authorization Inventory (Tableau) S~~ Authorization Turnaround Detail (LT0027C-GC)

CBAS Turnaround Time Compliance Source 2/1/2024 - Q3 2024: Jiva UM TAT Detail Report

CBAS fell below the turnaround time (TAT) goal of 95% in Q4 2023. In August 2023 an incident of TAT was reported to CalOptima Health leading to a SWAT analysis of the process and inventory. Approximately 335 aged inventory requests were identified and resolved within 2 days of identification. Processes were developed to support improved efficiency for staff, and additional support was implemented to monitor and control the Turnaround time for CBAS authorizations.

Beginning in Q3 2023, processes were developed to support improved efficiency for staff, and additional support was implemented to monitor and control TAT for CBAS authorizations. CBAS met TAT goals Q1 2024 – Q3. The current TAT is 2.42 days with a 99.8% compliance rate.

~~- Beginning in Q1 2023 CBAS TAT compliance dropped. During Q1 and Q2 2023 there was not a clear mechanism to report the CBAS TAT. In addition, additional centers were opening resulting in an increase in volume and an impact in Turnaround time. In August 2023 an incident of TAT was reported to CalOptima Health leading to a SWAT analysis of the process and inventory. Approximately 335 aged inventory requests were identified and resolved within 2 days of identification. Processes were developed to support improved efficiency for staff, and additional support was implemented to monitor and control the Turnaround time for CBAS authorizations. The current TAT is 2.42 days with a 99.8% compliance rate.~~

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CBAS Days Used Q4 2022 - Q3 2023				
Year	Quarter	Days Used / Days Authorized	% Used	Change From Previous Qtr.
~~2022~~	~~Qtr 4~~	~~81,150 / 165,447~~	~~49.05%~~	~~-27.79%~~
2023	Qtr 1	90,699 / 158,990	57.04%	7.99%
	Qtr 2	103,577 / 159,725	64.84%	7.80%
	Qtr 3	N/A	N/A	N/A

~~*Discontinued reporting this metric.~~

~~CBAS Days Used Source: CBAS Auth vs Claims X Ctr X month (Tableau)~~

~~MSSP admissions goal will exceed discharges by 5 per quarter.~~

~~The goal was not met due to staffing constraints. Continue with this goal.~~

MSSP Admissions & Discharges					
Year	Quarter	Admissions	Change From Previous Qtr.	Discharges	Change From Previous Qtr.
~~2022~~	~~Qtr 4~~	~~33~~	~~-8~~	~~33~~	~~-6~~
2023	Qtr 1	31	-2	32	-1
	Qtr 2	50	19	19	-13
	Qtr 3	N/A	N/A	N/A	N/A

~~*Discontinued reporting this metric.~~

MSSP Admissions & Discharges					
Year	Quarter	Admissions	Change From Previous Qtr.	Discharges	Change From Previous Qtr.
2023	Qtr. 4	37	0	20	12
2024	Qtr. 1	22	-15	25	5
	Qtr. 2	16	-6	21	-4
	Qtr. 3	33	17	37	16

MSSP Admissions & Discharges Source: MSSP Departmental Spreadsheet

MSSP admissions goal will exceed discharges by 5 per quarter.

-The goal was not met due to staffing constraints. Continue with this goal.

UTILIZATION PERFORMANCE / OUTCOMES

LTC and CBAS Transition

LTC Nursing Facility Members Transition to the Community

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LTC Nursing Facility Members Transition to the Community					
Year	Quarter	LOB	LTC Nursing Facility Members / Transition to Community	% Transitioned	Change From Previous Qtr.
2022	Qtr 4	Medi-Cal	220 / 4,918	4.47%	.36%
		~~One Care~~	~~9 / 173~~	~~5.20%~~	~~-1.94%~~
2023	Qtr 1	Medi-Cal	177 / 5,433	3.26%	-1.21%
		One Care	7 / 157	4.46%	-0.74%
	Qtr 2	Medi-Cal	231 / 5,525	4.18%	0.92%
		One Care	4 / 193	2.07%	-1.19%
	Qtr 3	Medi-Cal	224 / 5,602	3.99%	0.19%

LTC Nursing Facility Members Transition to the Community					
Year	Quarter	LOB	LTC Nursing Facility Members / Transition to Community	% Transitioned	Change From Previous Qtr.
2023	Qtr. 4	Medi-Cal	210	3.73%	0.14%
		One Care	2	1.03%	0.03%
2024	Qtr. 1	Medi-Cal	unknown*		
		One Care	unknown*		
	Qtr. 2	Medi-Cal	unknown*		
		One Care	unknown*		
	Qtr. 3 *	Medi-Cal	unknown*		

~~2103.73%.14%21.03%.03%UnknownUnknownUnknownUnknownUnknown~~

Source: LTC Nursing Facility Members Transition to the Community Source: LTC Discharge Tracking (LT0040)

** data not available in new clinical platform after ~~Jiva~~ (2/1/2024)*

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.
2023	Qtr 4	Medi-Cal	5,637 / 130,092	4.3%	0.02%
		One Care	195 / 17,569	1.1%	0.36%
2024	Qtr 1	Medi-Cal	50,66 / 123,265	4.1%	0.22%
		One Care	142 / 17,287	0.8%	0.71%
	Qtr 2	Medi-Cal	4,560 / 12,6395	3.6%	0.50%
		One Care	173 / 17,315	1.0%	0.18%
	Qtr 3	Medi-Cal	4,890 / 143,209	3.4%	0.20%
		One Care	165 / 17,251	1.0%	0.04%

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~~CBAS: Track CBAS participants who transition to LTC CBAS Members Discharged to LTC (LT0047)~~

CBAS Participants who Transitioned to LTC

Year	Quarter	LOB	Participants who Transitioned	% Transitioned	Change From Previous Qtr.
2022	Qtr 4	Medi-Cal	12 / 2,711	.44%	.13%
		One Care	0	0.00%	0.00%
2023	Qtr 1	Medi-Cal	5 / 2,638	.19%	.58%
		One Care	0	0.00%	0.00%
	Qtr 2	Medi-Cal	6 / 2,565	.23%	.04%
		One Care	0	0.00%	0.00%
	Qtr 3	Medi-Cal	N/A	N/A	N/A
		One Care	N/A	N/A	N/A

~~CBAS Participants who transition to LTC Source: CBAS Members Discharged to LTC (LT0047)~~

*~~*Discontinued reporting this metric~~*

Members Residing in LTC / Potential Nursing Home Eligible

Year	Quarter	LOB	Residing in LTC / Potentially Nuring Home Eligible	% Residing in ltC	Change From Previous Qtr.
2022	Qtr 4	Medi-Cal	4,918 / 128,249	3.83%	-0.01%
		~~One Care~~	~~173 / 16,622~~	~~1.18%~~	~~-0.06%~~
2023	Qtr 1	Medi-Cal	5,433 / 140,951	3.85%	0.02%
		One Care	157 / 17,332	0.91%	-0.27%
	Qtr 2	Medi-Cal	5,525 / 144,632	3.82%	-0.03%
		One Care	193 / 18,075	1.07%	0.16%
	Qtr 3	Medi-Cal	5,602 / 129.956	4.31%	0.49%
		One Care	207 / 14,089	1.47%	0.40%

~~5637/1300924.33.02%195/175691.11%.36%5066/1232654.11.22%142/17287.82%.71%4560/1263953.61%.50%173/173151.00%.18%4890/1432093.41%.20%165/17251.96%.04%~~

Members Residing in LTC Source: LTC Active Census (LT0012_GC) and Tableau Membership Detail

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PHARMACY UTILIZATION

~~Goals were met for two of the three adherence measures for year to date through the third quarter. Interventions include provider faxes, member educational materials, medication therapy management-eligible member education, and individual member refill reminders phone calls.~~

Jan-Sep 2024	Medication Adherence Rate for Diabetes Medications (ADH-Diabetes)	Medication Adherence Rate for Hypertension (RAS Antagonists) (ADH-RAS)	Medication Adherence Rate for Cholesterol (Statins) (ADH-Statins)
Goal	89.3%	92.0%	91.2%
OneCare Rate	90.4%	90.1%	89.0%

Pharmacy Utilization			
	Medication Adherence for Diabetes Medications (ADH-Diabetes)	Medication Adherence for Hypertension (RAS antagonists)	Medication Adherence Cholesterol (Statins)
Goal	89.3%	92.0%	91.2%
OneCare Rate	90.4%	90.1%	89.0%

Pharmacy Utilization			
	Medication Adherence for Diabetes Medications	Medication Adherence for Hypertension (RAS antagonists	Medication Adherence Cholesterol (Statins)
Rate	91%	91%	88%
Goal	90%	91%	91%

Source: CMS Acumen Jan-~~Oct~~ Sept 2024.

Goals were met for one of the three adherence measures for year to date through the third quarter. Interventions include provider faxes, member educational materials, medication therapy management-eligible member education, and individual member refill reminders phone calls.

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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 2023~~3~~4.

All of the clinical reviewers within the Medical Management Department passed IRR testing with a score of 90% or greater with the ~~except~~ exception ~~-~~of 2 temporary ~~one nurse in the~~ Prior Authorization nurses and 1 UM staff~~Department~~. ~~The~~ Staff that didn't pass underwent robust MCG re-training, cases were overseen through spot audits during re-training and staff were~~was~~ assigned additional cases that passed on second attempt above 90%.

Department	IRR Score
UM Clinical Staff: Prior Authorization	99.8%
UM Clinical Staff: Inpatient services	99.0%
Utilization Management	99.7%
Medical Directors (UM)	98.4%
Pharmacy: RPh	97.0%
LTSS: LTC	98.0%
LTSS: CBAS	98.3~~3~~%
LTSS: MSSP	97.5%
CalAIM	100.0%
Behavioral Health	~~Not Available~~ 99.5%

Source: https://learn.mcg.com/local/mcg_reports/index.php?c=report&a=completion

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MEMBER SATISFACTION

Satisfaction with the UM Program is evaluated based upon analysis of Grievances and Appeals, Member and Provider Experience Surveys, including the CAHPS survey, related to the UM Program. Complaints about the UM Program demonstrated some trends in the following categories:

- Member feedback obtained through Grievances and Appeals:
  - Approved referrals/authorizations to providers who are no longer contracted with CalOptima Health. Approved referrals/authorizations to providers who are not seeing new patients.
  - Approved referrals/authorizations to providers 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.
  - Approved referrals/authorizations to providers with limited panels, as there are some providers who only see members already affiliated with their organization.

- Member Feedback from the ~~2023~~ 2024 CAHPS Survey reporting measurement year

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- 20232 data:
  - 67.7%~~78.1%~~ of adult members reported through survey questions as usually or always got an appointment with a specialist as soon as needed, this is an de~~in~~crease from 78.11~~.3~~% from the previous survey for adult members.
  - 841~~.83~~% of adult members reported through survey questions that they felt it was usually or always easy to get the care, tests, or treatment needed, with a decrease from 81.3~~90.5~~% from the previous survey.
  - 68.3% of child members reported through survey questions as usually or always got an appointment with a specialist as soon as needed. There is no trend data from the year prior.
  - 814.737% of child members reported through survey questions that they felt it was usually or always easy to get the care, tests, or treatment a child needed~~, with~~ a ~~n~~ de~~in~~crease from 840.778% ~~from~~ during the previous survey period.

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PROVIDER EXPERIENCE

To evaluate provider experience, CalOptima Health analyzed provider grievances, provider UM appeals, and provider claims disputes. The top reason for provider grievances ~~weare for QI audit results.claims dispute~~according to QI Audit results was credentialing and CalOptima Health audit results.~~[NEED].s.~~ The top reasons for provider UM appeals were denial 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 956~~%~~% upheld. The top reasons for provider claims disputes were for level of payment including underpaid claims, contract rates, fee schedule, ~~bundling, down coding,~~ HCI edits and DRG payments. Based on provider experience data, CalOptima Health continues to show success in the education of~~to educate~~ providers on prior authorization requirements and claims payment policies.

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. Trend data related to authorization issues is reported quarterly at the Utilization Management Committee. In 20243, there were a total of ~~85~~38 PQIs related to related to treatment authorizations, of which ~~31~~23 (~~37~~60%) were related to authorizations denied or delayed.

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Potential Quality Issues (PQIs)					
Issue	**Q1 2024**	**Q2 2024**	**Q3 2024**	**Q4 2024**	**TOTAL**
Authorization denied or delayed	5	2	12	4	**23**
Coordination of care	0	0	0	2	**2**
Referral submitted to wrong specialist or specialty	1	0	0	2	**3**
Failure to submit referral timely	0	2	3	1	**6**
Failure to notify the member of the referral	0	0	0	1	**1**
Delay of service	0	0	1	0	**1**
Failure to refer	0	0	2	0	**2**
Total	**6**	**4**	**18**	**10**	**38**

*Q4 is October and November data only. Source CORE Report QI0089

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CalOptima is continually looking at improving response times to treatment authorizations including proactive peer to peer consultations and communication to expediate health plans decisions.

SUMMARY

CalOptima Health transitioned into a new clinical documentation platform in February 2024 impacting variations in the layout of reporting UM data compared to previous versions.

Workflow ~~P~~process improvements were enhanced~~developed~~ and implemented in February 2024~~2~~ with the transition to the new clinical documentation platform, Jiva. ~~as a result of the UM backlog continued in 2023,~~ eEfforts are reflected in the UM referral statistics ~~outlines~~outlined above. Medi-Cal and OC prior authorization turnaround time compliance remained above goal of 95% from Q4 202~~2~~3 – Q3 202~~3~~4. In addition, ~~P~~pharmacy turnaround time compliance remained above of ~~was 100~~95% ~~fron~~from Q4 2023 – Q3 2024~~in 2023~~.

~~While~~ TANF 18+ and TANF under 18 remained above goal with the exception of TANF 18+ in Q4 2023 which was under the inpatient bed day goal~~s~~., ~~the other aid code categories were above goal in ALOS,~~ Medi-Cal and OneCare inpatient turnaround time goals were above goal ~~met~~ in Q4 202~~2~~3-Q3 202~~3~~4 with exception of February 2024 for urgent cases. ~~, however r~~Retrospective goals were not met in several quarters in Q4 2023 – Q3 2024.~~all quarters.~~

Additional improvements included the addition of one (1) ~~four (4)~~ Medical Director for ~~newly developed positions~~ to support Medical Management Departments. Process improvements contributing to the 202~~3~~4 UM Program include but is not limited to, ~~i~~improved workflows, standardized documentation templates, enhanced LOA process, enhanced continuity of care process, enhancements ~~and implementation~~ of a TCS program, oversight of over and ~~underutilizaton~~underutilization patterns, and UM oversight of CalOptima Health's delegated entities. In addition, the following workgroups were developed to concentrate on specific areas within Medical Management, Case Management ~~Neuro/Spine~~ Workgroup~~,~~ and the

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EPSDT ~~Transplant~~ Workgroup~~., Bed Day Reduction Workgroup, and the UM Auth Strategy Workgroup.~~

Staffing metrics and productivity standards were enhanced~~developed~~ to ensure staff are working to their full capability and to address staffing needs.

The UMC, UM Medical Directors and Behavioral Health Medical Director continue to guide and support the CalOptima Health integrated UM/CM Program (medical, behavioral and pharmacy). The UMC, QIHEC and Medical ~~Director's continued~~Director's continued to guide and support process improvement, review and address over and under-utilization trends and continues to enhance the CalOptima Health UM/CM Program through Committee and Workgroup efforts.

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2024-5 Integrated Utilization Management and Case Management Program Description

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20245 Integrated Utilization Management and Case Management Program

Signature Page

Utilization Management Committee Chair:

Dabbah, Zeinab, M.D. ***Deputy Chief Medical Officer***	***Date***

Board of Directors' Quality Assurance Committee Chairperson:

~~Trieu Tran, M.D.~~Jose Mayorga, M.D.	***Date***

Board of Directors Chair:

Isabell~~a~~ BecerraClayton M. Corwin	***Date***

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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, 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 20244~~2~~, CalOptima Health's ~~Board of Directors and~~ Executive Team worked together to develop the 2025 3-year~~3~~ Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan ~~was approved by the~~is currently under final review of CalOptima Health Board of Directors ~~in~~ as of ~~June 2022~~January 2025. The Strategic plan once approved ~~and~~ will continue to be reviewed and updated, at a minimum of annually, based on CalOptima Health Board of Directors and Executive Team input. 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 ~~five Strategic~~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) - Adequate Control <8.0% measure.

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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
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

Commented [DZ1]: Is this suppose to be a measured goal?

- ~~Organizational and Leadership Development~~

~~Overcoming Health Disparities~~

~~Behavioral Health ()~~

- ~~**Finance and Resource Allocation**~~
- ~~**Accountabilities and Results Tracking**~~

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 ~~must~~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.

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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. Effective~~On~~ January 1, 2024, ~~a new law in~~ California ~~now allows~~expanded access to adults ages 26 through 49 to qualify for full Medi-Cal regardless of immigration status. Other Medi-Cal eligibility rules, including income limits, still apply. This latest expansion of Medi-Cal means that all Californians now have access to coverage~~; prior expansions extended coverage to undocumented children, young adults and people over 50.~~

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, 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 are not covered by CalOptima Health but may be provided by a different agency, but coordinated by CalOptima Health are indicated below:

- 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 enhance their Medi-Cal benefits. These partnerships are established as special services through a specific Memoranda of Understanding (MOU) with

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certain community agencies, including the 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 have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

Emergency Department Diversion Program

-Purpose:

Starting in January 2025, The two embedded CalOptima Health Care Managers (RN & MSW) will engage CalOptima Health members in the UCI Emergency Department to coordinate care with CalOptima Health departments (UM, CM, ECHPHM, LTSS, CalAIMCalAIMim and Customer Service) plus community resources in an expeditious manner. This is a program that will have rotating facility participation based on 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:

- Coordinate the member's plan of care with the facility University of California, Irvine (UCI) ED team, CalOptima Health and community resources.
-
-
- Coordinate PCP/specialist appointments, pharmacy, transportation, durable medical equipment (DME), Home Health, Hospice, Palliative Care, CalAIMCalAIMim, Behavioral Health, CalOptima Health CM and Enhanced Case Management ECM.)
- Support community resource access post ED visit without a hospital admission.

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- Prevent future ED visits by assisting with connection and access to careambulatory care and resources that can be coordinated at a lower level of care.
- Ensure that the member's ambulatory access to resources and care is in place and their social determinates of care health are addressed based on member needs and preferencesmet.

OneCare (HMO D-SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they 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. OC 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 the structure for supporting consistent provision of quality of care. Each member has a Case Management single point of contact, 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, the Case Management team works with our members and their doctors (PCP. specialists, behavioral health provider) to create an individualized health care plan that fits 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 QIHECQuality Improvement and Health Equity Transformation Program Priority Areas and Goals align with CalOptima Health's Strategic Goals and DHCS Bold Goals

1. Maternal Health
    a. Close racial/ethnic disparities in well-child visits and immunizations by 50%
    b. Close maternity care disparity for Black and Native American persons by 50%
2. Children's Preventive Care
    a. Exceed the 50th percentile for all children's preventive care measures
3. Behavioral Health Care
    a. Improve maternal and adolescent depression screening by 50%

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b. Improve follow-up for mental health substance disorder by 50%

4. Program Goals
   a. Medi-Cal: Exceed the minimum performance levels (MPLs) for the Medi-Cal
   ~~a.~~b. Accountability Set (MCAS)
   ~~b.~~c. 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 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 to work towards 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 ~~will~~ 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 ~~will use~~uses a phased-in approach to invest over the next four~~ive~~ 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.

Five-Year Hospital Quality Program

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

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CMS and The Leapfrog Group for quality outcomes, patient experience, and patient safety. Hospitals may earn annual incentives based on ~~achievement~~the achievement of benchmarks.

Whole-Child Model

California Children's Services (CCS) is a statewide program for children with certain serious medical conditions. CCS provides medical care, case management, physical/occupational therapy, and financial assistance. ~~As of~~Since July 1, 2019, through SB 586, 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 WCM services successfully transitioned to CalOptima Health in 2019 as the 5th MCP awarded this pilot program.~~ 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~~CalAIM)

California Advancing and Innovating Medi-Cal (~~CalAIM~~CalAIM) is a multiyear initiative, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of our population by implementing broad delivery system, program, and payment reforms across Medi-Cal.

CalOptima Health has been operating ~~CalAIM~~CalAIM services and supports since 2022 and continues to work on expanding member access. CalOptima Health's ~~CalAIM~~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 increase flexibility.
3. 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 has launched Enhanced Care Management (ECM) as well as all 14 Community Supports. ECM provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. Members are identified to participate in

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ECM services through either a risk stratification approach that proactively identifies members as falling into one of the 910 DHCS identified Populations of Focus (POF) or members who meet the DHCS eligibility criteria ~~can be~~are referred ~~in~~ to ECM so that they can receive the services.

ECM providers 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
6. Member and Family Supports
7. Coordination of and Referral to Community and Social Support Services

CalOptima Health has partnered with ~~several~~ local Community Based Organizations to provide the 14 Community Supports to our members in a medically appropriate, community-rooted, cost-effective manner. ~~Community Supports are alternatives to covered services, which are provided to reduce or avoid admissions~~admission to a hospital or skilled nursing facility admission, ~~emergency department visits, and discharge delays.~~

The 14 Community Supports are:

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)
6. Respite Services
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations (Home Modifications) includes Personal Emergency Response Systems (PERS)
12. Medically Tailored Meals/Medically Supportive Foods
13. Sobering Centers
14. Asthma Remediation

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Authorizations for ECM and Community Supports ~~can~~ ~~may be requested~~are coordinated through the CalOptima Health Connect CalAIM Portal. ~~and are managed by CalOptima Health's LTSS CalAIM~~CalAIM ~~team to determine eligibility for the requested support~~.

~~**Pharmacy Administration Changes**~~

~~**Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program (Medi-Cal Rx). Outpatient pharmacy claims processing/prior authorizations, formulary administration and pharmacy-related grievances are the responsibility of Medi-Cal Rx.**~~

~~**CalOptima Health Pharmacy Management staff continue to assist members with medication-related access issues. CalOptima Health-retained responsibilities to include physician-administered drug claims processing/prior authorizations, pharmacy care coordination, clinical aspects of pharmacy adherence, disease and medication management, and participation on the Medi-Cal Global Drug Utilization Review (DUR) Board. This change is for the Medi-Cal program only and does not affect OneCare or PACE.**~~

Population Health Management (PHM) Program Strategy

In 2023, DHCS launched Population Health Management (PHM), a cornerstone of the ~~CalAIM~~CalAIM program. CalOptima Health's approach to PHM aims to ensure the care and services provided to our 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.

CalOptima Health's PHM ~~address~~addresses the following four key strategies:

- 1. Keeping members healthy

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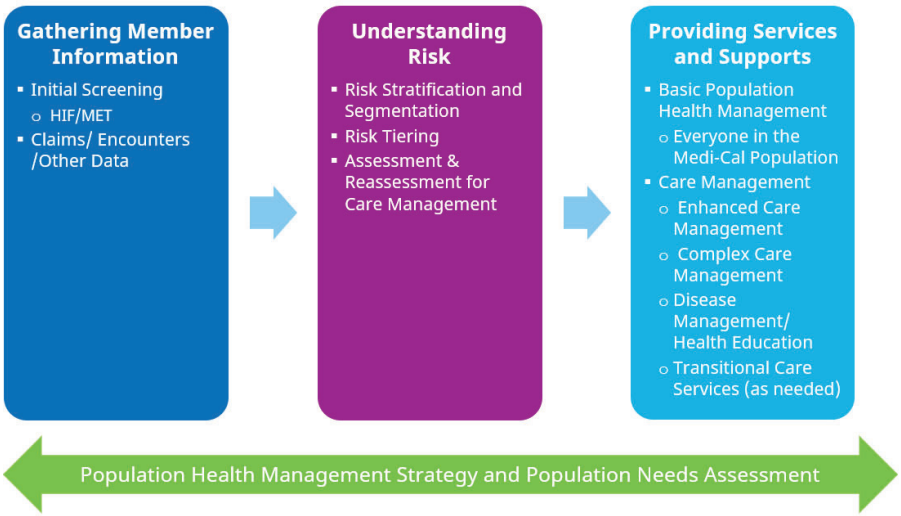
- 2. Managing members with emerging risks
- 3. Considering patient safety or outcomes across settings
- 4. Managing multiple chronic conditions

The PHM Framework outlines four key components for operationalizing the program:

1. Population Health Management Strategy and Population Needs Assessment;
2. Gathering member information;
3. Understanding risk; and
4. 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

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- Interventions to support health and wellness for all members

CalOptima Health analyzes the PHM approach annually and uses key performance indicators such as Primary Care, ambulatory care, ED visits and inpatient utilization and 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 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 10 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).

- 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.
- 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.

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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 ~~1,260~~1,236 primary care providers (PCPs), ~~9,053~~6,969 specialists, ~~44~~40 hospitals, ~~52~~57 Community Health Centers clinics and ~~107~~207 long-term care facilities.

Table 1: Provider Network Data (as of ~~October~~November ~~27~~31, 202~~3~~4)

	Number of Providers
Primary Care Providers	~~1,260~~1,236
Specialists	~~9,053~~6,969
Pharmacists	~~553~~517
Acute and Rehab Hospitals	~~44~~40
Community Health Centers	~~52~~57
Long-Term Care Facilities	~~107~~207

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 ~~Health~~ Network

Health Network/Delegate	Medi-Cal	OneCare
AltaMed Health Services	~~SRG~~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 ~~Care Network~~	HMO	HMO
Noble Mid-Orange County	SRG	SRG
Prospect Medical Group	HMO	HMO
United Care Medical Group	SRG	SRG

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CalOptima Health delegates UM activities for a portion of the CalOptima Health membership to HNs 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~~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 reporting of key performance metrics that are required 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. ~~Internal Audit Department and~~
- ~~r~~Reporting of key performance metrics ~~ed~~ 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 ~~Internal Audit~~ 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 DHCS, Centers for Medicare & Medicaid Services (CMS), NCQA, and CalOptima Health standards and program requirements.
- Annual approval of the HNs UM Program (or portions of the program that are delegated), as well as 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 l~~L~~ead by ~~Executive~~the Executive Director of ~~Clinical~~ Network Operations ~~and Medical Director Liaison~~. The~~, the~~ forum includes ~~representation~~representatives from Health Networks and CalOptima Health who come together to discuss ~~programmatic~~ 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~~operations by establishing a cohesive

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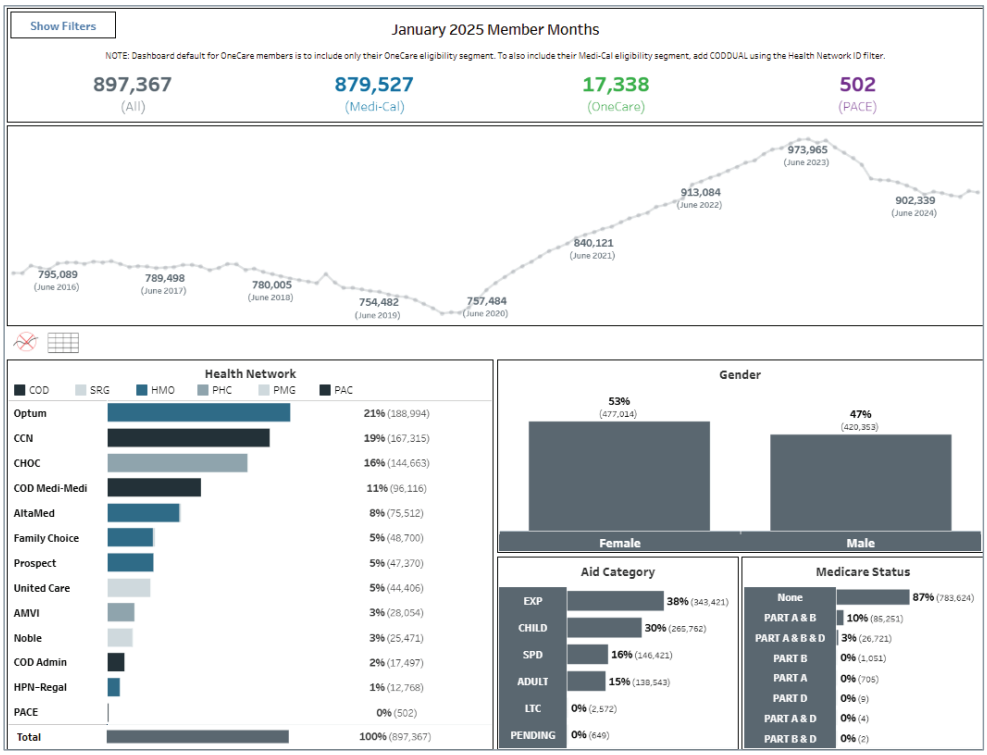
and unified approach to managing CalOptima Health members, regardless of who is managing the care of the member.

Figure 2. ~~January~~ January Member Overview



Source: Membership Dashboard tableau, data pulled 1/3/2025

~~*Source: Membership Dashboard tableau, data pulled 1/5/2024*~~

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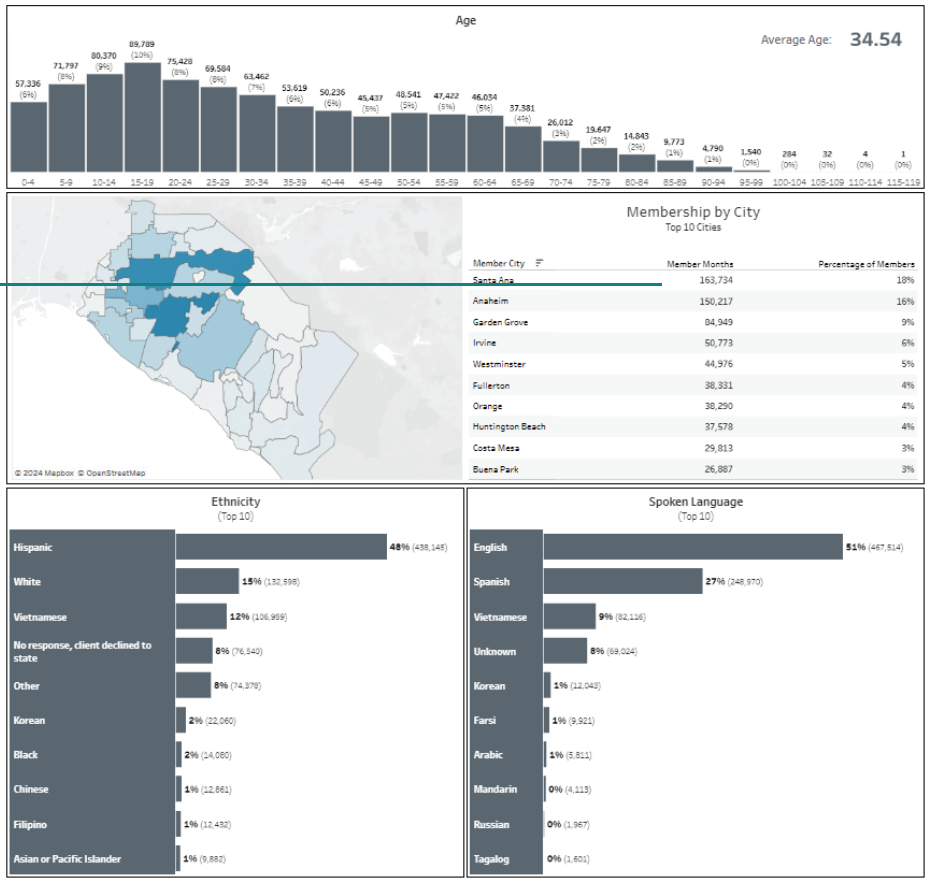
Figure 3. January Member Overview (continued)



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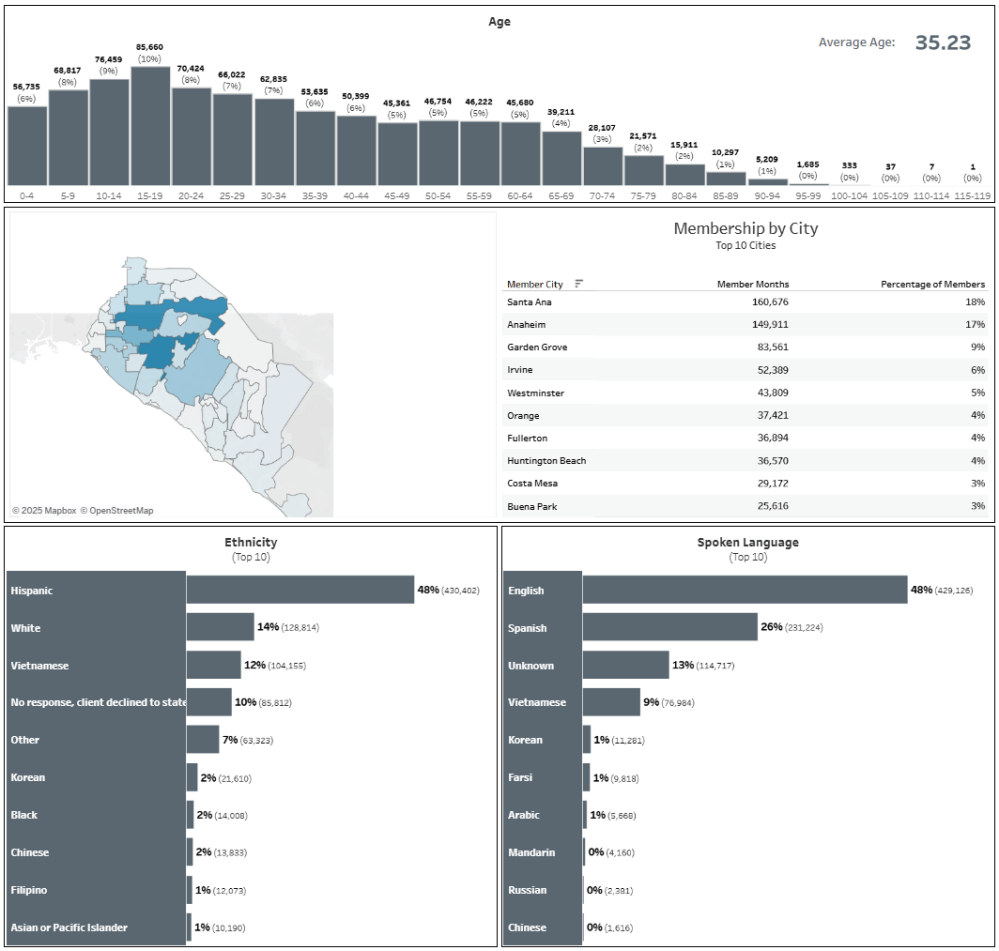

Source: Membership Dashboard tableau, data pulled 1/3/2025

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 and analysis of utilization trends including identification of under and over-utilization to ~~determine~~determine whether members are receiving appropriate services. 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 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, Long-term care and long-term services and supports. This 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 ~~approved~~ services must meet medical necessity criteria to be approved. The clinical decision process ~~initiates~~ commences upon receipt of a treatment authorization request. Request types include but are not limited to, authorization of specialty services, second opinions, outpatient services, ancillary services, post-stabilization inpatient services, ~~or~~ 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

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and abuse among practitioners and members. The UM Department works closely with the Regulatory Affairs and Compliance Department ~~Officer~~ and the Fraud, Waste and Abuse Unit to resolve any potential issues that may be identified. All UM team members and oversight Committees sign an annual attestation and are expected to abide by and ~~uphold,~~uphold CalOptima Health's policy for ensuring all medical decisions are made based within regulatory requirements and are not unduly influenced by financial considerations.

CalOptima Health provides Continuity of Care ~~services~~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 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 CalOptima Health, this is accomplished through the following goals: Assisting in the coordination of medically necessary 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 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, Behavioral Health and/or Population Health Management services~~,~~ and CCS as appropriate.

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- Promoting a high level of member, practitioner, and stakeholder satisfaction.
- Protecting the confidentiality of ~~members~~members' health and personal information.
- Identifying and reporting potential quality of care issues (PQIs) and Provider Preventable Conditions (PPCs) and refer them 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 ~~need~~the need for additional education or support.
- Promoting improved member outcomes by coordinating services with appropriate county/state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health.
- Work collaboratively with CalOptima Health's Health Network's to coordinate care for complex discharge needs and ~~CalAIM~~CalAIM services.
- Provide continuous identification of UM staffing needs including clinical, non-clinical and Medical Directors to address the needs of the members we serve.
- Provide continuous training for competency, as well as ensure staff are well versed in UM processes, regulatory requirement changes and workflow/process changes within the department.

UM Program Structure

The CalOptima Health UM Program ~~is designed to~~ ensures members ~~receives~~receive appropriate, cost-efficient~~,~~ and quality-based health care.~~ work in alignment with delegated entities.~~ The UM program is designed to support~~, for~~ optimal health outcomes and includes collaboration with but ~~is~~ not limited to, physicians, hospitals, health care delivery organizations, and ancillary service providers in the community ~~to ensure that the member receives appropriate, cost-efficient, quality-based health care.~~

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 ~~at least annually~~. The structure of the UM Program is designed to promote 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 disciplines within the organization. The organization chart and the UM Program ~~reflect~~ identify the Board of Directors as the governing body, ~~identifies~~ dictate senior management

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responsibilities, ~~as well as~~ 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 evaluated on an ongoing basis for efficacy and appropriateness of content by the Medical Management and Quality leadership team that may include 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 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 licensed clinicians. The screening is 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 offered behavioral health practitioners within the CalOptima Health provider network. If the member has significant to severe

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impairments, the member will be referred to specialty mental health services (SMHS) through the Orange County Mental Health Plan (OCMHP) 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 substance use disorder services will be referred to the Orange County Mental Health Plan (OCMHP).

Medi-Cal Behavioral Health Services include:
~~CalOptima Health offers outpatient mental health services to Medi-Cal members with mild to moderate impairment of mental, emotional, or behavioral functioning., Services include but are not limited to~~

- Outpatient individual, family and group psychotherapy
- ,Ppsychiatric consultation
- Outpatient ,medication management
- , and Ppsychological testing ~~when clinically indicated to evaluate a mental health condition.~~
- Behavioral Health Treatment (BHT)/Applied Behavior Analysis (ABA) for members 20 years and younger

~~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.~~

~~CalOptima Health covers medically necessary behavioral health treatment (BHT) for members 20 years and younger under Early and Periodic Screening, Diagnostic and Treatment (EPSDT). BHT services include applied behavior analysis (ABA) and a variety of other evidence-based behavioral interventions that have been identified as evidence-based approaches that prevent or minimize the adverse effects of behaviors that interfere with learning and social interaction.~~

~~CalOptima Health's behavioral health provider network consists of: Psychiatrists, Licensed Clinical Psychologist (PYSD), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), Licensed Clinical Professional Counselor(LPCC), Nurse Practitioner, Physician Assistant, Certified Nurse Specialist, Associate Social worker, Associate Marriage and Family Therapist, Psychological Assistant, Associate Professional Clinical Counselor, Board Certified Behavioral Analyst (BCBA), Board Certified Associate Behavior Analyst (BCaBA), Register Behavioral Technician (RBT).~~

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~~CalOptima Health does not require members, or their practitioners, to undergo triage and referral when seeking information about or approval of BH services. Most mental health services do not require a physician referral. Members may access mental health services by calling the CalOptima Health Behavioral Health Line at 855-877-3885. A CalOptima Health representative will conduct a brief telephonic screening to determine the reason for the call and the assistance needed. Mental health screenings are conducted by CalOptima Health's Behavioral Health Integration licensed clinicians using the most recent DHCS approved screening tool. The screening is 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 offered behavioral health providers within the CalOptima Health network. If the member has significant to severe impairments, the member will be referred to Specialty Mental Health Services (SMHS) through the Orange County Mental Health Plan (OCMHP) managed by the Orange County Health Care Agency.~~

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

One Care~~CalOptima Health offers the following~~ Behavioral Health ~~mental health~~ services include: ~~to OC members:~~

- Inpatient psychiatric hospitalization
- Intensive outpatient program (IOP)
- ~~and~~ Ppartial hospitalization program (PHP)
- Outpatient individual and group psychotherapy
- Outpatient medication management
- Psychological testing
- Opioid t~~T~~reatment p~~P~~rogram (OTP) services
- Electro c~~C~~onvulsive t~~T~~herapy (ECT)
- Transcranial m~~M~~agnetic s~~S~~timulation (TMS)
- Alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT)

~~**Most mental health services do not require a physician referral. Members**~~

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~~may access mental health services by calling the CalOptima Health Behavioral Health Line at 855-877-3885. A CalOptima Health representative will conduct a brief telephonic screening to determine the reason for the call and the assistance needed. Mental health screenings are conducted by CalOptima Health's Behavioral Health Integration licensed clinicians using the most recent approved screening tool. The screening is to make an initial determination of the member's impairment level. If the member has mild to moderate impairments due to a mental health condition, the member will be offered behavioral health practitioners within the CalOptima Health provider network. If the member has significant to severe impairments, the member will be referred to (SMHS) through the OCMHP.~~

~~CalOptima Health directly manages all administrative functions of the OC behavioral health benefits including UM, claims, provider network credentialing, member services and QI.~~

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. The responsibility to oversee the UM Program is delegated by the Board of Directors to the Board's Quality Assurance Committee (~~QAC) —~~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.

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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 ~~annual~~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) includes members with~~,~~ each seat representing~~s~~ 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 representatives 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

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- 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 broad provider community that serves CalOptima Health members. The PAC meets ~~at least quarterly~~bi-monthly and is open to the public. The members include:

- Health ~~n~~Networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied ~~h~~Health ~~s~~Services (two seats)
- Community ~~h~~Health ~~c~~Centers
- Health Care Agency (HCA) (standing seat)
- Long Term Services and Supports
- Non-physician ~~m~~Medical ~~p~~Practitioner
- Traditional ~~s~~Safety ~~n~~Net ~~p~~Provider
- Behavioral/~~m~~Mental ~~h~~Health
- Pharmacy

Whole-Child Model Family Advisory Committee

Whole-Child Model Family Advisory Committee (WCM FAC) ~~has been~~is 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 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 ~~can~~ 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:~~-~~

- ~~Family representatives:-~~
- Authorized Family Member ~~r~~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; ~~or~~-

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- 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, ~~PHM~~ 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 ~~Quality Analytics (QA),~~ Utilization Management (UM), Case Management (CM), ~~Population Health Management (PHM),~~ Pharmacy Management (PM), Behavioral Health Integration (BHI), and Long-Term Support Services (LTSS), ~~and Enterprise Analytics (EA).~~

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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 (EDCO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the UM, Care Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The EDCO serves as a member of the executive team, and, with the CMO, DCMO and the Executive Director of ~~Quality and Population Health Management.~~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 BHI leads strategies for integrating behavioral health across the health care delivery system and populations served.

Executive Director, ~~Population Health Management~~Equity and Community Health (ED ~~PHM~~ECH) is responsible for the management and oversight of CalOptima Health's disease management and health education departments. The ED ~~PHM~~ ECH oversees the development and implementation of companywide Population Health Management strategy to improve member experience, promote optimal health outcomes, ensure efficient care and improve health equity. The ED ~~PHM~~ ECH serves as a member of the executive team, 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. The Director of ~~Population Health Management~~Equity and Community Health reports to the ED ~~PHM~~ECH.

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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. All 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.

- 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 the implementation of the UM Program. The Medical Directors ensures 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, 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 normal business hours and on-call after hours. Also serves as the Chair of the UMC and the Benefit Management Subcommittee, 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.

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- The Medical Director oversees specialty programs and services, is 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, including PHM, disease management and health education programs, while also providing clinical quality oversight of the Program of All-Inclusive Care for the Elderly (PACE) Center.

- ~~**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 incumbent will have oversight of CalOptima Health's UM Program for CalOptima Health Community Network, CalOptima Health Direct and the delegated HNs. The Director is expected to serve as a liaison for various internal and external committees, workgroups, and operational meetings.~~

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

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Director, Quality Analytics isp responsible for leading collection, tracking and reporting of quality performance measures, including HEDIS and Stars metrics, as required by regulatory entities. Conducts data analysis to inform root cause analysis, identify opportunities for improvement, and measure effectiveness of interventions. Provides data analytical direction to support quality measurement activities for the agencywide QIHETP,rovides analytical direction to support quality measurement activities for the agencywide QI Program by managing, executing, and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. This position provides coordination and support to the QIHBEC and other committees to support compliance with regulatory and accreditation agencies.

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, Population Health Management (PHMEquity and Community Health (ECH) provides direction for program development and implementation for agencywide population health initiatives while ensuring linkages supporting a whole- person perspective to health and health care with Case Management, UMC, Pharmacy and BHI. This position oversees programs that promote health and wellness services for all CalOptima Health members. PHM ECH services include Perinatal Support Services (Bright Steps Program), Chronic Condition management services using health coaches and Registered Dietitians, and the Childhood Obesity Prevention Program (Shape Your Life). PHM ECH also supports the MOC implementation for members and r. Reports program progress and effectiveness to QIHEC and other committees to support compliance with regulatory and accreditation agency requirements.

Director, Internal Audit oversees and conducts compliance audits and monitoring of CalOptima Health's internal operations with an emphasis on 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 requirements for all programs. Specifically, the 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

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~~and controls. The position interacts with the Board of Directors, CalOptima Health Executives, Compliance Committee, departmental management, and legal counsel.~~

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 ~~to UM staff~~ on site or by telephone.

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 serve 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 clinical operational effectiveness between hospitals and all CalOptima Health and health network partners. Director is responsible for ensuring patient access through quality outcomes and a system approach to ensure inpatient care, transitional care services and communication amongst treatment teams. Director leads through a front-line, coordinated approach working with our hospitals, direct providers and health network partnerships to ensure exceptional direction and communication to 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.

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

Director, Quality Analytics is responsible for leading collection, tracking and reporting of quality performance measures, including HEDIS and Stars metrics, as required by regulatory entities. Conducts data analysis to inform root cause analysis, identify opportunities for improvement, and measure effectiveness of interventions. 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 compliance audits and monitoring of CalOptima Health's internal operations with an emphasis on 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 requirements for all programs. Specifically, the director leads the department in

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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 provides UM Department prior authorization compliance oversight of internal and external delegated health networks. The Sr. Manager leads inventory management process for improvement of all clinical operation teams to maximize efficiencies and ensure regulatory compliance.

Manager, Utilization Management RN/LVN (Inpatient Services~~Concurrent Review [CCR]~~(IP)) manages the day-to-day operational activities of the Department to ensure staff compliance with 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~~CCR~~) provides day-to-day supervision of assigned staff, monitors and oversees daily work assignment and activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload. The Supervisor is a resource to the IP~~CCR~~ 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 for~~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, ~~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. The Manager also establishes and maintains collaborative working relationships with internal and external resources to ensure appropriate support for utilization activities.

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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 ~~makes recommendations regarding assignments~~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 ~~while, providing ongoing monitoring and development of staff through training activities.~~ 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:

Notice of Action Medical Case Managers (RN/LVN) draft and evaluate 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. 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. 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.

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Quality Improvement (QI) Nurse Specialists Utilization Management~~Medical Case Managers (Clinical Auditors,~~ **(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 but are not limited ~~to,~~to prior authorization 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.

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 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

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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 ~~guideline~~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~~-Term Care (LTC) facilities authorization services for room and board, CBAS and MSSP, and staff associated with those programs.

Manager, Long-Term Services and Supports (CBAS/LTC/MSSP) develops and manages the LTSS department's work activities and team. 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.

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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 ~~member's~~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.

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.

Medical Case Managers (BH-RN/LVN or 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.) ~~provide~~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

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provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Medical Authorization Assistants (MAA BH) 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 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 are covered during the program, as applicable to specific job descriptions:

- 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.

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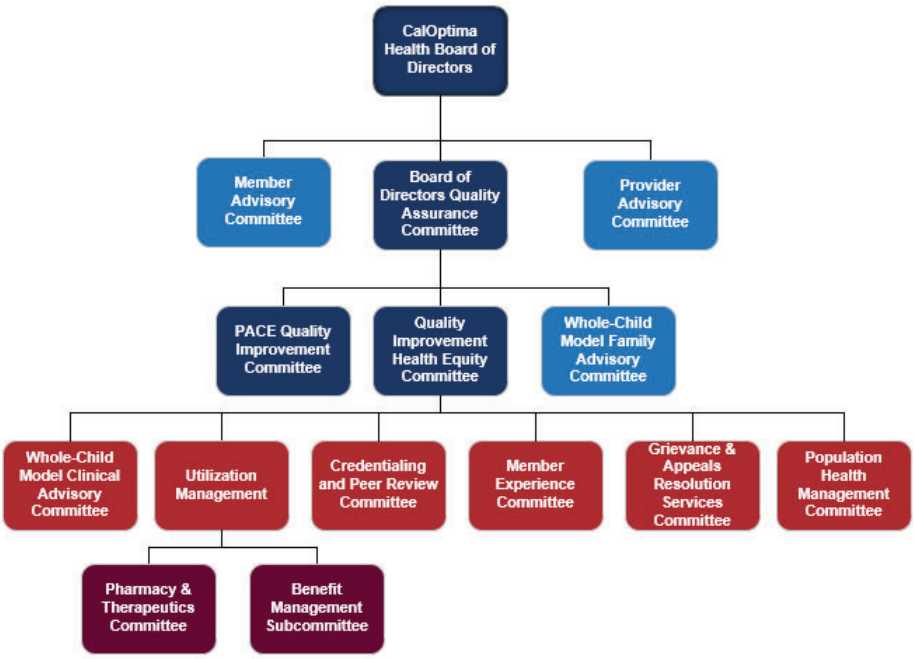
Utilization Management Committee (UMC)

Figure 4: Diagram representing the committee structure



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UMC

The UMC is led by a CalOptima Health Medical Director. This senior level physician is involved in UM activities, including but not limited ~~to,~~to implementation, supervision, 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 ~~Board~~the Board of ~~d~~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 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.

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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.

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

- 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, identify areas for performance improvement, and evaluate performance improvement initiatives.
- Reviews, assesses, and recommends utilization management best practices used for selected diagnoses or disease classes.

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- Conducts review of under/over utilization monitoring and makes recommendations in accordance with UM Policy and Procedure GG.1532: Over and Under Utilization Monitoring; makes recommendations for improving performance on identified over/under utilization.
- Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:
- Benefit Management Subcommittee (BMSC)
- P&T Committee
- Reports to the QIHEC on a quarterly basis, communicates significant findings and makes recommendations related to UM issues.

Departments Reporting Relevant Information on UM Issues:

- Delegation Oversight
- Behavioral Health
- Grievance and Appeals
- ~~UM Workgroup~~
- LTSS
- Pharmacy

UMC Membership

Voting Members in the UMC Committee include:

- Chief Medical Officer (Specialty: Emergency Medicine)
- Chief Health Equity Officer
- Deputy Chief Medical Office (Specialty: Internal Medicine)
- Medical Director who oversees Utilization Management (Specialty: Family Practice)
- Medical Director who oversees UM Program (Specialty: Internal Medicine)
- Medical Director who oversees Behavioral Health Program (Specialty: Psychiatry [Child/Adolescent & Adult])
- Medical Director who oversees Senior Programs (Internal Medicine)
- Medical Director who oversees Whole-Child Model Program (Specialty: Medicine/Pediatrics)
- Medical Director who oversees Quality and Analytics (Specialty: Pediatrics)
- Executive Director, Clinical Operations (Master of Science in Gerontology, Certified Case Manager)

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- Outside Practitioner[1] (Specialty: Family Medicine)
- Outside Practitioner (Specialty: Pediatrics)
- Outside Practitioner (Specialty: Neurology)
- Outside Practitioner (Specialty: Pulmonary)~~CMO/Deputy Chief Medical Office (DCMO)~~
- ~~Medical Director who oversees Utilization Management~~
- ~~Medical Director who oversees UM Program~~
- ~~Medical Director who oversees Behavioral Health Program~~
- ~~Medical Director who oversees Senior Programs~~
- ~~Medical Director who oversees Whole-Child Model Program~~
- ~~Medical Director who oversees Quality and Analytics~~
- ~~Executive Director, Clinical Operations~~
- ~~Up to six participating practitioners from the community~~[2]

Participating members of the UMC that don't have voting rights, although presents data, program outcomes and updates to policies consists of:

- Director, Utilization Management
- Director, Quality Improvement
- Director, Pharmacy
- Sr. Manager, Utilization Management
- UM Manager, Prior Authorization
- UM Manager, Inpatient Services~~Concurrent Review~~

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

[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.

[2] ~~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.~~

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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:

- ~~Maintaining a consistent benefit set for all lines of business.~~
- 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

- Medical Director who oversees UM services— Chairperson
- Medical Director who oversees Population Health and Equity
- Executive Director, Clinical Operations
- Director, UM (Alternate; Manager, Prior Authorization)
- Director, Behavioral Health Integration (Alternate: 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 recommendations from the BMSC are reported to the UMC on a quarterly basis.

UM Workgroup

The UM Workgroup is a sub-~~workgroup~~work group under the UMC. The Workgroup meets bi-monthly and includes staff members from UM, CM, BHI, and 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

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- Provide input on UM Department policies and procedures and desktop procedures
- Identify opportunities to optimize UM processes

The goals of the UM Workgroup includes but is 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

Based on discussions at the UM Workgroup, other Sub Workgroups were formed in 2023~~3~~4 and will continue in 20245

- ~~Brain/Spine Workgroup~~
- ~~Transplant Workgroup~~
- ~~UM Authorization Strategy Workgroup~~
- 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

~~Brain / Spine Workgroup~~

~~The Brain / Spine Workgroup meets monthly and consists of UM staff and UM leadership including Medical Directors. The goal of the Brain / Spine Workgroup is to ensure member requests for neurological and spine treatment and/or surgery are provided by appropriate medical practitioners based on member need and that services are provided in a timely manner. CPT codes are reviewed to determine if prior authorization is necessary.Transplant Workgroup~~

~~The Transplant Workgroup meets bi-monthly and consists of UM staff and UM leadership including Medical Directors. The goal of the Transplant Workgroup is to ensure members needing transplant services are case managed throughout the continuum of the transplant process (pre and post), in addition to assisting member families with lodging and meal needs.~~

~~CalOptima Health has three dedicated nurses as the point of contact for transplant cases. A UM Nurse is assigned to the pre-authorization needs of the members, one is assigned to the inpatient needs and the third is assigned to the post-transplant needs.~~

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~~**Transplant Workgroup team members also meet weekly with CalOptima Health's COE, UCSD. These rounding meetings allow CalOptima Health to assist UCSD with discharge and post discharge needs and the needs of the families. UM Authorization Strategy Workgroup**~~

~~The UM Authorization Strategy Workgroup consists of UM staff, UM leadership, Medical Directors, and representatives from Clinical Operations and Analytics. The workgroup supports ongoing strategic decisions and process improvement for the access and utilization of Utilization Management data.~~

High-Risk Management ~~Bed Day Reduction~~ Workgroup

The High-Risk Management ~~Bed Day Reduction~~ Workgroup was the Bed Day Reduction Workgroup established in 2023. In 2024 the name changed, and it was combined with the UM Authorization Strategy Workgroup. The High-Risk Management Workgroup is a cross-departmental clinical-lead work group designed to evaluate utilization data. The workgroup is responsible for identifying interventions to optimize utilization in the Emergency Department (ED), inpatient facilities and long-term care setting and improve patient outcomes. This focus 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. ~~for the development of strategies to improve outcomes for CalOptima Health members and establish bed day goals including readmission rates that will be presented to UMC ongoing. The Bed Day Reduction Workgroup establishes data-driven interventions to reduce inpatient admissions, bed days, decrease 30-day readmission, and reduce ED utilization through collaboration between Case Management, Utilization Management, Medical Affairs.~~

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. The workgroup monitors metrics, discusses performance, addresses trends, contributes to the analysis and action plan for decreasing over and underutilization that is reported up through the UMC.

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Early and Periodic Screening Diagnosis Treatment (EPSDT) Workgroup

The EPSDT Workgroup brings together representatives from the Medical Directors, Case Management, Utilization Management, Behavioral Health Integration, Delegation Oversight, and Quality Analytics to address EPSDT. The EPSDT workgroup began in April 2024 and covers all 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 protocols 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.

Integration with the QI Program

The UM Program is evaluated and submitted for review and approval annually by UMC, QIHEC and QAC, with final review and approval by the Board of Directors.

- 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 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.

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Integration with Other Processes

The UM CM Integrated Program, BH Program, LTSS Program, P&T, QI, Credentialing, Compliance and 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 ~~on~~in the appropriate form and forwarded to the QI Department for review and resolution. As a result, utilization of services is ~~inter- related~~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.

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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 OC. 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 ~~consists~~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 ~~R~~review
- Post-stabilization review
- Concurrent/Continued ~~S~~stay ~~R~~review for selected conditions
- Discharge Planning ~~R~~review
- Retrospective ~~R~~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:

- ~~Evidenced based~~Evidence-based clinical criteria or guidelines are applied consistently and regularly reviewed and updated.

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- 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.

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- 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 determinations.
- All providers are encouraged to request information regarding the criteria used in making a 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 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

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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~~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, and~~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 ~~is~~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.

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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 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

Appropriately licensed health care professional supervises all medical necessity review ~~decision~~decisions. The UM decision process requires that ~~qualified,~~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) 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 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, affirming 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

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Pharmacy Management is overseen by the CMO, and CalOptima Health's Director, Clinical Pharmacy Management. 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 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 ~~development~~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 January 1,2022, the 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 BHT services 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.

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Medicare

CalOptima Health's BHI department performs prior authorization review functions for One Care covered BH services. Services require prior authorization include inpatient psychiatric care, partial hospitalization program, intensive outpatient program, psychological testing, 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

1. Medi-Cal Provider Manual and Department of Health Care Services (DHCS) All Plan Letter's (APL)
2. National Correct Coding Initiative (NCCI) Policy Manual
3. CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook

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4. MCG Care Guidelines
5. Drug Compendia Micromedex DrugDex and American Hospital Formulary Service Drug Information (AHFS-DI)
~~4.~~6. Peer-Reviewed Medical Literature
~~5.~~7. National Comprehensive Cancer Network Guidelines (NCCN)
~~6.~~8. 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
    i. National Guideline Clearinghouse

Medicare (OneCare)

1. CMS National Coverage Determinations (NCD)
2. CMS Local Coverage Determination (LCD) (Noridian Local Contractor for California)
3. CMS Local Coverage Article (LCA)
4. CMS Manuals (Medicare Benefit Policy Manual, Medicare National (NCD) Manual, Medicare Claims Processing Manual, etc.)
5. National Correct Coding Initiative (NCCI) Policy Manual
6. CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook
7. Drug Compendia: Micromedex, DrugDex, American Hospital Formulary Service-Drug Information (AHFS-DI), Clinical Pharmacology
8. National Comprehensive Cancer Network Guidelines (NCCN) Drugs and Biologics Compendium, Lexi Drugs
9. MCG Care Guidelines
10. 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)

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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
i. National Guideline Clearinghouse

Whole Child Model (WCM)

1. California Children Services (CCS) Numbered Letters and CCS Information Notices
2. Medi-Cal Provider Manual and DHCS APLs
3. National Correct Coding Initiative (NCCI) Policy Manual
4. CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook
5. MCG Care Guidelines
6. Drug Compendia: Micromedex, DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology
7. National Comprehensive Cancer Network Guidelines (NCCN)
8. 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
   i. National Guideline Clearinghouse

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.

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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, 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 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 ~~h~~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~~-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

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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 contracted vendor. The vendor is not a delegated UM entity and ~~therefore,~~therefore does not make authorization decisions. Vendor staff take authorization information for the next business day response by CalOptima Health. In cases requiring immediate response vendor staff notifies 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

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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, ~~PHM~~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 decide among all relevant treatment options.

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- 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.

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~~Attachment A TIMELINES FOR MEDI-CAL~~

~~UM Decision and Notification Timelines~~

UM Decision and Notification Timelines ~~Medi-Cal Decision and Notification Timelines~~			
~~Type of Request~~	~~Decision~~	~~Initial Notification (I be Electronic or Writ~~	~~Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Membe~~
~~Routine (Non-urgent) Pr Service~~ ~~Prior Authorization / Prospective or outpatien service requests.~~	~~Approve, Modify, or Deny wi 5 business days from receipt the information reasonably necessary to render a decisio and no longer than 14 calend days from receipt of the request.~~	~~Practitioner: Electron within 24 hours of making the decision~~	~~Practitioner: Electronic Within 24 hours of makin the decision.~~ ~~Member: Written~~ ~~Notice must be postmar~~

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TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

			within 2 business days o decision not to exceed 1 calendar days from rece of the request.Within 2 business days of decisio
Routine (Non-urgent) Pr Service – Extension Nee • Additional clinical information required. • Require consultatio by an Expert Reviewer. • Additional examination or tests to b performed.	Approve, Modify, or Deny wi 5 business days from receipt the information reasonably necessary to render a decisi and no longer than 14 calen 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 Medic Director pend request, only where the member or memb provider requests an extens or CalOptima Health can	Practitioner: Electro within 24 hours of making the decision	Practitioner: Electronic Within 24 hours of maki the decision. Member: Written Within 2 business days o making the decision, no exceed 28 calendar days from the receipt of the request for service. Practitioner/Member:

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TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

	provide justification upon request by the State for the need for additional informat and how it is in the member' interest. • CalOptima Health will notify member and practitioner of decision to delay / defer, in writing, within 5 14 calendar days from the receipt of initi request. • • Notice of delay / deferr should include the additiona information needed to rende the decision, the type of exp reviewer and/or the additior examinations or tests requir and the anticipated date on		Written Notice of Action "Delay" notification with 14 calendar days from th receipt of the initial request.

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	which a decision will be rendered.		
	Additional information recei	Practitioner:	Practitioner: Electronic
	• If requested informatio received, decision must be made within 5 business days receipt of information, not t exceed 28 calendar days fro the date of initial receipt of t request.	Within 24 hours of making the decision	Within 24 hours of makin the decision. Member: Written Within 2 business days o making the decision, not exceed 28 calendar days from initial receipt of the

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TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

			request.
	Additional information incomplete or not received • If after 28 calendar day from receipt of the initial request for prior authorizati the provider has not complie with the request for additior information, the plan shall provide the member notice c denial.	Practitioner: Within hours of making the decision.	Practitioner: Electronic Within 24 hours of makir the decision Member: Written Within 2 business days o making the decision, not exceed 28 calendar days from receipt of the initia request.

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~~Working days = Monday through Friday excluding California State Holidays~~

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Medi-Cal Decision and Notification Timelines			
Type of Request	**Decision**	**Initial Notification (I be electronic or writ**	**Electronic/Written Notification of ADVERSE DETERMINATIONS to Practitioner and Membe**
Expedited Authorization (Pre-Service) • Provider or CalOpti Health determines that t standard timeframe cou seriously jeopardize the member's life or health o ability to attain, maintai	**Approve, Deny, or Modify wi 72 hours from receipt of the request.**	**Practitioner: Within hours of making the decision.**	**Practitioner: Electronic Within 24 hours of maki the decision. Member: Written Within 2 business days o making the decision, not extend 3 business days f the receipt of the reques**

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regain maximum functio • All necessary information received at time of initial request.			for serviceWritten notice within 72 hours from rec of the request.

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Expedited Authorization (Pre-Service) - Extension Needed • A request is extend when the member or provider requests the extension, or CalOptima Health justifies a need fo additional information a can demonstrate how th 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 wi 72 hours from receipt of the request Additional clinical informatio required: Upon the expiration of the 7 hours or as soon as you beco aware that you will not mee the 72-hour timeframe, whichever occurs first, notify the practitioner and membe using the "Delay" written notification, and insert speci about what has not been received,, what consultation needed and/or the additiona examinations or tests requir	Practitioner: Within hours of making the decision.	Practitioner: Electronic Within 24 hours of maki the decision. Member: Written Within 2 business days o making the decision, not extend 3 business days f the receipt of the reques for serviceWritten notice within 72 hours of the receipt of the request.

	~~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 calenda days if the member requests extension, or CalOptima Hea can provide justification upo request by the State for the need for additional informat and how it is in the member' interest.~~		
	~~Additional information recei~~ ~~• If requested informatio~~	~~Practitioner: Within hours of making the decision.~~	~~Practitioner: Electronic Within 24 hours of makir the decision~~

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TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

	~~received, decision must be made within 1 business day c receipt of information.~~		~~Member: Written~~ ~~Within 2 business days o making the decision~~
	~~Additional information incomplete or not received~~ ~~• Any decision delayed beyond the time limits is considered a denial and mus processed immediately as su~~	~~Practitioner: Within hours of making the decision.~~	~~Practitioner: Electronic Within 24 hours of makin the decision~~ ~~Member: Written Within business days of making decision.~~
~~Urgent Concurrent (Inpatient) Requests wh a provider indicates or CalOptima Health determines that the standard timeframe cou~~	~~Approve, Modify, or Deny wi 72 hours of receipt of the request.~~	~~Practitioner: Within hours of making the decision.~~	~~Practitioner: Electronic Within 24 hours of makin the decision.~~

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TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

seriously jeopardize the member's life or health ability to attain, maintai regain maximum functio	Extension: CalOptima Health may exter the time frame, by up to 14 calendar days, under the following conditions: Additio supporting clinical informati is needed.		Member: Written Within business days of making decision.
Concurrent (Inpatient) Concurrent review of inpatient treatment regi already in place, (inpatie ongoing ambulatory services). In the case of concurren review, care shall not be discontinued until the enrollee's treating provi has been notified of	Approve, Modify, or Deny wi 72 hours of last approved da decision consistent with urgency of member's medic condition. Extension: CalOptima Health may exter the timeframe 48 hours or u 14 calendar days under the following conditions:	Practitioner: Within hours of making the decision.	Practitioner: Electronic o Oral: Within 24 hours of receip the request. Member: Written Written notification with business days of decisio

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TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

CalOptima Health's decision, and a care plan has been agreed upon by the treating provider that appropriate for the med needs of that patient.	• Additional supporting clinical information is neede		Note: If oral notification is give within 24 hours of reque then written/electronic notification must be give no later than 2 business days after the oral notification.
Post-Service / Retrospec Review- All necessary information received at time of request (decisior and notification is requi within 30 calendar days from request).	Within 30 calendar days fron receipt of request. , that is reasonably necessary to mal decision	Practitioner: Within hours of making the decision.	Practitioner: Electronic Within 30 calendar days receipt of the request. Member: Written Within 30 calendar days receipt of request.

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Hospice - Inpatient Care	Within 24 hours of receipt of request.	Practitioner: Within hours of making the decision.	Practitioner: Electronic Within 24 hours of makir the decision. Member: Written Within 2 business days o making the decision.

[1] Working days = Monday through Friday excluding California State Holidays

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UM Decision and Notification Timelines

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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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.

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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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Attachment B
TIMEFRAMES FOR ONECARE DECISIONS AND NOTIFICATIONS

~~Attachment B TIMELINES FOR OneCare~~

~~OneCare Decisions 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.~~**
~~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.~~

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TIMEFRAMES FOR ONECARE DECISIONS AND NOTIFICATIONS

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.

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TIMEFRAMES FOR ONECARE DECISIONS AND NOTIFICATIONS

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.

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TIMEFRAMES FOR ONECARE DECISIONS AND NOTIFICATIONS

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

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Type of Request	Decision	Important Message (IM) from Medicare	Detailed 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.

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.

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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

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TIMEFRAMES FOR ONECARE DECISIONS AND NOTIFICATIONS

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.

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Attachment C
TIMEFRAMES FOR PHARMACY DECISIONS AND NOTIFICATIONS

~~Medi-Cal~~ 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.

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TIMEFRAMES FOR PHARMACY DECISIONS AND NOTIFICATIONS

Type of Request	Determination 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.
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.

Standard (Non-urgent) Preservice – Delay Needed	• 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.

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.

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TIMEFRAMES FOR PHARMACY DECISIONS AND NOTIFICATIONS

~~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.~~

~~Expedited (Urgent) Preservice/Concurrent - Delay Needed~~	• ~~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 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.~~

~~Post-Service/Retrospective~~	• ~~A decision to approve, modify, or deny is required within 30 calendar days of receipt of the request.~~

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.

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.

~~Type of Request~~	~~Determination Timeline~~
~~**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).~~
~~**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).~~
~~**Post-service/Retrospective**~~	~~A decision to approve or deny is required within 14 calendar days of the initial receipt of the request.~~

~~Type of Request~~	~~Notification Timeline (Member and Prescriber)~~
~~**Standard (Non-urgent) Preservice/Concurrent**~~	~~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).~~

Attachment C
TIMEFRAMES FOR PHARMACY DECISIONS AND NOTIFICATIONS

~~**Expedited (Urgent) Preservice/Concurrent**~~	~~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**~~	~~Within 14 calendar days of the initial receipt of the request.~~

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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 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, but~~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:

The request is made within sixty (60) calendar days after the initial date of service and one of the following conditions apply:

1. The Member has Other Health Coverage (OHC); or
2. 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 ,~~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 ~~extension~~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 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, with consideration for the most appropriate alternative to inpatient care. If at any time UM staff become aware of potential quality of care issue, 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, quality-driven treatment intervention for post-hospital care needs. It is a coordinated effort among the facility and CalOptima Health and includes participation from but is 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 are:

- 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.

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- 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 assists 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 lay language that is easily understandable at a ~~sixth-grade~~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

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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 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 who~~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 received by phone, fax, mail, online web submission or in person submission to Grievances and ~~a~~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 CalOptima Health Networks are handled by CalOptima Health GARS department. CalOptima Health collaborates with the community provider or delegated entity to gather the necessary information and supporting 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

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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 regulatory 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 in the review is directed to Quality Improvement for further review~~. This portion of the review~~ and a Potential Quality Issue (PQI) investigation is opened. ~~is covered by a~~PQI investigations ~~are confidential~~are confidential and peer protected ~~process~~ and ~~is~~are a separate process from the grievance and appeal ~~process~~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

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an expeditious manner as the matter requires, but no later than 72 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 members have a right to request an independent review if they disagree with the termination of services from a 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 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.

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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

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~~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.

CBAS

CBAS is an outpatient, facility-based program offering day-time care and health and social services to frail seniors and adults with disabilities 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.

MSSP

CalOptima Health is an approved MSSP site through California Department of Aging (CDA). ~~The MSSP program provides services and support to help people 65 and older who have a disability that puts them at risk of going to a nursing home. Services include, but are not limited to, senior center programs, case management, money management and counseling, respite, housing assistance, assistive devices, legal services, transportation, nutrition services, home health care, meals, personal care assistance with hygiene, personal safety, and activities of daily living.~~ The Multipurpose Senior Services Program (MSSP) provides social and health care services for people 65 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. The goal is to give members a chance to stay in their homes and enjoy a higher quality of life. To get these services, CalOptima Health members must: Be 65 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

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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 a wide choice of services based on the ~~member's~~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 by the UM ~~w~~Workgroup, identified stakeholders, Medical Director Team and reported to UMC. The UMC reviews ~~the~~ ~~O~~over/~~U~~under ~~U~~utilization data ~~report~~ on a quarterly basis and approves and monitors metrics, discusses performance, address identify trends, contributes to the analysis, and identifies action plan for decreasing over and underutilization.

Over/under utilization monitoring and performance are reported to the QIHEC ~~and QAC~~ on a quarterly basis.

~~Under and~~ The UMC may track and monitor over and underutilization data in ~~Over Utilization is tracked and monitored through~~ the following areas to include but not limited to~~and trends~~:

- 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

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- Behavioral health measures
- Other areas as identified

Program Evaluation

The UM Program is evaluated at least ~~annually~~annually, and modifications are made as necessary. 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 surveys
- 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 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 information gathered indicates areas of dissatisfaction, CalOptima Health develops an action plan

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and interventions to improve the areas of concern, 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~~Complex Case Management (CCM~~) 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~~Case ~~m~~Management ~~CCM~~ program and process include but are not limited to the following:

- ~~New DHCS contract goes into effect January 1, 2024.~~
- 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 targeted outreach and case management to support members who are risk stratified as high risk. Some high-risk members may primarily be utilizing the emergency department for care and develop best practices for outreaching to these members and improving their overall care.
- Continue 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.
- Transitioned to new clinical documentation platform in ~~February,~~February 2024.

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- ~~Beginning on January 1, 2022, CalOptima Health implemented two DHCS CalAIM~~CalAIM ~~components: Enhanced Care Management (ECM) and Community Supports. Enhanced Care Management provides a whole- person approach to care that addresses the clinical and non-clinical circumstances of high need Medi-Cal members. As of January 1, 2024 CalOptima Health operates all 14 Community supports and continues to identify members for enhanced care management through a fully integrated approach.~~
- ~~Effective January 1, 2022, DHCS carved out the outpatient pharmacy benefit for Medi-Cal beneficiaries from managed care plans and moved it to a state fee-for-service program, known as Medi-Cal Rx. CalOptima continues to coordinate and support members clinical pharmacy needs through program integration and advocacy. The OneCare program and medical pharmacy benefit continues to be managed by CalOptima Health.~~
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Team Composition and Roles

The Case Management Department consists of functional teams that focus on specific program activities. The teams are ~~multidisciplinary, and~~multidisciplinary and are composed of ~~nurse~~ Case Managers, Social Workers, Medical Assistants, Personal Care Coordinators, and ~~Member Liaison Specialists~~, as appropriate, to meet the needs of the member. Case Managers are assigned caseloads that are variable in volume depending on the complexity of the cases managed. The Case Management Teams include a Triage Team, Health Risk 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 to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Health Community Network and CalOptima Health Direct. The incumbent 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 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 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 projects associated with the department. The incumbent ensures compliance with department policies and procedures and supports the implementation of departmental projects. The incumbent may be required to attend joint operational and community meetings. 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 provides guidance to staff and directly handles complex case management referrals. The 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 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 responsible for ensuring~~providing ongoing~~ case management services for CalOptima Health members. ~~The position facilitates communication and coordination among all participants of the health care team and the members to ensure that the services are provided to promote quality, cost-effective outcomes.~~ 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 ~~address~~ 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.

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Social Worker provides administrative case management and coordination of benefits for carved-out services. The ~~Medical~~ Social Worker serves as a departmental resource regarding benefits and available resources for the aged, behavioral health, foster care and the disabled population. The ~~Medical~~ Social Worker also serves as a liaison to Orange County based community agencies.

Personal Care Coordinators 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 PCC's also ~~will~~ identify barriers to members' care and assist in improving these barriers for all levels of care. The incumbent 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 ensures 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 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 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

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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 highly qualified individuals with extensive experience and expertise in Case Management for staff positions. Qualifications and educational requirements are delineated in the position descriptions of the respective position.

Each new employee is provided ~~an intensive~~ orientation and job specific training with a staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job 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, 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
- CM Program: policies/procedures and desk top processes, etc.
- Medical Information System data entry
- ~~Application of Review Criteria/Guidelines~~
- Appeals Process
- QI Referral Process

Other ~~trainings~~training offered as appropriate

- Dementia Care Specialists
- Motivational Interviewing.

Licensed nursing staff are monitored for appropriate application of ~~Review Criteria/Guidelines,~~ NCQA requirements~~,~~ and case management documentation. Training opportunities are identified through regular administration of proficiency evaluations and addressed as immediately as they are identified. Any employee who fails the evaluation is ~~provided~~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 ~~participates~~participate annually in CalOptima Health model of care training.

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

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. Because Medi-Cal is always the payer of last resort, CalOptima Health must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to 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. If the provider is not termed due to 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 a new health plan.

CalOptima Health uses the following data sources to identify a member for case management:

- Pharmacy data
- Health Risk/Needs Assessment
- Claims or encounter data
- Hospital Discharge data
- Utilization Management data
- Laboratory results
- Data supplied by purchasers
- Data supplied by member or caregiver
- Data supplied by practitioners
- Risk Stratification and Segmentation (RSS)

- Health Information Form (HIF) if available

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 includes:

- Documented process to assess the needs of ~~member~~the member population.
- Development of the program through ~~use~~the use of evidenced 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.

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- Monitoring, reassessing, and modifying 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
- Identification of mental health needs and referral to Behavioral Health
- Identification of educational needs and referral to Population Health Management
- Referral to LTSS
- Assess and identify continuity of care needs and work collaboratively with UM department

Initial assessment of ~~member's~~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
- Medication reconciliation and compliance
- 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 that identifies the interventions required to provide appropriate care to the member.

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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
- Barriers to meeting goals and complying with self-management plan
- Scheduled time frame for follow-up and communication with members
- 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, Orange County 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 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 may include informing members about ways to obtain continued care through other sources, such as community resources.

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
- 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)

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- 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)
- ~~Collaborate~~Collaboration with the HCA/PDS TB Control Officer

Clinical Protocols

CalOptima Health is committed to serving the needs of all members assigned and places additional emphasis on the coordination of care for the vulnerable population. Approved clinical practice guidelines and nationally recognized protocols are used to guide treatment and care provided to the members. The use of clinical practice guidelines or nationally recognized protocols is challenging for the CalOptima Health membership as many of their needs are socioeconomic in nature. These 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~~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:

- ICT is convened with the member, PCP, and specialists (if appropriate).
- Participants of the ICT review the case and mutually develop an ICP, prioritized per member's preferences.
- 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.

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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

Basic Case Management

Basic case management activities by the primary care practitioner may include, but are not limited to:

- A health assessment of member's current acute, chronic and preventive health needs
- Development of the ~~member's~~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

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:

- Assistance with access to care issues;
- Health and disease-specific education;
- Referral to resources; and
- Coordination of care with all Providers.

Complex Case Management

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

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- 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 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; ~~or~~
- 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 appropriate CCM cases.

Children with Special Health Care Needs

Children with Special Health Care Needs (CSHCN) are 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.

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Case Management staff ~~ensures~~ensure coordination of care with other entities that provide services for Children 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
- ~~Prevent~~Preventing duplication of services
- Optimize ~~member's~~members' physical and emotional health and well-being
- ~~—~~Improve member's quality of life

Whole Child Model

The Whole-Child Model is a program that aims to help California Children's Services (CCS) ~~children~~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 includes:

- Personal Care Coordinator (PCC) will be assigned to each CCS-eligible Member.
- Perform initial and periodic outreach to assist the Member with Care Coordination
- Provide information, education and support continuously, as appropriate
- Assist the Member and the Member's family in understanding the CCS-eligible Member's health, other available services, and how to access those services.
- 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

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Transitional Care Services (TCS)

DHCS ~~has~~ outlined a phased approach in the Population Health Management (PHM) Policy Guide to provide Transitions of Care Services that started~~ing~~ January 1, 2023. Transitional Care Services are provided to members transitioning from levels of care, including ~~hospitalizations and skilled~~hospitals, institutions, other acute care facilities and skilled nursing facilities, post-acute car facilities or long term-care settings. ~~nursing facility~~. ~~Beginning in 2023, m~~Members identified as TCS High Risk, per DHCS definition, receive~~d~~ outreach from ~~Case Management~~ TCS staff.

The goal of outreach is to ensure all needs are met post hospitalization, including follow up visit with PCP, medication review, transportation needs, ~~and~~and -resolution of discharge summary follow up items such as home health, and durable medical equipment. An additional area of focus is referrals to resources and services that support independence such as IHSS, CBA and MSSP and services that support transition such as ~~CalAIM~~CalAIM Community supports. Texting campaign initiated October 2024 to outreach to members post-discharge. The TCS program Continue improving outreach efforts supporting transitions of care.

The TCS ~~Case Management~~dedicated staff are~~is~~ 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 ~~Case Management~~ staff are~~is~~ 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 ~~Case Management~~ staff do~~es~~ 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 support recently discharged members 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

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Transplant Program

The CalOptima Health Transplant Program is coordinated by the Medical Director, UM Department and CM Department staff.

The Transplant Program provides the resources and tools needed to proactively manage members identified as potential transplant candidates. The Case Management Department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence or CMS certified Centers for OneCare. Case Management follows the member and assists as needed through 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 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, the Transplant Program benefits the members, the community of transplant staff and the facilities. CalOptima Health monitors and maintains oversight of the Transplant Program and reports to the UM Committee 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~~, other than Kaiser Foundation Health Plan~~.

Palliative Care Services

The CalOptima Health Case Management and Utilization Management teams work collaboratively to ensure access to Palliative Care services. Palliative care is specialized medical care for people living with a serious illness. 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 members other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment.

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2025 Integrated Utilization Management and Case Management Program Description

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2025 Integrated Utilization Management and Case Management Program

Signature Page

Utilization Management Committee Chair:

Dabbah, Zeinab, M.D. ***Deputy Chief Medical Officer***	***Date***

Board of Directors' Quality Assurance Committee Chairperson:

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

Board of Directors Chair:

Isabel Becerra	***Date***

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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, 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 develop the 2025 3-year Strategic Plan. After engaging a wide variety of stakeholders and collecting feedback, the strategic plan is currently under final review of CalOptima Health Board of Directors as of January 2025. The Strategic plan once approved will continue to be reviewed and updated, at a minimum of annually, based on CalOptima Health Board of Directors and Executive Team input. 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) - 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
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. 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, 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, 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 are not covered by CalOptima Health but may be provided by a different agency, but coordinated by CalOptima Health are indicated below:

- 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 enhance their Medi-Cal benefits. These partnerships are established as special services through a specific Memoranda of Understanding (MOU) with certain community agencies, including the 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 have health care needs and meet the program eligibility criteria and guidelines.

These integrated LTSS benefits include three programs:

- Community-Based Adult Services (CBAS)
- Nursing Facility (NF) Services for Long-Term Care (LTC)
- Multipurpose Senior Services Program (MSSP)

Emergency Department Diversion Program

Purpose:
Starting in January 2025, two embedded CalOptima Health Care Managers (RN & MSW) will engage CalOptima Health members in the Emergency Department to coordinate care with CalOptima Health departments (UM, CM, ECH, LTSS, CalAIM and Customer Service) plus community resources in an expeditious manner. 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:

- Coordinate the member's plan of care with the facility ED team, CalOptima Health and community resources.
- Coordinate PCP/specialist appointments, pharmacy, transportation, durable medical equipment (DME), Home Health, Hospice, Palliative Care, CalAIM, Behavioral Health, CalOptima Health CM and Enhanced Case Management ECM.
- 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.

OneCare (HMO D-SNP)

Our OneCare (OC) members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for our members to get the health care they 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. OC 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 the structure for supporting

consistent provision of quality of care. Each member has a Case Management single point of contact, 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, the Case Management team works with our members and their doctors (PCP. specialists, behavioral health provider) to create an individualized care plan that fits 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 Quality Improvement and Health Equity Transformation Program Priority Areas and Goals align with CalOptima Health's Strategic Goals and DHCS Bold Goals

1. Maternal Health
    a. Close racial/ethnic disparities in well-child visits and immunizations by 50%
    b. Close maternity care disparity for Black and Native American persons by 50%
2. Children's Preventive Care
    a. Exceed the 50th percentile for all children's preventive care measures
3. Behavioral Health Care
    a. Improve maternal and adolescent depression screening by 50%
    b. Improve follow-up for mental health substance disorder by 50%
4. Program Goals
    a. Medi-Cal: Exceed the minimum performance levels (MPLs) for the Medi-Cal
    b. Accountability Set (MCAS)
    c. 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 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 to work towards 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 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.

Five-Year Hospital Quality Program

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 serious medical conditions. CCS provides medical care, case management, physical/occupational therapy, and financial assistance. Since July 1, 2019, through SB 586, 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, spanning from 2022 to 2027, by DHCS to improve the quality of life and health outcomes of our population by implementing 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 expanding 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 increase flexibility.
3. 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 has launched Enhanced Care Management (ECM) as well as all 14 Community Supports. ECM provides a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal members. 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.

ECM providers 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
6. Member and Family Supports
7. Coordination of and Referral to Community and Social Support Services

CalOptima Health has partnered with local Community Based Organizations to provide the 14 Community Supports to our members in a medically appropriate, community-rooted, cost-effective manner.

The 14 Community Supports are:

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)
6. Respite Services
7. Day Habilitation Programs
8. Nursing Facility Transition/Diversion to Assisted Living Facilities
9. Community Transition Services/Nursing Facility Transition to a Home
10. Personal Care and Homemaker Services
11. Environmental Accessibility Adaptations (Home Modifications) includes Personal Emergency Response Systems (PERS)
12. Medically Tailored Meals/Medically Supportive Foods
13. Sobering Centers
14. Asthma Remediation

Authorizations for ECM and Community Supports are coordinated through the CalOptima Health Connect CalAIM Portal.

Population Health Management (PHM) Program Strategy

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 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.

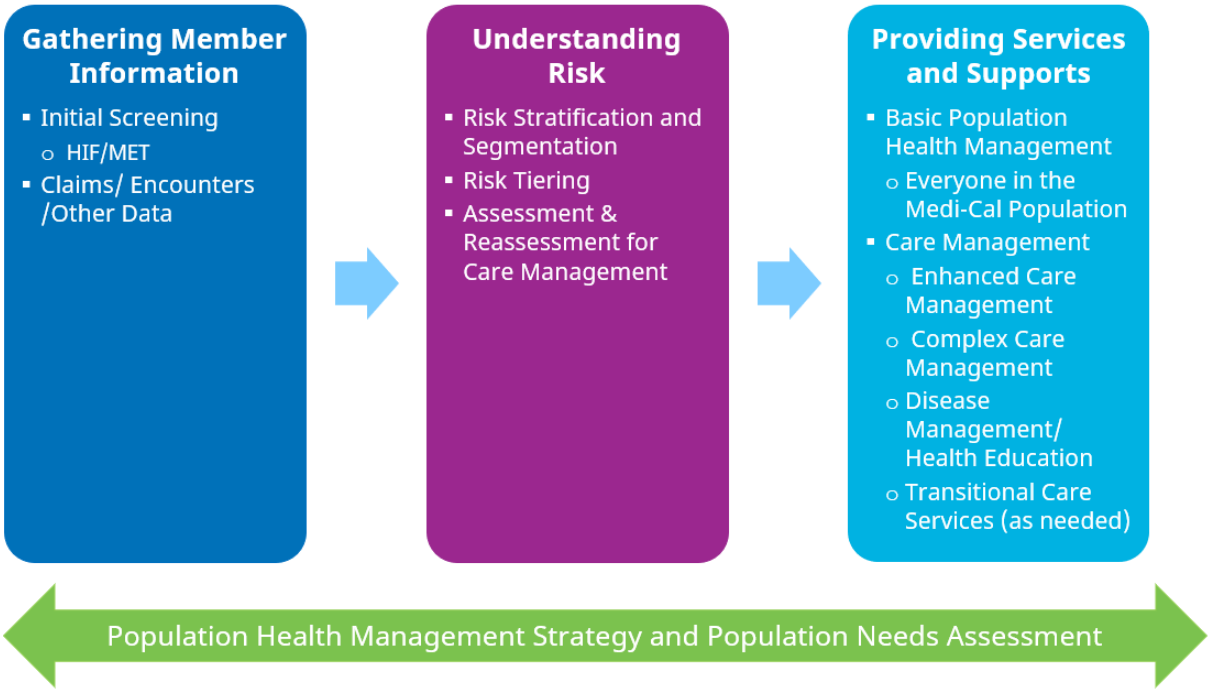
CalOptima Health's PHM addresses the following four key strategies:

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:

1. Population Health Management Strategy and Population Needs Assessment;
2. Gathering member information;
3. Understanding risk; and
4. 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 approach annually and uses key performance indicators such as Primary Care, ambulatory care, ED visits and inpatient utilization and 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 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 10 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).

- 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.
- 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 primary care providers (PCPs), 6,969 specialists, 40 hospitals, 57 Community Health Centers clinics and 207 long-term care facilities.

Table 1: Provider Network Data (as of November 27, 2024)

	Number of Providers
Primary Care Providers	1,236
Specialists	6,969
Pharmacists	517
Acute and Rehab Hospitals	40
Community Health Centers	57
Long-Term Care Facilities	207

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

CalOptima Health delegates UM activities for a portion of the CalOptima Health membership to HNs 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:

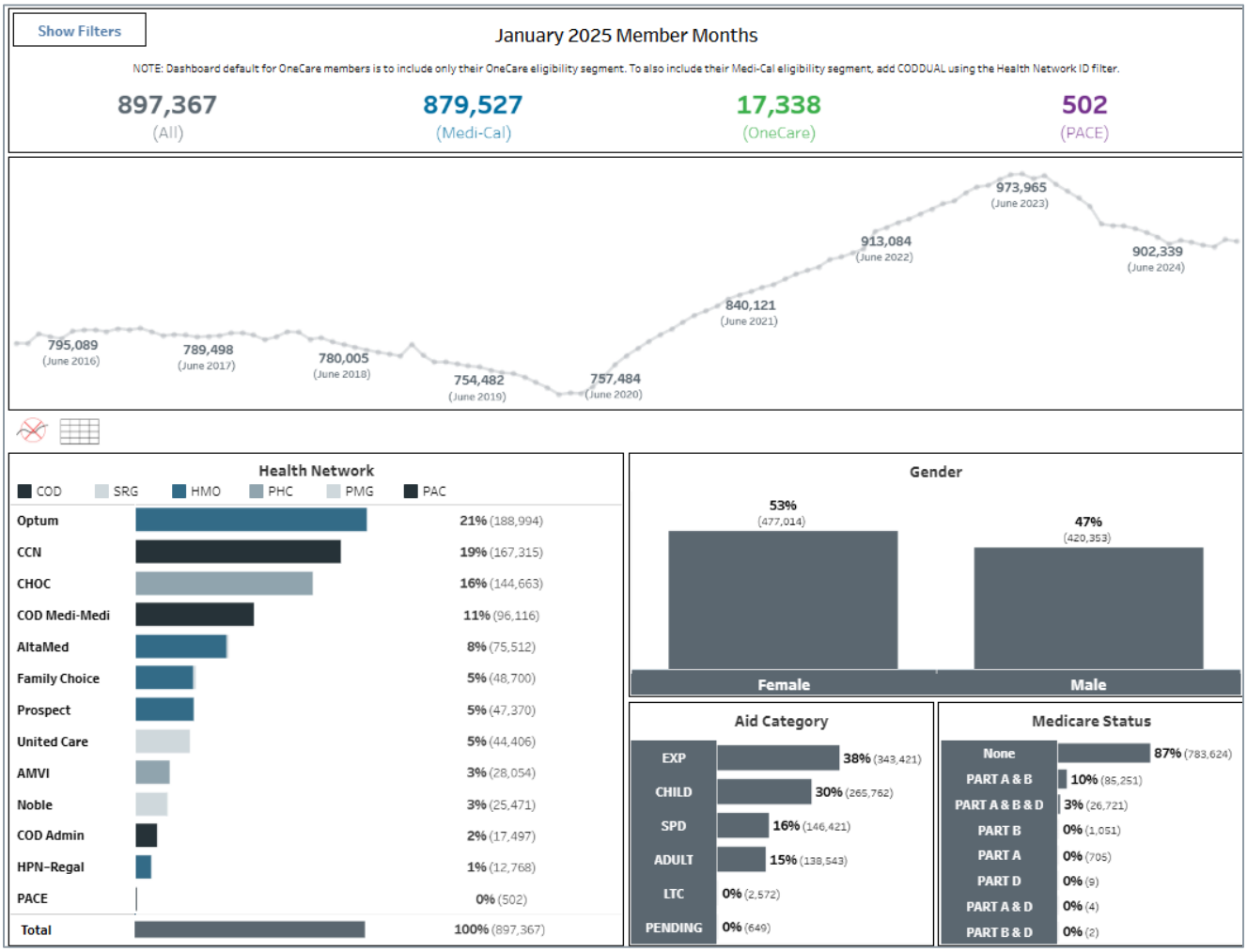
- Frequent reporting of key performance metrics that are required and/or developed by CalOptima Health's Claims, Credentialing, Customer Service, Equity & Community Health, and Utilization Management Departments in consultation with Delegation Oversight and Information Technology Services.
- Reporting of 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 DHCS, Centers for Medicare & Medicaid Services (CMS), NCQA, and CalOptima Health standards and program requirements.
- Annual approval of the HNs UM Program (or portions of the program that are delegated), as well as 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

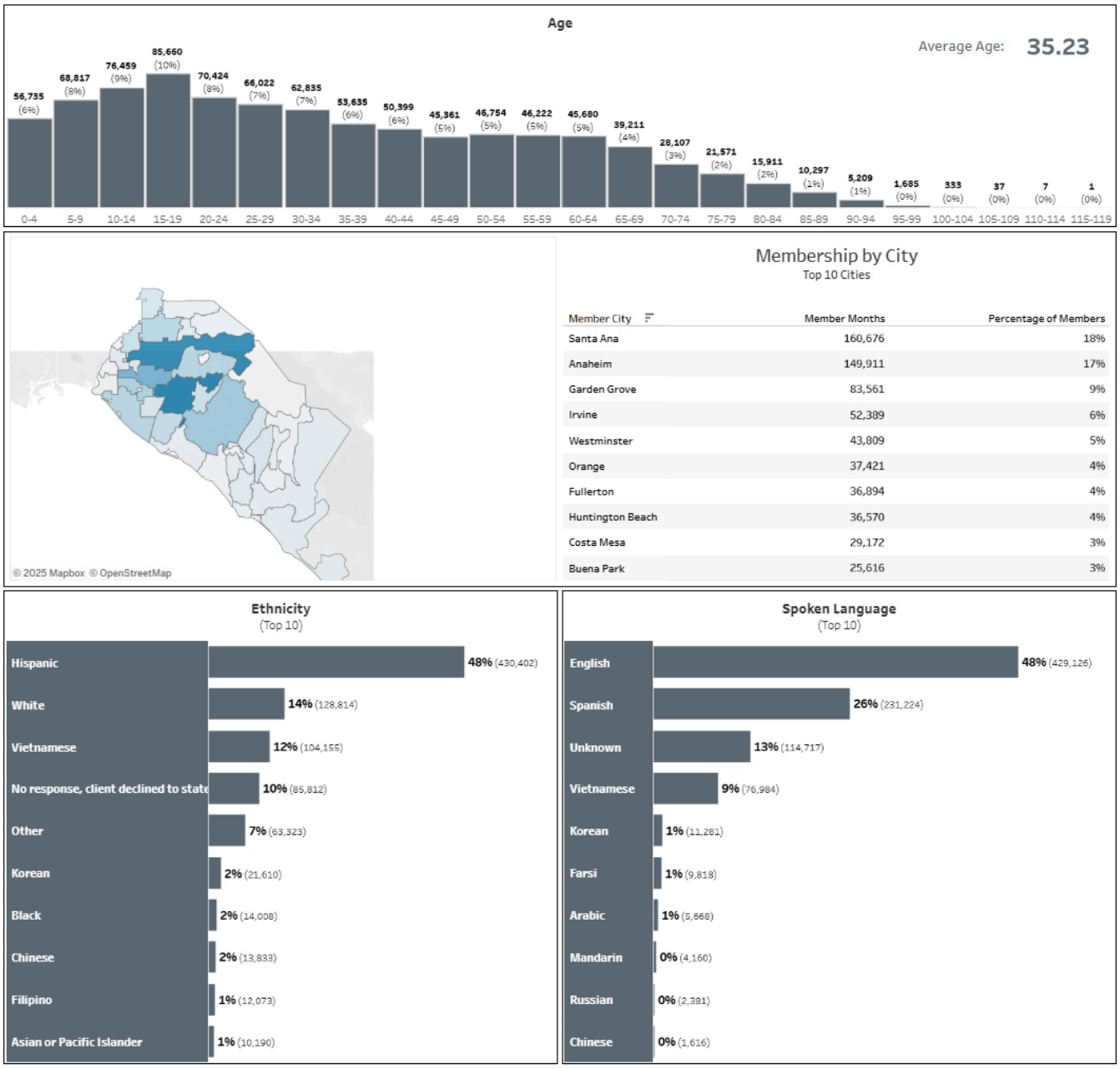
CalOptima Health's monthly Health Network Forum is led by the Executive Director of Network Operations. The forum includes representatives from Health Networks and CalOptima Health who come together to discuss enhancements and changes to the implementation and operation of medical management programs. 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 1/3/2025

Figure 3. January Member Overview (continued)



Source: Membership Dashboard tableau, data pulled 1/3/2025

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 and analysis of utilization trends including identification of under and over-utilization to determine whether members are receiving appropriate services. 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 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, Long-term care and long-term services and supports. This 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 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 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 sign an annual attestation and are expected to abide by and uphold CalOptima Health's policy for ensuring all medical decisions are made based within regulatory requirements and are not unduly influenced by financial considerations.

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 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 CalOptima Health, this is accomplished through the following goals: Assisting in the coordination of medically necessary 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 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, 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 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/state sponsored programs such as In-Home Supportive Services (IHSS), and County Specialty Mental Health.
- Work collaboratively with CalOptima Health's Health Network's to coordinate care for complex discharge needs and CalAIM services.
- Provide continuous identification of UM staffing needs including clinical, non-clinical and Medical Directors to address the needs of the members we serve.
- Provide continuous training for competency, as well as ensure staff are well versed in UM processes, regulatory requirement changes and workflow/process changes within the department.

UM Program Structure

The CalOptima Health UM Program ensures members receive appropriate, cost-efficient 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 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 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 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. 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 evaluated on an ongoing basis for efficacy and appropriateness of content by the Medical Management and Quality leadership team that may include 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 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 licensed clinicians. The screening is 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 offered 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 Mental Health Plan (OCMHP) 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 substance use disorder services will be referred to the Orange County Mental Health Plan (OCMHP).

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

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. 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) includes members with each seat representing a constituency served by CalOptima Health. The MAC ensures that CalOptima Health members' values and needs are integrated into the design, implementation, 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 representatives 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 broad provider community that serves CalOptima Health members. The PAC meets bi-monthly and is open to the public. The members 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); 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 (EDCO) is responsible for oversight of all operational aspects of key Medical Affairs functions including the UM, Care Coordination, Complex Case Management, and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The EDCO 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 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 disease management and health education departments. The ED ECH oversees the development and implementation of companywide Population Health Management strategy to improve member experience, promote optimal health outcomes, ensure efficient care and improve health equity. The ED ECH serves as a member of the executive team, and with the 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. 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. All 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.

- 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 the implementation of the UM Program. The Medical Directors ensures 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, 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 normal business hours and on-call after hours. Also serves as the Chair of the UMC and the Benefit Management Subcommittee, 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, is 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, including PHM, disease management and health education programs, while also providing 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.

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 serve 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 clinical operational effectiveness between hospitals and all CalOptima Health and health network partners. The Senior Director is responsible for ensuring patient access through quality outcomes and a system approach to ensure inpatient care, transitional care services and communication amongst treatment teams. Director leads through a front-line, coordinated approach working with our hospitals, direct providers and health network partnerships to ensure exceptional direction and communication to 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 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. 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, Quality Improvement is responsible for assigned day-to-day operations of the Quality Management functions, including credentialing, potential quality issues, facility site reviews (FSRs) and medical record reviews (MRRs), physical accessibility compliance and working with the ED Quality Improvement to oversee the QIHETP and maintain NCQA accreditation. This position also supports the QIHEC, the committee responsible for oversight and implementation of the QIHETP and QIHETP Work Plan.

Director, Quality Analytics, is responsible for leading collection, tracking and reporting of quality performance measures, including HEDIS and Stars metrics, as required by regulatory entities. Conducts data analysis to inform root cause analysis, identify opportunities for improvement, and measure effectiveness of interventions. 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 compliance audits and monitoring of CalOptima Health's internal operations with an emphasis on 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 requirements for all programs. Specifically, the 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 provides UM Department prior authorization compliance oversight of internal and external delegated health networks. The Sr. Manager leads inventory management process for improvement of all clinical operation teams to maximize efficiencies and ensure regulatory compliance.

Manager, Utilization Management RN/LVN (Inpatient Services (IP)) manages the day-to-day operational activities of the Department to ensure staff compliance with 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 staff, monitors and oversees daily work assignment and activities to ensure that service standards are met, 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:

Notice of Action Medical Case Managers (RN/LVN) draft and evaluate 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. 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. 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.

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 but are not limited to prior authorization 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.

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 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 authorization services for room and board, CBAS and MSSP, and staff associated with those programs.

Manager, Long-Term Services and Supports (CBAS/LTC/MSSP) develops and manages the LTSS department's work activities and team. 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.

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.

Medical Case Managers (BH-RN/LVN or 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 (MAA BH) 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 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 are covered during the program, as applicable to specific job descriptions:

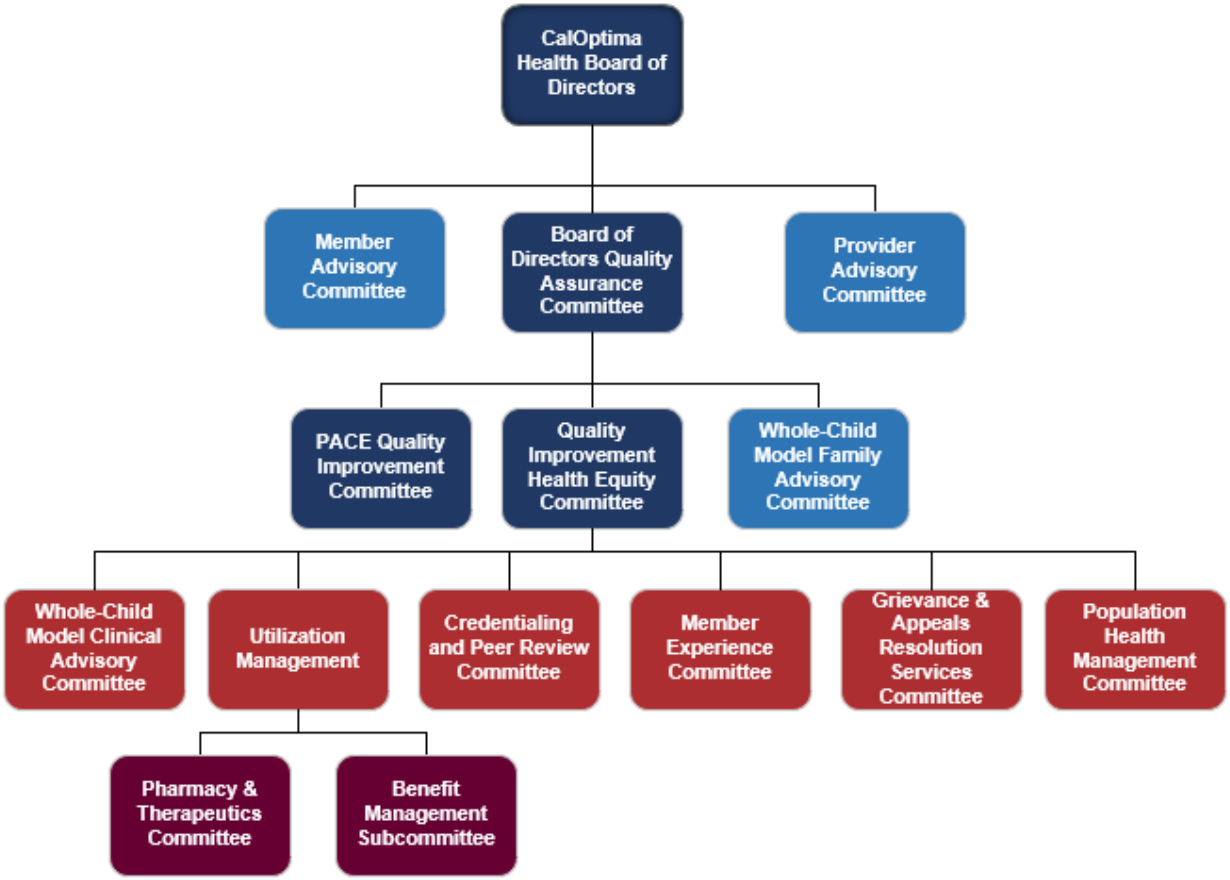
- CalOptima Health New Employee Orientation
- HIPAA and Privacy/Corporate Compliance
- Diversity, Inclusion, and Unconscious Bias
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- UM and CM Program, policies/procedures, etc.
- Medical Management information system 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



UMC

The UMC is led by a CalOptima Health Medical Director. This senior level physician is involved in UM activities, including but not limited to implementation, supervision, 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, 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 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.

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

- 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, identify areas for performance improvement, and evaluate performance improvement initiatives.
- Reviews, assesses, and recommends utilization management best practices used for selected diagnoses or disease classes.
- Conducts review of under/over utilization monitoring and makes recommendations in accordance with UM Policy and Procedure GG.1532: Over and Under Utilization Monitoring; makes recommendations for improving performance on identified over/under utilization.
- Reviews and provides recommendations for improvement, as needed, to reports submitted by the following:
- Benefit Management Subcommittee (BMSC)
- P&T Committee
- Reports to the QIHEC on a quarterly basis, communicates significant findings and makes recommendations related to UM issues.

Departments Reporting Relevant Information on UM Issues:

- 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 Chief Medical Office (Specialty: Internal Medicine)
- Medical Director who oversees Utilization Management (Specialty: Family Practice)
- Medical Director who oversees UM Program (Specialty: Internal Medicine)
- Medical Director who oversees Behavioral Health Program (Specialty: Psychiatry [Child/Adolescent & Adult])
- Medical Director who oversees Senior Programs (Internal Medicine)
- Medical Director who oversees Whole-Child Model Program (Specialty: Medicine/Pediatrics)
- Medical Director who oversees Quality and Analytics (Specialty: Pediatrics)
- Executive Director, Clinical Operations (Master of Science in Gerontology, Certified Case Manager)
- Outside Practitioner[1] (Specialty: Family Medicine)
- Outside Practitioner (Specialty: Pediatrics)
- Outside Practitioner (Specialty: Neurology)
- Outside Practitioner (Specialty: Pulmonary)

Participating members of the UMC that don't have voting rights, although presents data, program outcomes and updates to policies consists of:

- Director, Utilization Management
- Director, Quality Improvement

[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.

- Director, Pharmacy
- Sr. Manager, Utilization Management
- UM Manager, Prior Authorization
- UM Manager, Inpatient Services

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

- Medical Director who oversees UM services— Chairperson
- Medical Director who oversees Population Health and Equity
- Executive Director, Clinical Operations
- Director, UM (Alternate; Manager, Prior Authorization)
- Director, Behavioral Health Integration (Alternate: 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 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, and 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 goals of the UM Workgroup includes but is 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

Based on discussions at the UM Workgroup, other Sub Workgroups were formed in 2024 and will continue in 2025

- 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

High-Risk Management Workgroup

The High-Risk Management Workgroup was the Bed Day Reduction Workgroup established in 2023. In 2024 the name changed, and it was combined with the UM Authorization Strategy Workgroup. The High-Risk Management Workgroup is a cross-departmental clinical-lead work group designed to evaluate utilization data. The workgroup is responsible for identifying interventions to optimize utilization in the Emergency Department (ED), inpatient facilities and long-term care setting and improve patient outcomes. This focus 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. The workgroup monitors metrics, discusses performance, addresses trends, contributes to the analysis and action plan for decreasing over and underutilization that is reported up through the UMC.

Early and Periodic Screening Diagnosis Treatment (EPSDT) Workgroup

The EPSDT Workgroup brings together representatives from the Medical Directors, Case Management, Utilization Management, Behavioral Health Integration, Delegation Oversight, and Quality Analytics to address EPSDT. The EPSDT workgroup began in April 2024 and covers all 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 protocols 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.

Integration with the QI Program

The UM Program is evaluated and submitted for review and approval annually by UMC, QIHEC and QAC, with final review and approval by the Board of Directors.

- 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 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 OC. 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 any and all determinations.
- All providers are encouraged to request information regarding the criteria used in making a 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 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 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

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) 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 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, affirming 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

Pharmacy Management is overseen by the CMO, and CalOptima Health's Director, Clinical Pharmacy Management. 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 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 January 1,2022, the 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 BHT services 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 require prior authorization include inpatient psychiatric care, partial hospitalization program, intensive outpatient program, psychological testing, 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

1. Medi-Cal Provider Manual and Department of Health Care Services (DHCS) All Plan Letter's (APL)
2. National Correct Coding Initiative (NCCI) Policy Manual
3. CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook
4. MCG Care Guidelines
5. Drug Compendia Micromedex DrugDex and American Hospital Formulary Service Drug Information (AHFS-DI)
6. Peer-Reviewed Medical Literature
7. National Comprehensive Cancer Network Guidelines (NCCN)
8. 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
    i. National Guideline Clearinghouse

Medicare (OneCare)

1. CMS National Coverage Determinations (NCD)
2. CMS Local Coverage Determination (LCD) (Noridian Local Contractor for California)
3. CMS Local Coverage Article (LCA)
4. CMS Manuals (Medicare Benefit Policy Manual, Medicare National (NCD) Manual, Medicare Claims Processing Manual, etc.)
5. National Correct Coding Initiative (NCCI) Policy Manual

6. CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook
7. Drug Compendia: Micromedex, DrugDex, American Hospital Formulary Service-Drug Information (AHFS-DI), Clinical Pharmacology
8. National Comprehensive Cancer Network Guidelines (NCCN) Drugs and Biologics Compendium, Lexi Drugs
9. MCG Care Guidelines
10. 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
    i. National Guideline Clearinghouse

Whole Child Model (WCM)

1. California Children Services (CCS) Numbered Letters and CCS Information Notices
2. Medi-Cal Provider Manual and DHCS APLs
3. National Correct Coding Initiative (NCCI) Policy Manual
4. CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook
5. MCG Care Guidelines
6. Drug Compendia: Micromedex, DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology
7. National Comprehensive Cancer Network Guidelines (NCCN)
8. 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
i. National Guideline Clearinghouse

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, 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 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 contracted vendor. The vendor is not a delegated UM entity and therefore does not make authorization decisions. Vendor staff take authorization information for the next business day response by CalOptima Health. In cases requiring immediate response vendor staff notifies 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 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

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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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.

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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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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.

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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

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Attachment B
TIMEFRAMES FOR ONECARE DECISIONS AND NOTIFICATIONS

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

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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.

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.

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.

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 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:

The request is made within sixty (60) calendar days after the initial date of service and one of the following conditions apply:

1. The Member has Other Health Coverage (OHC); or
2. 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 an OC 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, with consideration for the most appropriate alternative to inpatient care. If at any time UM staff become aware of potential quality of care issue, 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, quality-driven treatment intervention for post-hospital care needs. It is a coordinated effort among the facility and CalOptima Health and includes participation from but is 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 are:

- 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 assists 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 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 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 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 CalOptima Health Networks are handled by CalOptima Health GARS department. CalOptima Health collaborates with the community provider or delegated entity to gather the necessary information and supporting 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 regulatory 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 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. At the

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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 members have a right to request an independent review if they disagree with the termination of services from a 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 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

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.

CBAS

CBAS is an outpatient, facility-based program offering day-time care and health and social services to frail seniors and adults with disabilities 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.

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 65 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. The goal is to give members a chance to stay in their homes and enjoy a higher quality of life. To get these services, CalOptima Health members must: Be 65 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 a wide choice 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 by the UM leadership team, the UM Workgroup, identified stakeholders, Medical Director Team and reported to UMC. The UMC reviews over/under utilization data on a quarterly basis and approves and monitors metrics, discusses performance, address identify trends, contributes to the analysis, and identifies action plan for decreasing over and underutilization.

Over/under utilization monitoring and performance are reported to the QIHEC on a quarterly basis.

The UMC may track and monitor over and underutilization 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. 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 surveys
- 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 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 information gathered indicates areas of dissatisfaction, CalOptima Health develops an action plan and interventions to improve the areas of concern, 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 targeted outreach and case management to support members who are risk stratified as high risk. Some high-risk members may primarily be utilizing the emergency department for care and develop best practices for outreaching to these members and improving their overall care.
- Continue 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.
- 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 and are composed of Case Managers, Social Workers, Medical Assistants, Personal Care Coordinators, and, as appropriate, to meet the needs of the member. Case Managers are assigned caseloads that are variable in volume depending on the complexity of the cases managed. The Case Management Teams include a Triage Team, Health Risk 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 to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Health Community Network and CalOptima Health Direct. The incumbent 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 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 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 projects associated with the department. The incumbent ensures compliance with department policies and procedures and supports the implementation of departmental projects. The incumbent may be required to attend joint operational and community meetings. 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 provides guidance to staff and directly handles complex case management referrals. The 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 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 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 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 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 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 ensures 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 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 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 highly qualified individuals with extensive experience and expertise in Case Management for staff positions. 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, 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
- CM Program: policies/procedures and desk top processes, etc.
- Medical Information System data entry
- Appeals Process
- QI Referral Process

Other training offered as appropriate

- Dementia Care Specialists

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- Motivational Interviewing.

Licensed nursing 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. 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 competency in their present jobs and/or prepares them for career advancement within CalOptima Health. Each year, a specific budget is set for continuing education for each licensed CM employee.

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. Because Medi-Cal is always the payer of last resort, CalOptima Health must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to 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. If the provider is not termed due to 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 a new health plan.

CalOptima Health uses the following data sources to identify a member for case management:

- Pharmacy data

- Health Risk/Needs Assessment
- Claims or encounter data
- Hospital Discharge data
- Utilization Management data
- Laboratory results
- Data supplied by purchasers
- Data supplied by member or caregiver
- Data supplied by practitioners
- Risk Stratification and Segmentation (RSS)
- Health Information Form (HIF) if available

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 includes:

- 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 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
- Identification of mental health needs and referral to Behavioral Health
- Identification of educational needs and referral to Population Health Management
- Referral to LTSS
- Assess and identify continuity of care needs and work collaboratively with UM department

Initial assessment 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
- Medication reconciliation and compliance
- 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 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
- Barriers to meeting goals and complying with self-management plan
- Scheduled time frame for follow-up and communication with members
- 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, Orange County 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 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 may include informing members about ways to obtain continued care through other sources, such as community resources.

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
- 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

CalOptima Health is committed to serving the needs of all members assigned and places additional emphasis on the coordination of care for the vulnerable population. Approved clinical practice guidelines and nationally recognized protocols are used to guide treatment and care provided to the members. The use of clinical practice guidelines or nationally recognized protocols is challenging for the CalOptima Health membership as many of their needs are socioeconomic in nature. These 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:

- ICT is convened with the member, PCP, and specialists (if appropriate).
- Participants of the ICT review the case and mutually develop an ICP, prioritized per member’s preferences.

- 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

Basic Case Management

Basic case management activities by the primary care practitioner may include, but are not limited to:

- 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

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:

- Assistance with access to care issues;
- Health and disease-specific education;
- Referral to resources; and
- Coordination of care with all Providers.

Complex Case Management

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 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 appropriate CCM cases.

Children with Special Health Care Needs

Children with Special Health Care Needs (CSHCN) are 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.

Case Management staff ensure coordination of care with other entities that provide services for Children 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

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 includes:

- Personal Care Coordinator (PCC) will be assigned to each CCS-eligible Member.

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- Perform initial and periodic outreach to assist the Member with Care Coordination
- Provide information, education and support continuously, as appropriate
- Assist the Member and the Member's family in understanding the CCS-eligible Member's health, other available services, and how to access those services.
- 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)

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 levels of care, including hospitals, institutions, other acute care facilities and skilled nursing facilities, post-acute care facilities or long term-care settings. Members identified as TCS High Risk, per DHCS definition, receive outreach from TCS staff.

The goal of outreach is to ensure all needs are met post hospitalization, including follow up visit with PCP, medication review, transportation needs, and resolution of discharge summary follow up items such as home health, and durable medical equipment. An additional area of focus is referrals to resources and services that support independence such as IHSS, CBA and MSSP and services that support transition such as CalAIM Community supports. Texting campaign initiated October 2024 to outreach to members post-discharge. The TCS program Continue improving outreach efforts supporting transitions of care.

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 support recently discharged members 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 Transplant Program provides the resources and tools needed to proactively manage members identified as potential transplant candidates. The Case Management Department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence or CMS certified Centers for OneCare. Case Management follows the member and assists as needed through 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 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, the Transplant Program benefits the members, the community of transplant staff and the facilities. CalOptima Health monitors and maintains oversight of the Transplant Program and reports to the UM Committee 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 is specialized medical care for people living with a serious illness. 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 members other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment.

CalOptima Health

Utilization Management Committee Quarter One 2025

Quality Assurance Committee Meeting
March 12, 2025

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.

Agenda

- 2024 UM Program Evaluation
- 2025 UM and CM Integrated Program Description

2024 UM Program Evaluation

Utilization Management (UM) Program Evaluation Purpose

- CalOptima Health annually evaluates the effectiveness of the UM program & evaluation through review of:
  - Structure and Process
  - Scope Impact
  - UM statistics and performances
  - Member satisfaction
  - Responsibility for the UM program
  - Medical Director's responsibilities
  - Significant changes, new initiatives and programs
  - Upcoming goals, projects and implementations

2024 UM Program Evaluation Improvements & Enhancements

- Utilization Management Program Evaluation (Q4 2023 – Q3 2024) Accomplishments
  - Focused Clinical and Process improvements:
    - Inventory oversight
    - Facility Rounds
    - Reporting
    - PSA process improvements
    - Pediatric Inpatient Review
    - Gender Affirming Care review
    - Custom DME workflow process
    - Refinement short stay (one day) reviews
    - Refine all pediatric reviews to ensure inclusion of EPSDT criteria

2024 UM Program Evaluation Improvements & Enhancements (cont'd)

- Successful Transition of Kaiser
- Launch of pediatric inpatient NICU and PICU facility rounds
- Established a clinical leadership workgroup for process improvement for interventions that support the UM Program
- UCSD Transplant Center of Excellence (COE), Transplant Team weekly rounding
- Removed preventative/screening PA requirements for OneCare
- Programmatic Enhancements including:
  - New clinical documentation platform
  - Provider portal automation/ referral intelligence rules
  - Transitions of care discharge
  - Continuity of Care

2024 UM Program Evaluation
Over & Under Utilization

- Over/Under Utilization Review:
  - Physical, behavioral health (BH) and pharmacy prior authorization and inpatient services
  - Appeal/ overturn rates
  - Member grievances
  - Potential quality issues (PQI)
  - Adult and children's access to PCP services
  - Appropriate RX utilization
  - Data from Compliance Department regarding fraud, waste and abuse

Inter-Rater Reliability (IRR)

Department	IRR Score
UM Clinical Staff: Prior Authorization	99.8%
UM Clinical Staff: Inpatient services	99.0%
Utilization Management	99.7%
Medical Directors (UM)	98.4%
Pharmacy: RPh	97.0%
LTSS: LTC	98.0%
LTSS: CBAS	98.3%
LTSS: MSSP	97.5%
CalAIM	100.0%
Behavioral Health	99.5%

All clinical reviewers within the Medical Management Department passed IRR testing with a score of 90% or greater with the exception of 2 temporary Prior Authorization nurses and 1 UM staff. Staff that didn't pass underwent robust MCG re-training, cases were overseen through spot audits during re-training and staff were assigned additional cases that passed on second attempt above 90%.

Source: https://learn.mcg.com/local/mcg_reports/index.php?c=report&a=completion

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CalOptima Health

TANF 18+ Medi-Cal Inpatient Utilization

Metric	Goal	2023 Q4	2024 Q1	2024 Q2	2024 Q3
Admits/1000 PTMPY	107.1	147.5 ↑	131.1 ↑	147.1 ↑	152.8 ↑
Days/1000 PTMPY	441.2	434.4 ↓	442.5 ↑	488.4 ↑	466.5 ↑
ALOS	3.7	3.0 ↓	3.4 ↓	3.3 ↓	3.1 ↓
Readmit %	14.7%	13.8% ↓	13.2% ↓	14.9% ↑	11.0% ↓

Metric	Goal	2023 Q4	2024 Q1	2024 Q2	2024 Q3
ED Visits / 1000 PTMPY	**459.4**	547.4 ↑	491.9 ↑	540.5 ↑	543.3 ↑

↑ Denotes comparison to goal

- **Admit/1000 Per Year** (PTMPY): Above goal of 107.1 in all 4 quarters driven by obstetrics including routine and C-Section delivery, antepartum disorders, and post partum. Obstetrics made up between 59.9% - 68.9% of all admits during the reporting period.
- **Bed Day/1000 Per Year** (PTMPY): Above goal of 441.2 in Q1 2024 and increased in Q2 2024. Decreased in Q3 2024 but remains above goal.
- **Average Length of Stay** (ALOS): Below the goal of 3.7 in all reported quarters.
- **Readmissions**: Readmits fell below the goal of 14.7% in Q4 2023 and Q1 2024,rose to slightly above goal for Q2 2024 before returning below goal in Q3 2024. Q2 2024 readmit rate driven by oncology admit and readmit conditions.
- **ED Visits/1000 Per Year (**PTMPY): ED utilization was above goal in Q4 2023 through Q3 2024.

CCN only, Duals, LTC/Acute Rehab, & WCM excluded
Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2023 – Q3 2024.

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CalOptima Health

TANF <18 Medi-Cal Inpatient Utilization

Metric	Goal	2023 Q4	2024 Q1	2024 Q2	2024 Q3
Admits/1000 PTMPY	13.9	24.5 ↑	28.7 ↑	30.1 ↑	29.1 ↑
Days/1000 PTMPY	193.7	346.8 ↑	369.4 ↑	341.5 ↑	349.3 ↑
ALOS	13.2	14.1 ↑	12.9 ↓	11.4 ↓	12.0 ↓
Readmit %	2.0%	4.0% ↑	2.0% ↓	5.0% ↑	2.9% ↑

Metric	Goal	2023 Q4	2024 Q1	2024 Q2	2024 Q3
ED Visits / 1000 PTMPY	349.1	422.8 ↑	370.5 ↑	353.2 ↑	334.2 ↓

↑ Denotes comparison to goal

- **Admit/1000 Per Year** (PTMPY): Above goal in all 4 quarters driven by Neonatology with an average of 57.3% of admits during the reporting period.
- **Bed Day/1000 Per Year** (PTMPY): Above goal driven by the Neonatology volume with roughly 80.9% of days during the reporting period. This rate has slightly trended down throughout 2024.
- **Average Length of Stay** (ALOS): Above goal in Q4 2023 and below goal in remaining 3 quarters due to continued focus on pediatric support and launch of facility rounds.
- **Readmission:** Above goal in Q4 driven by the low volume of admissions. The overall readmission rate is trending down slightly quarter over quarter during the reporting period.
- **ED Visits/1000 Per Year (**PTMPY): Above goal in Q4 2023 through Q2 2024 before trending under goal in Q3 2024.

CCN only, Duals, LTC/Acute Rehab, & WCM excluded
Source: Membership and Utilization Trends Tableau report, Data reflecting Q4 2023 – Q3 2024.

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CalOptima Health

WCM Inpatient Utilization

Metric	Goal	2023 Q4	2024 Q1	2024 Q2	2024 Q3
Admits/1000 PTMPY	n/a	244.2	257.1	280.6	260.0
Days/1000 PTMPY	n/a	1,706.7	1,928.1	1,677.6	1,369.4
ALOS	n/a	7.0	7.5	6.0	5.3
Readmit %	n/a	15.5%	12.4%	13.8%	10.8%

Metric	Goal	2023 Q4	2024 Q1	2024 Q2	2024 Q3
ED Visits / 1000 PTMPY	717.4	661.6 ↓	642.3 ↓	611.6 ↓	550.5 ↓

↑ Denotes comparison to goal

- **Admit/1000 Per Year** (PTMPY): Uptick in Q2 2024.
- **Bed Day/1000 Per Year** (PTMPY): Uptick in Q1 2024 from Q4 2023 before a decrease in Q2 2024 and Q3 2024
- **Average Length of Stay** (ALOS): Uptick in Q1 2024 from Q4 203 before a decrease in Q2 2024 and Q3 2024.
- **Readmissions**: Fluctuation in all 4 quarters
- **ED Visits/1000 Per Year** (PTMPY): ED utilization trended below goal in all 4 quarters

CCN only, Duals, LTC/Acute Rehab, & WCM excluded
Source: Membership and Utilization Trends Tableau report,
Data reflecting Q4 2023 – Q3 2024.

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CalOptima Health

Prior Authorization Turn Around Time – Medi-Cal and OneCare

Prior Authorization Turnaround Time Compliance (TAT) Q4 2023 - Q3 2024						
Year	Goal	Quarter	Month	Prospective Routine	Prospective Urgent	Retro Post Service
2023	95%	Q4	Oct	100.0%	99.8%	100.0%
			Nov	99.8%	99.8%	99.6%
			Dec	99.9%	99.8%	99.8%
2024	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%

Prior authorization turnaround time compliance remained compliant since Q4 2023. Continued to exceed the quarter over quarter goal of 95%, slight downward performance in February 2024 (JIVA implementation)

Source: Authorization Inventory Tableau Data Q4 2023-Q3 2024. Data pulled 11/20/24

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CalOptima Health

Inpatient Turn Around Time – Medi-Cal and OneCare

Inpatient Turnaround Time Compliance (TAT) Q4 2023 - Q3 2024 (CCN/COD)					
Year	Goal	Quarter	Month	Concurrent Review	Retro Post Service
2023	95%	Q4	Oct	99.7%	91.5%
			Nov	98.8%	100.0%
			Dec	98.9%	95.6%
2024	95%	Q1	Jan	99.6%	82.4%
			Feb	89.0%	98.4%
			March	95.7%	92.6%
	95%	Q2	April	92.4%	97.5%
			May	96.8%	93.6%
			June	95.6%	100.0%
	95%	Q3	July	97.7%	97.6%
			Aug	98.3%	98.4%
			Sept	98.7%	99.1%

Inpatient turnaround time compliance remained stable since Q4 2023 with exception of February 2024 (Jiva System migration). Average turnaround time compliance for retro post service request is 95.5%.

Source: Authorization Inventory Tableau Data Q4 2023-Q3 2024, Data pulled 11/20/24

Prior Authorization Referrals Processed- Medi-Cal and OneCare

Q1 2023 to January 2024

Referrals Processed	
Routine	82,834
Urgent	16,005
Retro	3,579
Total	102,418

Referrals Processed	
Faxed	74,503
COLAs (Portal)	68,318
Auto Auth	36,849
Total	179,670

Turnaround Time Compliance (TAT)	
Routine	99.9%
Urgent	99.8%
Retro	99.8%

Sources: Q4 2023 and Jan 2024 data pulled from prior clinical system. Authorization Turn Around Summary (CC0003A_GC), UM Incoming Fax Report (CC0195), Cerecon Referral Count (CC0087), and Auto Authorization Trend Report

February 2024 to Q3 2024

Referrals Processed	
Routine	216,260
Urgent	55,618
Retro	8,454
Total	280,332

Referrals Processed	
Faxed	41,455
COLAs (Portal)	235,094
Auto Auth	101,697
Total	378,246

Turnaround Time Compliance (TAT)	
Routine	99.7%
Urgent	99.6%
Retro	97.8%

Data for Q1 2024 - Q3 2024 provided by ad-hoc report from EA supplied 1/15/2025. Q1 2024 data excludes January due to system cutover starting Feb.1.

Referrals continued to increase across all 4 quarters. Turnaround compliance remained above goal of 95% in all 4 quarters.

2025 UM/CM Integrated Program Description

UM/CM integrated Program Goals and Initiatives

- The goal 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 CalOptima Health members through:
  - 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

UM Sub Workgroups

- **High Risk Care Management:** Implements clinical strategies to reduce unnecessary ED visits/hospitalizations, decrease length of stay in acute care and long-term acute care facilities, 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 addressing over and underutilization that is reported up through UM committee.
- **Gender Affirming Care:** Ensure equity 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

- **Early and Periodic Screening, Diagnostic and Treatment** (EPSDT): Medical Directors, Case Management, Utilization Management, Behavioral Health Integration, Delegation Oversight, and Quality Analytics teams convene to ensure access to EPSDT care and services.

- **ECM Clinical Oversight**: Establishes protocols for ECM clinical oversight and monitoring process for members enrolled in ECM. Ensures members are receiving appropriate clinical care and related social services and to support ECM providers serving members.

Case Management Program

Specialized Care Management Programs

- Transplant Program
  Enhanced Resources and programmatic design led by Transplant medical director for Case Managers to support members from listing to post Transplant.

- Palliative Care Program
  Collaborative approach between UM and CM to ensure access to palliative care services on the continuum of care.

- Emergency Department interventions and workgroup
  Develop CM protocols to address members with high emergency department utilization led by Medical Director and case management clinical leadership

Case Management Program

Updates and/or changes to the Case Management (CM) program and process include but are not limited to the following:

- Enhanced Care Management (ECM) and Community Supports program oversight
- Clinical documentation platform enhancements and new system implementation-JIVA
- Training/ tools in clinical protocols/standards of care for both CalOptima Health and Health Network staff.
- Targeted outreach and case management support to members experiencing transitions
- Case Management program enhancements for outreach to members with specialized needs

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 3, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

5. Receive and File 2024 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Assessment and Performance Improvement Work Plan Evaluation and Approve the 2025 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Work Plan

Contacts

Javier Sanchez, Executive Director Operational Management, (714) 986-6115
Donna Frisch, M.D., PACE Medical Director, (714) 714-8974
Monica Macias-Garcia, LCSW, PACE Director, (714) 468-1077

Recommended Actions

1. Receive and file the 2024 CalOptima Health Program of All-Inclusive Care for the Elderly Quality Improvement Work Plan Evaluation, and
2. Approve the 2025 Program of All-Inclusive Care for the Elderly Quality Improvement Work 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 seniors with those seniors 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, 2024, CalOptima Health PACE had 504 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) Work Plan that is evaluated annually. The results of the evaluation can directly lead to the revisions made to the following year's QI Work Plan. The QI Work Plan reflects the full range of services provided by CalOptima Health PACE. The goal of the QI Work Plan is to improve future performance through effective improvement activities driven by identifying key objective performance measures, tracking those measures, and reliably reporting on those measures to decision-making and care-giving staff.

The 2024 PACE QI Work Plan Evaluation analyzes the core clinical and service indicators to determine if the 2024 QI Work Plan achieved its key performance goals for the year.

CalOptima Health had the following achievements in 2024:

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1. Reached a milestone enrollment of 500 participants.
2. Implemented a plan to assist eligible participants with receiving the latest recommended COVID-19 vaccine, which became available in September 2024.
3. 91% of participants received their annual influenza vaccine, with continuation of vaccination efforts into Q1 2025.
4. 93.4% of eligible participants completed their recommended pneumococcal vaccine series.
5. 99% of participants had their medications reconciled within 7 days of hospital and/or skilled nursing facility discharge.
6. Successfully completed an extensive internal audit of PACE by the CalOptima Health Audit and Oversight team in June 2024, with minimal audit findings. All corrective actions were completed and closed without further action needed.

In 2025, CalOptima Health PACE continues to expand participant services, update quality element goals, and continues efforts to ensure comprehensive care. The 2025 PACE QI Work Plan reflects CalOptima Health's efforts to continue providing a high level of quality care while also focusing on improving health outcomes and access for PACE program participants.

Discussion

CalOptima Health PACE completes an annual evaluation of all quality metrics with data gathered throughout the year. This annual evaluation is reviewed with the PACE Quality Improvement Committee (PQIC) to determine which goals have been met and which metrics should be carried into the next QI Work Plan for the following year. CalOptima Health PACE has updated the 2025 QI Work Plan to ensure that it is aligned with health network and strategic organizational changes. This will ensure that all regulatory requirements and standards are met in a consistent manner. The 2025 PACE QI Work Plan, created in collaboration with the PQIC members, refines the PACE quality elements based on the current population's health needs. The 2025 PACE QI Work Plan challenges the PACE team to strive for improvement in areas of treatment, service, and health outcomes.

In 2025 PACE proposes its QI Work Plan:

1. To ensure that 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 participants in completing advanced health care directives to ensure that their health care wishes are followed.
3. To raise the benchmark goals of quality metrics to provide highest quality of care for participants.

Rationale for Recommendation

PACE organizations are required to establish a QI program. Through the Code of Federal Regulations (CFR), 42 CFR section 460.130 (a), the Centers for Medicare & Medicaid Services requires that a PACE organization develop, implement, maintain, and evaluate an effective, data-driven quality improvement program. As per 42 CFR section 460.132(a) and (b), a PACE organization must have a written quality improvement plan that is collaborative and interdisciplinary in nature. The PACE governing body must review the plan annually and revise it, if necessary.

Fiscal Impact

The recommended action has no additional fiscal impact beyond what was incorporated in the Fiscal Year (FY) 2024-25 Operating Budget. Staff will include expenditures for the period of July 1, 2025, through December 31, 2025, in the FY 2025-26 Operating Budget.

Concurrence

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

Attachments

1. 2024 PACE QI Work Plan Evaluation
2. PowerPoint Presentation: 2024 PACE QI Work Plan Evaluation
3. 2025 Proposed PACE QI Work Plan (Redline version)
4. 2025 Proposed PACE QI Work Plan (Clean version)
5. PowerPoint Presentation: 2025 Proposed PACE QI Work Plan

/s/ Michael Hunn *03/27/2025*
Authorized Signature **Date**

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CalOptima Health Program of All-Inclusive Care for the Elderly

2024

Quality Improvement Plan

Annual Evaluation

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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 Acting Chairperson:

_____ _____

Isabel Becerra **Date**

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2024 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 2024. 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 11 years and at the end of 2024, we reached a milestone number of 500 participants enrolled.

Despite several small COVID-19 surges throughout 2024, 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 new 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, Urdu and Korean. CalOptima Health PACE ensures that participants are always 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 2024 PACE QI Workplan Evaluation helps to identify key areas that offer opportunities for improvement that will be incorporated into the 2025 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 2024 PACE QI Plan was reviewed and approved by the CalOptima Health Board of Directors on April 4th, 2024.

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 2024, CalOptima Health PACE's accomplishments include:

1. Milestone enrollment number of 500 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 2024.
4. Continued to increase PACE Day center activities and attendance in accordance with infection control guidelines.
5. Distributed 13,906 home delivered meals throughout 2024.
6. 91% of participants received their annual Influenza vaccine, with continuation of vaccination efforts into Q1 2025.
7. 93.4% 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.
9. 99% of participants had their medications reconciled within 7 days of hospital and/or Skilled Nursing Facility (SNF) discharge.
10. Continued use of telehealth modalities, when appropriate, enabled participants to "visit" their providers from their homes.
11. 91.26% of participants with diabetes completed an annual eye exam.
12. Utilization:
    a. 0.02% of participants were placed in long-term health care in 2024.
    b. Continued the PACE Emergency Room (ER) Diversion program, with both ER and Hospital utilization goals met for 2024.

c. Continued to provide in-house specialist health care including podiatry and dental services for improved access and coordination of health care.

13. 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.
14. Successfully completed an extensive internal audit of our program by the CalOptima Health Audit and Oversight team in June 2024. Ultimately, PACE had minimal audit findings, and all corrective actions were completed and closed without further action needed.

SECTION 3: STRATEGIC GOALS AND OBJECTIVES

Accomplishments

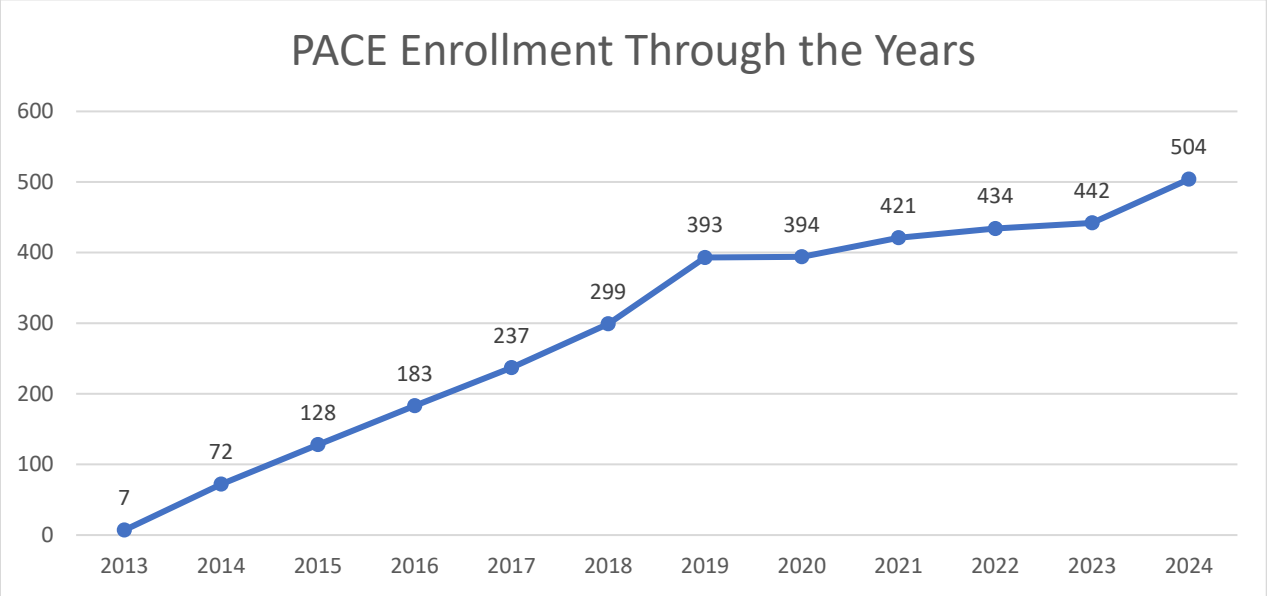
1. The QI program is organized to identify and analyze significant opportunities for improvement in clinical services, health care, and utilization. Accomplished and evidenced by:
    a. The ongoing Health Plan Management System (HPMS) and QI individual metric data collection and analysis.
    b. The 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 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.
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 2025, our goals for program growth remain intact and strategies are in place to expand our ability to serve even more participants in Orange County. We continue our aggressive marketing strategies which included rebranding and print, radio and television media to reach a wider audience throughout Orange County. The CalOptima Health executive team is working closely with PACE to develop exciting strategies for expansion in 2025.

2024 Quality Improvement Work Plan — Elements by Category:

Quality of Care and Services

QI24.01 PACE QAPI Plan and Work Plan will be evaluated annually

Approved by the CalOptima Health Board of Directors on April 4, 2024.

QI24.02 PACE QAPI Plan and Work Plan will be reviewed and updated annually

Approved by the CalOptima Health Board of Directors on April 4, 2024.

QI24.03 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, 2024.

Goal: Not Met

Data/Analysis: 91% of participants received the influenza vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement: With a year-end vaccination rate of 91%, we fell slightly short in meeting our 2024 goal. Our influenza vaccination efforts for the 2024/2025 flu season will extend through Q1 of 2025 where we will continue to reach out to those unvaccinated participants. Vaccines were pre-ordered in late spring from our distributer, and we began our process when vaccines arrived in September 2024. 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 2024. We will continue our goal of greater than or equal to 94% influenza vaccination into 2025.

QI24.04 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, 2024.

Goal: Not Met

Data/Analysis: 93.4% of participants received the pneumococcal vaccination by the year end.

Summary and Key Findings/Opportunities for Improvement: By the end of 2024, 93.4% 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. In 2025, we anticipate that the identification of those needing vaccine through review in the California Immunization Registry (CAIR2) will continue to increase our ability to meet and maintain the 94% goal moving forward.

QI24.05 Increase COVID-19 immunization rates for all eligible PACE participants

Goal: Greater than or equal to 50% of eligible participants will receive the latest CDC recommended COVID-19 vaccine by December 31st, 2024.

Goal: **Met**

Data/Analysis: 56.6% of participant received COVID-19 vaccination by Q4 2024.

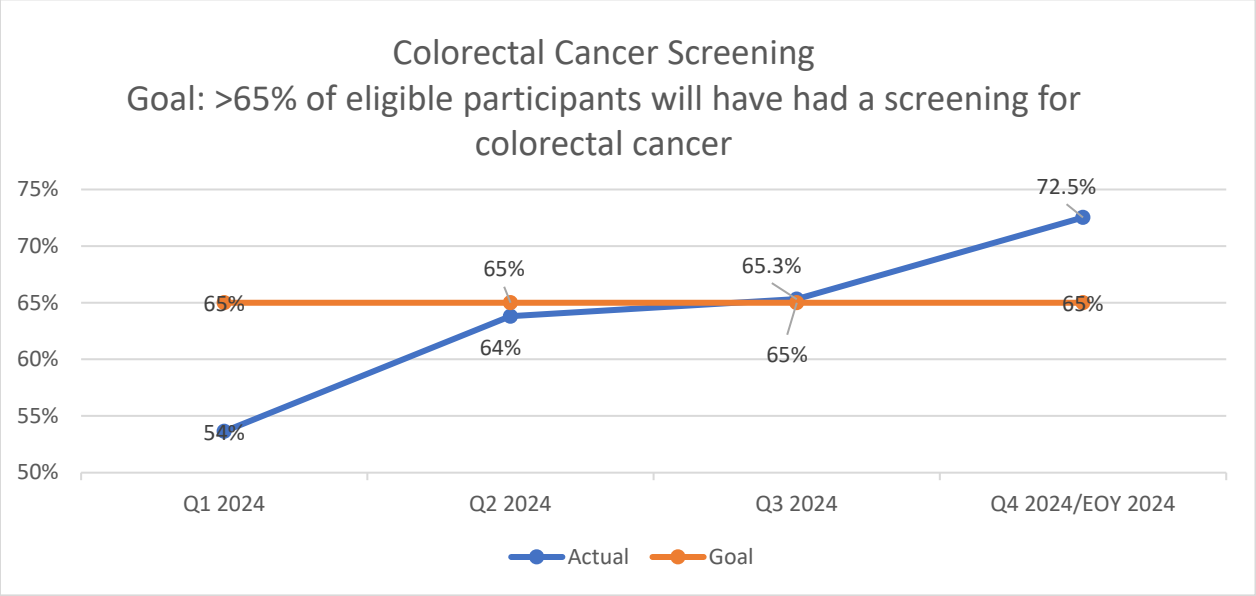
Summary and Key Findings/Opportunities for Improvement: COVID-19 vaccination recommendations continue to evolve as we have moved from the initial COVID-19 pandemic of 2019- 2023 to viewing COVID-19 as an infectious disease that requires yearly vaccinations similar to the influenza vaccine. Despite this, the patterns of COVID-19 outbreaks and the recommendations for vaccination continue to evolve in ways that are difficult to predict. Due to this, the PACE program has decided to remove this element from the PACE Quality Workplan while maintaining it as a quality initiative which still requires frequent monitoring and planning. We were able to meet our goal of 50% in 2024, despite noted “vaccine fatigue” among program participants. We will continue to endorse and educate participants on all COVID-19 vaccine recommendations as suggested by the Centers for Disease Control and Prevention (CDC).

QI24.06 Increase the number of participants who complete Colon Cancer Screening

Goal: > 65% of eligible participants will have had a screening for colorectal cancer by December 31st, 2024 (Comparable to the 2022 MEDICARE Quality Compass HEDIS 33.33rd percentile).

Goal: Met

Data/Analysis: 72.5% of eligible participants had a screening for colorectal cancer by December 31st, 2024.



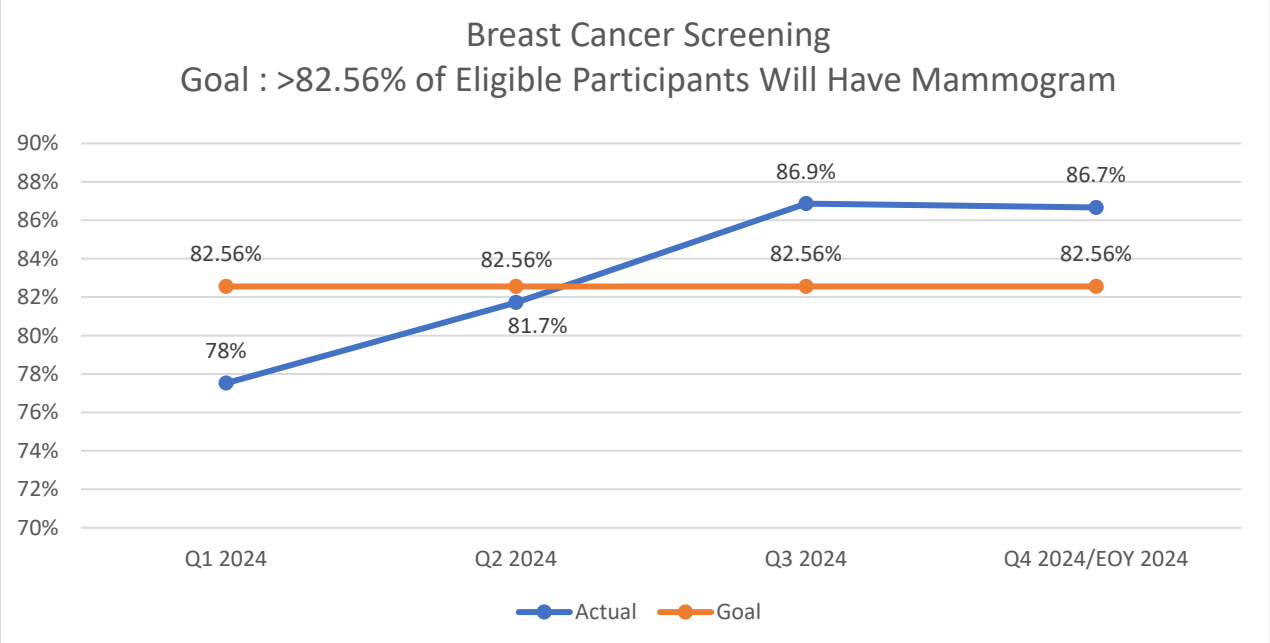
Summary and Key Findings/Opportunities for Improvement: Despite this being a new element introduced in 2024, we were able to meet and then exceed our goal for the year by Q3. We will continue this element into 2025 to ensure that our PACE participants are receiving the best possible chance at identifying colorectal cancer in its early stages when prognosis is better.

QI24.07 Increase the number of participants who complete Breast Cancer Screening

Goal: >82.56% of eligible participants will have a screening for breast cancer by December 31st, 2024 (Comparable to the 2022 MEDICARE Quality Compass HEDIS 90th percentile).

Goal: Met

Data/Analysis: 86.7% of eligible participants had a screening for breast cancer by December 31st, 2024.



Summary and Key Findings/Opportunities for Improvement: Similar to the colorectal cancer screening, this was a new element introduced in 2024 where we were able to meet and then exceed our goal for the year by Q3. We will continue this element in 2025 to ensure the earliest possible detection of breast cancer for our PACE participants.

QI24.08 Increase Physician Orders for Life-Sustaining Treatment (POLST) utilization for PACE participants

Goal: Greater than or equal to 95% of participants who have been enrolled in PACE for 6 months will have a POLST completed by December 31st, 2024.

Goal: Met

Data/Analysis: 98.6% of participants enrolled in the PACE for 6 months had a POLST by the end of 2024.

Quarters 2024	Completion Rate
Q1	98%
Q2	98%
Q3	99%
Q4	99.8%
EOY Average	**98.6%**

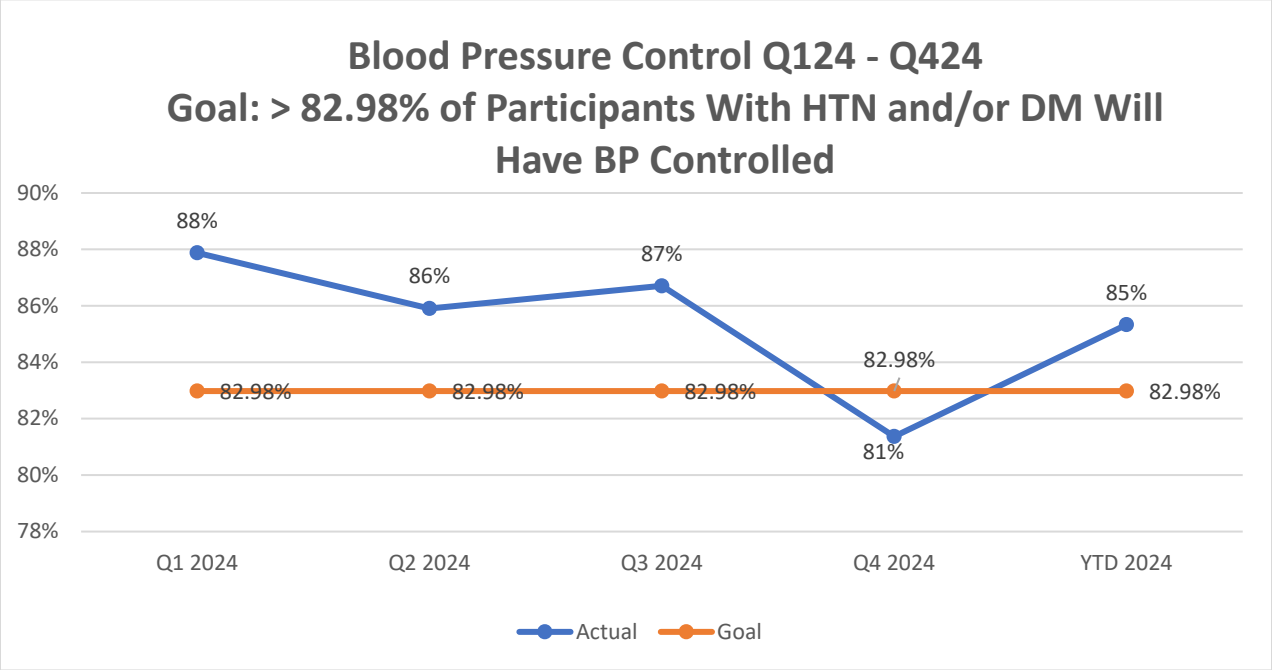
Summary and Key Findings/Opportunities for Improvement: We were able to once again meet and exceed our POLST goal in 2024. Through the efforts of our PCPs and the PACE Medical Director we were able to improve upon our 2023 year end performance of 96%. End-of-life decisions are reviewed with the participant by the Provider to complete this important document that respects the wishes of each participant. End-of-life and palliative health care discussions continue to be integrated into our Interdisciplinary Team (IDT) meetings and are documented in the participant's health care plan. In 2025, we will no longer keep this as a quality work plan element, focusing instead on our advance health care directive goals. However, the QI team will continue to monitor and report on POLST percentages as part of the clinic monthly monitoring report.

QI24.09 Increase the percentage of PACE participants with diabetes and/or hypertension who have their blood pressure under control (<140/90 mm hg)

Goal: >82.98% of participants with Hypertension and/or Diabetes will have their blood pressure controlled (Comparable to the 2022 MEDICARE Quality Compass HEDIS 90th percentile)

Goal: Met

Data/Analysis: The 2024 final average was 85%.



Summary and Key Findings/Opportunities for Improvement: Despite a slight dip in Q4, we were able to meet our overall average blood pressure monitoring goal for 2024. Blood pressure control is measured as regular readings of <140/90 mm HG.

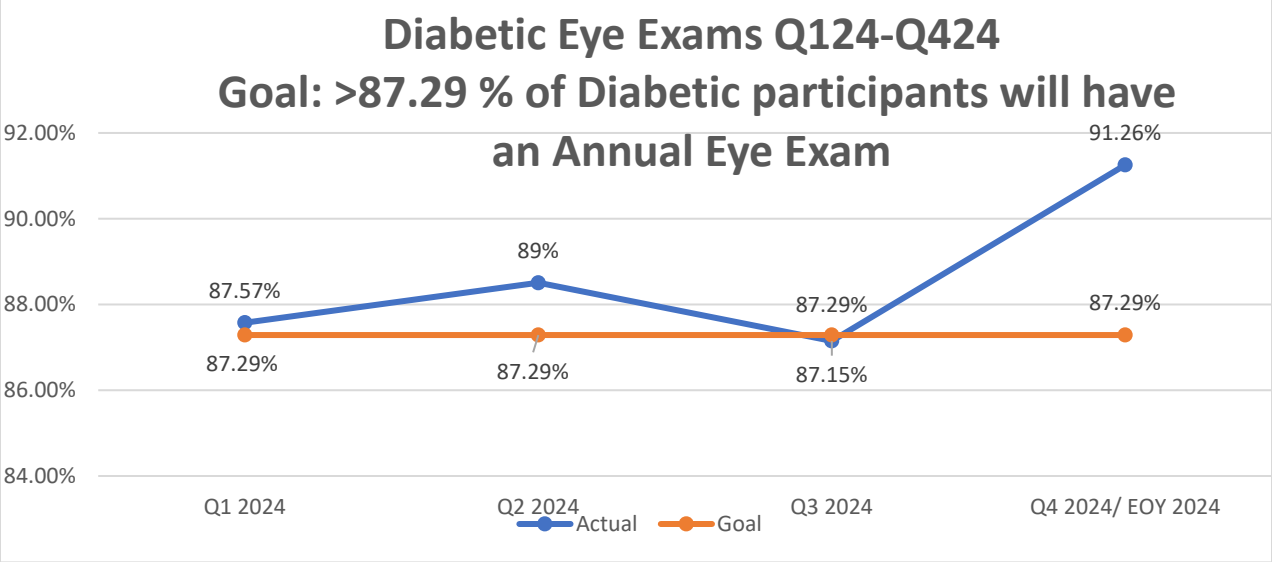
The 2025 goal will be increased from >82.98% to >85.60%. (Comparable to the 2023 MEDICARE Quality Compass HEDIS 90th percentile, exclusions defined in 2025 QI Work Plan).

QI24.10 Increase the percentage of PACE participants with diabetes who have had their annual diabetic eye exam completed

Goal: >87.29% of Diabetic participants will have an Annual Eye Exam (Comparable to the 2022 MEDICARE Quality Compass HEDIS 95th percentile)

Goal: Met

Data/Analysis: The 2024 final rate was 91.26%.



Summary and Key Findings/Opportunities for Improvement:

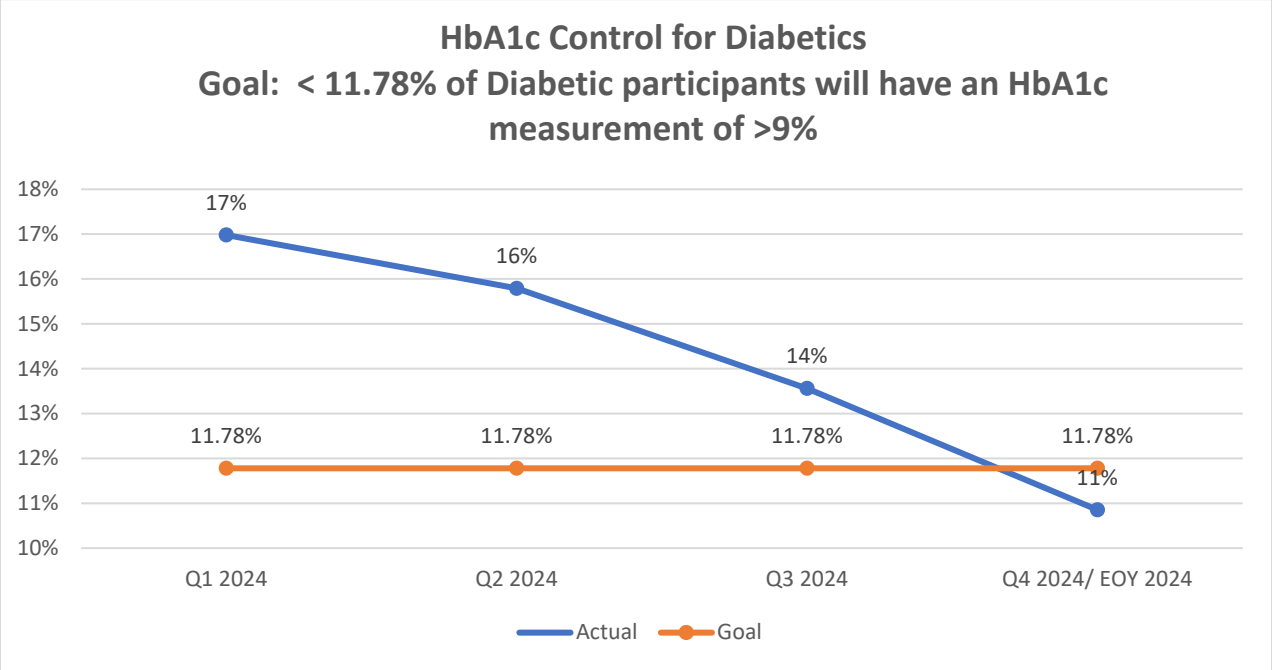
We exceeded our target goal, with 91.26% of diabetic participants having received an annual eye exam by the end of 2024. With the assistance of monthly reports generated by the PACE QI team, providers were alerted to those diabetic participants who required annual eye exams. Those participants were then scheduled for an appointment. Contracted ophthalmologists and optometrists are very diligent in their follow-up and provide our medical team with timely specialty reports. In 2024, the goal will be increased to >88.08% of Diabetics will have an Annual Eye Exam (Comparable to the 2023 MEDICARE Quality Compass HEDIS 95th percentile, exclusions defined in 2025 QI Work Plan).

QI24.11 Increase the percentage of PACE participants with diabetic blood sugar control

Goal: <11.78% of Diabetic participants will have an HbA1c measurement of >9% (Comparable to the 2022 MEDICARE Quality Compass HEDIS 90th percentile)

Goal: Met

Data/Analysis: 2024 ended with a rate of 11%.



Summary and Key Findings/Opportunities for Improvement: This was a new element in 2024. Through the diligent work of the PACE providers, the percentages dropped consistently each quarter, ending with the goal being achieved in Q4. In 2025, the goal will be changed to >12.24% of Diabetics will have an HbA1c >9 (Comparable to the 2023 MEDICARE Quality Compass HEDIS 70th percentile, exclusions defined in 2025 QI Work Plan). Strategies to reach this goal include the following: focus on health literacy and diabetes education, group diabetic education, dietary team becoming certified diabetes instructors, and providing 1:1 education with participants whose HbA1c is >9 through internal referral process.

QI24.12 Ensure participants are assessed for Osteoporosis

Goal: 75% of eligible participants will have a bone density scan to assess Osteoporosis

Goal: Met

Data/Analysis: The 2024 final rate was 86%.

Quarters 2024	Rate
Q1	79%
Q2	85%
Q3	88%
Q4	90%
EOY Average	**86%**

Summary Key Findings/Opportunities for Improvement: In 2024, we focused on ensuring that all eligible participants were scanned for osteoporosis risk using Dual-energy X-ray absorptiometry (DEXA). For 2025 we will adapt this element to focus specifically on all women over 65 years old, who are that the highest risk for osteoporosis and bone fractures. Our goal will remain that at least 75% of eligible participants will have a DEXA scan on file to identify and treat osteoporosis.

QI24.13 Reduce number of falls reported by PACE enrollees

Goal: <72 Falls reported per quarter in 2024.

Goal: Not Met

Data/Analysis:

Quarter 2024	# Falls Per Quarter
Q1	84
Q2	133
Q3	94
Q4	99
EOY Average	**103**

Summary Key Findings/Opportunities for Improvement:

We did meet our fall goals in 2024, with many of the falls attributed 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 2025 we will continue our increased surveillance of repeat faller by continuing mandatory home assessments and follow up completed

by PACE to reduce total number of falls at home. We have added an exclusion that participants with more than 3 reported falls in a quarter will be excluded from the data set, while having intensive follow up with their IDT and caregivers to develop personalized fall prevention strategies.

QI24.14 Reduce potentially harmful drug/disease interactions in the elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents

Goal: <25% of elderly PACE participants with Dementia will be prescribed a tricyclic antidepressant or anticholinergic agent. (Goal in line with 2022 Medicare Quality Compass HEDIS 95th percentile).

Goal: Met

Data/Analysis: The 2024 average rate was 18%

Quarters 2024	%Per Quarter
Q1	15%
Q2	17%
Q3	17%
Q4	23%
EOY	**18%**

Summary and Key Findings/Opportunities for Improvement: In 2024, only 18% of our elderly participants who were diagnosed with dementia were prescribed a tricyclic antidepressant or anticholinergic agent, meeting our goal. The PACE QI department worked closely with the medical team and generated reports of participants with dementia who were also prescribed cautionary medications. On a monthly basis our medical providers, clinical pharmacists and data specialists, review in detail all the medications that are considered “red flags” per CMS and Beer’s criteria. This is shared with other clinical medical providers and alternative medication options are discussed during provider meetings. Our clinical pharmacist is instrumental in reviewing medications ordered by providers, confirming that there are no contraindications to the drugs and then recommending alternative medication options, thereby preventing adverse outcomes. Due to consistently meeting our goal for this measure year after year, we will be removing this element in 2025. However, the QI team will continue to monitor and report on these percentages as part of the clinic monthly monitoring report.

QI24.15 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: Met

Data/Analysis: The 2024 rate was 100%

Quarters 2024	# 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 1 participant reevaluated (100%)

Summary and Key Findings/Opportunities for Improvement: In 2024 we were able to fully meet our goal of 100% provider opioid evaluation in each quarter. It should be noted that we have very few participants who exceed the established recommendations of daily morphine MME dosing. The PACE QI department works in concert with the pharmacy team to identify any participants who may be taking high dosage opioids. These specific participants are then added onto the provider's monthly schedule so that appropriate participant/PCP follow-up can occur. We will continue to track and monitor this element and anticipate that we will again achieve 100% in 2025.

QI24.16 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 2024.

Goal: Met

Data/Analysis: 99% of participants had medications reconciled within 7 calendar days post discharge in 2024.

Quarters 2024	# Participants with Medication Reconciliation within 7days of discharge
Q1	100%
Q2	100%
Q3	94%
Q4	100%
EOY Average	99%

Summary and Key Findings/Opportunities for Improvement: Reconciliation of medications post hospital and/or skilled nursing facility discharge remains one of our top 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. In 2024, we changed the goal of Post-Discharge Medication Reconciliation from the previous year. Our 2023 goal was to have ≥ 90% of

participants with medication reconciled *within 10* days after discharge. For 2024, this goal was shifted to better ensure that our participants' post-discharge needs are met in a timely manner to help prevent recurrent hospital admissions. We challenged ourselves with a new goal that ≥93% of participants will have their medications reconciled *within 7 calendar days* of hospital and/or skilled nursing facility discharge. We will maintain this important element in 2025.

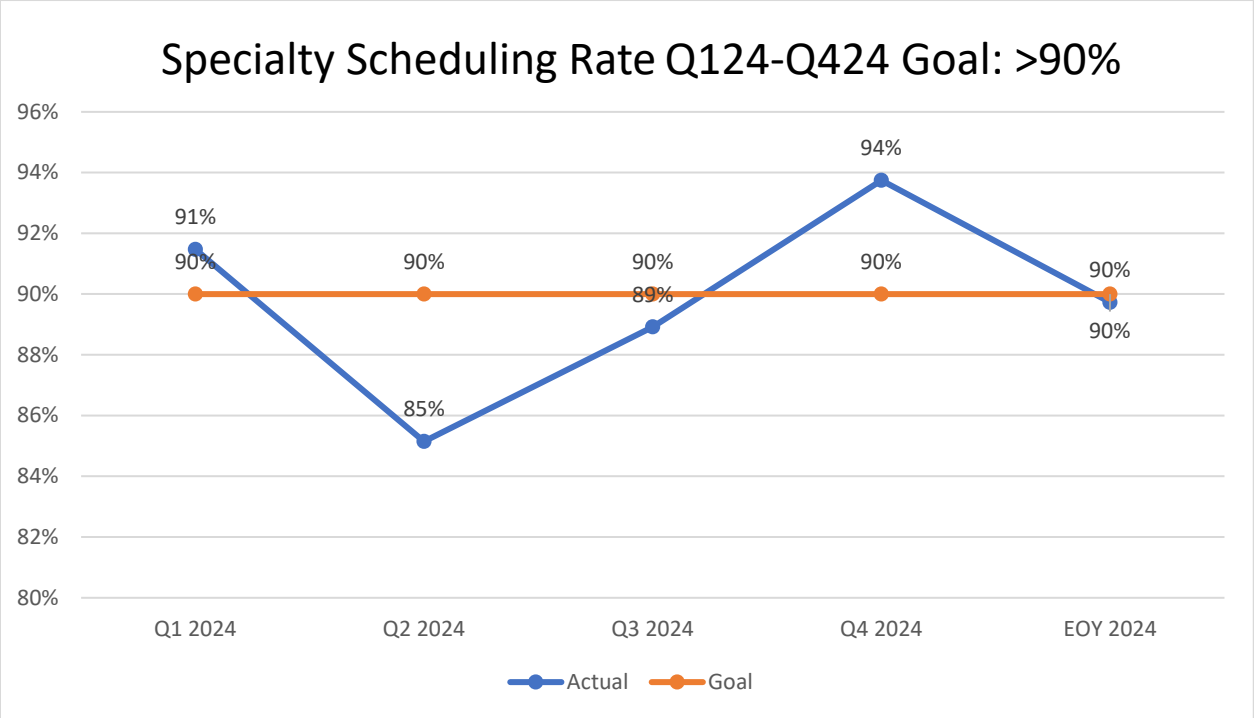
Access and Availability

QI24.17 Improve access to specialty health care providers

Goal: ≥ 90% of specialty health care authorizations will be scheduled within 14 calendar days in 2024

Goal: Met

Data/Analysis: The 2024 end of year average rate was 90%.



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 2024 and into 2025 we expanded the number of staff dedicated to scheduling specialty appointments.

Throughout 2024, we have been able to increase some of our in-house specialty health care activities, such as dentistry and podiatry care. At the end of 2024 we were able to contract with a cardiologist who will provide in house evaluation at our PACE center. As part of our operational Work Plan for 2025, we will continue to identify additional core specialists who understand the PACE model of care and are willing to work closely with the program. This will improve scheduling access as well as health care coordination through prompt consultation notes and real-time dialogue between the specialist and PACE PCP. Despite decrease in Q2 and Q3 2024, we ultimately met our quality goal for 2024.

In 2025 we are 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. Due to this, our 2025 goal will be 100% of specialty appointments scheduled within 7 calendar days of being authorized.

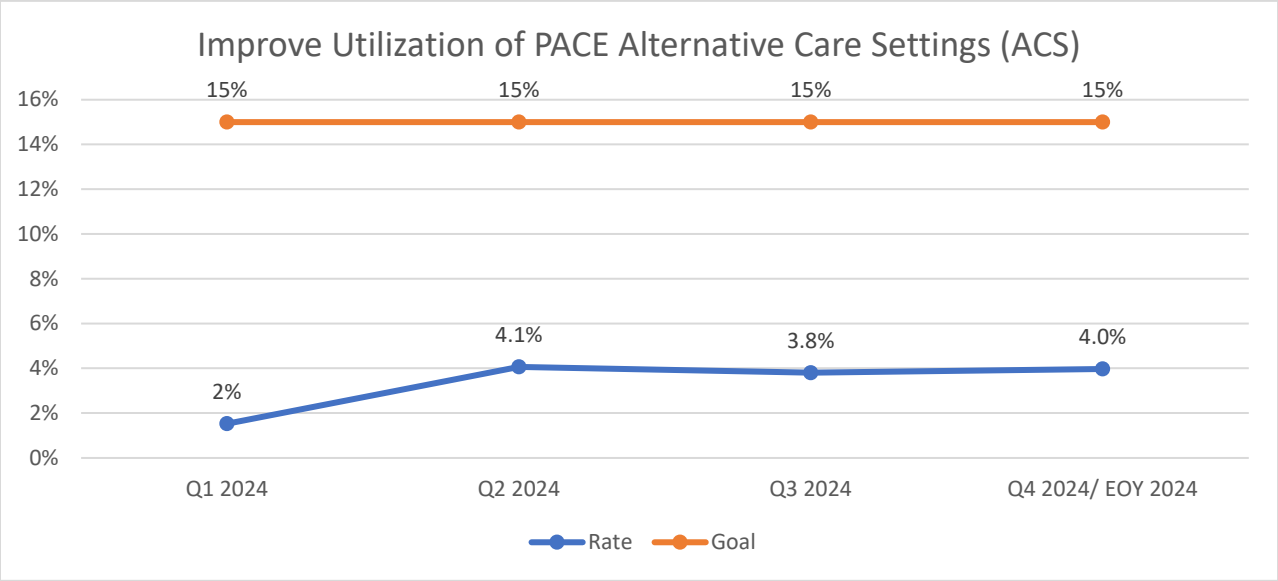
Utilization Management

QI24.18 Improve the rate of participants who attend PACE Alternative Care Settings (ACS)

Goal: ≥15% of all eligible PACE Enrollees will utilize day center services at one of the PACE Alternative Care Settings by end of 2024.

Goal: Not Met

Data/Analysis: The 2024 ending rate was 4%.



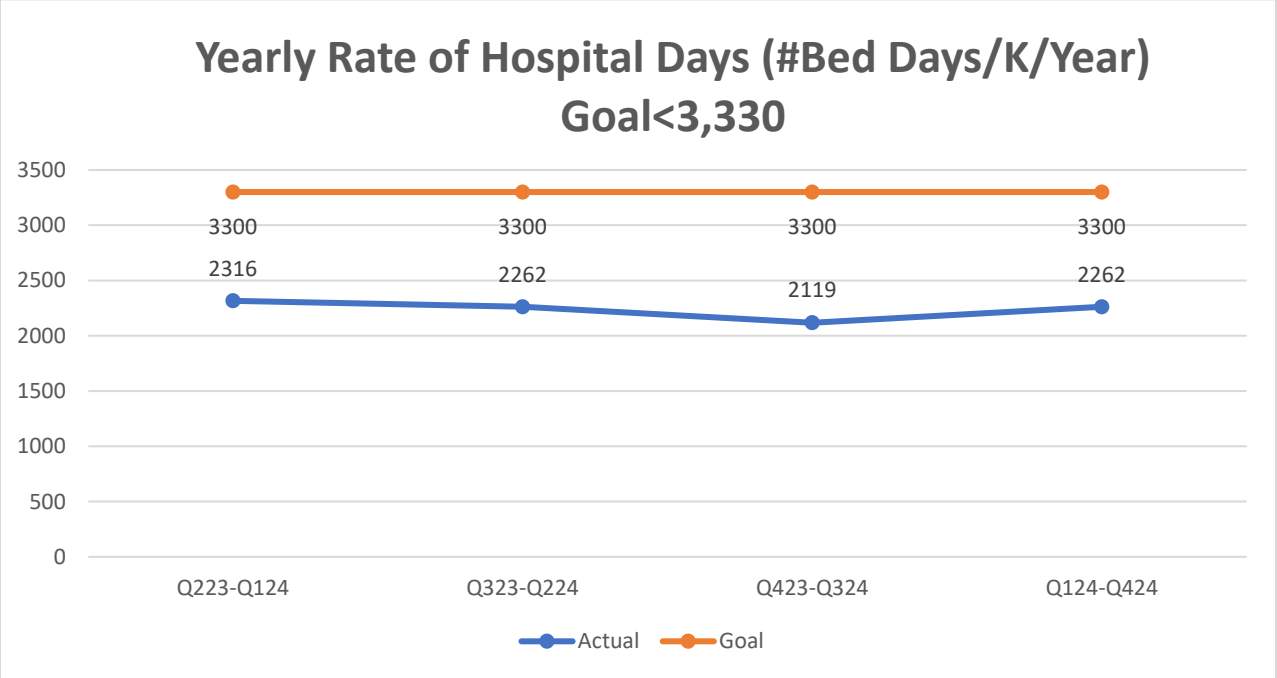
Summary and Key Findings/Opportunities for Improvement: There were multiple reasons that we did not meet our ACS utilization goals in 2024. There was an unexpected closure of 1 of our ACS partner sites as of August 2024. There was an unexpected inability of a different ACS partner site to engage with us after it underwent an acquisition by a new company within 2024. Additionally, there were operational barriers at another ACS partner site such as hours of operation and changes in operational days. In 2025, we will be lowering this goal to a more realistic 10% utilization. We plan to accomplish this goal using the following strategies: re-alignment of tasks for ACS partner sites, increasing reimbursement rate, shifting PACE operations for enrollment & assessments to be done at ACS site, plan to add 1-2 additional ACS contracted sites, and anticipating re-engagement of existing ACS site that changed ownership.

QI24.19 Reduce the rate of acute hospital days by PACE participants

Goal: < 3,330 hospital days per 1000 per year in 2024.

Goal: Met

Data/Analysis: The 2024 ending rate was 2262 bed days per 1000 per year.



Summary/Key Findings/Opportunities for Improvement

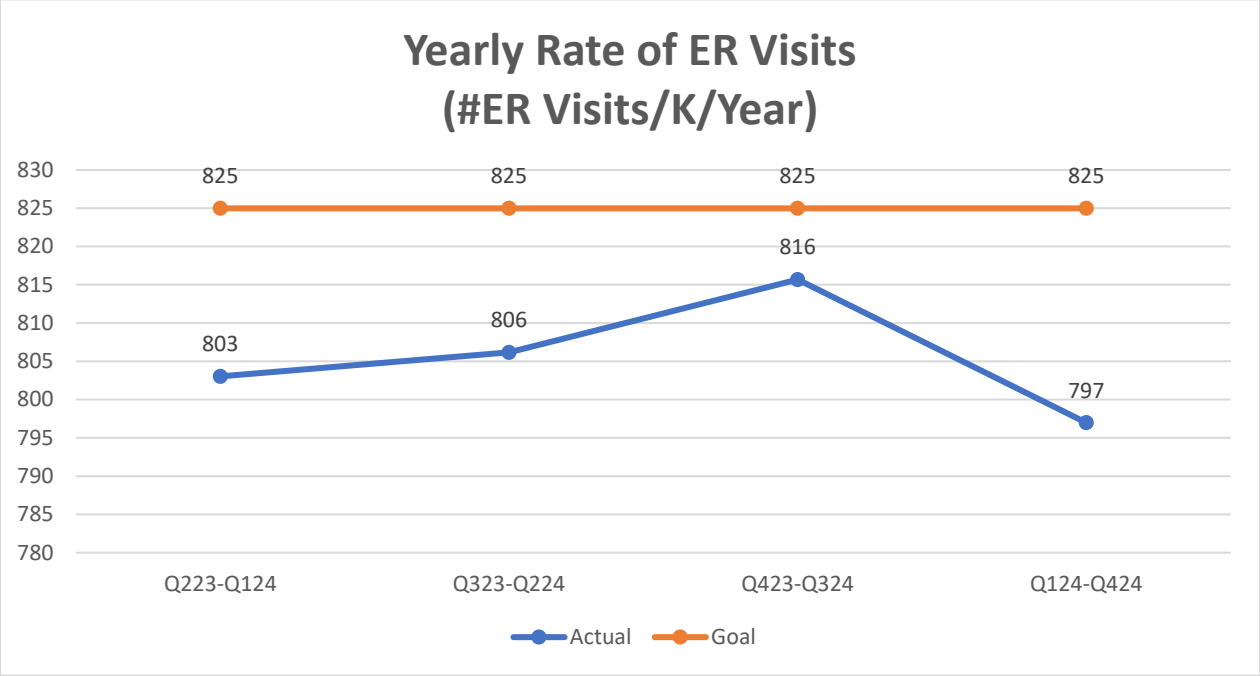
CalOptima Health PACE met our goal of <3,300 hospital days per 1000 per year by the end of 2024. Despite the high number of medically complex patients that are part of our program, we were able to reduce the overall number of hospital bed days and meet our end of year goal in 2024. PACE participants hospital days are monitored and analyzed by the PACE QI department who work 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 2025 Work Plan, while lowering our goal to <3,000 hospital days per 1000 per year by the end.

QI24.20 Reduce the rate of ER utilization by PACE participants

Goal: <825 emergency room visits per 1000 per year in 2024.

Goal: Met

Data/Analysis: The 2024 ending rate was **797** emergency room visits per 1000 per year.



Summary and Key Findings/Opportunities for Improvement:

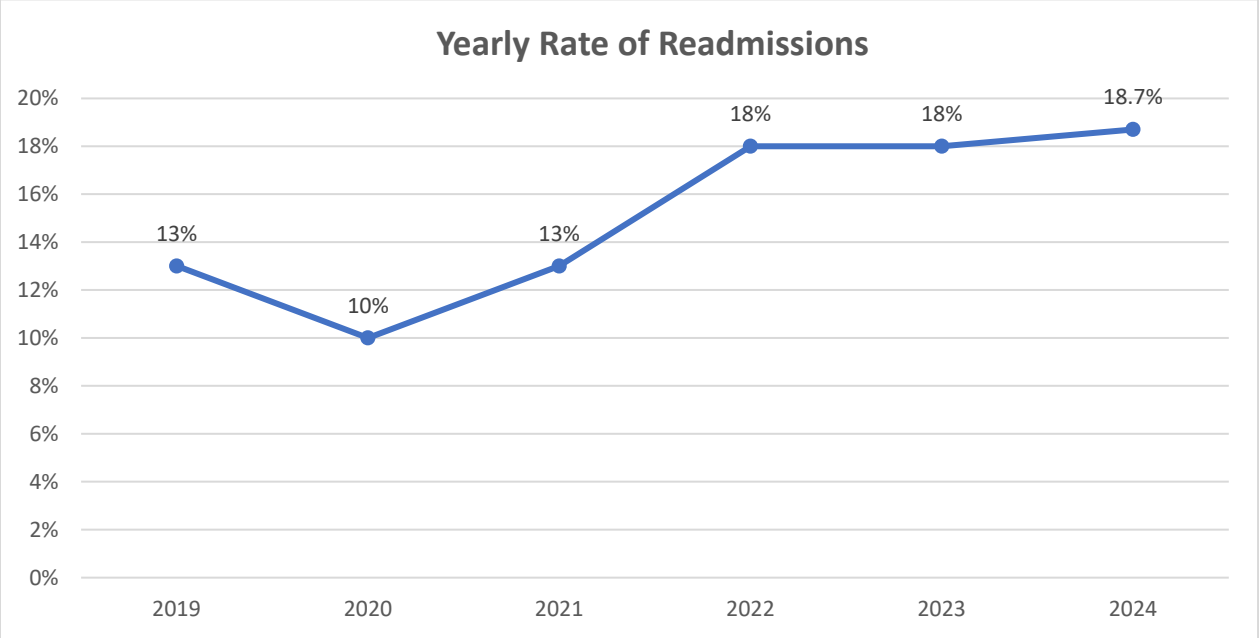
PACE noted another decline in ER visits per thousand per year in 2024. ER utilization by PACE participants is monitored and analyzed by the PACE QI department who work with the PACE Medical Director and clinical teams to develop strategies to lower ER utilization rates. Additionally, using our 24-hour on-call provider service, we provide round-the-clock assessment of participants and provide ER diversion as warranted. In 2025 we plan to improve even more upon this utilization element by changing the benchmark from <825 emergency room visits per 1000 per year to <820 emergency room visits per 1000 per year.

QI24.21 Reduce the 30-day all cause readmission rates by PACE participants

Goal: Less than 14% 30-day all cause readmissions in 2024.

Goal: Not Met

Data/Analysis: The 2024 end of year rate was 18.7%



Summary and Key Findings/Opportunities for Improvement:

PACE readmission rates tend to have variance due to a small group of participants with high level medical needs. We ended 2024 with an 18% 30-day readmission rate which indicates the same performance as in 2022 and 2023. Our major challenges are high number of participants on dialysis, participant who discharge against medical advice, and overall higher needs of our specific PACE participant population- especially at end of life. In 2025, we continue to strive to reach lower readmission rates and will maintain our goal of a <14% 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.

QI24.22 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 2024.

Goal: Met

Data/Analysis: 2024 rate was 0.02% of the PACE enrollment resided in long-term care.

Summary and Key Findings/Opportunities for Improvement: We ended 2024 with only 0.02% of our participants residing in LTC, surpassing our already very low 2023 end of year percentage of 0.92%. 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. In 2024 we again worked closely with CalOptima Health's Long Term Support Services (LTSS) department to identify and assist individuals who are no longer able to reside

safely in their homes. These participants had their health care safely transferred to provide the best possible outcome for the participants and families utilizing LTSS. In 2025, we plan to maintain our benchmark and continue to investigate solutions to address the individualized health care needs of our unique population. Documentation of participant choice in service options, including to remain with PACE under custodial care, will be very clearly stated in their records when deciding to stay with PACE program or disenrolling to other services.

Enrollment/Disenrollment

QI24.23 Increase the qualified lead to enrollment conversion rate

Goal: Increase the qualified lead to enrollment conversion rate to 70% in 2024.

Goal: Met

Data/Analysis: Final average rate was 71%.

Quarter 2024	Rate
Q1	84%
Q2	78%
Q3	56%
Q4	68%
EOY	**71%**

Summary and Key Findings/Opportunities for Improvement: In 2024, despite dips in Q3 and Q4, we again met our end of year average goal in the percentage of qualified leads to enrollment. The declines in conversions in Q3 and Q4 are most likely due to reaching out to a broader range of potential participants, some of whom may be less likely to make it final enrollment stage of process. Additionally, there has been more competition in the community with two other PACE centers now open and enrolling from the same population and service areas in Orange County. In 2025 we will continue to review and analyze the Qualified Lead to Enrollment conversion rate and develop additional strategies to improve our conversion rates. In 2024 we will maintain our conversion rate benchmark goal of 70%. In late 2024, we hired a new Marketing and Enrollment Manager who has begun strategizing innovative approaches for increasing enrollment conversion.

QI24.24 Decrease the number of controllable disenrollment within 90-days of enrollment

Goal: The percentage of participants who disenroll for controllable reasons from the program within the first 90 days of enrollment will be less than 6%

Goal: Not Met

Data/Analysis: Final average rate was 7.14 %.

Quarters 2024	Rate
Q1	5.56%
Q2	15.38%
Q3	6.67%
Q4	0%
EOY Average	**7.14%**

Summary and Key Findings/Opportunities for Improvement: In 2024, we did not meet our year end average goal to reduce the number of participants who disenroll for controllable reasons within their first 90 days with the PACE program. Despite this, we were able to achieve no 90 day disenrollments in Q4. In 2025, we will maintain this goal, while changing the wording from "90 days" to "3 months". One of our strategies to achieve this goal is that new 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. 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 also be re-educated by to identify any potential barriers or issues during the enrollment process that may lead to immediate disenrollment from program and determine suitability for CalOptima Health PACE

QI24.25 Decrease the PACE attrition rate

Goal: Maintain a PACE participant attrition rate of ≤8%

Goal: Met

Data/Analysis: Final average rate was 5%.

Quarters 2024	Rate
Q1	3.88%
Q2	5.26%
Q3	5.96%
Q4	4.81%
EOY	**5.00%**

Summary and Key Findings/Opportunities for Improvement:

PACE met our end of year goal in reducing the attrition rate. This was an element created in 2023 to improve our member retention by thoroughly investigating each PACE disenrollment. This goal was accomplished through examination of each potential disenrollment 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 2025.

Transportation

QI24.26 and QI24.27: Improve contracted transportation performance

Goal QI24.26: 100% of transportation trips will be less than 60 minutes in 2024

Goal: Not Met

Quarters 2024	Rate

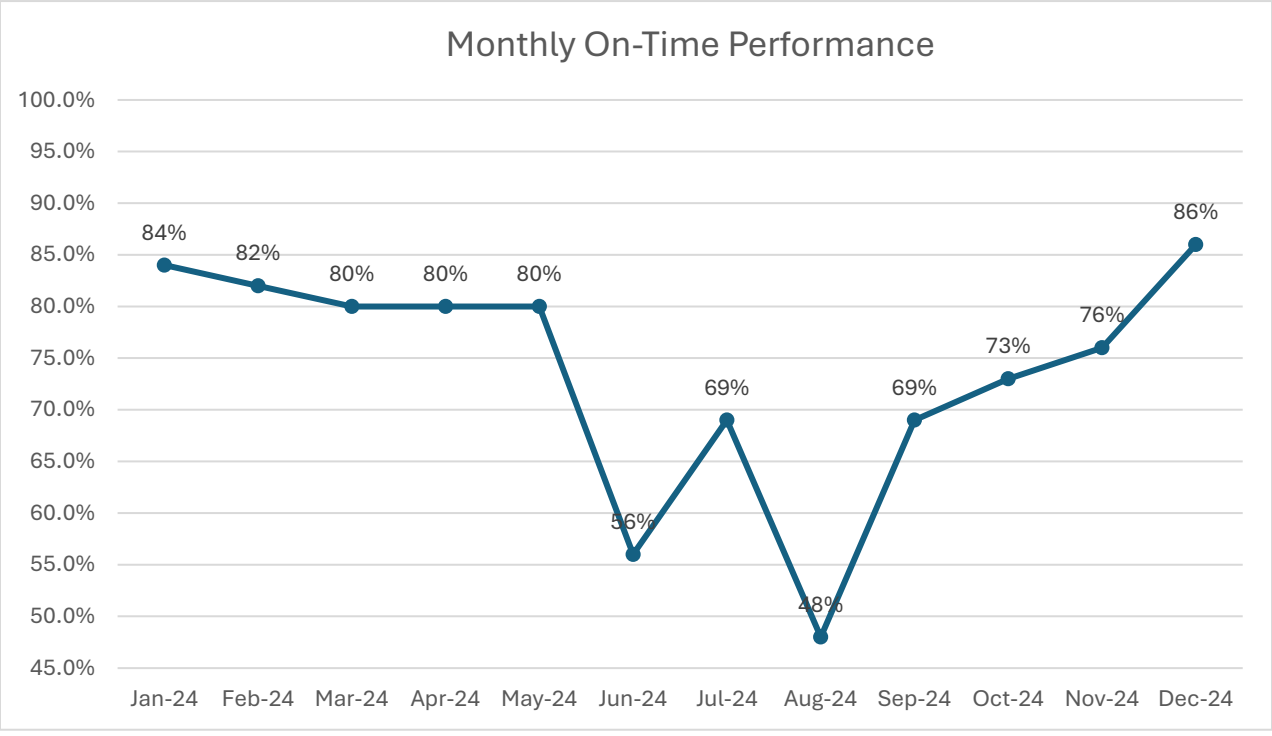
Q1	97%
Q2	97%
Q3	98%
Q4	99%
EOY	**99%**

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 rate of 99%. Unfortunately, it is a regulation that 100% of trips be less than 60 minutes and so in early 2024 PACE issued a Corrective Action Plan (CAP) to our transportation contracted vendor. This was also reported to the regulatory agencies CMS and DHCS. The CAP includes a process to provide a detailed report of any and all violations to PACE management within one day, with sanctions for each violations. The CAP will not be removed until the contractor has completed three months in a row with no violations. In November 2024, the transportation vendor terminated their previous transportation manager assigned to our program and temporarily replaced them with a higher-level staff member who has been able to reduce the number of violations significantly. We will continue this element in 2025 and hope to close the CAP within Q1 2025.

Goal QI24.27: ≥92% of all transportation rides will be on time in 2024

Goal: Not Met

Quarters 2024	Rate
Q1	82%
Q2	72%
Q3	62%
Q4	78%
EOY Average	**74%**



Summary and Key Findings/Opportunities for Improvement: For 2024, the contracted transportation vendor ended the year with an on-time performance rate of 74%, falling short of the goal that ≥92% of all transportation rides would be on-time in 2024. 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 2024 we added additional vans to the fleet in order to assist in improving performance goals. In 2025 we are exploring possible transportation subcontractors that could help with our dialysis trips with contribute to high utilization.

QI24.28: Transportation satisfaction

Goal: ≥93.6% on the Satisfaction with Transportation Services summary score on the 2024 PACE Satisfaction Survey

Goal: Unknown at this time

Data/Analysis: The 2024 Satisfaction with Transportation rate will not be available at time of this work plan review submission.

Summary and Key Findings/Opportunities for Improvement: In Summer/Fall 2024, CalOptima Health PACE once again contracted with Vital Research to conduct the annual Participant Satisfaction Survey. Vital Research interviewed our participants via telephone, to gauge the participants' satisfaction with CalOptima Health PACE services. This is a standardized survey completed by PACE organizations throughout California and the United States. Due to wildfire that occurred in Southern California in January 2025, DHCS granted Vital Research and extension in providing PACE centers with their survey. Usually provided by the end of January, the 2024 survey data will not be available until February 28th, 2025. Once the survey data is received, the PACE program will submit a supplemental document for review at the June 11th, 2025, Quality Assurance Committee meeting. We take satisfaction with services very seriously and always strive to maintain the highest level of satisfaction, addressing any concerns immediately. We will create satisfaction goals for 2025 based on the results of this survey.

Meals

QI24.29: Meal satisfaction

Goal: ≥ 71.5% on Satisfaction with Meals summary score on the 2024 PACE Satisfaction Survey

Goal: Unknown at this time

Data/Analysis: The 2024 Satisfaction with Meals rate will not be available at time of this work plan review submission.

Summary and Key Findings/Opportunities for Improvement: As noted in the previous satisfaction element, the satisfaction score is not available at time of the work plan review submission and will be submitted as a supplemental document for the June 11th, 2025, Quality Assurance Committee meeting.

Participant Overall Satisfaction

QI24.30 Improve the *overall* satisfaction of participants and their families with the CalOptima Health PACE program

Goal: Greater than or equal to 88.6% Overall Satisfaction Weighted Average on the 2024 PACE Satisfaction Survey.

Goal: Unknown at this time

Data/Analysis: The 2024 Overall Satisfaction rate will not be available at time of this work plan review submission.

Summary and Key Findings/Opportunities for Improvement: As noted in the previous satisfaction element, the satisfaction score is not available at time of the work plan review submission and will be submitted as a supplemental document for the June 11th, 2025, Quality Assurance Committee meeting.

SECTION 5: 2024 HEALTH PLAN MANAGEMENT

2024 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

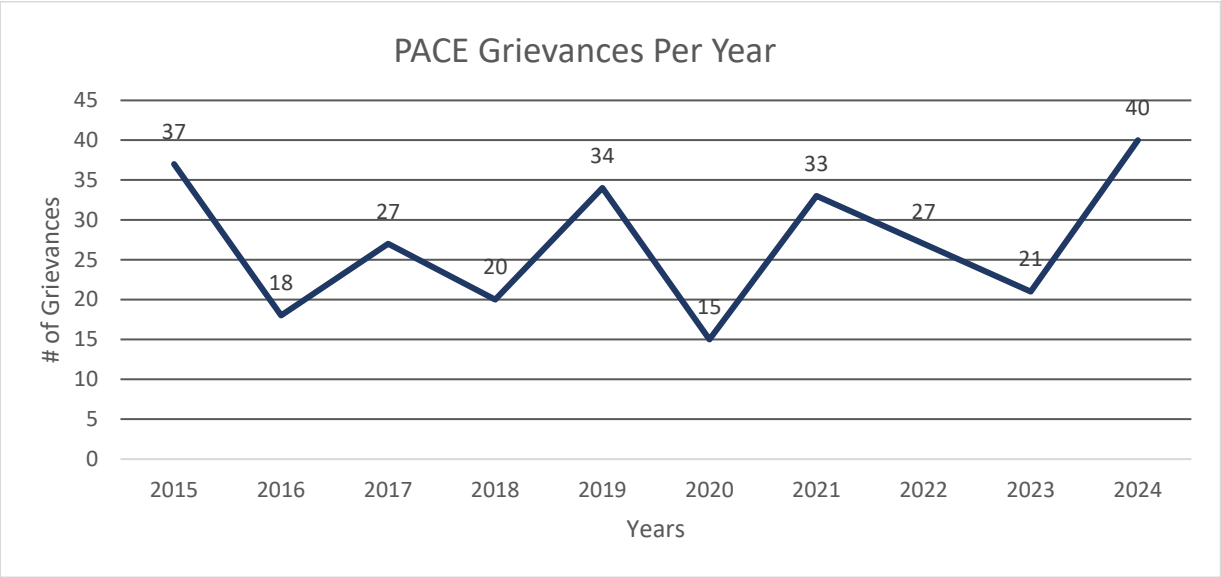
Grievances

Data Analysis:

Quarterly Grievances Q1 2024–Q4 2024

Grievance Categories							
	# Grievances	Transportation	Contracted Specialist	Medical Care	Communication	PACE Services	Contracted Facility
Q1 2024	5	2	0	0	3	0	0
Q2 2024	8	5	2	0	1	0	0
Q3 2024	16	4	3	2	2	4	1
Q4 2024	11	3	2	0	0	6	0

PACE Grievances Per Year 2015–2024



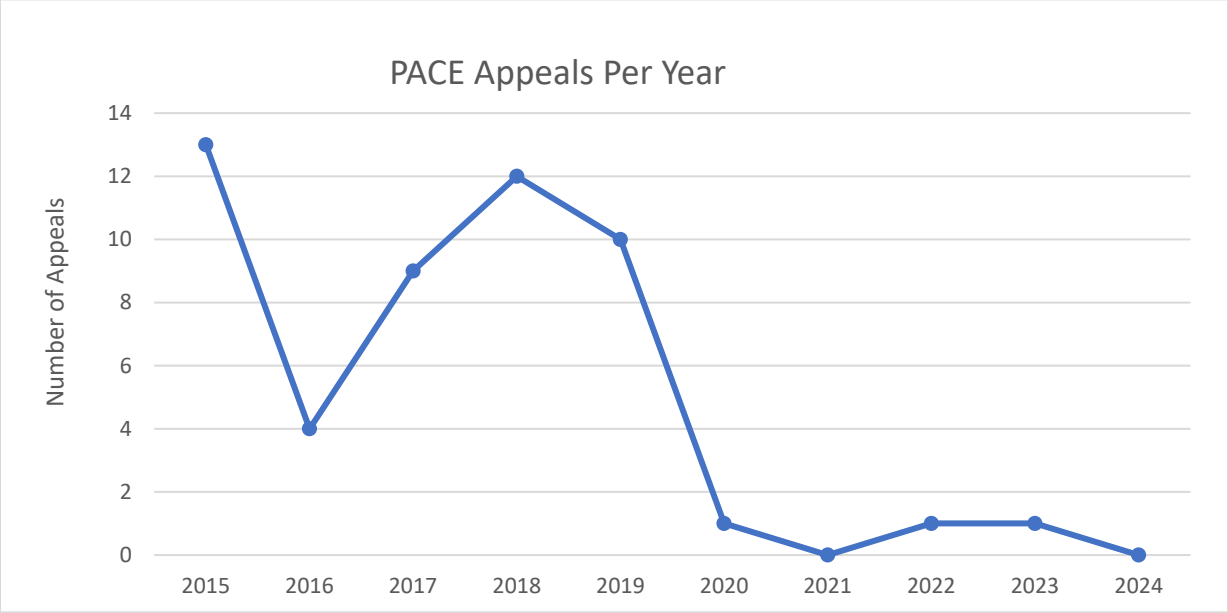
In 2024, we saw an increase in the number of grievances filed by participants. Many of the grievances that were filed were transportation related issues such as being picked up late. PACE service issues/communication related issues generally stemmed from dissatisfaction with ability to be seen by quickly 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 2015–2024

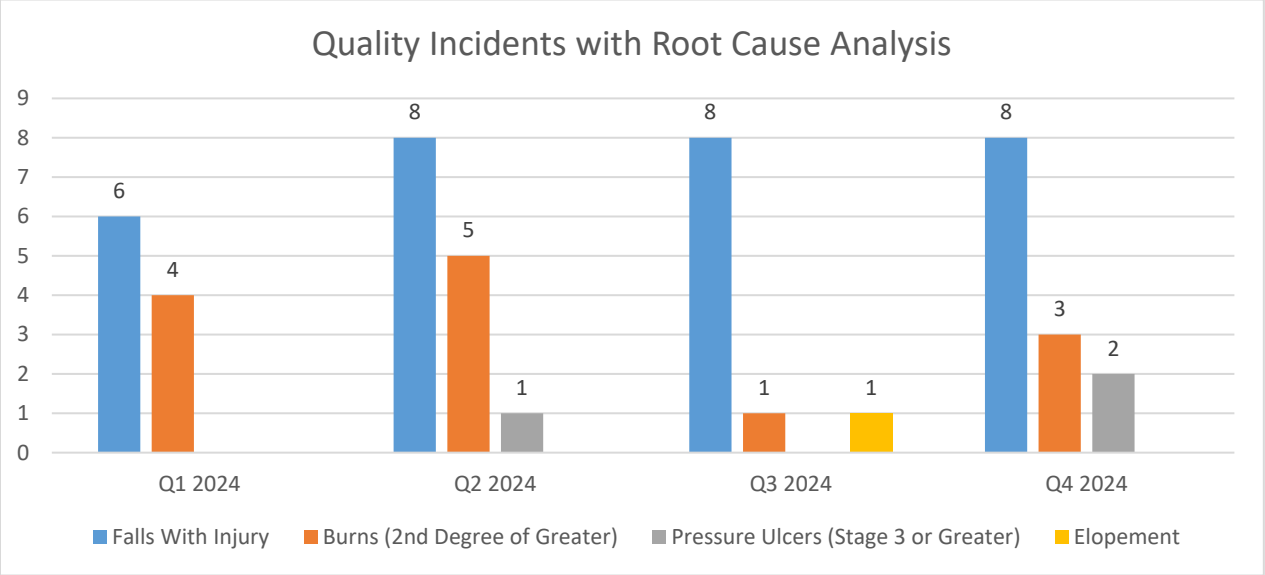


There were no PACE appeals in 2024. All participants are offered the right to appeal denials or partial denials of service determination requests (SDRs)if the IDT has determined that the participant does not need their requested item of service. Despite several denials of SDRs in 2024 and providing participant 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

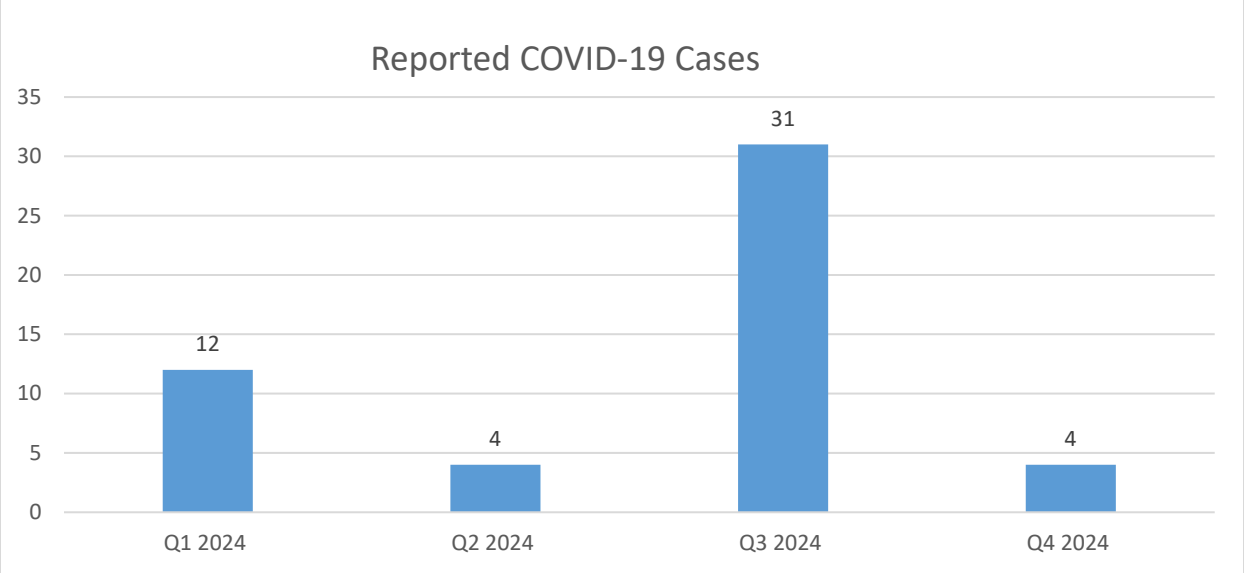
Description of Reportable Incidents: All quality incidents are monitored by the PACE QI team following PACE Quality Data Monitoring & Reporting Guidance document issued by CMS. Quality incidents including falls with injury, elopements, burns, pressure ulcers (stage III–IV, unstageable), motor vehicle 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 2024 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 continues to monitor for infectious disease outbreaks related to COVID-19 cases. Similar to what happened in 2023, In quarter 3 of 2024, we experienced a small surge in 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 2024.

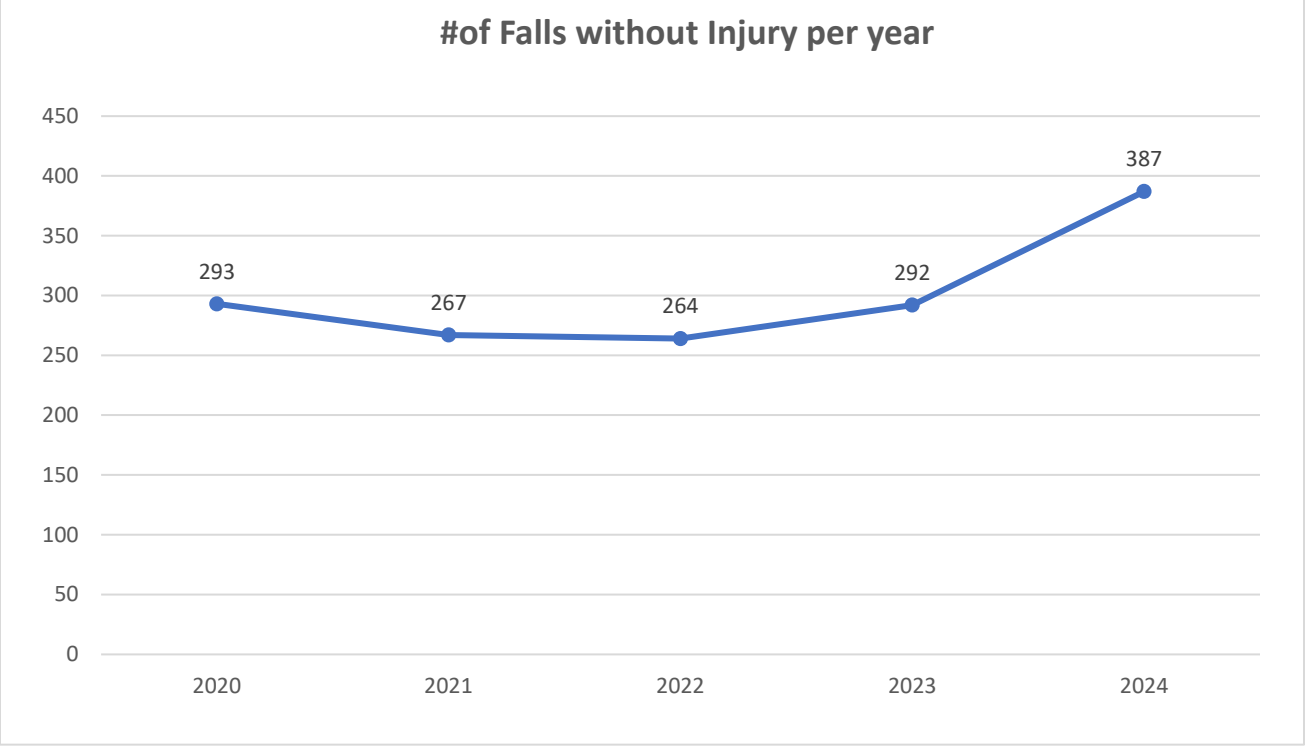


Medication Errors

A total of 2 medication errors were reported in 2024, a decrease from 2023. In Q3 there was an error in which the pharmacist ordered eye medication which was delivered and used by the wrong participant. The root cause of this error was that both participant had the same first and last name and the pharmacist failed to use an additional identifier. Pharmacist was counseled on their error, medication was reordered for correct participant and other participant was notified to stop using the eye medication that she did not need. Participant who had been incorrectly prescribed eye medication was evaluated by ophthalmologist, with no changes to vision. Another error also occurred in Q3 when an order for IV antibiotics that was supposed to be given at a dialysis center and at a skilled nursing center was not completed. The root cause of the error was a lack of communication between the provider who ordered the medication, and the medical case manager RN assigned to ensure the order was carried out, as well as the medical case manager not coordinating the infusion as assigned or ensuring the order had been completed. Due to this, the medication was given one week late. Neither of these medication errors resulted in any injury to participants.

Falls Without Injury

Data Analysis**:**



In 2024, we saw an increase in falls without injury from the 2023 figures. The reasons for this may be related to an increase in census as well as an increase in reports of multiple falls from the same participants. PACE records and investigates all reported fall, 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 2024, 7 total prospective enrollees were denied enrollment to CalOptima Health PACE. In 6 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 2024, we focused on our Quality Initiatives to improve the participant 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 status of PACE Quality Initiatives is presented to the PQIC on a quarterly basis. The program's three quality initiatives for 2024 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 ≥ 70% of participants having a completed AHCD in 2024. In order to improve the process of completing AHCDs, PACE had two staff members trained and certified to become Notary Publics. We ended 2024 with 36% of participants having a scanned AHCD in their medical record, not meeting out goal. Some challenged 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 2025 we will be changing our goal to reflect a more realistic ≥ 55%. 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 complete paperwork, which will make it easier to get completed.

- 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 2024. This goal was not met in Q2, but was met in Q1, Q3, and Q4. There total of 4 dental related grievance reported throughout 2024. We will wait to review the 2024 I-SAT survey results before deciding whether to continue this initiative into 2025. All grievances regarding dental care will be addressed immediately following regulations.

- 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 2024. 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 and Q4, however we had 4 valid grievances each in Q2 and Q3, not meeting our goal in those quarters. 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 2025.

SECTION 7: OPPORTUNITIES FOR IMPROVEMENT IN 2024

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.
   b. Participants receiving more than an average opioid dose of 90 MME or greater will continue to be closely monitored.
3. **Ensure the Appropriate Use of Resources**
   a. Inpatient/ER 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 ER and 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, and potential opening of additional sites will be completed in 2025.

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 over the past 11 years. 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: 2024 PACE QI EVALUATION

2024 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	Met/Not Met
QI24.01	Improve the Quality of Care for Participants	2023 PACE QAPI Plan and Work Plan Annual Evaluation	2023 PACE QAPI Plan will be evaluated by CalOptima Health Quality Assurance Committee in March 2024	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/13/2024	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Met
QI24.02	Improve the Quality of Care for Participants	2024 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 2024	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/13/2024	PACE Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Met
QI24.03	Improve the Quality of Care for Participants	Influenza Immunization Rates	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 2024	Improve compliance with influenza immunization recommendations (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Q1, Q3 and Q4 2024	12/31/2024	PACE Medical Director	91.0%	Not Met	N/A	N/A	60.0%	Not Met	91.0%	Not Met	91.0%	Not Met
QI24.04	Improve the Quality of Care for Participants	Pneumococcal Immunization Rates	≥94% of eligible participants will have completed their pneumococcal vaccination by December 31st, 2024	Improve compliance with pneumococcal immunization recommendations (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director	92.7%	Not Met	91.9%	Not Met	92.3%	Not Met	93.4%	Not Met	93.4%	Not Met
QI24.05	Improve Quality of Care for Participants	COVID-19 Immunization Rates	≥ 50% of eligible participants will receive the latest CDC recommended COVID-19 vaccine by December 31st, 2024	Improve compliance with current COVID-19 immunization recommendations (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director	54.1%	Met	56%	Met	57%	Met	57%	Met	56.6%	Met
QI24.06	Improve Quality of Care for Participants	Colorectal Cancer Screening	>65% of eligible participants will have had a screening for colorectal cancer by December 31st, 2024 (Comparable to the 2022 MEDICARE Quality Compass HEDIS 37.84th 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 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director	54%	Not Met	64%	Not Met	65.3%	Met	72.5%	Met	72.5%	Met
QI24.07	Improve Quality of Care for Participants	Breast Cancer Screening	>52.50% of eligible participants will have a screening for breast cancer by December 31st, 2024 (Comparable to the 2022 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 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director	78%	Not Met	81.72%	Not Met	86.9%	Met	86.7%	Met	86.7%	Met
QI24.08	Improve the Quality of Care for Participants	Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment	≥95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed	Ensure all PACE members are offered the opportunity to complete a POLST upon enrollment and every six months until they have one completed. In order to improve POLST utilization (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Clinical Operations Manager and PACE Medical Director	98%	Met	98%	Met	99%	Met	99.8%	Met	98.6%	Met
QI24.09	Improve the Quality of Care for Participants	Controlling High Blood Pressure	> 82.98% of participants with Hypertensionand/or Diabetes will have their blood pressure controlled (Comparable to the 2022 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 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director	87%	Met	86%	Met	87%	Met	81%	Not Met	85%	Met
QI24.10	Improve the Quality of Care for Participants	Diabetic Eye Care	> 87.29% of Diabetic participants will have an Annual Eye Exam (Comparable to the 2022 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 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director	87.57%	Met	89%	Met	87.15%	Not Met	91.26%	Met	91.26%	Met
QI24.11	Improve the Quality of Care for Participants	Diabetic Blood Sugar Control	<11.78% of Diabetic participants will have an HbA1c measurement of >9% (Comparable to the 2022 MEDICARE Quality Compass HEDIS 90th 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 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director	16%	Not Met	16%	Not Met	14%	Not Met	11%	Met	11%	Met
QI24.12	Improve the Quality of Care for Participants	Osteoporosis	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 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director	79%	Met	85%	Met	88%	Met	90%	Met	86%	Met
QI24.13	Ensure the Safety of Participants	Reduce Percentage of Falls Reported by PACE Enrollees	<72 falls reported per quarter in 2024	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 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Center Manager	84	Not Met	133	Not Met	94	Not Met	99	Not Met	103	Not Met
QI24.14	Improve the Quality of Care for Participants	Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	<25% (Comparable to the 2022 MEDICARE Quality Compass HEDIS 90th percentile)	PACE participants with a diagnosis of Dementia will be monitored by their Primary Care Providers and Clinic Pharmacists to ensure they are not prescribed medications that may cause harm (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director	15%	Met	17%	Met	17%	Met	23%	Met	18%	Met
QI24.15	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 2024.	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 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director	100%	Met	100%	Met	100%	Met	100%	Met	100%	Met
QI24.16	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 2024	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	12/31/2024	PACE Pharmacist	100%	Met	100%	Met	94%	Met	100%	Met	99%	Met
QI24.17	Ensure Appropriate Access and Availability	Improve Access to Specialty Care	≥90% of specialty care authorizations will be scheduled within 14 calendar days in 2023	Appointments for specialty care will be scheduled within 14 calendar days to improve access to specialty care	Quarterly	12/31/2024	PACE Clinical Operations Manager	91%	Met	85%	Not Met	89%	Not Met	94%	Met	90%	Met
QI24.18	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 2024.	Eligible participants will be scheduled for day center services to be provided by one of our contracted ACS (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Center Manager and PACE Program Manager for Community Based Services	2%	Not Met	4.1%	Not Met	3.8%	Not Met	3.8%	Not Met	4.0%	Not Met
QI24.19	Ensure Appropriate Use of Resources	Reduce Acute Hospital Day Utilization	<3,330 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 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director	2358	Met	2302	Met	2173	Met	2262	Met	2262	Met
QI24.20	Ensure Appropriate Use of Resources	Reduce Emergency Room Utilization	>825 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	12/31/2024	PACE Medical Director	789	Met	803	Met	816	Met	797	Met	797	Met
QI24.21	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 2024 PACE Quality Improvement Plan Description)	Quarterly	12/31/2024	PACE Medical Director	16%	Not Met	21%	Not Met	21%	Not Met	14.6%	Not Met	18.7%	Not Met
QI24.22	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	01/00/1900	PACE Center Manager	0%	Met	0%	Met	0%	Met	0.1%	Met	0.02%	Met
QI24.23	Improve Participant Experience	Enrollment/Disenrollment	The Qualified Lead-to-Enrollment conversion rate will be 70% in 20	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement	Quarterly	12/31/2024	PACE Marketing and Enrollment Manager	84%	Met	78%	Met	56%	Not Met	68%	Not Met	71%	Met
QI24.24	Improve Participant Experience	Enrollment/Disenrollment	The percentage of participants who disenroll for controllable reasons from the PACE program within the first 90 days of enrollment will be less than 6%	Review and analyze the participants who disenrolled from PACE within 90 days of enrollment (for controllable reasons) to develop strategies for improvement	Quarterly	12/31/2024	PACE Marketing and Enrollment Manager	5.56%	Met	15.38%	Not Met	6.67%	Not Met	0.00%	Met	7.14%	Not Met
QI24.25	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 2024.	Quarterly	12/31/2024	PACE Center Manager and PACE Director	3.88%	Met	5.26%	Met	5.96%	Met	4.81%	Met	5.00%	Met
QI24.26	Improve Participant Experience	Transportation Performance	100% of transportation trips will be less than 60 minutes in 2024.	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	12/31/2024	PACE Center Manager	97%	Not Met	97%	Not Met	98%	Not Met	99.9%	Not Met	98%	Not Met

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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	Met/Not Met
QI24.27	Improve Participant Experience	Transportation Performance	≥82% of all transportation rides will be on time in 2024	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	12/31/2024	PACE Center Manager	82%	Not Met	72%	Not Met	62%	Not Met	78%	Not Met	74%	Not Met
QI24.28	Improve Participant Experience	Transportation Satisfaction	≥83.6% Satisfaction with Transportation Services (2023 PACE National Average) on the 2024 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	12/31/2024	PACE Center Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
QI24.29	Improve Participant Experience	Participant Satisfaction with Meals	≥71.5% Satisfaction with Meals (2023 PACE National Average) on the 2024 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	12/31/2024	PACE Center Manager	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
QI24.30	Improve Participant Experience	Overall Participant Satisfaction	≥88.6% on the Overall Satisfaction-Weighted Average(2023 PACE National Average) on the 2024 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	12/31/2024	PACE Director	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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2024 PACE Quality Work Plan Evaluation

Quality Assurance Committee Meeting

March 12, 2025

Dr. Donna Frisch, PACE Medical 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.

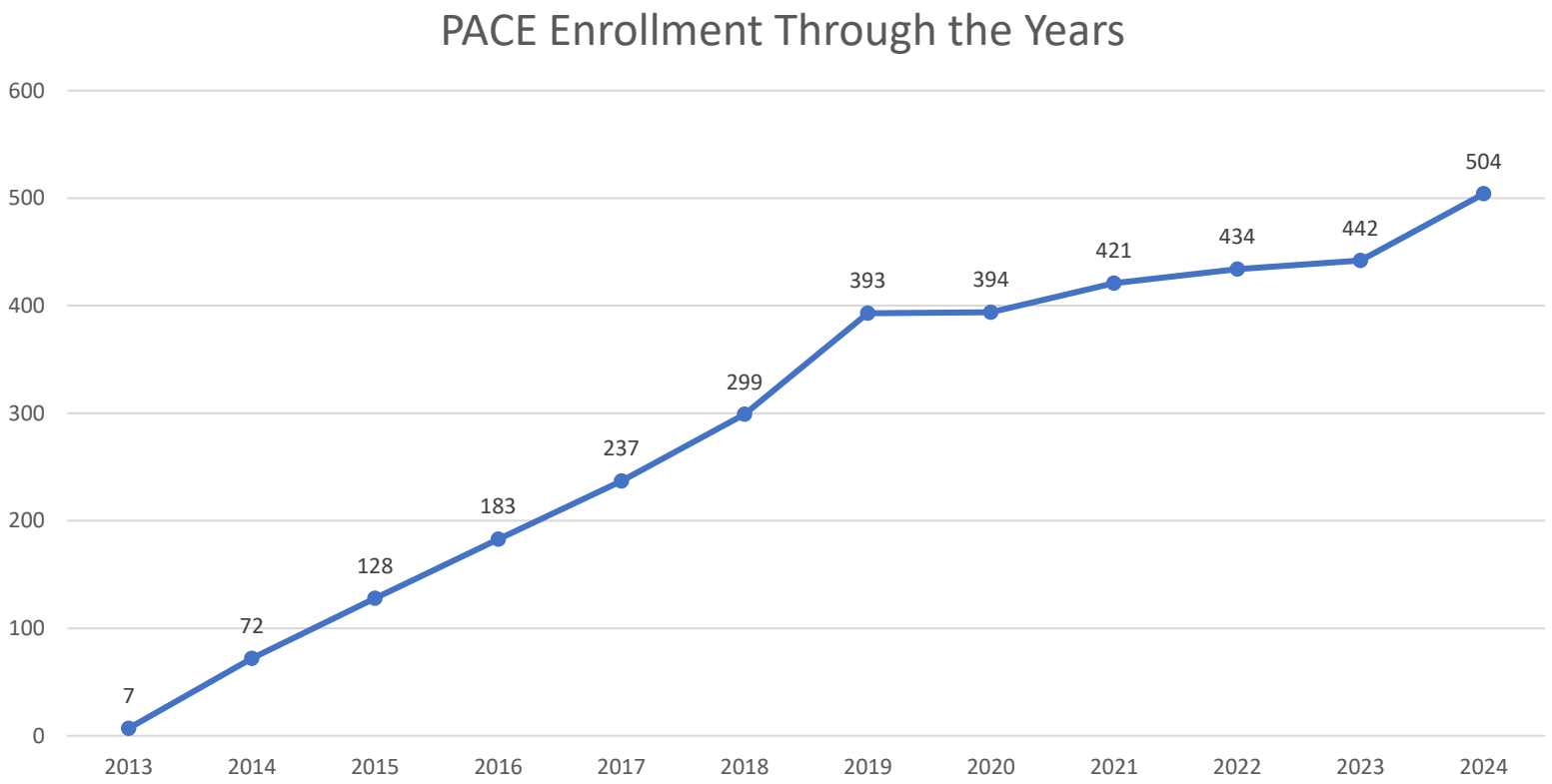
2024 PACE Accomplishments

- Milestone enrollment number of 500 enrolled participants
- 91% Influenza immunization rate by Q4 2024
- 93.4% Pneumococcal immunization rate by Q4 2024
- 98.6% of participants had a Physician's Order for Life-sustaining Treatment (POLST) completed
- Distributed 13,906 home delivered meals throughout 2024.

2024 PACE Accomplishments, Cont.

- New PACE quality work plan elements introduced in 2024
  - Colon Cancer Screening
    - Goal: > 65% of eligible participants will have had a screening for colorectal cancer by December 31st, 2024
    - **Goal was met by Q3 2024**
  - Breast Cancer Screening
    - Goal: >82.56% of eligible participants will have a screening for breast cancer by December 31st, 2024
    - **Goal was met by Q3 2024**
  - Diabetic Blood Sugar Control
    - Goal: <11.78% of Diabetic participants will have an HbA1c measurement of >9%
    - **Goal was met by Q4 2024**

CalOptima Health PACE Membership Growth 2013-2024



2024 saw PACE's highest number of active enrollees since opening in 2013. We reached a landmark number of 504 PACE enrollees by December 31st 2024.

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CalOptima Health

Workplan Element 10: Comprehensive Diabetes Care

Goal: > 87.29% of Diabetic participants will have an Annual Eye Exam (Comparable to the 2022 MEDICARE Quality Compass HEDIS 95th percentile)

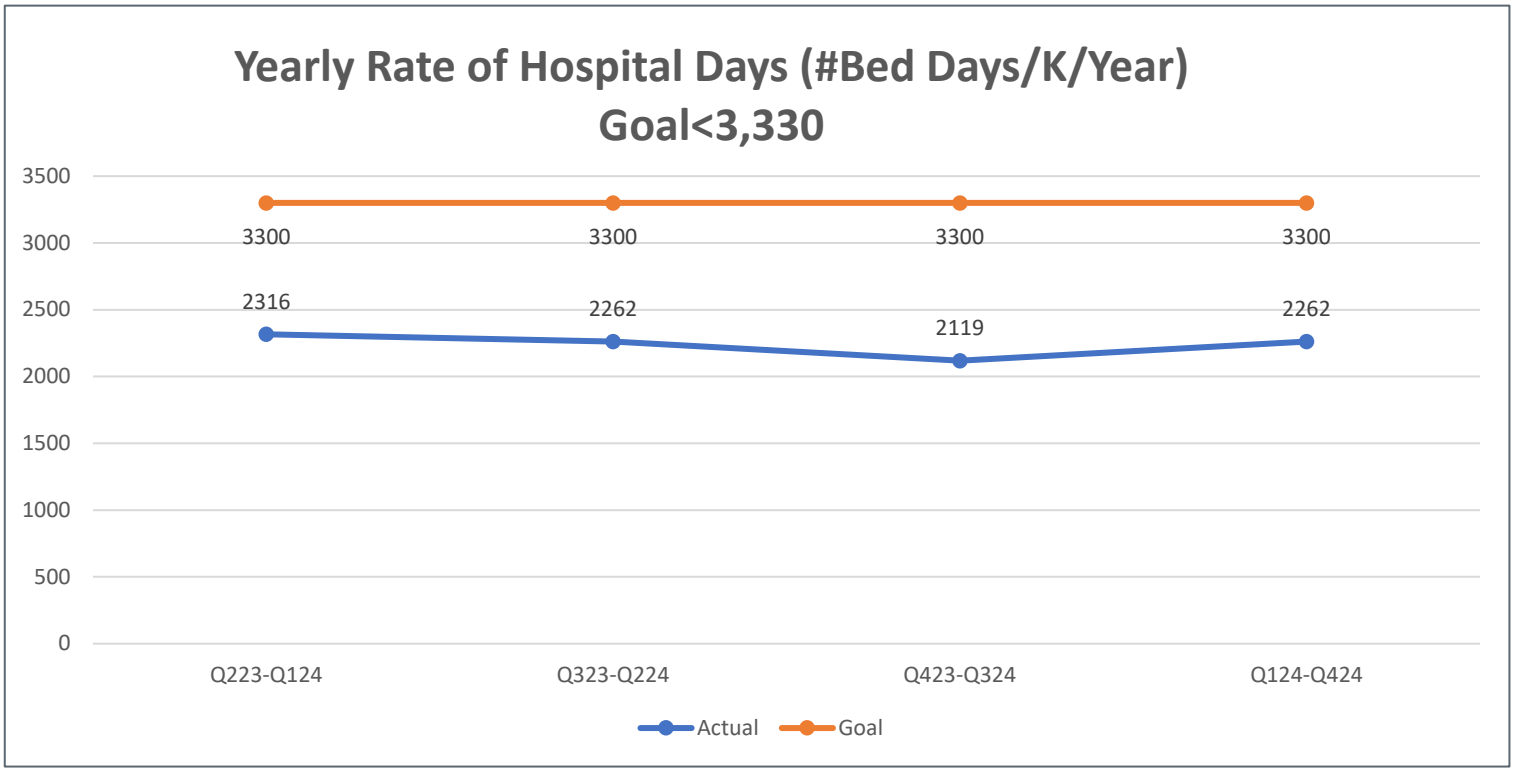
Higher Is Better		**Medicare Quality Compass 2022 HEDIS Percentiles**			
Domain	**2024 PACE Rate**	50th Percentile	75th Percentile	90th Percentile	**95th Percentile (PACE Goal)**
Annual Diabetic Eye Exams	**91.26%**	73.48%	79.81%	84.23%	**87.29%**

Workplan Element 14: Potential Harmful Drug/Disease Interactions in the Elderly

Goal: <25% of elderly PACE participants with Dementia will be prescribed a potentially harmful tricyclic antidepressant or anticholinergic agent. (Goal in line with Medicare Quality Compass HEDIS 95th percentile).

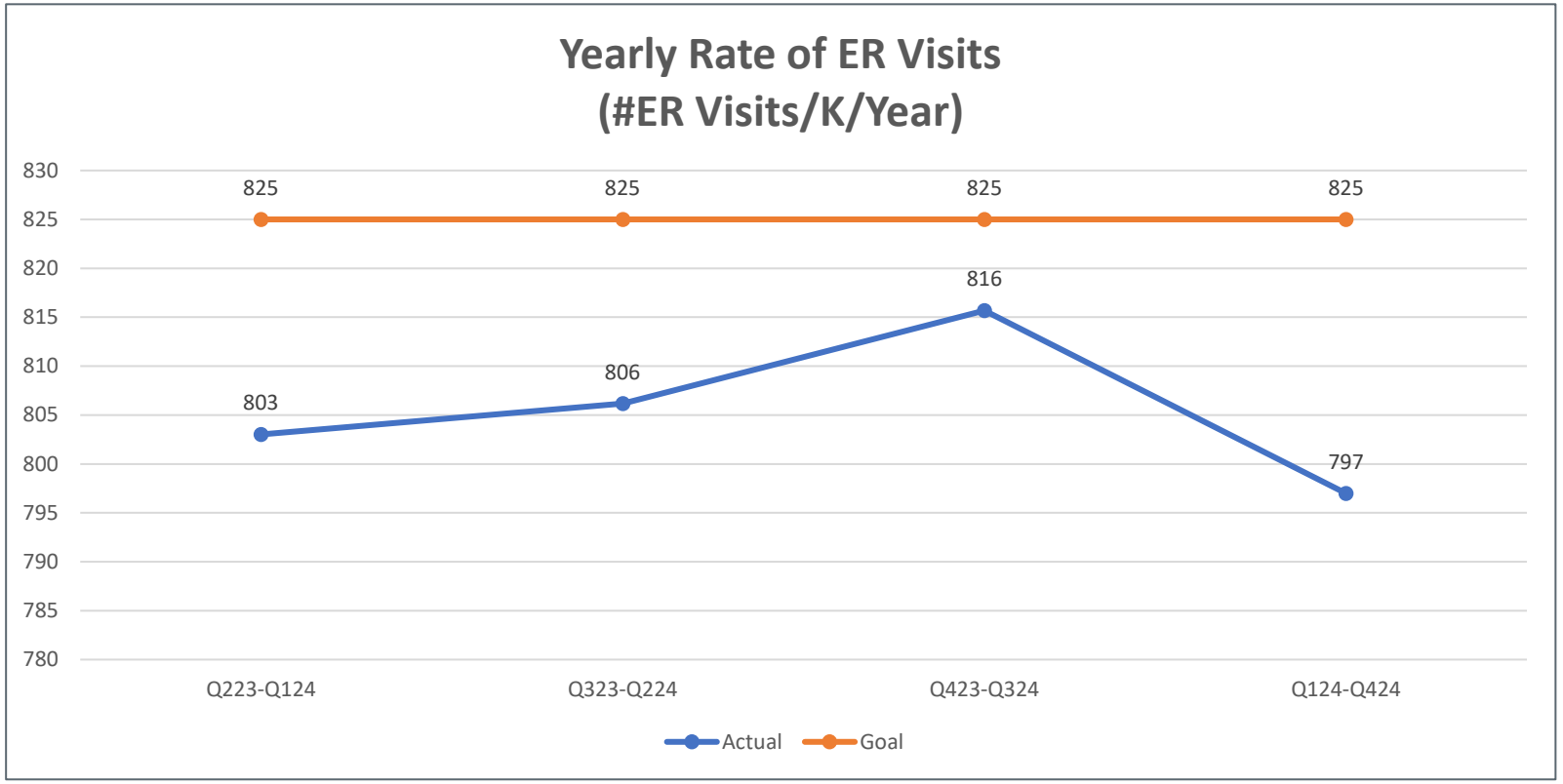
Lower Is Better		**Medicare Quality Compass 2022 HEDIS Percentiles**			
Domain	**2024 PACE Rate**	50th Percentile	75th Percentile	90th Percentile	**95th Percentile (PACE Goal)**
Dementia + Tricyclic Antidepressants or anticholinergic Agents	**18%**	<34.50%	<33.08%	<28.31%	**<25%**

Element 19: Hospital Utilization



Hospital Utilization Goals met in 2024

Element 20: ER Utilization Reduction



ER Utilization Goals met in 2024

Opportunities for Improvement in 2025

- Improve the Quality of Care for Participants
  - Updating all pneumococcal, COVID and influenza vaccine processes to always follow the latest CDC recommendations.
  - Raising the goal for our cancer screening elements for breast and colorectal cancer.
  - Raising the goals for diabetic eye exams.
  - Raising the goal for blood pressure monitoring element.

Opportunities for Improvement in 2024 (Cont.)

- Ensure the Safety of Participants and Clinical Care
  - Continuing efforts to reduce falls at home including home assessment review for repeat fallers and the reintroduction of the quarterly PACE fall committee in 2024.
  - Participants receiving more than an average MME dose of 90 MME will continue to be closely monitored.

- Ensure Appropriate Access and Availability
  - Improving utilization of our PACE Alternative Care Setting (ACS) sites, and potential opening of additional sites will be completed in 2025.

Opportunities for Improvement in 2024 (Cont.)

- Ensure the Appropriate Use of Resources
  - Inpatient/ER Utilization
    - Further expansion of our complex case management program with individualized interventions with a focus on high-risk participants.
    - 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.
    - Adjusting our goals for ER and Hospitalization to continue to reduce the number of visits.
  - Specialty Care
    - 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.
    - Adjusting our timeline goals for scheduling to improve timeliness of specialty appointments.

Opportunities for Improvement in 2024 (Cont.)

- Improve Participant Experience
  - Grievances and potential quality issues monitoring and thorough analysis. Use of transportation logs to resolve participant minor transportation issues immediately as they are reported.
  - Exploring the potential use of more frequent in-house meal satisfaction surveys and make refinements to our meal program based on that feedback.
  - 2024 survey data will be reviewed (once available) and quality metrics will focus on areas the PQIC determine to need additional review and development based on those survey results.

Questions?

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CALOPTIMA HEALTH PROGRAM ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) QUALITY IMPROVEMENT PLAN DESCRIPTION

20254

PACE Quality Improvement Subcommittee Chairperson:

Donna Frisch, M.D. **Date**
Medical Director, PACE

Board of Directors' Quality Assurance Committee Chairperson:

Jose Mayorga, M.D. ~~**Tricu Thanh Tran, M.D.**~~
~~—~~**Date**

Board of Directors Chairperson:

Isabel Becerra~~**Clayton Corwin**~~ **Date**

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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.
- The CalOptima Health PQIC completes an annual evaluation of the data collected throughout the year. This evaluation and analysis helps 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.

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 its activities to QIC, QAC, and the Board. The ~~PACE Clinical Medical Director,~~ PACE Program Director or PACE QI Manager may facilitate the meeting in the PACE Medical Director's absence. The ~~PACE Clinical Medical Director,~~ 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 Clinical Medical Director,~~ PACE Center Manager, PACE Clinical Operations Manager, PACE QI ~~Manager, PACE~~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 ~~administrative~~ 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 Clinical Medical Director,~~ PACE QI Manager, PACE Program Director, PACE Center Manager, PACE Clinical Operations Manager, PACE QI Program Specialist(s), PACE Marketing and ~~Intake/~~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 ~~or~~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.

20254 Committee Organization Structure — Diagram

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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 ~~the~~ 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.
- 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 ~~both~~ the PACE leadership staff. ~~and QAC~~.
- 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 90 days *for controllable reasons*.
- PACE will monitor attrition rate to identify any need for operational improvement to strategically support continued growth in 20254.

Clinically Relevant Data- Quality Workplan Elements

- Clinical measures from the 20254 QI Work Plan elements which include:
    - Influenza Immunizations Rates
        - Exclusion criteria:
            - Participants who have dx of Palliative Care Approach, ICD-10 Z515
            - Participants with diagnosis of Guillain Barre, ICD-10: G61.0
            - Participants who are allergic to Influenza vaccine
    - Pneumococcal Immunizations Rates
        - Exclusion criteria:
            - Participants who enroll in the program in December 20254
            - Participants who have dx of Palliative Care Approach, ICD-10 Z515
            - Participants who are allergic to Pneumococcal vaccine
    - ~~COVID-19 Immunization Rates~~
        - ~~Exclusion criteria:~~
            - ~~Participants who enroll in the program in December 2024~~
    - Colon Cancer Screening
        - Inclusion criteria:
            - Participants enrolled for at least six months ~~during measurement year (For Q1 2024, look at October 1, 2023, or earlier)~~
        - Exclusion criteria
            - Participants who are 76 years and older as of December 31, 20254
            - 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 ~~during measurement year (For Q1 2024, look at October 1, 2023, or earlier)~~
        - Exclusion criteria
            - Participants who are 76 years and older as of December 31, 20254
            - 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

- ~~Advance Health Care Planning: POLST Completion~~
  - ~~Exclusion criteria:~~
    - ~~Participants who have been enrolled <6 months.~~
- 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 ~~during measurement year (For Q1 2024, look at October 1 2023 or earlier)~~
  - Exclusion criteria:
    - Participants who are 76 years and older as of December 31, 2025~~4~~
    - 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 ~~during measurement year (For Q1 2024, look at October 1 2023 or earlier)~~
  - Exclusion criteria:
    - Participants who have dx of Palliative Care Approach, ICD-10 Z515
    - Participants who are 76 years and older as of December 31, 2025~~4~~
    - Participants who are legally blind in both eyes.
- Diabetes Care: HbA1c Control for Diabetics
  - Inclusion criteria:
    - Diagnosis of Diabetes Mellitus
    - Enrolled for at least six months ~~during measurement year (For Q1 2024, look at October 1, 2023, or earlier)~~
  - Exclusion criteria:
    - Participants who are 76 years and older as of December 31, 2025~~4~~
    - Participants who have dx of Palliative Care Approach (ICD-10 Z515)
    - Participants who have a dx of Frailty (ICD-10 code R54)
- Monitoring Participants for Osteoporosis
  - Inclusion criteria
    - Women over 65 years old~~All Diabetic participants, as well as Non-diabetic Women aged 55-85, and Non-diabetic Men aged 70-85.~~
    - Enrolled for at least six months ~~during measurement year (For Q1 2024, look at October 1, 2023, or earlier)~~
  - 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).

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        - Participants who report more than 3 falls in one quarter
    - ~~Potentially Harmful Drug-Disease Interactions in the Elderly: Dementia plus a tricyclic antidepressant or anticholinergic agent~~
        - ~~Inclusion criteria:~~
            - ~~Diagnosis of Dementia~~
            - ~~Continuous enrollment throughout year (enrolled for at least a year) (For Q1 2024, Look at enrollment from 3/1/23 and before)~~
            - ~~Participants who are 66 years and older as of December 31, 2023~~
        - ~~Exclusion criteria:~~
            - ~~Participants who have dx of Palliative Care Approach, ICD-10 Z515~~
            - ~~Participants with Schizophrenia or bipolar disorder~~
    - Monitoring of Risks from High Dosage Opioid Use
        - 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 Post Discharge from hospital or SNF.
    - Access to Specialty Care services.

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 on any corrective actions that may be implemented. Participants and caregivers will be informed of the results of the investigations and will be

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assisted with furtherment of the process as needed. Results will also be reported to the 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 t~~T~~he PACE QI manager and ~~as well as~~ either the PACE Director or the PACE Medical Director. The results ~~and~~ 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 20254, including a goal that 105% of all eligible PACE Enrollees will utilize day center services at one of the PACE ACS sites by the end of 20254.
- 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 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. ~~in our center~~.
- 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 2025~~4~~ 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~~70~~% of participants having a completed AHCD by the end of 2025~~4~~.
        - Exclusions:
            - Participants with MMSE <16. OR
            - Participants with MMSE 16 or >, but who have a capacity letter scanned into chart (new exclusion for 2025).
    - COVID 19 Immunization
        - This initiative will focus on increasing the number of PACE participants

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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.
  -

- ~~Dental Satisfaction~~
  - ~~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 2024.~~
- ~~Transportation Satisfaction~~
  - ~~This initiative will focus on reducing the number of PACE participants who have been dissatisfied with contracted transportation services, as identified by transportation grievances. The PACE leadership team has created a plan to be implemented by the PACE Center manager to utilize the transportation logs and to follow up with participants to assess their satisfaction and to identify any areas of concern or miscommunication regarding provision of services. The goal will be for PACE to have ≤ 3 transportation related grievance per quarter in 2024.~~

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)

20254 CalOptima PACE Quality Improvement (QI) Work Plan

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI245.01	Improve the Quality of Care for Participants	20234 PACE QAPI Plan and Work Plan Annual Evaluation	20234 PACE QAPI Plan will be evaluated by CalOptima Health Quality Assurance Committee in March 20245	PACE QAPI Plan and Work Plan will be evaluated for effectiveness on an annual basis	Annually	3/123/20254	PACE Medical Director
QI245.02	Improve the Quality of Care for Participants	20245 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 20245	QI Plan and QI Work Plan will be approved and adopted on an annual basis	Annually	3/123/20254	PACE Medical Director
QI245.03	Improve the Quality of Care for Participants	Influenza Immunization Rates	≥94% of eligible participants will have their annual influenza vaccination by December 31st, 20245	Improve compliance with influenza immunization recommendations (Exclusions defined within the 20245 PACE Quality Improvement Plan Description)	Q1, Q3 and Q4 20254	12/31/20254	PACE Medical Director
QI245.04	Improve the Quality of Care for Participants	Pneumococcal Immunization Rates	≥94% of eligible participants will have completed their pneumococcal vaccination by December 31st, 20245	Improve compliance with pneumococcal immunization recommendations (Exclusions defined within the 20245 PACE Quality Improvement Plan Description)	Quarterly	12/31/20254	PACE Medical Director
~~QI24.05~~	~~Improve Quality of Care for Participants~~	~~COVID-19 Immunization Rates~~	~~≥ 50% of eligible participants will receive the latest CDC recommended COVID-19 vaccine by December 31st, 2024~~	~~Improve compliance with current COVID-19 immunization recommendations (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)~~	~~Quarterly~~	~~12/31/2024~~	~~PACE Medical Director~~
QI245.056	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, 20245 (Comparable to the 20223 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 20245 PACE Quality Improvement Plan Description)	Quarterly	12/31/20254	PACE Medical Director
QI245.076	Improve Quality of Care for Participants	Breast Cancer Screening	>82.5680% of eligible participants will have a screening for breast cancer by December 31st, 20245 (Comparable to the 20223 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 20245 PACE Quality Improvement Plan Description)	Quarterly	12/31/20254	PACE Medical Director
~~QI24.08~~	~~Improve the Quality of Care for Participants~~	~~Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment~~	~~≥95% of participants who have been enrolled in the PACE program for 6 months will have a POLST completed~~	~~Ensure all PACE members are offered the opportunity to complete a POLST upon enrollment and every six months until they have one completed, in order to improve POLST utilization (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)~~	~~Quarterly~~	~~12/31/2024~~	~~PACE Clinical Operations Manager and PACE Medical Director~~
QI245.097	Improve the Quality of Care for Participants	Controlling High Blood Pressure	> 82.98-85.60% of participants with Hypertension *and/or* Diabetes will have their blood pressure controlled (Comparable to the 20223 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 20245 PACE Quality Improvement Plan Description)	Quarterly	12/31/20254	PACE Medical Director
QI245.108	Improve the Quality of Care for Participants	Diabetic Eye Care	> 87.29-88.08% of Diabetic participants will have an Annual Eye Exam (Comparable to the 20223 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 20245 PACE Quality Improvement Plan Description)	Quarterly	12/31/20254	PACE Medical Director

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI2~~45.119~~	**Improve the Quality of Care for Participants**	**Diabetic Blood Sugar Control**	<12.24 ~~11.78~~% of Diabetic participants will have an HbA1c measurement of >9% (Comparable to the 202~~3~~3 MEDICARE Quality Compass HEDIS ~~9~~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 2024~~5~~5 PACE Quality Improvement Plan Description)	Quarterly	12/31/2025~~4~~4	PACE Medical Director
QI2~~45.102~~	**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 2024~~5~~5 PACE Quality Improvement Plan Description)	Quarterly	12/31/2025~~4~~4	PACE Medical Director
QI2~~45.113~~	**Ensure the Safety of Participants**	**Reduce Percentage of Falls Reported by PACE Enrollees**	<72 falls reported per quarter in 2024~~5~~5	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 2024~~5~~5 PACE Quality Improvement Plan Description)	Quarterly	12/31/2025~~4~~4	PACE Center Manager
~~QI24.14~~	~~**Improve the Quality of Care for Participants**~~	~~**Reduce Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents**~~	~~<25% (Comparable to the 2022 MEDICARE Quality Compass HEDIS 95th percentile)~~	~~PACE participants with a diagnosis of Dementia will be monitored by their Primary Care Providers and Clinic Pharmacists to ensure they are not prescribed medications that may cause harm. (Exclusions defined within the 2024 PACE Quality Improvement Plan Description)~~	~~Quarterly~~	~~12/31/2024~~	~~PACE Medical Director~~
QI2~~45.125~~	**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 2024~~5~~5.	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 2024~~5~~5 PACE Quality Improvement Plan Description)	Quarterly	12/31/2025~~4~~4	PACE Medical Director
QI2~~45.136~~	**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 2024~~5~~5	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~~4~~4	PACE Pharmacist and PACE Clinical Operations Manager
QI2~~45.147~~	**Ensure Appropriate Access and Availability**	**Improve Access to Specialty Care**	100 ~~≥90~~% of specialty care authorizations will be scheduled within 7 ~~14~~ calendar days in 2024~~5~~5	Appointments for specialty care will be scheduled within 7 ~~14~~ calendar days to improve access to specialty care	Quarterly	12/31/2025~~4~~4	PACE Clinical Operations Manager
QI2~~45.158~~	**Ensure Appropriate Access and Availability**	**Improve Utilization of PACE Alternative Care Settings (ACS)**	≥1~~0~~5% of all eligible PACE Enrollees will utilize day center services at one of the PACE Alternative Care Settings by end of 2024.	Eligible participants will be scheduled for day center services to be provided by one of our contracted ACS (Exclusions defined within the 2024~~5~~5 PACE Quality Improvement Plan Description)	Quarterly	12/31/2025~~4~~4	PACE Center Manager and PACE Program Manager for Community Based Services

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
QI245.169	Ensure Appropriate Use of Resources	**Reduce Acute Hospital Day Utilization**	<3,33000 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 20245 PACE Quality Improvement Plan Description)	Quarterly	12/31/20254	PACE Medical Director
QI245.1720	Ensure Appropriate Use of Resources	**Reduce Emergency Room Utilization**	<8205 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	12/31/20254	PACE Medical Director
QI245.1821	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 20245 PACE Quality Improvement Plan Description)	Quarterly	12/31/20254	PACE Medical Director
QI245.1922	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	12/31/20254	PACE Medical Director and PACE Center Manager
QI245.2023	Improve Participant Experience	**Enrollment/Disenrollment**	The Qualified Lead-to-Enrollment conversion rate will be 70% in 20245	Review and analyze the Qualified Lead to Enrollment conversion rate and develop strategies for improvement	Quarterly	12/31/20254	PACE Marketing and Enrollment Manager
QI245.214	Improve Participant Experience	**Enrollment/Disenrollment**	The percentage of participants who disenroll for controllable reasons from the PACE program within the first 3 months 90 days of enrollment will be less than 6%	Review and analyze the participants who disenrolled from PACE within 3 months 90 days of enrollment (for controllable reasons) to develop strategies for improvement	Quarterly	12/31/20254	PACE Marketing and Enrollment Manager and PACE Center Manager
QI245.226	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 20245.	Quarterly	12/31/20254	PACE Center Manager and PACE Director
QI245.236	Improve Participant Experience	**Transportation Performance**	100% of transportation trips will be less than 60 minutes in 20245	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	12/31/20254	PACE Center Manager
QI245.247	Improve Participant Experience	**Transportation Performance**	≥92% of all transportation rides will be on-time in 20245	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	12/31/20254	PACE Center Manager

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
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	12/31/2025	PACE Center Manager and PACE Director
~~QI24.28~~	~~Improve Participant Experience~~	~~Transportation Satisfaction~~	~~≥93.6% Satisfaction with Transportation Services (2023 PACE National Average) on the 2024 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~~	~~12/31/20254~~	~~PACE Center Manager~~
~~QI24.29~~	~~Improve Participant Experience~~	~~Participant Satisfaction with Meals~~	~~≥71.5% Satisfaction with Meals (2023 PACE National Average) on the 2024 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~~	~~12/31/20254~~	~~PACE Center Manager~~
~~QI24.30~~	~~Improve Participant Experience~~	~~Overall Participant Satisfaction~~	~~≥88.6% on the Overall Satisfaction - Weighted Average (2023 PACE National Average) on the 2024 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~~	~~12/31/20254~~	~~PACE Director~~

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CALOPTIMA HEALTH PROGRAM ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) QUALITY IMPROVEMENT PLAN DESCRIPTION

2025

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:

Isabel Becerra **Date**

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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.

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 of 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 into 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.

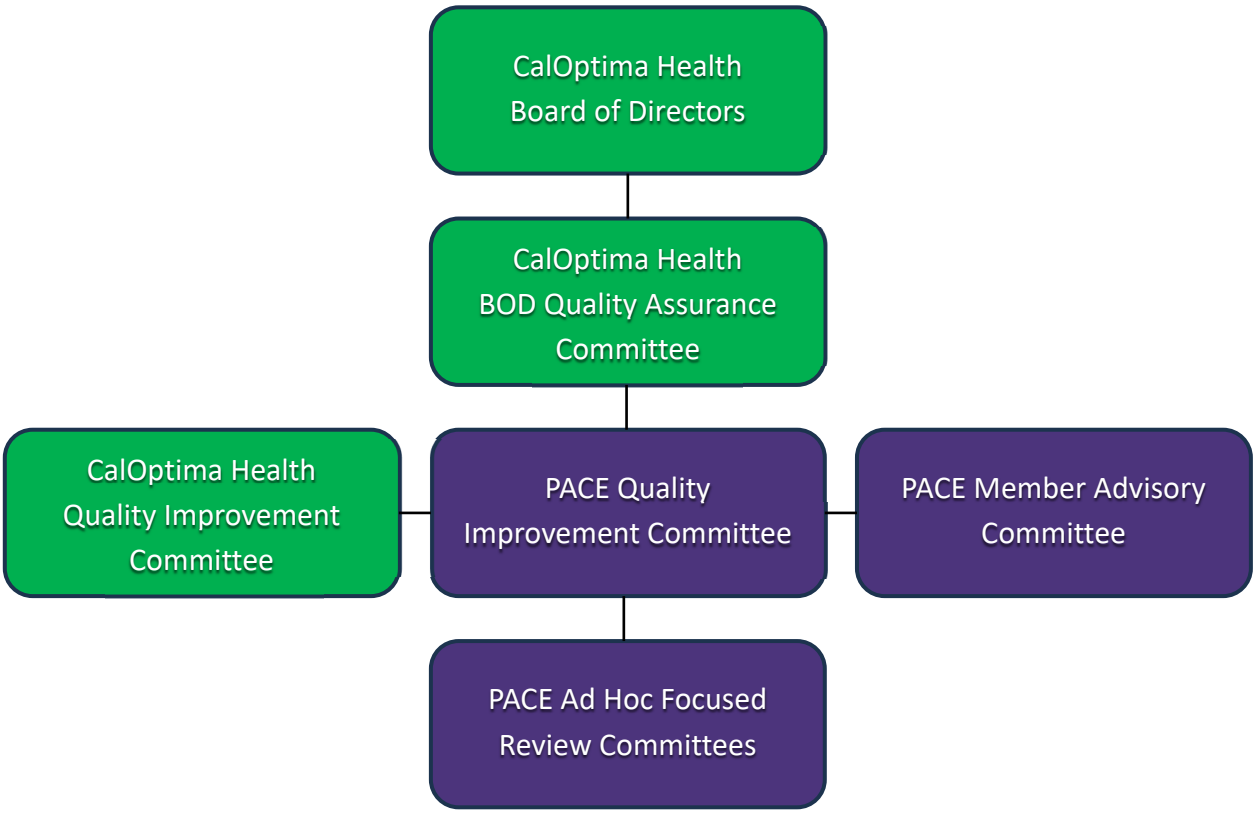
Membership
Membership will be flexible based on those with knowledge of the specific issues being addressed but will consist of at least four members to include at least two of the following positions and/or functions: PACE Medical Director, PACE QI Manager, PACE Program Director, PACE Center Manager, 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.

2025 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.
- 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 90 days *for controllable reasons*.
- PACE will monitor attrition rate to identify any need for operational improvement to strategically support continued growth in 2025.

Clinically Relevant Data- Quality Workplan Elements

- Clinical measures from the 2025 QI Work Plan elements which include:
    - Influenza Immunizations Rates
        - Exclusion criteria:
            - Participants who have dx of Palliative Care Approach, ICD-10 Z515
            - Participants with diagnosis of Guillain Barre, ICD-10: G61.0
            - Participants who are allergic to Influenza vaccine
    - Pneumococcal Immunizations Rates
        - Exclusion criteria:
            - Participants who enroll in the program in December 2025
            - Participants who have dx of Palliative Care Approach, ICD-10 Z515
            - 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, 2025
            - 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, 2025
            - 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, 2025
    - 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 Z515
    - Participants who are 76 years and older as of December 31, 2025
    - Participants who are legally blind in both eyes.
- Diabetes Care: HbA1c Control for Diabetics
  - Inclusion criteria:
    - Diagnosis of Diabetes Mellitus
    - Enrolled for at least six months
  - Exclusion criteria:
    - Participants who are 76 years and older as of December 31, 2025
    - Participants who have dx of Palliative Care Approach (ICD-10 Z515)
    - 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 more than 3 falls in one quarter
- Monitoring of Risks from High Dosage Opioid Use
  - Inclusion criteria:
    - Receiving prescription opioids milligram morphine dose MME >90 MME/day for ≥15 days.
  - Exclusion criteria:
    - Participants in Hospice Care
    - Participants with short term (<15 days) high dosage opioids.

- Medication Reconciliation Post Discharge from hospital or SNF.
- Access to Specialty Care services.

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 with 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 2025, including a goal that 10% of all eligible PACE Enrollees will utilize day center services at one of the PACE ACS sites by the end of 2025.
- 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 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 2025 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 2025.
        - Exclusions:
            - Participants with MMSE <16. OR
            - Participants with MMSE 16 or >, but who have a capacity letter scanned into chart (new exclusion for 2025).
    - 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)

2025 CalOptima PACE Quality Improvement (QI) Work Plan

QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
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
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
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
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
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
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
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
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
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
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

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
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
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
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
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
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
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
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
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

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QAPI Item#	Goal	Description	Objective	Activity	Reporting Frequency	Target completion	Responsible Person
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
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
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
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
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
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
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	12/31/2025	PACE Center Manager and PACE Director

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2025 Proposed PACE Quality Improvement Work Plan Description

Quality Assurance Committee Meeting

March 12, 2025

Dr. Donna Frisch, PACE Medical 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 Improvement (QI) Program Description

- Encompasses all clinical care, clinical services and organizational services provided to our participants
- Aligns with the PACE vision and mission
- Focuses on optimal health outcomes for our participants
- Uses evidence-based guidelines, data and best practices tailored to our populations
- Addresses the diabetic monitoring and cancer health screening needs of the unique PACE population
- Ensures compliance with CMS and DHCS regulatory standards for PACE program participants

2025 PACE (QI) Work Plan Goals

- Improve the Quality of Care for Participants
- Ensure the Safety of Clinical Care
- Ensure Appropriate Access and Availability
- Ensure Appropriate Use of Resources
- Improve Participant Experience

2025 PACE (QI) Work Plan Elements Changes

- In 2025, 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 2024 PACE Quality Workplan Review and the 2025 PACE Quality Improvement Plan Description
- The following slides reflect some of the changes that were made to the PACE Quality Workplan for 2024 including quality elements that were removed or modified

2025 PACE (QI) Work Plan Elements Removed

- **Removed Elements**
  - *Advanced Care Planning: Physician's Orders for Life-Sustaining Treatment (POLST)*
    - This goal was continuously met for the past several years and has become part of standard initial enrollment procedure for incoming enrollees
    - Despite removal from QI work plan, POLST percentages will continue to be measured and monitored by the PACE QI department
  - *Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents*
    - This goal was consistently met for the past several years
    - PACE PCPs, in addition to clinic pharmacist team, ensure that elderly participants with dementia are not prescribed harmful medications

2025 PACE (QI) Work Plan Elements Removed (Cont.)

- **Removed Elements**
  - *COVID-19 Immunization Rates*
    - This element is being removed from the QI Work Plan, *however* it will continue to be monitored as a Quality Initiative element
    - PACE continues to offer and provide the latest CDC recommended COVID-19 vaccines in the PACE clinic when they become available
    - PACE continues to encourage PACE participants to receive all recommended vaccinations to prevent against severe effects of infectious disease

2025 PACE (QI) Work Plan Elements Modified

- **Modified Elements**
  - *The following 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*

2025 PACE (QI) Work Plan Elements Modified (Cont.)

- **Modified Elements**
  - *Utilization*
    - ER Utilization objective was updated to reflect a new goal of reduced ER visits in 2025
    - Acute Hospital Utilization objective was updated to reflect a new goal of reduced hospital bed days in 2025
  - *Satisfaction*
    - At this time, PACE is awaiting the results of the 2024 Annual Integrated Satisfaction Measurement for PACE (I-SAT™) survey before setting satisfaction goals for 2025. The survey results were delayed until 2/28/25 due to the wildfire emergencies in Southern California in January 2025

2025 PACE Quality Initiatives

- **Advance Health Care Directive**
  - The goal for 2025 is ≥ 55% of participants will have a completed AHCD by the end 2025
  - The PACE Center Manager and PACE Social Work Supervisor have developed new strategies to meet this initiative in 2025, focusing on new program enrollees
- **COVID 19 Vaccination Rates**
  - The goal for 2025 is ≥ 50% of eligible participants will receive the latest CDC recommended COVID-19 vaccine by December 31st, 2025
- **Participant Satisfaction**
  - Participant satisfaction quality initiative to be developed for 2025 based on I-SAT survey results

Recommended Action

- Recommend approval of the 2025 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Improvement Plan Description

Questions?

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CalOptima Health Board Action Agenda Referral

Action To Be Taken April 3, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

6. Authorize and Direct Execution of Amendment 11 to Agreement 16-93274 Care Coordination Agreement with the California Department of Health Care Services in Order to Continue Operation of the Dual Eligible Special Needs Plan OneCare Program

Contact

John Tanner, Chief Compliance Officer, (657) 235-6997

Recommended Action

Authorize and direct the Chair of the Board of Directors to execute Amendment 11 to the Care Coordination Agreement between CalOptima Health and the Department of Health Care Services in order to continue operation of OneCare, CalOptima Health's Dual Eligible Special Needs Plan.

Background

As a County Organized Health System, CalOptima Health contracts with the Department of Health Care Services (DHCS) to provide health care services to Medi-Cal beneficiaries in Orange County. CalOptima Health's Primary Agreement with DHCS contains, among other terms and conditions, the payment rates CalOptima Health receives from DHCS to provide health care services to CalOptima Health Medi-Cal members. Until 2016, the Primary Agreement included language that incorporated provisions related to the Medicare Improvements for Patients and Providers Act (MIPPA) and eligibility criteria for the Dual Eligible Special Needs Plan (D-SNP).

In 2016, DHCS extracted the MIPPA-compliant language from the Primary Agreement and placed it in the standalone Care Coordination Agreement, also referred to as the State Medicaid Agency Contract (SMAC) by the Centers for Medicare & Medicaid Services (CMS). The CalOptima Health Board of Directors (Board) Chair executed the Care Coordination Agreement, which was ratified by the Board at the August 2016 Board meeting. Since then, there have been ten amendments to the Care Coordination Agreement, summarized in the attached Appendix 1. The existing Care Coordination Agreement is set to terminate on December 31, 2025, and contains no payment rates.

Via the Care Coordination Agreement with DHCS and the Medicare Advantage contract with CMS, CalOptima Health operates the OneCare line of business as an Exclusively Aligned Enrollment Integrated D-SNP, meaning that OneCare offers care coordination for the Medi-Cal and Medicare services to members who are enrolled with CalOptima Health for both Medicare and Medi-Cal benefits.

Discussion

Amendment to Agreement 16-93274 (Care Coordination Agreement)

On February 5, 2025, DHCS provided CalOptima Health with a draft SMAC amendment to extend the Care Coordination Agreement through December 31, 2026.

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CMS requires that plans renewing their D-SNP programs submit evidence of an MIPPA-compliant SMAC contract for the 2026 contract year by no later than July 1, 2025. Executing Amendment 11 to the Care Coordination Agreement is required in order for CalOptima Health to meet CMS's filing requirements and to continue operating CalOptima Health's D-SNP (OneCare) in contract year 2026. CalOptima Health has requested that DHCS send the final amendment to CalOptima Health as soon as possible in order to allow for immediate signature by CalOptima Health and prompt return to DHCS for counter-signature.

Amendment 11 contains language changes in addition to the extension of the expiration date. DHCS has only shared draft boilerplate contract amendments with CalOptima Health at this time. If the final contract amendment is not consistent with staff's understanding as presented in this document, or if it includes substantive and unexpected language changes, staff will return to the Board for further consideration of those changes. Attachment 3 "Additional Detail for CY 2026 Agreement 16-93274" includes further information regarding the language changes contained within the Care Coordination Agreement.

Fiscal Impact
The recommended action is operational in nature. Staff will include related OneCare expenses in future operating budgets.

Rationale for Recommendation
CalOptima Health's execution of Amendment 11 to the Care Coordination Agreement with the DHCS is necessary to ensure that CalOptima Health meets CMS requirements to continue operating the OneCare program during 2026.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Appendix summary of amendments to Agreements with DHCS
2. 2026 Draft Amendment to Agreement 16-93274
3. Additional Detail for CY 2026 Agreement 16-93274

.../s/ Michael Hunn *03/27/2025*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 6

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2022.	June 3, 2021
A–06 extends the Agreement 16–93274 with DHCS to December 31, 2023.	May 5, 2022
A–07 ratification to the Agreement 16–93274 to correct citation related to appeals and grievances in Exhibit A, Attachment 1: Coordination of Care, Section 18: Additional Guidance; and an update to amend the Information Sharing requirements outlined in Exhibit A, Attachment 1, Section 1.G of the amendment. **A–08** No changes in rates. Additional language updates for Section 18: Additional Guidance, for integrated appeals and grievance requirements for EAE D-SNPs. Added a definition for Care Coordinator, which previously existed.	October 6, 2022 Non-substantive language, therefore not brought to the BOD for additional ratification of the 2023 Amendment.
A–09 extends the Agreement 16–93274 with DHCS to December 31, 2024.	May 4, 2023
A–10 extends the Agreement 16–93274 with DHCS to December 31, 2025. Updates to specify requirement to include a question in the Member's Health Risk Assessment (HRA) to identify any engaged Caregiver and submit the HRA tool to DHCS. Added a provision (1.F.10) for a requirement to discuss advanced care planning in the Annual wellness visit or other provider visits. DHCS prefaced that language in the	May 2, 2024

Boilerplates on Advance Care Planning will be further clarified through guidance in a future revision of the 2025 D-SNP Policy Guide Care Coordination chapter. Updates to specify Integrated appeals and grievances procedures apply to all benefits offered under an EAE D-SNP including optional supplemental benefits. Revise existing definitions, as well as adds new terms.	

Exhibit A
SCOPE OF WORK

Exclusively Aligned Enrollment D-SNP

1. Service Overview

A. This Contract is being executed with this Contractor that is a Dual Eligible Special Needs Plan (D-SNP), [INSERT D-SNP LEGAL ENTITY NAME], that will be referred to in this Contract as D-SNP Contractor. The Medicare Advantage organization offering the D-SNP, D-SNP Contractor's parent organization, or another entity that is owned and controlled by the D-SNP Contractor's parent organization [INSERT LEGAL NAME OF ENTITY HOLDING THE MEDI-CAL MANAGED CARE PLAN] must also hold a Medi-Cal Managed Care Health Plan (MCP) Contract with California Department of Health Care Services (DHCS), or must be a subcontracted delegate health plan as defined in Welfare and Institutions Code (W&I) section 14184.208(h)(6), also referred to as an Exclusively Aligned Enrollment (EAE) D-SNP. D-SNP Contractor must have a Medicare Advantage Contract (H-Contract) that only includes D-SNPs within California in accordance with 42 CFR section 422.107(e). The H-Contract must include both EAE and Non-EAE plan benefit packages.

B. This D-SNP Contract is a Care Coordination and benefit coordination agreement. D-SNP Contractor is responsible for coordinating the delivery of all benefits covered by both Medicare and Medi-Cal, including those benefits not covered by the Medicare Advantage health plan under whose authority the D-SNP Contractor operates, and the Medi-Cal benefits identified in the Exhibit H attachment to this Contract and referenced below in Provision 3 of this Exhibit A. Coordination responsibility includes coordination of those Medi-Cal Services that are delivered via Medi-Cal Fee-For-Service (FFS), managed care, or other Medi-Cal delivery systems. These Medi-Cal benefits and services are defined in the contents of this D-SNP Contract.

C. This D-SNP Contract is for Applicable Integrated Plans as defined in 42 CFR section 422.561. D-SNP Contractor must limit enrollment to full-benefit Dual Eligible Members enrolled in an affiliated MCP, per 42 CFR section 422.561, that holds a capitated contract with DHCS or is a subcontracted delegate health plan as defined in W&I 14184.208(h)(6). Through the capitated MCP Contract, Medi-Cal benefits include primary care and acute care, including Medicare cost-sharing as defined in 28 Social Security

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Exhibit A
SCOPE OF WORK

Act (SSA) section 1905(p)(3)(B), (C), and (D), without regard to the limitation of that definition to qualified Medicare beneficiaries. Members enrolled in Applicable Integrated Plans have Skilled Nursing Facility (SNF) services (with coverage for a minimum of 180 days), Home Health Services (as defined at 42 CFR section 440.70), and Durable Medical Equipment (DME) including equipment and appliances, as well as medical supplies (as defined at 42 CFR section 440.70(b)(3)) covered by the capitated MCP Contract.

2. Project Representatives

A. The project representatives during the term of this D-SNP Contract will be:

Department of Health Care Services	**D-SNP Contractor**
Managed Care Operations Division Attn: Procurement & Contract Development Branch Chief	[D-SNP Name] Attn: [Contact Name]
Telephone: (916) 449-5000 FAX: (916) 449-5090	Telephone: [Contact Phone Number] Email: [Contact Email Address]

B. Direct all inquiries to:

Department of Health Care Services	**D-SNP Contractor**
Managed Care Operations Division Attn: Michelle Retke, Division Chief	[D-SNP Name] Attn: [Contact Name]
MS 4408 P.O. Box 997413 Sacramento, CA 95899-7413	[Address]
Telephone: (916) 449-5000 FAX: (916) 449-5090	Telephone: [Contact Phone Number] Email: [Contact Email Address]

C. Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this D-SNP Contract.

3. See the following attachments for a detailed description of the services to be performed:

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Exhibit A
SCOPE OF WORK

A. Exhibit A: Scope of Work

B. Exhibit H

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Exhibit A, Attachment 1
COORDINATION OF CARE

1. Care Coordination

This D-SNP Contract is a Care Coordination and benefit coordination agreement between D-SNP Contractor and DHCS. D-SNP Contractor is responsible for coordinating the delivery of all benefits and services covered by both Medicare and Medi-Cal, including when Medi-Cal Services are delivered via Medi-Cal FFS, managed care, or other Medi-Cal delivery systems. Without limitation, when Medically Necessary for the Member, D-SNP Contractor must coordinate care with providers and other entities for the Medi-Cal Services outlined in Exhibit H. D-SNP Contractor must educate Members through Member handbook and other contacts that D-SNP Contractor, and not the Member, is responsible for coordination of the Member's Medi-Cal and Medicare Services.

A. For coordination of behavioral health services, including specialty mental health and substance use disorder services, D-SNP Contractor must establish a cooperative working relationship with the Member's MCP and/or the county behavioral agency for care coordination, information sharing, and oversight. County behavioral health plan contact information can be found at the following link: https://www.dhcs.ca.gov/services/MH/MHSUD/Pages/CountyProgAdmins.aspx.

B. For coordination of In-Home Supportive Services (IHSS), D-SNP Contractor must establish a cooperative working relationship with the County IHSS Office for care coordination, information sharing, and oversight. County IHSS Office contact information can be found at: https://www.cdss.ca.gov/inforesources/county-ihss-offices.

C. For coordination of 1915 (c) Home and Community-Based Services (HCBS) waivers, D-SNP Contractor must establish a cooperative working relationship with HCBS waiver agencies for care coordination, information sharing, and oversight. A list of waiver programs can be found at: https://www.dhcs.ca.gov/services/Pages/medi-calwaivers.aspx.

D. For coordination of Medi-Cal dental benefits, D-SNP Contractor must contact the DHCS Dental ~~Administrative Service Organization (ASO~~Fiscal Intermediary-Dental Business Operations (FI-DBO) for provider information and the coordination of dental benefits for Members enrolled in Medi-Cal dental fee-

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Exhibit A, Attachment 1
COORDINATION OF CARE

for-service or contact the Medi-Cal Dental Managed Care Plan for Members enrolled in Medi-Cal Dental Managed Care. ~~ASO~~FI-DBO contact information can be found at the following link: https://smilecalifornia.org/contact-us/ and below ~~are~~is Medi-Cal Dental Managed Care contact information:

Liberty Dental Plan
Sacramento: (888) 703-6999 or (877) 855-8039 (TTY/TTD)
Los Angeles: (888) 703-6999 or (877) 855-8039 (TTY/TTD)

Health Net Dental Plan
Sacramento: (800) 977-7307 | TTY (800) 977-7307 (TTY 711)
Los Angeles: (800) 977-7307 | TTY (800) 977-7307 (TTY 711)

California~~-~~
~~Access~~ Dental ~~Plan~~Network
Sacramento: (~~877) 821-3234 |~~ 833) 479-1984 | 800-466-7566 (TTY~~:~~ ~~(800) 735-2929~~ /TTD)
Los Angeles: (~~888) 414-4110 |~~ 855) 388-6257 | 800-466-7566 (TTY~~:~~ ~~(800) 735-2929~~/TTD)

Please note: the Dental Managed Care Plans are subject to change. DHCS reserves the right to provide updated contact information for Dental Managed Care plans.

~~D~~E. For coordination of Medi-Cal pharmacy benefits, D-SNP Contractor must contact Medi-Cal Rx, and contact information can be found at: https://medi-calrx.dhcs.ca.gov/home/contact.

~~E~~F. If D-SNP Contractor offers Supplemental Benefits as referenced in Exhibit E, Attachment A, Definitions, of this Contract, also including Special Supplemental Benefits for the Chronically Ill (SSBCI) or Expanded Primarily Health-Related Benefits (EPHRB), those services must be coordinated as needed to ensure D-SNP Contractor tracks Member use of Supplemental Benefits and exhausts Supplemental Benefits prior to or concurrent with authorization of or referral for Medi-Cal benefits, including but not limited to Dental, Vision, Transportation, Community Supports, and Behavioral Health.

~~F~~G. D-SNP Contractor must implement a Special Needs Plan Model of Care (MOC). In addition to meeting requirements detailed at 42 CFR section 422.101(f) and earning approval from the National Committee for Quality Assurance (NCQA), the

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Contractor must include State-specific requirements outlined in the ~~2025~~2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx. D-SNP Contractor must additionally comply with State-specific Care Coordination requirements, which are fully outlined in the ~~2025~~2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website and may be amended from time to time. These State-specific requirements, which are outlined fully in the ~~2025~~2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide, include the following:

1) Incorporating Medi-Cal data into the D-SNP risk stratification process;

2) Incorporating Medi-Cal Services and providers, including palliative care teams as appropriate, into the development and execution of the Member's care plan and care team, including Medi-Cal Services accessed through the aligned MCP as well as Medi-Cal FFS and other Medi-Cal delivery systems (including Home and Community-Based Services programs);

3) Including a question in the Member's Health Risk Assessment (HRA) to identify any engaged Caregiver and submit the HRA tool to DHCS;

4) Assessing of Caregiver support needs, if a Member identifies a Caregiver, as part of the D-SNP assessment process;

5) Providing on at least an annual basis as feasible, and with the Member's consent, face-to-face encounters for the delivery of health care or care management or Care Coordination services;

6) Incorporating trained Dementia Care Specialists in care teams and encouraging primary care providers to leverage Dementia Care Aware resources for any primary care appointment to detect cognitive impairment;

7) Utilizing Long-Term Services and Supports (LTSS) liaisons in supporting care transitions;

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8) ~~Including four (4) or more populations of focus from the Medi-Cal Enhanced Care Management (ECM) program~~ Providing California Integrated Care Management (CICM) to specific vulnerable populations listed in the 2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide and demonstrating how the D-SNP Contractor's ~~model~~Model of ~~care~~Care includes and reflects the delivery of ~~ECM core~~ services to CICM populations;

~~8)~~9) Providing in-person care management to the CICM population, Adults Experiencing Homelessness;

~~9)~~10) Providing and coordinating inpatient and outpatient/community-based palliative care referrals and services for Members who meet Medi-Cal criteria for palliative care; and

~~10)~~11) Discussing advance care planning in the annual wellness visit or other provider visits.

~~G~~H. D-SNP Contractor is not responsible to provide or pay for any Medi-Cal benefits, or Medicare cost sharing obligations which are covered in full through Medi-Cal FFS or MCP Contract. Medi-Cal MCPs are responsible to pay Medicare cost sharing obligations for contracted benefits for MCP members. In addition, the MCP Contract requires the MCP to enter into a Coordination of Benefits Agreement with the Medicare program through the Centers for Medicare & Medicaid Services (CMS), and to participate in Medicare's automated claims crossover process for full-benefit Dual Eligible Members, in accordance with 42 CFR section 438.3(t). D-SNP Contractor shall maintain a current knowledge and familiarity of Medi-Cal benefits through ongoing reviews of California laws, rules, policies, and further guidance as posted on the DHCS website or otherwise provided by DHCS. D-SNP Contractor shall coordinate with the aligned MCP to support Medi-Cal eligibility retention efforts to the extent permitted by law, and guidance from CMS and DHCS. D-SNP Contractor shall timely coordinate Medi-Cal Services requiring referral and coordination of care as outlined in Exhibit H for its Members under this Contract.

This Provision details D-SNP Contractor's specific Medicare-Medi-Cal care coordination requirements. Medi-Cal Services are described in Title XIX of the Social Security Act, 42 CFR parts 440 and 441; the California

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Medicaid State Plan; Exhibit H; the DHCS and Medi-Cal websites and other relevant materials.

2. Information Sharing

A. D-SNP Contractor is responsible for complying with State policy implementing federal information sharing requirements for D-SNPs per 42 CFR section 422.107(d)(1), for the purpose of coordinating Medicare and Medi-Cal covered services between settings of care for all Members. This State policy is in addition to federal requirements for hospitals regarding electronic notifications listed in 42 CFR section 482.24(d). The goal of the information sharing policy is for D-SNP Contractor, either directly or through contracted providers or other entities, to timely notify the Member's MCP, or hospital and SNF admissions. Timely notification supports the coordination of and referrals to Medicare and Medi-Cal Services, including Home and Community Based Services.

1) To the extent permissible under applicable federal and State law and regulations, and not inconsistent with the Member's expressed privacy preferences, D-SNP Contractor will require their contracted hospitals and SNFs to use a secure email data exchange through a Health Information Organization, or an electronic process approved by DHCS, to inform D-SNP Contractor in a timely manner of any hospital or SNF admissions for all Members.

2) D-SNP Contractor will require contracted hospitals to make this notification either immediately prior to, or at the time of, the Member's discharge or transfer from the hospital's inpatient services, if applicable.

3) To the extent permissible under applicable federal and State law and regulations, and not inconsistent with the Member's expressed privacy preferences, D-SNP Contractor will require their contracted SNFs to use a secure email, a data exchange through a Health Information Organization, or an electronic process approved by DHCS, to inform D-SNP Contractor of any SNF admission, discharge, or transfer for all Members. For SNF admissions, D-SNP Contractor will require contracted SNFs to make this notification within 48 hours after any SNF admission. For SNF discharges or transfers, D-SNP Contractor will require contracted SNFs to make this notification in advance, if at all possible, or at the

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time of, the Member's discharge or transfer from the SNF.

4) In the event that the D-SNP Contractor authorizes another entity or entities to perform these notifications, D-SNP Contractor must retain responsibility for complying with this requirement. The D-SNP Contractor ultimately retains the responsibility for the notification requirements that are delegated to its contracted hospitals and SNFs.

B. D-SNPs will coordinate care management for their Members and facilitate Member access to needed LTSS, including in community-based settings to support care transitions.

3. Integrated Materials

A. D-SNP Contractor is responsible for providing integrated Member materials to Members. The State requirements described in this Paragraph are in addition to all existing Medicare marketing and communications requirements outlined in 42 CFR Part 422 Subpart V, 42 CFR Part 423 Subpart V, and 42 CFR section 438.10(d)(2), and as described in the Medicare Communications and Marketing Guidelines (MCMG). Required integrated Member materials will include:

1) Annual Notice of Change (ANOC);

2) Member Handbook;

3) Summary of Benefits;

4) Member Identification (ID) Card;

5) Provider/Pharmacy directory; and

6) List of Covered Drugs (Formulary).

B. D-SNP Contractor must have a single Member services/customer service phone number for Members to contact D-SNP Contractor regarding their Medicare or Medi-Cal benefits. D-SNP Contractor must use the single Member services phone number in all integrated Member materials.

C. D-SNP Contractor will be required to make all integrated Member materials available in the threshold languages for their aligned MCP

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Service Area. Threshold languages include both:

1) Medicare's five percent (5%) threshold for language translation as outlined in 42 CFR Part 422 ~~Subpart V~~.2267(a) and ~~42 CFR Part~~ 423 ~~Subpart V~~.2267(a); and

2) DHCS prevalent language requirements, i.e. the DHCS threshold and concentration standard languages, as specified in APL 21-004, or subsequent iterations, that provides guidance to Contractors on specific translation requirements for their Service Areas.

D. D-SNP Contractor must have a process for ensuring that Members can make a standing request to receive materials in alternative formats and in any non-English languages, at the time of request and on an ongoing basis thereafter, in accordance with 42 CFR section 422.2267 and section 423.2267, APL 21-004 or subsequent iterations, APL 22-002 or subsequent iterations, and the ~~2025~~2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide as applicable. The process must include how D-SNP Contractor will keep a record of the Member's information and utilize it as an ongoing standing request so the Member does not need to make a separate request for each item of material, and how a Member can change a standing request for preferred language and/or format.

E. D-SNP Contractor must identify in its provider directory those providers that accept both Medicare and Medi-Cal, i.e. providers that are currently registered providers under Medi-Cal and are also within D-SNP Contractor's network. D-SNP Contractor must comply with existing federal and State guidelines regulating print and online provider directories. Print and online directories for D-SNP Contractor must reflect all contracted and in-network providers for D-SNP Members. The provider directories must show the providers that are in the D-SNP Medicare and/or Medi-Cal networks in a clear manner for Members.

F. D-SNP Contractor must submit all communication and marketing materials in the Health Plan Management System (HPMS) that are required to be submitted as described here and in the MCMG under D-SNP Contractor's Medicare contract ID number. The multi-plan submission process is not applicable to D-SNP only contracts. In addition, when a third party, such as a pharmacy benefit manager (PBM), creates and distributes Member-specific materials on behalf of multiple organizations, it is not acceptable to use the material ID

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for another organization for materials the third-party providers to D-SNP enrollees. The material must be submitted in HPMS using a separate material ID number for the D-SNP contract and that material ID number must be included in the material. Additional guidance including the submission and review process for integrated Member materials is fully outlined in the ~~2025~~2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

G. D-SNP Contractor must have a single Application Programming Interface (API) for Members to access both Medicare and Medi-Cal information.

4. State-Specific Supplemental Benefits

Using Medicare rebate dollars, D-SNP Contractor must provide, at a minimum, the following supplemental benefits to Members:

A. $0 copay for one (1) routine eye exam every year; and

B. Every two (2) years, $100 for eyeglasses (frames and lenses) or up to $100 for contact lenses.

5. Quality and Data Reporting

A. D-SNP Contractor is responsible for reporting quality measures to DHCS. These quality measures are fully outlined in the ~~2025~~2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

~~B. This reporting will include:~~

~~1) Selected Healthcare Effectiveness Data and Information Set (HEDIS) measures, calculated at the plan benefit package (PBP) level for the PBPs included in this Contract;~~

~~2) State-specific Care Coordination and LTSS process measures;~~

~~3) State-specific dementia measures;~~

~~4) State-specific ECM-like care management measures;~~

~~5) State-specific palliative care measures; and~~

~~6) Integrated Appeals and Grievances data.~~

~~DHCS will add additional measures as needed, and details will be provided in the 2025 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.~~

6. Consumer Participation in Governance Boards

A. D-SNP Contractor must comply with federal requirements outlined in 42 CFR section 422.107(f) in addition to State-specific requirements outlined below. D-SNP Contractor must ensure consumer participation in governance boards that will provide regular feedback to the D-SNP Contractor on issues of duals-related topics, including plan management and Member care. D-SNP Contractor must consider region-specific meetings based on geographic county proximity rather than one State-wide setting, and ensure that the committee completes the following:

1) Meets at least quarterly throughout the Contract Year;

2) Has at least four (4) Member seats for individuals who have knowledge and perspective of EAE D-SNP topics to facilitate a variety of Member perspectives and unique lived experiences, including those using services such as Home and Community Based Services and Long-Term Care;

3) Includes a ratio of Members on the governance board focused on duals-related topics relative to the ratio of dual eligible Members enrolled with D-SNP Contractor;

4) Includes a reasonably representative sample of the population enrolled in D-SNP including Members, Member's family members, consumer advocates, and caregivers that reflect the demographic diversity of the D-SNP population, including individuals with disabilities; and

5) Solicits input on ways to improve access to Covered

Services, coordination of services (including all Medicare and Medi-Cal services), and health equity for underserved populations, among other topics.

B. D-SNP Contractor is responsible for reporting their committee charter and membership to DHCS annually by March 1, ~~2025~~2026, through its DHCS Contract Manager via email. D-SNP Contractor is also responsible for reporting meeting minutes and agendas to DHCS quarterly through its DHCS Contract Manager via email no later than 30 days after the end of each quarter. DHCS reserves the right to review and approve Enrollee membership. D-SNP Contractor can engage and recruit Members serving on existing committees.

7. State Guidance

A. In addition to the terms and conditions of this Contract, D-SNP Contractor must comply with State-specific departmental guidance in the ~~2025~~2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

B. To the extent that State guidance conflicts with Medicare requirements or regulations, D-SNP Contractor must comply with Medicare requirements and regulations. For purposes of this Provision State guidance only conflicts with Medicare requirements or regulations to the extent that the guidance requires conduct that would violate Medicare requirements or regulations.

8. Coverage Area and Eligible Beneficiaries

A. This Contract covers the Medicare H-contract and Plan Benefit Package (PBP) listed within the following table.

Plan PBPs	**H-Contract**	**Service Area of PBP**	**Eligible Populations within PBP**
[List PBP]	[List H-Contract]	[List County/ Counties]	[List eligible populations; e.g., QMB+, SLMB+, Other Full-Benefit Medi-Cal]

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B. Members covered under this Contract must include all full-benefit Dual-Eligible Beneficiaries 21 years of age or older, such as Qualified Medicare Beneficiaries Plus (QMB+), Specified Low-Income Medicare Beneficiaries Plus (SLMB+), and other full-benefit Dual-Eligible Beneficiaries who are enrolled with D-SNP Contractor and with the aligned Medi-Cal MCP. Covered Members include those who meet the following:

1) Are enrolled with D-SNP Contractor;

2) Who reside in the following county or counties to maximize the continuum of services available through both Medicare and Medi-Cal: [County]

3) Are already enrolled in the MCP affiliated with D-SNP Contractor.

C. D-SNP Contractor agrees to conduct enrollment of eligible persons in accordance with the policies and procedures set forth in this Contract and maintain EAE for the duration of the D-SNP Contract term.

9. Certification and Enrollment Reporting

A. D-SNP Contractor must submit to DHCS a certification, signed by the Chief Operations Officer or similar executive officer, that attests to the number of Members enrolled in D-SNP Contractor's D-SNP as of the effective date of this Contract.

B. By the fifth working day of each month during the term of this Contract, D-SNP Contractor must submit a report to DHCS, signed by the Chief Operations Officer or similar executive officer, summarizing the previous month's Enrollment numbers.

10. Member Billing Prohibitions

A. D-SNP Contractor and its contracted providers are prohibited from imposing cost-sharing requirements on Members that would exceed the amounts permitted under the California Medicaid State Plan, Section 1852(a)(7) of the Social Security Act, and 42 CFR section 422.504(g)(1)(iii). D-SNP Contractor must not bill any Member (including full-benefit Dual Eligible Beneficiaries

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such as QMB+, SLMB+, and other full-benefit Dual Eligible Beneficiaries) for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments, in accordance with Section 1902(n)(3)(B) of the Social Security Act, which prohibits a Medicare provider from billing a full-benefit Dual Eligible Beneficiary for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments.

B. Any Dual Eligible Beneficiary (including full-benefit Dual Eligible Beneficiaries such as QMB+, SLMB+, and other full-benefit Dual Eligible Beneficiaries) has no legal obligation to make further payment to a provider or to D-SNP Contractor for Medicare Part A or Part B cost sharing amounts. D-SNP Contractor's provider agreements must specify that a contracted Medicare provider agrees to accept D-SNP Contractor's Medicare reimbursement as payments in full for services rendered to Dual Eligible Enrollees, or to bill Medi-Cal or the Member's Medi-Cal MCP as applicable for any additional Medicare payments that may be reimbursed by Medi-Cal. D-SNP Contractor's provider agreements must require a contracted Medicare provider to comply with Welfare and Institutions Code section 14019.4.

11. Provider Network Requirements

A. D-SNP Contractor can obtain Medi-Cal participating providers by reviewing the California Health and Human Services Open Data Portal. Medi-Cal FFS Provider data can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers. Medi-Cal Managed Care Provider Network data can be found at: https://data.chhs.ca.gov/dataset/medi-cal-managed-care-provider-listing. Alternatively, D-SNP Contractor can obtain the file from the affiliated MCP.

B. D-SNP Contractor must comply with all applicable network guidance and network requirements outlined in the ~~2025~~2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

C. D-SNP Contractor that offers Dental Supplemental Benefits must report to DHCS on the level of overlap for their Medicare dental

network and the Medi-Cal Dental network, as outlined in the ~~2025~~2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide.

12. Medicare Continuity of Care

A. D-SNP Contractor must comply with State-specific requirements for Medicare primary and specialty care provider continuity of care. D-SNP Contractor must also comply with State-specific requirements for Durable Medical Equipment continuity of care as outlined in 42 CFR section 422.100(I)(2)(iii) and APL 23-022 or subsequent iterations to the extent that this requirement applies to the D-SNP Contractor. Further guidance is outlined in the ~~2025~~2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx. D-SNP Contractor must provide Members with the following:

1) A 12-month continuity of care period from the date of the Member's Enrollment in the D-SNP, for primary and specialty providers with whom the Member has a pre-existing relationship and who are willing to work with the D-SNP Contractor; and

2) Access to Medically Necessary Medicare-covered Durable Medical Equipment and medical supplies.

13. Medi-Cal and Medicare Eligibility Verification and MCP Enrollment Verification

A. It is the responsibility of D-SNP Contractor to verify the Medi-Cal eligibility of a Member. To facilitate this verification, D-SNP Contractor will have real-time access to the Medi-Cal eligibility verification system. D-SNP Contractor is required to check a Member's Medi-Cal MCP enrollment eligibility on a monthly basis.

B. To obtain Medicare Advantage and Medi-Cal eligibility, D-SNP Contractor must validate eligibility through its existing on-line and/or batch Medicare and Medi-Cal eligibility user interfaces.

1) Medicare and/or Medi-Cal eligibility systems will indicate whether a beneficiary is currently enrolled or is pending enrollment in a MCP at the time of the inquiry.

2) If the beneficiary meets the criteria for enrollment listed in Provision 8, Coverage Area and Eligible Beneficiaries, the eligible beneficiary may be enrolled with D-SNP Contractor.

C. D-SNP Contractor must ensure appropriate training of plan personnel and contracted providers regarding the use of the Medi-Cal Automated Eligibility Verification System (AEVS) interface and the appropriate interpretation of its eligibility results.

D. D-SNP Contractor's providers may use the Medicare Administrative Contractor (MAC) online provider portal to check their patient's Medicare eligibility. Additional information on checking Medicare eligibility can be found on the following link: https://www.cms.gov/MAC-info.

14. Medicare Deeming Period

For those Members who have lost Medi-Cal eligibility, D-SNP Contractor is required to maintain enrollment for such Members for at least a three-month deeming period following notification that the Member lost Medi-Cal eligibility. This requirement does not preclude D-SNP Contractor from offering a longer deeming period. D-SNP Contractor should inform its DHCS Contract Manager of the deeming period that it will provide.

15. Contract Term

This D-SNP Contract is effective from January 1, ~~2025~~2026, through December 31, ~~2025~~2026.

16. Termination

DHCS retains the right to terminate this D-SNP Contract at any time for cause or no cause.

17. Compensation

The State of California and DHCS must not provide any remuneration or other form of compensation for the performance of any duties or obligations provided under this D-SNP Contract.

18. CMS Documentation

A. D-SNP Contractor must submit to the DHCS contract manager,

after execution of this Contract but no later than September 30, ~~2024~~2025, a complete and accurate copy of the Medicare Advantage bid for the contract containing the PBPs covered by this Contract, as approved by CMS~~.~~, as well as any of the following materials (if not included in the approved bid):

~~B. If not included in the approved bid, the D-SNP Contractor must also provide to DHCS the following information, in a format as specified by DHCS, after execution of this Contract but no later than September 30, 2024 to the DHCS contract manager:~~

1) The current approved model of care, if not already submitted to DHCS.

2) A list of approved Supplemental Benefits included in the initial annual Medicare Advantage bid submission to CMS.

3) A list of approved Supplemental Benefits, inclusive of all benefits listed in the final Plan Benefit Package.

~~C~~B. D-SNP Contractor must submit to DHCS copies of CMS reporting, compliance, and audit findings.

19. Medicare Encounter Data Requirements

D-SNP Contractor must submit to DHCS electronic records of all encounters, including encounters resulting in zero Medicare claims, monthly, in a mutually agreed upon format. Each encounter record must be specific to the Member and provider, listing all the data elements required for each service. This data will provide DHCS with information on services paid for by Medicare. Additional details regarding this requirement are fully outlined in the ~~2025~~2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

20. Integrated Appeals and Grievances

A. D-SNP Contractor must adhere to the State-specific requirements described in this Contract, in addition to all existing Medicare requirements. In addition, D-SNP Contractor must implement a unified approach to appeals and grievances per 42 CFR sections 422.629-422.634, 438.210, 438.400, and 438.402. 42 CFR section 422.629(c) allows the State, at its discretion, to implement

standards for timeframes or notice requirements that are more protective for the Member than required by 42 CFR section 422.630 through 422.634.

B. D-SNP Contractor must provide information about its Integrated Appeals and Grievance system to all providers and subcontractors at the time they enter into a contract, including, at a minimum, information on Integrated Appeals, Integrated Grievances, State Hearings, and Independent Medical Review (IMR) procedures and timeframes, as applicable.

C. D-SNP Contractor must maintain records of the Integrated Appeals, Integrated Grievances, and Integrated Organization Determinations. The record of each Integrated Appeals, Integrated Grievances, and Integrated Organization Determinations must be accurately maintained in a manner accessible to the State and available upon request to CMS. Additionally, D-SNP Contractor must establish, implement, maintain, and oversee an Integrated Grievance and Integrated Appeal system to ensure the receipt, review, and resolution of Integrated Grievances and Appeals. D-SNP Contractor must ensure that the following requirements are met through its Integrated Grievance and Integrated Appeal system.

D. Integrated Appeals and Grievances procedures apply to all benefits offered under D-SNP Contractor including optional supplemental benefits. For benefits that are carved out, such as Medi-Cal Dental, D-SNP Contractor must also follow the regulations at 42 CFR section 422.562(a)(5) and 422.629(e) that require D-SNP Contractor to provide Members reasonable assistance completing forms and taking other procedural steps to assist Members with appeals and grievances. This includes offering to assist Members with obtaining Medi-Cal covered services and navigating Medi-Cal appeals and grievances in connection with the Member's own Medi-Cal coverage, regardless of whether such coverage is in Medi-Cal fee-for-service or a separate Medi-Cal Dental Managed Care Plan. If the Member accepts the assistance, the D-SNP Contractor should assist the Member as needed, such as identifying and reaching out to a Medi-Cal fee-for-service point of contact, providing assistance in filing an appeal or grievance, helping to obtain documentation to support a request for Medi-Cal appeal or grievance, or completing paperwork that may be needed in filing an appeal or grievance.

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E. For Integrated Grievances, D-SNP Contractor must have the following:

1) Procedure to allow a Member, Member's authorized representative, or their provider to file a standard or expedited Integrated Grievance orally or in writing with D-SNP Contractor at any time.

2) Procedure to ensure D-SNP Contractor sends a written acknowledgement of an Integrated Grievance that is dated and postmarked within five (5) calendar days of receipt in accordance with Health and Safety Code (H&S) section 1368(a)(4)(A) and 28 California Code of Regulations (CCR) section 1300.68(d)(1) and 42 CFR section 422.629(g).

3) Procedure to resolve standard Integrated Grievances as expeditiously as the Member's health condition requires, but no later than 30 calendar days from receipt of the Integrated Grievances in accordance with 42 CFR section 422.630.

4) Procedure to resolve expedited Integrated Grievances within 24 hours in accordance with 42 CFR section 422.630.

5) Procedure to provide a written resolution to the Member for an Integrated Grievance within the resolution timeframe for a standard and expedited Integrated Grievance when:

a) The Member submits an Integrated Grievance in writing;

b) The Member requests a written response;

c) The Integrated Grievance is related to quality of care, coverage dispute, or disputed health care service involving medical necessity or experimental or investigational treatment; or

d) The Integrated Grievance is not resolved by the next business day, regardless of the type of Integrated Grievance or how it is filed.

6) Procedure to log and report all Integrated Grievances.

F. For Integrated Organization Determinations, D-SNP Contractor

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must have the following:

1) Procedure for D-SNP Contractor to consider both Medicare and Medi-Cal coverage criteria when making an Integrated Organization Determination.

2) Procedure to provide timely notice of standard Integrated Organization Determinations as expeditiously as the Member's health condition requires, and no later than 14 calendar days from when it receives the request in accordance with 42 CFR section 422.631(d)(2)(i)(B).

3) Procedure to provide notice to Members of their appeal rights and State Hearing rights for all fully or partially denied Integrated Organization Determinations.

4) Procedure to include the most current State Hearing form with the Integrated Organization Determination notice when the following requirements are met:

    a) The denied Integrated Organization Determination is not for a Medicare-only service or benefit; and

    b) The Integrated Organization Determination is relating to a denial, in whole or in part, of a Medi-Cal Service or benefit, including cases where there is an overlap of Medicare and Medi-Cal.

5) For Knox-Keene licensed plans, a procedure to ensure compliance with H&S section 1367.01, including making Integrated Organization Determinations in a timely fashion appropriate for the nature of the Member's condition, not to exceed five (5) business days from D-SNP Contractor's receipt of information reasonably necessary to make the Integrated Organization Determination, and no later than 14 calendar days from the receipt of request in accordance with H&S section 1367.01(h)(1) and 42 CFR section 422.631(d)(2)(i)(B).

6) For Knox-Keene licensed plans, a procedure to inform Members of their rights to an IMR in accordance with the Knox-Keene Act, including but not limited to H&S sections 1368.03, 1370.4, and 1374.30, 28 CCR sections 1300.70.4 and 1300.74.30, and including verbatim language required

by H&S section 1368.02(b), as well as the most recent IMR form, application instructions, the Department of Managed Health Care's (DMHC's) toll-free telephone number, and an envelope addressed to DMHC when the following requirements are met:

a) The denied Integrated Organization Determination is for experimental or investigational therapy, or is a denial of urgent care or emergency service;

b) The denied Integrated Organization Determination is not for a Medicare-only service or benefit; and

c) The Integrated Organization Determination is relating to a denial, in whole or in part, of a Medi-Cal Service or benefit, including cases where there is an overlap of Medicare and Medi-Cal.

7) Procedure to provide timely notice of expedited Integrated Organization Determinations as expeditiously as the Member's health condition requires, and no later than 72 hours from when D-SNP Contractor receives the request in accordance with 42 CFR section 422.631(d)(2)(iv).

8) Procedure to ensure deadlines for integrated organization determinations are not extended in accordance with H&S section 1367.01.

9) Procedure to ensure that prior to terminating, suspending, or reducing a previously approved item or service, D-SNP Contractor must provide Members with an integrated coverage decision letter at least ten (10) calendar days in advance of the effective date of the adverse organization determination in accordance with 42 CFR section 422.631(d)(2)(i)(A).

10) For Knox-Keene licensed plans, a procedure to ensure that D-SNP Contractor must not rescind or modify an integrated organization authorization after the Provider renders the health care service in good faith in accordance with H&S section 1371.8.

G. For Integrated Appeals, D-SNP Contractor must have the following:

Exhibit A, Attachment 1
COORDINATION OF CARE

1) Procedure to provide written acknowledgement of receipt of all Integrated Appeals within five (5) calendar days in accordance with 42 CFR section 422.629(g) and H&S section 1368(a)(4)(A).

2) Procedure to resolve standard Integrated Appeals as expeditiously as the Member's health condition requires but to not exceeding 30 calendar days from the date of receipt of the request in accordance with 42 CFR section 422.633(f)(1).

3) Procedure to inform Members of their rights to a State Hearing and include the most current State Hearing form when the following requirements are met:

   a) The denied Integrated Appeal decision is not for a Medicare-only service or benefit; and

   b) The Integrated Appeal relates to a denial, in whole or in part, of a Medi-Cal Service or benefit, including cases where there is an overlap of Medicare and Medi-Cal.

4) For Knox-Keene licensed plans, a procedure to ensure that the Medi-Cal External Appeals processes are in accordance with DMHC's IMR System set forth in Article 5.55 of the Knox-Keene Act and the regulations promulgated thereunder.

5) For Knox-Keene licensed plans, a procedure to inform Members of their right to request an IMR in accordance with the Knox-Keene Act, including but not limited to H&S sections1368.03 and 1374.30, and 28 CCR section 1300.74.30, and including the verbatim language required by H&S section 1368.02, as well as the most recent IMR form, application instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC when the following requirements are met:

   a) The denied Integrated Appeal decision is not for a Medicare-only service or benefit; and

   b) The Integrated Appeal is relating to a denial, in whole or in part, of a Medi-Cal Service or benefit, including

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cases where there is an overlap of Medicare and Medi-Cal.

6) Procedure to resolve expedited Integrated Appeals within 72 hours of receipt of the Appeal in accordance with 42 CFR section 422.633(f)(2).

7) Procedure to ensure deadlines for Integrated Appeals of Medicare and Medi-Cal Services are not extended in accordance with APL 21-011 or any subsequent iterations of this APL.

8) Procedure to ensure D-SNP Contractor is obtaining all relevant information needed to make an Integrated Appeal decision within the required timeframes.

9) Procedure to ensure D-SNP Contractor continues the Member's benefits per 42 CFR section 422.632 while the Integrated Appeal is pending if all of the following are met:

   a) The Member files a request to continue benefits within ten calendar days of notice of adverse integrated organization determination;

   b) The integrated appeal involves the termination, suspension, or reduction of previously authorized services;

   c) The services were ordered by an authorized provider; and

   d) The period covered by the original authorization has not expired.

H. For a Reversal of Integrated Appeal Decisions, D-SNP Contractor must have the following:

1) Procedure to authorize or provide the service under dispute if D-SNP Contractor reverses its decision to deny, limit, or delay services that were not provided while the Appeal was pending within the following timeframes:

   a) As expeditiously as the Member's health condition requires and no later than 72 hours from the date it

reverses its determination; or

b) With the exception of a Medicare Part B drug, 30 calendar days after the date D-SNP Contractor receives the request for the Integrated Appeal; or

c) For a Medicare Part B drug, seven (7) calendar days after the date D-SNP Contractor receives the request for the Integrated Appeal.

2) Procedure to authorize or provide the disrupted service(s) if a State Hearing officer reverses D-SNP Contractor's Integrated Appeal decision to deny, limit, or delay services that were not provided while the Appeal was pending, as expeditiously as the Member's health condition requires but no later than 72 hours of the date it receives notice reversing the determination in accordance with 42 CFR section 422.634(d)(2).

3) Procedure to effectuate decisions made by a Part C independent review entity, an administrate law judge or attorney adjudicator at the Office of Medicare Hearings and Appeals, or the Medicare Appeals Council to reverse D-SNP Contractor's decision under the same timelines applicable to other Medicare Advantage plans as specified in 42 CFR sections 422.618,422.619, and 422.634(d)(3).

4) For Knox-Keene licensed plans, the procedure to promptly implement the decision of an IMR that a disputed health care service is medically necessary in accordance with H&S section 1374.~~3~~30.

21. Additional Guidance

A. For Marketing materials, D-SNP Contractor must include information about Medi-Cal Dental benefits. Additional details regarding this requirement are fully outlined in the ~~2025~~2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

B. D-SNP Contractor must include information about Medi-Cal Dental benefits in any materials that provide Member information about D-

Exhibit A, Attachment 1
COORDINATION OF CARE

SNP Dental Supplemental Benefits. Additional details regarding this requirement are fully outlined in the ~~2025~~2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide available on the DHCS website: https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx.

22. Noncompliance and Enforcement

DHCS may implement enforcement actions to address Contractor's performance and compliance issues through monitoring and oversight activities. If DHCS finds the Contractor is noncompliant with any of the obligations set forth in this Contract, the D-SNP Policy Guide, or D-SNP Reporting Requirements, DHCS may require the Contractor to develop and submit a Corrective Action plan response designed to correct or resolve such noncompliance. Corrective Action includes specific identifiable activities or undertakings by the Contractor which address deficiencies or noncompliance. DHCS is not required to impose a Corrective Action plan on Contractor before imposing any of the sanctions set forth in State and federal law. Noncompliance with this Contract may subject the Contractor to discontinuance of new enrollment, or termination of the Contract by DHCS.

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GTC 307

Exhibit C
GENERAL TERMS AND CONDITIONS

1. APPROVAL: This Agreement is of no force or effect until signed by both parties and approved by the Department of General Services, if required. D-SNP Contractor may not commence performance until such approval has been obtained.

2. AMENDMENT: No amendment or variation of the terms of this Agreement shall be valid unless made in writing, signed by the parties and approved as required. No oral understanding or Agreement not incorporated in the Agreement is binding on any of the parties.

3. ASSIGNMENT: This Agreement is not assignable by D-SNP Contractor, either in whole or in part, without the consent of the State in the form of a formal written amendment.

4. AUDIT: D-SNP Contractor agrees that the awarding department, the Department of General Services, the Bureau of State Audits, or their designated representative shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. D-SNP Contractor agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is stipulated. D-SNP Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. (Government Code Section 8546.7, Public Contract Code Section 10115 et seq., and California Code of Regulations, Title 2, Section 1896).

5. INDEMNIFICATION: D-SNP Contractor agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims and losses accruing or resulting to any and all contractors, suppliers, laborers, and any other person, firm or corporation furnishing or supplying work services, materials, or supplies in connection with the performance of this Agreement, and from any and all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by D-SNP Contractor in the performance of this Agreement.

6. DISPUTES: D-SNP Contractor shall continue with the responsibilities under this Agreement during any dispute.

7. TERMINATION FOR CAUSE: The State may terminate this Agreement and be relieved of any payments should D-SNP Contractor fail to perform the requirements of this Agreement at the time and in the manner herein provided. In the event of such termination the State may proceed with the work in any

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Exhibit C
GENERAL TERMS AND CONDITIONS

manner deemed proper by the State. All costs to the State shall be deducted from any sum due to D-SNP Contractor under this Agreement and the balance, if any, shall be paid to D-SNP Contractor upon demand.

8. INDEPENDENT CONTRACTOR*:* D-SNP Contractor, and the agents and employees of D-SNP Contractor, in the performance of this Agreement, shall act in an independent capacity and not as officers or employees or agents of the State.

9. RECYCLING CERTIFICATION: D-SNP Contractor shall certify in writing under penalty of perjury, the minimum, if not exact, percentage of post- consumer material as defined in the Public Contract Code Section 12200, in products, materials, goods, or supplies offered or sold to the State regardless of whether the product meets the requirements of Public Contract Code Section 12209. With respect to printer or duplication cartridges that comply with the requirements of Section 12156(e), the certification required by this subdivision shall specify that the cartridges so comply (Public Contract Code Section12205).

10. NON-DISCRIMINATION CLAUSE: During the performance of this Agreement, D-SNP Contractor shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40*),* marital status, and denial of family care leave. D-SNP Contractor shall insure that the evaluation and treatment of their employees and applicants for employment are free from such discrimination and harassment. D-SNP Contractor shall comply with the provisions of the Fair Employment and Housing Act (Government Code Section 12990 (a-f) et seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 8101 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations, are incorporated into this Agreement by reference and made a part hereof as if set forth in full. D-SNP Contractor shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other Agreement.

11. CERTIFICATION CLAUSES: The CONTRACTOR CERTIFICATION CLAUSES contained in the document CCC 307 are hereby incorporated by reference and made a part of this Agreement by this reference as if attached hereto.

12. TIMELINESS: Time is of the essence in this Agreement.

13. COMPENSATION:

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Exhibit C
GENERAL TERMS AND CONDITIONS

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

14. GOVERNING LAW: This D-SNP Contract is governed by and shall be interpreted in accordance with the laws of the State of California.

15. ANTITRUST CLAIMS:

    [Intentionally Left Blank – Not applicable to this D-SNP Contract]

16. CHILD SUPPORT COMPLIANCE ACT:

    [Intentionally Left Blank – Not applicable to this D-SNP Contract]

17. UNENFORCEABLE PROVISION: In the event that any provision of this Agreement is unenforceable or held to be unenforceable, then the parties agree that all other provisions of this Agreement have force and effect and shall not be affected thereby.

18. PRIORITY HIRING CONSIDERATIONS: If this D-SNP Contract includes services in excess of $200,000, D-SNP Contractor shall give priority consideration in filling vacancies in positions funded by the D-SNP Contract to qualified recipients of aid under Welfare and Institutions Code Section 11200 in accordance with Public Contract Code Section 10353.

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Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

1. Federal Equal Opportunity Requirements

A. D-SNP Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. D-SNP Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. D-SNP Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212). Such notices shall state D-SNP Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

B. D-SNP Contractor will, in all solicitations or advancements for employees placed by or on behalf of D-SNP Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

C. D-SNP Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of D-SNP Contractor's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

D. D-SNP Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act

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SPECIAL TERMS AND CONDITIONS

of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

E. D-SNP Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

F. In the event of D-SNP Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this D-SNP Contract may be cancelled, terminated, or suspended in whole or in part and D-SNP Contractor may be declared ineligible for further federal and State contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

G. D-SNP Contractor will include the Provisions of Paragraphs A through G in every purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or

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(38 USC 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each vendor. D-SNP Contractor will take such action with respect to any purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event D-SNP Contractor becomes involved in, or is threatened with litigation by a vendor as a result of such direction by DHCS, D-SNP Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2. Travel and Per Diem Reimbursement

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

3. Procurement Rules

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

4. Equipment Ownership / Inventory / Disposition

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

5. Subcontract Requirements

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

6. Income Restrictions

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

7. Audit and Record Retention

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

8. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder and the premises in which it is being performed. If any inspection or evaluation is made of the premises of D-SNP Contractor, D-SNP Contractor shall provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations shall be

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performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

It is mutually understood between the parties that this D-SNP Contract may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the D-SNP Contract were executed after that determination was made.

10. Intellectual Property Rights

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

11. Air or Water Pollution Requirements

Any federally funded agreement in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5:

A. Government contractors agree to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act [42 USC 1857(h)], Section 508 of the clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15).

B. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

12. Prior Approval of Training Seminars, Workshops or Conferences

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

13. Confidentiality of Information

A. D-SNP Contractor and its employees, agents shall protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this D-SNP Contract or persons whose names or identifying information become available or are disclosed to D-SNP Contractor, its employees or agents as a result of services performed under this D-SNP Contract, except for statistical information not identifying any such person.

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B. D-SNP Contractor and its employees or agents shall not use such identifying information for any purpose other than carrying out D-SNP Contractor's obligations under this D-SNP Contract.

C. D-SNP Contractor and its employees, or agents shall promptly transmit to the DHCS program contract manager all requests for disclosure of such identifying information not emanating from the client or person.

D. D-SNP Contractor shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS program contract manager.

E. For purposes of this Provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

F. As deemed applicable by DHCS, this Provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this D-SNP Contract or incorporated into this D-SNP Contract by reference.

14. Documents, Publications and Written Reports

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

15. Dispute Resolution Process

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

16. Financial and Compliance Audit Requirements

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

17. Human Subjects Use Requirements

By signing this D-SNP Contract, D-SNP Contractor agrees that if any performance under this D-SNP Contract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such

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examinations are performed shall meet the requirements of 42 USC 263a (CLIA) and the regulations thereto.

18. Novation Requirements

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

19. Debarment and Suspension Certification

A. By signing this D-SNP Contract, D-SNP Contractor agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

B. By signing this D-SNP Contract, D-SNP Contractor certifies to the best of its knowledge and belief, that it and its principals:

1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

2) Have not within a three-year period preceding this D-SNP Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State or local) transaction or contract under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, State or local) with commission of any of the offenses enumerated in Subprovision B.(2) herein;

4) Have not within a three-year period preceding this D-SNP Contract had one or more public transactions (federal, State or local) terminated for cause or default;

5) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

6) Will include a clause entitled, “Debarment and Suspension Certification’’ that essentially sets forth the provisions herein, in all

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lower tier covered transactions and in all solicitations for lower tier covered transactions.

C. If D-SNP Contractor is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to the DHCS program funding this D-SNP Contract.

D. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

E. If D-SNP Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this D-SNP Contract for cause or default.

20. Smoke-Free Workplace Certification

A. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where Women, Infants, and Children (WIC) coupons are redeemed.

B. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.

C. By signing this D-SNP Contract, D-SNP Contractor certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.

21. Covenant Against Contingent Fees

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D-SNP Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this D-SNP Contract upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by D-SNP Contractor for the purpose of securing business. For breach or violation of this warranty, DHCS shall have the right to annul this D-SNP Contract without liability or in its discretion to deduct from the D-SNP Contract price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

22. Payment Withholds

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

23. Performance Evaluation

DHCS may, at its discretion, evaluate the performance of D-SNP Contractor at the conclusion of this D-SNP Contract. If performance is evaluated, the evaluation shall not be a public record and shall remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

24. Officials Not to Benefit

No members of or delegate of Congress or the State Legislature shall be admitted to any share or part of this D-SNP Contract, or to any benefit that may arise therefrom. This Provision shall not be construed to extend to this D-SNP Contract if made with a corporation for its general benefits.

25. Four-Digit Date Compliance

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

26. Prohibited Use of State Funds for Software

D-SNP Contractor certifies that it has appropriate systems and controls in place to ensure that State funds will not be used in the performance of this Contract for the acquisition, operation or maintenance of computer software in violation of copyright laws.

27. Use of Small, Minority Owned and Women's Businesses

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[Intentionally Left Blank – Not applicable to this D-SNP Contract]

28. Alien Ineligibility Certification

By signing this D-SNP Contract, D-SNP Contractor certifies that he/she is not an alien that is ineligible for State and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 USC 1601, et. seq.)

29. Union Organizing

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

30. Contract Uniformity (Fringe Benefit Allowability)

[Intentionally Left Blank – Not applicable to this D-SNP Contract]

31. Lobbying Restrictions and Disclosure Certification

(Applicable to federally funded contracts in excess of $100,000 per 31 USC Section 1352)

A. Certification and Disclosure Requirements

1) Each person (or recipient) who requests or receives a contract, grant, or sub-grant, which is subject to 31 USC Section 1352, and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1, consisting of one page, entitled “Certification Regarding Lobbying”) that the recipient has not made, and will not make, any payment prohibited by Paragraph B of this provision.

2) Each recipient shall file a disclosure (in the form set forth in Attachment 2, entitled “Standard Form-LLL ‘disclosure of Lobbying Activities’”) if such recipient has made or has agreed to make any payment using non appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

3) Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph a(2) herein. An event that materially affects the accuracy of the information reported includes:

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a) A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

b) A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

c) A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract, grant or sub-grant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if required, to the next tier above.

5) All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

B. Prohibition

Section 1352 of Title 31, USC, provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

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Exhibit E, Attachment 1
DEFINITIONS

As used in this D-SNP Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this D-SNP Contract:

1. **Aligned Enrollment** means, per 42 CFR section 422.2, the Enrollment in a D-SNP of a full-benefit Dual Eligible Beneficiary whose Medi-Cal benefits are covered under a Medi-Cal managed care organization contract under section 1903(m) of the Social Security Act between California and D-SNP Contractor's MA organization, which is the parent organization, or another entity that is owned and controlled by D-SNP Contractor's parent organization.

2. **Applicable Integrated Plan** means, per 42 CFR section 422.561, the Medi-Cal managed care organization through which D-SNP Contractor, its parent organization, or another entity that is owned and controlled by its parent organization, covers Medi-Cal services for Dual Eligible Beneficiaries enrolled with D-SNP Contractor and such Medi-Cal managed care organization.

3. **Care Coordination or Coordination of Care** means a process used by a person or team to assist Members in accessing Medicare and Medi-Cal Services, as well as social, educational, and other support services, regardless of the funding source for the services. It is characterized by advocacy, communication, and resource management to promote quality, cost effectiveness, and positive outcomes.

4. **Care Coordinator** means a clinician or other trained individual who is employed or contracted by the Member's primary care provider or D-SNP Contractor, serves on one (1) or more Interdisciplinary Care Teams (ICT), and coordinates and facilitates meetings and other activities of those ICTs, as well as participates in the Health Risk Assessment of each Member on whose ICT they serve.

5. **Caregiver** means, per CY 2024 Physician Fee Schedule (Final Rule), an adult family member or other individual who has significant relationship with, and who provides a broad range of assistance to a Member with a chronic or other health condition, disability, or functional limitation, and a family member, friend or neighbor who provides unpaid assistance to a Member with a chronic illness or disabling condition.

6. **Centers for Medicare & Medicaid Services (CMS)** means the federal agency responsible for management of the Medicare and Medicaid programs.

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DEFINITIONS

7. **Confidential Information** means specific facts or documents identified as “confidential" by any law, regulations or contractual language.

8. **Covered Service(s)** means Care Coordination or Coordination of Care. This is the only service covered under this Contract.

9. **California Department of Health Care Services (DHCS)** means the single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

10. **D-SNP Contract** means this written agreement between DHCS and the D-SNP Contractor.

11. **Dementia Care Specialists** means D-SNP care coordinators/managers trained in understanding Alzheimer's disease and related dementias, symptoms, and progression; understanding and managing behaviors and communication problems; understanding caregiver stress and its management; and connecting enrollees and caregivers to community resources.

12. **Department of Health and Human Services (DHHS)** means the federal agency responsible for management of the Medicare and Medicaid programs.

13. **Director** means the Director of the California Department of Health Care Services.

14. **Dual-Eligible Beneficiary (or Enrollee)** means an individual who is enrolled for benefits under Part A of Title 42 of the United States Code (commencing with Section 1395c) and Part B of Title 42 of the United States Code (commencing with Section 1395j) and is also eligible for medical assistance under the Medi-Cal State Plan. This Contract is only for full-benefit Dual-Eligible Beneficiaries (QMB+, SLMB+, and other full-benefit Dual-Eligible Beneficiaries).

15. **Enrollment** means the process by which a beneficiary eligible for enrollment, as contained in Exhibit A, Attachment 1, Provision 8, and becomes a Member of the D-SNP Contractor’s D-SNP.

16. **Exclusively Aligned Enrollment** means that State Policy has limited a D-SNP’s membership to individuals with Aligned

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Enrollment.

17. **Facility** means any premise that is:

A. Owned, leased, used or operated directly or indirectly by or for D-SNP Contractor or its affiliates for purposes related to this Contract, or

B. Maintained by a provider to provide services on behalf of D-SNP Contractor.

18. **Grievance** means any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of D-SNP Contractor's or provider's operations, activities, or behavior, regardless of whether remedial action is requested.

19. **Integrated Appeal** means any of the procedures that deal with, or result from, adverse integrated organization determinations by D-SNP Contractor on the health care services the Member believes they are entitled to receive, including a delay in providing, arranging for, or approving the health care services such that a delay would adversely affect the health of the Member, or on any amounts the Member must pay for a service. An Integrated Appeal is made by a Member in an Applicable Integrated Plan and is subject to the Integrated Reconsiderations procedures in 42 CFR sections 422.629, 422.633, and 422.634.

20. **Integrated Grievance** means a dispute or complaint that would be defined and covered, for Grievances filed by a Member in a non-applicable integrated plan, under 42 CFR section 422.564 or 42 CFR sections 438.400 through 438.416. Integrated Grievances do not include Appeals procedures and QIO complaints, as described in 42 CFR section 422.564(b) and (c). An Integrated Grievance made a Member in an Applicable Integrated Plan is subject to the Integrated Grievance procedures in 42 CFR sections 422.629 and 422.630.

21. **Integrated Organization Determination** means an organization determination that would otherwise be defined and covered, for a non-Applicable Integrated Plan, as an organization determination under 42 CFR section 422.566, an adverse benefit determination under 42 CFR section 438.400(b), or an action under 42 CFR 431.201. An Integrated Organization Determination is made by a Member in an Applicable Integrated Plan and is subject to the Integrated Organization

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Determination procedures in 42 CFR sections 422.629, 422.631, and 422.634.

22. **Medi-Cal Managed Care Health Plan (MCP)** means a managed care health plan that contracts with DHCS for provision or arrangement of Medi-Cal benefits and services. For the purposes of this Contract, this includes Subcontracted Delegate Health Plans. A Subcontracted Delegate Health Plan is a health care service plan that is a subcontractor of a MCP that DHCS determines to have assumed the entire financial risk for all Medi-Cal Services provided to a Dual Eligible Beneficiary that are covered under the applicable comprehensive risk contract of the MCP.

23. **Medi-Cal Fee-For-Service (FFS)** means the Med-Cal delivery system in which providers submit claims to and receive payments from DHCS for services covered under Medi-Cal and rendered to Medi-Cal recipients.

24. **Medi-Cal Services** means all services covered by the Medi-Cal program as identified in Exhibit H, which is attached to this Contract.

25. **Medically Necessary or Medical Necessity** means reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and Title 22 CCR section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.

26. **Member** means any Dual-Eligible Beneficiary who is enrolled in with D-SNP Contractor.

27. **Service Area** means the county or counties that D-SNP Contractor is approved to operate in under the terms of this D-SNP Contract. A Service Area may have designated zip codes (under the U.S. Postal Service) within a county that are approved by DHCS to operate under the terms of this D-SNP Contract.

28. **State** means the State of California.

29. **Supplemental Benefits** means all of the following under Medicare Advantage definitions: Initial and Expansion Primarily Health Related Supplemental Benefits, Special Supplemental Benefits for the Chronically Ill, and Value Based-Insurance Design Model benefits.

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30. **Subcontracted Delegate Health Plan** means a health care service plan that is a subcontractor of a Medi-Cal MCP that DHCS determines to have assumed the entire financial risk for all Medi-Cal Services provided to a Member that is covered under the applicable comprehensive risk contract of the MCP.

31. **Working day(s)** mean State calendar (State Appointment Calendar, Standard 101) working day(s).

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

1. Governing Law

In addition to Exhibit C, Provision 14, Governing Law, D-SNP Contractor also agrees to the following:

A. If it is necessary to interpret this D-SNP Contract, all applicable laws may be used as aids in interpreting the D-SNP Contract. However, the parties agree that any such applicable laws shall not be interpreted to create contractual obligations upon DHCS or D-SNP Contractor, unless such applicable laws are expressly incorporated into this D-SNP Contract in some section other than this provision, Governing Law. The parties agree that any remedies for DHCS' or D-SNP Contractor's non-compliance with laws not expressly incorporated into this D-SNP Contract, or any covenants implied to be part of this D-SNP Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. This D-SNP Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this D-SNP Contract, both parties shall be deemed authors of this D-SNP Contract.

Any provision of this D-SNP Contract which is in conflict with current or future applicable federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the D-SNP Contract will be effective on the effective date of the statutes or regulations necessitating it and binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

B. Such amendment will constitute grounds for termination of this D-SNP Contract in accordance with the procedures and provisions of Provision 18, Paragraph C, Termination – D-SNP Contractor below. The parties shall be bound by the terms of the amendment until the effective date of the termination.

C. All existing policy guidance issued by DHCS, including the D-SNP Policy Guide, can be viewed at https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx and shall be complied with by D-SNP Contractor. All policy guidance issued by DHCS subsequent to the effective date of this D-SNP Contract must provide clarification of D-SNP Contractor's obligations pursuant to this D-SNP Contract, and may include instructions to D-

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SNP Contractor regarding implementation of mandated obligations pursuant to changes in State or federal statutes or regulations, or pursuant to judicial interpretation. In the event DHCS determines that there is an inconsistency between this D-SNP Contract and DHCS policy guidance, the D-SNP Contract shall prevail.

2. Entire Agreement

This written D-SNP Contract and any amendments constitute the entire agreement between the parties. No oral representations are binding on either party unless such representations are reduced to writing and made an amendment to the D-SNP Contract.

3. Amendment Process

In addition to Exhibit C, Provision 2, Amendment, D-SNP Contractor also agrees to the following:

Should either party, during the life of this D-SNP Contract, desire a change in this D-SNP Contract, that change shall be proposed in writing to the other party. The other party must acknowledge receipt of the proposal within ten (10) calendar days of receipt of the proposal. The party proposing any such change has the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal must set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this D-SNP Contract which would provide for the change. If the proposal is accepted, this D-SNP Contract will be amended to provide for the change mutually agreed to by the parties on the condition that the amendment is approved by DHHS, and the State Department of Finance, if necessary.

4. Change Requirements

A. General Provisions

The parties recognize that during the life of this D-SNP Contract, the Medi-Cal Managed Care program will be a dynamic program requiring numerous changes to its operations and that the scope and complexity of changes will vary widely over the life of the D-SNP Contract. The parties agree that the development of a system which has the capability to implement such changes in an orderly and timely manner is of considerable importance.

B. D-SNP Contractor's Obligation to Implement

The D-SNP Contractor must make changes mandated by DHCS. In the case of mandated changes in regulations, statutes, federal or State guidelines, or judicial interpretation, DHCS may direct the D-SNP Contractor to immediately begin implementation of any change by issuing a change order. If DHCS issues a change order, the D-SNP Contractor must implement the required changes while discussions are taking place. DHCS may, at any time, within the general scope of the D-SNP Contract, by written notice, issue change orders to the D-SNP Contract.

5. Delegation of Authority

DHCS intends to implement this D-SNP Contract through a single administrator, called the "Contracting Officer." The Director of DHCS will appoint the Contracting Officer. The Contracting Officer, on behalf of DHCS, will make all determinations and take all actions as are appropriate under this D-SNP Contract, subject to the limitations of applicable Federal and State laws and regulations. The Contracting Officer may delegate his/her authority to act to an authorized representative through written notice to the D-SNP Contractor.

D-SNP Contractor will designate a single administrator; hereafter called the "Contractor's Representative." The Contractor's Representative, on behalf of the D-SNP Contractor, will make all determinations and take all actions as are appropriate to implement this D-SNP Contract, subject to the limitations of the D-SNP Contract, Federal and State laws and regulations. The Contractor's Representative may delegate their authority to act to an authorized representative through written notice to the Contracting Officer. The Contractor's Representative will be empowered to legally bind the D-SNP Contractor to all agreements reached with DHCS. D-SNP Contractor shall designate Contractor’s Representative in writing and shall notify the Contracting Officer in accordance with Exhibit E, Attachment 2, Provision 13, Notices.

6. Authority of the State

Sole authority to establish, define, or determine the reasonableness, the necessity and level and scope of covered services under the Medi-Cal program administered in this D-SNP Contract or coverage for such services, or the eligibility of the beneficiaries or providers to participate in the Medi-Cal Program resides with DHCS. Sole authority to establish or interpret policy and its application related to the above areas will reside with DHCS.

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

The D-SNP Contractor may not make any limitations, exclusions, or changes in covered services; any changes in definition or interpretation of covered services; or any changes in the administration of the D-SNP Contract related to the scope of covered services, allowable coverage for those covered services, or eligibility of beneficiaries or providers to participate in the program, without the express, written direction or approval of the Contracting Officer.

7. Fulfillment of Obligations

No covenant, condition, duty, obligation, or undertaking continued or made a part of this D-SNP Contract will be waived except by written agreement of the parties hereto, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply; and, until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party will have the right to invoke any remedy available under this D-SNP Contract, or under law, notwithstanding such forbearance or indulgence.

8. Prohibition Against Assignments or Delegation of D-SNP Contractor's Duties and Obligations Under this D-SNP Contract

The D-SNP Contractor must not negotiate or enter into any agreement to assign or delegate the duties and obligations under this D-SNP Contract. If D-SNP Contractor fails to comply with this Provision, DHCS may terminate the D-SNP Contract for cause in compliance with Exhibit E, Attachment 2, Provision 17.

9. Prohibition Against Novations

D-SNP Contractor must not enter any novation agreements without prior discussion with DHCS.

10. Obtaining DHCS Approval

D-SNP Contractor must obtain written approval from DHCS prior to commencement of operation under this D-SNP Contract:

A. Within five (5) working days of receipt, DHCS must acknowledge in writing the receipt of any material sent to DHCS pursuant to this Provision.

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B. Within 60 calendar days of receipt, DHCS must make all reasonable efforts to approve in writing the use of such material provided to DHCS pursuant to this Provision to provide D-SNP Contractor with a written explanation why its use is not approved or provide a written estimated date of completion of DHCS' review process. If DHCS does not complete its review of submitted material within 60 calendar days of receipt, or within the estimated date of completion of DHCS review, D-SNP Contractor may elect to implement or use the material at D-SNP Contractor's sole risk and subject to possible subsequent disapproval by DHCS. This Provision must not be construed to imply DHCS approval of any material that has not received written DHCS approval.

11. Program

DHCS reserves the right to review and approve any changes to D-SNP Contractor's protocols, policies, and procedures as specified in this D-SNP Contract.

12. Certifications

D-SNP Contractor must comply with certification requirements set forth in 42 CFR 438.604 and 42 CFR 438.606.

In addition to Exhibit C, Provision 11, Certification Clauses, D-SNP Contractor also agrees to the following:

With respect to any report, invoice, record, papers, documents, books of account, or other Contract required data submitted, pursuant to the requirements of this D-SNP Contract, the Contractor's Representative or their designee will certify, under penalty of perjury, that the report, invoice, record, papers, documents, books of account or other Contract required data is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's knowledge and belief, unless the requirement for such certification is expressly waived by DHCS in writing.

13. Notices

All notices to be given under this D-SNP Contract will be in writing and will be deemed given when sent via certified mail or electronic mail (email). DHCS and D-SNP Contractor will designate email addresses for notices sent via email. Notices sent via certified mail must be addressed to the

following DHCS and D-SNP Contractor contacts:

California Department of Health Care Services	[D-SNP Contractor Name] ~~California~~
Managed Care Operations Division Attn: Michelle Retke, Division Chief	Attn: [Name~~,~~] ~~President~~ , Title]
MS 4408 P.O. Box 997413	[Address]
~~P.O. Box 997413~~	~~[City, State, Zip Code]~~
Sacramento, CA 95899-7413	[City, State Zip Code]

14. Term

The D-SNP Contract is effective January 1, ~~2025~~2026, and continues in full force and effect through December 31, ~~2025~~2026.

15. Service Area

The Service Area covered under this D-SNP Contract is stated in Exhibit A, Provision 8, Coverage Area and Eligible Beneficiaries. All D-SNP Contract provisions apply separately to each county within the Service Area.

16. D-SNP Contract Extension

DHCS has the exclusive option to extend the term of this D-SNP Contract for any reason, in any county within the Service Area, with at least nine (9) months' written notice to D-SNP Contractor before the end of the D-SNP Contract term.

17. Termination for Cause and Other Terminations

In addition to Exhibit C, Provision 7, Termination for Cause, D-SNP Contractor also agrees to the following:

A. DHCS-Initiated Terminations

1) DHCS will terminate this D-SNP Contract in the event that the Director determines that the health and welfare of Members is jeopardized by the continuation of the D-SNP Contract. Termination pursuant to the requirements in this Provision's Paragraph A.1) will be effective immediately upon the provision of written notice provided by DHCS to D-SNP Contractor.

2) Termination for Cause

a) DHCS may terminate this D-SNP Contract should D-SNP Contractor fail to perform the requirements of this Contract. In the event of such termination, DHCS may proceed with providing the services required under this D-SNP Contract in any manner deemed proper by DHCS.

b) DHCS may terminate this D-SNP Contract in the event that D-SNP Contractor enters negotiations to change ownership or actually changes ownership, enters negotiations to assign or delegate its duties and obligations under this D-SNP Contract to another party or actually assigns or delegates its duties or obligations under the D-SNP Contract.

c) Should DHCS terminate this D-SNP Contract for cause under this Provision's Paragraph A.2) of this D-SNP Contract, DHCS will provide D-SNP Contractor with at least 60 calendar days' notice prior to the effective date of termination, unless potential beneficiary harm requires a shorter notice period. D-SNP Contractor agrees that this notice provision is reasonable.

d) DHCS must terminate this D-SNP Contract under this Provision and pursuant to the provisions of Welfare and Institutions Code, Section 14197.7, and California Code of Regulations, Title 22, Section 53873.

B. D-SNP Contractor-Initiated Terminations

D-SNP Contractor may only terminate this D-SNP Contract when a change in contractual obligations is created by a State or federal change in the Medi-Cal program, or a lawsuit, that substantially alters the conditions under which the D-SNP Contractor entered into this D-SNP Contract, such that the D-SNP Contractor can demonstrate this to the satisfaction of DHCS.

C. Termination of Obligations

All obligations to provide services under this D-SNP Contract will

automatically terminate on the date the operations period ends.

18. Disputes

D-SNP Contractor must comply with and exhaust the requirements of this Provision when it initiates a contract dispute with DHCS. This Provision (Disputes) does not apply to challenges to Corrective Action plans as described in Exhibit A, Provision 22, or any other contract compliance action initiated by DHCS. In addition to Exhibit C, Provision 6, Disputes, D-SNP Contractor also agrees to the following:

A. Disputes Resolution by Negotiation

D-SNP Contractor agrees to make best efforts to resolve all contractual issues by negotiation and mutual agreement at the DHCS Contracting Officer level before appealing to the DHCS Office of Administrative Hearings and Appeals (OAHA). D-SNP Contractor must exhaust OAHA's appeal process before filing a writ in Sacramento County Superior Court. During the negotiations to resolve Contractor's issues, DHCS and Contractor may agree, in writing, to an extension of time for continuing negotiations to resolve Contractor's dispute before the decision of the DHCS Contracting Officer is issued.

B. Notice of Dispute

1) Within 30 calendar days from the date that the alleged dispute arises or otherwise becomes known to D-SNP Contractor, D-SNP Contractor must serve a written Notice of Dispute to the DHCS' Contracting Officer. D-SNP Contractor's failure to serve its Notice of Dispute within 30 calendar days from the date the alleged dispute arises or otherwise becomes known to D-SNP Contractor constitutes a waiver of all issues raised in D-SNP Contractor's Notice of Dispute.

2) The D-SNP Contractor's Notice of Dispute must include, based on the most accurate and substantiating information then available to the D-SNP Contractor, the following:

a) That it is a dispute subject to the procedures set forth in this Provision.

b) The date, nature, and circumstances of the conduct

which is subject of the dispute.

c) The names, phone numbers, functions, and conduct of each D-SNP Contractor, DHCS/State official or employee involved in or knowledgeable about the alleged issue that is the subject of the dispute.

d) The identification of any substantiating documents and the substances of any oral communications that are relevant to the alleged conduct. Copies of all identified documents will be attached.

e) Copies of all substantiating documentation and any other evidence.

f) The factual and legal bases supporting Contractor's Notice of Dispute.

g) The cost impact to D-SNP Contractor directly attributable to the alleged conduct, if any.

h) D-SNP Contractor's desired remedy.

3) The required documentation set forth above, in this Provision's Paragraph B.2), will serve as the basis for any subsequent appeal.

4) After D-SNP Contractor submits its Notice of Dispute with all accurate available substantiating documentation, D-SNP Contractor must comply with the requirements of Title 22, CCR, Section 53851(d) and must diligently continue performance of this D-SNP Contract, including compliance with contract requirements that are the subject of, or related to, D-SNP Contractor's Notice of Dispute.

5) If D-SNP Contractor requests and DHCS agrees, D-SNP Contractor's Notice of Dispute may be decided by an Alternate Dispute Officer (ADO). DHCS will designate an ADO who was not directly involved in the alleged conduct that prompted D-SNP Contractor's Notice of Dispute.

6) Any appeal of the DHCS Contracting Officer or ADO's decision to OAHA or a writ seeking review of OAHA's decision in

Sacramento County Superior Court shall be limited to the issues and arguments set forth and properly documented in D-SNP Contractor's Notice of Dispute, that were not waived or resolved.

C. The DHCS Contracting Officer's or ADO's Decision

Any disputes concerning performance of this D-SNP Contract will be decided by the DHCS Contracting Officer or the ADO in a written decision stating the factual basis for the decision. Within 30 calendar days of receipt of a Notice of Dispute, the Contracting Officer or the ADO shall either:

1) Find in favor of D-SNP Contractor, in which case the DHCS Contracting Officer or ADO may correct the earlier conduct which caused D-SNP Contractor to file a dispute; or

2) Deny D-SNP Contractor's dispute and, where necessary, direct the manner of future performance; or

3) Request additional substantiating documentation in the event the information in D-SNP Contractor's notification is inadequate to permit a decision to be made under Paragraphs B.2) or C.1) above. If the DHCS Contracting Officer or ADO determines that additional substantiating information is required, they will provide D-SNP Contractor with a written request identifying the issue(s) requiring additional substantiating documentation. D-SNP Contractor must provide that additional substantiating documentation no later than 30 calendar days from receipt of the request. Upon receipt of this additional requested substantiating information, the DHCS Contracting Officer or ADO shall have 30 calendar days to issue a decision. Failure to supply additional substantiating information requested by the DHCS Contracting Officer or ADO, or otherwise notify the DHCS Contracting Officer or ADO that no additional documents exist, within the time period specified above shall constitutes D-SNP Contractor's waiver of issues raised in D-SNP Contractor's Notice of Dispute.

A copy of the decision shall be served on D-SNP Contractor.

D. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision

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PROGRAM TERMS AND CONDITIONS

1) D-SNP Contractor will have 30 calendar days following the receipt of the DHCS Contracting Officer or ADO's decision to appeal the decision to the Director, through the OAHA. All of D-SNP Contractor's appeals are governed by Health and Safety Code, section 100171, except Government Code section 11511 will not apply.

2) All of D-SNP Contractor's appeals must be in writing and be filed with the OAHA and a copy sent to the Chief Counsel of DHCS and the DHCS Contract Manager. D-SNP Contactor's appeal shall be deemed filed on the date it is received by the OAHA. D-SNP Contractor's appeal will be known as Statement of Disputed Issues and must specifically set forth the unresolved issue(s) that remain in dispute and issues that have not been waived because of D-SNP Contractor's failure to provide all substantiating documentation to DHCS, as specified in Paragraph C of this Provision, and include D-SNP Contractor's contentions as to those issues. Additionally, D- SNP Contractor's appeal will be limited to those issues raised in its Notice of Dispute filed pursuant to Paragraph B, Notification of Dispute that have not been resolved or waived.

3) D-SNP Contractor has the burden of proof of demonstrating that its position is correct and must show by a preponderance of evidence that:

   a) DHCS acted improperly such that it breached this Contract; and

   b) D-SNP Contractor sustained a cost impact directly related to DHCS' breach.

4) OAHA's jurisdiction is limited to issues and arguments raised in the Notice of Dispute that were not waived by the untimely filing of the Notice of Dispute or Statement of Disputed Issues, by D-SNP's Contractor's failure to provide all requested substantiating documentation requested by the DHCS Contracting Officer or ADO, or by D-SNP's Contractor failure to notify the DHCS Contracting Officer or ADO that no additional documents exist within the required timeframe as required in Paragraph C(3), or otherwise resolved by D-SNP Contractor and DHCS.

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PROGRAM TERMS AND CONDITIONS

E. No Obligation to Pay Interest

If D-SNP Contractor prevails on its Notice of Dispute pursuant to a DHCS Contracting Officer's or ADO's decision, an OAHA decision, or an order or decision issued by the Sacramento County Superior Court or any California court of appeal, DHCS will not be required to pay interest on any amounts found to be due or owing to D-SNP Contractor arising out of the Notice of Dispute or any subsequent litigation.

F. D-SNP Contractor Duty to Perform

D-SNP Contractor must comply with all requirements of 22 CCR section 53851(d) and continue to perform all obligations under this D-SNP Contract, including continuing D-SNP Contract requirements that are the subject of, or related to, D-SNP Contractor's Notice of Dispute until there is a final decision from the DHCS Contracting Officer, the ADO or a decision on an appeal in Sacramento County Superior Court or any California Court of Appeal or the California Supreme Court.

G. Waiver of Claims

D-SNP Contractor waives all claims or issues if it fails to timely submit a Notice of Dispute with all substantiating documents within the timeframes set forth in Paragraph B of this Provision. D-SNP Contractor also waives all claims or issues set forth in its Notice of Dispute if it fails to timely submit all additional substantiating documentation within 30 calendar days at the DHCS Contracting Officer or ADO's request, or if it fails to notify the DHCS Contracting Officer or ADO, within 30 calendar days of DHCS Contracting Officer's or ADO's request, that no additional documents exist. D-SNP Contractor also waives all claims or issues set forth in its Notice of Dispute if it fails to timely appeal the DHCS Contracting Officer or ADO's decision in the manner and within the time specified in this Provision 18. D-SNP Contractor's waiver includes all damages whether direct or consequential in nature.

19. Audit

In addition to Exhibit C, Provision 4, Audit, D-SNP Contractor agrees to the following:

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

The D-SNP Contractor must maintain such books and records necessary to disclose how the D-SNP Contractor discharged its obligations under this D- SNP Contract. These books and records will disclose the quantity of Covered Services provided under this D-SNP Contract, the quality of those services, the manner for those services, the persons eligible to receive Covered Services, and the manner in which the Contractor administered its daily business.

A. Books and Records

These books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this D- SNP Contract including working papers; reports submitted to DHCS; all medical records, medical charts and prescription files; and other documentation pertaining to Covered Services rendered to Members.

B. Records Retention

Notwithstanding any other records retention time period set forth in this D-SNP Contract, these books and records must be maintained for a minimum of five years from the end of the current Fiscal Year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created or the D-SNP Contract is terminated, or, in the event the D-SNP Contractor has been duly notified that DHCS, Department of Health and Human Services (DHHS), Department of Justice (DOJ) or the Comptroller General of the United States, or their duly authorized representatives, have commenced an audit or investigation of the D-SNP Contract, until such time as the matter under audit or investigation has been resolved, whichever is later.

20. Inspection Rights

In addition to Exhibit D(F), Provision 8, Site Inspection, D-SNP Contractor also agrees to the following:

A. Through the end of the records retention period specified in Provision 19, Audit, Paragraph B, Records Retention above, D-SNP Contractor must allow the DHCS, DHHS, the Comptroller General of the United States, DOJ Bureau of Medi-Cal Fraud, Department of Managed Health Care (DMHC), and other authorized State agencies, or their duly authorized representatives, including DHCS' external quality review organization contractor, to

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audit, inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this D-SNP Contract, and to inspect, evaluate, and audit any and all premises, books, records, equipment, contracts, computers, or other electronic systems and facilities maintained by D-SNP Contractor pertaining to these services at any time during normal business hours. Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, and books of account, medical records, prescription files, laboratory results, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Provision 19, Audit, Paragraph B, Records Retention above, D-SNP Contractor shall furnish any record, or copy of it, to DHCS or any other entity listed in this section, at D-SNP Contractor's sole expense.

B. Access Requirements and State's Right to Monitor

Authorized State and federal agencies have the right to monitor all aspects of the D-SNP Contractor's operation for compliance with the provisions of this D-SNP Contract and applicable federal and State laws and regulations. Such monitoring activities include, but are not limited to, inspection and auditing of D-SNP Contractor and provider management systems and procedures, and books and records as the Director deems appropriate, at any time during the D-SNP Contractor's normal business hours. The monitoring activities may be announced or unannounced.

21. Confidentiality of Information

In addition to Exhibit D(F), Provision 13, Confidentiality of Information, D-SNP Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

A. Notwithstanding any other provision of this D-SNP Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42, CFR, Section 431.300 et seq., Welfare and Institutions Code, Section 14100.2, and regulations adopted thereunder. For the purpose of this D-SNP Contract, all information, records, data, and data elements collected and maintained for the operation of the D-SNP Contract and pertaining to Members shall be protected by

the D-SNP Contractor from unauthorized disclosure.

D-SNP Contractor may release medical records in accordance with applicable law pertaining to the release of this type of information. D-SNP Contractor is not required to report requests for medical records made in accordance with applicable law. Exhibit G is hereby incorporated into this Contract by reference.

B. With respect to any identifiable information concerning a Member under this D-SNP Contract that is obtained by the D-SNP Contractor, the D-SNP Contractor:

1) Will not use any such information for any purpose other than carrying out the express terms of this D-SNP Contract;

2) Will promptly transmit to DHCS all requests for disclosure of such information, except requests for medical records in accordance with applicable law;

3) Will not disclose, except as otherwise specifically permitted by this D-SNP Contract, any such information to any party other than DHCS without DHCS' prior written authorization specifying that the information is releasable under 42 CFR, Section 431.300 et seq., Welfare and Institutions Code, Section 14100.2, and regulations adopted thereunder; and

4) Will, at the termination of this D-SNP Contract, return all such information to DHCS or maintain such information according to written procedures sent to the D-SNP Contractor by DHCS for this purpose.

22. Third-Party Tort and Workers' Compensation Liability

D-SNP Contractor must identify and notify DHCS' Third Party Liability and Recovery Division of all instances or cases in which D-SNP Contractor believes an action by the Medi-Cal Member involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Member of funds to which DHCS has lien rights under Welfare and Institutions Code Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, D-SNP Contractor shall make no claim for recovery of the value of case management rendered to a Member in such cases or instances and such case or instance shall be referred to DHCS' Third Party Liability and Recovery Division within ten (10) calendar days of discovery. To assist DHCS in exercising its responsibility for such

recoveries, D-SNP Contractor shall meet the following requirements:

A. If DHCS requests service information and/or copies of reports for Covered Services to an individual Member, D-SNP Contractor must deliver the requested information within 30 calendar days of the request.

B. Information to be delivered must contain the following data items:

1) Member name.

2) Full 14-digit Medi-Cal number.

3) Social Security Number.

4) Date of birth.

5) Diagnosis code and description of illness/injury (if known).

6) Procedure code and/or description of services rendered (if known).

C. D-SNP Contractor must identify to DHCS' Third Party Liability and Recovery Division the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

D. If D-SNP Contractor receives any requests from attorneys, insurers, or beneficiaries for copies of referrals, D-SNP Contractor must refer the request to the Third Party Liability and Recovery Division with the information contained in Paragraph B above, and provide the name, address and telephone number of the requesting party.

E. Use the TPLManagedCare@dhcs.ca.gov inbox for all communications regarding D-SNP Contractor's service and utilization information, and paid invoices and claims submissions, to submit questions or comments related to the preparation and submission of these reports, and for issues related to accessing the secure file transfer protocol folders.

23. Records Related To Recovery for Litigation

A. Upon request by DHCS, D-SNP Contractor must timely gather,

preserve and provide to DHCS, in the form and manner specified by DHCS, any information specified by DHCS, subject to any lawful privileges, in D-SNP Contractor's possession, relating to threatened or pending litigation by or against DHCS.

B. If D-SNP Contractor asserts that any requested documents are covered by a privilege, D-SNP Contractor must:

1) Identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and

2) State the privilege being claimed that supports withholding production of the document.

C. Such a request must include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against DHCS. D-SNP Contractor acknowledges that time may be of the essence in responding to such request. D-SNP Contractor must use all reasonable efforts to immediately notify DHCS of any subpoenas, document production requests, or requests for records, received by D-SNP Contractor related to this D-SNP Contract.

24. Equal Opportunity Employer

D-SNP Contractor must comply with all applicable federal and State employment discrimination laws. D-SNP Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the D-SNP Contractor, state that it is an equal opportunity employer, and will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by DHCS, advising the labor union or workers' representative of the D-SNP Contractor's commitment as an equal opportunity employer and will post copies of the notice in conspicuous places available to employees and applicants for employment.

25. Discrimination Prohibitions

A. Member Discrimination Prohibition

D-SNP Contractor must not unlawfully discriminate against Members or beneficiaries eligible for enrollment into Contractor’s D-SNP on the basis of sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability,

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

physical disability, medical condition, genetic information marital status, gender, gender identity, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with the statutes identified in Exhibit E, Attachment 2, Provision 26 below, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. For the purpose of this D-SNP Contract, discrimination includes, but is not limited to, the following:

1) Denying any Member case any Covered Services;

2) Providing to a Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members under this Contract except where medically indicated;

3) Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service;

4) Restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or a beneficiary eligible for enrollment into the Contractor's D-SNP differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Service;

5) Assigning times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56.

6) Failing to make Auxiliary Aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability;

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7) Failing to ensure meaningful access to programs and activities for Limited English Proficient (LEP) Members and potential enrollees.

8) D-SNP Contractor must take affirmative action to ensure that Members are provided Covered Services without regard to sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56, except as needed to provide equal access to Limited English Proficient (LEP) Members or Members with disabilities, or as medically indicated.

9) For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

B. Discrimination Related to Health Status

D-SNP Contractor must not discriminate among eligible individuals on the basis of their health status requirements or requirements for health care services during Enrollment, re-enrollment or disenrollment. D-SNP Contractor will not terminate the Enrollment of an eligible individual based on an adverse change in the Member's health.

26. Federal and State Nondiscrimination Requirements

D-SNP Contractor must comply with all applicable federal requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities, as amended); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973, as amended; Titles I and II of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations issued under the above-listed statutes. D-SNP Contractor shall also comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, Sections 7405 and 11135 of the Government Code, Section 14029.91 of the Welfare and Institutions Code, and state implementing

regulations.

27. Discrimination Grievances

D-SNP Contractor must process a grievance for discrimination as required by APL 21-004 or subsequent iterations, and in accordance with federal and State nondiscrimination law as stated in 45 CFR section 84.7; 34 CFR section 106.8; 28 CFR section 35.107; and W&I Code section 14029.91(e)(4).

A. D-SNP Contractor must designate a discrimination grievance coordinator responsible for ensuring compliance with federal and State nondiscrimination requirements, and investigating discrimination grievances related to any action that would be prohibited by, or out of compliance with, federal or State nondiscrimination law.

B. D-SNP Contractor must adopt procedures to ensure the prompt and equitable resolution of discrimination grievances by D-SNP Contractor. D-SNP Contractor will not require a Member or potential enrollee to file a discrimination grievance with D-SNP Contractor before filing with the DHCS Office of Civil Rights or the U.S. Health and Human Services Office for Civil Rights.

C. Within ten calendar days of mailing a discrimination grievance resolution letter, D-SNP Contractor must submit the following information regarding the discrimination grievance in a secure format to the DHCS Office of Civil Rights:

1) The original discrimination grievance;

2) The provider's or other accused party's response to the discrimination grievance;

3) Contact information for the personnel primarily responsible for investigating and responding to the discrimination grievance on behalf of D-SNP Contractor;

4) Contact information for the person filing the discrimination grievance, and for the provider or other accused party that is the subject of the discrimination grievance;

5) All correspondence with the person filing the discrimination grievance regarding the discrimination grievance, including, but not limited to, the discrimination grievance acknowledgment letter and resolution letter; and

6) The results of D-SNP Contractor's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

28. Nondiscrimination Notice and Language Taglines

A. D-SNP Contractor must post (1) a DHCS-approved nondiscrimination notice, and (2) language taglines in a conspicuously visible font size in English, the threshold languages, and at least the top 15 non-English languages in the State, and any other languages, as determined by DHCS, explaining the availability of free language assistance services, including written translation and oral interpretation, and information on how to request Auxiliary Aids and services, including materials in alternative formats. The nondiscrimination notice and taglines shall include D-SNP Contractor's toll-free and TTY/TDD telephone number for obtaining these services, and shall be posted in the Member Services Guide/Evidence of Coverage, and in all Member information, informational notices, and materials critical to obtaining services targeted to Members, potential Members, applicants, and members of the public, in accordance with APL 21-004 and APL 22-002 or subsequent iterations, 42 CFR section 438.10(d)(2)-(3), Section 1557 of the Affordable Care Act, and W&I Code section 14029.91(f) and 14029.92(c).

B. D-SNP Contractor's nondiscrimination notice must include all information required by W&I Code section 14029.91(e) and APL 21-004 or subsequent iterations, any additional information required by DHCS, and must provide information on how to file a discrimination grievance with:

1) Both D-SNP Contractor and the DHCS Office of Civil Rights, if there is a concern of discrimination in the Medi-Cal program based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation or

identification with any other persons or groups defined in Penal Code 422.56. (W&I Code section 14029.91(e); H&S Code section 11135; and

2) The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability. (W&I Code section 14029.91(e)).

29. Small Business Participation and Disabled Veteran Business Enterprises (DVBE) Reporting Requirements

A. D-SNP Contractor must comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at Public Contract Code section 10230.

B. If for this D-SNP Contract, D-SNP Contractor made a commitment to achieve small business participation, then D-SNP Contractor must annually and within 60 calendar days of receiving final payment under this D-SNP Contract report to DHCS the actual percentage of small business participation that was achieved per Government Code section 14841.

C. If for this D-SNP Contract, D-SNP Contractor made a commitment to achieve DVBE participation, then D-SNP Contractor must annually and within 60 calendar days of receiving final payment under this D-SNP Contract certify in a report to DHCS the following:

1) The total amount Contractor received under the Contract;

2) The name and address of the DVBE(s) that participated in the performance of the Contract;

3) The amount each DVBE received from Contractor;

4) That all payments under the Contract have been made to the DVBE; and

5) The actual percentage of DVBE participation that was achieved, per Mil. & Vets. Code section 999.5(d), and Government Code section 14841.

30. Word Usage

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Unless the context of this D-SNP Contract clearly requires otherwise, (a) the plural and singular numbers is deemed to include the other; (b) the masculine, feminine, and neuter genders shall each be deemed to include the others; (c) "shall," "will," "must," or "agrees" are mandatory, and "may" is permissive; (d) "or" is not exclusive; and (e) "includes" and "including" are not limiting.

31. Federal False Claims Act Compliance

Effective January 1, 2007, D-SNP Contractor must comply with 42 USC Section 1396a (a)(68), Employee Education About False Claims Recovery, as a condition of receiving payments under this D-SNP Contract. Upon request by DHCS, D-SNP Contractor must demonstrate compliance with this provision, which may include providing DHCS with copies of D-SNP Contactor's applicable written policies and procedures and any relevant employee handbook excerpts.

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations, Parts 160 and 164 (collectively, and as used in this Agreement)

2. The term "Agreement" as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term "Business Associate" shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by Federal and/or state laws.

4.1 As used in this Agreement and unless otherwise stated, the term "PHI" refers to and includes both "PHI" as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

4.2 As used in this Agreement, the term "confidential information" refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which state and/or federal privacy and/or security protections apply.

5. D-SNP Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, "use or disclose PHI") in order to fulfill Business Associate's obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties."

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

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Exhibit G
BUSINESS ASSOCIATE ADDENDUM

7. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement on behalf of DHCS, provided that such use or disclosure would not violate HIPAA if done by DHCS.

   7.1 Specific Use and Disclosure Provisions. Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware that the confidentiality of the information has been breached.

8. **Compliance with Other Applicable Law**

   8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

      8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

      8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

   8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.

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8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

9.1 Nondisclosure. Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

9.2 Safeguards and Security.

9.2.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be, at a minimum, at Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.2.2 Business Associate shall, at a minimum, utilize an industry-recognized security framework when selecting and implementing its security controls, and shall maintain continuous compliance with its selected framework as it may be updated from time to time. Examples of industry-recognized security frameworks include but are not limited to

9.2.2.1 NIST SP 800-53 – National Institute of Standards and Technology Special Publication 800-53

9.2.2.2 FedRAMP – Federal Risk and Authorization Management Program

9.2.2.3 PCI – PCI Security Standards Council

9.2.2.4 ISO/ESC 27002 – International Organization for Standardization / International Electrotechnical Commission standard 27002

9.2.2.5 IRS PUB 1075 – Internal Revenue Service Publication 1075

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BUSINESS ASSOCIATE ADDENDUM

9.2.2.6 HITRUST CSF – HITRUST Common Security Framework

9.2.3 Business Associate shall maintain, at a minimum, industry standards for transmission and storage of PHI and other confidential information.

9.2.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.2.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

9.2.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.

9.3 Business Associate's Agent. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. **Mitigation of Harmful Effects**. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. **Access to PHI.** Business Associate shall make PHI available in accordance with 45 CFR section 164.524.

12. **Amendment of PHI.** Business Associate shall make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. **Accounting for Disclosures.** Business Associate shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

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Exhibit G
BUSINESS ASSOCIATE ADDENDUM

14. **Compliance with DHCS Obligations.** To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR Part 164, Subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

15. **Access to Practices, Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.

16. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

17. **Special Provision for SSA Data.** If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

18. **Breaches and Security Incidents.** Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

18.1 Notice to DHCS.

18.1.1 Business Associate shall notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to DHCS.

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18.1.2 Business Associate shall notify DHCS **within 24 hours by email** (or by telephone if Business Associate is unable to email DHCS) of the discovery of:

18.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

18.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

18.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

18.1.2.4 Potential loss of confidential data affecting this Agreement.

18.1.3 Notice shall be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information at Section 18.6. below.

Notice shall be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and shall include all information known at the time the incident is reported. The form is available online at https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Privacy-Incident-Report-PIR.pdf.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

18.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

18.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

18.2 Investigation. Business Associate shall immediately investigate such security incident or confidential breach.

18.3 **Complete Report**. To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR" must include any applicable additional information not included in the Initial Form. The Final PIR Form shall include an assessment of all known factors relevant to a determination of whether a breach occurred under HIPAA and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate shall make reasonable efforts to provide DHCS with such information. A "Supplemental PIR" may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate shall request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

18.4 **Notification of Individuals**. If the cause of a breach is attributable to Business Associate or its agents, Business Associate shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

18.5 **Responsibility for Reporting of Breaches to Entities Other than DHCS.** If the cause of a breach of PHI is attributable to Business Associate or its subcontractors, Business Associate is responsible for all required reporting of the breach as required by applicable federal and state law.

18.6 **DHCS Contact Information**. To direct communications to the above referenced DHCS staff, D-SNP Contractor shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

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DHCS Program Contract Manager	DHCS Privacy Office	DHCS Information Security Office
See the Scope of Work Exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

19. **Responsibility of DHCS.** DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

20. **Audits, Inspection and Enforcement**

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the DHCS Privacy Officer in writing. Whether or how DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

21. **Termination**

21.1 **Termination for Cause**. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

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21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 Judicial or Administrative Proceedings. DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 Disclaimer. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2. Amendment.

22.2.1 Any provision of this Agreement which is in conflict with current or future applicable Federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

Exhibit G
BUSINESS ASSOCIATE ADDENDUM

22.4 **No Third-Party Beneficiaries**. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 **Interpretation**. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6 **No Waiver of Obligations**. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

January 1, 2022 – December 31, 2026[i]
Updated May 22, 2024

Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Acupuncture Services	Other Practitioners' Services and Acupuncture Services	Acupuncture services are limited to treatment performed to prevent, modify, or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.	**X**	
Audiological Services	Audiology Services	Audiological services are covered when provided by persons who meet the appropriate requirements	**X**	
Behavioral Health Treatment (BHT)	Preventive Services - EPSDT	The provision of medically necessary BHT services to eligible Medi-Cal members under 21 years of age as required by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate and state plan.	**X**[ii]	
Blood and Blood Derivatives	Blood and Blood Derivatives	A facility that collects, stores, and distributes human blood and blood derivatives. Covers certification of blood ordered by a physician or facility where transfusion is given.	**X**	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
California Children Services (CCS)	EPSDT	California Children Services (CCS) are services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.	X[iii]	
Certified Family Nurse Practitioner	Certified Family Nurse Practitioners' Services	A certified family nurse practitioner who provides services within the scope of their practice.	X	
Certified Pediatric Nurse Practitioner Services	Certified Pediatric Nurse Practitioner Services	Covers the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks; can also include primary care services.	X	
Childhood Lead Poisoning Case Management (Provided by the Local County Health Departments)	EPSDT	A case of childhood lead poisoning (for purposes of initiating case management) as a child from birth up to 21 years of age with one venous blood lead level (BLL) equal to or greater than 15 µg/dL, or two BLLs equal to or greater than 10 µg/dL that must be at least 30 and no more than 600 calendar days apart, the first specimen is not required to be venous, but the second must be venous.		X

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Chiropractic Services	Chiropractors' Services	Services provided by chiropractors, acting within the scope of their practice as authorized by California law, are covered, except that such services are limited to treatment of the spine by means of manual manipulation.	X[iv]	
Chronic Hemodialysis	Chronic Hemodialysis	Procedure used to treat kidney failure - covered only as an outpatient service. Blood is removed from the body through a vein and circulated through a machine that filters the waste products and excess fluids from the blood. The “cleaned” blood is then returned to the body. Chronic means this procedure is performed on a regular basis. Prior authorization required when provided by renal dialysis centers or community hemodialysis units.	X	
Community Based Adult Services (CBAS)		CBAS Bundled services: An outpatient, facility-based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals, and transportation to eligible Medi-Cal beneficiaries. CBAS Unbundled Services: Component parts of CBAS center services delivered outside of centers, under certain conditions.	X	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Community Health Workers	Preventive Services	Preventive services by unlicensed community health workers, promotores, and community health representatives to prevent disease, disability, and other health conditions or their progression.	X[v]	
Comprehensive Perinatal Services	Extended Services for Pregnant Women-Pregnancy Related and Postpartum Services	Obstetrical, psychosocial, nutrition, and health education services, and related case coordination provided during pregnancy and up to 12 months following the last day of pregnancy.	X	
Dental Services (Covered under Medi-Cal)		Professional services performed or provided by dentists including diagnosis and treatment of malposed human teeth, of disease or defects of the alveolar process, gums, jaws, and associated structures; the use of drugs administered in-office, anesthetics, and physical evaluation; consultations; home, office, and institutional calls.	X[vi]	
Dyadic Services		Integrated physical and behavioral health screening and services for child, caregiver, and family.	X[5]	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Doula Services		Personal support by unlicensed providers to pregnant beneficiaries and their families throughout pregnancy, labor, and in the post-partum period.	X[5]	
Durable Medical Equipment	DME	Assistive medical devices and supplies. Covered with a prescription; prior authorization is required.	X	
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	EPSDT	Medicaid program's benefit for children and adolescents, providing a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children, and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act.	X	
Erectile and/or Sexual Dysfunction Drugs		Drugs for which the only FDA-approved indication is the treatment of sexual dysfunction or erectile dysfunction are not a benefit of the program. Drugs that are FDA-approved for the treatment of sexual dysfunction or erectile dysfunction in addition to one or more other indications, are a benefit only if the drug has is used for a FDA-approved indication outside of the treatment of sexual dysfunction or erectile dysfunction.		X

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Expanded Alpha-Fetoprotein Testing (Administered by Genetic Disease Branch of CDPH)		A simple blood test recommended for all pregnant women to detect if they are carrying a fetus with certain genetic abnormalities such as open neural tube defects, Down Syndrome, chromosomal abnormalities, and defects in the abdominal wall of the fetus.		X
Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes and Other Eye Appliances	Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes, and Other Eye Appliances	Eye appliances are covered on the valid prescription of a physician or optometrist.	X[vii]	
Federally Qualified Health Centers (FQHC) (Medi-Cal covered services only)	FQHC	Services described in 42 U.S.C. Section 1396d(a)(2)(C) furnished by an entity defined in 42 U.S.C. Section 1396d(l)(2)(B)).	X	
Hearing Aids	Hearing Aids	Hearing aids are covered only when supplied by a hearing aid dispenser on prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available in the community, plus an audiological evaluation including a hearing aid evaluation which must be	X	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		performed by or under the supervision of the above physician or by a licensed audiologist.		
1915(c) Home and Community- Based Waiver Services (Does not include EPSDT Services)		Provided and reimbursed as Medi-Cal covered benefits only: (1) For the duration of the applicable federally approved waiver, (2) To the extent the services are set forth in the applicable waiver approved by the HHS; and (3) To the extent the Department can claim and be reimbursed federal funds for these services.		X
Home Health Agency Services	Home Health Services- Home Health Agency	Covered as specified below when prescribed by a physician, physician assistant, nurse practitioner, or clinical nurse specialist and provided at the home of the beneficiary in accordance with a written treatment plan which the physician reviews every 60 days.	X	
Home Health Aide Services	Home Health Services- Home Health Aide	Covers skilled nursing or other professional services in the residence including part-time and intermittent skilled nursing services, home health aide services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.	X	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Home Health Pharmacy Services-Total Parenteral and Enteral Nutrition under Medi-Cal Rx.	Home Health	Nutritional products medically necessary because of chronic illness or trauma for patients who cannot be sustained through oral feeding and when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food that are billed by a pharmacy on a pharmacy claim, including formula, pumps, tubing, and general sub-categories, as described in the Medi-Cal Rx All Plan Letter (APL 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf).		**X**
Home Health Other Pharmacy Services-Total Parenteral and Enteral Nutrition	Home Health	Nutritional products medically necessary because of chronic illness or trauma for patients who cannot be sustained through oral feeding and when used as a therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food that are billed on medical and institutional claims as described in the Medi-Cal Rx All Plan Letter (APL 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL2	**X**	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		0-020.pdf).		
Hospice Care	Hospice Care	Covers services limited to individuals who have been certified as terminally ill in accordance with Title 42, CFR Part 418, Subpart B, and who directly or through their representative volunteer to receive such benefits in lieu of other care as specified.	**X**	
Hospital Outpatient Department Services and Organized Outpatient Clinic Services	Clinic Services and Hospital Outpatient Department Services and Organized Outpatient Clinic Services	A scheduled administrative arrangement enabling outpatients to receive the attention of a healthcare provider. Provides the opportunity for consultation, investigation, and minor treatment.	**X**	
Human Immunodeficiency Virus and AIDS drugs		Human Immunodeficiency Virus and AIDS drugs that are listed in the Medi-Cal Provider Manual		**X**

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Hysterectomy	Inpatient Hospital Services	Except for previously sterile women, a nonemergency hysterectomy may be covered only if: (1) The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representatives, if any, orally and in writing, that the hysterectomy will render the individual permanently sterile, (2) The individual and the individual's representative, if any, has signed a written acknowledgment of the receipt of the information in and (3) The individual has been informed of the rights to consultation by a second physician. An emergency hysterectomy may be covered only if the physician certifies on the claim form or an attachment that the hysterectomy was performed because of a life-threatening emergency in which the physician determined that prior acknowledgement was not possible and includes a description of the nature of the emergency.	**X**	
Indian Health Services (Medi- Cal covered services only)		Indian means any person who is eligible under federal law and regulations (25 U.S.C. Sections 1603c, 1679b, and 1680c) and covers health services provided directly by the United States Department of Health and Human Services,	**X**	

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		Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by contract.		
Inpatient Hospital Services	Inpatient Hospital Services	Covers delivery services and hospitalization for newborns; emergency services without prior authorization; and any hospitalization deemed medically necessary with prior authorization.	**X**	
Laboratory, Radiological and Radioisotope Services	Laboratory, X-Ray and Laboratory, Radiological and Radioisotope Services	Covers exams, tests, and therapeutic services ordered by a licensed practitioner.	**X**[viii]	
Licensed Midwife Services	Other Practitioners' Services and Licensed Midwife Services	When provided by a licensed midwife, the following are covered Medi-Cal services: (1) Attendance at cases of normal childbirth and (2) The provision of prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn.	**X**	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Local Educational Agency (LEA) Services	Local Education Agency Medi-Cal Billing Option Program Services	LEA health and mental health evaluation and health and mental health education services, which include any or all of the following: (A) Nutritional assessment and nutrition education, consisting of assessments and non-classroom nutrition education delivered to the LEA eligible beneficiary based on the outcome of the nutritional health assessment (diet, feeding, laboratory values, and growth), (B) Vision assessment, consisting of examination of visual acuity at the far point conducted by means of the Snellen Test, (C) Hearing assessment, consisting of testing for auditory impairment using at-risk criteria and appropriate screening techniques as defined in Title 17, California Code of Regulations, Sections 2951(c), (D) Developmental assessment, consisting of examination of the developmental level by review of developmental achievement in comparison with expected norms for age and background, (E) Assessment of psychosocial status, consisting of appraisal of cognitive, emotional, social, and behavioral functioning and self-concept through tests, interviews, and behavioral evaluations and (F) Health education and anticipatory guidance		**X**

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		appropriate to age and health status, consisting of non- classroom health education and anticipatory guidance based on age and developmentally appropriate health education.		
Long Term Care (LTC) Facility Services		Medically necessary care in a LTC facility or setting, including the following: • Skilled Nursing Facility (SNF), including a distinct part or unit of a hospital; • Intermediate Care Facility (ICF); • Intermediate Care Facility for Developmentally Disabled (ICF/DD); • Intermediate Care Facility for Developmentally Disabled with Habilitative (ICF/DDH); • Intermediate Care Facility for Developmentally Disabled with Nursing (ICF/DDN); • Subacute facility; • Pediatric Subacute Facility.	*Prior to 1/1/2023:* **X**[ix,x,xi] *After 1/1/2023 for SNF (in all counties):* **X** *After 1/1/2024 for ICF/DD, ICF/DDH, ICF/DDN, Subacute, and Pediatric Subacute*: **X**	**X**[15]
Medi-Cal Substance Abuse Services	Substance Abuse Treatment Services	Medically necessary substance abuse treatment to eligible beneficiaries includes: counseling services and behavioral therapy related to the drugs and biologicals covered under the		**X**

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		SUPPORT Act.		
Medical Supplies	Medical Supplies	Supplies are medically necessary when prescribed by a licensed practitioner. Does not include medical supplies carved-out to Medi-Cal Rx that are billed by a pharmacy on a pharmacy claim including medical supplies described in the Medi-Cal Rx All Plan Letter (ALP 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf).	**X**	
Medical & Non-Medical (NMT) Transportation Services	Transportation - Medical & Non-Medical Transportation (NMT) Services	Covers ambulance, litter van and wheelchair van medical transportation services when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care. NMT is transportation by private or public vehicle for beneficiaries who do not have another way to get to their appointment.	**X**	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Nurse Anesthetist Services	Other Practitioners' Services and Nurse Anesthetist Services	Covers anesthesiology services performed by a nurse anesthetist within the scope of his or her licensure.	**X**	
Nurse Midwife Services	Nurse-Midwife Services	An advanced practice registered nurse who has specialized education and training in both Nursing and Midwifery, is trained in obstetrics, and provides care for mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks.	**X**	
Optometry Services	Optometrists' Services	Covers eye examinations and prescriptions for corrective lenses.	**X**	
Organ and Bone Marrow Transplant Surgeries	Transplant	Medically necessary donor and recipient organ and bone marrow transplant surgeries for adult and pediatric transplant recipients and donors, including related services such as organ procurement and living donor care.	**X**	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Outpatient Mental Health	Outpatient Mental Health	Services provided by licensed health care professionals acting within the scope of their license for adults and children diagnosed with a mental condition as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Services include: • Preventive mental health services for potential mental health disorders not yet diagnosed • Behavioral health screenings and interventions • Mental health evaluation and treatment, including individual, group and family psychotherapy • Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition. • Outpatient services for purposes of monitoring drug therapy • Psychiatric consultation • Outpatient laboratory, drugs, supplies and supplements	X[xii]	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		• Mental health services for beneficiaries 21 years and over with mild to moderate distress or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders • Mental health services for beneficiaries under age 21 regardless of level of distress or impairment or the presence of a diagnosis, unless the recipient meets the criteria for Specialty Mental Health Services		
Organized Outpatient Clinic Services	Clinic Services and Organized Outpatient Clinic Services	In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in- home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	**X**	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Outpatient Heroin Detoxification Services	Outpatient Heroin Detoxification Services	Can cover various medications and treatments, allowing for day-to-day functionality for a person choosing to not admit as an inpatient. Routine elective heroin detoxification services are covered, subject to prior authorization, only as an outpatient service. Outpatient services are limited to a maximum period of 21 days. Inpatient hospital services shall be limited to patients with serious medical complications of addiction or to patients with associated medical problems which require inpatient treatment.		**X**
Part D Drugs		Drug benefits for full-benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act.		**X**
Personal Care Services	Personal Care Services	Services for categorically needy beneficiaries with a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services. Benefit known as In Home Supportive Services (IHSS).	**X**[14]	**X**[14]

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Pharmaceutical Services and Prescribed Drugs under Medi-Cal Rx	Pharmaceutical Services and Prescribed Drugs	Pharmacy benefits carved-out to Medi-Cal Rx, which are pharmacy benefits that are billed by a pharmacy on a pharmacy claim, including covered outpatient drugs and physician administered drugs, as described in the Medi-Cal Rx All Plan Letter (APL 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf).		**X**
Other Pharmaceutical Services and Prescribed Drugs	Pharmaceutical Services and Prescribed Drugs	Covers Pharmacy benefits that are billed on medical and institutional claims, including physician administered drugs, other outpatient drugs, legend, non-legend and specialty drugs that are not carved-out to Medi-Cal Rx as discussed above, and further described in Medi-Cal Rx All Plan Letter (APL 20-020: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2020/APL20-020.pdf).	**X**	
Pharmacist Services	Pharmacist Services	Pharmacists in a community pharmacy setting furnishing specified categories of drugs (furnishing of naloxone, self-administered hormonal contraceptives, nicotine replacement therapy, HIV pre-exposure and post-exposure prophylaxis, and initiating and administrating	**X**	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		immunizations).		
Physician Services	Physician Services	Covers primary care, outpatient services, and services rendered during a stay in a hospital or nursing facility for medically necessary services. Can cover limited mental health services when rendered by a physician, and limited allergy treatments.	**X**	
Podiatry Services	Other Practitioners' Services and Podiatrists' Services	Medically necessary Office visits are covered. All other outpatient services are subject to the same prior authorization procedures that govern physicians, and are limited to medical and surgical services necessary to treat disorders of the feet, ankles, or tendons that insert into the foot, secondary to or complicating chronic medical diseases, or which significantly impair the ability to walk. Services rendered on an emergency basis are exempt from prior authorization.	**X**	
Preventive Services	Preventive Services	All preventive services articulated in the state plan.	**X**	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Prosthetic and Orthotic Appliances	Prosthetic and Orthotic Appliances	All prosthetic and orthotic appliances necessary for the restoration of function or replacement of body parts as prescribed by a licensed physician, podiatrist or dentist, within the scope of their license, are covered when provided by a prosthetist, orthotist or the licensed practitioner, respectively	**X**	
Physical Therapy and Occupational Therapy	Physical Therapy and Occupational Therapy	Physical therapy and occupational therapy are covered when provided by persons who meet the appropriate requirements	**X**	
Private Duty Nursing	EPSDT	Private duty nursing is the planning of care and care of clients by nurses, whether a registered nurse or licensed practical nurse for individuals under 21 years of age.	**X**[2]	
Rehabilitation Center Outpatient Services	Rehabilitative Services	A facility providing therapy and training for rehabilitation on an outpatient basis. The center may offer occupational therapy, physical therapy, vocational training, and special training.	**X**	
Rehabilitation Center Services	Rehabilitative Services	A facility which provides an integrated multidisciplinary program of restorative services designed to upgrade or maintain the physical functioning of patients.	**X**	
Respiratory Care	Physician	A provider trained and licensed for respiratory	**X**	

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Services	Services	care to provide therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities affecting the pulmonary system and aspects of cardiopulmonary and other systems.		
Rural Health Clinic Services	Rural Health Clinic Services	Services described in 42 U.S.C. Section 1396d(a)(2)(B) furnished by a rural health clinic as defined in 42 U.S.C. Section 1396d(l)(1).	**X**	
Scope of Sign Language Interpreter Services	Sign Language Interpreter Services	Sign language interpreter services may be utilized for medically necessary health care services	**X**	
Services provided in a State or Federal Hospital		California state hospitals provide inpatient treatment services for Californians with serious mental illnesses. Federal hospitals provide services for certain populations, such as the military, for which the federal government is responsible.		**X**
Specialty Mental Health Services		Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.		**X**[xiii]

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities	Special Rehabilitative Services	Specialized rehabilitative services are covered. Such service must include the medically necessary continuation of treatment services initiated in the hospital or short-term intensive therapy expected to produce recovery of function leading to either (1) a sustained higher level of self- care and discharge to home or (2) a lower level of care. Specialized rehabilitation service shall be covered.	X[9]	
Speech Pathology	Speech Pathology	Services are covered when provided by persons who meet the appropriate requirements.	X	
State Supported Services		State funded abortion services that are provided through a secondary contract.	X	
Swing Bed Services	Inpatient Hospital Services	Swing bed services is additional inpatient care services for those who qualify and need additional care before returning home.	X	
Targeted Case Management Services (provided by Local Governmental Agencies)	Targeted Case Management	Persons who are eligible to receive targeted case management services must consist of the following Medi-Cal beneficiary groups: (1) high risk children under the age of 21, (2) medically fragile individuals; (3) children with an Individualized Education Plan or Individualized Family Service Plan; (4) individuals at risk of institutionalization; (5) individuals in jeopardy of		X

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
		negative health or psycho-social outcomes; and (6) individuals with a communicable disease. Targeted case management services must include at least one of the following service components: A documented assessment identifying the beneficiary's needs, development of a comprehensive, written, individual service plan, implementation of the service plan includes linkage and consultation with and referral to providers of service, assistance with accessing the services identified in the service plan, crisis assistance planning to coordinate and arrange immediate service or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific beneficiary, periodic review of the beneficiary's progress toward achieving the service outcomes identified in the service plan to determine whether current services should be continued, modified or discontinued.		

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Service	State Plan Service Category	Definition	Benefit Carved In to Managed Care	Benefit Carved Out of Managed Care*
Transitional Inpatient Care Services	Nursing Facility and Transitional Inpatient Care Services	Focuses on transition of care from outpatient to inpatient. Inpatient care coordinators, along with providers from varying settings along the care continuum, should provide a safe and quality transition.	**X**	
Tuberculosis (TB) Related Services (Provided by the Local County Health Departments)	TB Related Services	Covers TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.		**X**

[i] Coverage and reimbursement of COVID-19 vaccines and administration are carved out of Medi-Cal managed care for all eligible populations and are exclusively covered and reimbursed through the State's fee-for-service delivery system by all applicable providers.
[ii] Benefit coverage is limited to only beneficiaries under 21 years of age for services rendered pursuant to EPSDT requirements.
[iii] California Children Services (CCS) covered in COHS counties with the exception of Ventura County (Gold Coast Health Plan). CCS not covered in Non-COHS counties and Ventura County.
[iv] Chiropractic coverage is limited to only beneficiaries in "Exempt Groups": 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program; 2) beneficiaries residing in a SNF (Nursing Facilities Level A and Level B, including subacute care facilities; 3) beneficiaries who are pregnant; 4) CCS beneficiaries; 5) beneficiaries enrolled in the PACE; 6) beneficiaries who receive services at an FQHC or RHC; and 7) beneficiaries in hospital outpatient settings. Chiropractic services are not available at Indian Health Clinics except for those in the exempt groups.
[v] Coverage of benefit subject to federal approval in the Medi-Cal State Plan.
[vi] Dental services are carved in to managed care for Health Plan of San Mateo.
[vii] The fabrication of eyeglasses lenses are carved out statewide to FFS Medi-Cal contracted optical laboratories, with the exception of specialty

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Exhibit H
MEDI-CAL SERVICES CARVED IN AND CARVED OUT OF MEDI-CAL MANAGED CARE

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lenses (including lenses that exceed contract lab ranges), which remain the responsibility of the managed care plan.
[viii] Coverage and reimbursement of COVID-19 testing in school settings, to be carved out of managed care, covered and reimbursed through the state's Fee For Service delivery system.
[ix] Only covered for the month of admission and the following month in Non-COHS. Services covered in COHS.
[x] Services covered under managed care only in MLTSS Eligible Beneficiary Authorized Counties: Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. IHSS benefits are not part of this covered service.
[xi] ICF-DD residents are exempt from managed care plan enrollment in Coordinated Care Initiative Counties.
[xii] Services provided by primary care physicians; psychiatrists; psychologists; licensed clinical social workers; or other specialty mental health provider. Solano County for Partnership Health plan (COHS) covers specialty mental health, and Kaiser GMC covers inpatient, outpatient, and specialty mental health services.
[xiii] Kaiser members in Solano and Sacramento counties carved into managed care until 7/1/2023.
[14] Personal care services benefit carved-in to SCAN Connections and SCAN Connections at Home, and members of those plans are not eligible for In Home Supportive Services (IHSS). For all other plans, the IHSS personal care services benefit is carved-out of Medi-Cal managed care and is administered and authorized by county agencies.
[15] Intermediate Care Facility for Developmentally Disabled (ICF/DD) – Continuous Nursing Care (ICF/DD-CN) Homes are not subject to the LTC Carve-In Policy

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CalOptima Health

Additional Detail for CY 2026 Agreement 16-93274

Section/Provision:	PDF page	Updates to Provision:
Exhibit A - SCOPE OF WORK		
1. Care Coordination	4-5	• Added a provision (new 1.C) specifying that for coordination of 1915 (c) Home and Community-Based Services (HCBS) waivers, D-SNP Contractor must establish a cooperative working relationship with HCBS waiver agencies for care coordination, information sharing, and oversight. A list of waiver programs can be found at: **https://www.dhcs.ca.gov/services/Pages/medi-calwaivers.aspx**. • Updates to (1.D) Medi-Cal Dental Managed Care contact information, specifically for Los Angeles and Sacramento counties. Also removed reference to "Administrative Service Organization" and replaced it with a new term - "ASO Fiscal Intermediary - Dental Business Operations (FI-DBO)". • Added language (1.G.8) to specify the D-SNP Model of Care must provide California Integrated Care Management (CICM) to specific vulnerable populations listed in the **2026 CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide** and demonstrate how the D-SNP's MOC includes and reflects the delivery of services to CICM populations. Also added a provision (1.G.9) to require D-SNP to provide in-person care management to the CICM population, Adults Experiencing Homelessness.
5. Quality and Data Reporting	11-12	• Removal of provision (5.B) that specified the list of reporting requirements. Instead, D-SNP to comply with provision 5.A, which indicates D-SNP is responsible for reporting quality measures to DHCS, fully outlined in the chapter of the 2026 D-SNP Policy Guide.
13. Medi-Cal and Medicare Eligibility Verification and Medi-Cal Plan Enrollment	16	• Updated provision (13.A) to add language that the D-SNP Plan is required to check a Member's Medi-Cal MCP enrollment eligibility on a **monthly** basis.
15. Contract Term	17	• Modifies the contract term to be defined as only for 2026 - 1/1/26 -12/31/26.
18. CMS Documentation	17-18	• Technical edit to reword and renumber the provisions of this section, but requirement to provide DHCS the documentation remains unchanged.
22. Noncompliance and Enforcement	26	• Adding new provision (22) to specify DHCS' enforcement discretion over the D-SNP: ▸ DHCS may implement enforcement actions to address D-SNP's performance and compliance issues through monitoring and oversight activities. ▸ If DHCS finds D-SNP is noncompliant with any of the obligations set forth in this Contract, the D-SNP Policy Guide, or D-SNP Reporting Requirements, DHCS may require D-SNP to develop and submit a Corrective Action Plan response designed to correct or resolve such noncompliance. ▸ Corrective Action includes specific identifiable activities or undertakings by D-SNP which address deficiencies or noncompliance. ▸ DHCS is not required to impose a Corrective Action plan on D-SNP before imposing any of the sanctions set forth in State and federal law. Noncompliance with this Contract may subject D-SNP to discontinuance of new enrollment, or termination of the Contract by DHCS.
Exhibit E, Attachment 2 Program Terms and Conditions		
18. Disputes	52	• Updates to (18) provision to clarify that the Provision on Disputes does not apply to challenges to Corrective Action plans as described in Exhibit A, Provision 22, or any other contract compliance action initiated by DHCS.

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CalOptima Health Board Action Agenda Referral

Action To Be Taken April 3, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Ratify Amendments to CalOptima Health's Primary and Secondary Agreements with the California Department of Health Care Services Related to Calendar Year 2024 Rate Changes

Contacts

Nancy Huang, Chief Financial Officer, (657) 235-6935
John Tanner, Chief Compliance Officer, (657) 235-6997

Recommended Action

Ratify amendments between the California Department of Health Care Services and CalOptima Health related to Calendar Year 2024 rate changes.

Background

As a County Organized Health System, CalOptima Health contracts with the California Department of Health Care Services (DHCS) to provide health care services to Medi-Cal members in Orange County. CalOptima Health has a Primary and Secondary Agreement with DHCS. The Primary Agreement contains, among other terms and conditions, the payment rates CalOptima Health receives from DHCS to provide health care services. The Secondary Agreement is a companion agreement to CalOptima Health's Primary Agreement and covers specific Medi-Cal state-supported services for CalOptima Health's members enrolled under the Primary Agreement.

In January 2024, CalOptima Health entered into new Primary and Secondary Agreements with DHCS. The new Primary Agreement is numbered Agreement 23-30235, and the new Secondary Agreement is numbered Agreement 23-30267. Amendments to these new agreements are summarized in Attachment 1. Annual amendments for the DHCS Primary and Secondary agreements are a routine occurrence. The main changes in the current amendments are finalization of 2024 rates.

Discussion

Calendar Year (CY) 2024 Primary and Secondary Agreement Rates

Overview

The CalOptima Health Board of Directors Chair signed finalized 2024 Contract Amendments in early February to meet DHCS's deadline of February 14, 2025. Staff requests that the CalOptima Health Board of Directors ratify the Chair's execution of the amendments with DHCS. The anticipated impact of these updated final CY 2024 rate changes is identified in the Fiscal Impact section.

The mainstream capitation rates for January 1, 2024, through December 31, 2024, for CalOptima Health's Primary and Secondary Agreements were initially sent to CalOptima Health as draft rates in October 2023 and as final rates in December 2023. On September 24, 2024, DHCS provided CalOptima Health with updated final CY 2024 rates. The updated final CY 2024 rates were subsequently amended by DHCS and provided to CalOptima Health on December 30, 2024.

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On February 11, 2025, DHCS provided further CY 2024 rate details to CalOptima Health incorporating changes from the CY 2024 prospective rates, including which items are new additions, which items have been updated, and details regarding the supplemental exhibits included in the rate detail delivery.

Detailed Discussion
The updated final CY 2024 rates include the following updates:

Enrollment
- Projected enrollment is informed by enrollment through April 2024 and supplemental information through May 2024 provided at the managed care plan (MCP) – specific level.
- The Managed Care Organization (MCO) tax calculation used additional enrollment information through June 2024.

Population Acuity Adjustments
- Updated adjustment to utilize assumptions from the CY 2024 prospective rates.

Program Change Adjustments
- Targeted Rate Increases updated adjustment to utilize assumptions from the CY 2024 prospective rates.
- Transitional Care Services adjustment removed the unsatisfactory immigration status federal dollars that were accidentally included in the CY 2024 prospective rates.
- Long-Term Care (LTC) and hospice adjustments were updated to incorporate fee schedule changes associated with the termination of the public health emergency and final CY 2024 fee schedule rates, including the Skilled Nursing Facility Workforce Standard Program for Assembly Bill 1629 facilities.
- Ground Emergency Medical Transportation Quality Assurance Fee adjustment was updated to incorporate the final add-on amounts.
- Adjustments to the Children and Youth Behavioral Health Initiative to account for the impact of additional behavioral health services in schools for children and youth aged 0 – 25.

Risk Adjustment Updates
- Chronic Illness and Disability Payment System and Medicaid Rx: Updated to reflect a June 2022 through May 2023 study period and a four-month snapshot of January 2024 through April 2024. The credibility thresholds were updated to a threshold of at least 500 monthly scored recipients and at least a 2% market share within a given county/region for a given MCP/category of aid combination to be deemed credible.
- Behavioral Health Treatment (BHT): Updated using a January 2022 through December 2022 study period. Any member who had at least three BHT kick payments in CY 2022 was deemed a BHT utilizer. This process applied to the Child and Seniors and Persons with Disabilities category of aid only.
- LTC (Long-Term Stays): Updated using a January 2023 through September 2023 study period and January 2024 through April 2024 MCP enrollment information. Utilizers were defined as members with 90 or more consecutive days in a LTC facility and were further classified as Distinct-Part Nursing Facility or Intermediate Care Facility for the Developmentally Disabled if the member had 30 or more days at such a facility.

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- Community-Based Adult Services (CBAS): Updated using an October 2022 through September 2023 study period and January 2024 through April 2024 MCP enrollment information. Utilizers were defined as members with 25 or more CBAS days in the study period.
- Enhanced Care Management (ECM): Developed using ECM enrollment rosters from January through March 2024; ECM utilizers were defined as members included on ECM enrollment rosters.

Rate Add-Ons

- Pass-through payment for public Distinct-Part Nursing Facility services, which transitioned from the fee-for-service delivery system to the managed care delivery system beginning January 1, 2023.
- Includes the revised, 12-month, CY 2024 MCO Tax amounts, which are pending CMS approval.
- The per-member per-months for the MCO tax amounts were calculated based on the full 12-month liability using actual membership through June 2024 and projected membership for the remainder of 2024.
- Revised Hospital Quality Assurance Fee pass-through payment to reflect updates to the projected enrollment volume and underlying base rates.

Fiscal Impact

The updated final CY 2024 rate impact is fully reflected in the December 2024 unaudited financial statements.

Rationale for Recommendation

DHCS develops capitation rates according to base data reported by CalOptima Health through the rate development template process, adjusted for trends and program changes. Execution of the contract amendments will ensure revenues, expenses, and cash payment are consistent with the approved budget to support CalOptima Health operations.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Attachment 1_Appendix Summary of Amendments to Primary and Secondary Agreements with DHCS

/s/ Michael Hunn *03/27/2025*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 7

The following is a summary of amendments to the Primary Agreement (23-30235) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Primary Agreement	Board Approval
Primary Agreement 23-30235 provides language and benefit changes effective January 1, 2024.	December 7, 2023
A-01 incorporates Calendar Year (CY) 2024 capitation rates.	March 7, 2024
A-02 incorporates language and benefit changes effective January 1, 2024.	August 1, 2024
A-03 extends the term of the Primary Agreement and Secondary Agreement (23 – 30267) (by default) to December 31, 2025.	November 7, 2024
A-04 incorporates updated final Calendar Year (CY) 2024 capitation rates.	April 3, 2025
A-05 incorporates final Calendar Year (CY) 2025 capitation rates and extends the Enhanced Care Management (ECM) risk corridor rating period through December 31, 2025.	April 3, 2025

The following is a summary of amendments to the Primary Agreement (08-85214) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011

Amendments to Primary Agreement	Board Approval
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012
A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014

Amendments to Primary Agreement	Board Approval
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015
A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019

Amendments to Primary Agreement	Board Approval
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A–45 incorporates the new requirements of the 2018 Final Rule Amendment, Behavioral Health Treatment (BHT) and State Fiscal Year (SFY) 2018 – 19 capitation rates	June 7, 2018 August 1, 2019 August 6, 2020
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020
A-48 incorporates new Bridge Period, Health Homes Program (HHP) and Whole Child Model (WCM) language and adds 2019 – 2020 capitation rates	June 7, 2018 October 1, 2020 February 4, 2021
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020
A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021
A-51 incorporates full dual rates for Calendar Year (CY) 2021.	February 4, 2021
A-52 incorporates Calendar Year (CY) 2021 base amendment contract language.	October 7, 2021
A-53 incorporates Calendar Year (CY) 2021 fall amendment contract language.	October 7, 2021
A-54 extends the Primary Agreement with DHCS to December 31, 2022.	October 7, 2021
A-55 incorporates full dual rates for Calendar Year (CY) 2022.	March 3, 2022
A-56 incorporates updated Bridge Period (July 1, 2019 – December 31, 2020) capitation payment rates that are now split into rates for Satisfactory Immigration Status (SIS) and Unsatisfactory Immigration Status (UIS) members, and includes new corresponding rate tables that split each existing category into a SIS and UIS version.	October 1, 2020
A-57 incorporates Calendar Year (CY) 2022 risk mitigation language.	March 3, 2022
A-58 incorporates the COVID Vaccination Incentive Program.	March 3, 2022
A-59 incorporates new Calendar Year (CY) 2022 capitation rates and benefit changes implemented in CY 2022	August 5, 2021 March 3, 2022 August 4, 2022
A-60 incorporates new benefits changes for Calendar Year (CY) 2022.	August 4, 2022
A-61 incorporates new benefit changes for Calendar Year (CY) 2022.	May 4, 2023
A-62 extends the Primary Agreement with DHCS to December 31, 2023.	May 5, 2022
A-63 incorporates new benefits changes for Calendar Year (CY) 2023.	February 2, 2023

Amendments to Primary Agreement	Board Approval
A-64 incorporates updated Calendar Year (CY) 2021 capitation payment rates that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members.	Not applicable due to non – substantive changes.
A-65 incorporates updated Calendar Year (CY) 2022 Public Health Emergency (PHE) capitation rates.	November 2, 2023
A-66 incorporates updated Calendar Year 2022 Capitation Payment rates that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members and includes new corresponding rate tables that split each existing category into a SIS version and UIS version.	Not applicable due to non – substantive changes.
A-67 incorporates Calendar Year (CY) 2023 capitation rates and new benefits for CY 2023.	December 7, 2023
A-68 incorporates revised Calendar Year (CY) 2022 CCI Full Dual capitation rates.	June 1, 2023
A-69 incorporates updated Calendar Year (CY) 2023 capitation rates.	October 3, 2024

The following is a summary of amendments to the Secondary Agreement (23-30267) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Secondary Agreement	Board Approval
Agreement 23 – 30267 covers specific state – supported services to CalOptima Health's members enrolled under CalOptima Health's Primary Agreement (23 – 30235).	December 7, 2023
A-01 incorporates Calendar Year (CY) 2024 capitation rates.	March 7, 2024
A-02 incorporates updated final Calendar Year (CY) 2024 capitation rates.	April 3, 2025
A-03 incorporates final Calendar Year (CY) 2025 capitation rates.	April 3, 2025

The following is a summary of amendments to the Secondary Agreement (08-85221) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)

A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-09 incorporates updated Calendar Year (CY) 2022 Public Health Emergency (PHE) capitation rates.	November 2, 2023
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021

The following is a summary of amendments to the Secondary Agreement (22-20494) approved by the CalOptima Health Board of Directors (Board) to date:

Agreement 22-20494 incorporates both Hyde services ("Private Services") and the new Unsatisfactory Immigration Status members from January 1, 2023 to December 31, 2023.	December 1, 2022
A-01 incorporates rates for CY 2023 for Hyde services (now referred to as "Private Services") and the new Unsatisfactory Immigration Status (UIS) members.	December 1, 2022
A-02 incorporates updated Calendar Year (CY) 2023 capitation rates.	October 3, 2024

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2022.	June 3, 2021

A-06 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	May 5, 2022
A-07 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	October 6, 2022
A-08 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	Not applicable due to non – substantive changes.
A-09 extends Agreement 16 – 93274 with DHCS to December 31, 2024.	May 4, 2023
A-10 extends Agreement 16 – 93274 with DHCS to December 31, 2025.	May 2, 2024

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

The following is a summary of amendments to CalOptima Health's Agreement for Disclosure and Use of DHCS Data (2023 Post – Expiration Data Use Agreement (DUA)) and 2024 Operational Readiness (OR) DUA.

Amendments to Data Use Agreement	Board Approval
CY 2023 Data Use Agreement (DUA) allows for the exchange of information between DHCS and CalOptima Health after the current contract expires on December 31, 2023.	November 2, 2023
CY 2024 Operational Readiness (OR) DUA allows DHCS to initiate and execute the necessary data releases ahead of January 1, 2024 for DHCS to share necessary data with CalOptima Health.	November 2, 2023

CalOptima Health Board Action Agenda Referral

Action To Be Taken April 3, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

8. Ratify Amendments to CalOptima Health's Primary and Secondary Agreements with the California Department of Health Care Services Related to Calendar Year 2025 Rate Changes

Contacts

Nancy Huang, Chief Financial Officer, (657) 235-6935
John Tanner, Chief Compliance Officer, (657) 235-6997

Recommended Action

Ratify amendments between the California Department of Health Care Services and CalOptima Health related to Calendar Year 2025 rate changes.

Background

As a County Organized Health System, CalOptima Health contracts with the California Department of Health Care Services (DHCS) to provide health care services to Medi-Cal members in Orange County. CalOptima Health has a Primary and Secondary Agreement with DHCS. The Primary Agreement contains, among other terms and conditions, the payment rates CalOptima Health receives from DHCS to provide health care services. The Secondary Agreement is a companion agreement to CalOptima Health's Primary Agreement and covers specific Medi-Cal state-supported services for CalOptima Health's members enrolled under the Primary Agreement.

In January 2024, CalOptima Health entered into new Primary and Secondary Agreements with DHCS. The new Primary Agreement is numbered Agreement 23-30235, and the new Secondary Agreement is numbered Agreement 23-30267. Amendments to these new agreements are summarized in Attachment 1. Annual amendments for the DHCS Primary and Secondary agreements are a routine occurrence. The main changes in the current amendments are finalization of 2025 rates.

Discussion

Calendar Year (CY) 2025 Primary and Secondary Agreement Rates

Overview

The CalOptima Health Board of Directors Chair signed finalized 2025 Contract Amendments in early March to meet DHCS's deadline of March 6, 2025. Staff requests the CalOptima Health Board of Directors ratify the Chair's execution of the amendments with DHCS. The anticipated impact of these final CY 2025 rate changes is identified in the Fiscal Impact section. The Primary Agreement also extended the rating period for the Enhanced Care Management (ECM) risk corridor through December 31, 2025.

The mainstream capitation rates for January 1, 2025, through December 31, 2025, for CalOptima Health's Primary Agreement and Secondary Agreements were first sent to CalOptima Health as draft

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rates in October 2024 and as final rates in January 2025. The final rate delivery in January 2025 provided CY 2025 rate details to CalOptima Health incorporating changes from the CY 2025 prospective rates, including which items are new additions, which items have been updated, and details regarding the supplemental exhibits included in the rate detail delivery.

Detailed Discussion
The final CY 2025 rates include the following updates:

Enrollment
- Includes projected enrollment before and after the Medicare Part A Buy-in effective January 1, 2025.

Base Data Adjustments
- Region specific base adjustments were applied based on review of more recent experience (State Fiscal Year 2023-24 rate development template and quarterly financials through Quarter 2, 2024).
- Adjustments include increases in Community Supports relative to the base period across all regions.

Population Acuity Adjustments
- CY 2025 adjustment accounting for material shifts in Medi-Cal managed care enrollment, primarily driven by the public health emergency unwinding that would result in a change in the acuity level of that population.

Program Change Adjustments
- Long-Term Care (LTC) and hospice fee schedule changes.
- Additional Assembly Bill (AB) 97 buybacks.
- Dyadic Services: Adjustment quantifying the impact of offering new dyadic services and general behavioral health integration services and a variety of existing services.
- Community Health Worker (CHW): Adjustment quantifying the impact of adding skilled and trained CHWs who can provide preventive health services to non-ECM enrollees.
- Medicare Part A Buy-In: Effective January 1, 2025, DHCS began paying the Medicare Part A premium for eligible Medi-Cal members.
    - The rate adjustment accounts for the movement of members from seniors and persons with disability (SPD)-LTC to SPD-LTC/Full-Dual and the removal of costs associated with these members that will now be covered under Medicare Part A.
- Children and Youth Behavioral Health Initiative: Updated for data nuances that impacted the total amounts of dollars built in for this adjustment and for updated projected enrollment.
- Transitional Care Services (TCS): Effective January 1, 2024, increased TCS are required for both low-risk and high-risk members discharged from inpatient and LTC services.
- Targeted Rate Increases: Updated to include all final policy information, specifically for the Senate Bill 94 fee schedule, refinement of the Federally Qualified Health Center (FQHC) methodology to apply a model average increase for a code when there is no corresponding region average.

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- Wellness Coach: Intent of the Wellness Coach benefit is to service the 0-25-year-old population but is technically available for all adults.
- Major Organ Transplant (MOT): Adjustment accounting for MOT ramp-up that is not yet fully reflected in the base data used for CY 2025 rates.
- Ground Emergency Medical Transportation (GEMT) Quality Assurance Fee (QAF).
- Public Provider GEMT (PP – GEMT) as established by AB 1705 resulting in a per trip rate increase for GEMT public service providers.

Risk Adjustment Updates

- Chronic Illness and Disability Payment System and Medicaid Rx: Risk adjustment factors were updated using a September 2024 enrollment snapshot, accounting for the shift of members due to the Medicare Part A Buy-In, using the updated projected enrollment for the budget neutral calculation, and updated to use the combined SPD-LTC utilizer and snapshot information.
- Behavioral Health Treatment: Updated risk adjustment factors using a September 2024 enrollment snapshot, accounting for the shift of members due to the Medicare Part A Buy-In, using the updated projected enrollment for the budget neutral calculation, and updated to use the combined SPD-LTC utilizer and snapshot information.
- LTC: Updated risk adjustment factors using a September 2024 enrollment snapshot, accounting for the shift of members due to the Medicare Part A Buy-In, using the updated projected enrollment for the budget neutral calculation.
- Community-Based Adult Services: Updated risk adjustment factors using a September 2024 enrollment snapshot, accounting for the shift of members due to the Medicare Part A Buy-In, using the updated projected enrollment for the budget neutral calculation, and updated to use the combined SPD-LTC and SPD-LTC/ Full-Dual utilizer and snapshot information.
- ECM: Updated risk adjustment factors using a June 2024 ECM enrollment snapshot, accounting for the shift of members due to the Medicare Part A Buy-In, using the updated projected enrollment for the budget neutral calculation and updated to use the combined SPD-LTC utilizer and snapshot information.

Rate Add-Ons

- Adverse Childhood Experiences, Developmental Screening, and Proposition 56 Family Planning.
- FQHC Alternative Payment Methodology.
- Pass-through payments for the Hospital Quality Assurance Fee and Distinct-Part Nursing Facility services.
- Managed Care Organization tax.

Fiscal Impact

In aggregate across all aid categories, the draft CY 2025 rates are approximately 6.5% higher than the final CY 2024 rates. The draft CY 2025 rate impact is reflected in the unaudited monthly financial statements. Staff anticipates that DHCS will further update these draft rates in the future to reflect additional modifications from program changes and the implementation of Proposition 35.

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Rationale for Recommendation

DHCS develops capitation rates according to base data reported by CalOptima Health through the rate development template process, adjusted for trends and program changes. Execution of the contract amendments will ensure revenues, expenses and cash payment are consistent with the approved budget to support CalOptima Health operations.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Attachment 1_Appendix Summary of Amendments to Primary and Secondary Agreements with DHCS

/s/ Michael Hunn *03/27/2025*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 8

The following is a summary of amendments to the Primary Agreement (23-30235) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Primary Agreement	Board Approval
Primary Agreement 23-30235 provides language and benefit changes effective January 1, 2024.	December 7, 2023
A-01 incorporates Calendar Year (CY) 2024 capitation rates.	March 7, 2024
A-02 incorporates language and benefit changes effective January 1, 2024.	August 1, 2024
A-03 extends the term of the Primary Agreement and Secondary Agreement (23 – 30267) (by default) to December 31, 2025.	November 7, 2024
A-04 incorporates updated final Calendar Year (CY) 2024 capitation rates.	April 3, 2025
A-05 incorporates final Calendar Year (CY) 2025 capitation rates and extends the Enhanced Care Management (ECM) risk corridor rating period through December 31, 2025.	April 3, 2025

The following is a summary of amendments to the Primary Agreement (08-85214) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011

Amendments to Primary Agreement	Board Approval
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012
A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014

Amendments to Primary Agreement	Board Approval
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015
A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019

Amendments to Primary Agreement	Board Approval
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A–45 incorporates the new requirements of the 2018 Final Rule Amendment, Behavioral Health Treatment (BHT) and State Fiscal Year (SFY) 2018 – 19 capitation rates	June 7, 2018 August 1, 2019 August 6, 2020
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020
A-48 incorporates new Bridge Period, Health Homes Program (HHP) and Whole Child Model (WCM) language and adds 2019 – 2020 capitation rates	June 7, 2018 October 1, 2020 February 4, 2021
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020
A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021
A-51 incorporates full dual rates for Calendar Year (CY) 2021.	February 4, 2021
A-52 incorporates Calendar Year (CY) 2021 base amendment contract language.	October 7, 2021
A-53 incorporates Calendar Year (CY) 2021 fall amendment contract language.	October 7, 2021
A-54 extends the Primary Agreement with DHCS to December 31, 2022.	October 7, 2021
A-55 incorporates full dual rates for Calendar Year (CY) 2022.	March 3, 2022
A-56 incorporates updated Bridge Period (July 1, 2019 – December 31, 2020) capitation payment rates that are now split into rates for Satisfactory Immigration Status (SIS) and Unsatisfactory Immigration Status (UIS) members, and includes new corresponding rate tables that split each existing category into a SIS and UIS version.	October 1, 2020
A-57 incorporates Calendar Year (CY) 2022 risk mitigation language.	March 3, 2022
A-58 incorporates the COVID Vaccination Incentive Program.	March 3, 2022
A-59 incorporates new Calendar Year (CY) 2022 capitation rates and benefit changes implemented in CY 2022	August 5, 2021 March 3, 2022 August 4, 2022
A-60 incorporates new benefits changes for Calendar Year (CY) 2022.	August 4, 2022
A-61 incorporates new benefit changes for Calendar Year (CY) 2022.	May 4, 2023
A-62 extends the Primary Agreement with DHCS to December 31, 2023.	May 5, 2022
A-63 incorporates new benefits changes for Calendar Year (CY) 2023.	February 2, 2023

Amendments to Primary Agreement	Board Approval
A-64 incorporates updated Calendar Year (CY) 2021 capitation payment rates that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members.	Not applicable due to non – substantive changes.
A-65 incorporates updated Calendar Year (CY) 2022 Public Health Emergency (PHE) capitation rates.	November 2, 2023
A-66 incorporates updated Calendar Year 2022 Capitation Payment rates that are now split into rates for Satisfactory Immigration Status (SIS) members and Unsatisfactory Immigration Status (UIS) members and includes new corresponding rate tables that split each existing category into a SIS version and UIS version.	Not applicable due to non – substantive changes.
A-67 incorporates Calendar Year (CY) 2023 capitation rates and new benefits for CY 2023.	December 7, 2023
A-68 incorporates revised Calendar Year (CY) 2022 CCI Full Dual capitation rates.	June 1, 2023
A-69 incorporates updated Calendar Year (CY) 2023 capitation rates.	October 3, 2024

The following is a summary of amendments to the Secondary Agreement (23-30267) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Secondary Agreement	Board Approval
Agreement 23 – 30267 covers specific state – supported services to CalOptima Health's members enrolled under CalOptima Health's Primary Agreement (23 – 30235).	December 7, 2023
A-01 incorporates Calendar Year (CY) 2024 capitation rates.	March 7, 2024
A-02 incorporates updated final Calendar Year (CY) 2024 capitation rates.	April 3, 2025
A-03 incorporates final Calendar Year (CY) 2025 capitation rates.	April 3, 2025

The following is a summary of amendments to the Secondary Agreement (08-85221) approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)

A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018
A-09 incorporates updated Calendar Year (CY) 2022 Public Health Emergency (PHE) capitation rates.	November 2, 2023
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021

The following is a summary of amendments to the Secondary Agreement (22-20494) approved by the CalOptima Health Board of Directors (Board) to date:

Agreement 22-20494 incorporates both Hyde services ("Private Services") and the new Unsatisfactory Immigration Status members from January 1, 2023 to December 31, 2023.	December 1, 2022
A-01 incorporates rates for CY 2023 for Hyde services (now referred to as "Private Services") and the new Unsatisfactory Immigration Status (UIS) members.	December 1, 2022
A-02 incorporates updated Calendar Year (CY) 2023 capitation rates.	October 3, 2024

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2022.	June 3, 2021

A-06 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	May 5, 2022
A-07 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	October 6, 2022
A-08 extends Agreement 16 – 93274 with DHCS to December 31, 2023.	Not applicable due to non – substantive changes.
A-09 extends Agreement 16 – 93274 with DHCS to December 31, 2024.	May 4, 2023
A-10 extends Agreement 16 – 93274 with DHCS to December 31, 2025.	May 2, 2024

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Health Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

The following is a summary of amendments to CalOptima Health's Agreement for Disclosure and Use of DHCS Data (2023 Post – Expiration Data Use Agreement (DUA)) and 2024 Operational Readiness (OR) DUA.

Amendments to Data Use Agreement	Board Approval
CY 2023 Data Use Agreement (DUA) allows for the exchange of information between DHCS and CalOptima Health after the current contract expires on December 31, 2023.	November 2, 2023
CY 2024 Operational Readiness (OR) DUA allows DHCS to initiate and execute the necessary data releases ahead of January 1, 2024 for DHCS to share necessary data with CalOptima Health.	November 2, 2023

CalOptima Health Board Action Agenda Referral

Action To Be Taken April 3, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

9. Authorize the Chief Executive Officer to Execute Contract Amendments with Imagenet, LLC and Office Ally, Inc.

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Ladan Khamseh, Executive Director, (714) 246-8866

Recommended Actions

Make an exception to CalOptima Health Policy GA.5002: Purchasing Policy and authorize the Chief Executive Officer to extend the contracts with the following key operational system vendors under the existing terms and conditions without competitive procurement:

1. Imagenet, LLC. for a three-year term beginning July 1, 2026, with two one-year extension options, each exercisable at CalOptima Health's sole discretion.
2. Office Ally Inc. for a three-year term beginning January 1, 2026, with two one-year extension options, each exercisable at CalOptima Health's sole discretion.

Background

Imagenet, LLC (Imagenet) provides imaging, scanning, data lift, and document archive solutions. Multiple CalOptima Health departments utilize Imagenet scanning and image data lift to provide data files for claims and enrollment selection processes. Imagenet also provides electronic data imaging archives for provider documents, medication therapy management letter documentation, and historical grievance and appeals documentation. In 2023, a new provider dispute resolution (PDR) intake automation was added to improve efficiency with the PDR workflow. In addition to image data lift and PDR services, Imagenet provides CalOptima Health with imaging and postage for rejected claims and returned mail. Tight integrations have been built with this software solution to CalOptima Health's core system. Imagenet has provided these services to CalOptima Health since November 21, 2017, and received approval by the CalOptima Health Board of Directors (Board) on October 3, 2024, to extend the contract for one additional year through June 30, 2026.

Office Ally Inc. (Office Ally) is one of the claims administration clearinghouses that interact with providers in the community to submit claims electronically to CalOptima Health for payment consideration. Once submitted, Office Ally sends the claim files to CalOptima Health for processing. Office Ally has provided CalOptima Health electronic data interchange (EDI) clearinghouse services since July 1, 2004, and received the Board approval on December 1, 2022, to extend the contract for two additional years through December 31, 2025.

Discussion

The vendors listed above have established strong working relationships with both CalOptima Health and, crucially, CalOptima Health's provider community. These vendors are in full compliance with Department of Health Care Services (DHCS) guidelines and regulatory requirements, consistently

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surpassing all service level performance expectations. Replacing these vendors would require significant EDI mapping and logic changes within CalOptima Health systems.

Imagenet has customized certain data fields to accommodate the daily claims intake process. To engage a new vendor at this point would require substantial time and resources simply to reach CalOptima Health's current state due to the customization provided by Imagenet. CalOptima Health and Imagenet are now collaborating on a project aimed at converting the existing customized claims inbound files to a standardized Health Insurance Portability and Accountability Act compliant file format.

On July 18, 2024, CalOptima Health issued a comprehensive request for information (RFI) with a scope of work, including current known requirements to collect data and learn whether there were flexible systems capable of supporting future enhancements in features and functionality. The vendors who responded to the RFI included Catalyst Solutions, Citius Tech, Exela Technologies, Firstsource, GRM Information Management Services of California, and Imagenet. Based on the RFI demonstrations, CalOptima Health decided to remain with Imagenet because it provides pertinent service solutions to CalOptima Health's current needs (*e.g.*, PDR scanning services and imaging quality, scanning for other areas or additional form types, dedicated application environment, online claim submissions, project management support, and user training), the vendors responding to the RFI did not offer a response to those services or were unable to accommodate those services. The Imagenet contract expires on June 30, 2026. Staff recommend a three-year extension with two one-year extension options, each exercisable at CalOptima Health's sole discretion.

The Office Ally contract expires on December 31, 2025. By extending the contract term for three years beginning January 1, 2026, CalOptima Health will be able to maintain continuity of business operations without disrupting and impacting providers' ability to submit their claims electronically. In the provider community and delegated Health Network partners, Office Ally is considered the major clearinghouse for EDI. The 12-month average for CalOptima Health's claims volume is over 685,000 and 87% of those claims are submitted by providers through Office Ally.

Staff recommend that the Board authorize exceptions to CalOptima Health Policy GA.5002: Purchasing to allow CalOptima Health to extend its existing contracts with Imagenet and Office Ally under the same terms and conditions, for additional three-year terms with two additional one-year extension options, each exercisable at CalOptima Health's sole discretion, without competitive bidding.

Imagenet and Office Ally follow current CalOptima Health contract requirements, are not on any exclusion lists (System for Award Management, Office of the Inspector General, Medi-Cal Suspended and Ineligible), are not on the Medicare Preclusion List, and are actively listed with the California Secretary of State.

Fiscal Impact

The estimated annual fees for Imagenet are $600,000. Staff will include expenses for the period on and after July 1, 2026, in future CalOptima Health operating budgets.

The estimated annual fees for Office Ally are $1.5 million. Staff will include expenses for the period on and after January 1, 2026, in future CalOptima Health operating budgets.

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Rationale for Recommendation

Extending the contracts with Imagenet and Office Ally will ensure the continued, uninterrupted provision of services by these vendors and the seamless processing of claims payment to CalOptima Health's providers while allowing staff to work on other regulatory deliverables and critical projects.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by This Recommended Action

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
October 3, 2024	Authorize Extension of Contracts Related to CalOptima Health's Key Operational Systems	1-year contract extension	N/A
December 1, 2022	Authorize Contract Amendment Related to CalOptima Health's Key Operational System Vendors for Office Ally Inc., Change Healthcare Technologies LLC, and Health Management Systems, Inc.	2-year contract extension	N/A

/s/ Michael Hunn *03/27/2025*
Authorized Signature **Date**

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Attachment to the April 3, 2025 Board of Directors Meeting – Agenda Item 9

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Imagenet, LLC	10004 North Dale Mabry Highway Suite 110	Tampa	FL	33618
Office Ally Inc.	1300 SE Cardinal Court Suite 190	Vancouver	WA	98683

CalOptima Health Board Action Agenda Referral

Action To Be Taken April 3, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

10. Ratify List of Qualifying Funding Entities to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2024 (IGT14)

Contact

Donna Laverdiere, Executive Director, Strategic Development, (714) 986-6981

Recommended Actions

Ratify the following list of qualifying funding entities and allocations for participation in the Calendar Year 2024 Voluntary Rate Range Intergovernmental Transfer Program:

1. City of Brea Fire Department;
2. City of Laguna Beach Fire Department;
3. City of Newport Beach Fire Department;
4. City of Fountain Valley Fire Department;
5. Children & Families Commission of Orange County (First 5 of Orange County);
6. City of Fullerton Fire Department;
7. City of Orange Fire Department;
8. City of Huntington Beach Fire Department;
9. City of Anaheim Fire Department;
10. County of Orange Health Care Agency; and
11. University of California, Irvine.

Background

The Voluntary Rate Range Intergovernmental Transfer (VRR IGT) program allows the Department of Health Care Services (DHCS) and CalOptima Health to secure additional Medi-Cal dollars for eligible Orange County entities. For each IGT transaction, DHCS identifies the estimated member months for rate categories (*e.g.*, adult, adult optional expansion, child, long term care, seniors and persons with disabilities, and whole child model) and provides the total amount available for Orange County to contribute through funding entities. To receive funds, qualifying funding entities must identify their uncompensated costs for serving Medi-Cal members and provide a funding transfer amount to DHCS, which is then used to obtain a federal match. DHCS distributes the funds and the match to the qualifying funding entities through CalOptima Health. To date, CalOptima Health has participated in 13 VRR IGT transactions. CalOptima Health currently retains a 2% administrative fee of net proceeds for administration of the VRR IGT program.

On January 14, 2025, DHCS notified CalOptima Health regarding the Calendar Year (CY) 2024 VRR IGT program opportunity with approximately $60.8 million in contribution and $175.1 million in total funding availability for Orange County. CalOptima Health's submission of the required materials was due to DHCS by March 28, 2025. At the March 6, 2025, Board of Directors meeting, staff received approval to pursue funding partnerships with qualifying funding entities, submit the proposal to DHCS, execute agreements with the funding entities, and bring back the final list of funding entities and allocations at the April 3, 2025, Board of Directors meeting for ratification.

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Discussion

On February 4, 2025, CalOptima Health hosted an informational webinar and shared information about VRR IGT to eligible governmental entities to inform them of the CY 2024 (IGT 14) timeline, funding availability, submission process, and eligibility requirements that must be met to be considered for funding. CalOptima Health contacted the seven CY 2023 program participants and additional potential new qualifying funding entities via email to inform them about the webinar, and eight organizations attended. CalOptima Health received confirmation of participation from eleven entities. Each entity submitted their uncompensated Medi-Cal costs as well as the funding amount they were able to contribute to obtain matching funds. CalOptima Health calculated each participating entity's contribution amount and estimated payment based on the proportion of uncompensated costs compared to the total submitted as well as the amount of funds each entity could provide through the transfer.

CalOptima Health submitted the proposal to DHCS, along with the qualifying funding entities' supporting documents, on the submission deadline of March 28, 2025. The entities and their approximate contribution amounts are listed below.

Funding Entity	Calendar Year 2024 Total Transfer Amount to DHCS	Calendar Year 2024 Total Participation Percentage (%)
City of Brea Fire Department	$17,227	0.03%
City of Laguna Beach Fire Department	$131,610	0.22%
City of Newport Beach Fire Department	$147,823	0.24%
City of Fountain Valley Fire Department	$291,694	0.48%
Children & Families Commission of Orange County (First 5 of Orange County)	$303,251	0.50%
City of Fullerton Fire Department	$455,299	0.75%
City of Orange Fire Department	$506,263	0.83%
City of Huntington Beach Fire Department	$609,014	1.00%
City of Anaheim Fire Department	$1,000,000	1.64%
County of Orange Health Care Agency	$3,565,361	5.86%
University of California, Irvine	$53,813,863	88.45%
Total Funding Entities Participation	**$60,841,404**	**100.00%**
Total Available Non-federal Share IGT	**$60,841,404**	-

Due to the timing of the submission to DHCS, CalOptima Health staff request the Board of Directors ratify the list of qualifying funding entities and the funding allocations above that were submitted for the CY 2024 VRR IGT program to DHCS on March 28, 2025.

Fiscal Impact

The recommended action is net budget neutral. IGT 14 is expected to generate approximately $2.0 million for CalOptima Health to offset expenses for the administration of the VRR IGT program.

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Rationale for Recommendation

Submission of the proposal and authorization of funding agreements allows Orange County qualifying funding entities to participate in the CY 2024 VRR IGT program.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action.
2. Board Action Dated March 6, 2025, Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2024.
3. CalOptima Health Calendar Year 2024 Voluntary Rate Range Program Letter of Interest and Proposal to DHCS.

/s/ Michael Hunn *03/27/2025*
Authorized Signature **Date**

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Attachment 1

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
City of Anaheim	201 S Anaheim Blvd.	Anaheim	CA	92805
City of Brea	1 Civic Center Circle	Brea	CA	92821
City of Fountain Valley Fire Department	10200 Slater Avenue	Fountain Valley	CA	92708
City of Fullerton	312 Commonwealth Avenue	Fullerton	CA	92832
City of Huntington Beach Fire Department	2000 Main Street	Huntington Beach	CA	92648
City of Laguna Beach	505 Forest Avenue	Laguna Beach	CA	92651
City of Newport Beach Fire Department	100 Civic Center Drive	Newport Beach	CA	92660
City of Orange Fire Department	300 E. Chapman Avenue	Orange	CA	92866
County of Orange Health Care Agency	405 W. 5th Street, Suite 756	Santa Ana	CA	92701
First 5 Orange County Children & Families Commission	1505 E. 17th Street, Suite 230	Santa Ana	CA	92705
University of California, Irvine Medical Center	101 City Drive, Bldg 53, Suite 100	Orange	CA	92868

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CalOptima Health Board Action Agenda Referral

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

Consent Calendar

9. Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2024

Contact

Donna Laverdiere, Executive Director, Strategic Development, (714)-986-6981

Recommended Actions

Authorize the following activities to secure Medi-Cal funds through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2024:

1. Submission of a proposal to the California Department of Health Care Services to participate in the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2024;
2. Pursuit of funding partnerships with eligible participating entities; and
3. The Chief Executive Officer executing agreements with these entities and their designated providers, as necessary, to seek intergovernmental transfer funds.

Background

The Voluntary Rate Range Intergovernmental Transfer Program (VRRP) allows the Department of Health Care Services (DHCS) and CalOptima Health to secure additional Medi-Cal dollars through intergovernmental transfers from eligible Orange County governmental entities. The eligible governmental entities are public entities, including counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state.

For each Intergovernmental Transfer (IGT) transaction, DHCS identifies the estimated CalOptima member months for rate categories (*e.g.*, adult, adult optional expansion, child, long term care, seniors and persons with disabilities, and whole child model) and provides the total amount available for Orange County to contribute through funding entities. Participating governmental entities transfer public funds to DHCS, which is then used by DHCS to obtain a federal match. DHCS distributes the funds and the match to the eligible entities through CalOptima Health. To date, CalOptima Health has participated in thirteen transaction cycles of the VRRP.

CalOptima Health retains a 2% administrative fee of net proceeds to offset expenses for the administration of the VRRP.

There were seven program participants in the CY 2023 IGT 13 round:

- UCI Health;
- County of Orange;
- City of Orange;
- First 5 Orange County (formerly known as the Children and Families Commission);
- City of Newport Beach;
- City of Huntington Beach; and
- City of Fountain Valley.

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Discussion

On January 14, 2025, CalOptima Health received notification from DHCS regarding the IGT 14 opportunity with up to $175.1 million in total funding availability for Orange County. CalOptima Health's proposal, along with the proposed funding entities' supporting documents, are due to DHCS no later than March 28, 2025.

On February 4, 2025, CalOptima Health hosted an informational webinar and shared information about VRRP to potential participating eligible governmental entities to inform them of the CY 2024 VRRP (IGT 14) timeline, funding availability, submission process, and eligibility requirements that must be met in order to be considered for funding.

Eligible governmental entities must meet the following requirements:

- Only governmental entities that incur uncompensated costs for covered Medi-Cal services may be eligible for funding;
- Funding entities may not use recycled Medicaid funds or federal funds that are not eligible to fund the state share of the IGT;
- Funding entities must be:
    - Contracted CalOptima Health providers with uncompensated Medi-Cal expenditures, or costs which exceed payment from the plan for services rendered to Medi-Cal members.
    - Interested in providing local funds to act as a local IGT match.
- Funding entities must:
    - Certify that the funds provided are eligible for federal matching dollars.
    - Document uncompensated services (costs above reimbursement) provided to CalOptima Health members for dates of service between July 1, 2022, through June 30, 2023.

CalOptima Health staff is seeking Board of Directors' approval to authorize staff to submit the proposal letter to DHCS for participation in IGT 14 and to authorize the Chief Executive Officer to enter into agreements with each of the confirmed participating funding entities submitting a letter of interest, or their designated providers, for the purpose of securing available IGT funds. CalOptima Health staff will review the estimated contribution amounts and uncompensated Medi-Cal expenditures from participating funding entities to determine the IGT 14 allocation. Staff will return to the Board of Directors with the final list of participating funding partners and allocations for ratification at the April 3, 2025, meeting of the Board.

Consistent with the most recent IGT transaction, CalOptima Health will retain an administrative fee of 2% of net proceeds, with the remaining net proceeds distributed to the funding entities in compliance with VRRP requirements.

Fiscal Impact

Staff anticipate the recommended actions to be net budget neutral to CalOptima Health. IGT 14 is expected to generate approximately $2.6 million for CalOptima Health to offset expenses for the administration of the VRRP.

Rationale for Recommendation

Submission of the proposal and authorization of funding agreements will allow CalOptima Health to maximize Orange County's available Medi-Cal funding for Calendar Year 2024. It will also increase dollars to participating entities in Orange County to support Medi-Cal services provided to CalOptima Health members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CY 2024 Department of Health Care Services VRRP Notification
2. CY 2024 Attachment B Form for Governmental Funding Entities
3. Previous Board Action dated August 1, 2024, "Ratify List of Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2023 (IGT13)"

/s/ Michael Hunn *02/27/2025*
Authorized Signature **Date**

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DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

January 14, 2025

Nancy Huang
CFO
CalOptima
505 City Parkway West
Orange, CA 92868

SUBJECT: Calendar Year 2024 (January 1, 2024 – December 31, 2024) Voluntary Rate Range Program – Request for Medi-Cal Managed Care Plan's (MCP) Proposal

Dear Nancy Huang:

The Calendar Year 2024 Voluntary Rate Range Program, authorized by Welfare and Institutions (W&I) Code sections 14164, 14301.4, and 14301.5, provides a mechanism for funding the non-federal share of the difference between the lower and upper bounds of a MCP's actuarially sound rate range, as determined by the Department of Health Care Services (DHCS). Governmental funding entities eligible to transfer the non-federal share are defined as counties, cities, special purpose districts, state university teaching hospitals, and other political subdivisions of the state, pursuant to W&I Code section 14164(a). These governmental funding entities may voluntarily transfer funds to DHCS via intergovernmental transfer (IGT). These voluntary IGTs, together with the applicable Federal Financial Participation (FFP), will be used to fund payments by DHCS to MCPs as part of the capitation rates paid for the service period of January 1, 2024, through December 31, 2024.

DHCS shall not direct the MCP's expenditure of payments received under the Calendar Year 2024 Voluntary Rate Range Program. These payments are subject to all applicable requirements set forth in the MCP's contract with DHCS. These payments must also be tied to covered Medi-Cal services provided on behalf of Medi-Cal beneficiaries enrolled within the MCP's rating region.

The funds transferred by an eligible governmental funding entity must qualify for FFP pursuant to Title 42 Code of Federal Regulations (CFR) Part 433, Subpart B, including the requirements that the funding source(s) shall not be derived: from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as state match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the state as the source of funding.

DHCS shall continue to administer all aspects of the IGT related to the Calendar Year 2024 Voluntary Rate Range Program, including determinations related to fees.

PROCESS FOR CALENDAR YEAR 2024:

MCPs should refer to the estimated Calendar Year 2024 county/region-specific non-federal share required to fund available rate range amounts for the MCP (see Attachment C). As a reminder, participation in the Calendar Year 2024 Voluntary Rate Range Program is voluntary on the part of the transferring entity and the MCP. Note that the estimated Contribution (Non-Federal Share) amounts are based on final amended capitation rates (as of January 2025) and estimated member months, and the actual amounts may change based on finalized rates and updated enrollment estimates.

If an MCP elects to participate in the Calendar Year 2024 Voluntary Rate Range Program, the MCP must adhere to the process for participation outlined below:

Soliciting Interest

The MCP shall contact potential governmental funding entities to determine their interest, ability, and desired level of participation in the Calendar Year 2024 Voluntary Rate Range Program. All providers and governmental funding entities who express their interest directly to DHCS will be redirected to the applicable MCP to facilitate negotiations related to participation. If, following the submission of the MCP's proposal, one or more governmental funding entities included in the MCP's proposal are unable or unwilling to participate in the Voluntary Rate Range Program, the MCP shall attempt to find other governmental funding entities able and willing to participate in their place.

The MCP must inform all participating governmental entities that, unless DHCS determines a statutory exemption applies, IGTs submitted in accordance with W&I Code section 14301.4 are subject to an additional 20 percent assessment fee (calculated on the value of their IGT contribution amount) to reimburse DHCS for the administrative costs of operating the Voluntary Rate Range Program and to support the Medi-Cal program. DHCS will determine if a fee waiver is appropriate.

Submission Requirements

Once the MCP has coordinated with the relevant governmental funding entities, the following documents must be submitted to DHCS in accordance with the requirements and procedures set forth below:

- The MCP must submit a **proposal** to DHCS. This proposal must include:

    1. A cover letter signed by the MCP's Chief Executive Officer or Chief Financial Officer on **MCP letterhead**.
    2. The MCP's primary contact information (name, title, e-mail address, mailing address, and phone number).
    3. Rating region-specific summaries of the selected governmental funding entities, related providers, and participation levels specified for Calendar

Year 2024. The combined amounts or percentages must not exceed 100 percent of the estimated non-federal share of the available rate range amounts provided by DHCS. If the MCP is unable to use the entire available rate range, the MCP must indicate the unfunded amount and percentage.

4. All letters of interest (described below) and supporting documents must be attached to the proposal. If the Calendar Year 2024 Voluntary Rate Range Program Supplemental Attachment described below is not collected by the MCP and attached to the proposal at the time of submission, please indicate if the information will be submitted to DHCS directly by each governmental funding entity.

- The MCP must obtain a **letter of interest** from each governmental funding entity included in the MCP's proposal to DHCS. The highlighted sections in the letter of interest form provided in Attachment A must be filled out completely and printed on **the participating governmental funding entity's letterhead**. A separate letter of interest must be provided for each rating region. An individual who is authorized to sign the certification on behalf of the governmental funding entity must sign the letter of interest.

- The MCP must distribute to governmental funding entities and ensure submission to DHCS, either by the MCP or the governmental funding entity, of the **Calendar Year 2024 Voluntary Rate Range Program Supplemental Attachment** (see Attachment B) by **Friday, March 28, 2025**.

    - Please note: For MCPs that entered new rating regions in Calendar Year 2024, DHCS is granting a one-time exemption for Attachment B reporting from governmental funding entities in these rating regions. DHCS has indicated exempt rating regions for each MCP on the Attachment C documents using **purple highlight and a footnote**.

- The proposals and letters of interest are due to DHCS ***by 5pm on* Friday, March *28, 2025***. Please send a PDF copy of the required documents by e-mail to Vivian.Beeck@dhcs.ca.gov, and Scott.Gale@dhcs.ca.gov. ***Failure to submit all required documents by the due date may result in exclusion from the Calendar Year 2024 Voluntary Rate Range Program.***

Each proposal is subject to review and approval by DHCS. The review will include an evaluation of the proposed provider participation levels in comparison to their uncompensated contracted Medi-Cal costs and/or charges unless the applicable rating region is subject to a one-time exemption. DHCS reserves the right to approve, amend, or deny the proposal at its discretion.

Upon DHCS' approval of the governmental funding entities and non-federal share amounts for the Calendar Year 2024 Voluntary Rate Range Program, DHCS will provide the necessary funding agreement templates, forms, and related due dates to the specified governmental funding entities and MCP contacts. The governmental funding entities will be responsible for completing all necessary funding agreement

documents, responding to any inquiries necessary for obtaining approval, and obtaining all required signatures.

If you have any questions regarding this letter, please contact Vivian Beeck at (916) 345-8271 or by email at Vivian.Beeck@dhcs.ca.gov.

Sincerely,

DocuSigned by:
Michael Jordan
641B9785907E40F...

January 14, 2025

Michael Jordan Staff Services Manager II
Capitated Rates Development Division

Attachments

cc: Michael Hunn
CEO
CalOptima
505 City Parkway West
Orange, CA 92868

Vivian Beeck
Staff Services Manager I
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

Scott Gale
Associate Governmental Program Analyst
Capitated Rates Development Division
Department of Health Care Services
P.O. Box 997413, MS 4413
Sacramento, CA 95899-7413

Attachment B

Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2024 (January 1, 2024 through December 31, 2024)

Provider's Legal Name:	
County:	
Health Plan:	

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than March 28, 2025.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2022-23 (July 1, 2022 - June 30, 2023).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other				$ -	$ -
Total	$ -	$ -	$ -	$ -	$ -

* Include payments received and anticipated to be received, for dates of service from July 1, 2022 - June 30, 2023.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2022 - June 30, 2023 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? ***(Yes / No)***

If **No**, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds:

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding:

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

(iv) Does the transferring entity have general taxing authority? ***(Yes / No)***

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. ***(Yes / No)***

5. Comments / Notes

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CalOptima Health Board Action Agenda Referral

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

Consent Calendar

8. Ratify List of Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2023 (IGT13)

Contact

Donna Laverdiere, Executive Director, Strategic Development, (714) 986-6981

Recommended Actions

Ratify the following list of qualifying funding partners and allocations for participation in the Calendar Year 2023 Voluntary Rate Range Intergovernmental Transfer Program:

1. City of Fountain Valley Fire Department;
2. City of Huntington Beach Fire Department;
3. City of Orange Fire Department;
4. City of Newport Beach Fire Department;
5. Children and Families Commission of Orange County (First 5 of Orange County);
6. County of Orange Health Care Agency; and
7. University of California, Irvine.

Background

The Voluntary Rate Range Intergovernmental Transfer (IGT) program allows the Department of Health Care Services (DHCS) and CalOptima Health to secure additional Medi-Cal dollars for eligible Orange County entities. For each IGT transaction, DHCS identifies the estimated member months for rate categories (*e.g.*, adult, adult optional expansion, child, long term care, seniors and persons with disabilities, and whole child model) and provides the total amount available for Orange County to contribute through funding entities. To receive funds, eligible entities provide a dollar amount to DHCS, which is then used to obtain a federal match. DHCS distributes the funds and the match to the eligible entities through CalOptima Health. To date, CalOptima Health has participated in twelve Voluntary Rate Range IGT transactions. CalOptima Health currently retains a 2% administrative fee of net proceeds for administration of the Voluntary Rate Range IGT program.

On May 29, 2024, DHCS notified CalOptima Health regarding the Calendar Year (CY) 2023 Voluntary Rate Range IGT program opportunity with up to $52.5 million in contribution for Orange County. CalOptima Health's submission of the required materials was due to DHCS by July 10, 2024. At the June 6, 2024, Board of Directors meeting, staff received approval to pursue funding partnerships with eligible entities, submit the proposal to DHCS, execute agreements with the funding entities, and bring back the final list of funding partners and allocation at the August 1, 2024, Board of Directors meeting.

Discussion

CalOptima Health contacted the six CY 2022 Voluntary Rate Range program participants (University of California-Irvine, First 5 Orange County, the County of Orange, the City of Orange, the City of Newport Beach, and the City of Huntington Beach) to inform them of the CY 2023 Voluntary Rate Range IGT

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program timeline and funding availability. CalOptima Health also reached out to the City of Fountain Valley as they had recently inquired and expressed interest in participating.

CalOptima Health submitted the proposal to DHCS, along with the proposed funding entities' supporting documents, on July 8, 2024. The entities and their approximate contribution amounts are:

Funding Entity	**Calendar Year 2023 Total Transfer Amount**	**Calendar Year 2023 Total Participation Percentage (%)**
Children & Families Commission of Orange County (First 5 of Orange County)	$804,153	1.53%
City of Fountain Valley Fire Department	$779,540	1.48%
City of Huntington Beach Fire Department	$2,292,744	4.36%
City of Newport Beach Fire Department	$367,822	0.70%
City of Orange Fire Department	$579,294	1.10%
County of Orange Health Care Agency	$3,547,480	6.75%
University of California, Irvine	$44,180,379	84.07%
Total Funding Entities Participation	$52,551,412	100%
Unfunded	$0	0%
Total Available Non-federal Share IGT	$52,551,412	-

Due to the timing of the submission, CalOptima Health staff request the Board of Directors ratify the list of funding partners and the funding allocations above that were submitted for the CY 2023 Voluntary Rate Range IGT to DHCS on July 8, 2024.

Fiscal Impact
The recommended action is net budget neutral and has no additional fiscal impact.

Rationale for Recommendation
Submission of the proposal and authorization of funding agreements allows Orange County eligible funding partners to participate in the CY 2023 Voluntary Rate Range IGT program.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. Board Action Dated June 6, 2024, Authorize Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Rate Range Intergovernmental Transfer Program for Calendar Year 2023.
3. CalOptima Health Calendar Year 2023 Voluntary Rate Range Program Letter of Interest and Proposal to DHCS.
4. CY 2023 DHCS Attachment C CalOptima Health Estimated Funding Allocation.

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

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
City of Fountain Valley Fire Department	10200 Slater Avenue	Fountain Valley	CA	92708
City of Huntington Beach Fire Department	2000 Main Street	Huntington Beach	CA	92648
City of Newport Beach Fire Department	100 Civic Center Drive	Newport Beach	CA	92660
City of Orange Fire Department	300 E. Chapman Avenue	Orange	CA	92866
County of Orange Health Care Agency	405 W. 5th Street, Suite 756	Santa Ana	CA	92701
First 5 Orange County Children & Families Commission	1505 E. 17th Street, Suite 230	Santa Ana	CA	92705
University of California, Irvine Medical Center	101 City Drive, Bldg 53, Suite 100	Orange	CA	92868

CalOptima Health
A Public Agency
505 City Parkway West
Orange, CA 92868
☎ 714-246-8400
TTY: 711
caloptima.org

March 25, 2025

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter is to confirm CalOptima Health's interest in initiating Voluntary Rate Range (VRR) Intergovernmental Transfer (IGT for Calendar Year 2024 (January 1, 2024 through December 31, 2024) to enhance services for CalOptima Health's Medi-Cal members.

CalOptima Health is applying for the maximum amounts with four new funding entities in addition to the previous participants. For Orange County's proposed VRR IGT transaction for Calendar Year 2024, these funding entities have confirmed their participation as follows:

Funding Entity	Calendar Year 2024 Total Transfer Amount	Calendar Year 2024 Total Participation Percentage (%)
Children & Families Commission of Orange County (First 5 of Orange County)	$303,251.00	0.50%
City of Anaheim Fire Department	$1,000,000.00	1.64%
City of Brea	$17,227.00	0.03%
City of Fullerton	$455,299.00	0.75%
City of Fountain Valley	$291,694.00	0.48%
City of Huntington Beach	$609,014.00	1.00%
City of Laguna Beach	$131,610.00	0.22%
City of Newport Beach Fire Department	$147,823.00	0.24%
City of Orange	$506,263.00	0.83%
County of Orange Health Care Agency (OCHCA)	$3,565,361.00	5.86%
University of California, Irvine (UCI Health)	$53,813,863.00	88.45%
Total Funding Entities Participation	**$60,841,404.00**	**100%**

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The 11 funding entities are able to contribute up to $60,841,404 or 100 percent of the non-federal share IGT amount for Orange County. The unfunded portion is $0, or 0 (zero) percent of the non-federal share IGT amount. CalOptima Health intends to retain 2% of the transaction as an administrative fee.

Enclosed, please find the attachments as requested for each funding entity:

- Voluntary, non-binding letter of interest including:
  - Dollar amount to be contributed as non-federal share IGT
  - Funding entity contact information
  - Funding entity's Federal I.D. number
- Separate attachment for Calendar Year 2024 including the following data from July 1, 2022–June 30, 2023:
  - Inpatient/Outpatient charges, as applicable
  - Inpatient/Outpatient costs, as applicable
  - Payments for Inpatient/Outpatient services, as applicable
  - Unreimbursed costs for Inpatient/Outpatient services, as applicable scope of services

The point of contacts for CalOptima Health are:

Mr. Mike Wood
Manager, Regulatory Affairs & Compliance (Medi-Cal Regulatory Affairs)
CalOptima Health
505 City Parkway West
Orange, CA 92868
Email: mwood@caloptima.org
Phone: 714-246-8415

Ms. Annabel Vaughn
Director, Regulatory Affairs & Compliance (Medi-Cal)
CalOptima Health
505 City Parkway West
Orange, CA 92868
Email: avaughn@caloptima.org
Phone: 714-246-8676

Mr. John Tanner
Chief Compliance Officer
CalOptima Health
505 City Parkway West
Orange, CA 92868
Email: john.tanner@caloptima.org
Phone: 657-235-6997

Ms. Nancy Huang
Chief Financial Officer
CalOptima Health
505 City Parkway West
Orange, CA 92868
Email: nhuang@caloptima.org
Phone: 657-235-6935

Mr. Jason Kaing
Controller
CalOptima Health
505 City Parkway West
Orange, CA 92868
Email: jason.kaing@caloptima.org
Phone: 657-900-1373

Ms. Donna Laverdiere
Executive Director, Strategic Development
CalOptima Health
505 City Parkway West
Orange, CA 92868
Email: donna.laverdiere@caloptima.org
Phone: 714-986-6981

Please contact Mr. Mike Wood (primary contact) if you have any questions regarding this submission.

Sincerely,

Signed by:
Michael Hunn
EDDDDCC19C894FB...
Michael Hunn
Chief Executive Officer

Enclosures

cc:
Vivian Beeck, Staff Services Manager, California Department of Health Care Services
Michael Ha, Health Program Specialist, California Department of Health Care Services
Michael Jordan, Staff services Manager II, California Department of Health Care Services
Scott Gale, Associate Governmental Program Analyst, California Department of Health Care Services
Jim Vanderpool, City Manager, City of Anaheim
Jason Killebrew, Assistant City Manager, City of Brea
Kimberly Goll, Executive Director, First 5 Orange County Children & Families Commission
William McQuaid, Fire Chief, City of Fountain Valley
Adam Loeser, Fire Chief, City of Fullerton

Eric McCoy, Fire Chief, City of Huntington Beach
Niko King, Fire Chief, City of Laguna Beach
Jeff Boyles, Fire Chief, City of Newport Beach
Tom Kisela, City Manager, City of Orange
Jenna Sarin, Director of Public Health and Nursing, Orange County Health Care Agency
Chad Lefteris, FACHE, Chief Executive Officer, UC Irvine Health
Nancy Huang, Chief Financial Officer, CalOptima Health

FIRST 5 ORANGE COUNTY

1505 E. 17th Street, Suite 230
Santa Ana, CA 92705
714-834-5310 first5oc.org

ATTACHMENT A – LETTER OF INTEREST

March 19, 2025

David Bishop
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of the Children and Families Commission of Orange County (DBA First 5 Orange County), a governmental entity, federal I.D. Number 95-6000928, in working with **CalOptima Health** (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2024, through December 31, 2024. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

The Children and Families Commission of Orange County is willing to contribute approximately $303,251.00 for the Calendar Year 2024 (January 1, 2024 – December 31, 2024) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individuals from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Kimberly Goll, President CEO
Children and Families Commission of Orange County
1505 E. 17th Street, Suite 230
Santa Ana, CA 92705
(714) 920-2598
Kim.Goll@cfcoc.ocgov.com

Michael Garcell, Director of Finance and Administration
Children and Families Commission of Orange County
1505 E. 17th Street, Suite 230
Santa Ana, CA 92705
(714) 567-0160
Michael.Garcell@cfcoc.ocgov.com

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You may also contact our consultant, Gelmy Ruiz, with any questions or concerns regarding our participation in IGTs. Her contact information is (916) 329-8234 or gruiz@healthmanagement.com.

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Kimberly Goll
President/CEO

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Attachment B

Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2024 (January 1, 2024 through December 31, 2024)

Provider's Legal Name:	Children and Families Commission of Orange County
County:	Orange
Health Plan:	CalOptima

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than March 28, 2025.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2022-23 (July 1, 2022 - June 30, 2023).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$	$
Outpatient (not including pharmacy services billed by a pharmacy on a pharmacy claim)**				$	$
Pharmacy services billed by a pharmacy on a pharmacy claim**				$	$
All Other		$ 856,089.46		$	$ 856,089.46
Total	$	$ 856,089.46	$	$	$ 856,089.46

* Include payments received and anticipated to be received, for dates of service from July 1, 2022 - June 30, 2023.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2022 - June 30, 2023 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? **Yes**

If **No**, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

The Children and Families Commission of Orange County (First 5 Orange County) health care services are provided to children aged 0-5 and their caregivers and encompass pre and post-natal maternal health screenings; postpartum depression screening and referrals; lactation education and aid; parenting education; case management, care coordination and referrals to home visits to support the at-risk, postpartum population; and the provision of development assessments and screenings to identify children with autism and neurodevelopmental disorders. First 5 Orange County does not have a contract with CalOptima for services.

4. We ask that a duly authorized representative formally attest to the following:

(I) The legal name of the entity transferring funds: Children and Families Commission of Orange County

(II) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: County Commission

(III) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

Tobacco tax revenue collected by the State and distributed to Counties based on birthrates to develop, adopt, promote, and implement local early children development programs.

(IV) Does the transferring entity have general taxing authority? **No**

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. **Yes, 80% of revenue collected is distrubuted to counties.**

5. Comments / Notes

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Attestation by duly authorized representative:

Please print the Name (first & last), and Title: Kimberly Goll, President/CEO

Signature & Date: Kimberly Goll 3/4/2025

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Name	Title	Organization	Mailing Street Address	City	State	Zip	Email Address	Phone Number
Kimberly Goll	President/CEO	First 5 OC (Children and Families (	1505 E 17th St. suite 230	Santa Ana	CA	92705	kim.goll@cfcoc.ocgov.com	7149202598
Michael Garcell	Director Admin and Finance	First 5 OC (Children and Families (	1505 E 17th St. suite 230	Santa Ana	CA	92705	michael.garcell@cfcoc.ocgov.com	7145670160
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City of Anaheim

www.anaheim.net

March 18, 2025

David Bishop, Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of City of Anaheim, a governmental entity, federal I.D. Number 95-6000666, in working with CalOptima Health (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2024, through December 31, 2024. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

City of Anaheim is willing to contribute approximately $1,000,000 for the Calendar Year 2024 (January 1, 2024 - December 31, 2024) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individuals from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Robert Stuart, EMS Manager
200 S. Anaheim Boulevard, Suite 300, Anaheim, CA 92805
rstuart@anaheim.net / (714) 765-4035

Bryan Limon, Management Assistant II
200 S. Anaheim Boulevard, Suite 300, Anaheim, CA 92805
blimon@anaheim.net / (714) 765-4050

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Jim Vanderpool
City Manager

201 S. Anaheim Blvd.
M.S. # 101
Anaheim, CA 92805
TEL: 714.765.4000
FAX: 714.765.4008

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Attachment B

Voluntary Rate Range Program Supplemental Attachment

Calendar Year 2024 (January 1, 2024 through December 31, 2024)

Provider's Legal Name:	City of Anaheim
County:	Orange
Health Plan:	CalOptima

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than March 28, 2025.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2022-23 (July 1, 2022 - June 30, 2023).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**	$ 9,244,935.45	$ 9,244,935.45	$ 2,541,529.02	$ 6,703,406.43	$ 6,703,406.43
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other				$ -	$ -
Total	$ 9,244,935.45	$ 9,244,935.45	$ 2,541,529.02	$ 6,703,406.43	$ 6,703,406.43

* Include payments received and anticipated to be received, for dates of service from July 1, 2022 - June 30, 2023.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2022 - June 30, 2023 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? ***No***

If **No**, please specify the amount of funding available: $1,000,000

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

911 dispatched emergency treatment and ground ambulance transport

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: City of Anaheim

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: City

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

City of Anaheim General Fund

(iv) Does the transferring entity have general taxing authority? ***Yes***

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. ***N/A***

5. Comments / Notes

N/A

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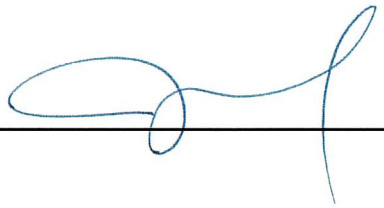
Attestation by duly authorized representative:

Please print the Name (first & last), and Title: Jim Vanderpool, City Manager

Signature & Date: 

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Name	Title	Organization	Mailing Street Address	City	State	Zip	Email Address	Phone Number
Robert Stuart	EMS Manager	Anaheim Fire & Rescue	200 S. Anaheim Boulevard, Suite 300	Anaheim	CA	92805	rstuart@anaheim.net	(714) 765-4035
Bryan Limon	Management Assistant II	Anaheim Fire & Rescue	200 S. Anaheim Boulevard, Suite 300	Anaheim	CA	92805	blimon@anaheim.net	(714) 765-4050
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CITY of BREA

ATTACHMENT A – LETTER OF INTEREST

David Bishop
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of City of Brea, a governmental entity, federal I.D. Number 95-6000681, in working with **CalOptima Health** (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2024, through December 31, 2024. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

City of Brea is willing to contribute approximately $17,227.00 for the Calendar Year 2024 (January 1, 2024 – December 31, 2024) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individuals from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Entity Contact Information for at least two employees:

Kristin Griffith, City Manager, 1 Civic Center Circle, kristing@cityofbrea.gov, 714-990-7710
Mark Terrill, Fire Chief, 1 Civic Center Circle, markt@cityofbrea.gov, 714-990-7646
Justin Zuhlke, EMS Division Chief, 1 Civic Center Circle, justinz@cityofbrea.gov, 714-671-6376

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Jason Killebrew
Assistant City Manager

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Attachment B
Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2024 (January 1, 2024 through December 31, 2024)

Provider's Legal Name:	City of Brea
County:	Orange
Health Plan:	CalOptima Health

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than March 28, 2025.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2022-23 (July 1, 2022 - June 30, 2023).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other	$ 49,296.28	$ 9,137.20	$ 664.56	$ 48,631.72	$ 8,472.64
Total				$ 48,631.72	$ 8,472.64

* Include payments received and anticipated to be received, for dates of service from July 1, 2022 - June 30, 2023

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2022 - June 30, 2023 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *(Yes / No)*

If **No**, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

Brea Fire Paramedics provided ALS level assessments and care. Emergency Ambualnce Services served as a 3rd party contracted BLS Ground Ambualnce transport service. Brea Fire contracted with Emergency Ambulance Services to receive an ALS pass through fee and a supply fee for ALS level transports.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: City of Brea

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: City

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

City General Fund

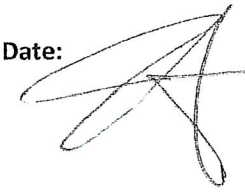
(iv) Does the transferring entity have general taxing authority? *(Yes / No)*

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. *(Yes / No)*

5. Comments / Notes

Attestation by duly authorized representative:

Please print the Name (first & last), and Title: JUSTIN ZUHLKE
BATTALION CHIEF

Signature & Date:  3/07/2025

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Name	Title	Organization	Mailing Street Address	City	State	Zip	Email Address	Phone Number
Kristin Griffith	City Manager	City of Brea	1 Civic Center Circle	Brea	Ca	92821	kristing@cityofbrea.gov	(714) 990-7711
Mark Terrill	Fire Chief	City of Brea	1 Civic Center Circle	Brea	Ca	92821	markt@cityofbrea.gov	(714) 990-7655
Dan Mielke	Deputy Chief	City of Brea	1 Civic Center Circle	Brea	Ca	92821	danielmi@cityofbrea.gov	(714) 671-4463
Justin Zuhlke	EMS Division Chief	City of Brea	1 Civic Center Circle	Brea	Ca	92821	justinz@cityofbrea.gov	(714) 671-6376
Danielle Boal	EMS Manager	City of Brea	1 Civic Center Circle	Brea	Ca	92821	danielleb@cityofbrea.gov	(714) 671-6365
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CITY OF FULLERTON

Fire Department

March 18, 2025

David Bishop, Division Chief
Capitated Rates Development Division
California Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of City of Fullerton, a governmental entity, Federal Tax I.D. Number 95-6000711, in working with **CalOptima Health** (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2024, through December 31, 2024. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

The City of Fullerton is willing to contribute approximately $455,299 for the Calendar Year 2024 (January 1, 2024 - December 31, 2024) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individuals from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Andrew Yang, Administrative Analyst II
City of Fullerton – Fire Department
312 E Commonwealth Ave
Fullerton, California 92832
andrew.yang@fullertonfire.org
(714) 738-3119

Rhonda Rosati, EMS Manager
City of Fullerton – Fire Department
312 E Commonwealth Ave
Fullerton, California 92832
rhonda.rosati@fullertonfire.org
(714) 738-4113

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Respectfully,

Adam Loeser
Fire Chief
City of Fullerton

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Attachment B

Voluntary Rate Range Program Supplemental Attachment

Calendar Year 2024 (January 1, 2024 through December 31, 2024)

Provider's Legal Name:	City of Fullerton
County:	Orange
Health Plan:	CalOptima Health

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than March 28, 2025.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2022-23 (July 1, 2022 - June 30, 2023).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other	$776,751.64	$1,936,182.14	$650,854.57	$ 125,897.07	$ 1,285,327.57
Total	$ 776,751.64	$ 1,936,182.14	$ 650,854.57	$ 125,897.07	$ 1,285,327.57

* Include payments received and anticipated to be received, for dates of service from July 1, 2022 - June 30, 2023.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2022 - June 30, 2023 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? ***Yes***

If **No**, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

Emergency prehospital care, including first responder EMS services, provided under a contract arrangement.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: City of Fullerton

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: City

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

City of Fullerton General Fund

(iv) Does the transferring entity have general taxing authority? ***Yes***

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control.

5. Comments / Notes

The data provided for this submission was sourced from billing reports generated by our EMS billing provider, Wittman Enterprises, LLC. Due to the nature of our billing records, information from multiple reports was compiled and reconciled to ensure a complete and accurate dataset, with all figures reflecting the service period from July 1, 2022 to June 30, 2023. The figures included in this attestation pertain exclusively to care provided to CalOptima patients.

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Attestation by duly authorized representative:

Please print the Name (first & last), and Title: Adam Loeser
Fire Chief - City of Fullerton

Signature & Date: 
Friday, March 21, 2025

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Name	Title	Organization	Mailing Street Address	City	State	Zip	Email Address	Phone Number
Andrew Yang	Administrative Analyst II	City of Fullerton	312 E Commonwealth Ave	Fullerton	CA	92832	andrew.yang@fullertonfire.org	(714) 738-3119
Rhonda Rosati	EMS Manager	City of Fullerton	312 E Commonwealth Ave	Fullerton	CA	92832	rhonda.rosati@fullertonfire.org	(714) 738-4113
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								( )

FOUNTAIN VALLEY

10200 Slater Avenue
Fountain Valley, CA 92708
Phone: (714) 593-4412
Fax: 714-593-4494
fountainvalley.gov

ATTACHMENT A – LETTER OF INTEREST

March 17, 2025

David Bishop
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of the City of Fountain Valley, a governmental entity, federal I.D. Number 95-2158356 (NPI: 1528109212), in working with **CalOptima Health** (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2024, through December 31, 2024. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

The City of Fountain Valley is willing to contribute approximately $291,694 for the Calendar Year 2024 (January 1, 2024 – December 31, 2024) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individuals from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Timothy Saiki, Battalion Chief
10200 Slater Avenue
Fountain Valley, CA 92708
Tim.Saiki@fountainvalley.gov
(949) 599-5058

William McQuaid, Fire Chief
10200 Slater Avenue
Fountain Valley, CA 92708
Bill.McQuaid@fountainvalley.gov
(714) 593-4436

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

William McQuaid
Fire Chief

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Attachment B

Voluntary Rate Range Program Supplemental Attachment
Calendar Year 2024 (January 1, 2024 through December 31, 2024)

Provider's Legal Name:	City of Fountain Valley
County:	Orange County, CA
Health Plan:	CalOptima Health

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than March 28, 2025.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2022-23 (July 1, 2022 - June 30, 2023).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other	$ 1,121,957.75	$ 794,147.28	$ 298,493.28	$ 823,464.47	$ 495,654.00
Total	$ 1,121,957.75	$ 794,147.28	$ 298,493.28	$ 823,464.47	$ 495,654.00

* Include payments received and anticipated to be received, for dates of service from July 1, 2022 - June 30, 2023.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2022 - June 30, 2023 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *YES*

If No, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

The City of Fountain Valley provides 911-response to medical calls, traffic accidents, and other emergencies requiring emergency medical care. The City's service model includes Advance Life Support (ALS) response daily via 3 fire apparatus (two engines, one ladder truck) with 1 company officer, 1 fire engineer, and 2 firefighter/paramedics each. It also includes two Basic Life Support (BLS) ambulances daily with 2 emergency medical technitions (EMTs) on each ambulance.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: City of Fountain Valley

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: City

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.) General Fund

(iv) Does the transferring entity have general taxing authority? *YES*

If No, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control.

5. Comments / Notes

CalOptima charges and payments provided via billing report from our contracted billing provider (Wittman). Costs calcuated using Fiscal Year 22/23 actual budget, CalOptima transport statistics from Wittman, and CAD data (call volume).

Attestation by duly authorized representative:
Please print the Name (first & last), and Title: William McQuaid, Fire chief

Signature & Date: [signature] 4/1/24

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Name	Title	Organization	Mailing Street Address	City	State	Zip	Email Address	Phone Number
Tim Saiki	Battalion Chief	City of Fountain Valley Fire Department	10200 Slater Avenue	Fountain Valley	CA	92708	tim.saiki@fountainvalley.gov	(949) 599-5059
Bill McQuaid	Fire Chief	City of Fountain Valley Fire Department	10200 Slater Avenue	Fountain Valley	CA	92708	bill.mcquaid@fountainvalley.gov	(714) 593-4436
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								( )
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								( )

March 18, 2025

ATTACHMENT A – LETTER OF INTEREST

David Bishop
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of the City of Huntington Beach, a governmental entity, federal I.D. Number 95-6000723, in working with **CalOptima Health** (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2024, through December 31, 2024. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

The City of Huntington Beach is willing to contribute approximately **$609,014** for the Calendar Year 2024 (January 1, 2024 – December 31, 2024) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individuals from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Eric McCoy, Fire Chief 2000 Main Street Huntington Beach, CA 92648 (714) 536-5411 emccoy@surfcity-hb.org	**Justin Fleming, Division Chief** 2000 Main Street Huntington Beach, CA 92648 (714) 536-5411 jfleming@surfcity-hb.org

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Eric McCoy

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Attachment B

Voluntary Rate Range Program Supplemental Attachment

Calendar Year 2024 (January 1, 2024 through December 31, 2024)

Provider's Legal Name:	City of Huntington Beach Paramedic Services, NPI 1568467264
County:	Orange County, CA
Health Plan:	Mcal HMO CalOptima

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than March 28, 2025.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2022-23 (July 1, 2022 - June 30, 2023).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (not including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other	$ 2,634,577.65	$ 2,643,916.64	$ 924,646.26	$ 1,709,931.39	$ 1,719,270.38
Total	$ 2,634,577.65	$ 2,643,916.64	$ 924,646.26	$ 1,709,931.39	$ 1,719,270.38

* Include payments received and anticipated to be received, for dates of service from July 1, 2022 - June 30, 2023.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2022 - June 30, 2023 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *Yes*

If **No**, please specify the amount of funding available:

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

We provide first responder, BLS, and full ALS 911 response and medical transport services to CalOptima patients with no contractual arrangement.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: City of Huntington Beach

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: City

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

The City of Huntington Beach general fund revenues.

(iv) Does the transferring entity have general taxing authority? *Yes*

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. *N/A*

5. Comments / Notes

Charges and payment data were provided by Wittman Enterprises. Cost data was taken from a third-party consultant's 2020 fee study report (The Matrix Group) and isolated to CalOptima transports during the given date range using the trip counts from Wittman Enterprises (9.22% or 1,311 out of 14,214 total transports).

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Attestation by duly authorized representative:

Please print the Name (first & last), and Title: Eric McCoy, Fire Chief

Signature & Date: 2/25/25

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Name	Title	Organization	Mailing Street Address	City	State	Zip	Email Address	Phone Number
Eric McCoy	Fire Chief	Huntington Beach Fire Department	2000 Main Street	Huntington Beach	CA	92648	emccoy@surfcity-hb.org	(714) 536-5411
David Cain	Interim Chief Financial Officer	City of Huntington Beach	2000 Main Street	Huntington Beach	CA	92648	david.cain@surfcity-hb.org	(714) 536-5630
Serena Bubenheim	Assistant Chief Financial Officer	City of Huntington Beach	2000 Main Street	Huntington Beach	CA	92648	serena.bubenheim@surfcity-hb.org	(714) 374-1567
Justin Fleming	Fire Division Chief	Huntington Beach Fire Department	2000 Main Street	Huntington Beach	CA	92648	jfleming@surfcity-hb.org	(714) 536-5564
Mindy James	Senior Management Analyst	Huntington Beach Fire Department	2000 Main Street	Huntington Beach	CA	92648	mindy.james@surfcity-hb.org	(714) 536-5408
Fire Department Accounts Payable	Fire Department Accounts Payable	Huntington Beach Fire Department	2000 Main Street	Huntington Beach	CA	92648	fdap@surfcity-hb.org	(714) 536-5411

ATTACHMENT A – LETTER OF INTEREST

March 5, 2025

David Bishop, Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of **City of Laguna Beach**, a governmental entity, federal I.D. Number **956000729**, in working with **CalOptima Health** (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2024, through December 31, 2024. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

City of Laguna Beach is willing to contribute approximately $131,610 for the Calendar Year 2024 (January 1, 2024 – December 31, 2024) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individuals from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Niko King, Fire Chief
30516 S. Coast Hwy. Laguna Beach, Ca 92651
nking@lagunabeachcity.net
949-497-0381

Erica Castillo, Director of Finance
505 Forest Ave. Laguna Beach, Ca 92651
ecastillo@lagunabeachcity.net
949-497-0307

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Niko King, Fire Chief

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Attachment B

Voluntary Rate Range Program Supplemental Attachment

Calendar Year 2024 (January 1, 2024 through December 31, 2024)

Provider's Legal Name:	City of Laguna Beach
County:	Orange
Health Plan:	CalOptima

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than March 28, 2025.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2022-23 (July 1, 2022 - June 30, 2023).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient	$ -	$ -	$ -	$ -	$ -
Outpatient (not including pharmacy services billed by a pharmacy on a pharmacy claim)**	$ 475,880.00	$ 489,600.00	$ 118,059.96	$ 357,820.04	$ 371,540.04
Pharmacy services billed by a pharmacy on a pharmacy claim**	$ -	$ -	$ -	$ -	$ -
All Other	$ -			$ -	$ -
Total	$ 475,880.00	$ 489,600.00	$ 118,059.96	$ 357,820.04	$ 371,540.04

* Include payments received and anticipated to be received, for dates of service from July 1, 2022 - June 30, 2023

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2022 - June 30, 2023 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *Yes*

If **No**, please specify the amount of funding available: N/A

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

The Laguna Beach Fire Department is a Public Provider Ground Emergency Medical Transport Agency. We provide ALS/BLS transport services to CalOptima members. All services are outpatient and on a non-contracted basis.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: City of Laguna Beach operating as the Fire Department

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: Local Agency

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

The funds for the IGT program are from local tax revenue collected and estimated to be unrestricted General fund monies.

(iv) Does the transferring entity have general taxing authority? *Yes*

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. *N/A*

5. Comments / Notes

Charges/Cost and Payment Data provided by third-party billing company, Wittman Enterprises, LLC.

Attestation by duly authorized representative:

Please print the Name (first & last), and Title: Niko King, Fire Chief

Signature & Date:

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Name	Title	Organization	Mailing Street Address	City	State	Zip	Email Address	Phone Number
Niko King	Fire Chief	City of Laguna Beach	505 Forest Ave.	Laguna Beach	Ca	92651	nking@lagunabeachcity.net	(949) 497-0381
Erica Castillo	Director of Finance	City of Laguna Beach	505 Forest Ave.	Laguna Beach	Ca	92651	ecastillo@lagunabeachcity.net	(949) 497-0307
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								( )

NEWPORT BEACH FIRE DEPARTMENT

100 CIVIC CENTER DRIVE, P.O. BOX 1768, NEWPORT BEACH, CA 92660
PHONE: 949-644-3355 WEB: www.newportbeachca.gov

JEFF BOYLES
Fire Chief

March 21, 2025

David Bishop
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of the City of Newport Beach, a governmental entity, federal I.D. Number 956000751 in working with **CalOptima Health** (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2024 through December 31, 2024. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

The City of Newport Beach is willing to contribute approximately $147,823 for the Calendar Year 2024 (January 1, 2024 – December 31, 2024) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individuals from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Kristin Thompson, EMS Division Chief: 100 Civic Center Drive, Newport Beach, CA 92660, kthompson@nbfd.net, (949)644-3385.

Raymund Reyes, Administrative Manager: 100 Civic Center Drive, Newport Beach, CA 92660, rreyes@nbfd.net, (949)644-3352.

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Jeff Boyles
Fire Chief

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Attachment B

Voluntary Rate Range Program Supplemental Attachment

Calendar Year 2024 (January 1, 2024 through December 31, 2024)

Provider's Legal Name:	City of Newport Beach
County:	Orange
Health Plan:	CalOptima

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than March 28, 2025.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2022-23 (July 1, 2022 - June 30, 2023).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**	$ 592,536.62	$ 633,894.00	$ 216,582.73	$ 375,953.89	$ 417,311.27
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other				$ -	$ -
Total	$ 592,536.62	$ 633,894.00	$ 216,582.73	$ 375,953.89	$ 417,311.27

* Include payments received and anticipated to be received, for dates of service from July 1, 2022 - June 30, 2023.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2022 - June 30, 2023 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? ***NO***

If **No**, please specify the amount of funding available: $375,954

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

All services provided to CalOptima members are on an oupatient basis and consist of emergency ambulance transportation services. These services are provided to the residents and visitors of Newport Beach on a non-contracted basis.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: City of Newport Beach operating as the Fire Department

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: City/Municipal Corporation

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

Source of IGT funding are estimated to be unrestricted General Fund monies from the City of Newport Beach

(iv) Does the transferring entity have general taxing authority? ***YES***

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. ***N/A***

5. Comments / Notes

Attestation by duly authorized representative:

Please print the Name (first & last), and Title: Jeff Boyles, Fire Chief

Signature & Date: 3/21/2025

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Name	Title	Organization	Mailing Street Address	City	State	Zip	Email Address	Phone Number
Jeff Boyles	Fire Chief	Newport Beach Fire Department	100 Civic Center Drive	Newport Beach	CA	92660	jboyles@nbfd.net	949-644-3101
Kristin Thompson	EMS Division Chief	Newport Beach Fire Department	100 Civic Center Drive	Newport Beach	CA	92660	kthompson@nbfd.net	949-644-3385
Raymund Reyes	Administrative Manager	Newport Beach Fire Department	100 Civic Center Drive	Newport Beach	CA	92660	rreyes@nbfd.net	949-644-3352
Lili Banuelos	Assistant Management Analyst	Newport Beach Fire Department	100 Civic Center Drive	Newport Beach	CA	92660	lbanuelos@nbfd.net	949-644-3360
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City of Orange

300 E. Chapman Ave.
Orange, CA 92866

ATTACHMENT A – LETTER OF INTEREST

David Bishop
Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Dear Mr. Bishop:

This letter confirms the interest of City of Orange, a governmental entity, federal I.D. Number 95-6000755, in working with **CalOptima Health** (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2024, through December 31, 2024. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

City of Orange is willing to contribute $506,263 for the Calendar Year 2024 (January 1, 2024 – December 31, 2024) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individuals from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Bryan Johnson, EMS Manager
1176 E. Chapman Ave. Orange, CA 92866
bjohnson@cityoforange.org (714) 288-2503

Nathalia Flores, Administrative Analyst
1176 E. Chapman Ave. Orange, CA 92866
nflores@cityoforange.org (714) 288-2533

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Tom Kisela
City Manager

Attachment B

Voluntary Rate Range Program Supplemental Attachment

Calendar Year 2024 (January 1, 2024 through December 31, 2024)

Provider's Legal Name:	City of Orange
County:	Orange
Health Plan:	CalOptima

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than March 28, 2025.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2022-23 (July 1, 2022 - June 30, 2023).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (not including pharmacy services billed by a pharmacy on a pharmacy claim)**	$ 2,161,822.46	$ 2,161,822.46	$ 732,621.42	$ 1,429,201.04	$ 1,429,201.04
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other				$ -	$ -
Total	$ 2,161,822.46	$ 2,161,822.46	$ 732,621.42	$ 1,429,201.04	$ 1,429,201.04

* Include payments received and anticipated to be received, for dates of service from July 1, 2022 - June 30, 2023.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2022 - June 30, 2023 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? *No*

If **No**, please specify the amount of funding available: $800,000

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

911 dispatched emergency treatment and ground ambulance transport

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: City of Orange

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: City

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

City of Orange's unreserved general fund

(iv) Does the transferring entity have general taxing authority? *Yes*

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control.

n/a

5. Comments / Notes

n/a

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Attestation by duly authorized representative:

Please print the Name (first & last), and Title: Tom Kisela, City Manager

Signature & Date: 3/12/2025

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Name	Title	Organization	Mailing Street Address	City	State	Zip	Email Address	Phone Number
Bryan Johnson	EMS Manager	City of Orange	1176 E. Chapman Ave	Orange	CA	92866	bjohnson@cityoforange.org	(714) 288-2503
Nathalia Flores	Administrative Analyst	City of Orange	1176 E. Chapman Ave	Orange	CA	92866	nflores@cityoforange.org	(714) 288-2533
								( )
								( )
								( )
								( )
								( )

VERONICA KELLEY, DSW, LCSW
AGENCY DIRECTOR

JENNA SARIN, MSN, RN, PHN
DIRECTOR OF PUBLIC HEALTH AND NURSING

405 W. 5th STREET, 7th FLOOR
SANTA ANA, CA 92701
www.ochealthinfo.com

OFFICE OF THE DIRECTOR

February 24, 2025

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Re: Attachment A-Letter of Interest for Voluntary Rate Range Program IGT 14

Dear Mr. Bishop:

This letter confirms the interest of County of Orange Health Care Agency, a governmental entity, federal I.D. Number 95-6000928, in working with CalOptima (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and for the service period of January 1, 2024 through December 31, 2024. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

Pending approval by the Orange County Board of Supervisors, the County of Orange Health Care Agency is willing to contribute approximately $3,565,361 for the Calendar Year 2024 (January 1, 2024 - December 31, 2024) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Anza Vang
Assistant Deputy Director, Public Health Services
Orange County Health Care Agency
405 W. 5th Street, 7th Floor, Santa Ana, Ca 92701
(714) 615-6958
avang@ochca.com

Kevin Clark

Fiscal Manager, Public and Correctional Health Services
Orange County Health Care Agency
405 W. 5th Street, 7th Floor, Santa Ana, Ca 92701
(714) 834-3158
kclark@ochca.com

I certify that I am authorized to sign this certification on behalf of the government entity and that the statements in this letter are true and correct.

Thank you for your consideration,

DocuSigned by:
Jenna Sarin
C68DF55E87AD4B4...

Jenna Sarin
Director of Public Health and Nursing

CC: Anza Vang, Assistant Deputy Director, Public Health Services
Kevin Clark, Fiscal Manager Public and Correctional Health Services
Strategic Development, CalOptima Health

Attachment B

Voluntary Rate Range Program Supplemental Attachment

Calendar Year 2024 (January 1, 2024 through December 31, 2024)

Provider's Legal Name:	Orange County Health Care Agency
County:	Orange
Health Plan:	CalOptima

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than March 28, 2025.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2022-23 (July 1, 2022 - June 30, 2023).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient				$ -	$ -
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**				$ -	$ -
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other	$ 18,091,129.78	$ 9,311,828.36	$ 52,292.17	$ 18,038,837.61	$ 9,259,536.19
Total	$ 18,091,129.78	$ 9,311,828.36	$ 52,292.17	$ 18,038,837.61	$ 9,259,536.19

* Include payments received and anticipated to be received, for dates of service from July 1, 2022 - June 30, 2023.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2022 - June 30, 2023 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? ***No***

If **No**, please specify the amount of funding available: $ 3,565,361.00

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

STD Clinic - Testing for sexually transmitted diseases (STD) including HIV. Treatment for STDs and linkage to care for individuals who test HIV-positive. Counseling and Prevention services for STDs and HIV.
TB Clinic - Diagnosis, treatment and case management for Orange County residents with tuberculosis (TB) disease.
Child Health Clinic - Sick child care, conducts developmental screening, and renders limited follow-up services for conditions found on the physical examination.
Medically High Risk Newborn Nursing Services - Public Health Nurse's (PHN) provide comprehensive case management services to medically fragile newborns and infants. A PHN assists parents/caregivers to help promote optimum growth and development in the infant; care for infants with special needs, and develop supportive family dynamic that promote attachment. Nurses provide continuing growth and developmental assessment, parental education and assistance in accessing necessary health services for high-risk infants.
Nurse Family Partnership (NFP) - NFP is an evidenced-based nurse home visiting program that improves the health, well-being and self-sufficiency of low-income, first-time parents and their children. Nurse case managers improve the following: pregnancy outcomes, child health and development and economic self-sufficiency of the family.
Perinatal Substance Abuse Nursing Services - Public Health Nurses provide case management services for pregnant persons who have a history of substance use disorder, mental health issues, homelessness, and/or have HIV infection. PHN aide clients in gaining access to necessary health services and pediatric care during the client's pregnancy and through the first 6-12 month of the child's life. Services include, case management, education, coordination of care, and referrals to resources so mothers will have a healthy-drug free delivery and positive development environment for the infant.
Adolescent Family Life Program (ALFP) - Offers comprehensive case management services from social workers and licensed clinicians to expectant and parenting teens up to the age of 21 years and their children. Case managers work closely with youth to improve the health and well-being of themselves and their children providing support and linkage to services such as health services, mental health services, developmental, education, child care, transportation, financial aid, legal services, and parenting classes .
Comprehensive Health Assessment Team (CHAT) and SHOPP - Homeless - PHN home visitation program serving residents of Orange County who are experiencing or are at risk for homelessness and have health needs. PHN provide comprehensive case management and care coordination services, health education referrals to resources for basic needs and community support services as well as assistance in applying for Medi-Cal health insurance and access to other Social Services and financial assistance programs.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: County of Orange

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: County

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)
Net County Cost and or Health Realignment

(iv) Does the transferring entity have general taxing authority? ***Yes***

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. ***(Yes / No)***

5. Comments / Notes

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Attestation by duly authorized representative:

Please print the Name (first & last), and Title: Jenna Sarin

Signature & Date: DocuSigned by: Jenna Sarin C68DF55E87AD4B4... 3/3/2025

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Name	Title	Organization	Mailing Street Address	City	State	Zip	Email Address	Phone Number
Jenna Sarin	Director of Public Health and Nursing	Orange County Health Care Agency	405 W. 5th Street	Santa Ana	CA	92701	jsarin@ochca.com	(714) 834-4099
Anza Vang	Assistant Deputy Director, Public Health Services	Orange County Health Care Agency	405 W. 5th Street	Santa Ana	CA	92701	avang@ochca.com	(714) 615-6958
Kevin Clark	Fiscal Manager, Public and Correctional Health Services	Orange County Health Care Agency	405 W. 5th Street	Santa Ana	CA	92701	kclark@ochca.com	(714) 834-3158
								( )
								( )
								( )
								( )

UCI Health

March 19, 2025

David Bishop
Acting Division Chief
Capitated Rates Development Division
Department of Health Care Services
1501 Capitol Avenue, MS 4413
P.O. Box 997413
Sacramento, CA 95899-7413

Re: **UCI Health and Cal Optima IGT 2024**

Dear Mr. Bishop:

This letter confirms the interest of Regents of the University of California, Irvine Medical Center, a governmental entity, federal I.D. Number 95-2226406 in working with Cal Optima (hereafter, "the MCP") and the California Department of Health Care Services (DHCS) to participate in the Voluntary Rate Range Program, including providing an Intergovernmental Transfer (IGT) to DHCS to be used as a portion of the non-federal share of actuarially sound Medi-Cal managed care capitation rate payments incorporated into the contract between the MCP and DHCS for the service period of January 1, 2024 through December 31, 2024. This is a non-binding letter, stating our interest in helping to finance health improvements for Medi-Cal beneficiaries receiving services in our jurisdiction. The governmental entity's funds are being provided voluntarily, and the State of California is in no way requiring the governmental entity to provide any funding.

Regents of the University of California, Irvine Medical Center is willing to contribute 88.4% of the total available for the Calendar Year 2024 (January 1, 2024 – December 31, 2024) as negotiated with the MCP. We recognize that, unless a waiver is approved by DHCS, there will be an additional 20-percent assessment fee payable to DHCS on the funding amount, for the administrative costs of operating the voluntary rate range program.

The following individual from our organization will serve as the point of communication between our organization, the MCP and DHCS on this issue:

Christopher M. Leo, Director of Government Affairs
UCI Health
101 City Drive, Suite 3100
Orange, CA 92868
cmleo@hs.uci.edu
(714) 456-2967

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Helena Easterday
UCI Health
333 City Blvd West, Suite 550
Orange, CA 92868
heasterd@hs.uci.edu
714.456.8364

I certify that I am authorized to sign this certification on behalf of the governmental entity and that the statements in this letter are true and correct.

Sincerely,

Chad T. Lefteris, FACHE
Chief Executive Officer
UCI Health

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Attachment B

Voluntary Rate Range Program Supplemental Attachment

Calendar Year 2024 (January 1, 2024 through December 31, 2024)

Provider's Legal Name:	University of California, Irvine
County:	Orange
Health Plan:	Kaiser

Instructions

Complete all yellow-highlighted fields. **Submit this completed form via e-mail to Vivian Beeck (Vivian.Beeck@dhcs.ca.gov) at the Department of Health Care Services (DHCS) by no later than March 28, 2025.**

1. In the table below, report charges/costs and payments received or expected to be received from the Health Plan indicated above for Medi-Cal services (Inpatient, Outpatient, and All Other) provided to Medi-Cal beneficiaries enrolled in the Health Plan and residing in the County indicated above, for dates of service from SFY 2022-23 (July 1, 2022 - June 30, 2023).

	Charges	Costs	Payments from Health Plan*	Uncompensated Charges (charges less payments)	Uncompensated Costs (Costs less payments)
Inpatient	$ 91,107,451.89	$ 67,979,799.13	$ 23,127,652.76	$ 67,979,799.13	$ 44,852,146.37
Outpatient (**not** including pharmacy services billed by a pharmacy on a pharmacy claim)**	$ 110,742,240.68	$ 83,938,949.28	$ 26,803,291.40	$ 83,938,949.28	$ 57,135,657.88
Pharmacy services billed by a pharmacy on a pharmacy claim**				$ -	$ -
All Other				$ -	$ -
Total	$ 201,849,692.57	$ 151,918,748.41	$ 49,930,944.16	$ 151,918,748.41	$ 101,987,804.25

* Include payments received and anticipated to be received, for dates of service from July 1, 2022 - June 30, 2023.

** As of January 1, 2021, the following pharmacy benefits when billed by a pharmacy on a pharmacy claim will no longer be managed care covered benefits and will be covered through Medi-Cal Rx instead: Covered Outpatient Drugs, including Physician Administered Drugs; Medical Supplies; and Enteral Nutritional Products. Therefore, any charges, costs, or payments associated with pharmacy services that were billed by a pharmacy on a pharmacy claim for the dates of service from July 1, 2022 - June 30, 2023 must be documented separately on the "Pharmacy services billed by a pharmacy on a pharmacy claim" line above.

2. Are you able to fund 100% of the higher of the uncompensated charges or uncompensated costs (as stated above)? ***Yes***

If **No**, please specify the amount of funding available: N/A

3. Describe the scope of services provided to the specified Health Plan's Medi-Cal members, and if these services were provided under a contract arrangement.

Yes, services are provided under contract arrangement. Inpatient and outpatient (including emergency services) medical services at UC Irvine Health are provided by UPS physicians. Physician medical specialty care includes those services considered tertiary and quaternary. UPS physician services are made available to CalOptima members through provider agreements between UPS and CalOptima.

4. We ask that a duly authorized representative formally attest to the following:

(i) The legal name of the entity transferring funds: UCI University Physicians & Surgeons (UPS)

(ii) The operational nature of the entity (county, city, special purpose district, state university teaching hospitals or other political subdivisions of the state) transferring funding: Governmental Funding Entitiy

(iii) The source of the funds:
(Funds must not be derived from impermissible sources such as recycled Medicaid payments, federal funds excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include patient care or other revenue received from programs such as Medicare or Medicaid to the extent that the program revenue is not obligated to the State as the source of funding.)

Patient care revenue

(iv) Does the transferring entity have general taxing authority? ***No***

If **No**, does the transferring entity receive State appropriations (identify level of appropriation)? This may include, but not limited to, annual State appropriations for various programs, or realignment funds to support programs transferred by State Law to local control. ***Yes***

5. Comments / Notes

The Regents of the University of California, a legal entity, makes the IGT contribution on behalf of each Medical Center location and does receive annual appropriations from the State general fund.

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Attestation by duly authorized representative:

Please print the Name (first & last), and Title:

Chad Lefteris, President and Chief Executive Officer

3/13/2025

Signature & Date:

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Name	Title	Organization	Mailing Street Address	City	State	Zip	Email Address	Phone Number
Randolph Siwabessy	CFO and Sr Vice President	UCI Health	1500 S Douglass Rd, Ste 200, Rte 183	Anaheim	CA	95806	rsiwabes@hs.uci.edu	(714) 456-5180
Neil Myers	Controller and Vice President	UCI Health	1500 S Douglass Rd, Ste 200, Rte 183	Anaheim	CA	92806	nmyers@hs.uci.edu	(714) 456-6829
Lynn Cross	Administrative Manager	UCI Health	1500 S Douglass Rd, Ste 200, Rte 183	Anaheim	CA	92806	blcross@hs.uci.edu	(714) 456-6245
Chris Leo	Director of Government Affairs	UCI Health	101 City Drive S, Blgd 54, 3rd Flr, Rm 3110	Orange	CA	92868	cmleo@hs.uci.edu	(714) 456-2967
Gina Churchill	Director of Reimbursement	UCI Health	1500 S Douglass Rd, Ste 200, Rte 183	Anaheim	CA	92806	carrollg@hs.uci.edu	(916) 240-3557

CalOptima Health Board Action Agenda Referral

Action To Be Taken April 3, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

11. Authorize Actions Related to a Contract with Infomedia Group, Inc. dba Carenet Healthcare Services

Contact

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

Recommended Actions

Authorize unbudgeted expenditures and appropriate funds in an amount not to exceed $1,762,500 from existing reserves to fund the contract with Infomedia Group, Inc. dba Carenet Healthcare Services for member engagement outbound call campaigns through June 30, 2025.

Background

On June 6, 2024, the CalOptima Health Board authorized CalOptima Health to contract with Infomedia Group, Inc. dba Carenet Healthcare Services (Carenet) for a three (3)-year term, effective July 1, 2024, to provide Nurse Advise Line services, after hours support for customer service and behavioral health, and member engagement strategies, which include live outbound call campaigns. The Fiscal Year (FY) 2024-25 Operating Budget included $2,375,000 for the Carenet contract, including $1.0 million for member engagement services.

In June 2024 and December 2024, CalOptima Health Quality Analytics department engaged Carenet to implement the following live outbound call campaigns:

- HEDIS Campaign: Supports closing gaps in care and improving quality results on Medi-Cal Managed Care Accountability Sets (MCAS) and Centers for Medicare & Medicaid Services (CMS) Star Ratings System (STARS).
- Just in Time Survey: Reminds members of CalOptima Health benefits and offers to assist with any outstanding issues. The goal of the campaign is to improve member experience and is launched ahead of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey sent to capture member experience with health care services.

Discussion

Between June 2024 and February 2025, the Carenet live outbound call campaign scheduled 28,639 member appointments for well child and adult visits, including preventive services such as breast and colorectal cancer screenings. With the success of the campaigns earlier in the fiscal year, the number of campaigns increased significantly, leading to the shortfall. Due to a high rate of successful appointment scheduling, staff recommends continuing the call campaign through the current FY 2024-25.

Beginning in February 2025, Carenet launched the Just In time Survey. The purpose of the outreach is to remind members of benefits, capture member experience, and help to solve any challenges through collaboration with CalOptima Health Customer Service. By providing positive interactions through the survey outreach, the goal is to help improve member utilization of benefits and perception of CalOptima Health. This initiative is also a key component of improving the CAHPS survey results. This call

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campaign was incorrectly unaccounted for in the FY 2024-2025 Operating Budget. Staff will include updated expenses in future operating budgets. The current campaign results are still pending.

Staff projects the Carenet contract will have a budget shortfall of $1,762,500 to support the live outbound call campaigns through June 30, 2025. To address the shortfall, staff requests that the Board authorize an allocation of up to $1,762,500 from existing reserves. Activities for the remainder of this fiscal year include outreach to schedule appointments for annual wellness visits, cancer screening, and diabetes management visits.

Fiscal Impact

The recommended action is an unbudgeted item. An allocation of up to $1,762,500 from existing reserves will fund the Carenet contract through June 30, 2025.

Rationale for Recommendation

Providing funding will ensure members are engaged through live outbound call campaigns that will seek to support member appointment scheduling, close quality care gaps, and improve member experience.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action

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Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
June 3, 2021	Consider Authorizing Amendment to Contract with Infomedia Group, Inc., dba Carenet Healthcare Services to Support Member Outreach Calls	July 1, 2019 – June 30, 2022	
August 4, 2022	Ratify Amendment to the Ancillary Services Contract with Infomedia Group Inc., dba Carenet Healthcare Services	June 30, 2022 – June 30, 2023	
June 1, 2023	Authorize Extending Contract with Infomedia Group, Inc., dba Carenet Healthcare Services for one year.	June 30, 2023 – June 30, 2024	
June 6, 2024	Approve Actions Related to a Contract with Infomedia Group, Inc. dba Carenet Healthcare Services	July 1, 2024 – June 30, 2027	

/s/ Michael Hunn *03/28/2025*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Infomedia Group Inc., dba Carenet Healthcare Services	11845 IH-10 West, Suite 400	San Antonio	TX	78230

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CalOptima Health Board Action Agenda Referral

Action To Be Taken April 3, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
12. Authorize Actions Related to the Contract with Mercury Healthcare, Inc. dba WebMD Ignite

Contact
Marie Jeannis, R.N., Executive Director, Equity and Community Health, (714) 246-8591

Recommended Actions
Make an exception to CalOptima Health Policy GA.5002: Purchasing and authorize the Chief Executive Officer to amend the contract with WebMD Ignite, without competitive procurement, to add HealthHub, a digital product to provide health education content and digital tools to CalOptima Health members.

Background/ Discussion
On November 2, 2023, the CalOptima Health Board of Directors (Board) authorized staff to execute a contract with Healthwise, Inc. (Healthwise) to provide Department of Health Care Services (DHCS)-approved clinical member education materials. Healthwise was identified as a sole source provider for health education materials due to its industry-standard content, which supports real-time coaching, member engagement, and gap closure in care. Healthwise allows materials to be integrated within ZeOmega, Inc.'s Jiva platform, the new CalOptima Health clinical care management system, to reduce printing and fulfillment costs and integrate materials in multiple formats, including videos, audio, and written content.

During the contracting process, Mercury Healthcare, Inc. (dba WebMD Ignite) announced its acquisition of Healthwise, effective February 29, 2024. This acquisition resulted in a pause in contracting efforts as CalOptima Health evaluated the implications of the transition and engaged with WebMD to assess the continuity of services under the newly merged entity. Following a thorough review, staff determined that executing a contract with WebMD Ignite – now the owner of Healthwise's content and integration with Jiva – was the most strategic path forward to ensure long-term stability, enhanced capabilities, and regulatory compliance. As a result, CalOptima Health executed a contract with WebMD Ignite, effective January 1, 2025, through December 31, 2027 (the Master Agreement).

Following the acquisition, WebMD Ignite introduced a digital product called HealthHub, which was not previously available under Healthwise. HealthHub provides a comprehensive, CalOptima Health-branded platform with integrated digital tools designed to increase member engagement and support self-management of health conditions. Features of HealthHub include:

- DHCS-approved health education materials, which include articles, videos, symptom checkers, personal risk calculators, and interactive tools.
- Structured learning experiences that strengthen member engagement through calls to action, such as appointment scheduling and provider searches.
- Content that promotes health literacy, preventive care, and chronic condition self-management.

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- Wellness and Health Promotion content accredited by the National Committee for Quality Assurance (NCQA).
- Web Content Accessibility Guidelines compliance to ensure inclusivity for all users.

WebMD Ignite's HealthHub offers an opportunity to expand CalOptima Health's member education and engagement capabilities as well as providing the following benefits:

- Branded health education content available in English and Spanish, with additional threshold languages to be added in 2025. CalOptima Health may also add materials translated into the languages spoken by our members if they are not yet available through WebMD.
- Reduction in staff hours to develop and maintain new health education materials in-house.
- Simplified regulatory compliance and accreditation requirements.
- Consistent branded member engagement resources that can be utilized by providers and across health networks.

For the amendment to add HealthHub to the Master Agreement, staff requests an exception to CalOptima Health Policy GA.5002: Purchasing, Section II.C.3, which requires a formal procurement for purchases of non-medical professional services and other contracts where the expected cost is estimated to be more than $250,000. With the addition of the HealthHub product, the cost of the WebMD Ignite Master Agreement will exceed the threshold amount.

Staff recommend updating the Master Agreement with WebMD Ignite to include HealthHub with an anticipated implementation date on and after July 1, 2025.

Fiscal Impact

The estimated one-time implementation cost for WebMD Ignite's HealthHub is approximately $21,000. The estimated annual license fee is approximately $140,000 for year one. Upon Board approval, staff will include the total estimated cost in the proposed Fiscal Year 2025-26 Operating Budget. Subsequent annual license fees will be included in future operating budgets.

Rationale for Recommendation

Integrating WebMD Ignite's HealthHub aligns with CalOptima Health's strategy to enhance health literacy, disease management, and digital engagement. HealthHub supports member education and access to evidence-based content, integrates with CalOptima's digital infrastructure, and ensures compliance with DHCS and NCQA standards for quality and accessibility.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

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Attachments

1. Entities Covered by this Recommended Action

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
11/2/2023	13. Approve Actions Related to the New Clinical Care Management System (ZeOmega Inc.)	3 year	$140,000

/s/ Michael Hunn *03/27/2025*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Mercury Healthcare, Inc., dba WebMD Ignite	283-299 Market Street 2 Gateway Center, 4th Floor	Newark	NJ	07102

CalOptima Health Board Action Agenda Referral

Action To Be Taken April 3, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

13. Adopt Resolution No. 25-0403-01 Approving Updated CalOptima Health Human Resources Policies

Contacts

Michael Hunn, Chief Executive Officer, (714) 246-8570
Steve Eckberg, Chief Human Resources Officer, (657) 328-9053

Recommended Actions

Adopt Resolution No. 25-0403-01 approving updated CalOptima Health policies:

1. AA.1252: Diversity, Equity, and Inclusion;
2. GA.8022: Performance and Behavior Standards; and
3. GA.8034: Service of Summons, Subpoenas, and Other Legal Documents.

Background

Near CalOptima Health's inception, the Board of Directors (Board) delegated authority to the Chief Executive Officer to develop and implement employee policies and procedures and to amend them as appropriate from time to time, subject to bi-annual updates to the Board. CalOptima Health's Bylaws require that the Board adopt by resolution, and from time to time amend, procedures, practices, and policies for, among other things, hiring employees and managing personnel.

Discussion

Staff has included the list of revised policies for Board approval and a summary of changes for the updated policies.

AA.1252: Diversity, Equity, and Inclusion: This policy describes CalOptima Health's Diversity, Equity, and Inclusion (DEI) commitment to support and advance its health equity strategy by building a diverse and inclusive staff while supporting health equity goals that are aimed at reducing bias and improving DEI within CalOptima Health's workplace, committees, and governing bodies.

Policy Section	Proposed Change	Rationale	Impact
III.E.3.	Added new section that specifies that CalOptima Health will provide trans-inclusive health care cultural competency training to be completed within forty-five (45) days for newly hired staff and every two (2) years thereafter.	To align policy with DHCS APL 24-017 requirements.	Provides employee development and training.

GA.8022: Performance and Behavior Standards: This policy outlines an approach that can be used, at CalOptima Health's discretion, depending on the nature of the issues that are to be addressed and the

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extent of such issues, to help correct and/or improve employee performance and behavior through corrective action or termination when employee performance and/or behavior is/are not meeting expectations, and/or fails to follow CalOptima Health's policies and procedures.

Policy Section	Proposed Change	Rationale	Impact
II.J	Expanded section on administrative leave to include information on maximum length of leave of three (3) months; required check-ins while on administrative leave; and a requirement for employee to return to work within twenty-four (24) hours' notice that administrative leave has ended. Four sub-sections were added as examples when administrative leave may be used, including in relation to CalOptima Health's Drug-free and Alcohol-free Workplace Policy; during an administrative investigation; when there is a failure to maintain job-required license and certification; and/or in egregious misconduct situations.	Provides additional guidance and parameters on the appropriate use of paid and unpaid administrative leave.	Provides clarity and consistency on administrative leave practices.
V.C.	Added policy reference for GA.8033: License and Certification Tracking.	Listed as an example where administrative leave may apply.	Aligns policy GA.8033 with policy GA.8022.

GA.8034: Service of Summons, Subpoenas, and Other Legal Documents: This policy clarifies CalOptima Health's responsibility related to receipt of service of legal papers not pertaining to CalOptima Health business.

Policy Section	Proposed Change	Rationale	Impact
II.D.	Edited language to reflect that in the event legal documents intended for a CalOptima Health employee are brought to a CalOptima Health facility for service, the "front desk staff will contact the CalOptima Health representative(s) designated to receive service. If the document does not pertain to CalOptima	Aligns with Section II.A. and provides direction to staff on how to treat servers of non-CalOptima Health legal documents.	Provides clarity and transparency on handling of employees' legal documents.

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	Health business, the representative will inform the server that such documents will not be accepted or forwarded by CalOptima Health, and the representative shall not physically take possession of such documents."		
III.Table.Responsible Party	Updated Responsible Party description to include Designated Representative for Document Service and to replace Admin Building with 505 Building and 500 Building.	Provides guidance to staff on how to interact with process server in all agency facilities.	Provides clarity and transparency on the handling of employees' legal documents.
III.Table.Action, Section 1	Added Section 1 procedure language of "Do not physically take possession of legal papers from the server."	Provides guidance to staff on how to respond to process server.	Provides clarity and transparency on the handling of employees' legal documents.
III. Table.Action, Section 2	Added Section 2 procedure on what to do if the server drops or otherwise leaves papers for employees on CalOptima Health property.	Provides guidance for staff on how to escalate for further assistance.	Provides clarity and transparency on the handling of employees' legal documents.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2024-25 Operating Budget.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Adopt Resolution No. 25-0403-01Approving Updated CalOptima Health Human Resources Policies
2. Updated CalOptima Health policies:
    a. AA.1252: Diversity, Equity, and Inclusion
    b. GA.8022: Performance and Behavior Standards
    c. GA.8034: Service of Summons, Subpoenas, and Other Legal Documents

/s/ Michael Hunn *03/27/2025*
Authorized Signature **Date**

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RESOLUTION NO. 25-0403-01

RESOLUTION OF THE BOARD OF DIRECTORS ORANGE COUNTY HEALTH AUTHORITY
d.b.a. CalOptima Health

APPROVE UPDATED CALOPTIMA HEALTH HUMAN RESOURCES POLICIES

WHEREAS, Section 13.1 of the CalOptima Health Bylaws provides that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices, and policies for, inter alia, hiring employees, and managing personnel;

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima Health employees at will, to set compensation within the boundaries of the budget limits set by the Board of Directors, to promulgate employee policies and procedures, and to amend said policies and procedures from time to time, subject to annual review by the Board of Directors, or a committee appointed by the Board of Directors for that purpose; and

WHEREAS, staff has revised certain policies and now presents those revised policies to the Board of Directors for approval.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the following updated CalOptima Health Human Resources policies:

1. AA.1252: Diversity, Equity, and Inclusion;
2. GA.8022: Performance and Behavior Standards; and
3. GA.8034: Service of Summons, Subpoenas, and Other Legal Documents.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima Health, this 3rd day of April 2025.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Isabel Becerra, Chair, CalOptima Health Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

Policy:	AA.1252
Title:	**Diversity, Equity, and Inclusion**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2025
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy describes CalOptima Health's Diversity, Equity, and Inclusion (DEI) commitment to support and advance its health equity strategy by building a diverse and inclusive staff while supporting health equity goals that are aimed at reducing bias and improving DEI within the workplace, its Committees, and Governance Bodies.

II. POLICY

A. As part of CalOptima Health's commitment to DEI, CalOptima Health shall:

1. Promote best practices in recruitment and hiring to increase the agency's ongoing commitment to DEI.

2. Build and develop a talented workforce that is reflective of the Orange County community CalOptima Health serves.

3. Maintain a consistent approach for building a diverse and inclusive staff.

4. Provide DEI training for all new hires and ongoing training for all Employees at least annually thereafter.

B. Our hiring and recruitment practices shall promote Diversity for both Internal and External Applicants, promotions and reclassifications, and temporary and permanent positions.

C. CalOptima Health shall regularly evaluate, at a minimum, the following:

1. How our workforce reflects the Diversity of the population served.

2. Which groups are inadequately represented in the workforce.

3. Whether specific groups are marginalized, disenfranchised or disempowered by our recruitment and hiring practices.

D. CalOptima Health shall ensure that our hiring and recruitment policies explicitly address how CalOptima Health promotes Diversity for our staff, Leadership, and Committees.

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E. CalOptima Health shall conduct an analysis at least annually to identify opportunities to improve Diversity, Equity, Inclusion and/or Cultural Humility for staff, Leadership, Governance Bodies, and Committees.

F. CalOptima Health shall implement interventions to address identified opportunities to improve Diversity, Equity, Inclusion and Cultural Humility for at least one of the groups (staff, Leadership, Committees or Governance Bodies).

III. PROCEDURE

A. Hiring and Recruiting

1. Staff and Leadership

a. CalOptima Health ensures that its hiring and recruitment process promotes Diversity for the staff and Leadership positions in accordance with the provisions in CalOptima Health Policy GA.8060: Recruitment, Selection, and Hiring.

b. To promote Diversity and Inclusion, the organization will develop and maintain all:

i. Job Descriptions to include the following:

a) Gender-neutral language;

b) Salary range for each position;

c) Mobility requirements; and

d) Reduce the requirements of each position to the "must-have" qualifications.

ii. Job Announcements to include the following:

a) Non-discrimination based on race, age sex, gender identity, disability, religion, and other enumerated protected characteristics as defined by law;

b) The organization's commitment to Diversity and Inclusion;

c) Equal Employment Opportunity Statement; and

d) Reasonable Accommodation Announcement.

2. Committee Membership

a. CalOptima Health shall ensure that its hiring and recruitment process promotes Diversity in its Quality Improvement Health Equity Committee (QIHEC) and its reporting subcommittees listed below:

i. Utilization Management Committee;

ii. Whole Child Model Clinical Advisory Committee (WCM CAC);

iii. Credentialing and Peer Review Committee (CPRC);

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iv. Population Health Management Committee (PHMC);

v. Grievances and Appeals Resolutions Services Committee (GARS); and

vi. Member Experience Committee (MEMx),

b. At a minimum, the seven (7) Committees will include a broad range of practitioners/providers and representatives from the community.

c. At least annually, CalOptima Health's Chief Medical Offer (CMO) or designee shall review and assess Committee membership composition to ensure representation from a diverse group of network providers and community representatives, in accordance with Policy GG.1620: Quality Improvement and Health Equity Committee, and in alignment with its membership composition.

d. The CMO or designee shall request for consideration, nominees that represent groups identified as being inadequately represented or underrepresented in the Committee, or groups identified as marginalized, disenfranchised or disempowered.

e. In addition, all nominees shall be vetted to ensure that they meet the following criteria:

i. Represent a health network or community organization that provides health care services and/or community support to CalOptima Health Members;

ii. Meet minimum experience/qualifications as noted in the bylaws;

iii. Are in good standing with CalOptima Health; and

iv. Do not have a conflict of interest that would prohibit Committee participation.

f. The CMO or designee, with input from other Committee members, shall select the most suitable candidate to participate on the Committee.

3. Governance Body

a. CalOptima Health's Governing Body is the Board of Directors (BOD), and all seats of the BOD are appointed by the Orange County Board of Supervisors, in accordance with Ordinance No. 16-001.

b. CalOptima Health has no authority or jurisdiction over the recruiting, hiring, or seating of the members of the BOD.

B. Recruitment and Selection:

1. To promote equal employment opportunity in the recruitment and selection of all qualified applicants, all vacant positions will be posted in accordance with CalOptima Health's merit-based, fair hiring policies and procedures described in CalOptima Health Policies GA.8025: Equal Employment Opportunity, GA.8030: Background Check, and GA.8060: Recruitment, Selection, and Hiring.

D. Performance Measures, Analysis and Reporting

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1. To monitor its hiring and recruiting processes, CalOptima Health will assess the performance using the following measures:

    a. Position Vacancy Rate (%);

    b. Time to Fill Vacancy (days); and

    c. Turnover Rate (%).

2. To promote Culturally and Linguistically Appropriate Services (CLAS) and DEI, the organization performs the following tasks:

    a. Collects and analyzes race/ethnicity, gender, age, and language data for staff and Leadership and compares it against the population served with the goal of the organization being representative of Orange County.

    b. Collects and analyzes race/ethnicity and gender data for Committees and Governing Bodies and compares it against the population served with the goal of being reflective of Orange County.

    c. Uses the data to identify groups that are inadequately represented in the workforce.

3. CalOptima Health monitors these metrics on an ongoing basis and analyzes the aggregated results at least annually against the goals.

4. CalOptima Health conducts qualitative analysis that includes identification of barriers, opportunities for improvement and actions or interventions to improve CLAS and DEI in recruiting practices.

5. CalOptima Health prioritizes the opportunities and actions to determine focus for the year for each of the groups.

6. CalOptima Health re-measures and analyzes the results of these metrics every year to assess whether identified actions and interventions were successful and will determine the need to discontinue, modify or implement new interventions.

E. Training:

1. CalOptima Health provides training to recruiters and hiring managers in recognizing unconscious biases and conducting standardized interviews to minimize the impact of biases and discrimination during the interview phase.

2. CalOptima Health provides training in accordance with CalOptima Health Policy AA.1251: Diversity, Equity and Inclusion Training Program, as follows:

    a. New Employees, including Leadership, complete training within ninety (90) days of hire.

    b. Existing Employees, including Leadership, complete training annually.

3. CalOptima Health will provide trans-inclusive health care cultural competency training to be completed within forty-five (45) days for newly hired staff and every two (2) years thereafter.

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~~3.~~4. CalOptima Health offers optional self-selected training to all Employees on topics relating to CLAS and DEI in both instructor led and eLearning formats.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy AA.1251: Diversity, Equity, and Inclusion Training Program
B. CalOptima Health Policy GA.8019: Promotions and Transfers
C. CalOptima Health Policy GA.8022: Performance and Behavior Standards
D. CalOptima Health Policy GA.8030: Background Check
E. CalOptima Health Policy GA.8060: Recruitment, Selection, and Hiring
F. CalOptima Health Policy GG.1620: Quality Improvement and Health Equity Committee (QIHEC)
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-016: Diversity, Equity, and Inclusion Training Program Requirements
~~F.~~H. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-017: Transgender, Gender Diverse Or Intersex Cultural Competency Training Program and Provider Directory Requirements
~~G.~~I. NCQA Standards for the Accreditation: Health Equity Standards

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2025	AA.1252	Diversity, Equity, and Inclusion	Administrative
Revised	TBD	AA.1252	Diversity, Equity, and Inclusion	Administrative

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IX. GLOSSARY

Term	Definition
Committee	Group of individuals, who may be employees and/or external to the organization, appointed for a specific function.
Cultural Humility	Ability of organizations, systems, and heath care professionals to value, respect and respond to diverse cultural health beliefs, behaviors and needs (e.g., social, cultural, linguistic) when providing health care services.
Diversity	Describes the presence of differences (e.g., race/ethnicity, preferred language, gender identity, sexual orientation, age, mobility) in the pool of candidates for employment opportunities that reflects the population served.
Employee	Any and all employees of CalOptima Health, including all permanent and temporary employees, volunteers, and other employed personnel.
Equity	Developing, strengthening and supporting procedural and outcome fairness in systems, procedure and resource distribution mechanisms to create fair opportunities for all individuals. Equity and "equitable" are distinct from equality or "equal", which refers to everyone having the same treatment but does not account for different needs to circumstances. Equity focus on eliminating barriers that have prevented the full participation of historically and currently oppressed groups.
External Applicant	Applicants to recruitments who are not employed by the organization.
Governance Body	The organization's board of directors, which is responsible for organizational governance.
Inclusion	Intentionally designed, active and ongoing engagement with individuals that ensures opportunities and pathways for participation in all aspects of a group, organization or community, including decision-making processes. Inclusion refers to how groups show that individuals are valued as respected members of the group, team, organization or community and is often created through progressive, consistent actions to expand, include and share.
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Quality Improvement Health Equity Committee (QIHEC)	A committee facilitated by CalOptima Health's medical director, or the medical director's designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions

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Policy:	AA.1252
Title:	**Diversity, Equity, and Inclusion**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/01/2025
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

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Back to Agenda Back to Item

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I. NCQA Standards for the Accreditation: Health Equity Standards

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/06/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2025	AA.1252	Diversity, Equity, and Inclusion	Administrative
Revised	TBD	AA.1252	Diversity, Equity, and Inclusion	Administrative

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IX. GLOSSARY

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Policy:	GA.8022
Title:	**Performance and Behavior Standards**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	04/03/2025
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines an approach that can be used, at CalOptima Health's discretion, depending on the nature of the issues that are to be addressed and the extent of such issues, to help correct and/or improve employee performance and behavior through corrective action or termination when employee performance and/or behavior is/are not meeting expectations, and/or fails to follow CalOptima Health's policies and procedures.

II. POLICY

A. As a public agency, CalOptima Health abides by its core values of Collaboration, Accountability, Respect, Excellence, and Stewardship and expects employees to be committed to ethical conduct, excellent service, consistent attendance, positive teamwork, and compliance with CalOptima Health policies and procedures. Appropriate conduct is expected at all times while employees are on duty and/or on CalOptima Health property.

B. Employment with CalOptima Health is at will. As at-will employees, CalOptima Health employees may be terminated at any time, with or without cause, and with or without advance notice.

C. In cases involving conduct that is a serious violation of policy, performance issue(s), or behavioral problem(s), or where the conduct cannot be corrected, immediate termination from employment may result.

D. Prior to issuing formal corrective action, depending on the severity or correctability of the issue, in certain circumstances at the discretion of CalOptima Health's management, CalOptima Health may elect to informally discuss and coach employees regarding their conduct or performance in order to provide the employee with an opportunity to correct or improve their performance and/or behavior. Corrective action does not apply to all performance issues or undesirable behaviors and will be issued on a case-by-case basis in a fair and consistent manner. CalOptima Health may issue any one of the corrective actions without regard to any particular order, repeat any one of the corrective actions, or immediately terminate employment.

E. CalOptima Health reserves the right to initiate corrective action or termination for various reasons, including, but not limited to:

1. Unsatisfactory work quality, or quantity;

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2. Failure to meet performance standards;

3. Behavioral-based problems that impact productivity, quality, service, or teamwork;

4. Excessive and/or habitual absenteeism, tardiness, or abuse of break and lunch privileges;

5. Insubordination, dishonesty, or negligence in the performance of duties;

6. Harassment or abusive conduct toward co-workers, supervisors, Members, visitors, or others encountered in the workplace;

7. Failure to return, damaging or unauthorized use of CalOptima Health-owned property or equipment;

8. Failure to pass a post-employment drug/alcohol, financial/credit, criminal background, or other position required background check;

9. Failure to maintain a license, certification, or educational qualification required by the employee's position;

10. Failure to follow instructions, policies, regulations, laws, or CalOptima Health policies and procedures;

11. Failure to follow established safety regulations;

12. Violation of CalOptima Health's Code of Conduct; and/or

13. Violation of any other CalOptima Health policy.

F. The type of corrective action will depend on multiple factors, including, but not limited to the nature of the offense, taking into consideration an employee's past performance and employment record, where applicable, and may range from counseling to immediate termination. Corrective action will be assessed in a fair and consistent manner in partnership with Human Resources (HR).

G. Employees are not guaranteed a right to corrective action prior to termination.

H. When used, the corrective action process may in some, but not all, cases consist of:

1. Informal Corrective Action, including:

a. Counseling discussion;

b. Documented Counseling Memo;

2. Formal Corrective Action, including:

a. Written Warning;

b. Performance Improvement Plan;

c. Final Warning;

d. Demotion; and/or

e. Termination.

I. Although one (1) or more of these corrective actions may be taken in connection with a particular employee, no formal order or system is necessary. An employee may, of course, resign at any time. The employee may be demoted as necessary. CalOptima Health may also terminate the employment relationship at any time without following any particular series of corrective actions depending on the individual circumstances surrounding the performance, behavior, or misconduct.

J. CalOptima Health may place an employee on administrative leave with or without pay while HR conducts an investigation and/or a final determination is pending, and/or when there is a risk to CalOptima Health if the employee is permitted to continue in their role. ~~If an employee for any reason represents a danger to themselves or other employees, demonstrates extreme misconduct and/or engages in an egregious act, CalOptima Health has the right to immediately remove the employee and place them on administrative leave with or without pay prior to initiating an investigation into the alleged misconduct. This will allow HR to conduct a full, fair investigation while minimizing any risks to the organization and others. An employee may be required to fully reimburse CalOptima Health for any salary provided during their administrative leave, as required, pursuant to California Government Code, Section 53243.~~

1. Paid administrative leave shall not extend beyond a maximum of three (3) months. Employees on paid administrative leave are required to contact their supervisor or designee at the end of each workweek unless otherwise specified in the administrative leave notice. Employees on either paid or unpaid administrative leave are required to return to active work status within twenty-four (24) hours' notice that administrative leave has ended.

2. Administrative leave may be used in employment circumstances that include, but are not limited to:

   a. Drug-free and Alcohol-free Workplace Policy: An employee may be placed on paid administrative when subject to a reasonable suspicion allegation and required to undergo a drug and alcohol test and while pending its results. If the test result is positive, the employee is placed on unpaid administrative leave pending the final determination of corrective action.

   b. Administrative Investigation: An employee may be placed on paid administrative leave pending the outcome of an investigation where the employee's presence at the worksite may interfere with or unduly influence the investigative process and/or the subject's access to agency resources poses a risk to the organization or others.

   c. License and Certification: An employee may be placed on unpaid administrative leave for a period if they fail to maintain a job required license or certification. Employees must provide verification of renewal within thirty (30) calendar days, in accordance with CalOptima Health Policy GA.8033: License and Certification Tracking.

   d. Egregious Misconduct: An employee may be placed on unpaid administrative leave if accused of certain types of criminal activity and/or engages in an egregious act such as workplace violence, Member abuse, intentional destruction of property, and/or financial fraud or theft.

3. An employee may be required to fully reimburse CalOptima Health for any salary provided during their paid administrative leave, as required, pursuant to California Government Code, Section 53243, if the employee is convicted of a crime involving an abuse of their office or position.

III. PROCEDURE

Responsible Party	Action
Supervisor	1. Partner with HR to discuss the employee issue. 2. Partner with HR to properly document performance and/or behavior issue, and if applicable determine the appropriate corrective action. 3. Discuss issue(s) with employee and ensure the employee signs and dates the appropriate corrective action form. 4. Return the signed corrective action form to HR to file in employee's personnel record. 5. Participate in and/or direct staff member(s) to participate in, any investigation into their performance, behavior, or potential violation of CalOptima Health policy or procedure, where applicable.
Employee	1. Employees are expected to take personal responsibility to fulfill the duties and responsibilities of their positions, as outlined in their job descriptions and as directed by their supervisors. They are expected to make immediate and sustained improvement in performance and behavior when issued corrective action. Employees are responsible for reviewing, understanding and abiding by CalOptima Health policies, procedures, core values, and Code of Conduct. 2. Employees are required to cooperate and participate in good faith in the corrective action process, so they have a clear understanding of which performance and/or behavioral areas require improvement. 3. Employees sign any corrective action form issued to them to acknowledge that the respective issues were discussed. After being issued corrective action, employees are required to correct or improve their performance or behavioral issue as described in the corrective action. Employees may submit a written response for consideration/reconsideration of the corrective action; however, a written response does not change the employee's responsibility to acknowledge receipt of the corrective action and demonstrate improvement. 4. Employees are required to cooperate in an administrative investigation by CalOptima Health (if applicable). Any failure to cooperate in good faith in a formal investigation may result in corrective action.
Human Resources (HR)	1. Partner with Supervisor to help plan appropriate corrective action to address employee's performance/behavior issues. 2. Assist Supervisor in properly documenting performance/behavior issues and partner in communicating these issues to the employee, if applicable. 3. Assist in completing corrective action and/or termination documentation. 4. Securely house and file all related forms and written correspondence in employee's personnel record.

Responsible Party	Action
	a. If issued to the employee, copies of Documented Counseling Memos, Written Warnings, Performance Improvement Plans, Final Warnings, and Termination Communication Memos are all held in the employee personnel file.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Government Code, §53243
B. CalOptima Health Code of Conduct
C. CalOptima Health Employee Handbook
D. ~~C.~~ CalOptima Health Policy GA.8033: License and Certification Tracking
~~D.~~E. Sample Documented Counseling Memo Template
~~E.~~F. Sample Final Warning Template
~~F.~~G. Sample Performance Improvement Plan
~~G.~~H. Sample Termination Communication Memo Template
~~H.~~I. Sample Written Warning Template

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
08/02/2018	Regular Meeting of the CalOptima Board of Directors
09/01/2022	Regular Meeting of the CalOptima Health Board of Directors
10/03/2024	Regular Meeting of the CalOptima Health Board of Directors
04/03/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8022	Progressive Discipline	Administrative
Revised	08/07/2014	GA.8022	Progressive Discipline	Administrative
Revised	08/02/2018	GA.8022	Performance and Behavior Standards	Administrative
Revised	09/01/2022	GA.8022	Performance and Behavior Standards	Administrative
Revised	10/03/2024	GA.8022	Performance and Behavior Standards	Administrative
Revised	04/03/2025	GA.8022	Performance and Behavior Standards	Administrative

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IX. GLOSSARY

Term	Definition
Counseling Memo	Oral discussion(s) between supervisor and employee with the purpose of notifying the employee and/or clarifying substandard employee performance/behavior or policy violation and exploration of possible causes. Goal is to change behavior. An informal written record of the counseling discussion, noting the date and recommended action is completed and held by the supervisor.
Demotion	A change of employee's position to one at a lower Salary Schedule pay grade, whether in the same or a different department. A demotion may be either voluntary or involuntary.
Documented Counseling Memo	An informal documentation of counseling issued to an employee to document substandard performance/behavior or policy violation specifically identifying areas requiring improvement.
Final Warning	A formal notification to an employee that their performance/behavior or violation(s) of CalOptima Health policy is at a very critical stage in their employment and that continued lack of improvement may result in termination.
Formal Corrective Action	A corrective action that places an employee in not good standing status where participation in an action/activity requires good standing eligibility for a period of time described in that policy or procedure.
Informal Corrective Action	A corrective action that does not affect good standing.
Member	A beneficiary enrolled in a CalOptima Health program.
Performance Improvement Plan	A formal action used to document performance and behavioral deficiencies or issues and create an action plan with goals and due dates to help employees correct and/or improve performance and behavior while still holding them accountable for past performance.
Termination	The end of the employment relationship.
Termination Communication Memo	Documentation of a decision to end the employment relationship from the employee's Department leadership to Human Resources.
Written Warning	A formal notification issued to an employee documenting unsatisfactory employee performance/behavior or policy violation.

Policy:	GA.8022
Title:	**Performance and Behavior Standards**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	04/03/2025
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy outlines an approach that can be used, at CalOptima Health's discretion, depending on the nature of the issues that are to be addressed and the extent of such issues, to help correct and/or improve employee performance and behavior through corrective action or termination when employee performance and/or behavior is/are not meeting expectations, and/or fails to follow CalOptima Health's policies and procedures.

II. POLICY

A. As a public agency, CalOptima Health abides by its core values of Collaboration, Accountability, Respect, Excellence, and Stewardship and expects employees to be committed to ethical conduct, excellent service, consistent attendance, positive teamwork, and compliance with CalOptima Health policies and procedures. Appropriate conduct is expected at all times while employees are on duty and/or on CalOptima Health property.

B. Employment with CalOptima Health is at will. As at-will employees, CalOptima Health employees may be terminated at any time, with or without cause, and with or without advance notice.

C. In cases involving conduct that is a serious violation of policy, performance issue(s), or behavioral problem(s), or where the conduct cannot be corrected, immediate termination from employment may result.

D. Prior to issuing formal corrective action, depending on the severity or correctability of the issue, in certain circumstances at the discretion of CalOptima Health's management, CalOptima Health may elect to informally discuss and coach employees regarding their conduct or performance in order to provide the employee with an opportunity to correct or improve their performance and/or behavior. Corrective action does not apply to all performance issues or undesirable behaviors and will be issued on a case-by-case basis in a fair and consistent manner. CalOptima Health may issue any one of the corrective actions without regard to any particular order, repeat any one of the corrective actions, or immediately terminate employment.

E. CalOptima Health reserves the right to initiate corrective action or termination for various reasons, including, but not limited to:

1. Unsatisfactory work quality, or quantity;

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2. Failure to meet performance standards;

3. Behavioral-based problems that impact productivity, quality, service, or teamwork;

4. Excessive and/or habitual absenteeism, tardiness, or abuse of break and lunch privileges;

5. Insubordination, dishonesty, or negligence in the performance of duties;

6. Harassment or abusive conduct toward co-workers, supervisors, Members, visitors, or others encountered in the workplace;

7. Failure to return, damaging or unauthorized use of CalOptima Health-owned property or equipment;

8. Failure to pass a post-employment drug/alcohol, financial/credit, criminal background, or other position required background check;

9. Failure to maintain a license, certification, or educational qualification required by the employee's position;

10. Failure to follow instructions, policies, regulations, laws, or CalOptima Health policies and procedures;

11. Failure to follow established safety regulations;

12. Violation of CalOptima Health's Code of Conduct; and/or

13. Violation of any other CalOptima Health policy.

F. The type of corrective action will depend on multiple factors, including, but not limited to the nature of the offense, taking into consideration an employee's past performance and employment record, where applicable, and may range from counseling to immediate termination. Corrective action will be assessed in a fair and consistent manner in partnership with Human Resources (HR).

G. Employees are not guaranteed a right to corrective action prior to termination.

H. When used, the corrective action process may in some, but not all, cases consist of:

1. Informal Corrective Action, including:

a. Counseling discussion;

b. Documented Counseling Memo;

2. Formal Corrective Action, including:

a. Written Warning;

b. Performance Improvement Plan;

c. Final Warning;

d. Demotion; and/or

e. Termination.

I. Although one (1) or more of these corrective actions may be taken in connection with a particular employee, no formal order or system is necessary. An employee may, of course, resign at any time. The employee may be demoted as necessary. CalOptima Health may also terminate the employment relationship at any time without following any particular series of corrective actions depending on the individual circumstances surrounding the performance, behavior, or misconduct.

J. CalOptima Health may place an employee on administrative leave with or without pay while HR conducts an investigation and/or a final determination is pending, and/or when there is a risk to CalOptima Health if the employee is permitted to continue in their role.

1. Paid administrative leave shall not extend beyond a maximum of three (3) months. Employees on paid administrative leave are required to contact their supervisor or designee at the end of each workweek unless otherwise specified in the administrative leave notice. Employees on either paid or unpaid administrative leave are required to return to active work status within twenty-four (24) hours' notice that administrative leave has ended.

2. Administrative leave may be used in employment circumstances that include, but are not limited to:

a. Drug-free and Alcohol-free Workplace Policy: An employee may be placed on paid administrative when subject to a reasonable suspicion allegation and required to undergo a drug and alcohol test and while pending its results. If the test result is positive, the employee is placed on unpaid administrative leave pending the final determination of corrective action.

b. Administrative Investigation: An employee may be placed on paid administrative leave pending the outcome of an investigation where the employee's presence at the worksite may interfere with or unduly influence the investigative process and/or the subject's access to agency resources poses a risk to the organization or others.

c. License and Certification: An employee may be placed on unpaid administrative leave for a period if they fail to maintain a job required license or certification. Employees must provide verification of renewal within thirty (30) calendar days, in accordance with CalOptima Health Policy GA.8033: License and Certification Tracking.

d. Egregious Misconduct: An employee may be placed on unpaid administrative leave if accused of certain types of criminal activity and/or engages in an egregious act such as workplace violence, Member abuse, intentional destruction of property, and/or financial fraud or theft.

3. An employee may be required to fully reimburse CalOptima Health for any salary provided during their paid administrative leave, as required, pursuant to California Government Code, Section 53243, if the employee is convicted of a crime involving an abuse of their office or position.

III. PROCEDURE

Responsible Party	Action
Supervisor	1. Partner with HR to discuss the employee issue. 2. Partner with HR to properly document performance and/or behavior issue, and if applicable determine the appropriate corrective action.

Responsible Party	Action
	3. Discuss issue(s) with employee and ensure the employee signs and dates the appropriate corrective action form. 4. Return the signed corrective action form to HR to file in employee's personnel record. 5. Participate in and/or direct staff member(s) to participate in, any investigation into their performance, behavior, or potential violation of CalOptima Health policy or procedure, where applicable.
Employee	1. Employees are expected to take personal responsibility to fulfill the duties and responsibilities of their positions, as outlined in their job descriptions and as directed by their supervisors. They are expected to make immediate and sustained improvement in performance and behavior when issued corrective action. Employees are responsible for reviewing, understanding and abiding by CalOptima Health policies, procedures, core values, and Code of Conduct. 2. Employees are required to cooperate and participate in good faith in the corrective action process, so they have a clear understanding of which performance and/or behavioral areas require improvement. 3. Employees sign any corrective action form issued to them to acknowledge that the respective issues were discussed. After being issued corrective action, employees are required to correct or improve their performance or behavioral issue as described in the corrective action. Employees may submit a written response for consideration/reconsideration of the corrective action; however, a written response does not change the employee's responsibility to acknowledge receipt of the corrective action and demonstrate improvement. 4. Employees are required to cooperate in an administrative investigation by CalOptima Health (if applicable). Any failure to cooperate in good faith in a formal investigation may result in corrective action.
Human Resources (HR)	1. Partner with Supervisor to help plan appropriate corrective action to address employee's performance/behavior issues. 2. Assist Supervisor in properly documenting performance/behavior issues and partner in communicating these issues to the employee, if applicable. 3. Assist in completing corrective action and/or termination documentation. 4. Securely house and file all related forms and written correspondence in employee's personnel record. a. If issued to the employee, copies of Documented Counseling Memos, Written Warnings, Performance Improvement Plans, Final Warnings, and Termination Communication Memos are all held in the employee personnel file.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Government Code, §53243
B. CalOptima Health Code of Conduct
C. CalOptima Health Employee Handbook
D. CalOptima Health Policy GA.8033: License and Certification Tracking
E. Sample Documented Counseling Memo Template
F. Sample Final Warning Template
G. Sample Performance Improvement Plan
H. Sample Termination Communication Memo Template
I. Sample Written Warning Template

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
08/02/2018	Regular Meeting of the CalOptima Board of Directors
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04/03/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8022	Progressive Discipline	Administrative
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IX. GLOSSARY

Term	Definition
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Termination	The end of the employment relationship.
Termination Communication Memo	Documentation of a decision to end the employment relationship from the employee's Department leadership to Human Resources.
Written Warning	A formal notification issued to an employee documenting unsatisfactory employee performance/behavior or policy violation.

Policy:	GA.8034
Title:	**Service of Summons, Subpoenas, and Other Legal Documents**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	04/03/2025
Applicable to:	☐ Medi-Cal ☐ OneCare ~~☐ OneCare Connect~~ ☐ PACE ☒ Administrative

I. PURPOSE

This policy clarifies CalOptima Health's responsibility related to receipt of service of legal papers not pertaining to CalOptima Health business.

II. POLICY

A. CalOptima Health shall not accept, or facilitate, service of legal papers, such as subpoenas, summons, or complaints, except for those which are directed to CalOptima Health, or its agents, and which relate to the business of CalOptima Health.

B. Most documents entitled Summons, Subpoena, Court Orders, Notices to Appear, etc., whether for civil, criminal, or administrative matters, require personal service to the individual. CalOptima Health has no obligation to accept, or facilitate, such service to employees or others when the legal papers are related to personal matters.

C. Consistent with CalOptima Health Policy AA.1215: Public Records Requests and Subpoenas, CalOptima Health should not accept legal documents that are not directly related to CalOptima Health business or Members.

~~D. In the event a notice is left at the place of employment (e.g., with the Front Desk Reception/Security), it will be forwarded on to the employee. However, this may not constitute proper service and the employee would need to discuss such a matter with their own legal counsel.~~

D. In the event a summons, subpoena, or other legal document intended for a CalOptima Health employee is brought to a CalOptima Health facility for service (e.g., front desk security or reception), front desk will contact the CalOptima Health representative(s) designated to receive service. If the document does not pertain to CalOptima Health business, the representative will inform the server that such documents will not be accepted or forwarded by CalOptima Health, and the representative shall not physically take possession of such documents.

E. Employees are advised to keep personal legal matters away from CalOptima Health premises and separate from their professional responsibilities to avoid any interference with the proper conduct of CalOptima Health's business.

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III. PROCEDURE

Responsible Party	Action
Designated Representative for Document Service, Front Desk Reception/ Security (~~Admin~~505 Building, 500 Building, and PACE)	1. Inform the process server that it is CalOptima Health's policy not to accept or facilitate service of legal papers related to personal matters at the work site. -Do not physically take possession of legal papers from the server. 2. If the server drops or otherwise leaves the papers on CalOptima Health property, notify Human Resources. ~~2.~~3. If a problem arises, contact CalOptima Health's legal counsel immediately.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy AA.1215: Public Records Requests and Subpoenas
B. CalOptima Health Policy AA.1217: Legal Claims and Judicial Review

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
01/05/2012	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
04/03/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8034	Service of Summons	Administrative
Revised	11/03/2016	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative
Revised	09/01/2018	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative
Revised	10/01/2020	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative
Revised	12/01/2022	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative
Revised	04/03/2025	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative

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IX. GLOSSARY

Term	Definition
Member	A beneficiary who is enrolled in a CalOptima Health program.

Policy:	GA.8034
Title:	**Service of Summons, Subpoenas, and Other Legal Documents**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	01/05/2012
Revised Date:	04/03/2025
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ PACE ☒ Administrative

I. PURPOSE

This policy clarifies CalOptima Health's responsibility related to receipt of service of legal papers not pertaining to CalOptima Health business.

II. POLICY

A. CalOptima Health shall not accept, or facilitate, service of legal papers, such as subpoenas, summons, or complaints, except for those which are directed to CalOptima Health, or its agents, and which relate to the business of CalOptima Health.

B. Most documents entitled Summons, Subpoena, Court Orders, Notices to Appear, etc., whether for civil, criminal, or administrative matters, require personal service to the individual. CalOptima Health has no obligation to accept, or facilitate, such service to employees or others when the legal papers are related to personal matters.

C. Consistent with CalOptima Health Policy AA.1215: Public Records Requests and Subpoenas, CalOptima Health should not accept legal documents that are not directly related to CalOptima Health business or Members.

D. In the event a summons, subpoena, or other legal document intended for a CalOptima Health employee is brought to a CalOptima Health facility for service (e.g., front desk security or reception), front desk will contact the CalOptima Health representative(s) designated to receive service. If the document does not pertain to CalOptima Health business, the representative will inform the server that such documents will not be accepted or forwarded by CalOptima Health, and the representative shall not physically take possession of such documents.

E. Employees are advised to keep personal legal matters away from CalOptima Health premises and separate from their professional responsibilities to avoid any interference with the proper conduct of CalOptima Health's business.

III. PROCEDURE

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Responsible Party	Action
Designated Representative for Document Service, Front Desk Reception/ Security (505 Building, 500 Building, and PACE)	1. Inform the process server that it is CalOptima Health's policy not to accept or facilitate service of legal papers related to personal matters at the work site. Do not physically take possession of legal papers from the server. 2. If the server drops or otherwise leaves the papers on CalOptima Health property, notify Human Resources. 3. If a problem arises, contact CalOptima Health's legal counsel immediately.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Policy AA.1215: Public Records Requests and Subpoenas
B. CalOptima Health Policy AA.1217: Legal Claims and Judicial Review

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/05/2012	GA.8034	Service of Summons	Administrative
Revised	11/03/2016	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative
Revised	09/01/2018	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative
Revised	10/01/2020	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative
Revised	12/01/2022	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative
Revised	04/03/2025	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative

IX. GLOSSARY

Term	Definition
Member	A beneficiary who is enrolled in a CalOptima Health program.

Financial Summary

February 28, 2025

Board of Directors Meeting

April 3, 2025

Nancy Huang, Chief Financial Officer

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.

Financial Highlights: February 2025

February 2025 Actual	February 2025 Budget	February 2025 $ Variance	February 2025 % Variance		July 2024 - February 2025 Actual	July 2024 - February 2025 Budget	July 2024 - February 2025 $ Variance	July 2024 - February 2025 % Variance
915,201	900,877	14,324	1.6%	Member Months	7,307,781	7,204,815	102,966	1.4%
404,370,448	359,579,579	44,790,869	12.5%	Revenues	3,226,637,951	2,852,425,304	374,212,647	13.1%
348,372,956	335,719,673	(12,653,283)	(3.8%)	Medical Expenses	2,977,380,617	2,838,113,466	(139,267,151)	(4.9%)
20,185,499	24,916,532	4,731,033	19.0%	Administrative Expenses	165,431,075	196,225,767	30,794,692	15.7%
35,811,992	**(1,056,626)**	**36,868,618**	**3,489.3%**	**Operating Margin**	**83,826,259**	**(181,913,929)**	**265,740,188**	**146.1%**
				Non-Operating Income (Loss)				
18,750,298	6,666,660	12,083,638	181.3%	Net Investment Income/Expense	134,694,484	53,333,280	81,361,204	152.6%
16,696	(117,280)	133,976	114.2%	Net Rental Income/Expense	(339,253)	(938,240)	598,987	63.8%
(4,662)	-	(4,662)	(100.0%)	Net MCO Tax	(6,361)	-	(6,361)	(100.0%)
(261,166)	(1,178,825)	917,659	77.8%	Grant Expense	(13,617,529)	(9,339,691)	(4,277,838)	(45.8%)
(48,431)	-	(48,431)	(100.0%)	Other Income/Expense	22,419	-	22,419	100.0%
18,452,735	**5,370,555**	**13,082,180**	**243.6%**	**Total Non-Operating Income (Loss)**	**120,753,760**	**43,055,349**	**77,698,411**	**180.5%**
54,264,727	**4,313,929**	**49,950,798**	**1,157.9%**	**Change in Net Assets**	**204,580,019**	**(138,858,580)**	**343,438,599**	**247.3%**
86.2%	*93.4%*	*(7.2%)*		*Medical Loss Ratio*	*92.3%*	*99.5%*	*(7.2%)*	
5.0%	*6.9%*	*1.9%*		*Administrative Loss Ratio*	*5.1%*	*6.9%*	*1.8%*	
8.9%	*(0.3%)*	*9.2%*		*Operating Margin Ratio*	*2.6%*	*(6.4%)*	*9.0%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
79.6%	*88.5%*	*(8.9%)*		**Adjusted MLR*	*86.3%*	*94.6%*	*(8.2%)*	
5.0%	*6.9%*	*1.9%*		**Adjusted ALR*	*5.4%*	*6.9%*	*1.5%*	

*Adjusted MLR /ALR excludes estimated Board-approved Provider Rate increases, Directed Payments and Community Reinvestment Accruals, but includes costs associated with CalOptima Health's Digital Transformation Strategy (DTS) budget.

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Financial Highlights Notes: February 2025

- Notable events/items in February 2025
  - Lower claims volumes in February due to less days in the month
    - Staff anticipates volume to normalize in March 2025
  - Favorable revenue due primarily to:
    - The revised Calendar Year (CY) 2025 draft rates received in December were favorable compared to budget assumptions. Staff anticipates additional rate amendments are forthcoming from the Department of Health Care Services (DHCS) due to program and member acuity changes.

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FY 2024-25: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) February 2025: $54.3 million, favorable to budget $50.0 million or 1,157.9% primarily due to:
    - Favorable net investment income, enrollment and CY 2025 premium capitation rates
  - Year To Date (YTD) July 2024 – February 2025: $204.6 million, favorable to budget $343.4 million or 247.3% primarily due to:
    - Favorable net investment income, premium capitation rates and enrollment in the Medi-Cal (MC) Line of Business (LOB)

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FY 2024-25: Management Summary (cont.)

- Enrollment
  - MTD: 915,201 members, favorable to budget 14,324 or 1.6%
  - YTD: 7,307,781 member months, favorable to budget 102,966 or 1.4%

- Revenue
  - MTD: $404.4 million, favorable to budget $44.8 million or 12.5% due to favorable enrollment and CY 2025 premium capitation rates
  - YTD: $3.226.6 million, favorable to budget $374.2 million or 13.1% driven by MC LOB due to CY 2022 Hospital Directed Payments (DP), favorable enrollment and premium capitation rates

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FY 2024-25: Management Summary (cont.)

- Medical Expenses
  - MTD: $348.4 million, unfavorable to budget $12.7 million or 3.8% driven by:
    - $8.6 million in MC Other Medical Expenses primarily due to CY 2025 Community Reinvestment and Quality Achievement accruals
    - $3.8 million in MC Professional and Managed Long-Term Services and Supports (MLTSS) expenses due to increase in utilization
    - $2.7 million in MC Incentive Payments expenses

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FY 2024-25: Management Summary (cont.)

- Medical Expenses (cont.)
  - YTD: $2,977.4 million, unfavorable to budget $139.3 million or 4.9% driven by:
    - $173.4 million in MC Other Medical Expenses due primarily to CY 2022 Hospital DP and CY 2025 Community Reinvestment and Quality Achievement accruals
    - Offset by $13.7 million in MC Incentive Payments expenses due to the timing of Hospital Quality Program (HQP) accruals

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FY 2024-25: Management Summary (cont.)

- Administrative Expenses
  - MTD: $20.2 million, favorable to budget $4.7 million or 19.0%
  - YTD: $165.4 million, favorable to budget $30.8 million or 15.7%

- Non-Operating Income (Loss)
  - MTD: $18.5 million, favorable to budget $13.1 million or 243.6% primarily due to net investment income of $18.8 million
  - YTD: $120.8 million, favorable to budget $77.7 million or 180.5% primarily due to net investment income of $134.7 million, offset by grant expense of $13.6 million

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FY 2024-25: Key Financial Ratios

- Medical Loss Ratio (MLR)

		Actual	Budget	Variance (%)
MTD	MLR	86.2%	93.4%	(7.2%)
	Adjusted MLR*	79.6%	88.5%	(8.9%)
YTD	MLR	92.3%	99.5%	(7.2%)
	Adjusted MLR*	86.3%	94.6%	(8.2%)

- Administrative Loss Ratio (ALR)

		Actual	Budget	Variance (%)
MTD	ALR	5.0%	6.9%	1.9%
	Adjusted ALR*	5.0%	6.9%	1.9%
YTD	ALR	5.1%	6.9%	1.8%
	Adjusted ALR*	5.4%	6.9%	1.5%

* Adjusted MLR/ALR excludes estimated Board-approved Provider Rate Increases, Directed Payments and Community Reinvestment Accruals, but include costs associated with DTS.

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FY 2024-25: Key Financial Ratios (cont.)

- Balance Sheet Ratios
  - Current ratio*: 1.9
  - Board Designated Reserve level: 2.92
  - Statutory Designated Reserve level: 1.11
    - During the monthly review, upon discovery that the reserve level exceeded the Board-approved limits of 100% to 110% of the minimum required Tangible Net Equity (TNE), Staff completed a transfer in March to bring the ratio back in compliance with the Board-approved policy
  - Net-position: $2.6 billion, including required TNE of $123.6 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations.

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Enrollment Summary: February 2025

February 2025					July 2024 - February 2025			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
148,457	138,187	10,270	7.4%	SPD	1,168,485	1,096,405	72,080	6.6%
264,926	271,981	(7,055)	(2.6%)	TANF Child	2,145,220	2,178,493	(33,273)	(1.5%)
131,244	138,300	(7,056)	(5.1%)	TANF Adult	1,049,245	1,103,765	(54,520)	(4.9%)
2,495	2,599	(104)	(4.0%)	LTC	19,924	20,844	(920)	(4.4%)
340,899	322,408	18,491	5.7%	MCE	2,705,836	2,585,674	120,162	4.6%
9,439	9,543	(104)	(1.1%)	WCM	77,449	76,456	993	1.3%
897,460	**883,018**	**14,442**	**1.6%**	**Medi-Cal Total**	**7,166,159**	**7,061,637**	**104,522**	**1.5%**
17,238	**17,374**	**(136)**	**(0.8%)**	**OneCare**	**137,594**	**139,366**	**(1,772)**	**(1.3%)**
503	**485**	**18**	**3.7%**	**PACE**	**4,028**	**3,812**	**216**	**5.7%**
538	**568**	**(30)**	**(5.3%)**	**MSSP**	**4,060**	**4,544**	**(484)**	**(10.7%)**
915,201	**900,877**	**14,324**	**1.6%**	**CalOptima Health Total**	**7,307,781**	**7,204,815**	**102,966**	**1.4%**

Note: MSSP enrollment is included in Medi-Cal Total.

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Consolidated Revenue & Expenses: February 2025 MTD

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	897,460	17,238		503	538		915,201
REVENUES							
Capitation Revenue	$ 361,120,473	$ 38,121,203	$ -	$ 4,882,368	$ 246,404	$ -	$ 404,370,448
Total Operating Revenue	**361,120,473**	**38,121,203**	**-**	**4,882,368**	**246,404**	**-**	**404,370,448**
MEDICAL EXPENSES							
Provider Capitation	114,493,573	17,124,851					131,618,424
Claims	119,474,324	5,632,347		1,519,760			126,626,431
MLTSS	46,578,186			6,027	38,645		46,622,858
Prescription Drugs		8,231,231		551,389			8,782,620
Case Mgmt & Other Medical	30,830,492	2,461,612		1,250,086	180,433		34,722,623
Total Medical Expenses	**311,376,575**	**33,450,041**	**-**	**3,327,262**	**219,078**	**-**	**348,372,956**
Medical Loss Ratio	*86.2%*	*87.7%*	*0.0%*	*68.1%*	*88.9%*	*0.0%*	*86.2%*
GROSS MARGIN	**49,743,897**	**4,671,163**	**-**	**1,555,105**	**27,326**	**-**	**55,997,492**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	11,051,703	985,293		168,934	103,063		12,308,992
Non-Salary Operating Expenses	3,062,220	839,708		93,860	1,426	10,516	4,007,729
Depreciation & Amortization	734,422			991			735,413
Other Operating Expenses	2,428,878	328,305		4,275	7,754		2,769,212
Indirect Cost Allocation, Occupancy	(678,379)	1,019,094		16,799	6,639		364,153
Total Administrative Expenses	**16,598,844**	**3,172,399**	**-**	**284,859**	**118,881**	**10,516**	**20,185,499**
Administrative Loss Ratio	*4.6%*	*8.3%*	*0.0%*	*5.8%*	*48.2%*	*0.0%*	*5.0%*
Operating Income/(Loss)	**33,145,053**	**1,498,763**	**-**	**1,270,246**	**(91,555)**	**(10,516)**	**35,811,992**
Investments and Other Non-Operating	(53,093)						18,452,735
CHANGE IN NET ASSETS	**$ 33,091,961**	**$ 1,498,763**	**$ -**	**$ 1,270,246**	**$ (91,555)**	**$ (10,516)**	**$ 54,264,727**
BUDGETED CHANGE IN NET ASSETS	(796,042)	578,805	-	185,752	(108,475)	(916,666)	4,313,929
Variance to Budget - Fav/(Unfav)	$ 33,888,003	$ 919,958	$ -	$ 1,084,494	$ 16,920	$ 906,150	$ 49,950,798

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CalOptima Health

Consolidated Revenue & Expenses: February 2025 YTD

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	7,166,159	137,594		4,028	4,060		7,307,781
REVENUES							
Capitation Revenue	$ 2,916,092,459	$ 276,416,567	$ (3,197,365)	$ 35,467,751	$1,858,538	$ -	$ 3,226,637,951
Total Operating Revenue	**2,916,092,459**	**276,416,567**	**(3,197,365)**	**35,467,751**	**1,858,538**	**-**	**3,226,637,951**
MEDICAL EXPENSES							
Provider Capitation	911,924,197	119,099,115	(1,453,037)				1,029,570,274
Claims	1,043,357,126	48,538,698	(184,151)	12,707,551			1,104,419,223
MLTSS	390,605,875			89,174	299,519		390,994,568
Prescription Drugs		69,841,088		4,669,284			74,510,372
Case Mgmt & Other Medical	352,903,403	13,328,750		10,158,487	1,495,539		377,886,179
Total Medical Expenses	**2,698,790,600**	**250,807,650**	**(1,637,188)**	**27,624,497**	**1,795,057**	**-**	**2,977,380,617**
Medical Loss Ratio	*92.5%*	*90.7%*	*51.2%*	*77.9%*	*96.6%*	*0.0%*	*92.3%*
GROSS MARGIN	**217,301,859**	**25,608,916**	**(1,560,177)**	**7,843,255**	**63,481**	**-**	**249,257,334**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	91,021,459	8,644,568		1,352,709	814,795		101,833,531
Non-Salary Operating Expenses	27,780,306	4,439,967		498,242	11,366	10,516	32,740,397
Depreciation & Amortization	5,915,069			7,738			5,922,808
Other Operating Expenses	21,222,741	705,761		69,328	61,898		22,059,730
Indirect Cost Allocation, Occupancy	(6,183,971)	8,857,912		141,453	59,215		2,874,610
Total Administrative Expenses	**139,755,604**	**22,648,209**	**-**	**2,069,471**	**947,274**	**10,516**	**165,431,075**
Administrative Loss Ratio	*4.8%*	*8.2%*	*0.0%*	*5.8%*	*51.0%*	*0.0%*	*5.1%*
Operating Income/(Loss)	**77,546,255**	**2,960,708**	**(1,560,177)**	**5,773,784**	**(883,793)**	**(10,516)**	**83,826,259**
Investments and Other Non-Operating	16,058						120,753,760
CHANGE IN NET ASSETS	**$ 77,562,313**	**$ 2,960,708**	**$ (1,560,177)**	**$ 5,773,784**	**$ (883,793)**	**$ (10,516)**	**$ 204,580,019**
BUDGETED CHANGE IN NET ASSETS	(170,458,508)	(8,028,102)	-	(689,399)	(904,588)	(1,833,332)	(138,858,580)
Variance to Budget - Fav/(Unfav)	$ 248,020,821	$ 10,988,810	$ (1,560,177)	$ 6,463,183	$ 20,795	$ 1,822,816	$ 343,438,599

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CalOptima Health

Balance Sheet: As of February 2025

ASSETS	
Current Assets	
Operating Cash	$545,443,753
Short-term Investments	1,690,602,820
Capitation Receivable	783,309,713
Receivables - Other	103,780,166
Prepaid Expenses	14,345,130
Total Current Assets	**3,137,481,583**
Capital Assets	
Capital Assets	194,413,361
Less Accumulated Depreciation	(92,700,687)
Capital Assets, Net of Depreciation	**101,712,674**
Other Assets	
Restricted Deposits	300,000
Board Designated Reserves	1,099,610,141
Statutory Designated Reserves	137,695,651
Total Other Assets	**1,237,605,792**
TOTAL ASSETS	**4,476,800,050**
Deferred Outflows	**75,899,007**
TOTAL ASSETS & DEFERRED OUTFLOWS	**4,552,699,057**

LIABILITIES & NET POSITION	
Current Liabilities	
Accounts Payable	$415,216,496
Medical Claims Liability	1,052,855,253
Accrued Payroll Liabilities	23,986,317
Deferred Revenue	47,557,277
Other Current Liabilities	-
Capitation and Withholds	134,430,791
Total Current Liabilities	**1,674,046,135**
Other Liabilities	
GASB 96 Subscription Liabilities	18,048,802
Community Reinvestment	138,415,777
Capital Lease Payable	262,741
Postemployment Health Care Plan	17,635,604
Net Pension Liabilities	45,981,359
Total Other Liabilities	**220,344,283**
TOTAL LIABILITIES	**1,894,390,418**
Deferred Inflows	**8,646,445**
Net Position	
Required TNE	123,552,530
Funds in Excess of TNE	2,526,109,664
TOTAL NET POSITION	**2,649,662,194**
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**4,552,699,057**

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Board Designated Reserve and TNE Analysis: As of February 2025

Board Designated Reserves

Investment Account Name	Market Value	Benchmark		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	549,962,291				
MetLife Tier One	549,647,850				
Board Designated Reserves	1,099,610,141	941,215,552	1,129,458,663	158,394,589	(29,848,521)
Current Reserve Level (X months of average monthly revenue) [1]	*2.92*	*2.50*	*3.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	Benchmark		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	68,965,593				
MetLife Tier Two	68,730,059				
Statutory Designated Reserves	137,695,651	123,552,530	135,907,783	14,143,121	1,787,868
Current Reserve Level (X min. TNE) [1]	*1.11* [2]	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

[2] *Adjustment to Statutory Designated Reserves made on March 17, 2025 to lower the current reserve level.*

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Spending Plan: As of February 2025

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 2/28/2025	**$2,649.7**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$1,099.6**			**41.5%**
	Statutory Designated Reserve[1]	**$137.7**			**5.2%**
	Capital Assets, net of Depreciation[2]	**$101.7**			**3.8%**
Resources Allocated[3]	Homeless Health Initiative[3]	$15.9	$61.7	$45.8	0.6%
	Housing and Homelessness Incentive Program[3]	22.1	87.4	65.3	0.8%
	Intergovernmental Transfers (IGT)	54.5	111.7	57.2	2.1%
	Digital Transformation and Workplace Modernization[4]	40.4	100.0	59.6	1.5%
	Mind OC Grant (Orange)	0.1	1.0	0.9	0.0%
	CalFresh Outreach Strategy	0.0	2.0	2.0	0.0%
	CalFresh and Redetermination Outreach Strategy	2.0	6.0	4.0	0.1%
	Coalition of Orange County Community Health Centers Grant	20.0	50.0	30.0	0.8%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	0.2	0.5	0.3	0.0%
	General Awareness Campaign	1.1	4.7	3.6	0.0%
	Member Health Needs Assessment	1.1	1.3	0.2	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	125.8	153.5	27.7	4.7%
	Medi-Cal Annual Wellness Initiative	2.5	3.8	1.3	0.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.4%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program Grant	3.5	5.0	1.5	0.1%
	Community Living and PACE center (previously approved for project located in Tustin)	17.6	18.0	0.4	0.7%
	Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program Grant	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund Grant	44.5	50.0	5.5	1.7%
	Distribution Event - Naloxone Grant	2.2	15.0	12.8	0.1%
	Garden Grove Bldg. Improvement	10.0	10.5	0.5	0.4%
	Post-Pandemic Supplemental	6.2	107.5	101.3	0.2%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	1.4%
	Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
	Outreach Strategy for newly eligible Adult Expansion members	3.8	7.6	3.8	0.1%
	Quality Initiatives from unearned Pay for Value Program	18.5	23.3	4.8	0.7%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.4	1.0	0.6	0.0%
	Medi-Cal Provider Rate Increases	385.9	526.2	140.3	14.6%
	Homeless Prevention and Stabilization Pilot Program	0.3	0.3	0.0	0.0%
	OneCare Member Engagement and Education	0.3	0.3	0.0	0.0%
	Subtotal:	**$832.0**	**$1,422.8**	**$590.7**	**31.4%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$478.6**			**18.1%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 147 days of CalOptima Health's current operations.
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements.
[3] See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.
[4] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

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Homeless Health Initiative and Allocated Funds: As of February 2025

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	879,957	83,304
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,883,740	6,005,173
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine[1]	10,076,652	7,333,162	2,743,490
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[2]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$101,800,000**	**$45,755,811**	**$56,044,188**
Transfer of funds to HHIP[2]	(40,100,000)	-	(40,100,000)
Program Total	**$61,700,000**	**$45,755,811**	**$15,944,188**

Notes:

[1]On March 7, 2024, CalOptima Health's Board of Directors approved $5 million to expand the Street Medicine Program. $3.2 million remaining from Street Medicine Initiative (from the HHI reserve) and $1.8 million from existing reserves to fund 2-year agreements to Healthcare in Action (Anaheim) and Celebrating Life Community Health Center (Costa Mesa).

[2]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1 million from HHI to HHIP.

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Housing and Homelessness Incentive Program
As of February 2025

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	54,930,994	28,988,750	25,942,244	18,000,195[1]
Existing Reserves & HHI Transfer	87,384,530	87,384,530	65,324,503	22,060,027	-
Total	**160,315,719**	**142,315,524**	**94,313,253**	**48,002,271**	**18,000,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	1,400,000	832,350	567,650	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,321,311	1,300,000	HHI & DHCS
Infrastructure Projects	5,832,314	5,391,731	440,583	HHI
Capital Projects	108,247,369	77,195,575	31,051,794	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	4,863,856	5,320,674	DHCS
Non-Profit Healthcare Academy	700,000	508,429	191,571	DHCS
Total of Approved Initiatives	**$133,185,524[1]**	**$94,313,252**	**$38,872,272**	

Notes:

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments.

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UNAUDITED FINANCIAL STATEMENTS

February 28, 2025

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CalOptima Health - Consolidated
Financial Highlights
For the Eight Months Ending February 28, 2025

February 2025					July 2024 - February 2025			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
915,201	900,877	14,324	1.6%	Member Months	7,307,781	7,204,815	102,966	1.4%
404,370,448	359,579,579	44,790,869	12.5%	Revenues	3,226,637,951	2,852,425,304	374,212,647	13.1%
348,372,956	335,719,673	(12,653,283)	(3.8%)	Medical Expenses	2,977,380,617	2,838,113,466	(139,267,151)	(4.9%)
20,185,499	24,916,532	4,731,033	19.0%	Administrative Expenses	165,431,075	196,225,767	30,794,692	15.7%
35,811,992	**(1,056,626)**	**36,868,618**	**3,489.3%**	**Operating Margin**	**83,826,259**	**(181,913,929)**	**265,740,188**	**146.1%**
				Non-Operating Income (Loss)				
18,750,298	6,666,660	12,083,638	181.3%	Net Investment Income/Expense	134,694,484	53,333,280	81,361,204	152.6%
16,696	(117,280)	133,976	114.2%	Net Rental Income/Expense	(339,253)	(938,240)	598,987	63.8%
(4,662)	-	(4,662)	(100.0%)	Net MCO Tax	(6,361)	-	(6,361)	(100.0%)
(261,166)	(1,178,825)	917,659	77.8%	Grant Expense	(13,617,529)	(9,339,691)	(4,277,838)	(45.8%)
(48,431)	-	(48,431)	(100.0%)	Other Income/Expense	22,419	-	22,419	100.0%
18,452,735	**5,370,555**	**13,082,180**	**243.6%**	**Total Non-Operating Income (Loss)**	**120,753,760**	**43,055,349**	**77,698,411**	**180.5%**
54,264,727	**4,313,929**	**49,950,798**	**1,157.9%**	**Change in Net Assets**	**204,580,019**	**(138,858,580)**	**343,438,599**	**247.3%**
86.2%	*93.4%*	*(7.2%)*		*Medical Loss Ratio*	*92.3%*	*99.5%*	*(7.2%)*	
5.0%	*6.9%*	*1.9%*		*Administrative Loss Ratio*	*5.1%*	*6.9%*	*1.8%*	
8.9%	*(0.3%)*	*9.2%*		*Operating Margin Ratio*	*2.6%*	*(6.4%)*	*9.0%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		
79.6%	*88.5%*	*(8.9%)*		**Adjusted MLR*	*86.3%*	*94.6%*	*(8.2%)*	
5.0%	*6.9%*	*1.9%*		**Adjusted ALR*	*5.4%*	*6.9%*	*1.5%*	

*Adjusted MLR /ALR excludes estimated Board-approved Provider Rate increases, Directed Payments and Community Reinvestment Accruals, but includes costs associated with CalOptima Health's Digital Transformation Strategy (DTS) budget.

CalOptima Health - Consolidated
Full Time Equivalent (FTE) Data
For the Eight Months Ending February 28, 2025

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1,327	1,361	34
OneCare	173	186	13
PACE	111	113	2
MSSP	22	25	3
Total	1,632	1,685	53

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	10,406	10,886	480
OneCare	1,368	1,488	120
PACE	853	904	51
MSSP	169	200	31
Total	12,797	13,479	682

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	677	649	(28)
OneCare	100	93	(7)
PACE	5	4	(1)
MSSP	24	23	(3)
Consolidated	561	535	(26)

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	689	649	(40)
OneCare	101	94	(7)
PACE	5	4	(1)
MSSP	24	23	(1)
Consolidated	571	535	(37)

Open FTE			
	Total	Medical	Admin
Medi-Cal	56	30	26
OneCare	7	7	0
PACE	4	4	0
MSSP	0	0	0
Total	67	41	26

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending February 28, 2025

MEMBER MONTHS		915,201		900,877		14,324
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$361,120,473	$402.38	$318,951,873	$361.21	$42,168,600	$41.17
OneCare	38,121,203	2,211.46	36,290,685	2,088.79	1,830,518	122.67
OneCare Connect	-		-		-	-
PACE	4,882,368	9,706.50	4,083,504	8,419.60	798,864	1,286.90
MSSP	246,404	458.00	253,517	446.33	(7,113)	11.67
Total Operating Revenue	404,370,448	441.84	359,579,579	399.14	44,790,869	42.70
MEDICAL EXPENSES						
Medi-Cal	311,376,575	346.95	299,343,087	339.00	(12,033,488)	(7.95)
OneCare	33,450,041	1,940.48	32,526,890	1,872.16	(923,151)	(68.32)
OneCare Connect					-	0.00
PACE	3,327,262	6,614.84	3,608,955	7,441.14	281,693	826.30
MSSP	219,078	407.21	240,741	423.84	21,663	16.63
Total Medical Expenses	348,372,956	380.65	335,719,673	372.66	(12,653,283)	(7.99)
GROSS MARGIN	55,997,492	61.19	23,859,906	26.48	32,137,586	34.71
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	12,308,992	13.45	12,863,584	14.28	554,592	0.83
Professional Fees	1,603,992	1.75	2,784,044	3.09	1,180,053	1.34
Purchased Services	1,647,335	1.80	3,138,805	3.48	1,491,471	1.68
Printing & Postage	756,403	0.83	748,528	0.83	(7,875)	-
Depreciation & Amortization	735,413	0.80	1,027,958	1.14	292,545	0.34
Other Expenses	2,769,212	3.03	3,909,790	4.34	1,140,578	1.31
Indirect Cost Allocation, Occupancy	364,153	0.40	443,823	0.49	79,670	0.09
Total Administrative Expenses	20,185,499	22.06	24,916,532	27.66	4,731,033	5.60
NET INCOME (LOSS) FROM OPERATIONS	35,811,992	39.13	(1,056,626)	(1.17)	36,868,618	40.30
INVESTMENT INCOME						
Interest Income	12,748,265	13.93	6,666,660	7.40	6,081,605	6.53
Realized Gain/(Loss) on Investments	355,642	0.39	-	-	355,642	0.39
Unrealized Gain/(Loss) on Investments	5,646,391	6.17	-	-	5,646,391	6.17
Total Investment Income	18,750,298	20.49	6,666,660	7.40	12,083,638	13.09
NET RENTAL INCOME/EXPENSE	16,696	0.02	(117,280)	(0.13)	133,976	0.15
NET MCO TAX	(4,662)	(0.01)	-	-	(4,662)	(0.01)
GRANT EXPENSE	(261,166)	(0.29)	(1,178,825)	(1.31)	917,659	1.02
OTHER INCOME/EXPENSE	(48,431)	(0.05)	-	-	(48,431)	(0.05)
CHANGE IN NET ASSETS	**54,264,727**	**59.29**	**4,313,929**	**4.79**	**49,950,798**	**54.50**
MEDICAL LOSS RATIO	**86.2%**		**93.4%**		**(7.2%)**	
ADMINISTRATIVE LOSS RATIO	**5.0%**		**6.9%**		**1.9%**	

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CalOptima Health- Consolidated - Year to Date
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2025

MEMBER MONTHS		7,307,781		7,204,815		102,966
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$2,916,092,459	$406.93	$2,536,558,157	$359.20	$379,534,302	$47.73
OneCare	276,416,567	2,008.93	282,105,522	2,024.21	(5,688,955)	(15.28)
OneCare Connect	(3,197,365)		-		(3,197,365)	0.00
PACE	35,467,751	8,805.30	31,733,489	8,324.63	3,734,262	480.67
MSSP	1,858,538	457.77	2,028,136	446.33	(169,598)	11.44
Total Operating Revenue	3,226,637,951	441.53	2,852,425,304	395.91	374,212,647	45.62
MEDICAL EXPENSES						
Medi-Cal	2,698,790,600	376.60	2,541,657,524	359.92	(157,133,076)	(16.68)
OneCare	250,807,650	1,822.81	264,481,689	1,897.75	13,674,039	74.94
OneCare Connect	(1,637,188)				1,637,188	0.00
PACE	27,624,497	6,858.12	30,048,325	7,882.56	2,423,828	1,024.44
MSSP	1,795,057	442.13	1,925,928	423.84	130,871	(18.29)
Total Medical Expenses	2,977,380,617	407.43	2,838,113,466	393.92	(139,267,151)	(13.51)
GROSS MARGIN	249,257,334	34.10	14,311,838	1.99	234,945,496	32.11
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	101,833,531	13.93	107,940,289	14.98	6,106,758	1.05
Professional Fees	10,710,915	1.47	15,067,386	2.09	4,356,471	0.62
Purchased Services	17,767,115	2.43	23,920,203	3.32	6,153,089	0.89
Printing & Postage	4,262,368	0.58	6,372,404	0.88	2,110,036	0.30
Depreciation & Amortization	5,922,808	0.81	8,223,664	1.14	2,300,856	0.33
Other Expenses	22,059,730	3.02	31,152,757	4.32	9,093,027	1.30
Indirect Cost Allocation, Occupancy	2,874,610	0.39	3,549,064	0.49	674,454	0.10
Total Administrative Expenses	165,431,075	22.64	196,225,767	27.24	30,794,692	4.60
NET INCOME (LOSS) FROM OPERATIONS	83,826,259	11.47	(181,913,929)	(25.25)	265,740,188	36.72
INVESTMENT INCOME						
Interest Income	115,550,180	15.81	53,333,280	7.40	62,216,900	8.41
Realized Gain/(Loss) on Investments	2,815,415	0.39	-	0.00	2,815,415	0.39
Unrealized Gain/(Loss) on Investments	16,328,889	2.23	-	0.00	16,328,889	2.23
Total Investment Income	134,694,484	18.43	53,333,280	7.40	81,361,204	11.03
NET RENTAL INCOME/EXPENSE	(339,253)	(0.05)	(938,240)	(0.13)	598,987	0.08
NET MCO TAX	(6,361)	0.00	-	0.00	(6,361)	0.00
GRANT EXPENSE	(13,617,529)	(1.86)	(9,339,691)	(1.30)	(4,277,838)	(0.56)
OTHER INCOME/EXPENSE	22,419	0.00	-	0.00	22,419	0.00
CHANGE IN NET ASSETS	**204,580,019**	**27.99**	**(138,858,580)**	**(19.27)**	**343,438,599**	**47.26**
MEDICAL LOSS RATIO	**92.3%**		**99.5%**		**(7.2%)**	
ADMINISTRATIVE LOSS RATIO	**5.1%**		**6.9%**		**1.8%**	

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CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending February 28, 2025

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	897,460	17,238		503	538	-	915,201
REVENUES							
Capitation Revenue	$ 361,120,473	$ 38,121,203	$ -	$ 4,882,368	$ 246,404	$ -	$ 404,370,448
Total Operating Revenue	**361,120,473**	**38,121,203**	**-**	**4,882,368**	**246,404**	**-**	**404,370,448**
MEDICAL EXPENSES							
Provider Capitation	114,493,573	17,124,851					131,618,424
Claims	119,474,324	5,632,347		1,519,760			126,626,431
MLTSS	46,578,186			6,027	38,645		46,622,858
Prescription Drugs		8,231,231		551,389			8,782,620
Case Mgmt & Other Medical	30,830,492	2,461,612		1,250,086	180,433		34,722,623
Total Medical Expenses	**311,376,575**	**33,450,041**	**-**	**3,327,262**	**219,078**	**-**	**348,372,956**
Medical Loss Ratio	*86.2%*	*87.7%*	*0.0%*	*68.1%*	*88.9%*	*0.0%*	*86.2%*
GROSS MARGIN	**49,743,897**	**4,671,163**	**-**	**1,555,105**	**27,326**	**-**	**55,997,492**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	11,051,703	985,293		168,934	103,063		12,308,992
Non-Salary Operating Expenses	3,062,220	839,708		93,860	1,426	10,516	4,007,729
Depreciation & Amortization	734,422			991			735,413
Other Operating Expenses	2,428,878	328,305		4,275	7,754		2,769,212
Indirect Cost Allocation, Occupancy	(678,379)	1,019,094		16,799	6,639		364,153
Total Administrative Expenses	**16,598,844**	**3,172,399**	**-**	**284,859**	**118,881**	**10,516**	**20,185,499**
Administrative Loss Ratio	*4.6%*	*8.3%*	*0.0%*	*5.8%*	*48.2%*	*0.0%*	*5.0%*
Operating Income/(Loss)	**33,145,053**	**1,498,763**	**-**	**1,270,246**	**(91,555)**	**(10,516)**	**35,811,992**
Investments and Other Non-Operating	(53,093)						18,452,735
CHANGE IN NET ASSETS	**$ 33,091,961**	**$ 1,498,763**	**$ -**	**$ 1,270,246**	**$ (91,555)**	**$ (10,516)**	**$ 54,264,727**
BUDGETED CHANGE IN NET ASSETS	(796,042)	578,805	-	185,752	(108,475)	(916,666)	4,313,929
Variance to Budget - Fav/(Unfav)	$ 33,888,003	$ 919,958	$ -	$ 1,084,494	$ 16,920	$ 906,150	$ 49,950,798

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CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Eight Months Ending February 28, 2025

	Medi-Cal	OneCare	OneCare Connect	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	7,166,159	137,594		4,028	4,060	-	7,307,781
REVENUES							
Capitation Revenue	$ 2,916,092,459	$ 276,416,567	$ (3,197,365)	$ 35,467,751	$ 1,858,538	$ -	$ 3,226,637,951
Total Operating Revenue	**2,916,092,459**	**276,416,567**	**(3,197,365)**	**35,467,751**	**1,858,538**	**-**	**3,226,637,951**
MEDICAL EXPENSES							
Provider Capitation	911,924,197	119,099,115	(1,453,037)				1,029,570,274
Claims	1,043,357,126	48,538,698	(184,151)	12,707,551			1,104,419,223
MLTSS	390,605,875			89,174	299,519		390,994,568
Prescription Drugs		69,841,088		4,669,284			74,510,372
Case Mgmt & Other Medical	352,903,403	13,328,750		10,158,487	1,495,539		377,886,179
Total Medical Expenses	**2,698,790,600**	**250,807,650**	**(1,637,188)**	**27,624,497**	**1,795,057**	**-**	**2,977,380,617**
Medical Loss Ratio	*92.5%*	*90.7%*	*0.0%*	*77.9%*	*96.6%*	*0.0%*	*92.3%*
GROSS MARGIN	**217,301,859**	**25,608,916**	**(1,560,177)**	**7,843,255**	**63,481**	**-**	**249,257,334**
ADMINISTRATIVE EXPENSES							
Salaries & Benefits	91,021,459	8,644,568		1,352,709	814,795		101,833,531
Non-Salary Operating Expenses	27,780,306	4,439,967		498,242	11,366	10,516	32,740,397
Depreciation & Amortization	5,915,069			7,738			5,922,808
Other Operating Expenses	21,222,741	705,761		69,328	61,898		22,059,730
Indirect Cost Allocation, Occupancy	(6,183,971)	8,857,912		141,453	59,215		2,874,610
Total Administrative Expenses	**139,755,604**	**22,648,209**	**-**	**2,069,471**	**947,274**	**10,516**	**165,431,075**
Administrative Loss Ratio	*4.8%*	*8.2%*	*0.0%*	*5.8%*	*51.0%*	*0.0%*	*5.1%*
Operating Income/(Loss)	**77,546,255**	**2,960,708**	**(1,560,177)**	**5,773,784**	**(883,793)**	**(10,516)**	**83,826,259**
Investments and Other Non-Operating	16,058						120,753,760
CHANGE IN NET ASSETS	**$ 77,562,313**	**$ 2,960,708**	**$ (1,560,177)**	**$ 5,773,784**	**$ (883,793)**	**$ (10,516)**	**$ 204,580,019**
BUDGETED CHANGE IN NET ASSETS	(170,458,508)	(8,028,102)	-	(689,399)	(904,588)	(1,833,332)	(138,858,580)
Variance to Budget - Fav/(Unfav)	$ 248,020,821	$ 10,988,810	$ (1,560,177)	$ 6,463,183	$ 20,795	$ 1,822,816	$ 343,438,599

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CalOptima Health

Highlights – Consolidated, for Eight Months Ending February 28, 2025

MONTH TO DATE RESULTS:

- Change in Net Assets is $54.3 million, favorable to budget $50.0 million
- Operating surplus is $35.8 million, with a surplus in non-operating income of $18.5 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $204.6 million, favorable to budget $343.4 million
- Operating surplus is $83.8 million, with a surplus in non-operating income of $120.8 million

Change in Net Assets by Line of Business (LOB) ($ millions):

February 2025				July 2024 - February 2025		
Actual	**Budget**	**Variance**	**Operating Income (Loss)**	**Actual**	**Budget**	**Variance**
33.1	(0.8)	33.9	Medi-Cal	77.5	(170.5)	248.0
1.5	0.6	0.9	OneCare	3.0	(8.0)	11.0
1.3	0.2	1.1	PACE	5.8	(0.7)	6.5
(0.1)	(0.1)	0.0	MSSP	(0.9)	(0.9)	0.0
0.0	0.0	0.0	OCC	(1.6)	0.0	(1.6)
0.0	(0.9)	0.9	Covered CA	0.0	(1.8)	1.8
35.8	**(1.1)**	**36.9**	**Total Operating Income (Loss)**	**83.8**	**(181.9)**	**265.7**
			Non-Operating Income (Loss)			
18.8	6.7	12.1	Net Investment Income/Expense	134.7	53.3	81.4
0.0	0.0	0.0	Net QAF & IGT Income/Expense	0.0	0.0	0.0
0.0	0.0	0.0	Other Income/Expense	0.0	0.0	0.0
18.5	**5.4**	**13.1**	**Total Non-Operating Income/(Loss)**	**120.8**	**43.1**	**77.7**
54.3	**4.3**	**50.0**	**TOTAL**	**204.6**	**(138.9)**	**343.4**

CalOptima Health - Consolidated
Enrollment Summary
For the Eight Months Ending February 28, 2025

February 2025					July 2024 - February 2025			
Actual	Budget	$ Variance	%Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	%Variance
148,457	138,187	10,270	7.4%	SPD	1,168,485	1,096,405	72,080	6.6%
264,926	271,981	(7,055)	(2.6%)	TANF Child	2,145,220	2,178,493	(33,273)	(1.5%)
131,244	138,300	(7,056)	(5.1%)	TANF Adult	1,049,245	1,103,765	(54,520)	(4.9%)
2,495	2,599	(104)	(4.0%)	LTC	19,924	20,844	(920)	(4.4%)
340,899	322,408	18,491	5.7%	MCE	2,705,836	2,585,674	120,162	4.6%
9,439	9,543	(104)	(1.1%)	WCM	77,449	76,456	993	1.3%
897,460	**883,018**	**14,442**	**1.6%**	**Medi-Cal Total**	**7,166,159**	**7,061,637**	**104,522**	**1.5%**
17,238	**17,374**	**(136)**	**(0.8%)**	**OneCare**	**137,594**	**139,366**	**(1,772)**	**(1.3%)**
503	**485**	**18**	**3.7%**	**PACE**	**4,028**	**3,812**	**216**	**5.7%**
538	**568**	**(30)**	**(5.3%)**	**MSSP**	**4,060**	**4,544**	**(484)**	**(10.7%)**
915,201	**900,877**	**14,324**	**1.6%**	**CalOptima Health Total**	**7,307,781**	**7,204,815**	**102,966**	**1.4%**
				Enrollment (by Network)				
355,795	302,807	52,988	17.5%	HMO	2,600,128	2,425,290	174,838	7.2%
170,488	178,623	(8,135)	(4.6%)	PHC	1,396,561	1,430,556	(33,995)	(2.4%)
67,861	132,515	(64,654)	(48.8%)	Shared Risk Group	846,440	1,064,614	(218,174)	(20.5%)
303,316	269,073	34,243	12.7%	Fee for Service	2,323,030	2,141,177	181,853	8.5%
897,460	**883,018**	**14,442**	**1.6%**	**Medi-Cal Total**	**7,166,159**	**7,061,637**	**104,522**	**1.5%**
17,238	**17,374**	**(136)**	**(0)**	**OneCare**	**137,594**	**139,366**	**(1,772)**	**(0)**
503	**485**	**18**	**3.7%**	**PACE**	**4,028**	**3,812**	**216**	**5.7%**
538	**568**	**(30)**	**(5.3%)**	**MSSP**	**4,060**	**4,544**	**(484)**	**(10.7%)**
915,201	**900,877**	**14,324**	**1.6%**	**CalOptima Health Total**	**7,307,781**	**7,204,815**	**102,966**	**1.4%**

Note:* Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2025

	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	YTD Actual	YTD Budget	Variance
HMOs															
SPD	17,150	16,511	16,610	16,774	20,293	20,211	20,247	20,491					148,287	131,278	17,009
TANF Child	66,405	65,921	65,198	64,503	77,875	77,766	77,607	76,962					572,237	552,094	20,143
TANF Adult	54,590	55,734	55,056	54,535	70,864	70,611	70,439	69,398					501,227	503,552	(2,325)
LTC	2				1		3	2					8		8
MCE	153,578	153,602	152,129	151,153	190,284	189,645	189,821	187,512					1,367,724	1,227,324	140,400
WCM	1,241	1,234	1,214	1,163	1,370	1,479	1,514	1,430					10,645	11,042	(397)
Total	292,966	293,002	290,207	288,128	360,687	359,712	359,631	355,795					2,600,128	2,425,290	**174,838**
PHCs															
SPD	4,906	4,644	4,820	4,796	4,736	4,780	4,737	4,799					38,218	36,089	2,129
TANF Child	140,053	138,903	137,874	136,823	136,101	135,163	133,694	132,827					1,091,438	1,130,160	(38,722)
TANF Adult	3,994	4,186	4,191	4,104	4,165	4,170	4,132	4,089					33,031	40,012	(6,981)
LTC													0		0
MCE	22,999	22,762	22,600	22,551	22,507	22,511	22,520	22,277					180,727	172,835	7,892
WCM	6,571	7,308	6,733	6,550	6,336	6,573	6,580	6,496					53,147	51,460	1,687
Total	178,523	177,803	176,218	174,824	173,845	173,197	171,663	170,488					1,396,561	1,430,556	**(33,995)**
Shared Risk Groups															
SPD	7,270	7,077	7,057	7,133	3,422	3,411	3,353	3,413					42,136	51,937	(9,801)
TANF Child	32,783	32,842	32,545	32,325	18,564	18,412	18,308	18,287					204,066	251,465	(47,399)
TANF Adult	27,519	29,041	28,870	28,586	11,818	11,756	11,734	11,438					160,762	232,128	(71,366)
LTC				1									1	8	(7)
MCE	74,704	74,918	74,517	74,138	34,102	34,260	34,467	34,469					435,575	523,192	(87,617)
WCM	702	701	716	707	91	362	367	254					3,900	5,884	(1,984)
Total	**142,978**	**144,579**	**143,705**	**142,890**	**67,997**	**68,201**	**68,229**	**67,861**					**846,440**	**1,064,614**	**(218,174)**
Fee for Service (Dual)															
SPD	100,293	99,792	100,297	100,986	101,924	102,883	104,042	104,622					814,839	758,630	56,209
TANF Child													0	10	(10)
TANF Adult	1,145	1,159	1,123	1,052	1,035	1,056	1,037	1,011					8,618	14,626	(6,008)
LTC	2,178	2,203	2,209	2,222	2,208	2,237	2,234	2,204					17,695	18,675	(980)
MCE	4,008	4,703	4,593	4,431	4,388	4,283	4,088	3,863					34,357	72,661	(38,304)
WCM	6	7	8	15	12	12	13	13					86	72	14
Total	**107,630**	**107,864**	**108,230**	**108,706**	**109,567**	**110,471**	**111,414**	**111,713**					**875,595**	**864,674**	**10,921**
Fee for Service (Non-Dual - Total)															
SPD	15,636	15,436	15,868	15,819	15,925	16,332	14,857	15,132					125,005	118,471	6,534
TANF Child	32,741	33,377	33,868	33,995	34,269	36,369	36,010	36,850					277,479	244,764	32,715
TANF Adult	40,618	42,145	42,625	42,860	43,229	44,456	44,366	45,308					345,607	313,447	32,160
LTC	278	254	271	278	285	295	270	289					2,220	2,161	59
MCE	80,536	82,491	83,546	83,778	84,679	89,895	89,750	92,778					687,453	589,662	97,791
WCM	1,205	1,184	1,178	1,114	1,177	1,198	1,369	1,246					9,671	7,998	1,673
Total	**171,014**	**174,887**	**177,356**	**177,844**	**179,564**	**188,545**	**186,622**	**191,603**					**1,447,435**	**1,276,503**	**170,932**
Grand Totals															
SPD	145,255	143,460	144,652	145,508	146,300	147,617	147,236	148,457					1,168,485	1,096,405	72,080
TANF Child	271,982	271,043	269,485	267,646	266,809	267,710	265,619	264,926					2,145,220	2,178,493	(33,273)
TANF Adult	127,866	132,265	131,865	131,137	131,111	132,049	131,708	131,244					1,049,245	1,103,765	(54,520)
LTC	2,458	2,457	2,480	2,501	2,494	2,532	2,507	2,495					19,924	20,844	(920)
MCE	335,825	338,476	337,385	336,051	335,960	340,594	340,646	340,899					2,705,836	2,585,674	120,162
WCM	9,725	10,434	9,849	9,549	8,986	9,624	9,843	9,439					77,449	76,456	993
Total MediCal MM	**893,111**	**898,135**	**895,716**	**892,392**	**891,660**	**900,126**	**897,559**	**897,460**					**7,166,159**	**7,061,637**	**104,522**
OneCare	**17,311**	**17,307**	**17,282**	**17,173**	**17,156**	**17,037**	**17,090**	**17,238**					**137,594**	**139,366**	**(1,772)**
PACE	**506**	**508**	**503**	**498**	**502**	**506**	**502**	**503**					**4,028**	**3,812**	**216**
MSSP	**473**	**480**	**487**	**506**	**524**	**519**	**533**	**538**					**4,060**	**4,544**	**(484)**
Grand Total	**910,928**	**915,950**	**913,501**	**910,063**	**909,318**	**917,669**	**915,151**	**915,201**					**7,307,781**	**7,204,815**	**102,966**

Note:* Total membership does not include MSSP

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ENROLLMENT:

Overall, February enrollment was 915,201

- Favorable to budget 14,324 or 1.6%
- Increased 50 from Prior Month (PM) (January 2025)
- Decreased 19,404 or 2.1% from Prior Year (PY) (February 2024)

Medi-Cal enrollment was 897,460

- Favorable to budget 14,442 or 1.6%
- Medi-Cal Expansion (MCE) favorable to budget 18,491
- Seniors and Persons with Disabilities (SPD) favorable to budget 10,270
- Temporary Assistance for Needy Families (TANF) unfavorable to budget 14,111
- Whole Child Model (WCM) unfavorable to budget 104
- Long-Term Care (LTC) unfavorable to budget 104
- Decreased 99 from PM

OneCare enrollment was 17,238

- Unfavorable to budget 136 or 0.8%
- Increased 148 from PM

PACE enrollment was 503

- Favorable to budget 18 or 3.7%
- Increased 1 from PM

MSSP enrollment was 538

- Unfavorable to budget 30 or 5.3%
- Increased 5 from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2025

Month to Date					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
897,460	**883,018**	**14,442**	**1.6%**	**Member Months**	**7,166,159**	**7,061,637**	**104,522**	**1.5%**
				Revenues				
361,120,473	318,951,873	42,168,600	13.2%	Medi-Cal Capitation Revenue	2,916,092,459	2,536,558,157	379,534,302	15.0%
361,120,473	**318,951,873**	**42,168,600**	**13.2%**	**Total Operating Revenue**	**2,916,092,459**	**2,536,558,157**	**379,534,302**	**15.0%**
				Medical Expenses				
114,493,573	111,429,008	(3,064,565)	(2.8%)	Provider Capitation	911,924,197	892,597,781	(19,326,416)	(2.2%)
55,508,702	60,388,497	4,879,795	8.1%	Facilities Claims	519,708,745	518,013,259	(1,695,486)	(0.3%)
63,965,622	61,450,395	(2,515,227)	(4.1%)	Professional Claims	523,648,381	544,503,538	20,855,157	3.8%
46,578,186	45,305,241	(1,272,945)	(2.8%)	MLTSS	390,605,875	388,002,158	(2,603,717)	(0.7%)
12,825,909	10,153,845	(2,672,064)	(26.3%)	Incentive Payments	97,649,408	111,337,637	13,688,229	12.3%
7,537,361	8,785,894	1,248,533	14.2%	Medical Management	67,188,928	72,561,482	5,372,554	7.4%
10,467,221	1,830,207	(8,637,014)	(471.9%)	Other Medical Expenses	188,065,067	14,641,669	(173,423,398)	(1,184.5%)
311,376,575	**299,343,087**	**(12,033,488)**	**(4.0%)**	**Total Medical Expenses**	**2,698,790,600**	**2,541,657,524**	**(157,133,076)**	**(6.2%)**
49,743,897	**19,608,786**	**30,135,111**	**153.7%**	**Gross Margin**	**217,301,859**	**(5,099,367)**	**222,401,226**	**4,361.3%**
				Administrative Expenses				
11,051,703	11,436,928	385,225	3.4%	Salaries, Wages & Employee Benefits	91,021,459	96,019,551	4,998,092	5.2%
1,494,938	1,715,220	220,283	12.8%	Professional Fees	10,016,075	12,199,140	2,183,065	17.9%
954,937	2,552,371	1,597,434	62.6%	Purchased Services	14,633,824	19,478,498	4,844,674	24.9%
612,345	515,048	(97,297)	(18.9%)	Printing & Postage	3,130,407	4,291,474	1,161,067	27.1%
734,422	1,026,358	291,936	28.4%	Depreciation & Amortization	5,915,069	8,210,864	2,295,795	28.0%
2,428,878	3,765,334	1,336,455	35.5%	Other Operating Expenses	21,222,741	30,011,062	8,788,321	29.3%
(678,379)	(606,431)	71,948	11.9%	Indirect Cost Allocation, Occupancy	(6,183,971)	(4,851,448)	1,332,523	27.5%
16,598,844	**20,404,828**	**3,805,984**	**18.7%**	**Total Administrative Expenses**	**139,755,604**	**165,359,141**	**25,603,537**	**15.5%**
				Non-Operating Income (Loss)				
(4,662)	-	(4,662)	(100.0%)	Net Operating Tax	(6,361)	-	(6,361)	(100.0%)
(48,431)	-	(48,431)	(100.0%)	Other Income/Expense	22,419	-	22,419	100.0%
(53,093)	**-**	**(53,093)**	**(100.0%)**	**Total Non-Operating Income (Loss)**	**16,058**	**-**	**16,058**	**100.0%**
33,091,961	**(796,042)**	**33,888,003**	**4,257.1%**	**Change in Net Assets**	**77,562,313**	**(170,458,508)**	**248,020,821**	**145.5%**
86.2%	***93.9%***	***(7.6%)***		***Medical Loss Ratio***	***92.5%***	***100.2%***	***(7.7%)***	
4.6%	***6.4%***	***1.8%***		***Admin Loss Ratio***	***4.8%***	***6.5%***	***1.7%***	

MEDI-CAL INCOME STATEMENT– FEBRUARY MONTH:

REVENUES are $361.1 million, favorable to budget $42.2 million:

- Favorable volume related variance of $5.2 million
- Favorable price related variance of $37.0 million
  - $39.7 million due to favorable member mix and draft Calendar Year (CY) 2025 capitation rates from the Department of Health Care Services (DHCS)
  - Offset by $3.6 million from Proposition 56, Enhanced Care Management (ECM) and Unsatisfactory Immigration Status (UIS) risk corridors

MEDICAL EXPENSES are $311.4 million, unfavorable to budget $12.0 million:

- Unfavorable volume related variance of $4.9 million
- Unfavorable price related variance of $7.1 million:
  - Other Medical Expenses unfavorable variance of $8.6 million primarily due to CY 2025 Community Reinvestment and Quality Achievement accruals
  - Incentive Payments expenses unfavorable variance of $2.5 million
  - Professional Claims, Provider Capitation and Managed Long-Term Services and Supports (MLTSS) expenses unfavorable variance of $3.3 million
  - Offset by:
    - Facilities Claims expenses favorable variance of $5.9 million due to lower than expected utilization
    - Medical Management expenses favorable variance of $1.4 million

ADMINISTRATIVE EXPENSES are $16.6 million, favorable to budget $3.8 million:

- Non-Salary expenses favorable to budget $3.4 million
- Salaries, Wages & Employee Benefits expenses favorable to budget $0.4 million

CHANGE IN NET ASSETS is $33.1 million, favorable to budget $33.9 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
17,238	**17,374**	**(136)**	**(0.8%)**	**Member Months**	**137,594**	**139,366**	**(1,772)**	**(1.3%)**
				Revenues				
29,582,314	26,833,156	2,749,158	10.2%	Medicare Part C Revenue	200,545,366	206,838,261	(6,292,895)	(3.0%)
8,538,890	9,457,529	(918,639)	(9.7%)	Medicare Part D Revenue	75,871,201	75,267,261	603,940	0.8%
38,121,203	**36,290,685**	**1,830,518**	**5.0%**	**Total Operating Revenue**	**276,416,567**	**282,105,522**	**(5,688,955)**	**(2.0%)**
				Medical Expenses				
17,124,851	16,375,111	(749,740)	(4.6%)	Provider Capitation	119,099,115	126,302,032	7,202,917	5.7%
3,817,165	4,541,703	724,538	16.0%	Inpatient	33,741,592	38,621,854	4,880,262	12.6%
1,815,182	1,605,056	(210,126)	(13.1%)	Ancillary	14,797,105	13,806,016	(991,089)	(7.2%)
8,231,231	8,081,427	(149,804)	(1.9%)	Prescription Drugs	69,841,088	70,811,182	970,094	1.4%
1,184,852	604,126	(580,726)	(96.1%)	Incentive Payments	4,461,616	3,979,805	(481,811)	(12.1%)
908,367	1,319,467	411,100	31.2%	Medical Management	8,039,262	10,960,800	2,921,538	26.7%
368,392	-	(368,392)	(100.0%)	Other Medical Expenses	827,872	-	(827,872)	(100.0%)
33,450,041	**32,526,890**	**(923,151)**	**(2.8%)**	**Total Medical Expenses**	**250,807,650**	**264,481,689**	**13,674,039**	**5.2%**
4,671,163	**3,763,795**	**907,368**	**24.1%**	**Gross Margin**	**25,608,916**	**17,623,833**	**7,985,083**	**45.3%**
				Administrative Expenses				
985,293	1,158,010	172,717	14.9%	Salaries, Wages & Employee Benefits	8,644,568	9,669,075	1,024,507	10.6%
93,211	142,033	48,822	34.4%	Professional Fees	654,063	953,614	299,551	31.4%
624,826	513,960	(110,866)	(21.6%)	Purchased Services	2,765,652	3,917,500	1,151,848	29.4%
121,671	222,950	101,279	45.4%	Printing & Postage	1,020,251	1,930,600	910,349	47.2%
328,305	121,954	(206,351)	(169.2%)	Other Operating Expenses	705,761	972,482	266,721	27.4%
1,019,094	1,026,083	6,989	0.7%	Indirect Cost Allocation, Occupancy	8,857,912	8,208,664	(649,248)	(7.9%)
3,172,399	**3,184,990**	**12,591**	**0.4%**	**Total Administrative Expenses**	**22,648,209**	**25,651,935**	**3,003,726**	**11.7%**
1,498,763	**578,805**	**919,958**	**158.9%**	**Change in Net Assets**	**2,960,708**	**(8,028,102)**	**10,988,810**	**136.9%**
87.7%	***89.6%***	***(1.9%)***		***Medical Loss Ratio***	***90.7%***	***93.8%***	***(3.0%)***	
8.3%	***8.8%***	***0.5%***		***Admin Loss Ratio***	***8.2%***	***9.1%***	***0.9%***	

ONECARE INCOME STATEMENT– FEBRUARY MONTH:

REVENUES are $38.1 million, favorable to budget $1.8 million:

- Unfavorable volume related variance of $0.3 million
- Favorable price related variance of $2.1 million primarily due to retroactive adjustments for End-Stage Renal Disease (ESRD)

MEDICAL EXPENSES are $33.5 million, unfavorable to budget $0.9 million:

- Favorable volume related variance of $0.3 million
- Unfavorable price related variance of $1.2 million primarily due to additional capitation expense accruals

ADMINISTRATIVE EXPENSES are $3.2 million, favorable to budget $12,591

- Salaries, Wages & Employee Benefits expenses unfavorable to budget $172,717
- Non-Salary expenses unfavorable to budget $160,127

CHANGE IN NET ASSETS is $1.5 million, favorable to budget $0.9 million

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
503	**485**	**18**	**3.7%**	**Member Months**	**4,028**	**3,812**	**216**	**5.7%**
				Revenues				
3,421,268	3,043,953	377,315	12.4%	Medi-Cal Capitation Revenue	26,368,115	23,936,054	2,432,061	10.2%
1,155,992	792,620	363,372	45.8%	Medicare Part C Revenue	6,529,491	5,881,742	647,749	11.0%
305,108	246,931	58,177	23.6%	Medicare Part D Revenue	2,570,145	1,915,693	654,452	34.2%
4,882,368	**4,083,504**	**798,864**	**19.6%**	**Total Operating Revenue**	**35,467,751**	**31,733,489**	**3,734,262**	**11.8%**
				Medical Expenses				
1,250,086	1,318,608	68,522	5.2%	Medical Management	10,158,487	10,924,502	766,015	7.0%
586,096	698,746	112,650	16.1%	Facilities Claims	5,484,979	5,919,022	434,043	7.3%
690,445	775,641	85,196	11.0%	Professional Claims	5,336,410	6,534,282	1,197,872	18.3%
551,389	519,683	(31,706)	(6.1%)	Prescription Drugs	4,669,284	4,358,136	(311,148)	(7.1%)
6,027	35,830	29,803	83.2%	MLTSS	89,174	228,807	139,633	61.0%
243,218	260,447	17,229	6.6%	Patient Transportation	1,886,162	2,083,576	197,414	9.5%
3,327,262	**3,608,955**	**281,693**	**7.8%**	**Total Medical Expenses**	**27,624,497**	**30,048,325**	**2,423,828**	**8.1%**
1,555,105	**474,549**	**1,080,556**	**227.7%**	**Gross Margin**	**7,843,255**	**1,685,164**	**6,158,091**	**365.4%**
				Administrative Expenses				
168,934	164,395	(4,539)	(2.8%)	Salaries, Wages & Employee Benefits	1,352,709	1,380,867	28,158	2.0%
3,910	8,708	4,798	55.1%	Professional Fees	18,927	69,964	51,037	72.9%
67,563	72,474	4,911	6.8%	Purchased Services	367,606	524,205	156,599	29.9%
22,387	10,530	(11,857)	(112.6%)	Printing & Postage	111,709	150,330	38,621	25.7%
991	1,600	609	38.1%	Depreciation & Amortization	7,738	12,800	5,062	39.5%
4,275	14,252	9,977	70.0%	Other Operating Expenses	69,328	103,213	33,885	32.8%
16,799	16,838	39	0.2%	Indirect Cost Allocation, Occupancy	141,453	133,184	(8,269)	(6.2%)
284,859	**288,797**	**3,938**	**1.4%**	**Total Administrative Expenses**	**2,069,471**	**2,374,563**	**305,092**	**12.8%**
1,270,246	**185,752**	**1,084,494**	**583.8%**	**Change in Net Assets**	**5,773,784**	**(689,399)**	**6,463,183**	**937.5%**
68.1%	***88.4%***	***(20.2%)***		***Medical Loss Ratio***	***77.9%***	***94.7%***	***(16.8%)***	
5.8%	***7.1%***	***1.2%***		***Admin Loss Ratio***	***5.8%***	***7.5%***	***1.6%***	

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CalOptima Health
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
538	**568**	**(30)**	**(5.3%)**	**Member Months**	**4,060**	**4,544**	**(484)**	**(10.7%)**
				Revenues				
246,404	253,517	(7,113)	(2.8%)	Revenue	1,858,538	2,028,136	(169,598)	(8.4%)
246,404	**253,517**	**(7,113)**	**(2.8%)**	**Total Operating Revenue**	**1,858,538**	**2,028,136**	**(169,598)**	**(8.4%)**
				Medical Expenses				
180,433	207,784	27,351	13.2%	Medical Management	1,495,539	1,662,272	166,733	10.0%
38,645	32,957	(5,688)	(17.3%)	Waiver Services	299,519	263,656	(35,863)	(13.6%)
180,433	207,784	27,351	13.2%	Total Medical Management	1,495,539	1,662,272	166,733	10.0%
38,645	32,957	(5,688)	(17.3%)	Total Waiver Services	299,519	263,656	(35,863)	(13.6%)
219,078	**240,741**	**21,663**	**9.0%**	**Total Program Expenses**	**1,795,057**	**1,925,928**	**130,871**	**6.8%**
27,326	**12,776**	**14,550**	**113.9%**	**Gross Margin**	**63,481**	**102,208**	**(38,727)**	**(37.9%)**
				Administrative Expenses				
103,063	104,251	1,188	1.1%	Salaries, Wages & Employee Benefits	814,795	870,796	56,001	6.4%
1,417	1,417	0	0.0%	Professional Fees	11,333	11,336	3	0.0%
9	-	(9)	(100.0%)	Purchased Services	33	-	(33)	(100.0%)
7,754	8,250	496	6.0%	Other Operating Expenses	61,898	66,000	4,102	6.2%
6,639	7,333	694	9.5%	Indirect Cost Allocation, Occupancy	59,215	58,664	(551)	(0.9%)
118,881	**121,251**	**2,370**	**2.0%**	**Total Administrative Expenses**	**947,274**	**1,006,796**	**59,522**	**5.9%**
(91,555)	**(108,475)**	**16,920**	**15.6%**	**Change in Net Assets**	**(883,793)**	**(904,588)**	**20,795**	**2.3%**
88.9%	***95.0%***	***(6.1%)***		***Medical Loss Ratio***	***96.6%***	***95.0%***	***1.6%***	
48.2%	***47.8%***	***(0.4%)***		***Admin Loss Ratio***	***51.0%***	***49.6%***	***(1.3%)***	

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CalOptima Health
OneCare Connect - Total
Statement of Revenue and Expenses
For the Eight Months Ending February 28, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
-	-	-	**0.0%**	**Member Months**	-	-	-	**0.0%**
				Revenues				
-	-	-	0.0%	Medicare Part C Revenue	(3,197,365)	-	(3,197,365)	(100.0%)
-	-	-	**0.0%**	**Total Operating Revenue**	**(3,197,365)**	-	**(3,197,365)**	**(100.0%)**
				Medical Expenses				
-	-	-	0.0%	Provider Capitation	(1,453,037)	-	1,453,037	100.0%
-	-	-	0.0%	Facilities Claims	(184,151)	-	184,151	100.0%
-	-	-	**0.0%**	**Total Medical Expenses**	**(1,637,188)**	-	**1,637,188**	**100.0%**
-	-	-	**0.0%**	**Gross Margin**	**(1,560,177)**	-	**(1,560,177)**	**(100.0%)**
				Administrative Expenses				
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	**(1,560,177)**	-	**(1,560,177)**	**(100.0%)**
0.0%	***0.0%***	***0.0%***		***Medical Loss Ratio***	***51.2%***	***0.0%***	***51.2%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	

CalOptima Health
Covered CA
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
-	-	-	**0.0%**	**Member Months**	-	-	-	**0.0%**
				Revenues				
-	-	-	0.0%	Medi-Cal Capitation Revenue	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Medical Expenses				
-	-	-	**0.0%**	**Total Medical Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Gross Margin**	-	-	-	**0.0%**
				Administrative Expenses				
10,516	916,666	906,150	98.9%	Professional Fees	10,516	1,833,332	1,822,816	99.4%
10,516	**916,666**	**906,150**	**98.9%**	**Total Administrative Expenses**	**10,516**	**1,833,332**	**1,822,816**	**99.4%**
				Non-Operating Income (Loss)				
-	-	-	0.0%	Net Operating Tax	-	-	-	0.0%
-	-	-	0.0%	Net QAF & IGT Income/Expense	-	-	-	0.0%
-	-	-	0.0%	Other Income/Expense	-	-	-	0.0%
-	-	-	**0.0%**	**Total Non-Operating Income (Loss)**	-	-	-	**0.0%**
(10,516)	**(916,666)**	**906,150**	**98.9%**	**Change in Net Assets**	**(10,516)**	**(1,833,332)**	**1,822,816**	**99.4%**
0.0%	***0.0%***	***0.0%***		***Medical Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	

CalOptima Health
Building - 505 City Parkway
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Administrative Expenses				
58,464	22,905	(35,559)	(155.2%)	Purchased Services	406,729	183,240	(223,489)	(122.0%)
181,030	195,000	13,970	7.2%	Depreciation & Amortization	1,447,508	1,560,000	112,492	7.2%
24,795	26,654	1,859	7.0%	Insurance Expense	197,993	213,232	15,239	7.1%
130,194	181,186	50,992	28.1%	Repair & Maintenance	953,238	1,449,488	496,250	34.2%
42,864	56,824	13,960	24.6%	Other Operating Expenses	473,447	454,592	(18,855)	(4.1%)
(437,346)	(482,569)	(45,223)	(9.4%)	Indirect Cost Allocation, Occupancy	(3,478,915)	(3,860,552)	(381,637)	(9.9%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

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CalOptima Health
Building - 500 City Parkway
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
156,423	135,866	20,557	15.1%	Rental Income	1,251,387	1,086,928	164,459	15.1%
156,423	**135,866**	**20,557**	**15.1%**	**Total Operating Revenue**	**1,251,387**	**1,086,928**	**164,459**	**15.1%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
39,723	9,330	(30,393)	(325.8%)	Purchased Services	327,353	74,640	(252,713)	(338.6%)
58,789	51,000	(7,789)	(15.3%)	Depreciation & Amortization	432,973	408,000	(24,973)	(6.1%)
8,226	8,746	520	6.0%	Insurance Expense	66,075	69,968	3,893	5.6%
(19,777)	94,592	114,369	120.9%	Repair & Maintenance	364,963	756,736	391,773	51.8%
19,722	25,978	6,256	24.1%	Other Operating Expenses	205,698	207,824	2,126	1.0%
(11,298)	-	11,298	100.0%	Indirect Cost Allocation, Occupancy	(147,951)	-	147,951	100.0%
95,385	**189,646**	**94,261**	**49.7%**	**Total Administrative Expenses**	**1,249,112**	**1,517,168**	**268,056**	**17.7%**
61,039	**(53,780)**	**114,819**	**213.5%**	**Change in Net Assets**	**2,275**	**(430,240)**	**432,515**	**100.5%**

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CalOptima Health
Building - 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Eight Months Ending February 28, 2025

Month to Date					Year to Date			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
-	-	-	0.0%	Professional Fees	-	-	-	0.0%
29,226	42,500	13,274	31.2%	Purchased Services	219,693	340,000	120,307	35.4%
9,397	21,000	11,603	55.3%	Depreciation & Amortization	75,179	168,000	92,821	55.3%
4,751	-	(4,751)	(100.0%)	Insurance Expense	36,998	-	(36,998)	(100.0%)
298	-	(298)	(100.0%)	Repair & Maintenance	1,880	-	(1,880)	(100.0%)
671	-	(671)	(100.0%)	Other Operating Expenses	7,777	-	(7,777)	(100.0%)
-	-	-	0.0%	Indirect Cost Allocation, Occupancy	-	-	-	0.0%
44,343	**63,500**	**19,157**	**30.2%**	**Total Administrative Expenses**	**341,527**	**508,000**	**166,473**	**32.8%**
(44,343)	**(63,500)**	**19,157**	**30.2%**	**Change in Net Assets**	**(341,527)**	**(508,000)**	**166,473**	**32.8%**

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OTHER PROGRAM INCOME STATEMENTS – FEBRUARY MONTH:

PACE

- **CHANGE IN NET ASSETS** is $1.3 million, favorable to budget $1.1 million

MSSP

- **CHANGE IN NET ASSETS** is ($91,555), favorable to budget $16,920

Covered CA

- **CHANGE IN NET ASSETS** is ($10,516), favorable to budget $0.9 million

NON-OPERATING INCOME STATEMENTS – FEBRUARY MONTH:

BUILDING 500 City Parkway

- **CHANGE IN NET ASSETS** is $61,039, favorable to budget $114,819
  - Net of $156,423 in rental income and $95,385 in expenses

BUILDING 7900 Garden Grove Blvd

- **CHANGE IN NET ASSETS** is ($44,343), favorable to budget $19,157

INVESTMENT INCOME

- Favorable variance of $12.1 million due to $6.1 million of interest income and $6.0 million of realized and unrealized gain on investments

CalOptima Health
Balance Sheet
February 28, 2025

		February-25	January-25	$ Change	% Change
ASSETS					
Current Assets					
	Cash and Cash Equivalents	545,443,753	470,286,895	75,156,858	16.0%
	Short-term Investments	1,690,602,820	1,717,421,060	(26,818,240)	(1.6%)
	Capitation Receivable	783,309,713	728,404,881	54,904,833	7.5%
	Receivables - Other	103,780,166	97,673,244	6,106,922	6.3%
	Prepaid Expenses	14,345,130	13,759,190	585,940	4.3%
	Total Current Assets	**3,137,481,583**	**3,027,545,271**	**109,936,312**	**3.6%**
Board Designated Assets					
	Board Designated Reserves	1,099,610,141	1,091,569,915	8,040,227	0.7%
	Statutory Designated Reserves	137,695,651	136,311,403	1,384,248	1.0%
	Total Designated Assets	**1,237,305,792**	**1,227,881,318**	**9,424,475**	**0.8%**
Restricted Deposit		**300,000**	**300,000**	**-**	**0.0%**
Capital Assets, Net		**101,712,674**	**101,508,156**	**204,518**	**0.2%**
Total Assets		**4,476,800,050**	**4,357,234,744**	**119,565,306**	**2.7%**
Deferred Outflows of Resources					
	Advance Discretionary Payment	49,999,717	49,999,717	-	0.0%
	Net Pension	24,549,290	24,549,290	-	0.0%
	Other Postemployment Benefits	1,350,000	1,350,000	-	0.0%
	Total Deferred Outflows of Resources	**75,899,007**	**75,899,007**	**-**	**0.0%**
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		**4,552,699,057**	**4,433,133,751**	**119,565,306**	**2.7%**
LIABILITIES					
Current Liabilities					
	Accounts Payable	415,216,496	351,118,555	64,097,941	18.3%
	Medical Claims Liability	1,052,855,253	1,070,061,981	(17,206,727)	(1.6%)
	Accrued Payroll Liabilities	23,986,317	23,142,071	844,246	3.6%
	Deferred Revenue	47,557,277	44,342,333	3,214,944	7.3%
	Other Current Liabilities	-	-	-	0.0%
	Capitation & Withholds	134,430,791	128,169,083	6,261,708	4.9%
	Total Current Liabilities	**1,674,046,135**	**1,616,834,023**	**57,212,112**	**3.5%**
GASB 96 Subscription Liabilities		18,048,802	20,237,234	(2,188,432)	(10.8%)
Community Reinvestment		138,415,777	128,162,741	10,253,036	8.0%
Capital Lease Payable		262,741	266,593	(3,852)	(1.4%)
Postemployment Health Care Plan		17,635,604	17,607,889	27,715	0.2%
Net Pension Liability		45,981,359	45,981,359	-	0.0%
Total Liabilities		**1,894,390,418**	**1,829,089,839**	**65,300,578**	**3.6%**
Deferred Inflows of Resources					
	Net Pension	2,248,445	2,248,445	-	0.0%
	Other Postemployment Benefits	6,398,000	6,398,000	-	0.0%
	Total Deferred Inflows of Resources	**8,646,445**	**8,646,445**	**-**	**0.0%**
Net Position					
	Required TNE	123,552,530	129,294,670	(5,742,140)	(4.4%)
	Funds in excess of TNE	2,526,109,664	2,466,102,797	60,006,867	2.4%
	Total Net Position	**2,649,662,194**	**2,595,397,467**	**54,264,727**	**2.1%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION		**4,552,699,057**	**4,433,133,751**	**119,565,306**	**2.7%**

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BALANCE SHEET – FEBRUARY MONTH:

ASSETS of $4.6 billion increased $119.6 million from January or 2.7%

- Capitation Receivables increased $54.9 million due to the timing of cash receipts
- Operating Cash and Short-term Investments net increase of $48.3 million due to the timing of cash disbursements
- Board Designated Reserves increased $9.4 million due to a decrease in long term interest rates resulting in an increase in the value of fixed income investments

LIABILITIES of $1.9 billion increased $65.3 million from January or 3.6%

- Accounts Payable increased $64.1 million due primarily to the MCO tax accrual
- Community Reinvestment increased $10.3 million due to CY 2025 accrual
- Capitation & Withholds increased $6.3 million due to provider quality incentive program accruals
- Medical Claims Liabilities decreased $17.2 million

NET ASSETS of $2.6 billion, increased $54.3 million from January or 2.1%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of February 28, 2025

Board Designated Reserves

Investment Account Name	Market Value	Benchmark		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	549,962,291				
MetLife Tier One	549,647,850				
Board Designated Reserves	1,099,610,141	941,215,552	1,129,458,663	158,394,589	(29,848,521)
Current Reserve Level (X months of average monthly revenue) [1]	*2.92*	*2.50*	*3.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	Benchmark		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	68,965,593				
MetLife Tier Two	68,730,059				
Statutory Designated Reserves	137,695,651	123,552,530	135,907,783	14,143,121	1,787,868
Current Reserve Level (X min. TNE) [1]	*1.11*[2]	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

[2] *Adjustment to Statutory Designated Reserves made on March 17, 2025 to lower the current reserve level*

CalOptima Health
Statement of Cash Flow
February 28, 2025

	February 2025	July 2024 - February 2025
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	54,264,727	204,580,019
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation & Amortization	984,629	7,878,469
Changes in assets and liabilities:		
Prepaid expenses and other	(585,940)	(3,176,011)
Capitation receivable	(61,011,754)	(332,403,396)
Medical claims liability	(17,206,727)	(98,988,871)
Deferred revenue	3,214,944	32,296,114
Payable to health networks	6,261,708	(41,802,903)
Accounts payable	64,097,941	242,896,889
Accrued payroll	871,961	(1,634,747)
Other accrued liabilities	8,060,752	33,078,442
Net cash provided by/(used in) operating activities	58,952,240	42,724,006
GASB 68, GASB 75 and Advance Discretionary Payment Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES:		
Change in Investments	26,818,240	87,293,119
Change in Property and Equipment	(1,189,147)	(13,030,335)
Change in Restricted Deposit & Other	-	-
Change in Board Designated Reserve	(9,424,475)	(99,542,354)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	16,204,618	(25,279,570)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	75,156,858	17,444,436
CASH AND CASH EQUIVALENTS, beginning of period	470,286,895	527,999,317
CASH AND CASH EQUIVALENTS, end of period	**545,443,753**	**545,443,753**

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CalOptima Health
Spending Plan
For the Eight Months Ending February 28, 2025

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 2/28/2025	**$2,649.7**			**100.0%**
Resources Assigned	Board Designated Reserve[1]	**$1,099.6**			**41.5%**
	Statutory Designated Reserve[1]	**$137.7**			**5.2%**
	Capital Assets, net of Depreciation[2]	**$101.7**			**3.8%**
Resources Allocated[3]	Homeless Health Initiative[3]	$15.9	$61.7	$45.8	0.6%
	Housing and Homelessness Incentive Program[3]	22.1	87.4	65.3	0.8%
	Intergovernmental Transfers (IGT)	54.5	111.7	57.2	2.1%
	Digital Transformation and Workplace Modernization[4]	40.4	100.0	59.6	1.5%
	Mind OC Grant (Orange)	0.1	1.0	0.9	0.0%
	CalFresh Outreach Strategy	0.0	2.0	2.0	0.0%
	CalFresh and Redetermination Outreach Strategy	2.0	6.0	4.0	0.1%
	Coalition of Orange County Community Health Centers Grant	20.0	50.0	30.0	0.8%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	OneCare Member Health Rewards and Incentives	0.2	0.5	0.3	0.0%
	General Awareness Campaign	1.1	4.7	3.6	0.0%
	Member Health Needs Assessment	1.1	1.3	0.2	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	125.8	153.5	27.7	4.7%
	Medi-Cal Annual Wellness Initiative	2.5	3.8	1.3	0.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.4%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program Grant	3.5	5.0	1.5	0.1%
	Community Living and PACE center (previously approved for project located in Tustin)	17.6	18.0	0.4	0.7%
	Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program Grant	2.1	2.7	0.6	0.1%
	CalOptima Health Provider Workforce Development Fund Grant	44.5	50.0	5.5	1.7%
	Distribution Event - Naloxone Grant	2.2	15.0	12.8	0.1%
	Garden Grove Bldg. Improvement	10.0	10.5	0.5	0.4%
	Post-Pandemic Supplemental	6.2	107.5	101.3	0.2%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	1.4%
	Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
	Outreach Strategy for newly eligible Adult Expansion members	3.8	7.6	3.8	0.1%
	Quality Initiatives from unearned Pay for Value Program	18.5	23.3	4.8	0.7%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.4	1.0	0.6	0.0%
	Medi-Cal Provider Rate Increases	385.9	526.2	140.3	14.6%
	Homeless Prevention and Stabilization Pilot Program	0.3	0.3	0.0	0.0%
	OneCare Member Engagement and Education	0.3	0.3	0.0	0.0%
	Subtotal:	**$832.0**	**$1,422.8**	**$590.7**	**31.4%**
Resources Available for New Initiatives	Unallocated/Unassigned[1]	**$478.6**			**18.1%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 147 days of CalOptima Health's current operations.
[2] Increase due to the adoption of GASB 96 Subscription-Based Information Technology Arrangements.
[3] See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.
[4] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

CalOptima Health
Key Financial Indicators
As of February 28, 2025

	Item Name	February 2025					July - February 2025				
		Actual	Budget	Variance	%		Actual	Budget	Variance	%	
Income Statement	Member Months	915,201	900,877	14,324	1.6%		7,307,781	7,204,815	102,966	1.4%	
	Operating Revenue	404,370,448	359,579,579	44,790,869	12.5%		3,226,637,951	2,852,425,304	374,212,647	13.1%	
	Medical Expenses	348,372,956	335,719,673	(12,653,283)	(3.8%)		2,977,380,617	2,838,113,466	(139,267,151)	(4.9%)	
	General and Administrative Expense	20,185,499	24,916,532	4,731,033	19.0%		165,431,075	196,225,767	30,794,692	15.7%	
	Non-Operating Income/(Loss)	18,452,735	5,370,555	13,082,180	243.6%		120,753,760	43,055,349	77,698,411	180.5%	
	Summary of Income & Expenses	54,264,727	4,313,929	49,950,798	1,157.9%		204,580,019	(138,858,580)	343,438,599	247.3%	

Ratios	Medical Loss Ratio (MLR)	Actual	Budget	Variance		Actual	Budget	Variance	
	Consolidated	86.2%	93.4%	(7.2%)		92.3%	99.5%	(7.2%)	

	Administrative Loss Ratio (ALR)	Actual	Budget	Variance		Actual	Budget	Variance	
	Consolidated	5.0%	6.9%	1.9%		5.1%	6.9%	1.8%	

Key:

> 0%	
> -20%, < 0%	
< -20%	

Investment	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
	@2/28/2025	2,904,076,737	2,921,329,201	(17,252,464)	(0.6%)

Unallocated/Unassigned Reserve Balance	Current Month @ February 2025	Fiscal Year Ending June 2024	Change	%
Consolidated	478,615,163	187,643,914	290,971,248	155.1%
*Days Cash On Hand**	147			

*Total Designated Reserves and unallocated reserve amount can support approximately 147 days of CalOptima Health's current operations.

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CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Eight Months Ending February 28, 2025

	February 2025				July 2024 - February 2025				All Time to Date			
	Actual Spend	Approved Budget	Variance $	Variance %	Actual Spend	Approved Budget	Variance $	Variance %	Actual Spend	Approved Budget	Variance $	Variance %
Capital Assets (Cost, Information Only):												
Total Capital Assets	**1,509,813**	**1,041,246**	**(468,567)**	**(45.0%)**	**5,117,977**	**2,711,982**	**(2,405,995)**	**(88.7%)**	**13,560,837**	**26,775,691**	**13,214,854**	**49.4%**
Operating Expenses:												
Salaries, Wages & Benefits	504,026	589,848	85,822	14.5%	4,581,322	4,718,784	137,462	2.9%	15,587,589	15,725,051	137,462	0.9%
Professional Fees	(72,364)	567,319	639,683	112.8%	3,429,919	4,213,222	783,303	18.6%	5,190,982	5,974,285	783,303	13.1%
Purchased Services	24,040	142,000	117,960	83.1%	153,103	1,136,000	982,897	86.5%	303,103	1,286,000	982,897	76.4%
GASB 96 Amortization Expenses	51,082	293,417	242,335	82.6%	387,637	2,347,336	1,959,699	83.5%	2,358,840	4,318,539	1,959,699	45.4%
Other Expenses	609,720	703,444	93,723	13.3%	4,523,365	5,952,882	1,429,517	24.0%	18,052,857	19,482,374	1,429,517	7.3%
Medical Management	229,256	-	(229,256)	0.0%	1,834,052	-	(1,834,052)	0.0%	4,585,130	2,751,078	(1,834,052)	(66.7%)
Total Operating Expenses	**1,345,761**	**2,296,028**	**950,267**	**41.4%**	**14,909,397**	**18,368,224**	**3,458,827**	**18.8%**	**46,078,501**	**49,537,327**	**3,458,827**	**7.0%**

Funding Balance Tracking:	**Approved Budget**	**Actual Spend**	**Variance**
Beginning Funding Balance	100,000,000	100,000,000	-
Less:			
Capital Assets[1]	31,525,709	13,560,837	17,964,872
FY2023 Operating Budget[2]	8,381,011	8,381,011	-
FY2024 Operating Budget	22,788,092	22,788,092	-
FY2025 Operating Budget	27,552,335	14,909,397	12,642,938
Ending Funding Balance	**9,752,853**	**40,360,663**	**30,607,810**
Add: Prior year unspent Operating Budget	-		
Total Available Funding	**9,752,853**		

[1] Staff will continue to monitor the project status of DTS' Capital Assets.
[2] Unspent budget from this period is added back to available DTS funding.
[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

Note: Report includes applicable transactions for GASB 96, Subscriptions - Based Information Technology Arrangements.

CalOptima Health
Summary of Homeless Health Initiatives (HHI) and Allocated Funds
As of February 28, 2025

Funds Allocation, approved initiatives:	**Allocated Amount**	**Utilized Amount**	**Remaining Approved Amount**
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-
Recuperative Care	6,194,190	6,194,190	-
Medical Respite	250,000	250,000	-
Day Habilitation (County for HomeKey)	2,500,000	2,500,000	-
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	879,957	83,304
FQHC (Community Health Center) Expansion	21,902	21,902	-
HCAP and CalOptima Health Days	9,888,914	3,883,740	6,005,173
Vaccination Intervention and Member Incentive Strategy	123,348	54,649	68,699
Street Medicine[1]	10,076,652	7,333,162	2,743,490
Outreach and Engagement	7,000,000	-	7,000,000
Housing and Homelessness Incentive Program (HHIP)[2]	40,100,000	-	40,100,000
Subtotal of Approved Initiatives	**$101,800,000**	**$45,755,811**	**$56,044,188**
Transfer of funds to HHIP[2]	(40,100,000)	-	(40,100,000)
Program Total	**$61,700,000**	**$45,755,811**	**$15,944,188**

Notes:

[1]On March 7, 2024, CalOptima Health's Board of Directors approved $5 million to expand the Street Medicine Program. $3.2 million remaining from Street Medicine Initiative (from the HHI reserve) and $1.8 million from existing reserves to fund 2-year agreements to Healthcare in Action (Anaheim) and Celebrating Life Community Health Center (Costa Mesa).

[2]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1 million from HHI to HHIP.

CalOptima Health
Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds
As of February 28, 2025

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	54,930,994	28,988,750	25,942,244	18,000,195[1]
Existing Reserves & HHI Transfer	87,384,530	87,384,530	65,324,503	22,060,027	-
Total	**160,315,719**	**142,315,524**	**94,313,253**	**48,002,271**	**18,000,195**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	1,400,000	832,350	567,650	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,321,311	1,300,000	HHI & DHCS
Infrastructure Projects	5,832,314	5,391,731	440,583	HHI
Capital Projects	108,247,369	77,195,575	31,051,794	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	4,863,856	5,320,674	DHCS
Non-Profit Healthcare Academy	700,000	508,429	191,571	DHCS
Total of Approved Initiatives	**$133,185,524[1]**	**$94,313,252**	**$38,872,272**	

Notes:
[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments.

CalOptima Health
Budget Allocation Changes
Reporting Changes as of February 28, 2025

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	ITS - Applications Management - System Development Enhancement for CalAIM	ITS - Applications Management - Care Management System - ZeOmega JIVA	$249,000	To reallocate funds from ITS - Applications Management - System Development Enhancement for CalAIM to Care Management System – ZeOmega JIVA for reporting post Go Live.	2024-25
July	Medi-Cal	Accounting - Purchased Services	Accounting - Printing and Postage	$20,000	To reallocate funds from Accounting - Purchased Services to Accounting – Printing and Postage to provide additional funding for toner purchase.	2024-25
August	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - VMWare	ITS - Infrastructure - Other Operating Expenses - IT Service Management	$38,490	To reallocate funds from ITS - Infrastructure - Maintenance HW/SW - Server - VMWare to IT Service Management to address additional licensing needs and increased costs for the Impact Guide.	2024-25
August	Medi-Cal	IS - Applications Management - Professional Fees - Salesforce CRM	ITS - Applications Management - Other Operating Expenses - Crowe Subscription License Fee	$38,500	To reallocate funds from ITS - Applications Management - Salesforce CRM to Crowe Subscription License Fee to provide funding needed for its licensing.	2024-25
August	Medi-Cal	ITS - Infrastructure - Modern Customer Contact Center	ITS - Infrastructure - Network Bandwidth Upgrade for All Sites (Wide Area Network)	$10,349	To reallocate funds from ITS - Infrastructure - Modern Customer Contact Center to Network Bandwidth Upgrade for All Sites (Wide Area Network) due to increase in expenses.	2024-25
August	Medi-Cal	ITS - Infrastructure - Modern Customer Contact Center	ITS - Application Development - Digital Transformation Strategy Planning and Execution Support	$32,425	To reallocate funds from ITS - Infrastructure - Modern Customer Contact Center to Digital Transformation Strategy Planning and Execution Support due to increase in expenses.	2024-25
August	Medi-Cal	ITS - Infrastructure - Modern Customer Contact Center	ITS - Applications Management - Clinical Data Sets Quality Assurance & Data Aggregator Validation	$70,000	To reallocate funds from ITS - Infrastructure - Modern Customer Contact Center to Clinical Data Sets Quality Assurance & Data Aggregator Validation due to increase in expenses.	2024-25
August	Medi-Cal	ITS - Application Development - Other Operating Expenses - Veracode Code Scanning	Executive Office - Other Operating Expenses - CEO Leadership Alliance of Orange County (CLAOC)	$40,000	To reallocate funds from ITS - Application Development - Veracode Code Scanning to Executive Office - CEO Leadership Alliance of Orange County (CLAOC) Associations dues.	2024-25
September	OneCare	Communications - Purchased Services - Advertising	Communications - Professional Fees	$144,000	To reallocate funds from Communications - Advertising - Outdoor to Professional Fees to provide additional funding for Runyon Saltzman for Marketing.	2024-25
September	Medi-Cal	ITS - Applications Management - Other Operating Expenses - HW/SW Maintenance	Executive Office - Other Operating Expenses - Professional Dues	$50,000	To reallocate funds from ITS - Applications Management - HW/SW Maintenance to Executive Office - Professional Dues for coverage of expenses.	2024-25
September	Medi-Cal	Accounting - Purchased Services	Accounting - Other Operating Expenses - Office Supplies	$15,000	To reallocate funds from Accounting - Change Health Care - Claims Processing/Mailing to Office Supplies to provide additional funding needed to replenish check stock.	2024-25
September	PACE	PACE Administrative - Professional Fees	PACE Administrative - Other Operating Expenses - Subscriptions	$15,000	To reallocate funds from PACE Administrative - DHCS Annual Fee to Subscriptions to provide funding for DHCS PACE Licensing Fees.	2024-25
September	Medi-Cal	ITS - Application Development - Other Operating Expenses - HW/SW Maintenance	ITS - Applications Management - Other Operating Expenses - Care Management System - HealthEdge	$158,000	To reallocate funds from ITS - Application Development - Capital Software Expense to ITS - Applications Management - HealthEdge to help pay for Guiding Care Read Only invoice.	2024-25
September	OneCare	Sales & Marketing - Purchased Services	ITS - Applications Management - Professional Fees	$50,000	To reallocate funds from Sales & Marketings - Purchased Services - General to ITS - Applications Management – Enthrive to engage Enthrive for additional builds to the agent portal.	2024-25
September	Medi-Cal	ITS - Infrastructure - Professional Fees	ITS - Infrastructure - Other Operating Expenses - Subscriptions	$32,000	To reallocate funds from ITS - Infrastructure - MSFT Azure Assistance to Delphix - Continuous Data FACETS to cover the renewal subscription being higher than the anticipated amount.	2024-25
November	PACE	PACE Marketing - Member Communication	PACE Marketing - Advertising	$84,000	To reallocate funds from PACE Marketing - Printing and Postage to Purchased Services to provide additional funding needed for advertisement extension.	2024-25
December	Medi-Cal	Executive Office - Professional Fees	Executive Office - Professional Dues	$30,000	To reallocate fund from Executive Office - Professional Fees to Other Operating Expenses - Professional Dues for the Center for Corporate Innovation Membership due.	2024-25
January	Medi-Cal	Medical Management - Professional Fees	Medical Management - Other Operating Expenses - Training & Seminars	$40,000	To reallocate funds from Medical Management - Professional Fees to Other Operating Expenses - Training & Seminars for the Mandatory DHCS Training.	2024-25
January	OneCare	Quality Analytics - Purchased Services	Case Management - Purchased Services	$50,000	To reallocate funds from Quality Analytics - Purchase Services to Case Management - Purchase Services for the OC Members Health Education training.	2024-25
January	Medi-Cal	ITS - Application Development - Other Operating Expenses - HW/SW Maintenance	ITS - Applications Management - Other Operating Expenses - HW/SW Maintenance	$20,000	To reallocate funds from IS - Application Development - Other Operating Expenses - HW/SW Maintenance to IS - Application Management - Other Operating Expenses - HW/SW Maintenance for additional Subscription License fees.	2024-25
January	Medi-Cal	IS - Application Development - Human Resources Electronic Record System	IS - Application Development - Human Resources Capital Management Solution Software	$40,000	To reallocate funds from IS - Application Development - Human Resources Electronic Record System project to Human Resources Capital Management Solution Software project due to project schedule extension.	2024-25
January	Medi-Cal	IS - Application Development - Human Capital Management Integration	IS - Application Development - Human Resources Capital Management Solution Software	$63,000	To reallocate funds from IS - Application Development - Human Capital Management Integration project to Human Resources Capital Management Solution Software project due to project schedule extension.	2024-25
January	Medi-Cal	IS - Infrastructure - Compliance and Risk Management System	IS - Infrastructure - Technology Asset Inventory Tracking Application	$100,000	To reallocate funds from IS - Infrastructure - Compliance and Risk Management System project to Technology Asset Inventory Tracking Application for addition of Service Mapping and Cloud Discovery for ServiceNow.	2024-25
January	Medi-Cal	Claims Administration - Purchased Services	ITS - Applications Management - Professional Fees	$27,000	To reallocate funds from Claims Administration - Purchased Services - General to ITS - Applications Management - Professional Fees for Moss Adams additional Audit Tool customization/enhancements.	2024-25
January	Medi-Cal	ITS - Applications Management - Professional Fees	ITS - Applications Management - Other Operating Expenses - HW/SW Maintenance	$48,000	To reallocate funds from ITS - Applications Management - Professional Fees to Other Operating Expenses - Maintenance HW/SW for Moss Adams Audit Tools.	2024-25
February	OneCare	Communications - Printing and Postage - Member Communication	Communications - Professional Fees	$105,000	To reallocate funds from Communications - Printing and Postage - Member Communication to Professional Fees to start the initial development of the Caregiver Campaign.	2024-25
February	PACE	PACE Marketing - Printing and Postage - Member Communication	PACE Marketing - Other Operating Expenses - Public Activities	$10,970	To reallocate funds from PACE Marketing - Printing and Postage - Member Communication to Other Operating Expenses - Public Activities for promotional items.	2024-25
February	Medi-Cal	Facilities - Other Operating Expenses - Computer Supply/Minor Equipment	Facilities - Other Operating Expenses - Repairs & Maintenance - Building	$100,000	To reallocate funds from Facilities - Other Operating Expenses - Comp supply/Minor Equipment to Repairs & Maintenance - Building for 7th and 9th break rooms.	2024-25
February	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Subscriptions	ITS - Infrastructure - Other Operating Expenses - HW/SW Maintenance	$24,140	To reallocate funds from ITS - Infrastructure - Other Operating Expenses - Subscriptions to HW/SW Maintenance for additional Palo Alto licenses.	2024-25
February	Medi-Cal	Cyber Security - Other Operating Expenses - Subscriptions	ITS - Infrastructure - Professional Fees	$240,000	To reallocate funds from Cyber Security - Other Operating Expenses - Subscriptions to IS - Infrastructure - Professional Fees for the funding of new scope of work for Axis Data Masking.	2024-25
February	Medi-Cal	Facilities - Printing and Postage - Postage	Facilities - Professional Fees	$60,000	To reallocate fund from Facilities - Printing and Postage - Postage to Professional Fees to fund CBRE real estate services.	2024-25
February	Medi-Cal	Facilities - Office Tenant Improvements	505 Building - Front/Back Entrance Door Upgrade	$30,978	To reallocate funds from Office Tenant Improvements to Front/Back Entrance Door Upgrade for Building 505 Lobby Door Replacement.	2024-25
February	Medi-Cal	Cyber Security - Other Operating Expenses - HW/SW Maintenance	Enterprise Data and Systems Integrations - Other Operating Expenses - Maint HW/SW - GASB 96 -	$80,000	To reallocate funds from Cyber Security - Other Operating Expenses - Maint HW/SW to Enterprise Data and Systems Integrations - Other Operating Expenses - Maint HW/SW - GASB 96 - Variable Exp DTS for Edifecs Contract Renewal.	2024-25
February	Medi-Cal	ITS - Application Development - Purchased Services	ITS - Application Development - Other Operating Expenses - HW/SW Maintenance	$150,000	To reallocate funds from IS-Application Development - Purchase Services to Other Operating Expenses - Maintenance HW/SW for Secure Auth and DayForce InView.	2024-25

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $250,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Board of Directors Meeting
April 3, 2025

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima Health's Board of Directors including, but not limited to, updates on internal and health network monitoring and audits conducted by CalOptima Health's Delegation Oversight and Internal Audit departments, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. Medicare

a. **2025 Department of Managed Health Care (DMHC) Routine Financial Examination:**

Update

- February 11, 2025 – Plan Representation letter submitted to DMHC.
- February 25, 2025 – DMHC issued Preliminary Findings Report.
  - One (1) deficiency noted related to the Plan's failure to timely file four (4) key personnel/management changes with DMHC. A Corrective Action Plan (CAP) has been issued to the impacted operational area.
- CalOptima Health has 45 calendar days to review and respond to the Preliminary Findings Report. The internal deadline to review and provide a response is March 19, 2025.

Previously Reported

- Pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act, the DMHC is responsible for conducting routine financial examinations of each health plan and issuing a public report for each plan.
- The purpose of the financial examinations is to evaluate and report on regulatory compliance with the Knox Keene Act. Each financial examination discusses plan performance in the areas of health plan fiscal and administrative functions.
- September 5, 2024 – the DMHC engaged CalOptima Health for the 2025 DMHC Routine Examination.
  - The examination will be of the Plan's fiscal and administrative affairs, including an examination of CalOptima Health's financial reports.
- January 31, 2025 – Audit sessions completed.

b. **2025 Centers for Medicare & Medicaid Services (CMS) Readiness Checklist *(applicable to OneCare)***

Update

- The validation audit activities have been completed and closed as of February 10, 2025.

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Previously Reported -- Background

- The 2025 CMS Readiness Checklist summarized a subset of key operational requirements solely for the purpose of providing a tool to be used in preparation for the upcoming year. It does not supersede requirements established in statutes or regulations as they related to Medicare Advantage Organizations (MAOs), Prescription Drug Plans (PDPs), 1876 Cost Plans and the Program of All-inclusive Care for the Elderly (PACE). CMS recommends that organizations review this checklist and take necessary steps to fulfill requirements for CY 2025.

c. **2025 Medicare Part C and Part D Data Validation Audit (MDVA) *(applicable to OneCare)***

Update

- February 21, 2025 – CalOptima Health completed the submission of all the Part C/D reporting measures to CMS.
- Regulatory Affairs and Compliance (RAC) Medicare has requested the business areas update the audit documents by March 12, 2025.
- Audit kick-off call scheduled for March 12, 2025. Audit sessions are to be conducted in April.

d. **2023 Medicare Part D Improper Payment Measure (IPM)**

Update

- February 18, 2025 – CalOptima Health submitted the requested prescription drug event (PDE) documentation.
- CMS informed the documentation passed the initial CMS validation checks.
- Awaiting Interim Findings Report.

Previously Reported - Background

- The Medicare Part D IPM is conducted to validate the accuracy of the PDE data submitted by Medicare Part D sponsors to CMS for CY 2023 payments. The results of these activities will be used to calculate a national program-wide improper payment rate for Medicare Part D.
- January 10, 2025 – CMS selected contract H5433 for the inclusion in the CY 2023 Medicare Part IPM.
- One PDE was selected.

2. Medi-Cal

a. 2025 Department of Health Care Services (DHCS) Routine Medical Audit

Update

- CalOptima Health awaits the issuance of DHCS's draft audit report.
- Regulatory Affairs and Compliance (RAC) Medi-Cal continues to work with internal business areas to address the preliminary findings, as necessary.

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Previously Reported

- January 27, 2025, through January 29, 2025 – DHCS was onsite to interview CalOptima Health staff.
  - DHCS initially planned to be onsite through February 7, 2025, however, determined that no follow-up sessions were needed.
- February 7, 2025 – DHCS hosted a preliminary exit conference via webinar.
  - Six preliminary findings were communicated during the exit conference.
- Anticipated Next Steps:
  - In approximately two to three months DHCS will send a draft audit report to CalOptima Health, which will be three (3) business days prior to the formal Exit Conference (date is to be determined).
  - During the Exit Conference, DHCS will explain the findings, and give CalOptima Health an opportunity to ask questions.
  - If CalOptima Health has any statements to express or wants to submit additional information, CalOptima Health must submit the response to DHCS, in writing, within 15 calendar days from the date of the Exit Conference.

Previously Reported – Audit Details and Background

- October 23, 2024 – DHCS engaged CalOptima Health in its annual, routine medical audit.
  - The audit will consist of an evaluation of CalOptima Health's compliance with its contract and regulations in six (6) categories:
    - Utilization management
    - Case management and coordination of care
      - New area to be audited in this category:
        - Enhanced Care Management (ECM)
    - Availability and accessibility
    - Member's rights
    - Quality management
    - Administrative and organizational capacity
      - New area to be audited in this category:
        - Encounters
  - New areas to be audited
    - Enhanced Care Management (ECM)
    - Encounters
  - The audit is considered a limited-scope audit and requires the participation of two (2) CalOptima Health Networks: Children's Hospital of Orange County Health Alliance (CHOC) and Optum for UM only
  - Onsite interviews will be conducted with CalOptima Health staff, including Medical Director, Director of Quality Management, Director of Utilization Management, Member Services Manager, Provider Relations Manager, Health Education Coordinator, Grievance Coordinator, and other staff as necessary.
  - The audit will involve a review of pre-onsite documents, staff interviews and medical record review.
- January 27, 2025 through February 7, 2025 – DHCS begin the onsite visit with an Entrance Conference and conduct staff interviews throughout the rest of the onsite visit.

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b. 2024 DHCS Routine Medical Audit

Update

- CalOptima Health awaits DHCS feedback on its February 2025 Corrective Action Plan (CAP) response.

Previously Reported

- DHCS provided a response on January 31, 2025, accepting 9 of the 10 CAPs.
  - The remaining CAP was pending evidence of a monitoring report, which was submitted to DHCS on February 5, 2025.
- CalOptima Health is awaiting DHCS review of the final scheduled deliverable.

Previously Reported – Audit Details and Background

- August 22, 2024 – CalOptima Health received a formal request for corrective action plan (CAP) from DHCS.
- September 23, 2024 – CalOptima Health provided its timely Corrective Action Plan (CAP) submission to DHCS.
  - CalOptima Health is required to submit monthly updates, on the 15th of each month, to DHCS until the final CAP deliverable is completed.
  - Final CAP deliverable is scheduled to be completed by January 2025
    - October 15, 2024 – CalOptima Health provided its first monthly update to DHCS following the initial CAP submission in September.
- For background the DHCS Routine Medical Audit consists of DHCS's review of both the Primary (aka "Main Contract") and Secondary contracts (aka "State Supported Services"). The findings are as follows:
  - Primary/Main Contract
    - Draft & Final Report Identified **10 Findings**
  - Secondary Contract - State Supported Services (SSS)
    - Draft & Final Report Identified **No Findings**

B. Regulatory Notices of Non-Compliance

- CalOptima Health did not receive any notices of non-compliance from its regulators for the month of February 2025.

C. Updates on Health Network Monitoring and Audits

a. Health Network Audits

- CalOptima Health's Delegation Oversight (DO) department completed annual audits on the following delegated health networks to assess their capabilities and performance with delegated activities:
  - Family Choice Medical Group/Family Choice Health Services/Conifer Health Solutions – Lookback December 1, 2023, to October 31, 2024.
- CalOptima Health's Delegation Oversight (DO) department completed an MSO Readiness audit on the following delegated health networks to assess their capabilities and performance with delegated activities:

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- Family Choice Medical Group/Family Choice Health Services/Family Choice Management Services/Altura MSO.

D. Internal Audit Department (IAD)

a. Internal Annual Audits in Progress

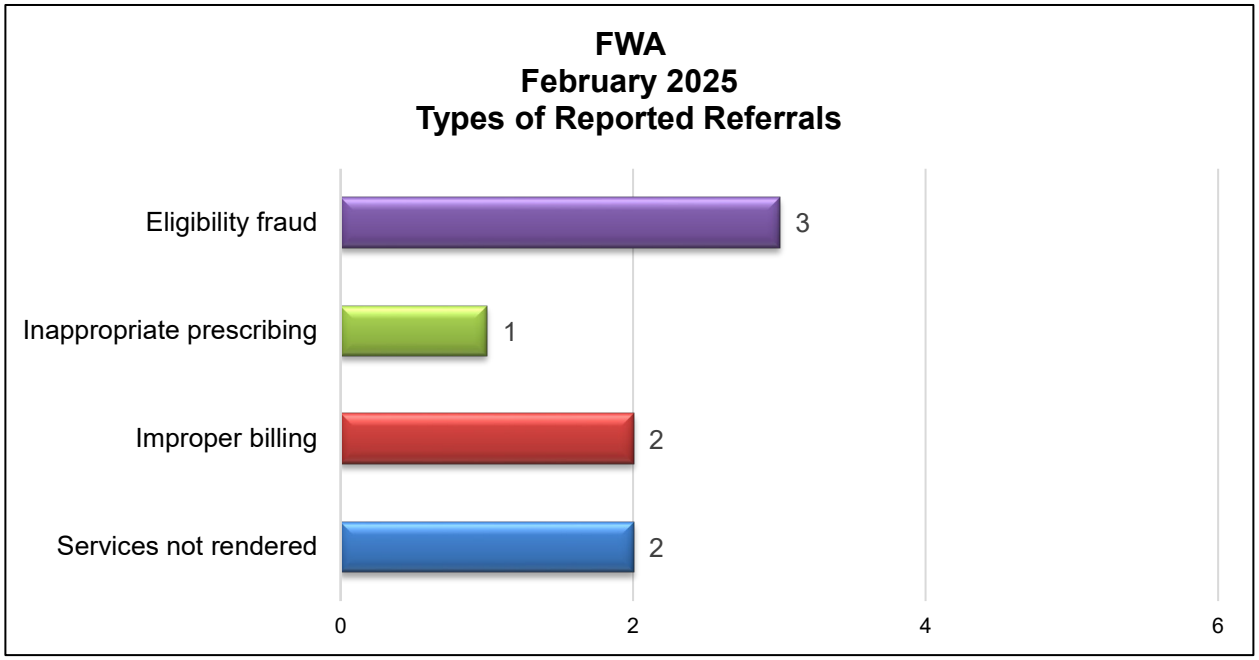
- 2024 Utilization Management (OneCare)
- 2024 Utilization Management (Medi-Cal)
  - Audit was closed-out effective 3/4/25
- 2024 Behavioral Health (BH) (Medi-Cal)
- 2024 Pharmacy (Medi-Cal)
- Pharmacy (OneCare) Annual Audit
- 2024 Grievance & Appeals Resolution (CDAG-OneCare)
- 2025 Access & Availability (Medi-Cal)
- 2025 Customer Service (Medi-Cal) Department
- 2025 Customer Service (OneCare) Department

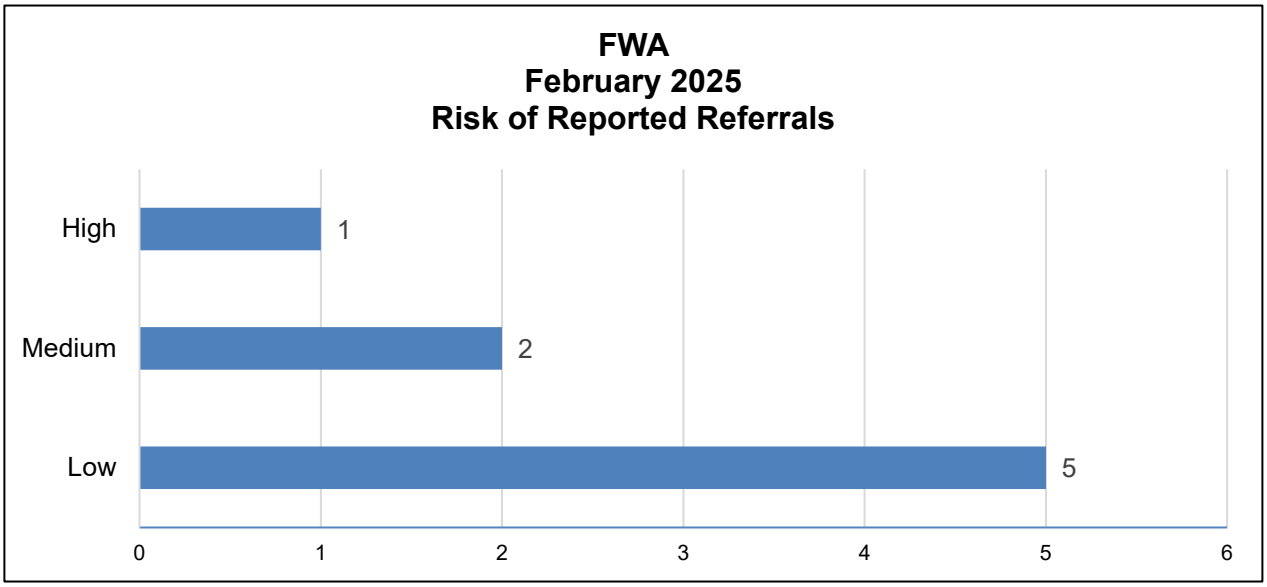
b. Board-Approved Grants and Initiatives Review

Grants currently under review include:

- Be Well/Mind OC, Irvine
  - Grant is in process. Review will resume upon close of grant in May-June 2025.
- Housing for Health Orange County
  - Grant is closed
- Talbert Medical Group dba Optum
  - Grant is closed

E. Fraud, Waste & Abuse (FWA) Investigations





Total Number of New Cases Referred to DHCS (State)	8
Total Number of New Cases Referred to DHCS and CMS	2
Total Number of Referrals Reported	**8**

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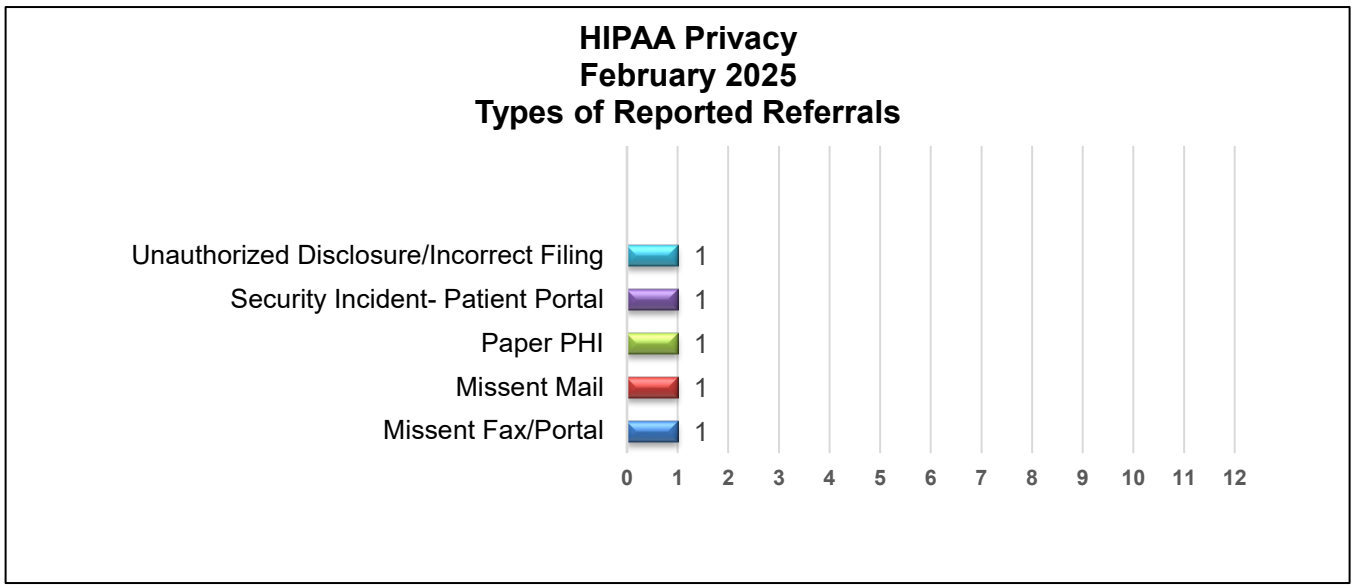
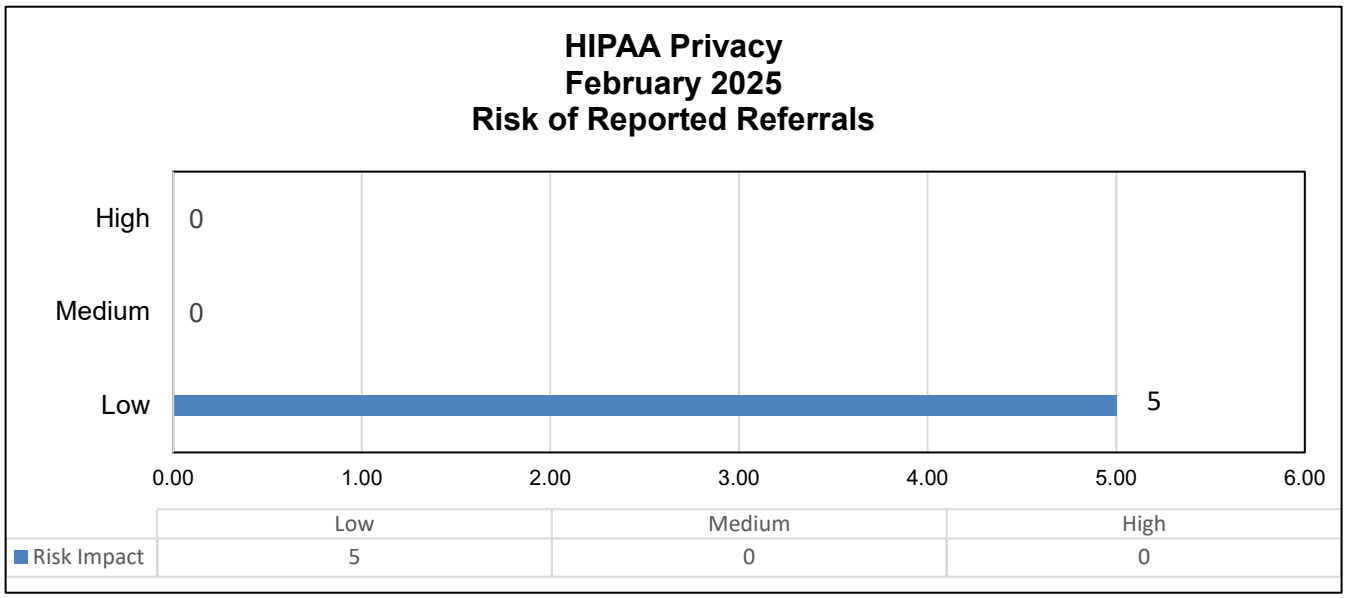
F. Privacy Update





Total Number of Referrals Reported to DHCS (State)	5
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

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Grievance and Appeals Resolution Services (GARS) Member Trend Report Calendar Year 2024

Board of Directors Meeting

April 3, 2025

Ladan Khamseh, Executive Director, 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.

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Agenda

- Definitions
- Executive Summary
- Grievance Volume and Trends
- Grievance Actions Taken
- Appeals Volume and Trends
- Appeals Actions Taken

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CalOptima Health

Definitions

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

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

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Executive Summary

- CalOptima Health received a total of 4,437 grievances and 387 appeals for the combined Medi-Cal and OneCare lines of business. The turnaround time for both complaint types remained compliant averaging a closure rate of 25 days.

Grievances

- Medi-Cal experienced a decrease in grievances from 4,387 in the third quarter to 4,018 in the fourth quarter, representing a decrease of 9% from the prior quarter. Grievance types making up the overall fourth quarter volume included dissatisfaction with Provider/Staff Attitude, transportation issues, and grievances related to provider services (no specific provider trends were identified).

- OneCare experienced a decrease in grievances from 486 in the third quarter to 419 in the fourth quarter, representing a decrease of 16%. Grievance types making up this volume included dissatisfaction with Provider/Staff Attitude, PAPA Pal grievances for service visits and transportation grievances regarding driver punctuality and scheduling.

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Executive Summary (Continued)

Appeals

- Medi-Cal experienced an increase in appeals from 328 in the third quarter to 346 in the fourth quarter, representing an increase of 5%, with an overturn rate decrease from 31% to 30%. Attributing to the overall appeal volume was appeals for redirections and modifications to community specialists and CalAim Personal Care/Homemaker Services.

- OneCare experienced a decrease in appeals from 50 in the third quarter to 41 in the fourth quarter representing a decrease of 18%, with an overturn rate increase from 33% to 44%. Contributing to the appeals volume were inpatient hospital care with non-contracted providers, redirected authorizations from tertiary providers to the community providers who can treat the condition, and DME requests.

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CalOptima Health

Grievances

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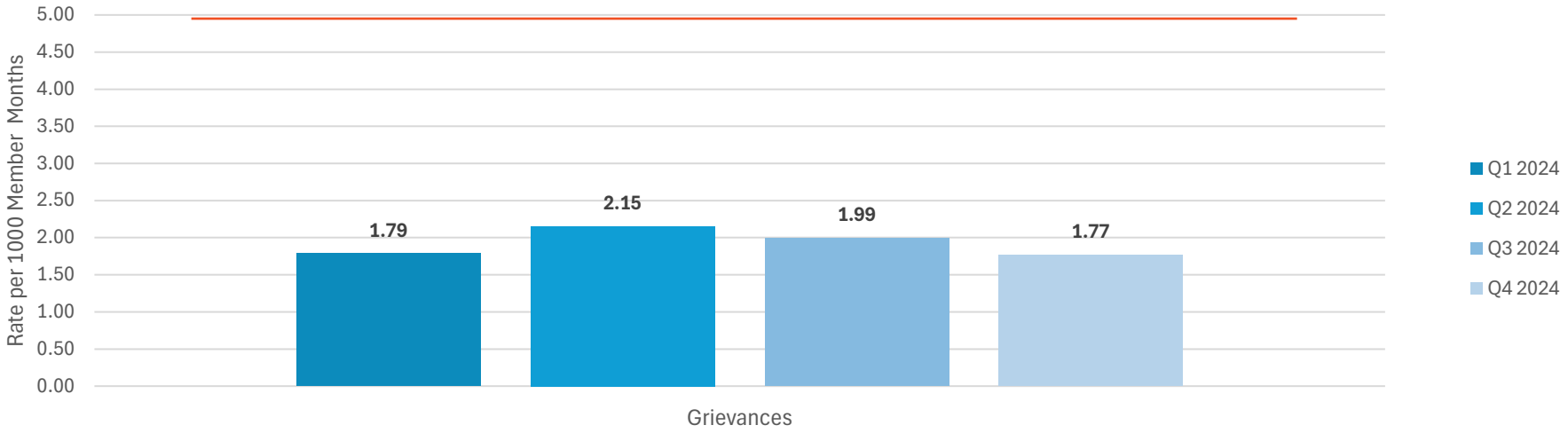
CalOptima Health

Grievance Volume and Compliance

Timeframe	Total Grievances
Q4-2024	4,437
Q3-2024	4,873
Q2-2024	4,593
Q1-2024	3,596

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



Complaint Type	Required Turn Around Time (TAT)	CalOptima Average TAT (Q3)	Compliance Percentage (Q4)
Grievances	30 Days	24 Days	99.9%

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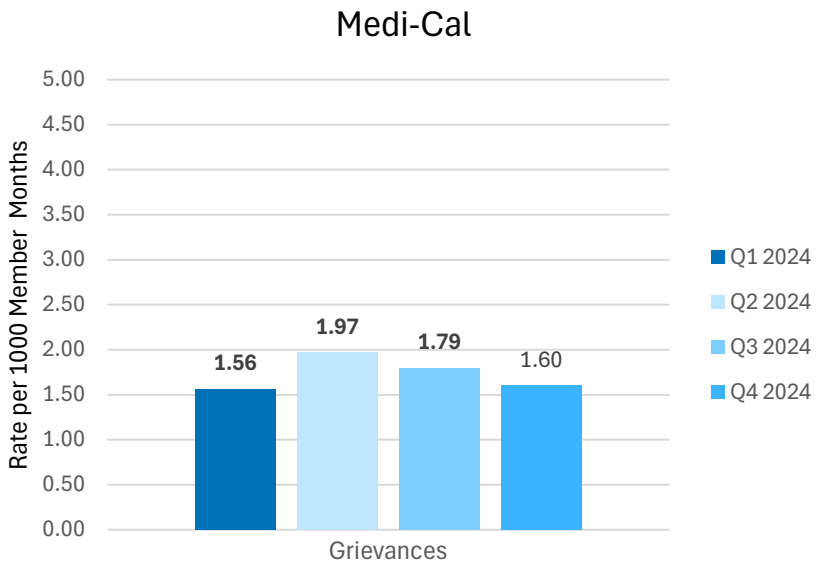
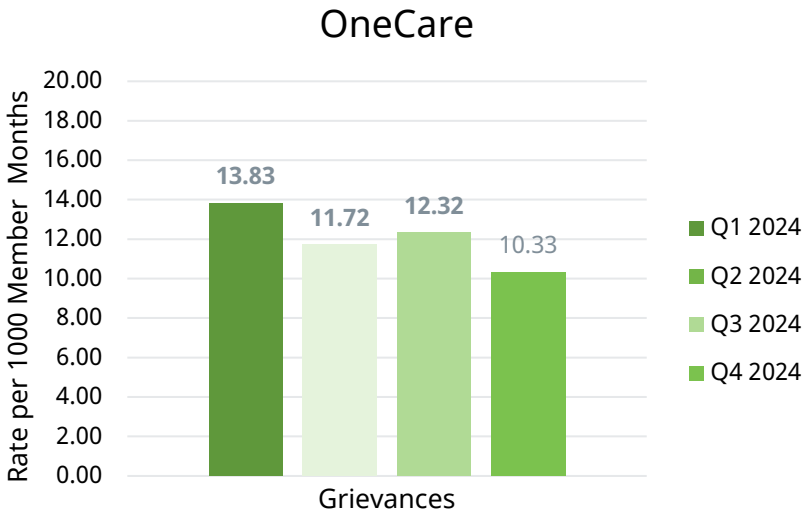
CalOptima Health

Grievance Volume by Line of Business (LOB)



Total Grievances

Q4 2024	4,018
Q3 2024	4,387
Q2 2024	4,170
Q1 2024	3,127



Total Grievances

Q4 2024	419
Q3 2024	486
Q2 2024	423
Q1 2024	469

Includes customer service data

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CalOptima Health

CalOptima Health Comparison

- National Committee for Quality Assurance (NCQA) benchmark is 5, meaning we should receive less than 5 grievances per 1,000 member months

- DHCS rolling average across all similar plans is 3.1 grievances per 1,000 member months. Please note that DHCS delays publication by two quarters

- CalOptima Health remains below both the industry average and the NCQA benchmark at 1.5 grievances per 1,000 member months

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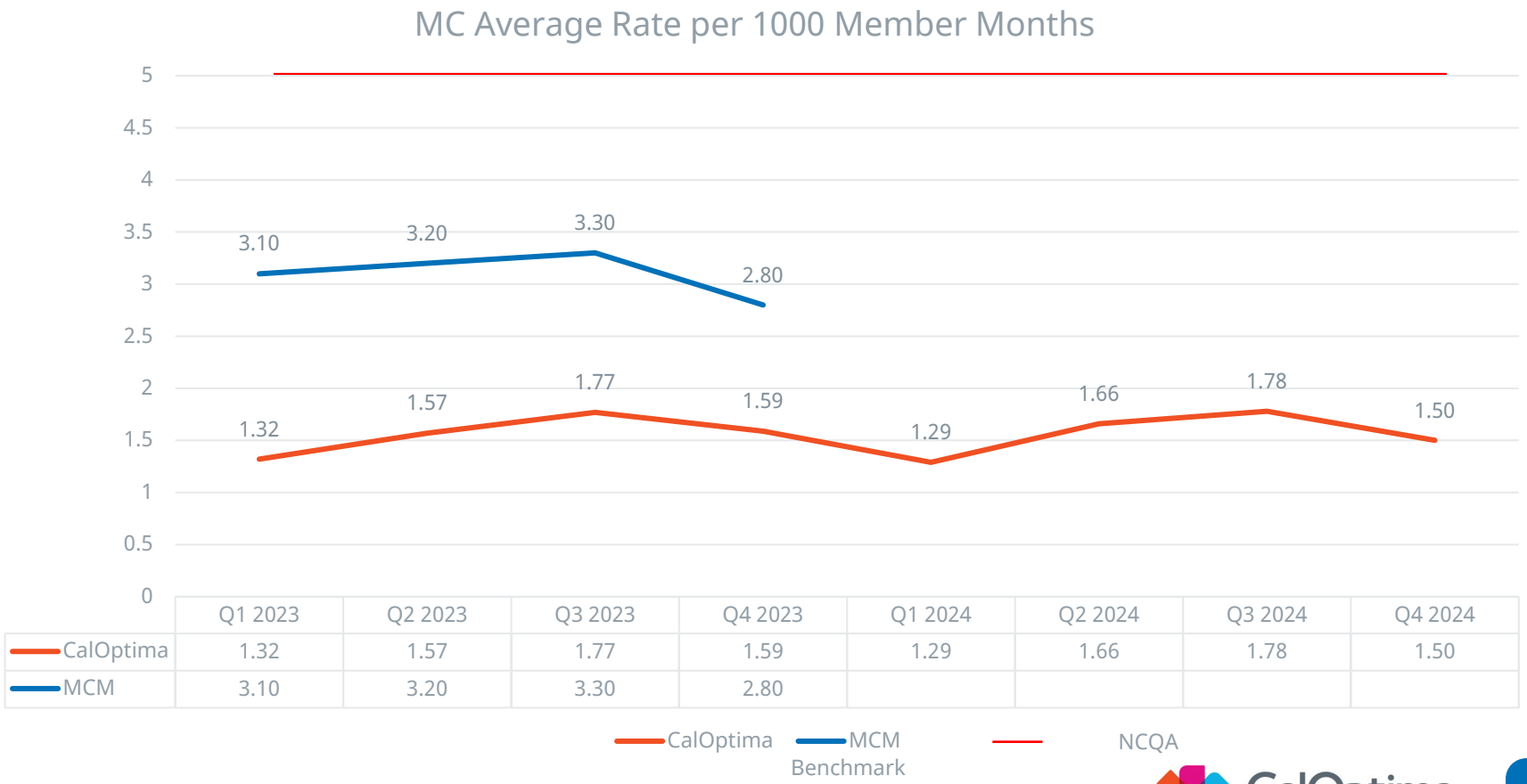
CalOptima Health

CalOptima Health Comparison

- National Committee for Quality Assurance (NCQA) benchmark is 5 - meaning we should receive less than 5 grievances per 1,000 member months.
- DHCS rolling average across all similar Plans is 3.1 per 1,000 Member Months – please note that DHCS delays publication by at least two quarters.
- CalOptima Health remains below both the industry average and the NCQA benchmark at 1.50 grievances per 1,000 member months.



	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024
CalOptima	1.32	1.57	1.77	1.59	1.29	1.66	1.78	1.50
MCM	3.10	3.20	3.30	2.80				

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Grievance Type by LOB 2024

	Medi-Cal				OneCare			
	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Quality of Service	2,034	2,668	2,702	2,485	366	326	371	334
Quality of Care	320	505	586	480	27	34	51	22
Access	594	789	882	875	54	47	49	49
Billing	190	208	217	178	22	16	15	14
TOTAL	**3,127**	**4,170**	**4,387**	**4,018**	**469**	**423**	**486**	**419**

Quarter 4 Total	4,437
Quarter 3 Total	4,873
Quarter 2 Total	4,593
Quarter 1 Total	3,596

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CalOptima Health

Medi-Cal Grievance Trends for Q4

Quality of Service

Trend	Percentage of Total Volume
Provider / Staff Attitude	19% (475)
Plan Customer Service	18% (458)
Authorization	9% (226)

Quality of Care

Trend	Percentage of Total Volume
Quality of Care	61% (291)
Authorization	9% (39)
Inappropriate Care	5% (25)

Access

Trend	Percentage of Total Volume
Timely Access	16% (137)
Provider Availability	15% (136)
Referral	14% (121)

Billing

Trend	Percentage of Total Volume
Provider Direct Member Billing	65% (117)
Provider Balance Billing	28% (52)
Denial of Pmt. Request	4% (8)

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CalOptima Health

OneCare Grievance Trends for Q4

Quality of Service

Trend	Percentage of Total Volume
Provider / Staff Attitude	26% (87)
Plan Customer Service	16% (52)
Driver Punctuality	15% (50)

Access

Trend	Percentage of Total Volume
Timely Access	18% (9)
Scheduling	12% (6)
Technology / Telephone	12% (6)

Quality of Care

Trend	Percentage of Total Volume
Quality of Care	45% (10)
Inappropriate Care	36% (8)
Driver Punctuality	14% (3)

Billing

Trend	Percentage of Total Volume
Provider Direct Member Billing	50% (7)
Provider Balance Billing	21% (3)

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CalOptima Health

Actions Taken in Response to Trends

- Q4 trends identified
  - Medi-Cal and OneCare grievances regarding transportation providers.
  - Medi-Cal and OneCare Grievances against the staff at Physician offices.
  - OneCare grievances related to OneCare supplemental benefits (PaPa Pal).

- Actions Taken
  - Transportation trends continue to be reviewed through weekly meetings with CalOptima Health leaders and transportation vendor, Modivcare for continued remediation efforts.
  - There were no trending providers identified. Department continues to track provider specific grievances monthly.
  - PaPa Pal grievances related to timeliness and attendance were discussed with medical management for remediations. Annual review of the vendor to occur in first quarter 2025 where GARS will be in attendance.

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Appeals

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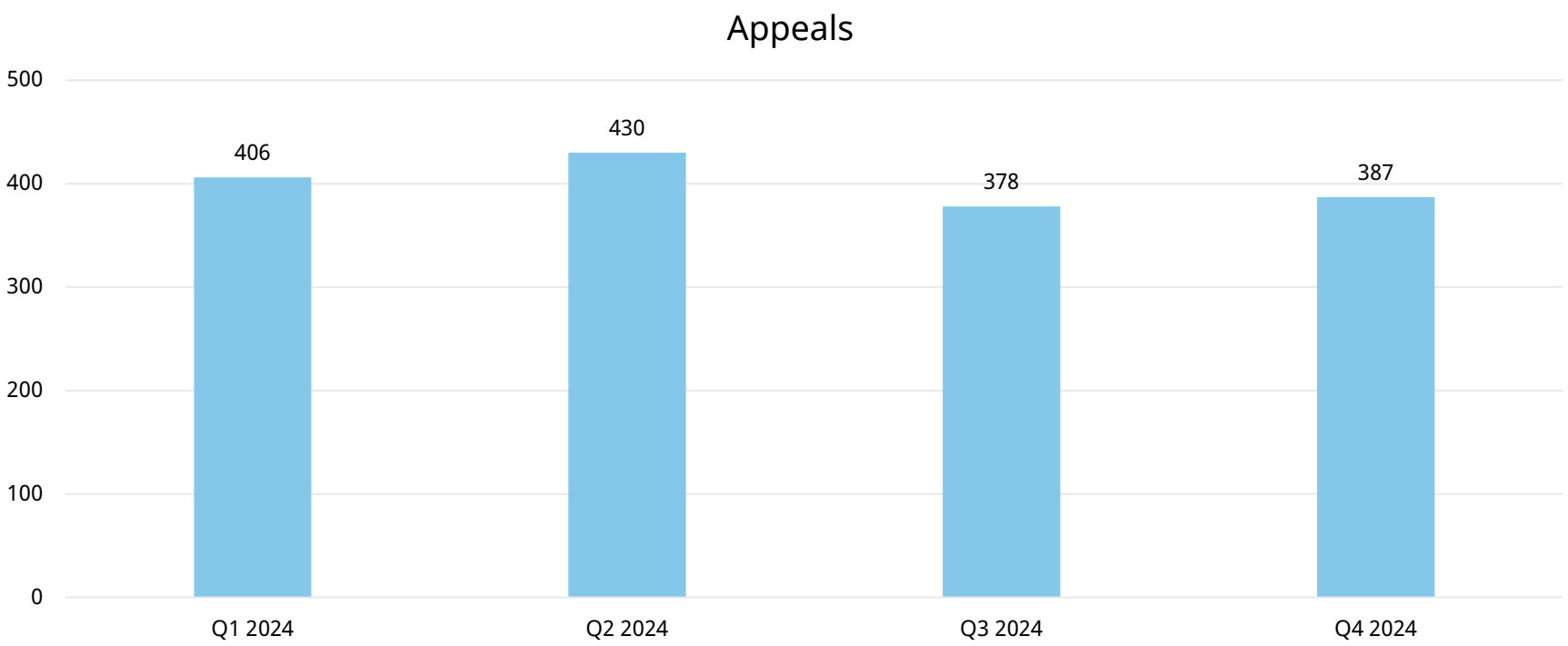
CalOptima Health

Appeals Volume and Compliance

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.



Complaint Type	Required Turn Around Time (TAT)	CalOptima TAT	Compliance Percentage
Appeals	30 Days	25 Days	99%

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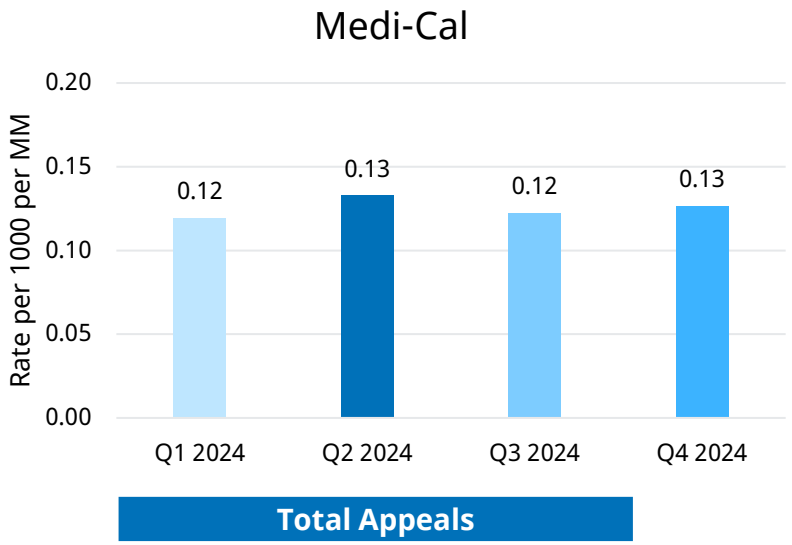
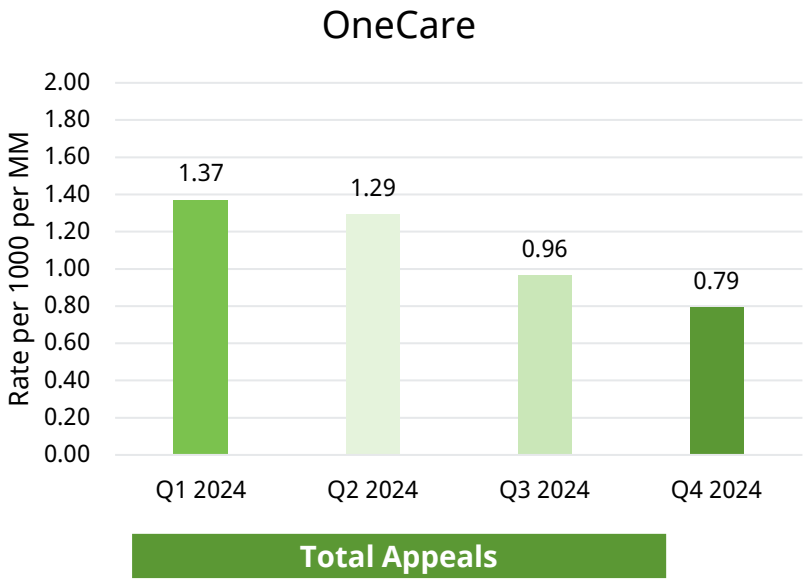
CalOptima Health

Appeals Volume by LOB





Q4 2024	346
Q3 2024	328
Q2 2024	356
Q1 2024	320

Q4 2024	41
Q3 2024	50
Q2 2024	67
Q1 2024	71

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Appeal Types by LOB CY-2024

	Medi-Cal				OneCare			
	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2024	Q2 2024	Q3 2024	Q4 2024
Specialty Care	181	176	181	200	34	32	23	8
Behavioral Health (BH)	19	57	11	8	0	0	0	0
Outpatient Services	61	51	61	47	9	8	10	6
DME	26	39	42	32	15	15	11	9
Orthotics/Prosthetics	12	9	1	7	3	0	0	0
Hospital Inpatient	9	11	9	3	5	6	0	14
CALAim	4	4	10	37	0	0	0	4
SNF-LTACH-ARU	8	7	11	10	1	1	0	0
Other	0	2	2	2	4	5	6	0
TOTAL	**320**	**356**	**328**	**346**	**71**	**67**	**50**	**41**

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CalOptima Health

Appeal Types by LOB CY-2024 (Cont.)

- **Specialty Care-** Specialties trending in 2024 were: Rheumatology, Orthopedic Surgery, Hematology/Oncology, Ophthalmology and Endocrinology.
- **Behavioral Health (BH)-** Applied Behavioral Analysis (ABA) Services were the highest trended in the BH category for 2024.
- **Outpatient Services-** This category includes the following trending in 2024: Radiologic Imaging (MRI's/CT's), Physical Therapy, Speech Therapy, Occupational Therapy, and Laboratory Services.
- **DME-** This category includes all DME related appeals, the following trended in 2024: Hearing Aides, Wheelchairs (powered, custom and accessories) and cranial remolding helmets.
- **Other-** This category includes Home Health appeals and transportation related appeals.

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CalOptima Health

Actions Taken in Response to Trends

- Q4 trends identified
  - Initial authorizations to general specialists vs. the sub-specialty needed to treat the member's condition.
  - Authorized specialists unable to see the member in a timely manner based on the member’s needs.

- Actions Taken
  - The GARS Department notifies the Health Network of the criteria used in the appeal overturn decision which serves as provider education.
  - GARS Department performs tracking and trending of Health Network overturns to share with the Health Networks for continued monitoring and process improvement.

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CHAMBER HILL

MEMORANDUM

TO: CalOptima Health
Board of Directors

FROM: Chamber Hill Strategies

DATE: March 24, 2025

SUBJECT: Board of Directors Report – April 2025

CalOptima Health, Chamber Hill Strategies Continue Outreach on Capitol Hill
CalOptima Health and Chamber Hill Strategies (CHS) continue to be in regular contact with congressional offices representing CalOptima Health's members and Orange County in Congress. In March, CHS was in contact with the Orange County congressional delegation about CalOptima Health and its programs while also stressing the importance of ensuring support for CalOptima Health and its members. California and Orange County offices contacted included: Senator Alex Padilla (D-CA), Senator Adam Schiff (D-CA), Representative Lou Correa (D-CA-46), Representative Young Kim (R-CA-40), Representative Derek Tran (D-CA-45), Representative Dave Min (D-CA-47), Representative Linda Sanchez (D-CA-38), and Representative Mike Levin (D-CA-49).

CalOptima Health, Chamber Hill Strategies Partner on Orange County Meetings
CalOptima Health and Chamber Hill Strategies continued to partner in scheduling in-person meetings on behalf of CalOptima Health Chief Executive Officer Michael Hunn and other executive management team members with members of the Orange County delegation. CalOptima Health CEO Michael Hunn and Senior Director of Federal and Local Government Affairs Jordan Abushawish met with Representative Dave Min (D-CA-47) at Rep. Min's offices in Costa Mesa on March 18 and then on March 19 met with Representative Lou Correa (D-CA-46) at Rep. Correa's offices in Santa Ana. The meetings provided an opportunity to highlight CalOptima Health programs and priorities, to discuss issues being raised in Washington, to reconnect with Rep. Correa, and to connect Rep. Min, who was first elected to the House in November, with CalOptima Health. Additional meetings with members of the Orange County congressional delegation are in the process of being scheduled.

Congress Approves Measure to Fund Government, Extend Funding for Health Programs
On Friday, March 14, the United States Senate, in a 54-46 vote, approved passage of H.R. 1968, the Full-Year Continuing Appropriations and Extensions Act, 2025, which funds the government through the end of Fiscal Year 2025 (FY25). The Senate's action followed the U.S. House of Representatives, which had passed the legislation in a 217-213 vote on Tuesday, March 11. Without congressional action, funding for the operations of the federal government was set to expire on March 14. With President Trump signing H.R. 1968 into law, the legislation, also referred to as a continuing resolution (or CR), averted a federal government shutdown and funded the federal government through the end of FY25 (i.e. September 30) at FY24 funding levels. Also of note, the legislation included the extension of several health provisions through September 30, including telehealth flexibility, funding for community health centers, and payments to Medicaid

Disproportionate Share Hospital (DSH). The provisions were necessary as funding for these health care programs, and several others, was set to expire on either March 31 or April 1.

Senate Committee Hears from Dr. Oz on CMS Nomination
On March 14, 2025, the Senate Finance Committee held a hearing to hear testimony from and ask questions of Mehmet Oz, MD, President Trump's nominee to serve as Administrator of the Centers for Medicare and Medicaid Services (CMS). Among Senators on the Committee, there was bipartisan agreement on certain topics, such as the need to address the high cost of health care, the benefits of telehealth, and the need to address concerns about the Medicare Advantage (MA) program, but there was considerable disagreement on the potential impact of the current budget process in Congress on Medicaid spending. During the hearing, Democratic Senators expressed concerns about potential reductions in Medicaid spending. When asked about potential cuts, Oz stated he had not seen legislation but expressed support for Medicaid funding. Regarding work requirements, Oz expressed support and noted that he did not envision the requirements being barriers to coverage. Regarding Medicaid expansion, Democratic Senators expressed concerns that budget reductions could lead some states to drop coverage for the expansion population, and when asked about Medicaid expansion, Oz noted his belief that expansion has worked for some states but that other states may try other ways to provide coverage to the uninsured.

MACPAC Holds February Meeting, Discusses Behavioral Needs, Opioid Use, HCBS
The Medicaid and CHIP Payment and Access Commission (MACPAC) met on February 27 and 28, covering a range of topics that included residential treatment for youth with behavioral health challenges, opioid use disorder (OUD) treatment, home- and community-based services (HCBS), and Medicaid supplemental payments. Discussions on residential treatment highlighted challenges such as Medicaid's Institutions for Mental Diseases (IMD) exclusion, funding limitations, workforce shortages, and inconsistent admission processes. Commissioners emphasized the need for better data tracking, care coordination, and expanded home- and community-based services. Additional sessions examined the Self-Directed Model in HCBS, noting significant variations among the states and challenges in oversight and consumer support. Commissioners debated consumer-directed care versus agency-based models and pushed for using Electronic Visit Verification (EVV) data to track access and quality. The opioid use disorder discussion highlighted persistent stigma, provider shortages, and barriers to access, with a focus on improving prior authorization and patient outreach. A final panel on Section 1115 substance use disorder demonstrations included state Medicaid leaders sharing lessons on flexibility, peer coaching, and funding strategies.

MACPAC Releases March 2025 Report to Congress
On March 13, MACPAC released its March 2025 Report to Congress. The report examines key aspects of Medicaid managed care HCBS, with a focus on improving oversight, access, and administrative efficiency, and includes recommendations aimed at improving oversight, access, and efficiency within Medicaid's managed care and HCBS programs. The first chapter examines the managed care external quality review (EQR) process for Medicaid managed care organizations (MCOs), analyzes how states implement EQR requirements, and includes recommendations to improve transparency and the usability of annual EQR reports. The second chapter explores state eligibility and enrollment processes for HCBS, while emphasizing the use of presumptive and expedited eligibility flexibilities for non-modified adjusted gross income (non-MAGI) populations, and recommends clearer federal guidance to help states streamline enrollment and improve access. The third chapter examines reducing the administrative burden of HCBS programs and recommends extending the renewal period for HCBS programs under waivers from five to ten years, which would reduce the frequency of renewal processes and would aim at allowing states to focus on improving service delivery rather than administrative tasks.

MedPAC Hold March Meeting, Examines I-SNPs
On March 6 and 7, the Medicare Payment Advisory Commission (MedPAC) held its March 2025 meeting. While most sessions did not touch on Medicaid and were focused on Medicare policy, one session examined Institutional Special Needs Plans (I-SNPs). In the session, MedPAC explored I-

SNPs, which serve nursing home residents requiring long-term care. I-SNP enrollees typically have longer stays and lower mortality rates, but the plans are more costly than other Medicare options. MedPAC found that I-SNPs reduce hospitalizations but are subject to limitations in risk adjustment and data exclusions. Commissioners discussed ways to improve I-SNP care quality, increase adoption, and integrate these plans with other models like D-SNPs and PACE.

CMS Proposes Changes to Health Insurance Marketplace

On March 10, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule, the "Marketplace Integrity and Affordability Proposed Rule," which would amend standards of the Health Insurance Marketplaces under the Affordable Care Act (ACA). The proposed rule would change and end several policies initiated under the previous administration. Among the changes, the proposed rule would end the monthly special enrollment period (SEP) for low-income individuals, require more rigorous eligibility verifications, reduce the open enrollment period, and reinstate pre-enrollment verifications for consumers using SEPs. It also introduces changes to how subsidies are allocated, requiring verification of income inconsistencies and limiting automatic enrollment in certain plans. CMS argues that these changes will protect consumers, reduce premiums for non-subsidized enrollees, and lower federal spending. The proposed rule also includes changes affecting Deferred Action for Childhood Arrivals (DACA) recipients, who would lose subsidized coverage, and it adds sex-trait modification to the list of items that cannot be covered as an essential health benefit starting in 2026. In making the changes, CMS cites concerns over improper enrollments and rising federal costs. While CMS states that the aim of the policy shifts is to improve program integrity, some are expressing concerns that the changes result in fewer being covered by the ACA exchanges and negatively impact access to care for vulnerable populations.

CALOPTIMA HEALTH - STATE LEGISLATIVE REPORT
March 24, 2025

General Update

The mood in the Capitol continues to be grim with the foreboding of what is to come from the federal government. California remains one of the most active legal challengers of Trump's policies. During his first administration, California sued the federal government 123 times and won 2/3 of those cases.

Since Trump's second administration, California has filed eight lawsuits. Attorney General Rob Bonta is actively fighting against Trump's policies relating to the defunding of public health research, changes to birthright citizenship, mass deportation, and federal budget cuts affecting state programs. There will be more to come.

Budget Update

The legislature is completely entrenched in budget subcommittee hearings, listening to various stakeholders state their cases for continued funding in this challenging budget cycle. The legislature must pass a budget bill to the Governor by June 15.

On March 12, the California Department of Finance (DOF) notified the Joint Legislative Budget Committee that it approved an interim loan of $3.44 billion (the maximum allowable under law) to pay Medi-Cal providers. This loan is expected to be paid back with a junior budget bill as part of the budget package this year.

Then, on March 17, the Assembly Budget Subcommittee on Health held an informational hearing on several health-related issues and learned that an additional $2.8 billion was needed to pay providers through the current fiscal year (June 30). This, combined with the $3.44 loan, shows a Medi-Cal deficit of $6.24 billion. DHCS Director Michelle Baass attributed the deficit to several factors including:

- Prescription drug costs
- Overall enrollment growth in Medi-Cal
- Higher enrollment in undocumented coverage (an $8.5 billion cost to the General Fund)
- Higher enrollment among seniors due to deletion of the asset test
- $1 billion General Fund loss because of Proposition 35 (MCO Tax)
- Original budget projections only had one month of data on the cost of several new policies

Chair Dawn Addis-D (San Luis Obispo) and Committee Members Mia Bonta-D (Oakland) and Pilar Schiavo-D (Santa Clarita) vigorously defended their commitment to continued coverage for the undocumented. While the current fiscal challenges are seen as "solvable," the potential $880 billion in cuts to Medicaid by the federal government (over ten years) causes much more serious concerns.

New data from the DOF shows that February 2025 revenues continue to show positive trends: they are about 25% ($2.3 billion) higher than anticipated. This brings the current 2024–25 fiscal year-to-date General Fund revenues up almost 4% ($4.6 billion) above budget estimates.

PACE Proposed Changes – Two issues have arisen in the budget process related to PACE operations: 1) a Budget Change Proposal (BCP) and Trailer Bill Language (TBL) to implement a fee assessment on PACE organizations to fund 33 new DHCS positions (about $6 million/year) to support the rapid expansion of PACE; and 2) a second TBL to allow sanctions to be levied against PACE organizations to achieve uniformity in sanctions across Medi-Cal programs. CalPACE, the association representing PACE programs statewide, is in active opposition to both proposals and is submitting a letter to committees.

During the Assembly Budget Subcommittee on Health hearing on March 17, Committee Member Mia Bonta-D (Oakland) was very concerned with the DHCS budget proposals because of the slim margins PACE programs are operating under, the importance of the work they do, and the lack of detailed information from DHCS on how the fees to be charged were determined. She was particularly concerned with the lack of an impact study. Her colleagues agreed with her. There was no decision made at this informational hearing. This will now go to the Senate Budget Subcommittee on Health on March 27. CalPACE will continue their opposition.

Key Legislation Updates

SB 324 (Menjivar-D) – Community Provider Preference for Enhanced Care Management (ECM) – Senate President Pro Tem Mike McGuire-D is a Principal Co-author. This bill requires a Medi-Cal managed care plan, for purposes of covering the ECM benefit, or if it elects to cover a Community Support, to give preference to contracting with community providers, when they are available in the county and have the applicable ECM or Community Support experience. This bill will be heard at the Senate Health Committee hearing on April 2.

AB 543 (González-D) – Street Medicine – Would allow full-scope presumptive eligibility for individuals experiencing homelessness; would also allow a member who is experiencing or at-risk of homelessness to seek Medi-Cal covered services directly from any Medi-Cal provider, including off the premises of the provider's site. This bill is scheduled to be heard in the Assembly Health Committee on April 1.

SB 306 (Becker-D) – Prior Authorization – Would prohibit plans from imposing prior authorization on a provider for a period of one year, if 90% or more of that provider's requests were approved the prior year. This bill is not yet scheduled for an Assembly Health Committee hearing.

Other Program Updates

Behavioral Health Transformation (BHT) (Proposition 1) – Round 1 (Launch Ready) grant funding for the Behavioral Health Continuum Infrastructure Program (BHCIP) is underway. DHCS will award up to $3.3 billion in grants in May 2025. Round 2 (Unmet Needs) solicitations will also be released in May.

California's Essential Health Benefits (EHBs) – With potential changes to the Affordable Care Act looming, a legislative joint hearing was held on February 11 to review possible additions to California's EHBs, which have not changed since 2012. Proposed benefit expansions include hearing aids, adult dental, and durable medical equipment. An application will be submitted to CMS in May with an effective date of the new plan, if approved, in January 2027.

2025–26 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
SB 476 Valladares	**Residential Therapeutic Programs:** States the intent of the Legislature to enact legislation relating to short-term residential therapeutic programs. ***Potential CalOptima Health Impact*:** Unknown at this time.	**02/20/2025** Introduced	CalOptima Health: Watch
SB 482 Stern	**Mental Health Diversion:** Would require that a court be satisfied that a recommended mental health treatment program is consistent with the underlying purpose of mental health diversion and meets the specialized treatment needs of the defendant. ***Potential CalOptima Health Impact*:** Increased oversight of behavioral health treatment for members.	**02/20/2025** Introduced	CalOptima Health: Watch
SB 626 Smallwood-Cuevas	**Maternal Mental Health Screenings and Treatment:** Would require a licensed health care practitioner who provides perinatal care for a patient to screen, diagnose and treat the patient for a maternal mental health condition. ***Potential CalOptima Health Impact:*** Increased access to behavioral health services for eligible members.	**02/21/2025** Introduced	CalOptima Health: Watch
SB 812 Allen	**Qualified Youth Drop-In Center Health Care Coverage:** Would require a health plan to provide coverage for mental health and substance use disorders at a qualified youth drop-in center that receives funding from the Children and Youth Behavioral Health Initiative (CYBHI) or is approved by a Local Education Agency (LEA) to be reimbursed by the health plan. ***Potential CalOptima Health Impact*:** Increased access to behavioral health services for CalOptima Health Medi-Cal youth members.	**02/21/2025** Introduced	CalOptima Health: Watch
AB 37 Elhawary	**Behavioral Health Workforce:** Would require the California Workforce Development Board to study how to expand the workforce of mental health service providers providing services to homeless persons. ***Potential CalOptima Health Impact*:** Increased access to behavioral health services for members experiencing homelessness.	**12/02/2024** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 348 Krell	**Full-Service Partnership:** Would establish presumptive eligibility for Full-Service Partnership programs. ***Potential CalOptima Health Impact*:** Increased continuity of care for members with serious mental illness.	**01/29/2025** Introduced	CalOptima Health: Watch
AB 384 Connolly	**Inpatient Prior Admission Authorization:** Would prohibit a health plan from requiring prior authorization for admission to medically necessary 24-hour care in inpatient settings, including general acute care hospitals and psychiatric hospitals, for mental health and substance use disorders (SUDs) as well as for any medically necessary services provided to a beneficiary while admitted for that care. ***Potential CalOptima Health Impact*:** Modified utilization management (UM) procedures for covered Medi-Cal benefits.	**02/04/2025** Introduced	CalOptima Health: Watch
AB 423 Davies	**Discharge and Continuing Care Planning:** Would mandate regulations for discharge and continuing care planning from a facility providing alcoholism or drug abuse recovery and treatment services, including the creation of a plan to help patients return to their home community and scheduled follow-up with a mental health or SUD professional no more than seven days after discharge. ***Potential CalOptima Health Impact*:** Increased continuity of care for members who have received SUD treatment.	**02/05/2025** Introduced	CalOptima Health: Watch
AB 618 Krell	**Behavioral Health Data Sharing:** Would require each Medi-Cal managed care plan (MCP), county specialty mental health plan (MHP) and Drug Medi-Cal program to electronically share data for its members to support coordination of behavioral health services. Would also require the California Department of Health Care Services (DHCS) to determine minimum data elements and the frequency and format of data sharing through a stakeholder process and guidance, with final guidance to be published by January 1, 2027. ***Potential CalOptima Health Impact*:** Increased coordination between Medi-Cal delivery systems regarding behavioral health services.	**02/12/2025** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 877 Dixon	**Nonmedical SUD Treatment:** Would require DHCS and the California Department of Managed Health Care (DMHC) to send a letter to the chief financial officer of every health plan (including a Medi-Cal MCP) that provides SUD coverage in residential facilities. The letter must inform the plan that SUD treatment in licensed and certified residential facilities is almost exclusively nonmedical, with rare exceptions, including for billing purposes. These provisions would be repealed on January 1, 2027. ***Potential CalOptima Health Impact*:** Enhanced transparency and clarity around nonmedical treatment provided for SUDs.	**02/20/2025** Introduced	CalOptima Health: Watch
AB 951 Ta	**Autism Diagnosis:** Would prohibit a health plan from requiring an enrollee previously diagnosed with pervasive developmental disorder or autism to receive a diagnosis to maintain coverage for behavioral health treatment for their condition. ***Potential CalOptima Health Impact*:** Increased access to care for specific behavioral health treatments.	**02/21/2025** Introduced	CalOptima Health: Watch
AB 1090 Davies	**Behavioral Health and Wellness Screenings:** States the intent of the Legislature to enact legislation relating to behavioral health and wellness screenings. ***Potential CalOptima Health Impact*:** Unknown at this time.	**02/21/2025** Introduced	CalOptima Health: Watch
Budget			
SB 65 Weiner	**Budget Act of 2025:** Would make appropriations for the government of the State of California for the 2025–26 fiscal year in alignment with the governor's proposed budget released on January 10, 2025. ***Potential CalOptima Health Impact*:** Adjusted but broadly sustained funding for programs impacting members.	**01/10/2025** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
California Advancing and Innovating Medi-Cal (CalAIM)			
SB 324 Menjivar	**Enhanced Care Management (ECM) and Community Supports Contracting:** Would require a Medi-Cal MCP to give preference to contracting with community providers when covering the ECM benefit and/or Community Supports. In addition, would require DHCS to develop standardized templates to be used by MCPs. Would also require DHCS to develop guidance to allow community providers to subcontract with other community providers. Finally, would require DHCS to annually update rate guidance as a benchmark for MCPs to use to reimburse for ECM and Community Supports. ***Potential CalOptima Health Impact*:** Increased collaboration with community providers and standardized contracts.	**02/11/2025** Introduced	CalOptima Health: Watch
AB 543 Gonzalez	**Street Medicine:** Would integrate street medicine services for homeless individuals under Medi-Cal, mandating presumptive eligibility for full Medi-Cal benefits for homeless persons and authorizing any enrolled provider to determine eligibility. Would also require plans to allow homeless beneficiaries to access services from any provider outside traditional sites. Additionally, would require systems for beneficiaries to inform plans of their homeless status and mandate data sharing between Medi-Cal and the California Statewide Automated Welfare System (CalSAWS). ***Potential CalOptima Health Impact*:** Decreased service coordination and oversight related to street medicine providers.	**02/12/2025** Introduced	CalOptima Health: Watch
Covered Benefits			
SB 40 Wiener	**Insulin Coverage:** Effective January 1, 2026, would prohibit a health plan from imposing a copayment or other cost sharing of more than $35 for a 30-day supply of an insulin prescription drug or imposing a deductible, coinsurance, or any other cost sharing on an insulin prescription drug. Would also prohibit a health plan from imposing step therapy protocols as a prerequisite to authorizing coverage of insulin on and after January 1, 2026. ***Potential CalOptima Health Impact:*** Decreased out-of-pocket costs for future members enrolled in Covered California line of business; new UM procedures.	**12/02/2024** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 62 Menjivar **AB 224** Bonta	**Essential Health Benefits (EHBs):** States the intent of the Legislature to review California's EHB benchmark plan and establish a new benchmark plan for the 2027 plan year. Would limit the applicability of the current benchmark plan benefits to plan years on or before the 2027 plan year. ***Potential CalOptima Health Impact:*** New covered benefits for future members enrolled in Covered California line of business.	**01/09/2025** Introduced	CalOptima Health: Watch
SB 466 Caballero	**Women's Health:** States the intent of the Legislature to enact legislation relating to women's health. ***Potential CalOptima Health Impact:*** Unknown at this time.	**02/20/2025** Introduced	CalOptima Health: Watch
SB 535 Richardson **AB 575** Arambula	**Obesity Prevention Treatment and Parity Act:** Would require an individual or group health care plan that provides coverage for outpatient prescription drug benefits to cover at least one specified anti-obesity medication and intensive behavioral therapy for the treatment of obesity without prior authorization. ***Potential CalOptima Health Impact:*** Expanded covered benefits for future members enrolled in Covered California line of business.	**02/12/2025** Introduced	CalOptima Health: Watch
AB 242 Boerner	**Genetic Disease Screening:** Would expand statewide newborn screenings to include Duchenne muscular dystrophy by January 1, 2027. ***Potential CalOptima Health Impact:*** Expanded covered benefits for members.	**1/15/2025** Introduced	CalOptima Health: Watch
AB 298 Bonta	**Cost-Sharing Under Age 21:** Effective January 1, 2026, would prohibit a health plan from imposing a deductible, coinsurance, copayment, or other cost-sharing requirement for in-network health care services provided to an individual under 21 years of age, with certain exceptions for high deductible health plans that are combined with a health savings account. ***Potential CalOptima Health Impact:*** Increased costs for CalOptima Health; decreased costs for future members enrolled in Covered California line of business under 21 years of age.	**01/23/2025** Introduced	CalOptima Health: Watch
AB 350 Bonta	**Fluoride Treatments:** Would require a health plan to provide coverage for fluoride varnish in the primary care setting for children under 21 years of age by January 1, 2026. ***Potential CalOptima Health Impact:*** New covered benefit for pediatric members.	**01/29/2025** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 432 Bauer-Kahan	**Menopause:** Would require a health plan to provide coverage for evaluation and treatment options for perimenopause and menopause. Would also require a health plan to annually provide clinical care recommendations for hormone therapy to all contracted primary care providers who treat individuals with perimenopause and menopause. ***Potential CalOptima Health Impact:*** New covered benefits for members; increased communications to providers.	**02/05/2025** Introduced	CalOptima Health: Watch
AB 636 Ortega	**Diapers:** Would add diapers as a covered Medi-Cal benefit for the following individuals, contingent upon an appropriation by the Legislature: • Children greater than three years of age diagnosed with a condition that contributes to incontinence • Other individuals under 21 years of age to address a condition pursuant to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standards ***Potential CalOptima Health Impact:*** New covered benefit for pediatric members.	**02/13/2025** Introduced	CalOptima Health: Watch
Medi-Cal Eligibility and Enrollment			
AB 315 Bonta	**Home and Community-Based Alternatives (HCBA) Waiver:** Would remove the cap on the number of HCBA Waiver slots and instead require DHCS to enroll all eligible individuals who apply for HCBA Waiver services. By March 1, 2026, would require DHCS to seek any necessary waiver amendments to ensure there is sufficient capacity to enroll all individuals currently on a waiting list. Would also require DHCS by March 1, 2026, to submit a rate study to the Legislature addressing the sustainability, quality and transparency of rates for the HCBA Waiver. ***Potential CalOptima Health Impact*:** Expanded member access to HCBA Waiver services.	**01/23/2025** Introduced	CalOptima Health: Watch
AB 974 Patterson	**Managed Care Enrollment Exemption:** States the intent of the Legislature to enact legislation that would exempt from mandatory enrollment in a Medi-Cal MCP any dual-eligible and non-dual-eligible beneficiaries who receive services from a regional center and who use the Medi-Cal fee-for-service delivery system as a secondary form of health care coverage. ***Potential CalOptima Health Impact:*** Decreased number of members.	**02/21/2025** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1012 Essayli	**Unsatisfactory Immigration Status:** Would make an individual who does not have satisfactory immigrant status ineligible for Medi-Cal benefits. In addition, would transfer funds previously appropriated for such eligibility to a newly created Serving our Seniors Fund to restore and maintain payments for Medicare Part B premiums for eligible individuals. ***Potential CalOptima Health Impact:*** Decreased number of members.	**02/21/2025** Introduced	CalOptima Health: Watch
AB 1161 Harabedian	**State of Emergency Continuous Eligibility:** Would require DHCS and the California Department of Social Services, to provide continuous eligibility for its applicable programs (including Medi-Cal and CalFresh) to a beneficiary who has been displaced or otherwise affected by a state of emergency or a health emergency for at least 90 days after declaration or at least the entire duration of the emergency, whichever is longer. ***Potential CalOptima Health Impact*:** Extended Medi-Cal eligibility for certain members.	**02/21/2025** Introduced	CalOptima Health: Watch
Medi-Cal Operations and Administration			
SB 278 Cabaldon	**Health Data HIV Test Results:** Would permit additional disclosures to DHCS staff and Medi-Cal MCPs to improve care coordination and quality programs for HIV-positive beneficiaries. Would also update existing laws to enhance quality improvement efforts in HIV care under Medi-Cal. Would additionally require the development of a mechanism through which Medi-Cal beneficiaries can opt out of such disclosures. ***Potential CalOptima Health Impact:*** Increased coordination of care for HIV-positive members.	**02/04/2025** Introduced	CalOptima Health: Watch
SB 497 Wiener	**Legally Protected Health Care Activity:** Would prohibit a health care provider, health plan, or contractor from releasing medical information related to a person seeking or obtaining gender-affirming health care or mental health care in response to a criminal or civil action. Would also prohibit these entities from cooperating with or providing medical information to an individual, agency, or department from another state or to a federal law enforcement agency or in response to a foreign subpoena. ***Potential CalOptima Health Impact:*** Increased protection of medical information related to gender-affirming care; increased staff training regarding disclosure processes.	**02/20/2025** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 530 Richardson	**Medi-Cal Time and Distance Standards:** Would extend current Medi-Cal time and distance standards indefinitely. In addition, would require a Medi-Cal MCP to ensure that each subcontractor network complies with certain appointment time standards and incorporate into reporting to DHCS. Additionally, the use of telehealth providers to meet time or distance standards would not absolve the MCP of responsibility to provide a beneficiary with access, including transportation, to in-person services if the beneficiary prefers. ***Potential CalOptima Health Impact:*** Increased oversight of contracted providers; increased reporting to DHCS.	**02/21/2025** Introduced	CalOptima Health: Watch
SB 660 Menjivar	**California Health and Human Services Data Exchange Framework (DxF):** Would require the Center for Data Insights and Innovation within California Health and Human Services Agency (CalHHS) to absorb all functions related to the DxF initiative, including the data sharing agreement and policies and procedures, by January 1, 2026. Additionally, would expand DxF to include social services information. ***Potential CalOptima Health Impact:*** Increased care coordination with social service providers.	**02/20/2025** Introduced	CalOptima Health: Watch
AB 40 Bonta	**Abortion as Emergency Service:** Would expand the definition of emergency services to include surgery and reproductive health services, including abortion, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. ***Potential CalOptima Health Impact:*** Expanded coverage of abortion services for members.	**12/02/2024** Introduced	CalOptima Health: Watch
AB 45 Bauer-Kahan	**Reproductive Privacy Data:** States the intent of the Legislature to enact legislation to make it unlawful to geofence an entity that provides in-person health care services. Would also prohibit health care providers from releasing medical research information related to an individual seeking or obtaining an abortion in response to a subpoena or request, if that subpoena or request is based on another state's laws that interfere with a person's rights under the Reproductive Privacy Act. ***Potential CalOptima Health Impact:*** Increased protection of medical information related to abortions; increased staff training regarding disclosure processes.	**12/02/2024** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 257 Flora	**Specialty Telehealth Network Demonstration:** Would require the establishment of a demonstration project for a telehealth and other virtual services specialty care network designed to serve patients of safety-net providers. ***Potential CalOptima Health Impact:*** Expanded member access to telehealth specialists.	**01/16/2025** Introduced	CalOptima Health: Watch
AB 302 Bauer-Kahan	**Confidentiality of Medical Information Act:** Would prohibit a health care provider, health plan or contractor from disclosing medical information in response to another state's court order based on a law in that state which interferes with California law. Would also prohibit such entities from disclosing medical information based solely on patient authorization. ***Potential CalOptima Health Impact:*** Increased protection of medical information; increased staff training regarding disclosure processes.	**01/23/2025** Introduced	CalOptima Health: Watch
AB 316 Krell	**Artificial Intelligence Defenses:** Prohibits a defendant that developed or used artificial intelligence from asserting a defense that artificial intelligence autonomously caused the alleged harm to the plaintiff. ***Potential CalOptima Health Impact:*** Increased liability related to UM procedures.	**01/24/2025** Introduced	CalOptima Health: Watch
AB 403 Ortega	**Medi-Cal Community Health Service Workers:** Would require DHCS to annually review the Community Health Worker (CHW) benefit and present an analysis to the Legislature beginning July 1, 2027. The analyses would include an assessment of Medi-Cal MCP outreach and education efforts, CHW utilization and services, demographic disaggregation of the CHWs and beneficiaries receiving services, and fee-for-service reimbursement data. ***Potential CalOptima Health Impact:*** New reporting requirements to DHCS.	**02/04/2025** Introduced	CalOptima Health: Watch
AB 577 Wilson	**Prescription Drug Antisteering:** Would prohibit a health plan or pharmacy benefit manager (PBM) from engaging in specified steering practices, including requiring an enrollee to use a retail pharmacy for dispensing prescription oral medications and imposing any requirements, conditions, or exclusions that discriminate against a physician in connection with dispensing prescription oral medications. ***Potential CalOptima Health Impact:*** Increased oversight of contracted PBM and referral processes.	**02/12/2025** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 688 Gonzalez	**Telehealth for All Act of 2025:** Beginning in 2028 and every two years thereafter, would require DHCS to use Medi-Cal data and other data sources to produce analyses in a publicly available Medi-Cal telehealth utilization report. ***Potential CalOptima Health Impact:*** New reporting requirements to DHCS.	**02/14/2025** Introduced	CalOptima Health: Watch
AB 894 Carrillo	**Immigration and Patient Privacy:** Would state the intent of the Legislature to enact legislation protecting the privacy of undocumented Californians. ***Potential CalOptima Health Impact:*** Increased protection of medical information; increased staff training regarding disclosure processes.	**02/20/2025** Introduced	CalOptima Health: Watch
AB 980 Arambula	**Health Plan Duty of Care:** As it pertains to the required "duty of ordinary care" by a health plan, would define "medically necessary health care service" to mean legally prescribed medical care that is reasonable and comports with the medical community standard. ***Potential CalOptima Health Impact:*** Modified UM procedures.	**02/21/2025** Introduced	CalOptima Health: Watch
Older Adult Services			
SB 242 Blakespear	**Medicare Supplemental Coverage Open Enrollment Periods:** Would make Medicare supplemental benefit plans available to qualified applicants with end stage renal disease under the age of 64 years. Would also create an annual open enrollment period for Medicare supplemental benefit plans and prohibit such plans from denying an application or adjusting premium pricing due to a preexisting condition. ***Potential CalOptima Health Impact:*** Expanded Medicare coverage options for dual-eligible members.	**01/30/2025** Introduced	CalOptima Health: Watch
SB 412 Limón	**Home Care Aides:** Would require a home care organization to ensure that a home care aide completes training related to the special care needs of clients with dementia prior to providing care and annually thereafter. ***Potential CalOptima Health Impact:*** New training requirements for PACE staff.	**02/14/2025** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 346 Nguyen	**In-Home Supportive Services (IHSS) Certification:** Expands the definition of a "licensed health care professional" who is allowed to certify IHSS eligibility to include any person who is a health care practitioner under the Business and Provisions Code. Would also clarify that, as a condition of receiving paramedical services, an applicant or recipient is required to obtain a certification from a licensed health care professional, as specified. ***Potential CalOptima Health Impact:*** New training requirements for PACE staff; streamlined enrollment of PACE participants into IHSS.	**01/29/2025** Introduced	CalOptima Health: Watch
AB 960 Garcia	**Dementia Patient Visitation:** Would require a health facility to allow a patient with demonstrated dementia needs to have a family or friend caregiver with them as needed. ***Potential CalOptima Health Impact:*** New visitation policies for PACE center.	**02/21/2025** Introduced	CalOptima Health: Watch
Providers			
SB 32 Weber	**Maternity Ward Closures:** States the intent of the Legislature to enact legislation to address maternity ward closures. ***Potential CalOptima Health Impact:*** Continued member access to maternity wards.	1**2/02/2024** Introduced	CalOptima Health: Watch
SB 250 Ochoa Bogh	**Medi-Cal Provider Directory — Skilled Nursing Facilities:** Would require a provider directory issued by a Medi-Cal MCP to include skilled nursing facilities as a searchable provider type. ***Potential CalOptima Health Impact:*** Modifications to CalOptima Health's online provider directory.	**01/30/2025** Introduced	CalOptima Health: Watch
SB 306 Becker	**Prior Authorization Gold Carding:** Would restrict health plans from requiring prior authorization for a covered health care service if certain conditions are met, such as approving 90% or more requests in the previous year. If a service qualifies for this exemption, it must be listed on the provider's website by March 15 annually. ***Potential CalOptima Health Impact:*** Implementation of new UM procedures to assess provider approval rates; decreased number of prior authorizations.	**02/10/2025** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 504 Laird	**HIV Reporting:** Would authorize a health care provider for a patient with an HIV infection that has already been reported to a local health officer to communicate with a local health officer or the California Department of Public Health (CDPH) to obtain public health recommendations on care and treatment or to refer the patient to services provided by CDPH. ***Potential CalOptima Health Impact:*** Increased coordination of care for HIV-positive CalOptima Health.	**02/20/2025** Introduced	CalOptima Health: Watch
AB 29 Arambula	**Adverse Childhood Experiences (ACEs) Screening Providers:** Would require DHCS to include community-based organizations, local health jurisdictions and doulas as qualified providers for ACEs trauma screenings and require clinical or other appropriate referrals as a condition of Medi-Cal payment for conducting such screenings. ***Potential CalOptima Health Impact:*** Increased access to care for pediatric members with ACEs.	**12/02/2024** Introduced	CalOptima Health: Watch
AB 50 Bonta	**Over-the-Counter Contraceptives:** Would allow pharmacists to provide over-the-counter hormonal contraceptives without following certain procedures and protocols, such as requiring patients to complete a self-screening tool. As such, these requirements would become limited to prescription-only hormonal contraceptives. ***Potential CalOptima Health Impact:*** Increased member access to hormonal contraceptives.	**12/02/2024** Introduced	CalOptima Health: Watch
AB 55 Bonta	**Alternative Birth Centers Licensing:** Would remove the requirement for alternative birth centers to provide comprehensive perinatal services as a condition of CDPH licensing and Medi-Cal reimbursement. ***Potential CalOptima Health Impact:*** Decreased member access to comprehensive perinatal services; reduced operating requirements for alternative birth centers.	**12/02/2024** Introduced	CalOptima Health: Watch
AB 220 Jackson	**Medi-Cal Subacute Care Authorization:** Would mandate health facilities providing pediatric or adult subacute care to include a specific DHCS form with treatment authorization requests, preventing Medi-Cal MCPs from creating their own criteria for determining medical necessity outside of those specified in the form. Would allow DHCS to impose sanctions on non-compliant Medi-Cal MCPs. ***Potential CalOptima Health Impact:*** Modified UM procedures and forms.	**01/08/2025** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 280 Aguiar-Curry	**Provider Directory Accuracy:** Would require health plans to maintain accurate provider directories, starting with minimum 60% accuracy by July 1, 2026, and increasing to 95% by July 1, 2029, or otherwise receive administrative penalties. If a patient relies on inaccurate directory information, would require the provider to be reimbursed at the out-of-network rate without the patient incurring charges beyond in-network cost-sharing amounts. Would also allow DMHC to create a standardized format to collect directory information as well as establish methodologies to ensure accuracy, such as use of a central utility, by January 1, 2026. ***Potential CalOptima Health Impact:*** Increased oversight of CalOptima Health provider directory; increased coordination with contracted providers; increased penalty payments to DHCS.	**01/21/2025** Introduced	CalOptima Health: Watch
AB 375 Nguyen	**Qualified Autism Service Paraprofessional:** Would expand the definition of "health care provider" to also include a qualified autism service paraprofessional. ***Potential CalOptima Health Impact:*** Increased access to autism services for eligible members; additional provider contracting and credentialing.	**02/04/2025** Introduced	CalOptima Health: Watch
AB 416 Krell	**Involuntary Commitment:** Would authorize a person to be taken into custody by an emergency physician under the Lanterman-Petris-Short Act and would exempt the emergency physician from criminal and civil liability. ***Potential CalOptima Health Impact:*** New legal standards for certain CalOptima Health providers.	**02/05/2025** Introduced	CalOptima Health: Watch
AB 510 Addis	**Utilization Review Appeals and Grievances:** Would require that an appeal or grievance regarding a decision to delay, deny or modify health services be reviewed by a physician matching the specialty of the service within two business days. In urgent cases, responses must match the urgency of the patient's condition. If these deadlines are not met, the authorization request would be automatically approved. ***Potential CalOptima Health Impact***: Expedited and modified UM, grievance and appeals procedures for covered Medi-Cal benefits; increased hiring of specialists to review grievances and appeals.	**02/10/2025** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 512 Harabedian	**Prior Authorization Timelines:** Would shorten the timeline for prior authorization requests to no more than 48 hours for standard requests or 24 hours for urgent requests, starting from plan receipt of the information reasonably necessary and requested by the plan to make the determination. ***Potential CalOptima Health Impact***: Expedited and modified UM procedures for covered Medi-Cal benefits.	**02/10/2025** Introduced	CalOptima Health: Watch
AB 517 Krell	**Wheelchair Prior Authorization:** Would prohibit a Medi-Cal MCP from requiring prior authorization for the repair of a Complex Rehabilitation Technology (CRT)-powered wheelchair, if the cost of repair does not exceed $1,250. Would also no longer require a prescription or documentation of medical necessity, if the wheelchair has already been approved for use by the patient. Additionally, would require supplier documentation of the repair. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**02/10/2025** Introduced	CalOptima Health: Watch
AB 539 Schiavo	**One-Year Prior Authorization Approval:** Would require a prior authorization for a health care service to remain valid for a period of at least one year from the date of approval. ***Potential CalOptima Health Impact:*** Modified UM procedures for covered Medi-Cal benefits; decreased number of prior authorizations; increased costs.	**02/11/2025** Introduced	CalOptima Health: Watch
AB 787 Papan	**Provider Directory Disclosures:** Would require a health plan to include at the top of its provider directory a statement advising an enrollee to contact the plan for assistance in finding an in-network provider. Would also require the plan to respond within 24 hours if contacted for such assistance and to provide a list of in-network providers confirmed to be accepting new patients within two business days. ***Potential CalOptima Health Impact:*** Expanded customer service support and staff training; technical changes to CalOptima Health's provider directory.	**02/18/2025** Introduced	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1041 Bennett	**Provider Credentialing:** Would require a health plan to credential a provider within 90 days from the receipt of a completed application, or otherwise conditionally approve the credential. A plan would be required to notify the provider whether the application is complete within 10 days of receipt. In addition, would require DMHC to establish minimum standards or policies and processes to streamline and reduce redundancy and delay in provider credentialing. Additionally, would require health plans to use a standardized credentialing form on and after July 1, 2027, or six months after the form is completed, whichever is later, with updates to the forms every three years thereafter. ***Potential CalOptima Health Impact:*** Expedited and modified credentialing procedures for interested providers.	**02/21/2025** Introduced	CalOptima Health: Watch
Rates & Financing			
SB 339 Cabaldon	**Medi-Cal Laboratory Rates:** Would allow Medi-Cal reimbursement rates to clinical laboratory or laboratory services for the diagnosis and treatment of sexually transmitted infections to exceed the average lowest rate of other payers and other state Medicaid programs for similar services. ***Potential CalOptima Health Impact*:** Increased payments to contracted clinical laboratories.	**02/12/2025** Introduced	CalOptima Health: Watch
Social Determinants of Health			
SB 16 Blakespear	**Homelessness:** States the intent of the Legislature to enact legislation to address homelessness. ***Potential CalOptima Health Impact:*** Unknown at this time.	**12/02/2024** Introduced	CalOptima Health: Watch

Information in this document is subject to change as bills proceed through the legislative process.

Last Updated: March 24, 2025

2025 Federal Legislative Dates

January 3	119th Congress, 1st Session convenes
July 25–September 1	Summer recess for House
August 2–September 1	Summer recess for Senate
December 19	1st session adjourns

Source: Floor Calendars, United States Congress: https://www.congress.gov/calendars-and-schedules

2025 State Legislative Dates

January 6	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
February 21	Last day for legislation to be introduced
April 10–20	Spring recess
May 2	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house
May 9	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house
May 23	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house
June 2–6	Floor session only
June 6	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 18	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 18–August 17	Summer recess
August 29	Last day for fiscal committees to report bills in their second house to the Floor
September 2–12	Floor session only
September 5	Last day to amend bills on the Floor
September 12	Last day for each house to pass bills; interim recess begins upon adjournment
October 12	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2025 Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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About CalOptima Health

CalOptima Health is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to serve member health with excellence and dignity, respecting the value and needs of each person. We provide coverage through three major programs: Medi-Cal, OneCare (HMO D-SNP) and the Program of All-Inclusive Care for the Elderly (PACE).

CalOptima Health Community Outreach Summary — March and April 2025

Background

CalOptima Health is committed to serving the community by sharing information with current and potential members and strengthening relationships with community partners. To this end, our team attends community coalitions, collaborative meetings and advisory groups and supports our community partners' public activities. Participation includes providing Medi-Cal educational materials and, if criteria are met, financial support and/or CalOptima Health-branded items.

CalOptima Health's participation in public activities promotes:

- Member interaction/enrollment in a CalOptima Health program
- Community awareness of CalOptima Health
- Partnerships that increase positive visibility and relationships with community organizations

Community Outreach Highlight

On Friday, March 21, CalOptima Health collaborated with Crime Survivors Resource Center and took a proactive step to address the opioid crisis by hosting a Naloxone Distribution Event for providers and community stakeholders. As part of CalOptima Health's Drive to Revive campaign, this event provided free doses of 8 mg naloxone and training resources, equipping them with critical tools to prevent opioid overdoses.

Beyond distribution, the event emphasized education to reinforce the importance of naloxone's life-saving potential and train recipients on how to identify an overdose and the proper administration of naloxone in emergency situations. We encouraged our partners to distribute the naloxone and share the training information in their communities, ensuring more individuals have access to this vital information and are prepared to administer naloxone in a crisis.

CalOptima Health remains committed to supporting overdose prevention and working with local organizations to keep our communities safe, one spray at a time.

Summary of Public Activities

As of March 10, CalOptima Health plans to participate in, organize or convene 79 public activities in March and April. There were 46 public activities in March, including 16 virtual community/collaborative meetings, 16 community events, 13 community-based presentations and one Health Network Forum. In April, there will be 33 public activities, including 15 virtual community/collaborative meetings, 14 community events, two community-based presentations, one Cafecito Meeting and one Health Network Forum. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided four endorsements since the last reporting period (i.e., letters of support, program/public activity events with support or use of name/logo). Endorsement requests must meet the requirements of CalOptima Health's Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for Letters of Support and Use of CalOptima Health's Name and Logo. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

1. Letter of support for Moving Forward Psychological Institute, Inc.'s application for the OC Community Services' Special Projects Workforce Development Services Grant
2. Letter of support for Hurtt Family Health Clinic's application for HRSA's Healthy Tomorrows Partnership for Children Program funding
3. Letter of support for Project Hope Alliance's application for the Regional Investment Initiative Catalyst Funding
4. Letter of support for Community Action Partnership of Orange County's (CAP OC) application to support their California First Weatherization Training Facility proposal

For additional information or questions, contact CalOptima Health Community Relations Director Tiffany Kaaiakamanu at 714-222-0637 or tkaaiakamanu@caloptima.org.

Attachment to the
April 3, 2025
CalOptima Health
Outreach Summary

Community events hosted by CalOptima Health and community partners in March and April 2025:

March 2025

March 1, 9 a.m.–1 p.m., Community Resource Fair, hosted by CalOptima Health and the City of Laguna Niguel

Crown Valley Community Center, 29751 Crown Valley Pkwy., Laguna Niguel

- At least 20 staff members attended (in person)
- Health/Resource Fair, open to the public

March 1, 9 a.m.–1 p.m., Community Resource Fun Fair, hosted by Garden Grove Unified School District

Santiago High School, 12342 Trask Ave., Garden Grove

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

March 1, 10 a.m.–3 p.m., Veterans Stand Down, hosted by the National Veterans Service

Garden Grove Elks Lodge, 11551 Trask Ave., Garden Grove

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

March 2, 12–6 p.m., Annual Ethiopian Day, hosted by Ethio-American Generational Bridge

Craig Regional Park, 3300 S. State College Blvd., Fullerton

- Sponsorship fee: $500; included a resource table, half-page ad and feature in the program
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

March 4, 8–9:30 a.m., CalOptima Health Medi-Cal Overview in Spanish

Olive Street Elementary School, 890 S. Olive St., Anaheim

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

March 5, 11 a.m.–Noon, CalOptima Health Medi-Cal Overview in English

Wellness Center Central, 401 S. Tustin St., Orange

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

March 6, 8:30–9:30 a.m., CalOptima Health Medi-Cal Overview in Spanish
Esqueda Elementary School, 2240 S. Main St., Santa Ana

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

March 6, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services
Balsam Curtis Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

March 7, 8–9:30 a.m., CalOptima Health Medi-Cal Overview in English
Olive Street Elementary School, 890 S. Olive St., Anaheim

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

March 7, 11 a.m.–1 p.m., Golden Futures Expo, hosted by Golden Futures Expo
Hyatt Regency Newport Beach, 1107 Jamboree Rd., Newport Beach

- Sponsorship fee: $595; included a resource booth, organization's name and profile in expo guide, organization hyperlink on website and promotional item in swag bag.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

March 8, 11 a.m.–1 p.m., Deaf/Hard of Hearing Resource Fair, hosted by the Regional Center of Orange County
Anaheim Central Public Library, 500 Broadway Ave., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

March 8, 7:30 a.m.–1 p.m., Social Drivers Conference, hosted by the American Academy of Pediatrics
UCI Sue Gross Auditorium, 854 Health Sciences Rd., Irvine

- Sponsorship fee: $1,000; included a resource booth.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

March 10, 10–11 a.m., CalOptima Health Medi-Cal Overview in English and Spanish
Mercy House, Virtual

- At least one staff member presented
- Community-based organization presentation, open to members/community

March 11, 8:30–9:30 a.m., CalOptima Health Medi-Cal Overview in Spanish
Sierra Preparatory Academy, 2021 N. Grand Ave., Santa Ana

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

March 11, 9–10 a.m., CalOptima Health Medi-Cal Overview in English
Maxim Healthcare Services, Virtual

- At least one staff member presented
- Community-based organization presentation, open to members/community

March 12, 11 a.m.–Noon, CalOptima Health Medi-Cal Overview in English
Project Kinship, Virtual

- At least one staff member presented
- Community-based organization presentation, open to members/community

March 13, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services
Ventura Greenacre Moraga Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

March 14, 9–10 a.m., CalOptima Health Medi-Cal Overview in English
Cal State Fullerton School of Nursing, Virtual

- At least one staff member presented
- Community-based organization presentation, open to members/community

March 18, 6–7 p.m., CalOptima Health Medi-Cal Overview in Spanish
Think Together, Virtual

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

March 19, 5–7 p.m., Back to School Night and Open House, hosted by Centralia Elementary School
Centralia Elementary School, 195 N. Western Ave., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

March 21, 9 a.m.–Noon, Naloxone Distribution Event, hosted by CalOptima Health and Crime Survivors Resource Center
Location to be determined

- At least eight staff members attended (in person)
- Health/Resource Fair, open to the public

March 21, 8:45–9:45 a.m., CalOptima Health Medi-Cal Overview in Spanish
Lowell Elementary School, 700 Flower St., Santa Ana

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

March 26, 8 a.m.–4 p.m., 2025 Spirituality Conference, hosted by Hoag Hospital
Fullerton Free Church, 2801 N. Brea Blvd., Fullerton

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

March 26, 4:30–5:30 p.m., CalOptima Health Medi-Cal Overview in Spanish
Project Access Hermosa Village Apartments, 1515 S. Calle Del Mar, Anaheim

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

March 27, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services
Ventura Greenacre Moraga Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

March 27, 4:30–5 p.m., CalOptima Health Medi-Cal Overview in Spanish
Cesar E. Chavez High School, 2128 Cypress Ave., Santa Ana

- At least one staff member presented (in person)
- Community-based organization presentation, open to members/community

March 29, 8–11 a.m., Kids Fishing Derby, hosted by the Office of Orange County Supervisor Doug Chaffee
Ralph B. Clark Regional Park, 8800 Rosecrans Ave., Buena Park

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

March 29, 9 a.m.–1 p.m., Community Healthcare and Social Services Expo, hosted by the Office of Orange County Supervisor Janet Nguyen and the County of Orange Social Services Agency
Freedom Hall, 16801 Euclid St., Fountain Valley

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

March 30, 4–6 p.m., Health and Wellness Fair, hosted by the City of Fullerton
Fullerton Community Center, 340 W. Commonwealth Ave., Fullerton

- Registration fee: $100; included a resource table.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

April 2025

April 3, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services
Colchester and Vancouver Neighborhood

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

April 4, 4–6 p.m., Community Wellness Gathering & Resource Fair, hosted by OMID Multicultural Institute for Development

Metro East Senior Apartment, 2222 E. 1st St., Santa Ana

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

April 5, 9 a.m.–1 p.m., Good to Go Fair, hosted by Pretend City

Pretend City Children's Museum, 29 Hubble, Irvine

- Sponsorship fee: $2,500; includes a resource table, logo on banner and signage, and inclusion as sponsor on collateral materials.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

April 5, 10 a.m.–1 p.m., Health Fair, hosted by the City of Anaheim Mayor Pro Tem Norma Kurtz and Olive Street Elementary School

Olive Street Elementary School, 890 S. Olive St., Anaheim

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

April 6, 10 a.m.–1 p.m., Health Fair, hosted by the Second Baptist Church

Second Baptist Church, 4300 Westminster Ave., Santa Ana

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

April 8, 4–5 p.m., CalOptima Health Medi-Cal Overview in Spanish

Baden Powell Head Start, 801 S. Gaymont St., Anaheim

- At least one staff member to present (in person)
- Community-based organization presentation, open to members/community

April 10, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Philadelphia and Olive Neighborhood

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

April 19, 10 a.m.–3 p.m., 2025 LGBTQ+ Youth Convening, hosted by the OC LGBTQ Center and Santa Ana Unified School District

Segerstrom High School, 2301 W. Macarthur Blvd., Santa Ana

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

April 19, 11 a.m.–3 p.m., Community Resource Fair, hosted by CalOptima Health and Olive Community Services

Islamic Center of Yorba Linda, 4382 Eureka Ave., Yorba Linda

- At least 20 staff members to attend (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

April 22, 11 a.m.–2 p.m., Cal State Fullerton Mental Health Resource Fair, hosted by Partners4Wellness

Cal State Fullerton, 800 N. State College Blvd., Fullerton

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

April 24, 10 a.m.–2 p.m., Job and Resource Fair, hosted by Huntington Beach Adult School

Ocean View High School, 1701 Gothard St., Huntington Beach

- Sponsorship fee: $15,000; includes a resource table, logo on flyer and speaking opportunity.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

April 25, 8 a.m.–4 p.m., Meeting of the Minds, hosted by Mental Health Association of Orange County

Anaheim Marriott, 700 W. Convention Way, Anaheim

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

April 26, 7–11 a.m., SuperHero Run Walk, hosted by Crime Survivors Resource Center

Mason Park, 18712 University Dr., Irvine

- Sponsorship fee: $500; includes a resource table, marketing on signage, promotional materials in event bag, event shirts and medals and 10 complimentary runner/walker passes.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

April 26, 11 a.m.–3 p.m., Dia Del Niño, hosted by Unidos South OC

Stone Field Park, 31422 Camino Capistrano, San Juan Capistrano

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

April 29–30, TBD, Annual Health Summit, hosted by Family Voices of California

Virtual

- Sponsorship fee: $5,000; includes verbal recognition at the summit and logo or name placement on marketing materials that include invitations, emails, social media, event website and FVCA website. Logo or name placement at the event includes slides, handouts and event website.
- At least one staff member to attend
- Health/Resource Fair, open to the public

April 30, 10–11:30 a.m., CalOptima Health Medi-Cal Overview in English

Laura's House, Virtual

- At least one staff member to present
- Community-based organization presentation, open to members/community

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation Exhibitor/Attendee

These sponsorship request(s) and community event(s) met the requirements of CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at:
https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx

FY2025-2027 Strategic Plan
Organization Goals and Performance Metrics
Executive Status Report

Performance Year: FY 2025
Reporting Period: Jan 2025 - March 2025
Reporting Date: 4/1/2025

= Actual = Target

Strategic Priority	1.0 Equity and Population Health

CalOptima Health will infuse the pursuit of health equity throughout our work and will continue to innovate and develop tools and interventions that advance the physical, behavioral, and social health of our members.

Organization Goal	3-Year Performance Metric	Owner	Key Highlights To-Date	Actual	3- Year Target	Performance Indicators
1.1 Utilize technology and innovation to strengthen equity and population health management programs.	At least 50% of the participants who complete the 12 month program will report 5% weight loss or 0.2% decrease in Hemoglobin A1c*	Marie Jeannis	• In the process of credentialing a new text and web-based Diabetes Prevention Program provider. • Developed interactive text message campaign to enroll members in DM program.	0%	50%	0% 25% 50% 75% 100% *New Measure - no data available at this time*
1.2 Implement a consistent model of care for population health/care management, including delegated networks.	Percentage of members successfully enrolled in Complex Case Management	Kelly Giardina	• Delegated Medical Group CEOs provided draft Case Management communication on staffing and caseload expectations including minimum Complex Case Management member case volume expectations	0.03%	0.05%	0.00% 0.01% 0.02% 0.03% 0.04% 0.05% *.05% = ~400 members*
1.3 Annually assess members' health and social needs and utilize data to develop targeted interventions.	Percentage of members assessed for social needs and referred for appropriate interventions within 30 days*	Marie Jeannis	• Conducted data analysis to establish SDOH screening benchmark • Updated SDOH dashboard to include additional SDOH Z-codes • Implemented SDOH screenings at community events	0%	30%	0% 10% 20% 30% 40% 50% *New Measure - no data available at this time*
1.4 Increase access to preventive services for vulnerable populations in pursuit of health equity.	Percentage of compliance with Prenatal and Postpartum Care (PPC) measures	Marie Jeannis	• Maternal Health and Breast-Feeding event - served 181 participants • Maternal and Infant Wellness pilot events - served 48 pregnant and postpartum families	65%	90%	0% 25% 50% 75% 100%

**New Measure - no data available*

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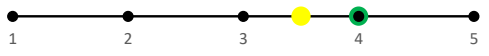
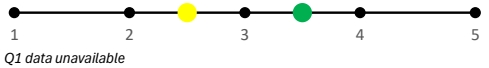
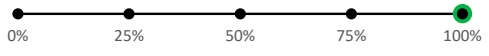
Strategic Priority	**2.0 Quality and Value**
CalOptima Health is committed to providing the highest quality physical, behavioral, and social health care to our members and to ensuring sound stewardship of public dollars by achieving greater value.	

Organization Goal	3-Year Performance Metric	Owner	Key Highlights To-Date	Actual	3- Year Target	Performance Indicators
2.1 Achieve NCQA rating of 4-stars for Medi-Cal. Achieve CMS rating of 3.5-stars for Medicare.	Medi-Cal Star Rating	Linda Lee	• Initial data run completed. Quality improvement initiatives implemented for high priority measures	3.5	4	 *Q1 data unavailable*
	Medicare Star Rating	Linda Lee	• Initial data run completed. Quality improvement initiatives in development for high priority measures	2.5	3.5	 *Q1 data unavailable*
2.2 Improve access to care by strengthening the delivery system through provider support and workforce initiatives.	Percentage of providers meeting Time and Distance standards – Plan and Subdelegate level (DHCS) - CCN	Michael Gomez	• Streamlined standardized processes for production of Annual Network Certification, Subdelegated Network Certification, Primary Care Provider capacity • Completed 2024 SNC DHCS submission	100%	100%	
	Percentage of providers meeting Time and Distance standards – Plan and Subdelegate level (DHCS) - Health Network	Michael Gomez	• Issued Corrective Action Plans to health networks in areas of non-compliance • Continue to monitor compliance and improve communication of results on an ongoing basis	98%	100%	
2.3 Increase provider engagement through improved provider tools, data exchange, and collaboration.	Overall provider satisfaction score*	Michael Gomez	• Identifying potential vendors to conduct annual provider satisfaction assessment	0%	70%	 *New Measure - no data available at this time*
2.4 Expand the delivery of BH services, invest in the workforce, and drive quality improvement through innovation.	Percentage of Follow-Up After Emergency Department Visit for Mental Illness (FUM) within 30 days**	Carmen Katsarov	• Sending daily real time Emergency Department (ED) data to Health Networks • BH virtual vendor TELEMED2U conducting outreach to Members that have ED visits to close care gaps • Working with OC HCA for improved data exchange for Follow-Up After Emergency Department Visit for Mental Illness (FUM)	10	75	 *Percentile based HEDIS benchmarks*

**New Measure - no data available; ** Percentile based on HEDIS benchmarks*

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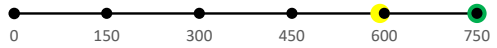
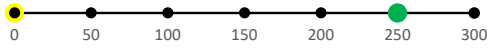
● = Actual ● = Target

Strategic Priority	**3.0 Community Partnerships and Investments**
CalOptima Health will continue to demonstrate our partnership with Orange County members, providers, county agencies, and community organizations through CalAIM programs and robust community investments and partnerships to advance health, safety, and wellbeing for all members.	

Organization Goal	3-Year Performance Metric	Owner	Key Highlights To-Date	Actual	3- Year Target	Performance Indicators
3.1 Expand social support services through Medi-Cal Transformation and other social health initiatives.	Number of members served through Street Medicine	Kelly Bruno-Nelson	• 20 individuals have been permanently housed by the Street Medicine Program since program launch in April 2023 • Expansion to Santa Ana was approved by the Board on 3/6/2025; RFP for a Street Medicine provider released, with recommended provider to be presented for BOD approval in June 2025	593	750	
3.2 Expand community involvement in co-creation of solutions that best serve members.	Number of individuals who attend or participate in community listening sessions, focus groups, or stakeholder engagement sessions*	Marie Jeannis	• Data being collected for current listening sessions • New vendor selection for focus groups/listening sessions	0	250	 *New Measure - no data available at this time*
3.3 Prioritize community investments that advance health equity, drive prevention, and improve access to care.	Percentage of net income allocated to community investments in health equity, prevention, and access to care	Donna Laverdiere	• Management and review of active grants is ongoing • Oct-Dec 2024 impact summaries reported at March BOD • Received final Community Reinvestment guidance from DHCS; planning began in March	17.7%	7.5%	
3.4 Ensure that all community investment programs include clear accountability metrics and regular performance monitoring requirements.	Percentage of grant agreements in compliance with reporting requirements	Donna Laverdiere	• Total grants in compliance with reporting timelines and completeness:194/195 • Implemented Grants Management Policy and Grants Auditing Policy • Established Community Investment & Oversight Committee	99%	100%	

**New Measure - no data available*

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= Actual = Target

Strategic Priority	4.0 Operations, Finance and People

Investing in our performance is vital to allowing CalOptima Health to ensure the highest level of care and service to our members across their lifespan.

Organization Goal	3-Year Performance Metric	Owner	Key Highlights To-Date	Actual	3- Year Target	Performance Indicators
4.1 Improve the turnaround time for treatment authorization for direct and delegated networks.	Treatment authorization processing time (days) for all providers (Routine)	Kelly Giardina	• Attac consulting group contract signed 1/22/2025. Consultant group retained to develop an updated prior authorization list and continued improvements to timeliness of processing treatment authorizations	1.73	0	0 1 2 3 4 *Q1 actual is for CCN only; Target is TBD; no baseline data available at this time*
	Treatment authorization processing time (days) for all providers (Urgent)	Kelly Giardina	• Attac consulting group contract signed 1/22/2025. Consultant group retained to develop an updated prior authorization list and continued improvements to timeliness of processing treatment authorizations	13.26	0	0 5 10 15 *Q1 actual is for CCN only; Target is TBD; no baseline data available at this time*
4.2 Improve the turnaround time for claims payment for direct and delegated networks.	Claims auto-adjudication rate - Medi-Cal	Ladan Khamseh	• Claims and IT continue to implement the removal of manual processing with automation logic in Facets	82%	84%	0% 25% 50% 75% 100%
	Claims auto-adjudication rate - OneCare	Ladan Khamseh	• Claims and IT continue to implement the removal of manual processing with automation logic in Facets	77%	74%	0% 25% 50% 75% 100%
4.3 Launch and grow programs that take care of our members and their families across their lifespan.	Membership growth by Line of Business - OneCare	Donna Laverdiere	• Added new flexcard benefit and a second plan option • New marketing vendor onboarded to develop a campaign to promote growth of OneCare	17340	30000	10000 15000 20000 25000 30000
	Membership growth by Line of Business - PACE	Donna Laverdiere	• New marketing campaign developed to promote growth of PACE enrollment • New Sales and Marketing Manager hired	502	700	0 175 350 525 700
	Membership growth by Line of Business - Covered CA*	Donna Laverdiere	• Received Board of Supervisors ordinance change approval • Initiated DMHC filing and conducted pre-filing conference • Engaged with Milliman on rate development for network contracts	0	10000	0 2500 5000 7500 10000 *New Measure - no data available at this time*

**New Measure - no data available*

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CalOptima Health

FY2025-2027 Strategic Plan
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Performance Year: FY 2025
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= Actual = Target

Strategic Priority	**4.0 Operations, Finance and People**
Investing in our performance is vital to allowing CalOptima Health to ensure the highest level of care and service to our members across their lifespan.	

Organization Goal	3-Year Performance Metric	Owner	Key Highlights To-Date	Actual	3- Year Target	Performance Indicators
4.4 Optimize the Medicare line of business to improve the member retention rate and support growth.	Voluntary Disenrollment rate	Javier Sanchez	• Added new flexcard benefit and a second plan which is contributing to retention and growth • Developing provider education dinner series to improve member experience, member retention and Stars performance	1.56%	5%	1% 2% 3% 4% 5% *-Inverse measure (lower is better)* *-Overall target is <5% for each calendar year end*
4.5 Implement the comprehensive Digital Transformation strategic roadmap to improve member experience and efficiency.	Percentage of Digital Transformation projects completed on time and within budget	Donna Laverdiere	• Internet and network bandwidth upgrades completed in December 2024 • The Salesforce implementation for Provider Life Cycle Management is being adjusted to meet credentialing benchmarks	20%	95%	0% 25% 50% 75% 100%
4.6 Optimize member engagement functions to improve member retention, satisfaction, and outcomes.	CAHPS Rating of Health Plan	Ladan Khamseh	• After-Call Survey: 96 surveys completed (84 satisfied 12 dissatisfied=88%) • Just in time outreach Survey: 3,997 surveys completed (3,796 satisfied 201 dissatisfied= 95%)	2	4	1 2 3 4 5
4.7 Ensure fiscal accountability and stewardship, including a balanced operating budget, quarterly budget reconciliation, and vendor and provider contracting.	Quarterly ALR measure	Nancy Huang	• $6.1M favorable variance in Salaries, Wages, & Benefits • $24.7M favorable variance in other administrative expense categories	5.3%	7.0%	0% 3% 5% 8% 10%
4.8 Launch expanded employee development and retention efforts to drive employee engagement and advancement.	Percentage of open positions filled by qualified internal candidates	Steve Eckberg	• HR Strategic plan and annual objectives developed for FY26 to support infrastructure	38%	50%	0% 25% 50% 75% 100%

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CalOptima Health Board Action Agenda Referral

Action To Be Taken April 3, 2025
Regular Meeting of the CalOptima Health Board of Directors

Report Item

15. Approve Modifications to CalOptima Health Statutory and Board-Designated Reserve Funds Policy

Contact

Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action

Approve modifications to CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds, effective upon Board approval.

Background

CalOptima Health regularly reviews its policies and procedures to ensure they are current and align with federal and state health care program requirements, contractual obligations, laws, and CalOptima Health operations. CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds was last revised on May 2, 2024, to update the range for the Board-designated Reserve Fund to between 2.5 months to 3.0 months of consolidated monthly revenue, create a Statutory Reserve Fund to ensure compliance with tangible net equity requirements, and remove language to subtract working capital deficits from reserves.

Discussion

In March 2025, the California Department of Health Care Services (DHCS) reported on higher-than-expected expenses in the Medi-Cal program. To address the budget shortfall through June 30, 2025, DHCS requested immediate funding of approximately $6.2 billion. The primary drivers creating the budget shortfall were full Medi-Cal expansion to undocumented immigrants, uncertain cash flow from Managed Care Organization tax revenue under Proposition 35, and increased prescription drug costs.

Considering the uncertainties in the Medicaid program at the federal level and the fiscal sustainability of full Medi-Cal eligibility expansion at the state level in the upcoming fiscal year, staff is recommending modifications to this policy to ensure CalOptima Health's long-term financial viability. Staff recommends updating the range for the Board-designated Reserve Fund from 2.5 months to 3.0 months of consolidated monthly revenue to a range of 2.5 months to 4.0 months of consolidated monthly revenue.

Increasing the upper limit of the Board-designated Reserve Fund will provide additional stability during potential delays of capitation revenue and regulatory updates or program changes in Medi-Cal eligibility or covered services. The updates will help CalOptima Health maintain operations without cash flow disruptions. The updated reserve level will better protect CalOptima Health's healthcare delivery system, provide assurance to provider partners, and ensure access to quality health care services for members.

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Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2024-25 Budget.

Rationale for Recommendation
Updates to CalOptima Health Policy GA.3001 will promote fiscal prudence, sound stewardship of public funds and improve CalOptima Health's short-term and long-term financial viability.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Health Policy GA.3001: Board-Designated Reserve Funds

/s/ Michael Hunn *03/27/2025*
Authorized Signature **Date**

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Policy:	GA.3001
Title:	**Statutory and Board-Designated Reserve Funds**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	11/01/1996
Revised Date:	04/03/2025
Applicable to:	☒ Administrative ☐ Covered California ☐ Medi-Cal ☐ OneCare ☐ PACE

I. PURPOSE

This policy establishes CalOptima Health's policy and procedure for the creation, maintenance, and utilization of reserve funds to meet statutory requirements and for the benefit of CalOptima Health's long-term financial viability.

II. POLICY

A. The Statutory and Board-designated Reserve Funds are created for the purposes of keeping CalOptima Health reserve levels in compliance with State requirements, maintaining CalOptima Health's healthcare delivery system during short-term crises, and protecting CalOptima Health's long-term financial viability.

B. Statutory Reserve: As required by CalOptima Health's Contract with the Department of Health Care Services (DHCS), CalOptima Health shall, at all times, maintain in the Statutory Reserve Fund the minimum required Tangible Net Equity (TNE).

1. The minimum required TNE shall be calculated in accordance with Title 28 California Code of Regulations, Section 1300.76.

2. The goal of this reserve is to maintain the fund level between 100% and 110% of the minimum required TNE.

C. Board-designated Reserve: As established by the CalOptima Health Board of Directors (Board), the goal of this reserve is to maintain the Board-designated Reserve Fund level at no less than two and a half (2.5) months' consolidated capitation revenues and no more than four (4.0)~~three (3.0)~~ months' consolidated capitation revenues.

1. This is a minimum threshold and not a mandate to draw reserves down to this level.

2. The Board shall have discretion on the appropriate reserve level above the minimum threshold, taking into account current and future economic conditions.

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3. One (1) month's consolidated capitation revenues is calculated based on the average consolidated capitation revenue, excluding special pass-through payments, such as Quality Assurance Fees (QAF), the Managed Care Organization (MCO) tax, and Intergovernmental Transfers (IGT) or prior year rate adjustments implemented in the current year during the most recent twelve (12) month period for which all capitation payments have been received by CalOptima Health, and for which internally-prepared financial statements are available.

D. Creation of the Statutory Reserve and Board-designated Reserve Funds

1. CalOptima Health shall establish separate and distinct accounts for each reserve fund.

   a. CalOptima Health shall utilize the Tier 1 investment portfolio to ensure adequate reserves in compliance with the Board-designated Reserve Fund level between two and a half (2.5) and ~~three (3.0)~~ four (4.0) times of monthly consolidated capitation revenues.

   b. CalOptima Health shall utilize the Tier 2 investment portfolio to ensure adequate reserves in compliance with the Statutory Reserve Fund level between 100% and 110% of the minimum required TNE.

2. Management shall transfer, from time to time, funds into the Statutory Reserve or the Board-designated Reserve Funds no greater than the net available for reserves for any given Fiscal Year, plus additional funds, if deemed appropriate.

   a. On a Fiscal Year-to-date basis, the net available for reserves is equal to the excess of capitation revenues, investment income, and other income over the combined medical and administrative costs for the same fiscal period.

   b. CalOptima Health's Fiscal Year begins on July 1 of each year and ends on June 30 of the following year.

E. Review and Utilization of the Board-designated Reserve Fund

1. The Board shall review levels of total assets and the Board-designated Reserve Fund, at minimum, on an annual basis, including, but not limited to, during the development of the strategic plan and the preparation of the annual operating budget. As part of this review, the Board shall assess resources to be used for the purposes of expanding access to care, improving member benefits, and/or augmenting provider reimbursement, in accordance with Title 4, Division 11 of the Codified Ordinances of the County of Orange, California.

2. Utilization of the Board-designated Reserve Fund during a delay in capitation revenues from the State.

   a. In the event of a delay in CalOptima Health's receipt of capitation revenues from the State and provided the Board-designated Reserve Funds level is within the range as set forth in Section II.C of this policy, Management is authorized to use Board-designated Reserve funds to provide up to four (4.0) ~~three (3.0)~~ months of continuous payments to Providers and vendors without the approval of the Board.

   b. In the event the Board-designated Reserve Fund approaches zero, CalOptima Health may elect, with approval of the Board, to cease payments to Providers and vendors until such time as the State restores capitation revenues to CalOptima Health.

3. Except as authorized in Section II.E.2.a. of this policy, any withdrawals from the Board-designated Reserve Fund shall be approved by the Board through the annual budget process, or through a separate Board action at a regular or special meeting of the Board. The Budget is CalOptima Health's Board-approved annual operating budget that incorporates net assets available for reserves.

4. The Board, through approval of a Board Action Request, may specifically designate all or a portion of the Board-designated Reserve Fund for one (1) or more Special Purposes at any time.

   a. A Special Purpose is a specifically designated use, as determined solely by the Board, that best addresses a programmatic or financial need facing CalOptima Health.

   b. The Board may remove or modify any or all such specific designations previously imposed through a subsequent Board action.

5. Management shall notify the Board of all uses from the Board-designated Reserve Fund, regardless of prior approval requirements as set forth in this policy.

6. On an annual basis, the Board may review this policy concurrently with the approval of the annual operating budget.

III. PROCEDURE

A. Calculation and transfers to or from the Statutory Reserve Fund

1. The Statutory Reserve shall be calculated monthly in accordance with Title 28, California Code of Regulations (CCR), Section 1300.76.

2. Prior to the end of each month-end close, CalOptima Health's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or designee, shall instruct the Controller or designee, to transfer a specified dollar amount into or from the Statutory Reserve Fund (from or to CalOptima Health's operating funds) to ensure compliance with 100% to 110% the minimum required TNE.

B. Transfers to or from the Board-designated Reserve Fund

1. Prior to the end of each month-end close, CalOptima Health's CEO, CFO, or designee, shall instruct the Controller or designee, to transfer a specified dollar amount into or from the Board-designated Reserve Fund (from or to CalOptima Health's operating funds).

2. The transfer shall be consistent with either the Board-approved Budget or a subsequent Board action.

C. Financial Reporting on the Statutory Reserve and the Board-designated Reserve Funds

1. While reporting each month's financial results, the CFO or designee, shall routinely update the Board as to the status of the Statutory Reserve and the Board-designated Reserve Funds.

2. The status report shall be rendered on a quarterly basis or more frequently, as directed by the Board.

D. Utilization of the Board-designated Reserve Fund for Special Purposes

1. In accordance with Section II.E.4. of this policy, Management shall, upon its own initiative or at the request of the Board, prepare and submit a Board Action Request to specifically designate, for one (1) or more Special Purposes, all or a portion of the Board-designated Reserve Fund. If the Board approves such Board Action Request, Management shall describe the specific designations of such funds on subsequent CalOptima Health balance sheets.

2. The subsequent removal or modification of a previously Board-approved specific designation of Board-designated Reserve funds shall follow the same process as that utilized for creating the original designation. If the Board subsequently approves the removal or modification of a specific designation, Management shall appropriately adjust future CalOptima Health balance sheets to properly account for such removal or modification.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. Title 28, California Code of Regulations (CCR), Section 1300.76

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

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Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1996	GA.3001	Board-Designated Reserve Funds	Administrative
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IX. GLOSSARY

Not Applicable

Policy:	GA.3001
Title:	**Statutory and Board-Designated Reserve Funds**
Department:	Finance
Section:	Not Applicable
CEO Approval:	*/s/*
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IX. GLOSSARY

Not Applicable