

2026 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM

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2026 QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM SIGNATURE PAGE

Quality Improvement Health Equity Committee Chair:

Richard R. Lopez, Jr. M.D. 10/16/2026

Richard Lopez, Jr. M.D. **Date**
CalOptima Health Interim Chief Medical Officer

1. CalOptima Health Overview

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

1.1 Our Strategic Plan

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

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

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

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

The four Strategic Priorities are:

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

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

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

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

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

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

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

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

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

The 2025 CQS outlines DHCS' comprehensive approach to developing, implementing, and maintaining a quality strategy that encompasses all Medi-Cal delivery systems—managed care, fee-for-service, behavioral health, dental, and other departmental programs. The strategy defines measurable goals, emphasizes the use of CMS Core Set measures, and tracks improvement while adhering to federal and state requirements. It reinforces DHCS' commitment to reducing health disparities and advancing health equity in every aspect of program design and delivery.

The report describes DHCS' quality improvement infrastructure, the development and review process for the CQS, managed care standards and evaluation requirements, continuous program quality improvement, and the state's plan to identify, evaluate, and reduce health disparities. It

also defines “significant change" and highlights additional quality improvement efforts in programs outside managed care.

The 2025 CQS highlights DHCS' ongoing delivery system reform efforts, including California Advancing and Innovating Medi-Cal (CalAIM), Behavioral Health Transformation, and new initiatives such as BH-CONNECT. These efforts focus on reducing variation and complexity, managing member risk through population health strategies, and improving quality outcomes through value-based initiatives and payment reform.

Quality Strategy Goals

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

Quality Strategy Guiding Principles

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

1.1.3. Health Equity Framework

CalOptima Health is committed to advancing health equity and serving members with the excellence, dignity and care they deserve. This commitment extends into the heart of the communities our members call home.

Our vision for health equity remains ambitious, centered on all our operational and strategic priorities. To advance health outcomes and drive meaningful impact, our health equity strategic framework is anchored in five focus areas:

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



1.2 Program Structure

"Better. Together." is CalOptima Health's motto, and it means that by working together, we can make things better — for our members and community. As Orange County's single largest health insurer, we provide coverage through three major programs:

1.2.1. Medi-Cal

Medi-Cal — known nationally as Medicaid — is a public health insurance program for low-income people administered by the state in partnership with the federal government. It covers those with incomes below 138% of the Federal Poverty Level, which includes families with children, seniors, people with disabilities, foster care children, pregnant women and people with specific diseases. CalOptima Health provides health care coverage for Orange County residents who are eligible for full Medi-Cal.

1.2.1.1. Medi-Cal Scope of Services

Under our Medi-Cal program, CalOptima Health provides a comprehensive scope of acute, specialty, mental health and preventive care services for Orange County's Medi-Cal and dual eligible population, including eligible conditions under California Children's Services (CCS) managed by CalOptima Health through the Whole-Child Model (WCM) program that began in 2019. CalOptima Health also offers medical equipment and supplies, vision care, transportation and long-term care for our members.

CalOptima Health provides Enhanced Care Management (ECM) and all 14 Community Supports to address social drivers of health and assist members with finding stable or safe housing, accessing healthy food, transitioning back home or getting support in the home. As of January 2026, CalOptima Health will provide the 15th Community Support service, Transitional Rent, for members eligible under the Behavioral Health Population of Focus as required by DHCS.

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

- Pharmacy benefits and services when billed by a pharmacy on a pharmacy claim are provided by the DHCS through a pharmacy benefit manager
    - Covered outpatient drugs, eligible under the pharmacy benefit;
    - Enteral nutrition products; and
    - Specific Medical supplies including diabetic supplies (testing supplies, Continuous Glucose Monitoring devices, disposable insulin delivery devices, insulin syringes, and pen needles), miscellaneous medical supplies, and certain contraceptive devices
- Specialty mental health services are administered by the Orange County Health Care Agency (OCHCA)
- Substance use disorder services are administered by OCHCA
- Dental services are provided through the Medi-Cal Dental Program

1.2.1.1.1 Dental

CalOptima Health provides medically necessary dental-related services that require clinical oversight beyond the scope of dental personnel. These services include laboratory testing, physical examinations for admission to medical facilities, outpatient surgical center procedures, and inpatient hospitalizations associated with dental care. The designated Dental Liaison staff in the Utilization Management department supports Medi-Cal dental providers by facilitating referrals to additional covered services and ensuring members receive appropriate follow-up.

CalOptima Health promotes awareness of available Medi-Cal dental benefits through multiple communication channels, including the Medi-Cal Member Handbook, care management interactions, annual wellness visits, and comprehensive health education materials. CM

assessments consistently evaluate members' dental service utilization and coordinate care when needed.

As part of the Facility Site Review (FSR) and Medical Record Review (MRR) processes, CalOptima Health verifies that pediatric providers perform required Dental/Oral Health Assessments, including fluoride varnish applications. To support pediatric preventive care, CalOptima Health implements multimodal outreaches—such as mailing birthday cards and sending text message reminders—to notify members and parents or guardians when children are due for age-appropriate dental, vision, and hearing screenings.

1.2.1.1.2 Treatment of Tuberculosis (TB)

CalOptima Health providers may identify Medi-Cal members at risk for TB through the Initial Health Appointment (IHA) process or assessments conducted in acute care settings. When an evaluation indicates possible active TB, the provider must refer the member to the Orange County Health Care Agency (OCHCA) Pulmonary Disease Services (PDS) for care management. If a provider determines that a member may have difficulty adhering to TB treatment, CalOptima Health or the delegated Health Network must refer the member to the HCA/PDS TB Control Officer for Directly Observed Therapy (DOT).

CM staff coordinate care for members diagnosed with TB and facilitate referrals to community programs, including the OCHCA Tuberculosis Program. Members may also be identified through the Targeted Case Management (TCM) Plan Data Feed from DHCS, providing an additional mechanism for outreach and support. When appropriate, CM conducts follow-up outreach to ensure continued engagement in treatment and care coordination.

CalOptima Health maintains a memorandum of understanding (MOU) with OCHCA, and quarterly meetings are held to promote transparency, strengthen coordination, and address operational needs. These meetings focus on managing referrals, preventing service duplication, resolving issues, enhancing collaborative workflows, and supporting member engagement.

In addition, CalOptima Health collaborates with OCHCA to deliver training on tuberculosis screening and management, further supporting provider awareness and ensuring alignment with public health standards.

1.2.1.1.3 Women, Infants, and Children (WIC) Supplemental Nutrition Program

CalOptima Health established the WIC program's processes and procedures to identify and support eligible members. Upon screening, members who are pregnant, breastfeeding, postpartum, or legal guardians of a child under age five are referred to WIC and assisted with program linkage. As part of the referral process, CalOptima Health provides WIC agencies with the member's hemoglobin or hematocrit laboratory values upon request, and documents both the referral and laboratory information in the member's medical record to support continuity of care.

In alignment with contract obligations, CalOptima Health maintains Memoranda of Understanding (MOUs) with four WIC agencies in Orange County: OCHCA WIC, PHFE WIC, Camino Health Center, and Planned Parenthood of Orange and San Bernardino Counties. Quarterly collaboration meetings with these agencies focus on service updates, coordination opportunities, and optimization of referral pathways to ensure members efficiently access WIC benefits.

CalOptima Health partners with WIC agencies to strengthen provider education and enhance alignment across programs. These efforts included training providers on the appropriate prescribing process for therapeutic formula, reviewing updates to the WIC food package, and expanding awareness of services available to Medi-Cal members and WIC participants. This collaboration supports improved service coordination, ensures adherence to regulatory requirements, and enhances member engagement in WIC resources.

1.2.1.1.4 Indian Health Care Providers

CalOptima Health has identified a staff person, the Senior Manager in the Provider Relations department, to serve as the designated tribal liaison and the primary point of contact for inquiries from the Indian Health Service or internal departments regarding member grievances or service requests. In this role, the Senior Manager coordinates with the appropriate internal teams to resolve issues, facilitates necessary meetings, monitors communication with the Indian Health Clinic (IHC), and ensures all matters are fully addressed and resolved

1.2.1.1.5 Justice Involved (JI) Reentry Coordination

CalOptima Health has designated liaisons for JI reentry coordination. They support correctional facilities, pre-release care management providers, and Enhanced Care Management (ECM) providers throughout the reentry planning process to ensure timely linkage and continuity of care.

The JI Liaisons assigned all California Department of Corrections and Rehabilitation referrals promptly and met regularly with JI ECM providers to prepare for the launch of pre-release services. Their efforts included developing Orange County–specific workflows and operational expectations, participating in recurring meetings with county partners, and actively planning for the implementation of pre-release services. These activities strengthened coordination across systems and contributed to a standardized, collaborative reentry process.

1.2.1.2. Members With Special Health Care Needs

CalOptima Health is committed to ensuring that members with special health care needs — including seniors, individuals with disabilities, children and youth with special health care needs (CYSHCN), and those with chronic or complex conditions — receive coordinated, accessible and high-quality care. Our approach is grounded in equity, member-centeredness and collaboration with community partners.

To ensure that clinical services as described above are accessible and available to members with special health care needs, such as seniors, people with disabilities and people with chronic conditions, CalOptima Health offers specialized care management (CM) and Complex Case Management (CCM) services to support members with high-risk or medically complex conditions. These services are designed to:

- Promote continuity of care across providers and settings
- Address both clinical and social determinants of health
- Develop and monitor Individualized Care Plans (ICPs) tailored to each member's goals, needs, and preferences

CCM is provided in collaboration with the member's health network, primary care provider and specialists.

Services for members with special needs are embedded within CalOptima Health's Utilization Management (UM)/Case Management (CM) Integrated Program and Population Health Management (PHM) Strategy. These frameworks ensure:

- Proactive identification of high-risk members
- Timely outreach and engagement
- Alignment with National Committee for Quality Assurance (NCQA) and DHCS standards for quality and access

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

1.2.1.2.1 Persons with Developmental Disabilities

CalOptima Health ensures coordinated, person-centered services for members with Developmental Disabilities (DD). CalOptima Health and delegated Health Networks identify and refer members with, or at risk for, developmental delay to the Regional Center of Orange County (RCOC) for Early Start or Lanterman Act services. The Regional Center (RC) Liaison serves as the primary point of contact for members and families, assisting with service navigation, addressing access or care concerns, and supporting the timely resolution of issues. These services may include respite, out-of-home placement, supportive living, and other resources as appropriate. Upon member or representative consent, RCOC notifies CalOptima Health to coordinate care and ensure provision of all medically necessary covered services—including out-of-network care when needed—behavioral health treatment (BHT), referrals to Home and Community-Based Services (HCBS) waivers, and collaboration with Primary Care Providers (PCPs) to deliver services outlined in the Individualized Family Service Plan (IFSP.)

CM teams within CalOptima Health and delegated Health Networks refer members to home and community-based services supporting individuals with intellectual and developmental disabilities. Within the Behavioral Health (BH) Line, staff identify members who may benefit from Early Start and provide families with information and referrals to RCOC. Support is also provided for members transitioning out of Early Start, including assistance with developmental evaluations and linkage to Applied Behavior Analysis (ABA) services when indicated.

To strengthen coordination and alignment in service planning, CalOptima Health participates in quarterly meetings with RCOC. In addition, talking points and educational materials are being developed to ensure consistent communication with members and partners.

CalOptima Health maintains an MOU with the Local Health Department, with quarterly collaboration focused on care coordination, referrals, reducing duplication of services, dispute resolution, and enhanced member engagement. Although no MOU currently exists with RCOC, coordination is facilitated through member-consent–based information sharing.

Members enrolled in CM are assessed for potential eligibility for Federal Medicaid Waiver programs. When eligibility is indicated, CM staff provide education, facilitate referrals, and coordinate with the appropriate HCBS or waiver program to ensure timely access to needed supports.

1.2.1.3. Medi-Cal Managed Long-Term Services and Supports

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

1.2.1.3.1. In-Home Supportive Services (IHSS):

IHSS provides in-home assistance to eligible aged, blind and disabled individuals as an alternative to out-of-home care and enables members to remain safely in their own homes. CalOptima Health LTSS is responsible for the IHSS referral process to the County of Orange Social Service Agency, which manages the program.

CalOptima Health identifies potential IHSS candidates and coordinates referrals to the County Social Services Agency (SSA). While SSA is responsible for conducting assessments, determining eligibility, and authorizing IHSS services, CalOptima Health supports the process by submitting referrals, complying with information-sharing requirements, reviewing IHSS assessments when available, and providing ongoing care coordination for members enrolled in IHSS.

CalOptima Health manages the IHSS referral workflow by serving as the central conduit between members or providers and the County SSA. When an IHSS application is received, it is

promptly forwarded to SSA via email in accordance with the longstanding MOU, which outlines CalOptima Health's role in initiating referrals. Due to the absence of an updated MOU and current data-sharing agreement, SSA does not share member-specific information with CalOptima Health unless a valid release of information is on file.

Quarterly collaboration meetings between CalOptima Health and SSA provide a structured forum to discuss program updates, improve coordination, and strengthen referral processes. These meetings support alignment across both agencies while adhering to privacy requirements and ensuring members receive timely assistance connecting to IHSS services.

1.2.1.3.2. Home and Community-Based Waiver Programs:

CalOptima Health identifies, refers, assesses, and coordinates services for older adults who meet nursing facility level criteria but can safely remain at home through the Multipurpose Senior Services Program (MSSP). MSSP reduces institutionalization through comprehensive CM, close collaboration with MSSP providers, and timely referral and assessment practices.

CalOptima Health directly manages MSSP as an internal plan benefit; it is not carved out to an external agency and continues to operate as a dedicated department within the organization. In 2025, the California Department of Aging (CDA) allocated 113 new participant slots to CalOptima Health's MSSP program, all of which were successfully filled, with an additional 20 slots expected in the upcoming fiscal year.

Members enrolled in CM will be assessed for eligibility for Federal Medicaid Waiver programs. When a member is identified as potentially eligible, CM staff will provide education, facilitate referrals, and coordinate with the appropriate Home and Community-Based Services (HCBS) or waiver program.

This includes identification and referral to programs such as:

HCBS Waivers:

- AIDS Medi-Cal Waiver Program;
- Assisted Living Waiver (ALW);
- Home and Community-Based Alternatives (HCBA) Waiver;
- Home and Community-Based Services Waiver for the Developmentally Disabled (HCBSDD)
- Waiver; and
- Self-Determination Program
- Long Term Services and Supports (LTSS):
- Community-Based Adult Services (CBAS);
- In-Home Support Services (IHSS); and
- Multipurpose Senior Services Program (MSSP).

These integrated LTSS benefits also include the following programs:

- 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.
- 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 CBASMultipurpose Senior Services Program (MSSP): Intensive home- and community-based care coordination of a wide range of services and equipment to support members in their home and avoid institutionalization. CalOptima Health LTSS monitors the level of member access to MSSP as well as its role in diverting members from institutionalization.
- CalAIM Community Supports: CalOptima Health LTSS is responsible for the clinical review and medical necessity determination for members referred to CalAIM. LTSS collaborates with CalOptima Health CalAIM operations to monitor overall program utilization.

1.2.2. OneCare (HMO D-SNP)

Since 2005, CalOptima Health has offered OneCare, our Medicare Advantage Dual Eligible Special Needs Plan, to low-income seniors and individuals with disabilities who qualify for both Medicare and Medi-Cal. Our OneCare members have Medicare and Medi-Cal benefits covered in one single plan, making it easier for them to get the health care they need. OneCare has extensive experience serving the complex needs of frail, disabled, dual-eligible members in Orange County.

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

1.2.2.1. OneCare Scope of Services

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

In addition to the comprehensive scope of acute care, preventive care and behavioral health services covered under Medi-Cal and Medicare, OneCare members are eligible for supplemental benefits, such as allowances for over-the-counter items, food and produce for qualifying members, vision, access to no-cost gym memberships, comprehensive dental and companion care.

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

CalOptima Health PACE is a long-term comprehensive health care program that helps older adults to remain as independent as possible. PACE coordinates and provides all necessary preventive, primary, acute, and long-term care services, enabling seniors to continue living in their community.

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

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

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

1.2.4. Covered California

CalOptima Health is preparing to launch a new Covered California product line, effective January 1, 2027, which will expand its commercial offerings under the Knox-Keene Act license. This strategic initiative aligns with CalOptima Health's mission to serve member health with excellence and dignity.

CalOptima Health submitted an initial filing to DMHC on June 16, 2025, along with a second filing with provider network rosters on October 31, 2025. Engagement with Covered California's Plan Management Advisory Group is ongoing to align with policy and regulatory changes and internal leadership check-ins and contract amendments are being tracked to ensure timely execution and compliance.

To ensure compliance with Covered California's Qualified Health Plan (QHP) standards, CalOptima Health is initiating a multi-phase approach focused on operational readiness and quality improvement in 2026.

Quality focus areas for 2026 include:

- Alignment with Covered California Quality Transformation Initiative (QTI) measures and implement the HEQMS Benchmark
- Preparation for NCQA Health Plan Accreditation for Covered California product

1.3 Provider Partners

CalOptima Health Providers can choose from several options to participate in CalOptima Health's programs and deliver health care services to members. Providers can contract directly with CalOptima Health through CalOptima Health Direct, which consists of CalOptima Health Direct-Administrative and CalOptima Health Community Network (CHCN). Providers also have the option to contract directly with one of our delegated health networks. CalOptima Health members can choose between CHCN or one of 10 health networks, which represent more than 9,000 providers.

1.3.1. CalOptima Health Direct (COD)

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

1.3.1.1. CalOptima Health Direct-Administrative (COD-A)

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

1.3.1.2. CalOptima Health Community Network (CHCN)

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

1.3.2. CalOptima Health Contracted Health Networks

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

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

Through our delegated health networks, CalOptima Health members have access to more than 1,200 Primary Care Providers (PCPs), more than 7,500 specialists, 42 acute and rehabilitative hospitals, 70 community health centers and 234 long-term care facilities.

CalOptima Health contracts with the following:

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

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

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

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

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

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

1.4. Membership Demographics

Membership Data* (as of November 30, 2025)

Total CalOptima Health Membership	Program	Members
877,271	Medi-Cal	858,441
Prior month: 877,802	OneCare (HMO D-SNP)	18,287
	Program of All-Inclusive Care for the Elderly (PACE)	543

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

Member Demographics (as of November 30, 2025)

Member Age	
0 to 5	8%
6 to 18	22%
19 to 44	34%
45 to 64	20%
65 +	16%

Language Preference	
English	56%
Spanish	29%
Vietnamese	9%
Korean	2%
Other	2%
Farsi	1%
Chinese	<1%
Arabic	<1%
Russian	<1%

Medi-Cal Aid Category	
Expansion	38%
Temporary Assistance for Needy Families	36%
Seniors	13%
Optional Targeted Low-Income Children	7%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

2. Quality Improvement and Health Equity Transformation Program Overview

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

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

CalOptima Health's QIHETP includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members, including those with limited English proficiency or diverse cultural and ethnic backgrounds, regardless of

race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. All services are provided in a culturally and linguistically appropriate manner.

CalOptima Health is committed to promoting diversity, equity and inclusion in practices throughout the organization, including Human Resources best practices for recruiting and hiring, to ensure the CalOptima Health workforce has the experience, knowledge or expertise relevant to meet the needs of our members. Additionally, as part of the new hire process and annual compliance, employees receive training on cultural competency, bias, diversity, equity and inclusion.

2.1. Quality Improvement and Health Equity Transformation Program Purpose, Scope, and Goals

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

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

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

The **scope** of CalOptima Health QIHETP focuses on the specific needs of CalOptima Health's members and stakeholders (health care providers, community-based organizations and government agencies), incorporating CQI methodologies such as Plan-Do-Study-Act (PDSA). The QIHETP implements a systematic approach to accomplish the following annually:

- Identify and analyze significant opportunities for improvement in care and service to advance CalOptima Health's strategic mission, goals and objectives.
- Foster the development of improvement actions, along with systematic monitoring and evaluation, to determine whether these actions result in progress toward established benchmarks or goals.
- Focus on quality improvement and health equity activities carried out on an ongoing basis to support early identification and timely correction of quality-of-care issues to ensure safe care and experiences.

- Maintain organization-wide practices that support health plan and health equity accreditation by the NCQA and meet CMS quality and measurement reporting requirements.

The QIHETP's ongoing responsibilities include the following:

- Developing plans to measure, assess and improve the quality of the organization's governance, management, delivery system and support processes.
- Supporting the provision of a consistent level of high-quality care and service for members throughout the contracted provider networks, as well as monitoring utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers.
- Recommending delivery system reform to ensure high-quality and equitable health care.
- Monitoring quality of care and services from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals.
- Ensuring contracted facilities, as required by federal and state laws, report to OCHCA communicable and non-communicable disease/conditions using specific methods and timeframes, as listed on the OCHCA website. Key reportable categories include vaccine-preventable diseases, foodborne and enteric diseases, healthcare-associated infections (HAIs), vector-borne diseases, emerging and other infections, neurological and systemic diseases, diseases related to environmental exposures or injuries, and outbreaks.
- Promoting member safety and minimizing risk through the implementation of safety programs and early identification of issues that require intervention and/or education, and working with appropriate committees, departments, staff, practitioners, provider medical groups and other related organizational providers to ensure that steps are taken to resolve and prevent recurrences.
- Educating the workforce and promoting a continuous quality improvement and health equity culture at CalOptima Health.
- Ensuring the annual review and acceptance of the Utilization Management (UM)/Case Management (CM) Integrated Program Description, and the Culturally and Linguistically Appropriate Services (CLAS) Program, including the work plans and the annual evaluations of these programs/strategies.

In collaboration with the Compliance Audit & Oversight departments, the QIHETP ensures the following standards or outcomes are carried out and achieved by CalOptima Health's contracted health networks:

- Support the organization's strategic quality and business goals by using resources appropriately, effectively and efficiently.
- Continuously improve clinical care and service quality provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population.
- Identify in a timely manner the important clinical and service issues facing members relevant to their demographics, risks, disease profiles for both acute and chronic illnesses and preventive care.

- Ensure continuity and coordination of care between specialists and primary care providers, and between medical and BH practitioners by annually evaluating and acting on identified opportunities.
- Ensure accessibility and availability of appropriate clinical care and a network of providers with experience in providing care for the population.
- Monitor the qualifications and practice patterns of all individual providers in the network to deliver quality care and service.
- Promote the continuous improvement of members and provider satisfaction, including the timely resolution of complaints and grievances.
- Ensure the reliability of risk prevention and risk management processes.
- Ensure compliance with regulatory agencies and accreditation standards.
- Promote the effectiveness and efficiency of internal operations.
- Ensure the effectiveness and efficiency of operations associated with functions delegated to the contracted health networks.
- Ensure the effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima Health's strategic direction in support of its mission, vision and values.
- Ensure compliance with up-to-date Clinical Practice Guidelines and evidence-based practice.

CalOptima Health's Quality Improvement Health Equity Transformation Program (QIHETP) Goals are aligned with CalOptima Health's mission, vision and values.

Medi-Cal QIHETP Goals

- Meet and exceed the minimum performance levels (MPLs) for the Medi-Cal Accountability Set (MCAS).
- Maintain NCQA Health Plan and Health Outcomes Accreditation (formerly known as Health Equity Accreditation).
- Attain a 4.5 NCQA Health Plan Rating.

OneCare QIHETP Goals

- Attain a Four-Star Rating for Medicare.

Covered California QIHETP Goals

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

2.2 National Committee for Quality Assurance Accreditation

CalOptima Health is a NCQA accredited health plan and achieved its initial commendable Health Plan Accreditation for the Medi-Cal product in August 2012. Most recently, in July 2024, CalOptima Health completed a triennial renewal survey for NCQA Health Plan Accreditation. triannual renewal survey for NCQA Health Plan Accreditation and received 135.50 out of 140

allowable points through the document submission and file review process. From this renewal survey, CalOptima Health was awarded Accredited Status, effective through July 10, 2027.

In alignment with CalOptima Health's commitment to advancing health equity, CalOptima Health pursued and successfully attained initial Health Outcomes Accreditation, formerly known as Health Equity Accreditation, for the Medi-Cal product. This recognition took place on December 16, 2025, and will remain valid until December 16, 2028. CalOptima Health received full points and achieved a score of 100% , as an extension of the existing Health Plan Accreditation.





2.3. Conflict of Interest

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

2.4. Non-Discrimination

CalOptima Health is dedicated to creating a professional work environment free from discrimination and harassment. It has policies and procedures that describe how to identify, report and handle discrimination both in the workplace and within the Quality Improvement Health Equity Committee (QIHEC) and its subcommittees. The policy for the QIHEC requires all individuals serving in appointed, volunteer or staff roles to complete an annual attestation. Participants must not discriminate against or harass any other participant, member or provider based on protected categories such as age, disability, ethnicity, gender, marital status, national origin, race, religion or sexual orientation.

2.5. Confidentiality

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

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

3. Authority and Accountability

3.1. CalOptima Health Board of Directors

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

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

The QIHETP is based on the ongoing systematic collection, integration and analysis of clinical and administrative data to identify member needs, risk levels and appropriate interventions. CalOptima Health uses this information to ensure that the program meets the specific needs of our members, promotes health equity among targeted population segments, and improves overall population health and member experience. The CMO is responsible for identifying suitable interventions and allocating the necessary resources to implement the QIHETP in accordance with federal and state regulations, contractual obligations, and fiscal constraints.

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

3.2. Board of Directors' Quality Assurance Committee

The Board of Directors' Quality Assurance Committee (QAC) is a Board committee comprising a subset of the Board of Directors' members. The QAC conducts annual evaluations, provides strategic direction, and makes recommendations regarding the overall QIHETP and directs any necessary modifications to QIHETP policies and procedures to ensure compliance with the QI and Health Equity contractual and regulatory standards. QAC receives quarterly progress reports from the QIHEC, which describe the improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC makes recommendations to the full Board of Directors for annual approval, with modifications and appropriate resource allocations, for the QIHETP and the Work Plan of the QIHETP. The full Board of Directors receives QAC meeting materials.

3.3. Member Advisory Committee

CalOptima Health is committed to providing member-focused care through active engagement with members and their communities. The Member Advisory Committee (MAC) has 20 voting members, with each seat representing a constituency served by CalOptima Health. The MAC ensures that members' values and needs are integrated into the design, implementation, operations and evaluation of the overall QIHETP. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

3.4. Provider Advisory Committee

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

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

3.5. Whole-Child Model Advisory Committee

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

The WCM FAC includes the following 11 voting seats:

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

- Consumer advocates

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

3.6. Role of the Chief Executive Officer

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

The CAO works closely with and makes presentations to the leadership team, CalOptima Health Board of Directors, elected officials, regulatory agencies, associations, contractors and key stakeholders

3.7. Role of the Chief Executive Officer

Chief Executive Officer (CEO) develops and directs the successful implementation of short and long-term strategic goals and plans for CalOptima Health. The CEO establishes and implements the mission, vision, policies and practices of CalOptima Health, as directed by the Board of Directors, and in the best interests of the members served through the CalOptima Health initiatives. The CEO allocates financial and employee resources to fulfill program objectives. The CEO delegates authority, when appropriate, to the Chief Operating Officer (COO), Chief Medical Officer (CMO) and the Chief Financial Officer (CFO). The CEO ensures that the QIHEC satisfies all remaining requirements of the QIHETP, as specified in the state and federal contracts.

3.8. Role of the Chief Medical Officer

Chief Medical Officer* (CMO) oversees the agency's medical care delivery system, including the development and implementation of strategies and procedures for all medical services, clinical operations and quality programs. This position establishes standards for evaluating providers for inclusion in CalOptima Health's program and for the ongoing performance of participating providers. The CMO ensures that the care provided by the delegated networks meets all quality and regulatory requirements. The CMO is responsible for determining the medical necessity and appropriateness of medical services. The CMO has overall responsibility for the QIHETP and supports efforts to ensure that the QIHETP objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QIHE activities to the Board of Directors' QAC.

3.9. Role of the Chief Operating Officer

The Chief Operating Officer (COO) serves as a key leader within the health plan and holds the authority and accountability to lead areas assigned to next-level capabilities and operational efficiencies consistent with the strategic plan, goals and objectives for CalOptima Health. The COO manages organizational projects, ensuring that operations perform effectively and provides updates to the Board. The COO provides leadership and oversight to the day-to-day operations of several departments and senior leaders, including Customer Service, Information Technology, Enterprise Project Management Office, Network Operations, Grievance and Appeals Resolution Services (GARS), Claims Administration, Quality, and Coding Initiatives.

3.10. Role of the Chief Compliance Officer

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

3.11. Role of the Chief Information Officer

Chief Information Officer (CIO) is responsible for establishing a technology vision and roadmap that aligns with CalOptima Health's business strategy and the delivery of capabilities required to achieve business success, and for executing that roadmap. Under the leadership of the Chief Operating Officer (COO), the incumbent will participate in and contribute to overall CalOptima Health operations and strategy development, bringing a current knowledge and future vision to leverage information and technology in business model design, business processes, operational improvements and support for the CalOptima Health mission. The incumbent will launch new programs, implement new systems, integrate new vendor solutions and provide direction to cross-functional teams. The incumbent will work across all departments on major initiatives and lead through influence and communication. The incumbent will also be responsible for clearly communicating the organization's technology strategy, status and progress to executives, the board of directors and the advisory committees.

3.12. Role of the Chief Financial Officer

Chief Financial Officer (CFO) manages CalOptima Health's financial strategy, ensuring fiscal responsibility and resource allocation to support organizational priorities, including quality improvement and health equity initiatives.

3.13. Role of the Chief Health Equity Officer

Chief Health Equity Officer (CHEO) co-chairs the QIHEC and is responsible for establishing CalOptima Health's health equity and population health framework, as well as short- and long-range goals, procedures and practices that are in alignment with and support the organization's mission and vision, while developing policies and practices to eliminate and prevent health inequities and address structural and SDOH issues impacting the organization's members. The CHEO works to create health equity-focused resources, training programs, communications, and innovations to promote integration of health equity within member-facing products.

3.14. Role of the Chief Human Resources Officer

Chief Human Resources Officer (CHRO) is responsible for the overall talent strategy and administration of the human resources department, functions, policies and procedures and employee compensation, benefits and retirement, recruitment, employee relations, HRIS, leave and accommodation, and training and education programs for CalOptima Health. The CHRO leads and enhances the overall service delivery, coordination, and evaluation of all HR activities in accordance with CalOptima Health policies and procedures, as well as those identified in the Employee Handbook. The CHRO works in consultation with the Office of the CEO, the other Executive Offices, the Executive Directors, Directors and staff, and helps develop efficient processes that align with CalOptima Health's mission and vision as well as the organizational goals and priorities established by the Board of Directors.

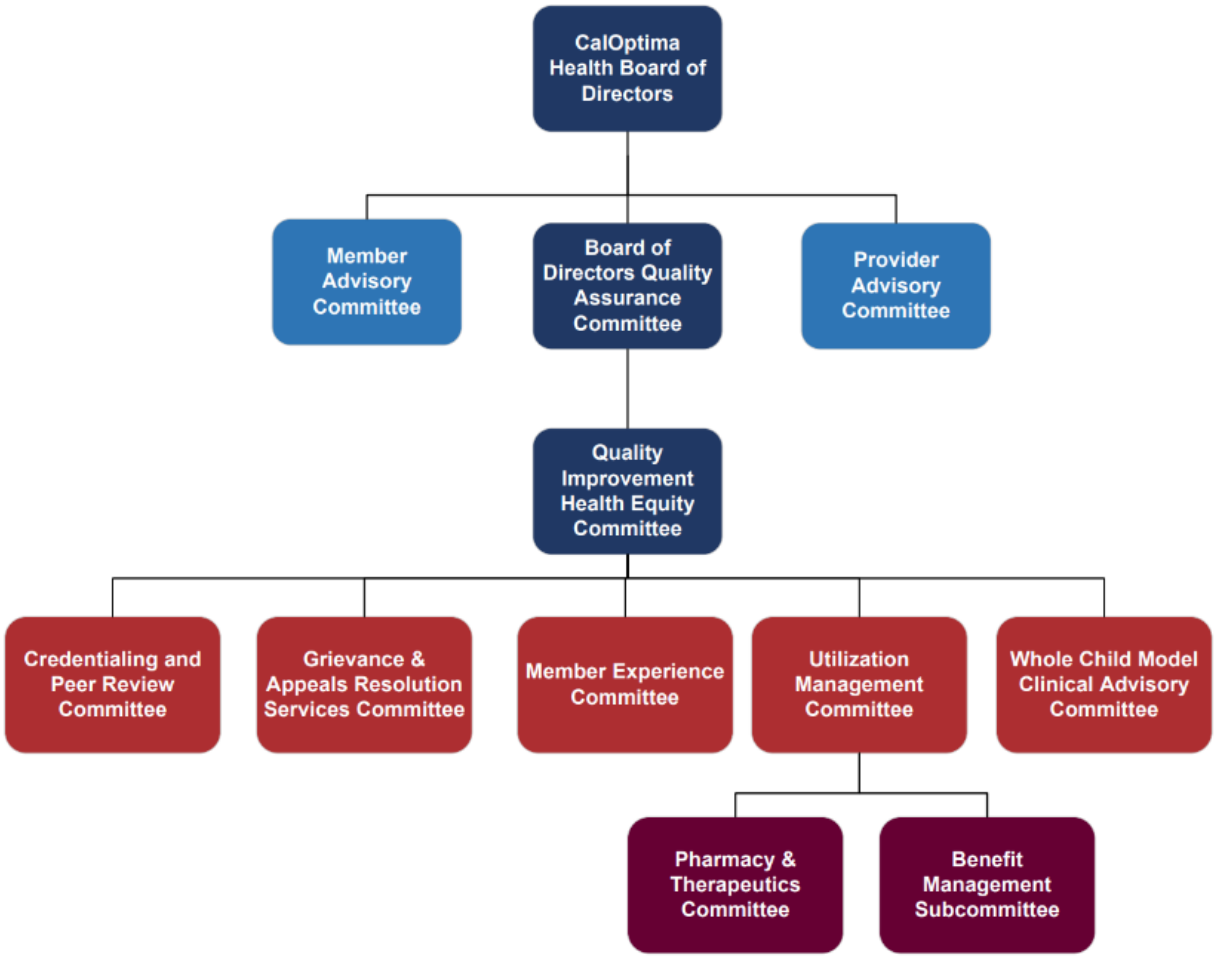
3.15. Role of the Deputy Chief Medical Officer

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

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

3.16. Quality Improvement and Health Equity Transformation Program Committee Structure

QIHETP Committee Structure — Diagram



3.17. Quality Improvement Health Equity Committee

The Quality Improvement Health Equity Committee (QIHEC) is the foundation of the QIHETP and is accountable to the QAC. The QIHEC is chaired by the CMO and the CHEO. Together, they develop and oversee the QIHETP, QIHETP Work Plan and QIHETP Evaluation activities.

The purpose of the QIHEC is to provide overall direction for the continuous health equity-centered quality improvement process, develop and oversee the QIHETP activities that are consistent with CalOptima Health's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program. It monitors compliance with regulatory, licensing and accrediting body standards relating to QIHETP projects and activities. In addition, and most importantly, it

ensures that members receive optimal quality of care. Performance measurements, improvement activities, and interventions are reviewed, approved, processed, monitored and reported through the QIHEC.

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

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

Responsibilities of the QIHEC include:

- Review, contribute to and approve the QIHETP, UM/CM Integrated Program, CLAS Program, and Population Health Management (PHM) Strategy annually.
- Analyze and evaluate the results of QIHE activities, including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and the findings and activities of other quality committees.
- Recommend policy decisions and priority alignment of the QIHETP subcommittees for effective operation and achievement of objectives.
- Oversee the analysis and evaluation of QIHETP activities.
- Ensure practitioner participation through attendance and discussion in the planning, design, implementation and review of QIHETP activities.
- Identify, prioritize, and institute needed actions and interventions to improve quality.
- Ensure appropriate follow-up of quality activities to determine the effectiveness of quality improvement-related actions and remediation of identified performance deficiencies.
- Monitor overall quality compliance for the organization to quickly resolve deficiencies that affect members.
- Evaluate practice patterns of providers, practitioners and delegated health networks, including over-/under-utilization of physical and BH care services.

- Recommend practices so that all members receive medical and BH care that meets CalOptima Health standards.
- Review and assess compliance of the Cultural Competency and Diversity, Equity and Inclusion (DEI) training program.
- Provide a written summary of the QIHEC activities to the QAC and make the summary publicly available on CalOptima Health's website.

The QIHEC oversees and coordinates member outcome-related QIHE actions. Member outcome-related QIHE actions consist of well-defined, planned QIHE projects that address and achieve improvement in major focus areas of clinical and non-clinical services. The QIHEC also recommends strategies for disseminating all study results to CalOptima Health contracted providers and practitioners, as well as delegated health networks.

3.17.1 Quality Improvement Health Equity Committee Physician Participation

The QIHEC is chaired by the CMO designee, the Quality Medical Director, and the Chief Health Equity Officer (CHEO). The medical director is a physician who holds a current and unrestricted license in California. The QIHEC has participation from a broad range of network providers, including physicians, and they are also required to have a current and unrestricted California license. Changes to participating physicians are communicated to the QIHEC Program Specialist and QIHEC Chairperson. Changes include but are not limited to a change in health network affiliation or closing a physician panel.

On a monthly basis, the CalOptima Health Human Resources department requests a list of QIHEC members to monitor for provider exclusion or preclusion in accordance with CalOptima Health Policy HH.2021 Exclusion and Preclusion Monitoring.

3.18. Credentialing and Peer Review Committee (CPRC)

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

The CPRC reviews, investigates and evaluates the credentials of all CalOptima Health providers, in partnership with health networks and other delegated entities. CPRC maintains a continuous review of the qualifications and/or performance of providers every three years. In addition, the CPRC reviews and monitors quality of care issues, identifying trends across the continuum of CalOptima Health's contracted providers, delegated health networks and organizational providers to ensure a commitment to member safety and delivering error-free outcomes. The CPRC, chaired by the CalOptima Health CMO or physician designee, consists of CalOptima Health Medical Directors and physician representatives from contracted health networks. Participants represent a range of practitioners and specialties from CalOptima Health's provider network. CPRC meets a minimum of six times per year and reports through the QIHEC

quarterly. The voting member composition and quorum requirements of the CPRC are defined in its charter.

3.19. Utilization Management Committee (UMC)

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

The UMC monitors the utilization of medical services and delegated health networks to identify areas of underutilization or overutilization that may adversely impact member care. The UMC oversees Inter-Rater Reliability (IRR) testing to ensure consistency in the application of nationally recognized criteria for medical necessity determinations. The committee also participates in the development of evidence-based clinical practice guidelines and completes an annual review, updating the guidelines to ensure they are in accordance with recognized clinical organizations, evidence-based, and comply with regulatory and other organizational standards. These clinical practice guidelines and nationally recognized evidence-based guidelines are approved annually, at a minimum, at the UMC. The UMC meets quarterly and reports to the QIHEC. The composition of UMC voting members (including a BH practitioner*) and the quorum requirements are defined in its charter.

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

3.19.1. Pharmacy & Therapeutics (P&T) Committee

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

3.19.2. Benefit Management Subcommittee (BMSC)

The BMSC is a subcommittee of the Utilization Management Committee (UMC). The purpose of the BMSC is to oversee, coordinate and maintain a consistent set of benefits and benefit interpretations as it relates to CalOptima Health's responsibilities for administration of member benefits, prior authorization and financial responsibility requirements. The BMSC makes recommendations regarding revisions and updates to CalOptima Health's authorization rules based on benefit updates and makes recommendations regarding the need for prior authorization for specific services. The BMSC reports to the UMC and ensures that benefit updates are implemented and communicated accordingly to internal CalOptima Health staff, and are provided to contracted participating provider physicians. The Regulatory Affairs and Compliance department provides technical support to the subcommittee, which includes analyzing regulations and guidance that impact the benefit sets and CalOptima Health's authorization rules. The voting member composition and quorum requirements of the BMSC are defined in its charter.

3.20. Whole-Child Model Clinical Advisory Committee (WCM)

The WCM CAC advises on clinical and behavioral issues related to CCS-eligible conditions, including matters such as treatment authorization guidelines, and ensures that these guidelines are integrated into the design, implementation, operation and evaluation of the CalOptima Health WCM program. The WCM CAC works in collaboration with county CCS, CCS-paneled providers, RCOC, and the County of Orange Social Services Agency. The WCM CAC meets four times a year and reports to the QIHEC. The voting member composition and quorum requirements of the WCM CAC are defined in its charter.

3.21. Member Experience Committee (MEMX)

Improving member experience is a top priority of CalOptima Health. The MEMX committee was formed to ensure a strategic focus on the issues and factors that influence members' experience with the health care system. The MEMX committee assesses information and data directly from members, which includes the annual results of CalOptima Health's Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, member complaints, grievances and appeals. MEMX identifies opportunities to implement initiatives to improve our members' overall experience. The Network Adequacy and Timely Access Workgroups, which report to the MEMX committee, monitor a member's ability to get needed care and get care quickly, by monitoring the provider network, reviewing customer service metrics, and evaluating authorizations and referrals for "pain points" in health care that impact our members at the plan and health network level, where appropriate. The MEMX committee, which includes the Network Adequacy and Timely Access Workgroups, meets at least quarterly and is accountable for meeting regulatory requirements related to access and implementing targeted initiatives to

improve the member experience and demonstrate significant improvement in subsequent CAHPS survey results.

3.22. Grievance and Appeals Resolution Services (GARS) Committee

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

3.23. Delegation Oversight Committee (DOC)

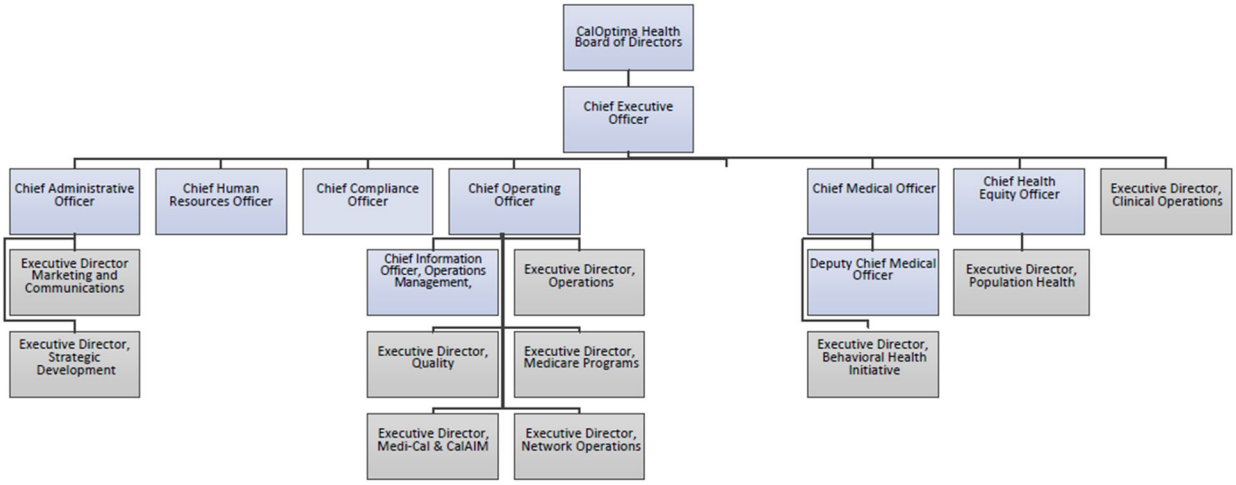
The Delegation Oversight Committee (DOC) is responsible for overseeing the delegated functions carried out by CalOptima Health's First Tier, Downstream, and Related Entities (FDRs), including health networks. The DOC monitors delegated FDR adherence to federal and state regulations, contractual requirements, and accreditation standards through regular audits, performance reviews, and risk assessments. It identifies compliance gaps, recommends appropriate corrective actions or sanctions, provides recommendations on the scope, frequency, and nature of delegate reporting, oversight, and auditing activities, and supports the development and implementation of corrective action plans. The DOC meets at least quarterly and communicates its findings and recommendations to the Compliance Committee. The voting member composition and quorum requirements of the DOC are defined in Policy HH.4001.

3.24. Compliance Committee

The Compliance Committee, chaired by the CCO, is composed of CalOptima Health's executive staff, including but not limited to the CEO, COO, CIO, CMO and CFO. The role of the Compliance Committee is to oversee and ensure the implementation of the Compliance Program and to participate in carrying out the provisions of the Compliance Plan. The Compliance Committee meets at least quarterly, or more frequently as necessary, to ensure reasonable oversight of the Compliance Program.

4. CalOptima Health Organizational Structure

4.1. Organizational Chart — Diagram



CalOptima Health's QIHETP Support Positions and Job Descriptions (See Appendix A)

4.2. Organizational Structure

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

4.3. Organizational Resources

CalOptima Health's budgeting process includes personnel, information technology services resources, and other clinical and administrative costs projected for the QIHETP. These resources are regularly revisited to ensure adequate support for CalOptima Health's QIHETP.

The QIHE staff directly impacts and influences the QIHEC and related committees through monitoring, evaluation and interventions, and provides various committees with the outcomes and effectiveness of corrective actions. In addition to CalOptima Health's CEO, CMO, COO, CHEO and CHRO, Appendix B includes a list of CalOptima Health's staff positions that provide direct support for organizational and operational QIHETP functions and activities. In addition, CalOptima Health maintains enough administrative and clinical staff with the necessary knowledge and experience to assist and support the staff roles listed in Appendix B in carrying out their QIHETP responsibilities.

4.4. Staff Orientation, Training and Education

CalOptima Health seeks to recruit highly qualified individuals with extensive experience and expertise in the health services field. Qualifications and educational requirements are delineated in the respective position descriptions. Each new employee receives intensive orientation and job-specific training with a designated staff member. The following topics are covered during the introductory period, with specific training, as applicable to individual job descriptions:

- CalOptima Health New Employee Orientation and Boot Camp (CalOptima Health programs)
- HIPAA Rules and Compliance
- Fraud, Waste and Abuse
- Compliance and Code of Conduct Training
- Cybersecurity Awareness
- Workplace Harassment Prevention training
- Use of technical equipment (phones, computers, printers, fax machines, etc.)
- Applicable department program training, policies and procedures
- Diversity, Equity and Inclusion Training Program
    - Cultural Competency: The Foundation of Equitable Health Care
    - Diversity, Equity, Inclusion and Belonging
    - Health Equity Fundamentals
- Transgender, Gender Diverse, Intersex (TGI) Cultural Competency Training Program

Employees are required to complete annual compliance training courses on the topics listed above. The frequency of the training varies by topic and depends on the employee's job position. CalOptima Health encourages and supports continuing education and training for employees, which enhances their competency in their current roles and/or prepares them for career advancement within CalOptima Health. Each year, a specific budget is set for education reimbursement for employees.

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

CalOptima Health provides comprehensive physical and BH care services based on the philosophy of a medical home for each member. The primary care provider serves as the medical home for members who previously found it challenging to access services within their community.

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

- Clinical care and service
- Credentialing and peer review

- Cultural and Linguistic services
- Cultural Responsiveness
- BH care
- Access and availability
- Continuity and coordination of care
- Health Risk Assessment/Health Needs Assessment
- Special Needs Program Model of Care
- Transitions of care
- Value-Based Payment Programs
- Pediatric and Adult Wellness
- PIPs and CCIPs
- Prenatal and postpartum care
- Preventive care, including:
    - Initial Health Appointment
    - Behavioral Assessment
    - Immunizations
    - Blood Lead Screenings
- Diagnosis, care and treatment of acute and chronic conditions
- Care management, including complex care management
- Prescription drug services
- Hospice care
- Palliative care
- Major organ transplants
- Health education and promotion
- Disease management
- Member experience and satisfaction
- Patient safety

Administrative oversight:

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

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

4.5.1. Quality Improvement (QI) Department

The QI department fully aligns with departments throughout the organization to support the organizational mission, strategic goals and processes that monitor and drive improvements in quality of care and services. The QI department is responsible for coordinating the development and implementation of the QIHETP, which outlines the QIHE goals, objectives, and methods for evaluating and improving quality. It supports the QIHEC and subcommittees to ensure that all QIHETP activities are performed, integrated and communicated internally and to the contracted delegated health networks, thereby achieving the goal of improved care and services for members. The QI department plays a central role in ensuring that members receive high-quality, safe and effective care. It monitors quality care and service by ensuring that credentialing standards, policies, and procedures are implemented to provide a qualified provider network for our members, by conducting site reviews and by overseeing a systematic process that includes a review of potential quality issues (PQIs), or a suspected deviation from the standard of care, that involves CalOptima Health's Credentialing and Peer Review Committee. The QI department is also responsible for ensuring compliance with federal and state regulations and leads the effort in the timely submission of the NCQA Health Plan and Health Equity Accreditation Surveys.

4.5.2 Quality Analytics

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

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

- Report, monitor and trend outcomes
- Conduct measurement analysis to evaluate goals, establish trends and identify root causes
- Establish measurement benchmarks and goals
- Support efforts to improve internal and external customer satisfaction
- Improve organizational quality improvement functions and processes for both internal and external customers
- Collect clear, accurate and appropriate data used to analyze the performance of specific quality metrics and measure improvement
- Coordinate and communicate organizational, health network and provider-specific performance on quality metrics, as required
- Participate in various reviews through the QIHETP, including but not limited to network adequacy, access to care and availability of practitioners
- Facilitate satisfaction surveys for members
- Incentivize health networks and providers to meet quality performance targets and deliver quality care

- Design and develop member, provider and organization-wide initiatives to improve - quality of care

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

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

4.5.3. Equity and Community Health

The Equity and Community Health department is committed to advancing health equity by ensuring all members have a fair and just opportunity to achieve their highest level of health. Our approach embeds health equity into organizational structures and practices, is co-created with the community, and continuously refined through data and feedback. The department is dedicated to integrating health equity, member-centered care, meaningful community engagement, and data-driven decision-making throughout the organization.

4.5.4. Office of Compliance

The Office of Compliance is responsible for monitoring and driving interventions to ensure that CalOptima Health's QIHETP and quality-related activities align with applicable laws, regulations and internal policies and that providers and health networks meet state, federal and contract requirements. The Office of Compliance provides oversight of CalOptima Health's regulatory and compliance functions, including the development and amendment of CalOptima Health's policies and procedures to ensure adherence to regulatory and contract requirements. The Compliance staff monitors changes in regulatory requirements that impact quality measures and care delivery, and ensures timely updates to policies and procedures. The Compliance staff works in collaboration with the Audit & Oversight Department to conduct audits and monitor the implementation of quality activities, detecting noncompliance and risk. The Office of Compliance refers any potential noncompliance issues or trends encountered during audits of health providers, networks and other functional areas for investigation.

4.5.5. Population Health Management

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

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

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

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

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

In 2026, the PHM Work Plan will continue to focus on meeting member needs through high-quality care delivery and service coordination. CalOptima Health identified opportunities to expand outreach and initiate new initiatives focused on improving health outcomes as follows:

- Improve access to preventive screenings and services for all CalOptima Health members, with a particular focus on pregnant/postpartum members and children.
- Enhance Disease Management programs to assist members with diabetes and other chronic conditions.
- Expand CalAIM Community Supports and the Street Medicine Program to connect members with whole-person care approaches and address social drivers of health.

- Enhance follow-up care after Emergency Department visits related to mental health and alcohol and other drug abuse or dependence.
- Improve member experience for members who participate in PHM services like complex case management and disease management.

Further details of the PHM Program, activities and measurements can be found in the 2026 PHM Strategy (Appendix B).

4.5.6. Care Coordination and Care Management

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

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

CalOptima Health's Care Management (CM) program includes three care management levels that reflect the acuity of needs: complex case management, care coordination and basic case management. Members within defined models of care (WCM and OneCare) are risk-stratified upon enrollment using a plan-developed tool. This risk stratification informs the HRA/HNA

outreach process. The tool utilizes information from various data sources, including acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy records.

Qualifying members may be referred to ECM as appropriate.

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

The comprehensive risk assessment facilitates care planning and offers actionable items for the interdisciplinary care team (ICT). Risk assessments may be completed face-to-face, virtually, telephonically or in a paper-based format, accommodating threshold language preferences. Risk assessments for WCM and OneCare are completed initially and then annually.

4.5.6.2 Interdisciplinary Care Team (ICT)

The Interdisciplinary Care Team (ICT) facilitates the formal and informal collaborative process of developing, implementing and refining an Individualized Care Plan (ICP) that facilitates integrated, informed and synchronized communication to address the evolving needs and goals of each member. An ICT is linked to members to assist in care coordination and services to achieve the individual's health goals. If a meeting is required of the care team, the following individuals are always invited to the ICT meeting: the member (and caregivers or an authorized representative with the member's approval or appropriate authorization to act on the member's behalf) and the PCP. Other disciplines are included as needed, such as a Medical Director, specialist(s), care manager, BH specialist, pharmacist, social worker, palliative ICT, dementia care specialist, dietitian and/or long-term care manager. The ICT is designed to ensure that members' needs are identified and managed by an appropriately composed team.

- ICT meetings are facilitated by the health network case manager.
- The team is composed of the member, caregiver or authorized representative, health network Medical Director, PCP and/or specialist, care manager, BH specialist and social worker.
- The ICT coordinates and facilitates communication between members, PCP and specialists, as appropriate.
- An ICT meeting can be requested by a member or the member's PCP.

4.5.6.3 Individualized Care Plan (ICP)

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

4.5.6.4 Whole-Child Model (WCM)

The goal of care management for WCM is a single integrated system of care that provides coordination for CCS-eligible and non-CCS-eligible conditions. CalOptima Health WCM Case Management is a member and family-centered care approach to ensure needed clinical and non-clinical services for the CCS-eligible condition are made available to each WCM member through comprehensive, interdisciplinary, and person-centered care management and Care Coordination to provide case finding, authorizations for services and Care Coordination to ensure that WCM members have access to CCS-paneled providers, equipment and medically necessary services. The model uses risk stratification to identify members who have more complex health care needs to outreach for an HNA. A collected HNA informs the ICP development and the ICT.

Further details of the WCM care coordination program, activities and measurements can be found in the UM/CM Integrated Program Description.

4.5.7. Utilization Management

Utilization Management (UM) oversees coverage of health care services, treatments and supplies for all lines of business based on the terms of the plan and member eligibility at the time of service. Services, treatments and supplies are available and accessible to all members, including those with LEP or diverse cultural and ethnic backgrounds, regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status or disability. Decisions are made based on medical necessity. Medically necessary services are those that are provided to a member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the member's condition, disease, illness or injury; (iii) not primarily for the convenience of the member or health care provider; and (iv) not more costly than an alternative service, or suite of services, and at least as likely to produce equivalent results.

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

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

4.5.8. Behavioral Health (BH)

CalOptima Health is responsible for providing quality BH across the continuum of care, including mental health, substance use services and BH treatment, including applied behavioral analysis. BH Integration (BHI) focuses on prevention, recovery, resiliency and rehabilitation. As part of the QIHETP, with direction and guidance from the QIHEC, BHI and other supporting departments, continue to monitor the BH care that CalOptima Health provides our members and continue to seek ways to improve BH care.

CalOptima Health's BH Medical Director provides clinical and administrative leadership for all behavioral health services while ensuring regulatory compliance with state and federal requirements like Medi-Cal and the CalAIM initiative. Key responsibilities include overseeing utilization management (UM) and quality improvement (QI) programs, making clinical coverage determinations for treatment requests and appeals, and engaging in peer-to-peer consultations with network providers. A crucial part of the position involves leading the integration of BH and physical health by collaborating with medical directors and other departments to develop and implement whole-person care strategies, manage co-occurring conditions, and ensure seamless coordination of care across primary care and specialty settings. This leader also develops clinical policies, educates staff and providers on best practices, and uses data analysis to enhance program effectiveness and achieve quality outcomes for members.

BHI quality team functions and coordinates with the broader Quality Department. The BHI quality team plays a central role in identifying behavioral health (BH) care gaps and driving targeted interventions.

Sr. Manager II of Quality and Programs, Behavioral Health Integration, is directly involved in:

- Leading BHI quality team meetings
- Coordinating with the Director and the Executive Director of BHI on strategic decisions
- Overseeing policy development and compliance processes with the Office of Compliance

The work is grounded in continuous data monitoring through tools such as HEDIS, Stars metrics, internal dashboards, and root cause analysis to uncover systemic barriers to care.

BHI has clinical auditor positions that support both BHI and other departments as subject matter experts for the BHT/ABA benefit and program. They are both internal and external facing. Some key functions include reviewing treatment plans to identify areas that drive best practices, developing training materials, facilitating training sessions to improve quality upstream, and developing audit tools to ensure consistency in decision-making for BH UM.

The BHI UM department staff participate in the yearly IRR along with other departments that are responsible for UM to support consistency of application in nationally recognized criteria for making medical necessity determinations, as well as development of evidence-based clinical practice guidelines, and complete an annual review and update the clinical practice guidelines to

make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other organization standards.

BHI has a BHQI workgroup that meets monthly and consists of the BH medical director, other medical directors, the Executive Director, the Director of BH, the quality leadership team, and other member- and provider-facing departments. The overall purpose is to review BHI quality opportunities and interventions. Goals include analyzing the effectiveness of existing interventions for quality improvement and reporting, as well as collaboration in the development of new interventions when necessary.

The BHQI (Behavioral Health Quality Improvement) workgroup is a monthly convening that includes:

- The BH Medical Director and other internal medical directors
- Executive Director and Director of Behavioral Health Integration
- Quality leadership team
- Leadership from member- and provider-facing departments

This multidisciplinary composition ensures that both clinical and operational perspectives are integrated into quality improvement efforts.

The workgroup's stated mission is to:

- Review BHI quality opportunities and interventions
- Analyze the effectiveness of existing interventions
- Work collaboratively to develop innovative strategies that enhance member engagement, address care gaps, and support comprehensive whole-person health

This is consistently reflected in meeting agendas, coaching documentation, and internal communications within the organization.

4.5.8.1 Medi-Cal Behavioral Health (BH)

CalOptima Health provides outpatient mental health services to members with mild to moderate impairment in mental, emotional, or behavioral functioning. These services include:

- Individual, group, and family psychotherapy
- Psychological testing to evaluate mental health conditions
- Psychiatric consultation
- Medication management
- Behavioral Health Treatment (BHT) for children under 21
- Transcranial Magnetic Stimulation (TMS) when clinically indicated

Members with severe BH impairment needs are referred to the Orange County Behavioral Health Plan (BHP) for specialty mental health services.

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

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

CalOptima Health members can access mental health services directly, without a physician referral. A CalOptima Health representative will conduct a brief mental health telephonic screening to make an initial determination of the member's impairment level. If the member has mild to moderate impairments, the member will be referred to BH practitioners within the CalOptima Health provider network. If the member has moderate to severe impairments, the member will be referred to specialty mental health services through the BHP.

CalOptima Health's approach to care coordination emphasizes the framework below:

- Integrated care management for members with complex needs, including those with co-occurring physical and behavioral health conditions.
- Standardized member identification using Health Risk Assessments (HRAs) and claims data.
- Multidisciplinary care planning involves PCPs, specialists, social workers, and behavioral health providers.

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

4.5.8.2 OneCare Behavioral Health

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

4.5.8.3 Virtual Behavioral Health Care

In 2024, CalOptima Health partnered with the virtual vendor TeleMed2U to launch additional behavioral health telehealth services, expanding access to outpatient therapy for members ages 13 and older and to psychiatry for members ages 5 and older. Routine monitoring of utilization is conducted, including demographic details including language, age, and gender, as well as the timeliness of access. Data is segmented in various ways to identify disparities, which are addressed in monthly meetings with the vendor. For example, reviewing language capabilities to assist members in their primary language helps expand access and ensures they can connect with clinicians who meet their linguistic and cultural needs.

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

The MOC is a document required by CMS for a D-SNP. The MOC defines the care management policies, procedures and operational systems for OneCare. It is "member-centric" with the ongoing focus on the member and the member's family/caregiver.

The MOC goals are:

- Improve coordination of care
- Appropriate utilization of services for preventive health and chronic conditions
- Improving member experience
- Enhanced care transitions across all health care settings and providers

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

- Initial Health Risk Assessment and annual reassessment for each enrollee
- Individualized Care Plan
- Interdisciplinary Care Team
- Transition of Care Protocols

5. Program Documents

5.1. Quality Improvement and Health Equity Transformation Program Work Plan

The QIHETP Work Plan outlines key activities for the year. It is reviewed and approved by the QIHEC and the Board of Directors' QAC. The QIHETP Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QIHETP Work Plan is monitored by CalOptima Health throughout the year. A QIHETP Work Plan addendum may be established to address the unique needs of members, newly identified problems or trends, actions taken to improve care where deficiencies are identified, and follow-up as indicated.

The QIHETP Work Plan is the operational and functional component of the QIHETP and is based on CalOptima Health priorities, the most recent and trended HEDIS, CAHPS, Health Equity and Quality Data (HEQMS), Quality Rating System (QRS) data, physician quality measures and other measures identified for attention, including any specific requirements mandated by contracts, regulatory agencies or accreditation standards. As such, measures targeted for improvement may be adjusted mid-year when new scores or results are received.

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

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

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

The QIHETP Work Plan supports the comprehensive annual evaluation and planning process, which includes reviewing and revising the QIHETP and applicable policies and procedures. The QIHETP Work Plan encompasses all quality improvement focus areas, goals, improvement activities, progress toward these goals, and associated timeframes. Planned activities include strategies to improve access to care, service delivery, quality of care, and over- and under-utilization, as well as member population health management. All goals will be measured and monitored in the QIHETP Work Plan, reported to QIHEC on a quarterly basis, and evaluated annually. A copy of the current QIHETP Work Plan is publicly available on the CalOptima Health website.

For the annual QIHETP Work Plan, see Appendix A.

5.2. Quality Improvement and Health Equity Program Evaluation

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

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

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

5.3. Review and Approval of Program Documents

On an annual basis, the QIHETP Description, QIHETP Work Plan, and QIHETP Evaluation are presented to the CalOptima Health Board of Directors and the Board of Directors' QAC for review and approval. The QAC is a Board committee that comprises a subset of the members of the Board of Directors and is responsible for the direction of the program and actively evaluates the annual plan to determine areas for improvement. Board of Directors comments, actions and responsible parties assigned to implement changes are documented in the Board of Directors meeting minutes.

6. Quality Improvement and Health Equity Processes

6.1. QIHE Project Selection and Focus Areas

Performance and outcome improvement projects identified through continuous internal monitoring activities will be selected from the following areas:

- Potential quality issue (PQI) review processes
- Provider and facility reviews
- Preventive care audits
- Access to care studies
- Member experience surveys
- HEDIS results
- NCQA Health Plan and Health Outcomes Standards
- NCQA Health Plan Rating measures
- Other opportunities for improvement as identified by QIHEC and/or the subcommittee's data analysis

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, behavioral health (mental health/substance abuse disorder), emergency services, inpatient services, ancillary care services, with specific emphasis on the following areas:

- Access to and availability of services, including appointment availability
- Continuity of care for members
- Provisions of chronic care services
- Access to and provision of preventive services

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

- Staff, administration and physicians provide vital information necessary to support continuous performance improvement and occur at all levels of the organization.
- Individuals and administrators initiate improvement projects within their area of authority that support the strategic goals of the organization.
- Other prioritization criteria include the expected impact on performance (if the performance gap or potential risk for non-performance is so great as to make it a priority), and items deemed to be high-risk, high-volume or problem-prone processes.
- Project coordination occurs through the various leadership structures: Board of Directors, management, QIHEC, UMC, etc., depending on the scope of work and impact of the effort.

CalOptima Health collaborates with delegated business partners to coordinate QI activities for all lines of business through the following:

- Monthly Health Network Forums
- Quarterly Health Network Collaborative Quality Forums
- Biannual Joint Operation Meetings (JOM) with health networks.

These improvement efforts are often cross-functional and require dedicated resources to assist in data collection, analysis and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups.

6.2. QIHE Project Measurement Methodology

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

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

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

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

Plan 1) Identify opportunities for improvement.

2) Define baseline.

3) Describe root cause(s) including barrier analysis.

4) Develop an action plan.

Do 5) Communicate the change plan.

6) Implement the change plan.

Study 7) Review and evaluate the result of the change.

8) Communicate progress.

Act 9) Reflect and act on learning.

10) Standardize the process and celebrate success.

11) As needed, initiate corrective action plan(s), which may include enhanced monitoring and/or re-measurement activities.

6.3. Types of QIHE Projects

CalOptima Health implements several types of improvement projects, including QIPs, PIPs, CCIPs and PDSAs, to improve processes and member outcomes. For each QI Project, specific interventions are developed and implemented to achieve the stated goals and objectives. Interventions for each project must:

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

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

6.4. Improvement Standards

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

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

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

6.5. Documentation of QIHE Projects

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

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

6.6. Communication of QIHE Activities

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

- Practitioner participation in the QIHEC and its subcommittees
- Health Network Forums, Medical Directors' Meetings, Health Network Collaborative Quality Forums, Joint Operations Meetings (JOMs)
- MAC and PAC
- Other ongoing ad hoc meetings

7. Quality Improvement Initiatives

7.1. Quality of Care

7.1.1. Quality Analytics

By analyzing data that CalOptima Health currently receives (e.g., claims data, pharmacy data and encounter data) in the data warehouse, Quality Analytics staff identify members for quality improvement and access to care interventions, to support improved health care as well as HEDIS scores and CAHPS results. This information will guide CalOptima Health and our delegated health networks in identifying gaps in care and metrics requiring improvement. Examples of quality care analyses include:

- Pediatric and Adolescent Wellness: Children's Preventive and Screening Services
- Evaluation of Maternal and Child Health: Prenatal and Postpartum Services
- Adult Wellness: Preventive and Screening Services
- Medication Management
- BH: Care Coordination and Follow-up
- Performance Improvement Projects (PIPs)
- Chronic Care Improvement Projects (CCIPs)
- Improve Timely Access: Appointment Availability/Telephone Access

7.1.1.1. Encounter Data Validation

Accurate and complete encounter data are crucial for assessing quality, monitoring program integrity, and making informed financial decisions. CalOptima Health's health networks must submit complete, timely, reasonable and accurate encounter data that adheres to the guidelines specified in the companion guides for facility and professional claim types, as well as the data format specifications. A health network submits encounter data through the CalOptima Health File Transfer Protocol (FTP) site.

As directed by DHCS, CalOptima Health participates in the External Quality Review Organization's (EQRO) validation of encounter data from the previous 12 months. DHCS releases the results of the validation study annually in DHCS's yearly Encounter Data Validation Study Report. CalOptima Health reviews the report and extracts key findings from medical record reviews on encounter data completeness and accuracy to identify opportunities for improvement.

7.1.2. Comprehensive Credentialing Program

The comprehensive credentialing process is designed to provide primary source verification (PSV) of a practitioner's qualifications, experience and competencies, to ensure the individual meets established standards for credentialing and recredentialing. PSV includes but is not limited to licensure, education, training, board certification, work history and professional background, to validate elements of competency of practitioners working within the CalOptima Health

contracted delivery system. CalOptima Health contracts with an NCQA-certified Credentialing Verification Organization to assist with the credentialing process, which involves vetting practitioners and organizational providers.

Practitioners are credentialed and recredentialed according to regulatory and accreditation standards (CMS, DMHC and NCQA) and are verified to be in good standing in Medicare and Medi-Cal programs. The scope of the credentialing program includes, but is not limited to, licensed Medical Doctors (MDs), Doctors of Osteopathy (DOs), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic (DC), Doctor of Dental Surgery (DDS), Doctor of Medical Dentistry (DMD), Advance Practice Professional (APP), Certified Nurse Midwife (CNM), Clinical Nurse/Specialist, Nurse Practitioner, Physician Assistant, including Optometrist, Physical Therapist, Occupational Therapist, Speech and Language Therapist, Audiologist, and behavioral health practitioners, including Psychiatrists, Addiction Medicine Specialists, Psychologists, Clinical Social Workers (master's level), and Psychiatric Nurse Practitioners as well as medical group entity, where applicable, both in the delegated and CalOptima Health direct contract environments. Credentialing and recredentialing activities are performed at CalOptima Health and/or are delegated to health networks and other delegates.

CalOptima Health performs credentialing and recredentialing of organizational providers, including but not limited to acute care hospitals, home health agencies, skilled nursing facilities, free-standing surgery centers, and dialysis centers. The intent of this process is to assess that these entities meet regulatory requirements, comply with standards for quality of care and are in good standing with state and federal agencies.

CalOptima Health recredentials providers every 36 months. Between recredentialing cycles, CalOptima Health conducts ongoing monitoring of sanctions, which include but are not limited to state or federal sanctions, exclusions, debarments, or other restrictions on licensure or limitations on the practice of medicine, including Medicare and Medicaid participation and eligibility, quality concerns, and member complaints. At recredentialing, CalOptima Health considers PVS, QI elements and other performance monitoring activities into consideration during the review process.

7.1.3. Facility Site, Medical Record and Physical Accessibility Reviews

CalOptima Health does not delegate facility site, medical record or physical accessibility reviews to other managed care plans. CalOptima Health assumes responsibility for conducting and coordinating facility site reviews (FSRs) and medical record reviews (MRRs) for delegated health providers and networks. CalOptima Health retains coordination, maintenance and oversight of the FSR/MRR process. CalOptima Health collaborates to coordinate the FSR/MRR process, minimizing duplication of site reviews and supporting consistency in site reviews for shared providers.

CalOptima Health completes initial site reviews and subsequent periodic FSR, MRR and Physical Accessibility Review Surveys (PARS), per DHCS requirements for all contracted primary care provider (PCP) sites that participate in the provider network, regardless of the status of a site's other accreditations and certifications.

Site reviews are conducted as part of the initial credentialing process. All PCP sites must undergo an initial site review and receive a minimum passing score of 80% on the FSR Site Review Tool. This requirement is waived for pre-contracted provider sites that have documented proof of another local managed care plan completing a site review with a passing score within the past three years. This is in accordance with the DHCS All Plan Letter (APL) 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review and CalOptima Health policies. An initial medical record review shall be completed within 90 calendar days from the date that members are first assigned to the provider. An additional 90-day extension may be allowed only if the provider does not have enough assigned members to complete a review of the required number of medical records. Subsequent site reviews, consisting of an FSR, MRR and PARS, are conducted at least every three years, beginning no later than three years after the initial FSR and at least every three years thereafter. Minimum passing score for FSR and MRR is 80%.

CalOptima Health may review sites more frequently, as per local collaborative decisions or when deemed necessary based on monitoring, evaluation, or follow-up issues related to a corrective action plan (CAP). If the provider site does not meet compliance with review criteria and CAP requirements within the established CAP timeline and/or fails the FSR or MRR on its third consecutive attempt, no CAP will be issued, and the provider site will be removed from CalOptima Health's provider network. If terminated, a provider site may reapply for participation in the CalOptima Health provider network after three years from the effective date of the termination.

CalOptima Health conducts additional DHCS-required reviews for assessing the level of physical accessibility for PCP sites, high-volume specialty sites, providers of ancillary services, and CBAS centers that serve a high volume of SPDs. Results from the PARS include the level of access met at each provider site and are displayed on the CalOptima Health provider directory. The PARS identifies whether each provider site has or does not have access in the following categories:

- Parking
- Building interior and exterior
- Restroom
- Exam room
- Exam table/scale
- Participant areas
- Patient diagnostic and treatment use
- Medical equipment

7.1.4. Medical Record Documentation

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

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

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

7.1.5. Corrective Action Plan(s) to Improve Quality of Care and Services and Implementation and Evaluation of Interventions to Reduce Health Disparities

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

- Development of cross-departmental teams using continuous improvement tools (i.e., quality improvement plans or PDSA) to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.
- Formal or informal discussion of the data/problem with the involved practitioner/provider, either in the respective committee or by a Medical Director.
- Further observation and monitoring of performance via the appropriate clinical monitor. (This process shall determine if follow-up action has resolved the original problem.)
- Intensified evaluation/investigation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e., when the current data is insufficient to fully define the problem.
- Changes in policies and procedures when the monitoring and evaluation results may indicate problems that can be corrected by changing policy or procedure.

7.1.6. Quality Performance Measures

CalOptima Health collects, tracks, and reports all quality performance measures on an annual basis. Measure rates are validated by an NCQA-certified auditor and reported to NCQA and other entities as required.

7.1.6.1. HEDIS® Measures

CalOptima Health's Health Care Effectiveness Data and Information Set (HEDIS) are collected from various data sources, including claims and encounters, lab data, pharmacy data, state registry and claims data, medical charts and supplemental data from our plan partners. Surveys are conducted annually, and results are audited by an NCQA-approved external survey organization. Results are used by CalOptima Health to measure progress toward meeting goals and objectives, improve the quality, equity, and value of health care services, and to develop quality improvement strategies, goals, objectives and activities.

7.1.6.1.1. OneCare Stars

CalOptima Health's OneCare program is required to participate in the CMS Star Rating program each year. This program comprises more than 40 quality measures, including HEDIS measures, member survey measures such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Health Outcomes Survey (HOS), administrative measures, and pharmacy measures. To ensure high quality and continued improvement of these measures, CalOptima Health has extensive strategies and initiatives, including a Stars Executive Steering Committee, several working sessions with various departments, member experience improvement work groups, and regular meetings with health network partners and providers.

7.1.6.1.2. Medi-Cal Managed Care Accountability Set (MCAS)

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

7.1.6.2. Disparities Reduction Program, Including Collection of Member Demographic Data

CalOptima Health fosters a culture of equity within its health plan operations and through its participating providers. CalOptima Health shall maintain a disparities reduction program, including the collection of member demographic data, stratification of quality measures by demographic factors, and implementation and evaluation of interventions to reduce health disparities. CalOptima Health's disparities reduction program shall be subject to review by

Covered California annually to evaluate compliance with the requirements set forth in its contract. CalOptima Health shall conduct quality improvement and disparities reduction activities compliant with federally required Quality Improvement Strategy (QIS) requirements.

7.1.6.3. Value-Based Payment Program

CalOptima Health's Value-Based Payment Performance Program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health networks, including CHCN, and delegated health networks' primary care providers are eligible to participate in the Value-Based Payment Programs. CalOptima Health has adopted the Integrated Healthcare Association pay-for-performance methodology to assess performance.

CalOptima Health launched the Behavioral Health Pay-for-Value Programs (July 2024 through December 2027) to improve care for members receiving mental health and BHT services. This initiative reflects our ongoing commitment to improving behavioral health outcomes and value-based care. It uses a performance-driven, prospective pay-for-value model that features incentives for mental health providers and Applied Behavior Analysis (ABA) providers to meet specific quality metrics.

7.1.6.4 Hospital Quality Program 2023–2027

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

7.2. Access to Care

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

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

- Annual Network Certification (ANC) with DHCS
- Subcontracted Network Certification (SNC) with DHCS
- Network Adequacy Validation with the External Quality Review Organization (EQRO)
- Network Adequacy Monitoring with CMS
- Annual Timely Access Survey

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

7.2.1. Availability of Primary Care Providers (PCPs) by Language

CalOptima Health monitors member and provider demographics, threshold languages, and the availability of PCPs and clinic staff quarterly to oversee the language landscape within the network. CalOptima Health supports the provision of care to members in their preferred language and promotes network development to ensure access and availability of PCPs by language. Providers can share PCP and clinic staff languages through various processes throughout the year. Information is accessible to members on the provider search tool or via requests.

7.2.2. Availability of Practitioners

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

7.2.3. Appointment Access

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

Providers who do not meet timely access standards are re-measured and tracked. Follow-up action may include education, enhanced monitoring and/or issuance of a corrective action, as well as potential sanctions.

7.2.4. After-Hours Access to Care

CalOptima Health monitors PCP after-hours care in accordance with DHCS and NCQA standards to ensure members have proper access to care after hours on an annual basis. CalOptima Health's Access and Availability policies include after-hours phone access. CalOptima Health surveys providers on BH follow-up care, emergency instructions for callers, and the availability of on-call providers. To ensure members know how to access care after hours, CalOptima Health publishes and distributes educational materials for members describing appropriate use of their PCP, minute care, urgent care and the emergency room (ER). A provider directory is available online.

Additionally, CalOptima Health nurse advice line is available 24/7 to assist members with access to care after hours. CalOptima Health monitors access to the nurse advice line in accordance with NCQA standards on a quarterly basis.

7.2.5. Telephone Access to CalOptima Health Staff

CalOptima Health monitors access to its Customer Service department and nurse advice line on a quarterly basis. To ensure that members can access their provider via telephone to obtain care, CalOptima Health monitors access to ensure members have access to their PCP during business hours. Providers not meeting timely access standards are remeasured and tracked, and follow-up action may include education, enhanced monitoring, issuance of a corrective action and potential sanctions.

7.3. Member and Provider Satisfaction

7.3.1. Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CalOptima Health participates in the CAHPS program to better understand our members' experience and improve the quality of care. Results are used to measure progress, improve quality, reduce disparities, and improve health equity and outcomes. Focus is placed on coordinating efforts intended to improve performance on CAHPS survey items for both the adult and child populations.

7.3.2. Member Satisfaction Studies

Improving member experience is a top priority of CalOptima Health and has a strategic focus on the issues and factors that influence the member's experience with the health care system.

CalOptima Health evaluates and assesses member-reported experiences to determine how well plan providers are meeting members' expectations and goals. Annually, CalOptima Health fields the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. Focus is placed on coordinating efforts intended to improve performance on CAHPS survey items for both the adult and child populations.

CalOptima Health conducts comprehensive BH surveys and analyses annually to assess member satisfaction regarding BH services. Two separate surveys are administered: the Behavioral Health Member Satisfaction: Applied Behavior Analysis (ABA) Services Survey and the Behavioral Health Member Satisfaction: Mental Health (MH) Services Survey. The MH version of the survey assesses both psychotherapy and medication services, whereas the ABA version is solely for ABA services. The survey questions focus on telehealth services, access to services, treatment experience and overall experience.

Additionally, CalOptima Health reviews customer service metrics and evaluates complaints, grievances, appeals, authorizations and referrals to identify "pain points" that impact members at both the plan and health network levels.

7.3.3. Grievances and Appeals

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

7.3.4. Provider Satisfaction

CalOptima Health monitors performance areas affecting provider satisfaction to assess the satisfaction experienced by CalOptima Health's network of PCPs and BH providers, such as network adequacy, provider call center trends, provider complaints and provider surveys. The information obtained is used to measure how well the health plan meets our providers' expectations and needs. We examine the satisfaction of the provider network in the following areas: overall satisfaction, claims payment issues, authorizations, access standards, quality management, coordination of care, pharmacy, CalOptima Health Customer Service staff and provider relations. Based on the information gathered, findings are reported to the QIHEC. The committee reviews the findings and makes recommendations on potential opportunities for improvements.

7.4. Patient Safety Program

Patient safety is a top priority for CalOptima Health. By encouraging members and their families to play an active role in ensuring their care is safe, medical errors can be reduced. Active, involved and informed members and families are vital members of the health care team.

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

- Identification and prioritization of member safety-related risks for all CalOptima Health members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on risk assessment
- Health education and health promotion
- Over/under-utilization monitoring
- Medication management
- Population Health Management
- Operational aspects of care and service

- Care provided in various health care settings
- Quality-of-care investigations
- Ongoing monitoring of our provider network
- Disease surveillance and reporting

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

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

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

- Improving medical record documentation and legibility, establishing timely follow-up for lab results, addressing and distributing data on adverse outcomes or polypharmacy issues by the P&T Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance safety.
- Alerting pharmacies to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), which helps ensure the appropriate drug is being delivered.
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to ensure timely and accurate communication.
- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety.

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

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

- Institutional settings:
    - Falls and other prevention programs
    - Identification and corrective action implemented to address postoperative complications
    - Quality-of-care issues, critical incident identification, appropriate investigation and remedial action

    - Administration of influenza and pneumonia vaccines
    - COVID-19 infection prevention and protective equipment

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

7.4.1. Health Education and Wellness

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

The Health Education programs identify, assess, stratify and implement appropriate interventions for all members, focusing on wellness, prevention, and including chronic conditions. Programs and materials employ educational strategies and methods tailored for members, families and caregivers to make informed health decisions and modify health behaviors throughout the lifespan. Moreover, these programs are structured with an "equity lens" to address mental wellness and the social drivers of health that most impact members. The programs are designed to achieve behavioral change over time and are reviewed annually. Covered topics include the management of asthma, diabetes, hyperlipidemia, prenatal health, proper exercise, nutrition and weight management, as well as tobacco cessation, immunizations and well-child visits.

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

- Behavior modification and healthy lifestyle management techniques
- Health education programs and services, including topics on medication education to ensure adherence to appropriate pharmacotherapy treatment plans

- Online health educational videos and resources
- Informational booklets about key conditions
- Referrals to community or external resources

Member educational classes are offered in various formats, considering accessibility and adaptability. Members may participate in classes through virtual sessions.

7.4.2. Managing Members with Emerging Risk

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

Interventions include coordinating care for members and providing services, resources, and support to help them learn to manage their condition and care for themselves.

7.4.3 Disease Management Program

CalOptima Health's Disease Management program supports members with chronic conditions, such as diabetes, asthma and heart failure, through personalized, evidence-based care. The program utilizes data-driven targeting to identify at-risk individuals and provides timely outreach, health coaching, and culturally tailored education in members' preferred languages. Services include symptom management, lifestyle guidance, and navigation to clinical and community resources. By aligning with primary care and case management, the program promotes medication adherence, self-monitoring, and the implementation of prevention strategies. The goal is to empower members to manage their health, reduce disparities, and prevent complications, emergency visits and hospitalizations, ultimately improving quality of life.

7.4.4. Continuity of Care Studies and Evaluations

CalOptima Health offers continuity of care to newly enrolled members who transition from other health plans or to existing members whose covered services are transitioned from Medi-Cal or other programs, or due to a provider's termination from the CalOptima Health network of providers. CalOptima Health educates members about continuity of care, access to and availability of services. CalOptima Health's monitoring processes ensure and improve the quality of care, accessibility, and timely access to care.

Continuity of care is a key determinant for overall health outcomes. Comprehensive continuity of care improves patient safety, avoids duplicate assessments and costs, procedures or testing, and results in better treatment outcomes. Continuity of care guidelines include the process for identifying newly enrolled members who transition into CalOptima Health and for existing members whose covered services are transitioned from other programs to CalOptima Health. Guidelines include services provided to a member rendered by an out-of-network provider with whom the member has a pre-existing provider relationship.

Continuity of care is monitored through QI studies and annual evaluations of network adequacy, timely access and access to care. This includes processes for correcting network deficiencies, applying for Alternative Access Standards when necessary, and ensuring that providers comply with access standards and timely access requirements. For example, QI studies can be used to investigate the causes of continuity problems and make recommendations aimed at improving the level of continuity provided at a provider clinic, or to assess the effectiveness of information exchange between medical care providers working in different care settings. The results of QI studies and annual evaluations are presented and discussed by the BMSC, MEMX, and/or GARS committees, as well as QIHEC. Based on the findings, the committee members recommend

opportunities for improvement that should be implemented by the department responsible for enhancing continuity of care.

7.4.5. Appropriate Medication Utilization

CalOptima Health continuously monitors pharmaceutical data to identify patient safety issues. Drug Utilization Review (DUR) is a structured, ongoing program that evaluates, analyzes and interprets drug usage against predetermined standards and undertakes actions to obtain improvements. The DUR process is designed to help pharmacists identify potential drug-related problems by analyzing patterns of medication use. The goal of the DUR process is to identify potential drug-to-drug interactions, patterns of overutilization and underutilization, high- and low-dose alerts, medication duplication, and other critical elements that can affect patient safety. The DUR study data is collected via an administrative data extraction of paid pharmaceutical claims. Actual prescribing patterns of PCPs, BH practitioners and specialists are compared with CalOptima Health standards. The results of the quantitative analysis are presented to CalOptima Health's P&T Committee, a subcommittee of the Utilization Management Committee. The UMC reports quarterly to the QIHEC for discussion and action, as necessary.

7.4.6. Peer Review Process for Potential Quality Issues

Peer Review is coordinated through the QI department. Medical Directors triage potential quality of care issues and conduct reviews of suspected physician and ancillary care quality issues. All potential quality of care cases are reviewed by a Medical Director, who determines a proposed action based on the severity of the case. The Medical Director presents cases, determined to be quality-of-care issues, to CPRC, and upon discussion, CPRC provides the final action(s). As cases are presented to CPRC, the discussion of care includes determining the appropriate action and severity level of the case, resulting in a committee-wide IRR process. The QI department tracks, monitors and trends PQI cases to identify opportunities for improving care and service. Results of quality-of-care reviews and tracking and trending of quality-of-service issues are reported to the CPRC and are also reviewed at the time of recredentialing. Potential quality-of-care case referrals are referred to the QI department from various departments throughout CalOptima Health, including but not limited to Prior Authorization, Concurrent Review, Care Management, Legal, Compliance, Customer Service, Pharmacy and GARS, as well as from providers, health networks and regulatory agencies.

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

7.5. Cultural and Linguistic Services Program

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

The most common languages spoken by CalOptima Health members across all programs are English, 57%; Spanish, 29%; Vietnamese, 9%; Farsi, 1%; Korean, 1%; Chinese, less than 1%; Arabic, less than 1%; Russian, less than 1%, and other languages are less than 2%. CalOptima Health provides member materials in the following eight languages: English, Spanish, Vietnamese, Farsi, Korean, Chinese, Arabic and Russian.

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

Objectives for serving a culturally and linguistically diverse membership include:

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

Serving a culturally and linguistically diverse membership includes:

- Analyzing significant health care disparities in clinical areas to ensure health equity.
- Using practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved.
- Considering outcomes of member grievances and complaints.
- Conducting member-focused interventions with culturally competent outreach materials that focus on race-, ethnic-, language- or gender-specific risks.
- Conducting member-focused groups or key informant interviews with cultural or linguistic members to determine how to meet their needs.

- Identifying and reducing a specific health care disparity affecting a cultural, racial or gender group.
- Implementing and maintaining annual sensitivity, diversity, communication skills, Health Equity, and cultural competency training and related training (e.g., providing gender-affirming care) for CalOptima Health employees and contracted provider staff (clinical and non-clinical).

Further details of the CLAS Program, activities and measurements can be found in the CLAS Program Description.

Appendix:

A. CalOptima Health's QIHETP Support Positions and Job Descriptions

B. 2026 QIHETP Work Plan

   i. HEDIS MY2025 Medicaid Goals

   ii. HEDIS MY 2025 Medicare Goals

C. 2026 Population Health Management Strategy

D. 2026 Culturally and Linguistically Appropriate Services (CLAS) Program Description

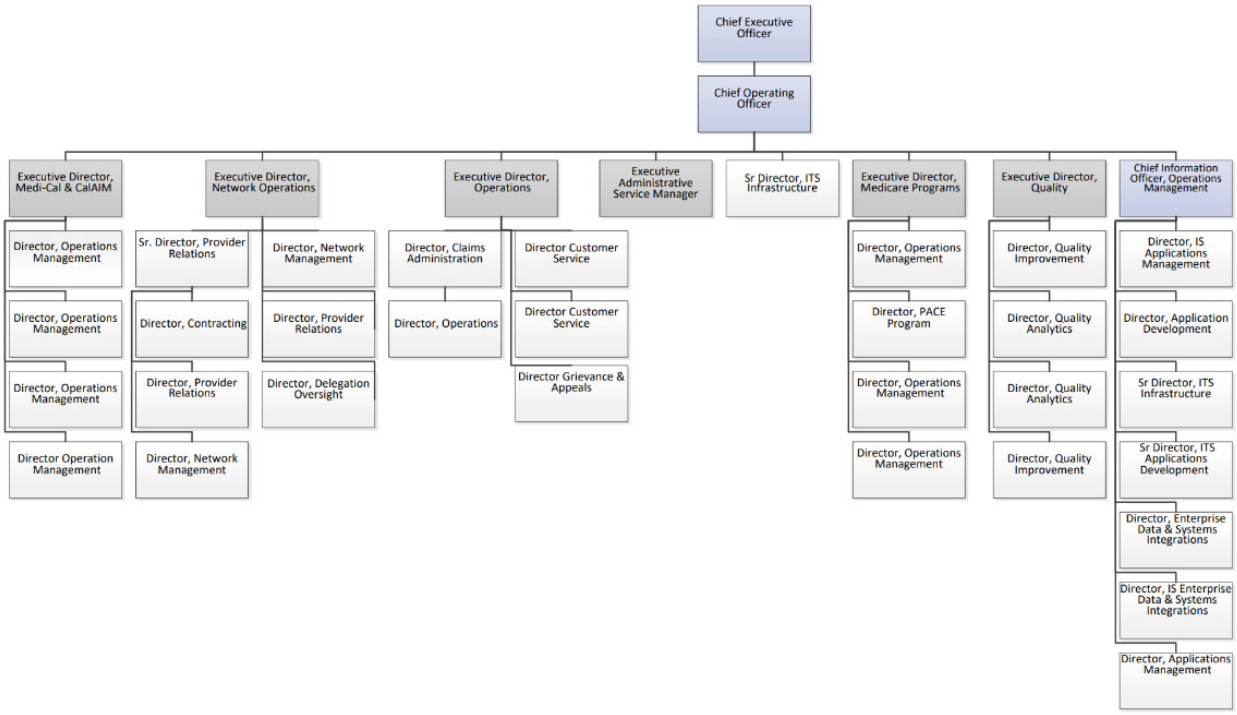
E. CalOptima Health Measurement Year (MY) 2026 Medi-Cal and OneCare Pay for Value Programs

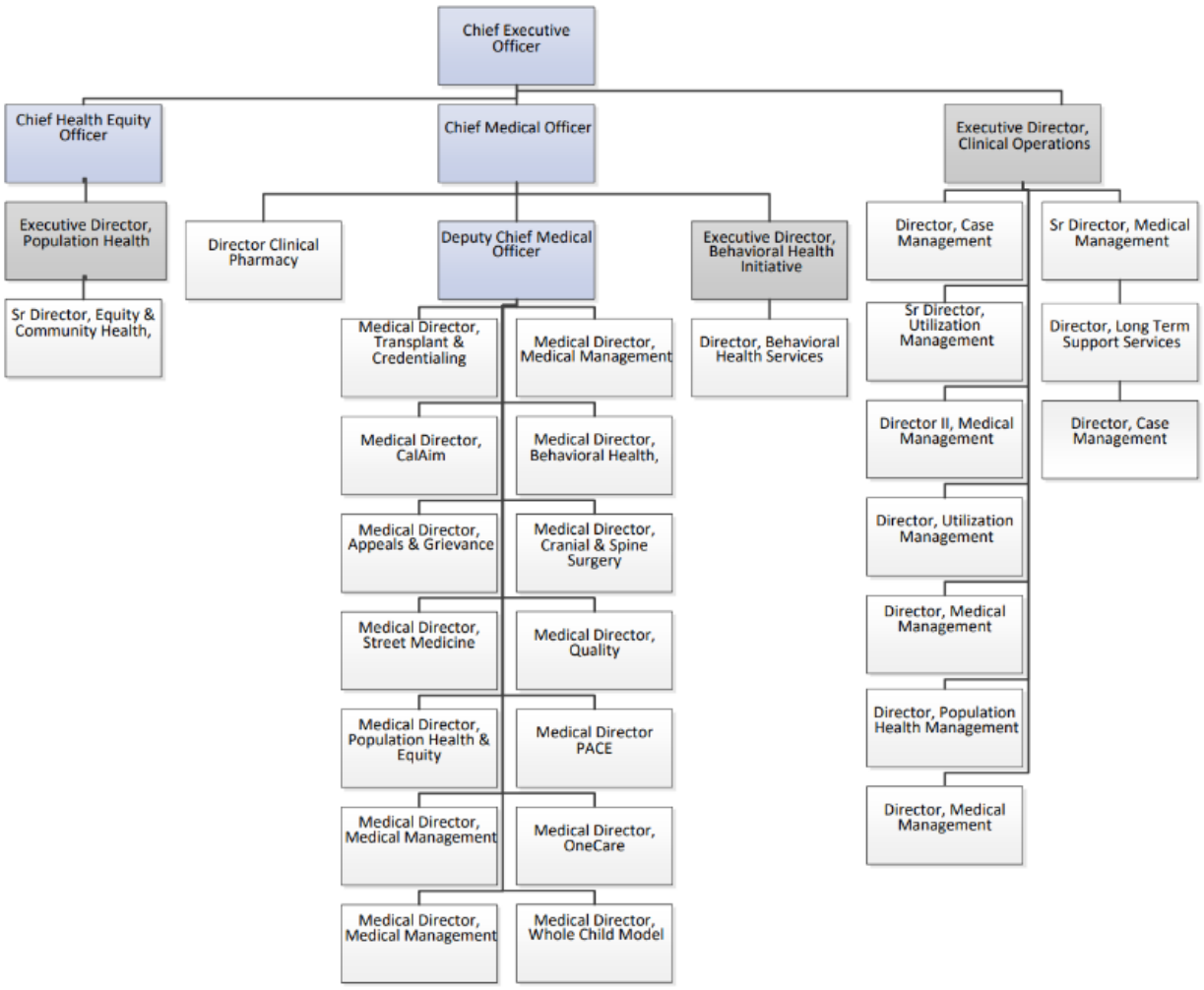
F. CalOptima Health Measurement Year (MY) 2026 Behavioral Health Integration Pay for Value Program

APPENDIX A

CalOptima Health's QIHETP Support Positions and Job Descriptions

Organizational Chart — Diagram





Quality Improvement and Health Equity Transformation Program Organizational Structure

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

Medical Director* (Behavioral Health) The CalOptima Health Medical Director (Behavioral Health) is a key member of the medical management team and will be responsible for providing physician leadership in the Medical Affairs division, serving as a liaison to other CalOptima Health operational and support departments. They will collaborate with the other Medical Directors and clinical, nursing and non-clinical leadership staff across the organization in areas including Quality Management, Utilization and Care Management, Health Education/Disease Management, Long Term Care, Pharmacy, Behavioral Health Integration, Program for All Inclusive Care for the Elderly (PACE) as well as support departments including Compliance, Information Technology Services, Claims, Contracting and Provider Relations.

Medical Director* (Medical Management) (13) is a key member of the medical management team and will be responsible for providing physician leadership in the Medical Management division, serving as liaison to other CalOptima Health operational and support departments. The Medical Director will collaborate with the other Medical Directors and clinical, nursing and non-clinical leadership staff across the organization in areas including CalAIM, Credentialing, Quality Management, Utilization and Care Management, Health Education/Disease Management, Long Term Care, Pharmacy, Program for All Inclusive Care for the Elderly (PACE), Street Medicine, Transplant, OneCare, Whole-Child Model, Population Health & Equity, Appeals & Grievance as well as support departments including Compliance, Information Technology Services, Claims, Contracting and Provider Relations.

Executive Director (Behavioral Health Integration (BHI)) is responsible for oversight of CalOptima's Behavioral Health (BH) program including utilization of services, quality outcomes, and the coordination and true integration of care between Physical and BH practitioners across all lines of businesses. The Executive Director serves as a member of the executive team and, with the CMO, assures that Medical Management is aligned with CalOptima's strategic and operational priorities. The Executive Director is a key leader within the health plan and is accountable for leading the areas assigned to next-level capabilities and operational efficiencies consistent with the strategic plan, goals, and objectives for CalOptima. The Executive Director will anticipate continuously improving, communicate, and leverage resources and achieving set accountabilities with constraints of limited resources. The Executive Director will be responsible for new program implementation of the implementation of initiatives in the above areas

Executive Director (Clinical Operations) is responsible for the performance of all operational aspects of key functional areas in Medical Management including Case Management, Long Term Services and Support (LTSS), and Utilization Management (UM), along with new clinical program implementation related to initiatives in all areas. The Executive Director serves as a member of the executive team, and with the CMO to ensure that the above aspects of Medical Management are aligned with CalOptima's strategic and operational priorities. The Executive Director is an important leader within the health plan and is accountable for leading the areas assigned to next-level capabilities and operational efficiencies consistent with the strategic plan, goals, and objectives for CalOptima. The Executive Director will be expected to anticipate, continuously improve, communicate, and leverage resources, as well as balance achieving set accountabilities.

Executive Director (Marketing and Communications) will be responsible for leading CalOptima Health's internal and external communications, marketing, community relations and strategic communications. The Executive Director will serve as a member of the executive team and work in collaboration and coordination with the leadership team to support the agency in communicating organizational goals and will plan, develop and implement strategies to effectively communicate the CalOptima Health's mission, vision and strategic priorities with

internal and external key stakeholders including employees, the public, members, government officials and the media.

Executive Director (Medi-Cal/CalAIM) is responsible for the implementation of CalAIM, a whole-system, person-centered delivery system reform to improve quality and care to members. The Executive Director manages the governance of key decisions to ensure that goals and objectives are accomplished within the constraints of budget, schedule, and customer expectations. The Executive Director is responsible for overall project coordination, including planning and sequencing work, setting milestones and deadlines, assigning responsibilities, facilitating cross-functional workgroups, monitoring progress, and reporting project status. Acting as a subject matter expert for CalAIM and related initiatives, the Executive Director works closely with elected officials, regulatory agencies, contractors, associations and key stakeholders.

Executive Director (Medicare Programs) will be responsible for implementation of products for older adults and individuals eligible for coverage under Medicare and Medi-Cal (Dual eligible). The Executive Director will be responsible for the Medicare Advantage product(s), Program of All Inclusive Care for the Elderly (PACE), and OneCare Sales and Marketing. The Executive Director will manage the governance of key decisions to ensure that membership and financial goals and objectives are accomplished within the constraints of budget, schedule, and customer expectations. The Executive Director will be responsible for overall project coordination, including planning and sequencing work, setting milestones and deadlines, assigning responsibilities, facilitating cross-functional workgroups, monitoring progress and reporting project status. The Executive Director, Medicare Programs, will be the subject matter expert for related initiatives, working closely with elected officials, regulatory agencies, contractors, trade associations and key stakeholders.

Executive Director (Network Operations) is responsible for the development, expansion, and support of the plan's provider delivery system to support the operation of all lines of business or programs. The Executive Director maintains a leadership role for delivery system operations across multiple models including direct contract, delegation, full risk, and accountable care organization. The Executive Director is also responsible for implementing strategies that achieve the established program objectives and to leverage the core competencies of the plan's existing administrative infrastructure to build an effective and efficient operational unit to serve enrollees and contribute to the delivery of accessible, cost effective, quality healthcare services throughout the service delivery network. The Executive Director leads and directs the integrated operations of the provider network contracted under the various programs and coordinates organizational efforts internally as well as externally with members, providers, and other stakeholders.

The Executive Director is responsible for the overall success of network operations for the planning and implementation to fulfill the plan's strategic objectives as related to contracting and operations of the provider delivery system. The Executive Director is responsible for providing

relations and support, including provider education and problem resolution. The Executive Director and their staff must have the ability to collaborate with all internal departments to support and assist delegated provider entities and directly contracted providers in their day-to-day interactions and transactions with the plan**.**

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

Executive Director (Population Health) will be responsible for oversight of key medical affairs functions including Population Health Management which includes Health Education. The ED of Population Health Management will serve as a member of the executive team and, with the CMO, ensure that medical affairs align with CalOptima Health's strategic and operational priorities. The Executive Director is a key leader and will be responsible for leading the areas assigned to next-level capabilities and operational efficiencies consistent with the strategic plan, goals and objectives for CalOptima Health. The Executive Director will anticipate continuously improving, communicate and leverage resources.

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

Executive Director (Strategic Development) serves as a member of the executive team responsible for the oversight and implementation of CalOptima Health's strategic development programs. Under the general guidance of the Chief Strategy Officer (CSO), the Executive Director works closely with top level leadership to plan, develop, implement strategies and carry out organizational goals and priorities to effectively promote and implement CalOptima Health's mission and vision with internal and external contacts including employees, the public, members, government officials and the media.

Director (Behavioral Health Services) provides program development and leadership to the implementation, expansion and/or improvement of processes and services that lead to the integration of physical and behavioral healthcare services for all CalOptima members across all lines of business. The Director of Behavioral Health Services is responsible for the management and strategic direction of the Behavioral Health Integration (BHI) department, clinical operations, program initiatives, and community partnerships. The Director of Behavioral Health Services will ensure the department is compliant with all local, state, and federal regulations and that accreditation standards and all policies and procedures meet current requirements. The Director of Behavioral Health Services will work closely with the Medical Director of Behavioral Health to lead the agency in the development and successful implementation of both short and long-term strategic goals and objectives towards integrated care. The Director of Behavioral Health Services will play an important leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors, executives and departmental directors, plan members, contracted providers, Regulatory Affairs, and Legal Counsel, state and federal officials, and representatives of other agencies. The Director of Behavioral Health Services will be expected to participate with other senior staff within the department in monitoring, analyzing, and reporting to the Executive team on changes in the healthcare delivery environment and program opportunities affecting or available to assist CalOptima in integrating physical and behavioral healthcare services.

Director (Case Management) directs all Case Management programs for CalOptima members to ensure that these functions are properly implemented by all CalOptima Health Networks and contracted provider groups, including CalOptima Community Network and CalOptima Direct. The Director of Case Management is responsible for all departmental compliance with all local, state and federal regulations and ensures that accreditation standards are current and all policies and procedures meet current requirements.

Director (Case Management) (Clinical Operations Administration) will lead the operational components to develop and implement an ongoing comprehensive, outcome-driven clinical strategy to enhance and increase the capacity of Medical Management programs and services for CalOptima Health members. The Director will be responsible for initiating and/or further developing best practice model design and framework that includes visual and technical toolkits for internal and external Health Network Partners to support regulatory and contractual compliance and high caliber medical care. The Director will develop strategies to enhance the programmatic approach to clinical operations that provide strategic efficiencies and economies of scale for increased member outreach and repeatability. The Director will be a thought leader and contributor to organizational alignment, program approach, planning, change management and delivery.

Director (Claims Administration) serves as the leader, decision maker for the development and daily management of the Claims Operations, Coding Initiative, and e-Business departments. The Director of Claims Administration will be responsible for directing claims processing, recovery, reporting and coding processes. Responsibilities also include developing and implementing a strategic plan for CalOptima's claims operations including, planning for growth, developing claims policies and standards, budgeting, quality assurance, and efficiency improvements such as

streamlining processes and increasing claim automation. Staff development and the ability to build and foster a team environment are essential.

Director (Clinical Pharmacy) will provide strategic leadership and operational oversight for all aspects of pharmacy services within a managed care organization, including Medi-Cal, OneCare (HMO SNP), and Covered California. The Director will be responsible for designing, implementing, and evaluating pharmacy benefit programs that align with clinical goals, financial sustainability, regulatory compliance, and member outcomes. The Director will lead formulary strategy, utilization management, quality initiatives, and vendor performance-including Pharmacy Benefit Manager (PBM) oversight-and serves as the organization's principal pharmacy advisor to executive leadership and the Board of Directors. The Director will ensure compliance with Centers for Medicare & Medicaid Services (CMS), state Medicaid, Covered California, Department of Managed Health Care (DMHC), and National Committee for Quality Assurance (NCQA) standards while advancing initiatives to improve population health, medication adherence, and cost-effective drug use. This Director will require a dynamic, data-driven leader with extensive experience in managed care pharmacy, cross-functional collaboration, and a strong understanding of the regulatory environment governing Medicare, Medicaid, and commercial health plans. The Director will ensure alignment with CalOptima Health's mission to serve member health with excellence and dignity, respecting the value and needs of each person through collaboration with our providers, community partners and local stakeholders.

Director (Contracting) leads the Contracting department and is responsible for the development and implementation of contracting strategies for providers and other business entities, management and monitoring of contractual relationships with existing provider networks and contractors. The Director of Contracting conducts and coordinates financial analysis to determine and design contracting strategies for CalOptima and negotiate provider contracts.

Director (Customer Service) (2) provides leadership, day-to-day management, strategic direction and support to CalOptima Health’s Customer Service operations that include: Medi-Cal, Member Liaison, Behavioral Health, and Utilization Management/Authorization contact centers, CalOptima Health Reception and satellite locations (i.e., Orange County Community Service Center in Westminster), and member portal. The Director of Customer Service will guide staff in the implementation of strategic and tactical directions to improve efficiencies to ensure high quality and responsive services to members, providers, contracted vendors and regulatory agencies. The Director of Customer Service will regularly interact with all levels of internal CalOptima Health staff, as well as external contacts with regulatory agencies, contracted vendors, community-based organizations and medical groups/health networks.

Director (Delegation Oversight) oversees and conducts independent audits of CalOptima Health's contracted partners’ performance of delegated functions. The Director of Delegation Oversight will lead the department in developing audit protocols for all CalOptima Health’s delegates to ensure compliance with contractual, statutory and regulatory requirements, as well as accreditation standards and CalOptima Health’s policies and procedures as it relates to CalOptima Health's programs. The Director of Delegation Oversight will work collaboratively with internal and external partners to promote compliance with requirements. The Director of

Delegation Oversight interacts with CalOptima Health executives, departmental management, delegates and potential delegates, and legal counsel

Director (Enterprise Analytics) will provide leadership to the executive team and key leaders across CalOptima Health in the development of Business Intelligence strategy and roadmap of analytical capabilities. The Director provides management, oversight, and direction of CalOptima Health's Business Intelligence tools to support organizational reporting needs. The Director will work closely with departments that provide data to support the development or extend the data architecture and data definitions. The Director works with key users of data, to develop the platform(s) and capabilities to meet the critical analytical needs of CalOptima staff and external stakeholders. This Director will play a key leadership role, interacting with all levels of CalOptima staff and external stakeholders, including the Board of Directors, executive staff, members, providers, health network management, legal counsel, State and Federal representatives, and representatives of other agencies.

Director (Grievance and Appeals) is responsible for the development and management of the Grievance and Appeals Resolution Services (GARS) department. The Director of Grievance and Appeals ensure service standards and established policies and procedures regarding the appeals and grievance processes adhere to regulatory requirements. The Director of Grievance and Appeals collaborate regularly with all CalOptima Health's staff levels and external contacts with regulatory agencies, health networks, community-based organizations and medical groups. The Director of Grievance and Appeals maintain knowledge of all new regulatory guidelines impacting GARS for all CalOptima Health programs.

Director/Sr. Director (Information Services) Provide management, oversight, and direction of core administrative and clinical systems in support of organizations' day-to-day operational needs. Responsibilities include configuration management and development of such applications, integration of disparate systems and the design of solutions to meet the business requirements. Interacts with Managers and Directors throughout the organization. Assists in systems functions and upgrades and data integrity management.

Director/Dr. Director (Information Technology – Digital and Enterprise Applications, Architecture and Shared Services) The Director will be accountable for the Information Technology (IT) strategy and execution for digital technologies (web applications/portals), enterprise applications (HR, Finance, Compliance, etc.), enterprise architecture, and shared services (QA/testing, release management, and environment management). The Director will work closely with business leadership and the department staff to find solutions and deliver the technology required to support existing and new applications and technology. The Director will be responsible for the effective and efficient management and delivery of all third-party and internal IT resources to implement new systems and enhancements and ensure ongoing support. As a member of the department's leadership team, the Director will contribute to the development and execution of the organizational technology strategy, ensure its alignment with the organization's business strategy, and ensure the delivery of capabilities required to achieve business success. The Director will have extensive health plan technology experience, strong project management acumen, excellent vendor management skills, financial management expertise, and a superior, service-oriented approach to IT.

Director (Long Term Support Services) is responsible for the overall planning, implementation and evaluation of CalOptima Health's Long Term Support Services (LTSS) programs, which include Long Term Care (LTC), Community Based Adult Services (CBAS), CalAIM authorizations and the Multi-Senior Services Program (MSSP). The Director of Long-Term Support Services will ensure high quality and responsive service for CalOptima Health members residing in LTC facilities or who participate in community based LTSS programs. The Director of Long-Term Support Services will be responsible for the LTSS department's continuous compliance with contractual, regulatory and accreditation standards. The Director of Long-Term Support Services will stay current with industry developments and regulatory changes that may impact CalOptima Health's program.

Director/Sr. Director (Medical Management) (3) will lead the execution and oversight of operational components to support and increase the capacity of Medical Management programs and services for CalOptima Health members. The Director will be responsible for high-level program oversight, design and day-to-day portfolio execution. The Director will be responsible for alignment with organizational goals, regulatory compliance and member-focused outcomes within the clinical teams. The Director will manage cross-functional teams, oversee program implementation when project scale and size is smaller than enterprise formal program support and drive innovation and efficiency within the program.

Director (Network Management) (2) is responsible for providing leadership and direction to ensure proactive development, management, communication, support, and issue resolution for all CalOptima Health contracted providers. CalOptima Health's contracted providers include delegated plans and health networks, multi-specialty physician groups, hospitals, ancillary services providers, community clinics, community support providers, and other partners. The Director of Network Management serves as the strategic, operational and communications lead between CalOptima Health and these critical partners. The Director of Provider Relations develops the overarching provider engagement and partnership strategy to ensure quality of member care, provider satisfaction, provider compliance with contractual and regulatory requirements, and active provider engagement in CalOptima Health's goals and priorities.

Director (Operations) is responsible for providing oversight of operations system contracts, liaison efforts with all parties, and prioritizing and tracking configuration requests. The Director of Operations will lead the development of protocols to track, prioritize and oversee operations system integration. The Director of Operations is to be also responsible for new and change request tracking and completions, defect management and process enhancement recommendations to create continued automation and efficiency. The Director ensures internal and external entities meet operations configuration deadlines and that all defects, system issues and planned outages are researched, planned and communicated to provide minimal impact on delivery of services.

Director of Operations (Network Management) (6) is responsible for all operational aspects of the Network Management department. The Director will oversee the onboarding of all new provider partners, provider data management and analysis, and provider directory production. The Director will be responsible for ensuring CalOptima Health meets and exceeds access and

availability standards. The Director implements strategies that achieve the established CalOptima Health objectives; meet regulatory requirements and National Committee for Quality Assurance (NCQA) standards, leverage the core competencies of CalOptima Health's existing administrative infrastructure to build an effective and efficient operational unit to serve CalOptima Health's members and ensure the delivery of accessible, cost effective, quality healthcare services throughout CalOptima Health's service delivery network.

Director (PACE) assumes overall leadership and responsibility for PACE. The Director has overall accountability for the program's oversight and administration, which includes effective planning, development and evaluation of the program's operations, quality improvement and marketing and enrollment. The Director ensures that the above aspects of PACE are aligned with CalOptima Health's strategic and operational priorities. The Director is accountable for leading the PACE program in county-wide expansion activities, including next-level capabilities and operational efficiencies consistent with the strategic plan, goals and objectives of CalOptima Health. The Director will identify the needs of seniors in Orange County and strategize initiatives that meet these opportunities.

Sr. Director (Provider Relations) will be responsible for developing and executing opportunities for CalOptima Health to expand its provider network to enhance access to care and quality of care for members across all lines of business. The Sr. Director of Provider Relations will direct and lead the exploration of new opportunities and partnerships, develop innovative contracting models and provide overall leadership in execution of new contracts. The Senior Director will also assist in the oversight and onboarding of new health networks and Management Services Organizations. The Sr. Director of Provider Relations will effectively partner across CalOptima Health's departments and leadership and will cultivate meaningful relationships with the Orange County provider community

Director/Sr. Director (Population Health Management) will advance population-wide health and well-being for CalOptima members by coordinating the development and implementation of a comprehensive population health management plan and health equity framework aligned with the organization's strategic goals. The Director provides oversight and supervision of staff to monitor the implement organization-wide population health initiatives amongst internal departments; contracted providers health networks and external stakeholders aligned with CalOptima's overall mission and strategic goals. The Director ensures that the department meets ongoing regulatory compliance and accreditation standards. The Director plays a key leadership role, interacting with all levels of CalOptima staff and external stakeholders, including the board of directors, executive staff, members, providers, health network management, legal counsel, state and federal representatives, and representatives of other agencies to implement programs and Quality Improvement (QI) processes that improve cost savings, quality outcomes and member/provider satisfaction

Director Provider Relations (Network Management) will be responsible for providing leadership and direction to ensure proactive development, management, communication, support, and issue resolution for all CalOptima Health contracted providers. CalOptima Health's contracted providers include delegated plans and health networks, multi-specialty physician groups, hospitals, ancillary services providers, community clinics, community support providers,

and other partners. The Director serves as the strategic, operational and communications lead between CalOptima Health and these critical partners. The Director of Provider Relations will develop the overarching provider engagement and partnership strategy to ensure quality member care, provider satisfaction, provider compliance with contractual and regulatory requirements, and active provider engagement in CalOptima Health's goals and priorities.
Day to day responsibilities include, but are not limited to: 1) managing and supervising staff, directing all the day-to-day activities of the Provider Relations department; 2) performing as the entry and exit point for all communications with providers including timely communication of program materials; 3) receiving, tracking, resolving and documenting issues; 4) ensuring outgoing and incoming reporting activities for purposes of oversight; 5) facilitating the communications and collections of regulatory and ad hoc audit deliverables; and 6) providing new provider training and on-going education of all providers.

Director Provider Relations (Network Management) (Health Network Relations) is responsible for providing leadership and direction to ensure proactive development, management, communication, support, and issue resolution for CalOptima's providers who contract with CalOptima under risk-based and delegated arrangements. CalOptima's delegated health networks are comprised of multi-specialty physician groups, hospitals, and restricted Knox-Keene licensed entities. The Direct of Health Network Relations serves as the strategic, operational and communications lead between CalOptima and these critical partners.
The Director responsibilities include, but are not limited to: 1) managing and supervising staff, directing all the day-to-day activities of the Network Management department; 2) performing as the entry and exit point for all communications with delegated entities; 3) documenting, tracking and resolving issues; 4) supporting and facilitating outgoing and incoming reporting activities for purposes of oversight; 5) facilitating the communications and collections of regulatory and ad hoc audit deliverables; and 6) providing new delegated provider training and on-going education of all delegated providers.

Director Provider Network (Operations) will lead the development and implementation of outcome-driven strategies to engage, support and build the capacity of CalOptima Health's provider delivery system. The Director will be responsible for initiating and/or deepening partnerships resulting in CalOptima Health increasing its access to services and the quality of services available to members. In addition, the Director will work across the organization to enhance quality programs and performance outcomes for the provider network. The Director will be a thought leader and contributor to programming approaches, planning, changing management and delivery.

Director (Quality Improvement) oversees the day-to-day operations of the QI department and is responsible for the execution and coordination of all quality assurance and improvement activities. The Director of Quality Improvement plans, develops, organizes, monitors, communicates, and recommends modifications to the QI program and all QI policies and procedures. It is the Director's responsibility to interface with other departments on QI issue.

Director (Quality Improvement) (Credentialing) is responsible for overseeing the process of verifying and maintaining health care provider credentials, ensuring compliance with all relevant regulations and standards, overseeing a contracted credentialing verifications organization

(CVO), managing a team of credentialing staff, and ensuring ongoing monitoring of the provider network. The Director of Quality Improvement (Credentialing) is responsible for the development and implementation of quality improvement programs and activities related to providers credentialing to ensure compliance with current policies, procedures and regulatory credentialing standards, which is critical to ensure member care and safety at CalOptima Health. The Director of Quality Improvement (Credentialing) develops and implements policies and procedures to streamline the credentialing workflow within CalOptima Health.

Director (Quality Analytics) is responsible for providing leadership to ensure reporting, tracking and trending of quality performance metrics required by regulators or CalOptima Health leadership. The Director of Quality Analytics will oversee the timely delivery of regulatory required Healthcare Effectiveness Data and Information Set (HEDIS) metrics to National Committee for Quality Assurance (NCQA), California Department of Health Care Services (DHCS) and Center for Medicare and Medicaid (CMS) and will provide vision to enhance data collection to improve the organization's quality performance to meet strategic goals. The Director of Quality Analytics will be responsible for the strategic vision of the department to meet future expanded requirements of performance measurement evolution from DHCS, Department of Managed Health Care (DMHC) and NCQA. Director II, (Quality Analytics) is a key thought leader providing frequent feedback to stakeholder organizations including NCQA, DHCS and Association of Community Affiliated Plans (ACAP) regarding proposed, new or changed quality measurement requirements. Additionally, Director of Quality Analytics will provide leadership for the development, implementation and evolution of provider pay for value programs including alternative payment model programs or incentive programs mandated by DHCS and/or DMHC. The Director of Quality Analytics will oversee the development and implementation of all company surveys to measure member and provider satisfaction and will oversee the data analytics team that supports population health management, network adequacy reporting and ad hoc quality measurement performance requests. The Director of Quality Analytics will coordinate communication, keeping senior management and stakeholders informed of health plan and health network quality metrics performance results. The Director of Quality Analytics will work collaboratively with management throughout the organization to promote enhancement of organizational performance and supports the Quality Improvement Committee and sub-committees, as well as other key discussions on strategic and policy-related issues

Director (Quality Analytics) (Medicare Stars and Quality Initiatives) will be responsible for the development and implementation of programs and initiatives to improve quality outcomes across all lines of business consistent with CalOptima Health's mission, vision and values. The Director will manage data analysis to identify and prioritize new opportunities, develop strategies and business cases, develop implementation plans, evaluate impact and provide overall leadership for quality initiatives. The Director will function as a business lead for large-scale, cross-functional quality improvement projects that require interfacing and partnering with CalOptima Health's departments, leadership and provider network. The Director will be responsible for the strategic vision of the department to meet future expanded requirements of performance measurement evolution from the Centers for Medicare and Medicaid Services (CMS), Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC) and National Committee for Quality Assurance (NCQA). The Director will be a key

thought leader providing frequent feedback to stakeholder organizations, including the NCQA, DHCS and Association of Community Affiliated Plans (ACAP) regarding proposed, new or changed quality measurement requirements

Director/Sr. Director (Utilization Management) is responsible for the oversight, planning, organization, implementation and evaluation of all activities and personnel engaged in Utilization Management (UM) departmental operations. The Director of Utilization Management provides leadership and direction to the Utilization Management department to ensure compliance with all local, state and federal regulations, accreditation standards are current and all policies and procedures meet current requirements. Director of Utilization Management has oversight of CalOptima Health's Utilization Management program for CalOptima Health Community Network, CalOptima Health Direct and the delegated health networks. The Director III is expected to serve as a liaison for various internal and external committees, workgroups, and operational meetings.

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

2026 QI Work Plan

2026 Quality Improvement Health Equity Transformation Program Work Plan **Organization: CalOptima Health**

Purpose: The Quality Improvement (QI) Work Plan outlines the organization's annual priorities for improving clinical quality, member experience, patient safety, access, and health equity. It serves as a roadmap for implementing interventions, monitoring performance, and evaluating outcomes in alignment with NCQA standards and organizational goals.

Monitoring of Previously Identified Issues: CalOptima Health ensures continuous monitoring of issues identified in prior evaluations, regulatory requirements, and member feedback. Each initiative in the work plan includes measurable objectives and goals, accountable owners, planned activities and completion dates, monitoring cadence, and whether the item was carried over from the previous work plan, including the reasons. Performance is reviewed quarterly by the QIHEC and annually evaluated to determine the effectiveness of interventions, need for intervention updates, and whether to retire or add initiatives, as appropriate.

Annual Evaluation: At year-end, CalOptima Health compares performance against targets, evaluates intervention effectiveness, documents lessons learned, and updates the work plan for the next cycle.

Submitted and approved by QIHEC: 01/13/2026
Quality Improvement Health Equity Committee Chairperson:

Richard Pitts, D.O., Ph.D. Date 3/11/2026

Submitted and approved by QAC: 03/19/2026
Board of Directors' Quality Assurance Committee Chairperson:

Jose Mayorga, M.D. Date 3/19/2026

I. PROGRAM OVERSIGHT

1 2026 Quality Improvement Health Equity and Transformation Program (QIHETP) Description, the 2026 Annual Work Plan and the 2025 QIHETP Evaluation
2 2026 Integrated Utilization Management (UM) and Case Management (CM) Program Description and the 2025 Integrated UM CM Program Evaluation
3 2026 Population Health Management (PHM) Strategy and the 2025 PHM Strategy Evaluation
4 2026 Cultural and Linguistic Accessibility Services (CLAS) Program and the 2025 CLAS Program Evaluation
5 Quality Improvement Health Equity Committee (QIHEC)
6 Credentialing Peer Review Committee (CPRC)
7 Grievance and Appeals Resolution Services (GARS) Committee
8 Member Experience (MEMX) Committee
9 Utilization Management Committee (UMC)
10 Whole Child Model - Clinical Advisory Committee (WCM CAC)
11 National Committee for Quality Assurance (NCQA) Accreditation
12 External Quality Review Requirements
13 Quality Performance Reporting
14 Quality Performance Improvement
15 Value Based Payment Program: Health Network
16 Value Based Payment Program: Behavioral Health
17 Value Based Payment Program: Hospital

II. QUALITY OF CLINICAL CARE

18 PHM Strategy: Keeping Children Healthy w Performance Improvement Project (PIP)
19 CalOptima Health Comprehensive Community Cancer Screening Program (CCCSP)
20 Maternal Health Program
21 Population Health Management/Care Management
22 Health Education Program
23 Disease Management Program
24 Disease Management Program: Chronic Conditions Improvement Project (CCIP)
25 CalAIM Enhanced Care Management and Community Supports
26 Street Medicine
27 Complex Case Management Program
28 Utilization Management Program
29 Long-Term Support Services (LTSS)
30 Delegation Oversight
31 Special Needs Plan (SNP) Model of Care (MOC)
32 Behavioral Health Services
33 Behavioral Health Services: Care Coordination and Follow-up Care with Performance Improvement Projects (PIPs) Medi-Cal BH
34 Medication Adherence
35 Cozeva PayerOne Software Solution
36 At-Home Visit Program
37 At-Home Lab Testing

IX. QUALITY OF SERVICE- Access

38 Improve Network Adequacy: Reducing Gaps In Provider Network
39 Improve Timely Access: Appointment Availability/Telephone Access

X. QUALITY OF SERVICE- Member Experience

40 Improve Member Experience/CAHPS
41 Grievance and Appeals Resolution Services
42 Customer Service Call Center

XI. SAFETY OF CLINICAL CARE

43 Emergency Department Program
44 Transitional Care Services (TCS)
45 Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance
46 Potential Quality Issues Review
47 Sentinal Event Monitoring and Disease Surveillance
48 Quality Assurance Performance Improvement (QAPI) for Long-Term Care Services
49 Provider Credentialing and Recredentialing

XII. Cultural and Linguistic Appropriate Services (CLAS)

50 Language Services: Cultural and Linguistics and Language Accessibility
51 Data Collection on Member Demographic Information
52 Data Collection on Practitioner Demographic Information
53 Network Cultural Responsiveness: Provider Trainings to Improve Care or Service Delivery
54 Network Cultural Responsiveness: Building and Maintaining a Responsive Work Force

2026 QI Work Plan

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
1	Program Oversight	Quality Documents	2026 Quality Improvement Health Equity and Transformation Program (QIHETP) Description, the 2026 Annual Work Plan and the 2025 QIHETP Evaluation	1. Obtain QIHEC Approval of the 2026 QIHETP Description and Workplan by January 31, 2026, and the Board approval by April 30, 2026 2. Implement initiatives for the 2026 QIHETP Description and Workplan starting January 1, 2026. 3. Complete Evaluation of the 2025 QIHETP Description and Work Plan and obtain QIHEC approval by January 31, 2026, and the Board approval by April 30, 2026	Medi-Cal and OneCare Program	1. Develop the 2026 QIHETP Description and Work Plan and obtain QIHEC and board approval. 2. Collaborate with business owners to ensure the QIHETP Description and Work Plan initiatives are implemented. 3. Develop the 2026 QIHETP Evaluation and obtain QIHEC and board approval.	1. 01/31/2026; 04/30/2026 2. Varies based on intervention; to be completed by 12/31/2026 3. 01/312026; 04/30/2026	QIHEC: 1/13/2026 QAC: 03/19/2026 BOD: 04/02/2026	Marsha Choo	Program Specialist of Quality Improvement	Quality Improvement	Yes - Regulatory / Contractual
2	Program Oversight	Quality Documents	2026 Integrated Utilization Management (UM) and Case Management (CM) Program Description and the 2025 Integrated UM CM Program Evaluation	1. Obtain QIHEC Approval of the 2026 Integrated Utilization Management (UM) and Case Management (CM) Program Description by February 10, 2026, and the Board approval by April 30, 2026 2. Implement initiatives for the 2026 Integrated Utilization Management (UM) and Case Management (CM) Program Description starting January 1, 2026. 3. Complete Evaluation of 2025 Integrated UM CM Program Description and obtain Board approval by April 30, 2026	Medi-Cal and OneCare Program	1. Develop the 2026 Integrated Utilization Management (UM) and Case Management (CM) Program Description and obtain UMC approval. 2. Obtain QIHEC Approval of the 2026 Integrated Utilization Management (UM) and Case Management (CM) Program Description and the Board approval. 3. Implement initiatives for the 2026 Integrated Utilization Management (UM) and Case Management (CM) Program Description starting January 1, 2026. 4. Complete Evaluation of 2025 Integrated UM CM Program Description and obtain QIHEC and board approval.	1. 01/30/2026 2. 02/10/2026; 04/30/2026 3. Varies based on intervention; to be completed by 12/31/2026 4. 02/10/2026; 04/30/2026	UMC: 01/22/2026 QIHEC: 02/10/2026 QAC: 03/19/2026 BOD: 04/02/2026	Kelly Giardina	Director of Utilization Management	Utilization Management	Yes - Regulatory / Contractual
3	Program Oversight	Quality Documents ; PHM	2026 Population Health Management (PHM) Strategy and the 2025 PHM Strategy Evaluation	1. Obtain QIHEC Approval of the 2026 Population Health Management (PHM) Strategy by January 31, 2026, and the Board approval by April 30, 2026 2. Implement initiatives for the 2026 Population Health Management (PHM) Strategy starting January 1, 2026. 3. Complete the Evaluation of the 2025 PHM Strategy by April 30, 2026	Medi-Cal	1. Develop the 2026 PHM Strategy and obtain QIHEC and board approval. 2. Collaborate with business owners to ensure the 2026 PHM Strategy initiatives are implemented. 3. Develop the 2026 PHM Strategy Evaluation and obtain QIHEC and board approval.	1. 01/31/2026; 04/30/2026 2. Varies based on intervention; to be completed by 12/31/2026 3. 01/312026; 04/30/2026	QIHEC: 1/13/2026 QAC: 03/19/2026 BOD: 04/02/2026	Katie Balderas	Program Manager Case Management	Case Management	Yes - Regulatory / Contractual
4	Program Oversight	Quality Documents ; CLAS	2026 Cultural and Linguistic Accessibility Services (CLAS) Program and the 2025 CLAS Program Evaluation	1. Obtain QIHEC Approval of the 2026 Cultural and Linguistic Accessibility Services (CLAS) Program by January 31, 2026, and the Board approval by April 30, 2026 2. Implement initiatives for the 2026 Cultural and Linguistic Accessibility Services (CLAS) Program starting January 1, 2026. 3. Complete the Evaluation of the 2025 CLAS Program and obtain Board approval by April 30, 2025 4. Presents to and obtains input from the Member Advisory Committee (MAC)	Medi-Cal and OneCare Program	1. Develop the 2026 CLAS Program and obtain QIHEC and board approval. 2. Collaborate with business owners to ensure the 2026 CLAS Program initiatives are implemented. 3. Develop the 2026 CLAS Program Evaluation and obtain QIHEC and board approval. 4. Present CLAS findings and activities to MAC and obtain feedback from the committee.	1. 01/312026; 04/30/2026 2. Varies based on intervention; to be completed by 12/31/2026 3. 01/31/2026; 04/30/2026 4.12/10/2026	QIHEC: 1/13/2026 QAC: 03/19/2026 BOD: 04/02/2026	Albert Cardenas	Manager of Cultural and Linguistics	Customer Service / Cultural and Linguistic Services	Yes - Regulatory / Contractual

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5	Program Oversight	Committee	Quality Improvement Health Equity Committee (QIHEC)	1. Convene at least 8 times a year, maintain and approve minutes, and report committee key findings/updates, activities, and recommendations to QAC quarterly. 2. Conduct oversight of quality Improvement and health equity outcomes and activities in the QIHETP and annual workplan.	Medi-Cal and OneCare Program	1. Convene monthly QIHEC meetings, maintain and approve minutes, and report on all items listed in the 2026 QIHETP Work Plan. 2. Report on QIHEC activities to QAC Quarterly	1. Monthly in 2026 01/13/2026; 02/10/2026; 03/10/2026; 04/14/2026; 05/12/2026; 06/09/2026; 07/14/2026; 08/11/2026; 09/08/2026;10/13/2026; 11/10/2026; 12/08/2026 2. Quarterly 2026	Report to QAC: Q1: 3/19/2026 Q2: 6/18/2026 Q3: 10/22/2026 Q4: 12/17/2026	Marsha Choo	Program Specialist of Quality Improvement	Quality Improvement	New - Program Oversight
6	Program Oversight	Committee	Credentialing Peer Review Committee (CPRC)	1. Convene at least 8 times a year, maintain and approve minutes, and report committee key findings/updates, activities, and recommendations to QIHEC quarterly. 2. Conduct Peer Review of Provider Network by reviewing Credentialing Files, Quality of Care cases, and Facility Site Review to ensure quality of care delivered to members in the timely manner.	Medi-Cal and OneCare Program	Convene at least 8 times a year, maintain and approve minutes, and report on the following activities: 1. Peer review investigations of potential quality issues (PQI), initial and recredentialing of CHCN providers, credentialing oversight and ongoing monitoring of the entire provider network, and initial and periodic site review activity (FSR, MRR, PARS) for Medi-Cal. 2. Trends and results are presented to the committee quarterly and reported to QIHEC quarterly.	Monthly in 2026 01/29/2026; 02/26/2026; 03/26/2026; 04/23/2026; 05/28/2026; 06/25/2026; 07/23/2026; 08/27/2026; 09/24/2026; 10/22/2026; 11/19/2026; 12/17/2026	Report to QIHEC: Q1: 03/10/2026 Q2: 06/09/2026 Q3: 09/08/2026 Q4: 12/08/2026	Laura Guest	Manager of Quality Improvement	Quality Improvement	Yes - Regulatory / Contractual
7	Program Oversight	Committee	Grievance and Appeals Resolution Services (GARS) Committee	1. Convene at least quarterly, maintains and approve minutes, and report committee key findings/updates, activities, and recommendations to QIHEC quarterly. 2. Conduct oversight of Grievances and Appeals to resolve complaints and appeals for members and providers in a timely manner.	Medi-Cal and OneCare Program	Convene at least quarterly, maintain and approve minutes, and report on the following activities: 1. Grievances, Appeals and Resolution of complaints by members and providers for CalOptima Health's network and the delegated health networks. 2. Trends and results are presented to the committee by product quarterly and reported to QIHEC quarterly.	Quarterly GARS Committee meeting: Q1: 03/12/2026 Q2: 05/19/2026 Q3: 08/18/2026 Q4: 11/17/2026	Report to QIHEC: Q1: 03/10/2026 Q2: 06/09/2026 Q3: 09/08/2026 Q4: 12/08/2026	Heather Sedillo	Manager of Grievance and Appeals	GARS	Yes - Program Oversight

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8	Program Oversight	Committee	Member Experience (MEMX) Committee	1. Convene at least quarterly, maintains and approve minutes, and reports committee key findings/updates, activities, and recommendations to QIHEC quarterly. 2. Conduct oversight of Member Experience activities to improve quality of service, member experience and access to care.	Medi-Cal and OneCare Program	Convene at least quarterly, maintain and approve minutes, and report on the following activities: 1. The MEMX Committee conducts an annual review of CalOptima Health's CAHPS survey results, oversees provider network performance, including access and availability, monitors customer service metrics, and evaluates complaints, grievances, appeals, authorizations, and referrals to identify systemic 'pain points' that affect member experience and quality of care. 2. Trends and results are presented to the committee quarterly and reported to QIHEC quarterly.	Quarterly MEMX Committee meetings: Q1: 01/27/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/06/2026	Report to QIHEC: Q1: 03/10/2026 Q2: 06/09/2026 Q3: 09/08/2026 Q4: 12/08/2026	Kelli Glynn	Manager of Quality Analytics / Project Manager of Quality Analytics	Quality Analytics	Yes - Program Oversight
9	Program Oversight	Committee	Utilization Management Committee (UMC)	1. Convene at least quarterly, maintain and approve minutes, and report committee key findings/updates, activities, and recommendations to QIHEC quarterly. 2. Conduct internal and external oversight of UM activities to ensure over- and under- utilization patterns do not adversely impact member's care.	Medi-Cal and OneCare Program	Convene at least quarterly, maintain and approve minutes, and report on the following activities: Internal Oversight 1. Quarterly Audits to review UM activities including decisions and workflows. 1.a. Monitor adherence to clinical guidelines and regulatory requirements. 2. Discuss utilization trends and outliers. 3. Track quality metrics (readmission rates, ER visits, preventive care compliance). External Oversight 1. Collaborate with delegated entities quarterly to review UMC updates, program evaluation, processes and outcomes. 1.a. Discuss utilization trends and outliers. 1.b. Track quality metrics (readmission rates, ER visits, preventive care compliance). 1.c. Present findings to UMC. 2. Annual DO Program audit to monitor adherence to program. 2.a. Validate compliance with contractual and accreditation standards (e.g., NCQA, DHCS) 3. Review monthly performance dashboards for leadership visibility. 3.a. Escalate patterns that indicate risk to member safety or care quality.	Quarterly UMC meetings: Ad-Hoc - 01/22/2026 Q1: 02/19/2026 Q2: 05/21/2026 Q3: 08/20/2026 Q4: 11/19/2026	Report to QIHEC: Q1: 03/10/2026 Q2: 06/9/2026 Q3: 09/8/2026 Q4: 12/8/2026	Kelly Giardina	Director of Utilization Management	Utilization Management	Yes - Regulatory / Contractual
10	Program Oversight	Committee	Whole Child Model - Clinical Advisory Committee (WCM CAC)	1. Convene at least quarterly, maintain and approve minutes, and report committee key findings/updates, activities, and recommendations to QIHEC quarterly. 2. Ensures that clinical and behavioral health services for children eligible with California Children Services (CCS) are integrated into the design, implementation, operation, and evaluation of the CalOptima Health WCM program in collaboration with County CCS, Family Advisory Committee, and Health Network CCS Providers.	Medi-Cal Members	Convene at least quarterly, maintain and approve minutes, and report on the following activities: 1. WCM CAC reviews WCM data and provides clinical and behavioral service advice regarding Whole Child Model operations, and Annual Pediatric Risk Stratification Process (PRSP) monitoring (Q3) 2. Trends and results are presented to the committee quarterly and reported to QIHEC quarterly.	Quarterly WCM CAC meetings: Q1: 02/17/2026 Q2:.05/19/2026 Q3: 08/18/2026 Q4:11/17/2026	Report to QIHEC: Q1: 03/10/2026 Q2: 06/09/2026 Q3: 09/08/2026 Q4: 12/08/2026	Thanh-Tam Nguyen, MD/Hannah Kim	Program Specialist of Quality Improvement	Medical Management	Yes - Regulatory / Contractual

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
11	Program Oversight	Regulatory	National Committee for Quality Assurance (NCQA) Accreditation	1. CalOptima Health must maintain full NCQA Health Plan (HP) Accreditation for Medi-Cal 2. CalOptima Health must maintain full NCQA Health Outcomes Survey (HOS) Accreditation for Medi-Cal. Perform readiness assessment on the newly released 2026 Health Outcomes standards. 3. CalOptima Health must attain operational readiness for NCQA Health Plan (HP) Accreditation for Covered California by December 31, 2026.	Medi-Cal Program	1. Complete Year One deliverables for NCQA Health Plan (HPA) Accreditation 2. Complete Year Two deliverables due except for Delegation oversight for NCQA Health Plan (HPA). 3. Assessment on the new Health Outcomes (HO) standards 4. Engage with NCQA consultants (HMA) to add Covered California as an accreditation.	1. 4/30/2026 2. 12/31/2026 3. 3/31/2026 4. 3/31/2026	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Marsha Choo	Program Manager of Quality Improvement (NCQA)	Quality Improvement	Yes - Regulatory / Contractual
12	Program Oversight	Regulatory	External Quality Review Requirements	Ensure CalOptima Health complies with the following requirements: 1. Quality Performance Measures - Reported under Quality Performance Reporting 2. Performance Improvement Projects (PIPs) - Reported under the area of focus for the PIP 3. Consumer Satisfaction Survey - Reported under the Member Experience and CAHPS 4. Network Adequacy Validation - Reported under Improve Network Adequacy: Reducing Gaps In Provider Network 5. Encounter Data Validation 6. Focused Studies - Reported under the area of focus for the focused study	Medi-Cal Program	1. Participate in any EQRO activities 2. Review all EQRO Reports annually to ensure compliance and report to QIHEC	1. Ongoing 2. 9/30/26	Report to QIHEC 09/24/2026	Marsha Choo	Program Specialist of Quality Improvement	Quality Improvement	Yes - Regulatory / Contractual
13	Program Oversight	Regulatory	Quality Performance Reporting	Track and report quality performance measures required by regulatory bodies against the following goal: 1. Achieve 100% reportable for Managed Care Accountability Set (MCAS) 2. Achieve 100% reportable for OneCare STAR measures	Medi-Cal and OneCare Program	1. Submit MCAS audited IDSS and member-level details to NCQA/DHCS 2. Submit OneCare audited IDSS and member-level details to NCQA/CMS	1. 6/15/2026 2. 6/15/2026	Report to QIHEC 05/12/2026 08/11/2026	Paul Jiang	Manager of Quality Analytics	Quality Analytics	Yes - Regulatory / Contractual

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
14	Program Oversight	Quality Improvement	Quality Performance Improvement	Achieve performance goals for the following quality programs: 1. Achieve or exceed the 50th percentile (minimum performance level) for Managed Care Accountability Set (MCAS) measures 2. Achieve an overall CMS Star rating of 4 stars 3. Achieve an overall NCQA Health Plan Rating of 4.5 stars 4. Improve from the HEDIS MY2024 final rate to meet the HEDIS MY2025 goal by September 30, 2026 for the following measures: • MC Immunization Status - Pneumonia (MC) • OC Care for Older Adults (COA) • OC Breast Cancer Screening (BCS) • MC Lead Screening in Children (LSC) • MC Appropriate Testing for Pharyngitis (CWP) • MC Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB) (Please refer to the attached HEDIS MY2025 Medicare and Medicaid goal sheets for the 2026 HEDIS goals)	Medi-Cal and OneCare Program	1. Implement a comprehensive member outreach strategy across all lines of business using multi-modal engagement (phone, SMS, email, IVR, Member Portal, and mailers). 2. Deploy an at-home visit and care gap closure program with multiple partners (please see these specific activities for details). 3. Forecast end-of-year performance for Medi-Cal MCAS and CMS Stars measures and establish monthly targets for measure owners. 4. Establish reporting to monitor NCQA Health Plan Rating performance throughout the measure year. 5. Deploy the Cozeva PayerOne software solution to achieve automatic bidirectional data exchange with Health Network partners, integrate high-volume provider EMR systems with Cozeva to automatically extract quality data elements for gap closure, onboard providers to the Cozeva user interface, and support year-round collection of supplemental data (please see this specific activity for details). 6. Execute the Quality Improvement Grant Program to provide support to Health Networks with the planning, implementation, and monitoring of quality improvement activities. 7. Establish regular performance review meetings with high-volume providers in partnership with the Provider Relations Department and/or Health Network partners. 8. Distribute provider-facing playbooks for HEDIS and CAHPS improvement. 9. Collaborate with radiology facilities to achieve standing orders, obtain historical data, and complete member outreach to positively impact Breast Cancer Screening and Osteoporosis Screening. 10. Lead several cross-functional workstreams with multiple departments to assess and improve CMS Stars performance.	1. 12/31/2026 2. 4/30/2026 3. Q2 2026 4. Q2 2026 5. 7/31/2026 6. 12/31/2026 7. 4/30/2026 8. 4/30/2026 9. 12/31/2026 10. Q1 2026	Report overall performance to QIHEC 05/12/2026 08/11/2026 Report measure performance to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Kelli Glynn	Manager of Quality Analytics	Quality Analytics	Yes - Prior Year Evaluation (goal not met)
15	Program Oversight	P4V	Value Based Payment Program: Health Network	Complete the MY2025 Medi-Cal and OneCare P4V program quality score calculation and pay out the incentives to health networks and CHCN providers.	Medi-Cal and OneCare Program	Calculate the MY2025 final HEDIS results by Health Networks complete the Health Network quality rating calculation	Medi-Cal 10/31/2026 OneCare 12/31/2026	Report to QIHEC 05/12/2026	Paul Jiang	Manager of Quality Analytics	Quality Analytics	Yes - Regulatory / Contractual
16	Program Oversight	P4V	Value-Based Payment Program: Behavioral Health	Implement a behavioral health value-based payment program and report on progress made towards achievement of goals; distribution of earned P4V incentives and quality improvement grants	Medi-Cal and OneCare Program	1. Calculate measurement periods' results for each 6-month measurement period throughout 2026 for planned payouts in 2026. 2. Continue work with IT for provider portal P4V enhancements 3. Present progress and outcomes at QAC in 2026	Ongoing 12/31/2026	Report to QIHEC 05/12/2026	Carmen Katsarov	Director of Behavioral Health Integration	Behavioral Health Integration	New - Program Oversight
17	Program Oversight	P4V	Value-Based Payment Program: Hospital	Complete MY2025 hospital quality score calculations and pay out incentives to qualified hospitals	Contracted hospitals	Solicit hospital stakeholder feedback for program enhancements Revise program for MY2026 Calculate MY2025 program results	12/31/2026	Report to QIHEC 05/12/2026	Linda Lee	Director of Quality Analytics / Program Manager (Quality Incentives)	Quality Improvement / Quality Analytics	Yes - Program Oversight

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18	Program Oversight/Quality of Clinical Care	PHM Strategy; HE	PHM Strategy: Keeping Children Healthy with Performance Improvement Project (PIP)	Implement the PHM Strategy for keeping children healthy, report key findings and activities, analyze barriers and improvement efforts, and compare program data against the following goals. Improve from the HEDIS MY2024 final rate to meet the HEDIS MY2025 goal by September 30, 2026 for the following Managed Care Accountability Set (MCAS) measures: 1. Childhood Immunization Status (CIS) Combo 10 2. Immunizations for Adolescents (IMA) Combo 2 3. Well-Child Visits in the First 30 Months of Life (W30) - Well-Child Visits in the First 15 Months - Well-Child Visits for Age 15 Months-30 Months 4. Child and Adolescent Well-Care Visits (WCV) (Please refer to the attached HEDIS MY2025 Medicare and Medicaid goal sheets for the 2026 HEDIS goals) Health Equity Goals: 1. Improve the Childhood Immunization Status (CIS) Combo-10 HEDIS measure, from the stratified rate to the MY 2024 aggregate final rate of 38.69% by September 30, 2026 for the following populations: • Black: 21.88% • White: 21.89% • Native Hawaiian/Other Pacific Islander: 17.65% 2. Improve the Immunizations for Adolescents (IMA) Combo- 2 HEDIS measure, from the stratified rate to the MY 2024 aggregate final rate of 46.21% by September 30, 2026 for the following populations: • Black: 26.92% • White: 20.77% • Native Hawaiian/Other Pacific Islander: 27.03% 3. Improve the Child and Adolescent Well-Care Visits (WCV) HEDIS measure, from the stratified rate to the MY 2024 aggregate final rate of 55.46% by September 30, 2026 for the following populations: • Black: 40.49% • White: 40.04% • Native Hawaiian/Other Pacific Islander: 37.97% 4. Improve the Well-Child Visits in the First 15 Months (W30) Measure rate among Black/African American from 53.06% to the aggregate final rate of 70.28%. (Clinical - PIP)	Pediatric and adolescent Medi-Cal members	Clinical Operations Activities: 1. Provide verbal and written member education on important milestones. Quality Analytics Activities: 1. Deploy multi-modal outreach campaigns to eligible members; utilize text, email, phone, IVR, and/or mailers to encourage well visit and immunization completion. 2. Create member- and provider-facing materials to address vaccine hesitancy. 3. Proactively outreach to members that will age into the HEDIS measures. For example, contact the parents/guardians of 1-year-old members to ensure accordance with W30 and CIS timeframes. 4. Deploy the Cozeva PayerOne software solution to achieve automatic bidirectional data exchange with Health Network partners, integrate high-volume provider EMR systems with Cozeva to automatically extract quality data elements for gap closure, onboard providers to the Cozeva user interface, and support year-round collection of supplemental data (please see this specific activity for details). 5. PIP campaign: improve compliance for Childhood Immunization Status (CIS), Immunizations for Adolescents (IMA), and Child and Adolescent Well-Care Visits (WCV) among Black, White, and Native Hawaiian/Other Pacific Islander populations through the deployment of culturally tailored, multi-modal outreach campaigns in collaboration with multiple departments.	Clinical Operations Activities: 1. 12/31/2026 Quality Analytics Activities: 1. 12/31/2026 2. Q1 2026 3. 12/31/2026 4. 07/31/2026 5.12/31/2026	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Megan Dankmyer / Kelli Glynn	Sr. Manager of Case Management / Manager of Quality Analytics	Quality Analytics	Yes - Program Oversight; CIS and IMA - Prior Year Evaluation (goal not met); W30 and WCV - Maintain and Monitor

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19	Program Oversight/Quality of Clinical Care	Program Oversight	CalOptima Health Comprehensive Community Cancer Screening Program (CCCSP)	Implement the CCCSP and report on progress made towards the achievement of goals: 1. Community grants to meet their proposed screening rates for BCS, CCS, COL, and Lung by January 30, 2027. 2. Decrease late-stage cancer diagnosis rates 3. Increase early-stage discovery through improved awareness and access to cancer screening Improve from the HEDIS MY2024 final rate to meet the HEDIS MY2025 goal by September 30, 2026 for the following measures: 1. MC Cervical Cancer Screening (CCS) 2. MC Colorectal Cancer Screening (COL) 3. MC Breast Cancer Screening (BCS-E) (Please refer to the attached HEDIS MY2025 Medicare and Medicaid goal sheets for the 2026 HEDIS goals)	Medi-Cal Members	1. Distribute member-facing [General, BCS, CCS, COL, LUNG] Cancer Screening Direct Mailers 2. Launch updated mPulse Cancer Screening Campaigns for General, BCS, CCS, COL, Lung, and the revised Cancer Treatment campaign. 3. Continue to hold in-person meetings with grantees to review progress reports and share member success stories. 4. Collaborate with Communications to capture impactful member success stories and report to the Board. 5. Collaborate with Kelli Glynn (QI) to identify and engage clinics with high volumes of BCS non-compliance and utilize Alinea mobile mammogram services to improve screening rates and meet STAR measures. 6. Plan for objective evaluation regarding the effectiveness of the Cancer screening program in increasing screening rates and awareness, while identifying opportunities for improvement. 7. Develop a reporting method for Community Grants to capture the total number of cancers found in each category and their stages. 8. Conduct a deeper analysis between the Native Hawaiian population and all ethnic population groups to determine if there is a disparity in cervical cancer screening rates. Once there is a better understanding of the disparity, a more realistic HE goal can be developed.	1. March 31, 2026 2. General by 3/31/2026; BCS by 4/30/2026; CCS by 5/31/2026; COL by 7/31/2026; Lung by 8/31/2026; Cancer Treatment by 9/30/2026 3. Progress Report #4 on 2/17/2026; Member Success Story #2 by 5/18/2026; Progress Report #5 by 8/17/2026; Member Success #3 by 11/16/2026; Final Progress Report by 2/15/2027 4. By each of the "Member Success Story" meeting dates listed above 5. Ongoing 12/31/2026 6. Ongoing 12/31/2026 7. By 5/18/2026 8. By 3/31/2026	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Dr. Richard Pitts	Program Manager of Medical Management	Medical Management	Yes - Program Oversight; MC CCS, MC COL and MC BCS-E - Prior Year Evaluation (goal not met)
20	Program Oversight/Quality of Clinical Care	PHM Strategy	Maternal Health Program	Implement the Maternal Health Program, report key findings and activities, analyze barriers and improvement efforts, and compare program data against the following goals. Improve from the HEDIS MY2024 final rate to meet the HEDIS MY2025 goal by September 30,2026 for the following measures: 1. MC Prenatal (PPC) 2. MC Postpartum (PPC) (Please refer to the attached HEDIS MY2025 Medicare and Medicaid goal sheets for the 2026 HEDIS goals)	Medi-Cal Members with a positive pregnancy	1. Targeted prenatal and postpartum telephonic outreach to educate members on the importance of preventative visits. 2. Assist members with appointment scheduling if barriers or gaps in care are identified during telephonic outreach. 3. Deploy a texting campaign to encourage timely postpartum visits. 4. Improve postpartum visit compliance and enhance member engagement through promotion of postpartum health rewards. 5. Ensure maternal health programmatic alignment with providers and Health Networks. 6. Enhanced reporting to proactively identify and monitor status of perinatal members. 7. Continue internal maternal health workgroup to ensure alignment of initiatives across the organization. 8. Provide targeted interventions for identified at-risk populations.	1. 12/31/26 2. 12/31/26 3. 11/30/26 4. 12/31/26 5. 9/30/26 6. 9/30/26 7. 12/31/26 8. 12/31/26	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Megan Dankmyer	Sr. Manager of Case Management	Case Management	Yes - Program Oversight; MC PPC - Prior Year Evaluation (goal not met)

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21	Program Oversight/Quality of Clinical Care	Program Oversight	Population Health Management/Care Management	Conduct Population Needs Assessment 1. Complete Population Needs Assessment to inform PHM Strategy and Quality Improvement strategies. Initial Screening and Assessment 1. Increase the IHA completion rate for all new Medi-Cal members from 34.4% to 40% and for new Medi-Cal members ≥18 months from 71.5% to 75%. 2. Track and trend the collection rate of HIF/MET and increase the rate of SPD HRAs completed within 90 days of enrollment from 66% to 70% by 12/31/2026 3. Early and Periodic Screening, Diagnostic and Treatment (EPSDT): Improve ensuring utilization of EPSDT criteria within UM decision from 67% to 70% by 12/31/2026. 4. OC Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)Total Risk Stratification 1. Increase the rate of high-risk members with an intervention by 5% from Q1-Q3 2025 average of 72% by 12/31/2026	Population Needs Assessment: Medi-Cal population Initial Screening and Assessment: 2a. Newly enrolled Medi-Cal members 2b. Newly enrolled SPD members 3. All members under 21 4. Members with multiple high-risk conditions Risk Stratification: 1. High-risk members per CalOptima RSS	Population Needs Assessment: Validate standards, secure data, draft report, finalize and share report. Initial Screening and Assessment 1a. Review/refine IHA logic (including outreach attempts), monitoring benchmarks, and Health Network oversight. 1b. Strengthen SDOH screening and documentation process for new Medi-Cal members via IHA 2a. Quarterly track and trend collection rate of HIF/MET 2b i). Quarterly tracking of HRA collection rates for newly enrolled SPD members. 2b ii). Barrier analysis for non-collected SPD HRA from 2025 data 2b iii). Identify and implement two strategies to address identified barriers EPSDT 3. i) Annual audit of 10 files from each HN by CalOptima Health medical director of HN UM decisions. 3. ii). Annual EPSDT training for providers and HNs. 3. iii). Annual training for care coordination with regional center for providers and HNs. 3. iv). Continue meeting in workgroup at a minimum of quarterly to review collected data to address potential gaps in delivery of EPSDT services. 4. Assisting OneCare members discharged from ED with follow-up appointments within 7 days. a). Case Management will continue to outreach to all members admitted. b). UM notification to PCP of all admissions and discharges c). Implement post discharge program with Papa and share with all health networks d). PointClickCare discharge sharing (implemented 9/18/2025) e) Point clickCare admission notifications (live 12/15/2025) f) Provider Portal enhancement- PCP notification for admissions and discharges (implemented 10/2025) Risk Stratification: track and trend MY rates 1a. Quarterly track and trend High-risk members per CalOptima Health RSS who have an intervention: 1b i). Barrier analysis for high-risk members without intervention for 2025. 1b ii). Identify and implement two strategies to address identified barriers	Complete Population Needs Assessment by end of Q2. Initial Screening and Assessment 2a Q4 2025 by 3/31/2026; Q1 2025 by 6/30/2026; Q2 2026 by 9/30/2026; Q3 by 12/31/2026 2b i) Q4 2025 by 2/8/2026; Q1 by 5/8/2025; Q2 by 8/8/2025; Q3 by 11/8/2026 2b ii) 6/30/2026 2b iii) 12/31/2026 3. i. Q2 and Q4 2026 3. ii. by Q4 2026 3. iii. by Q4 2026 3. iv. Q1, Q2, Q3 and Q4 2026 4. a-f update quarterly x4 by 12/31/2026 Review quarterly. Risk Stratification: 1a Q 2025 by 3/31/2026; Q1 2025 by 6/30/2026; Q2 2026 by 9/30/2026; Q3 by 12/31/2026 1b i) 3/31/2026 1b ii). 6/30/2026 1b iii). 9/30/2026	Report to UMC Q1 - 02/19/2026 Q2 - 05/21/2026 Q3 - 08/20/2026 Q4 - 11/19/2026	Katie Balderas / Hannah Kim	Manager of Case Management	Case Management	Yes - Program Oversight and Prior Year Evaluation (IHA)

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22	Program Oversight	Program Oversight	Health Education Program	Implement the Health Education Program, report key findings quarterly to QIHEC to analyze barriers and improvement efforts, and compare program data against the following goals. 1. By December 31, 2026, 95% timely (up to 14 days) fulfillment of health education materials and referrals. 2. By December 31, 2026, increase the rate of members' participation and access to multimodal health education content by 15%	Medi-Cal Members	1. Develop a standardized Health Education playbook that involves analyzing health data, surveying members, and collaborating with health networks. 2. Develop a communication and evaluation strategy to monitor the Diabetes Prevention Program. 3. Identify priority areas based on prevalent health issues, knowledge gaps, or population needs. Use a multimodal approach for health education, including self-care guides, interactive tools, virtual classes, texts, and mailings. 4. Create a tracking process for capturing member participation and access to health education material.	1. By the end of Q1, 2026. 2. By the end of Q2, 2026. 3. Ongoing- end of Q4 2026 4. By the end of Q1, 2026.	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Aulina Bradley	Manager of Case Management	Case Management	Yes - Program Oversight
23	Program Oversight/Quality of Clinical Care	PHM Strategy	Disease Management Program (Emerging Risk)	Implement the Disease Management Program, report key findings and activities, analyze barriers and improvement efforts, and compare program data against the following goals. 1. By December 31, 2026, 90% of members who participate in the Disease Management program from January 1 to December 31, 2026, will report satisfaction. 2. By December 31, 2026, increase rate of Health Coaching engagement to members with high/mod risk conditions from 7.5%% to 15%. Improve from the HEDIS MY2024 final rate to meet the HEDIS MY2025 goal by September 30, 2026, for the following measures: 1. MC and OC Eye Exam for Patients with Diabetes (EED) 2. MC Kidney Health Evaluation for Patients with Diabetes (KED) 3. MC and OC HBD (GSD) 4. MC and OC Controlling High Blood Pressure (CBP) (Please refer to the attached HEDIS MY2025 Medicare and Medicaid goal sheets for the 2026 HEDIS goals)	CalOptima Health members with chronic conditions, including diabetes, asthma, congestive heart failure, and hypertension.	1. Develop a standardized Disease Management playbook inclusive of member identification/stratification, interventions, and Health Network/provider collaboration strategies. 2. Use multimodal methods of outreach (text, WebMD, mailings) to identify members for Disease Management services and provide evidence-based health education and self-management resources. 3. Integrate new methods to monitor and improve clinical outcomes and satisfaction for members with chronic conditions.	1. By end of Quarter 1, 2026. 2. Ongoing. 3. Ongoing	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Katie Balderas	Manager of Case Management	Case Management	Yes - Program Oversight; MC EED - Prior Year Evaluation (goal not met); OC EED MC KED, MC and OC GSD, and MC and OC CBP - Prior Year Evaluation (continued improvement, maintenance and monitoring)

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24	Program Oversight/Quality of Clinical Care	Improvement Project	Disease Management Program: Chronic Conditions Improvement Project (CCIP)	Chronic Conditions Improvement Project (CCIP): Implement a targeted outreach campaign using multi-modal communication (SMS, email, phone calls, and/or mailers) to engage CalOptima Health Community Network (CHCN) OneCare hypertensive and diabetic members with an HbA1c > 9%. CCIP Goals: 1. Reach at least 50% of identified members by December 2026. 2. Achieve a 10% improvement in compliance for the Glycemic Status Assessment for Patients with Diabetes (GSD) and Controlling Blood Pressure (CBP) HEDIS measures amongst the targeted population by the end of the campaign.	CCIP: CalOptima Health Community Network (CHCN) OneCare hypertensive and diabetic members with an HbA1c > 9%	1. Member identification: use claims, clinical, and HEDIS data to identify 'uncontrolled' diabetic and hypertensive OneCare CHCN members (defined by an HbA1c >9% and eligibility for the Controlling Blood Pressure (CBP) HEDIS measure). 2. Personalized messaging: develop culturally tailored scripts for SMS, email, phone calls, and/or mailers emphasizing the importance of testing and follow-up care. 3. At-home support: provide eligible members with at-home lab testing for HbA1c and a blood pressure cuff for at-home monitoring. 4. Health education: provide members with health coaching and WebMD resources. 5. Tracking and reporting: log all outreach attempts and member responses in a centralized way to monitor engagement, outcomes, and quality care gap closure.	1. By 01/31/2026 2. Ongoing 12/31/2026 3. Ongoing 12/31/2026 4. Ongoing 12/31/2026 5. Ongoing 12/31/2026	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Kelli Glynn	Manager of Quality Analytics	Quality Analytics	Yes - Regulatory / Contractual
25	Program Oversight	PHM Strategy	CalAIM Enhanced Care Management and Community Supports (Patient Safety or Outcomes Across Settings)	Continue to ensure ECM and Community support are accessible to members who qualify for services and ensure services provided meet required quality standard by December 31, 2026. 1) Increase ECM authorization for services by 5%. 2) Complete the annual ECM audit process. 2) Complete the initial audit for the Housing Trio of Community Support services. 3) Develop the audit process for the Personal Care and Homemaker community support service. 4) Require recuperative care providers to complete the NIMRC certification process.	Members who qualify for CalAIM services.	1. Implement an annual CalAIM training schedule to support all CalAIM providers in providing quality services aligned with CalOptima Health's standards of care. 2. Utilize the results of the ECM audit to develop training workshops for contracted ECM providers. 3. Utilize results of the Housing Trio audit to develop training workshops for contracted housing providers. 4. Develop audit templates for Personal Care and Homemaker services audit. 5. Work with NIMRC to ensure the recuperative care certification process is successful.	1. December 31, 2026 2. August 31, 2026 3. August 31, 2026 4 December 31, 2026 5. December 31, 2026	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Mia Arias	Director of Medi-Cal and CalAIM	Medi-Cal and CalAIM	Yes - Program Oversight
26	Program Oversight	PHM Strategy	Street Medicine (Patient Safety or Outcomes Across Settings)	1. Sustain or exceed 80% of unhoused participating members connected to an active PCP throughout 2026. 2. Sustain or exceed 90% of unhoused participating members engaged with CalAIM ECM and Housing Navigation throughout 2026. 3. By December 2026, increase the rate of unhoused participants connected to a shelter or other housing option to 20%.	Members experiencing homelessness, members with serious mental/substance use disorders	Goal 1: (1) Offer all enrolled members the opportunity for the street medicine provider to serve as PCP. (2) Assist all enrolled members who elect to have street medicine serve as their PCP in calling Customer Service for a change. (3) Obtain Release of Information for any enrolled member who wants to keep their assigned PCP to enable communication between both providers. Goal 2: (1) Upon enrollment, submit CalAIM authorizations for ECM and Housing Navigation. (2) As needed, submit re-authorizations. (3) Provide service delivery of both services at routine, bi-monthly intervals at minimum. Goal 3: (1) Offer all enrolled members temporary shelter, if available, at each time of service. (2) Work with each enrolled member at becoming 'document ready'. (3) Enter all enrolled members into the Coordinated Entry System for housing opportunities.	Continue all activities through 2026	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Nicole Garcia	None	Medi-Cal and CalAIM	Yes - Program Oversight

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27	Program Oversight	PHM Strategy	Complex Case Management Program (Managing Multiple Chronic Conditions)	Implement the Complex Case Management Program, report key findings and activities, analyze barriers and improvement efforts, and compare program data against the following goals. 1. Ensure provision of CCM services resulting in optimal care coordination as evidenced through monthly auditing of 5 files or 5% (whichever is larger) of files for each HN, resulting in a minimum score of 90% by 12/31/2026. 2. Members who participated in the CCM program will report 90% overall satisfaction by December 31, 2026. 3. By 12/31/2026, 90% of members who participated in the CCM program and completed a survey in 2026 will report that the program was "helpful" or "very helpful" to meet their care goals.	The population of focus includes members with the most complex health care needs. Most frequently managed conditions, diseases or high-risk groups*	Goal 1: Enhance Staff Competency in PH5 Elements D and E 1a. Training and educational opportunities for all health networks on the 2026 PHM5 Element D and E and complex conditions/situations 1b. Develop new training materials utilizing feedback from HMA consultants during the recent mock audit. 1c. Provide 1:1 and group training as needed and intervene immediately and meet to discuss audit outcomes for all health networks. Goal 2: Enhance Member Experience with Complex Case Management (CCM) Program 2a. Share Member Satisfaction (MSS) scores with all health networks on a quarterly basis. 2b. Conduct quarterly leadership meetings to review MSS scores and member feedback to collaborate on strategies to improve outcomes. Goal 3: Member-Centric Care Planning 3a. Continue training and education on member centric care plans for all health networks as needs arise.	Goal 1a. by 3/31/2026 Goal 1b. by 1/31/2026 Goal1c. through 12/31/2026 Goal 2a. Q1, Q2, Q3, Q4 2026 Goal 2b. Q1, Q2, Q3, Q4 2026 Goal 3a. through 12/31/2026	Report to UMC: Q1: 02/19/2026 Q2: 05/21/2026 Q3: 08/20/2026 Q4: 11/19/2026	Megan Dankmyer / Hannah Kim	Quality Improvement Nurse	Case Management	Yes - Program Oversight

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28	Program Oversight	Committee	Utilization Management Program	1. By 12/31/26, all key metrics will demonstrate a 5% reduction from prior year performance based on line of business and aid category 2. Key metrics include; Admit PTMPY, ALOS, Days PTMPY, Readmit Percent, ED PTMPY *Expansion & TANF 18+ Admit PTMPY Goal 114.9 ALOS Goal 4.3 Days PTMPY Goal 515.9 Readmit Goal 16.4% *TANF Under 18 Admit PTMPY Goal 29.1 ALOS Goal 12.2 Days PTMPY Goal 374.7 Readmit Goal 2.2% *SPD Admit PTMPY Goal 241.5 ALOS Goal 5.7 Days PTMPY Goal 1,438.7 Readmit Goal 21.6% *LTC Admit PTMPY Goal 554.0 ALOS Goal 7.4 Days PTMPY Goal 4,276.0 Readmit Goal 22.2% *OneCare Admit PTMPY Goal 261.5 ALOS Goal 5.5 Days PTMPY Goal 1,520.3 Readmit Goal 14.6% *WCM Admits PTMPY Goal 308.2 ALOS Goal 9.1 Days PTMPT Goal 2,926.6 Readmit Goal 3.7%	Utilization Management of OC and Medi-Cal CCN/COD populations	1. Review of quarterly data at UMC meetings 2. Implementation of interventions identified at the various workgroups led by CalOptima Health Medical Directors	1. UMC meetings: Q1 - 02/19/2026 Q2 - 05/21/2026 Q3 - 08/20/2026 Q4 - 11/19/2026 2. Ongoing 12/31/2026	Report to UMC: Q1: 02/19/2026 Q2: 05/21/2026 Q3: 08/20/2026 Q4: 11/19/2026	Stacie Oakley	Director of Case Management	Utilization Management	New - Program Oversight

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29	Program Oversight	Program Oversight	Long-Term Support Services (LTSS)	Implement the LTSS program, report key findings and activities, analyze barriers and improvement efforts and compare program data against the 95% compliance with the following TATs: 1. CalAIM Turnaround Time (TAT): Determination completed within 5 business days for routine authorizations and 72 hours for expedited authorizations. 2. CBAS Inquiry to Determination (TAT): Determination completed within 30 calendar days. 3. CBAS Turnaround Time (TAT): Routine determination completed within 5 business days. 4. LTC Turnaround Time (TAT): Determination completed within 5 business days.	1. Long Term Care-Custodial 2. CBAS 3. CalAim Community Supports	1. Evaluation of the current utilization of LTSS. 2. Maintain current business and expand as needed for current and any new LTSS programs. 3. Continuous process improvement in DTPs, and management of member, provider, and CalOptima Health requests. 4. Meet or exceed all regulatory and policy TAT goals.	End of Q1, Q2, Q3 & Q4.	Report to UMC: Q1: 02/19/2026 Q2: 05/21/2026 Q3: 08/20/2026 Q4: 11/19/2026	Scott Robinson	Manager of Long-Term Support Services	Long Term Support Services	Yes - Program Oversight
30	Program Oversight	Program Oversight	Delegation Oversight	Implement annual oversight and performance monitoring for delegated activities and report key findings and/or activities, analyze barriers, and improvement efforts and compare program data against the following goals: 1. By December 31, 2026, conduct an annual audit for each delegate and issue CAPs, as needed. 2. Conduct a pre-delegation assessment for all potential delegates prior to execution of the delegation agreement.	Delegated health networks and FDRs.	Report on Delegation Oversight activities to CPRC or another applicable Committee at least semi-annually	01/31/2026 & 07/31/2026	Report to QIHEC: Q1: 03/10/2026 Q2: 06/09/2026 Q3: 09/08/2026 Q4: 12/08/2026	Stacy Baker	Manager of Delegation Oversight	Delegation Oversight	Yes - Program Oversight

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31	Quality of Clinical Care	Program Oversight	Special Needs Plan (SNP) Model of Care (MOC)	1. Decrease the number of reset HRAs identified on 1/1/2026 5% by 12/31/2026 2. Increase the number of Initial members with an ICP per CMS criteria within 90 days of eligibility from 95% to 98% by 12/31/2026. 3. Increase the number of members with a formal or informal ICT collaboration from 90% to 95% by 12/31/2026. 4. Track and trend HRA Star Status and annual face-to-face visit quarterly. 5. CalOptima Health D SNP 2027 MOC revision submission	1. OneCare Members 2. Newly enrolled Members 3. OneCare members	1a. Quarterly tracking of reset HRA rate 1b. HRA initial and annual HRA outreach 1c. HRA reminders through texting and postcards 1d. Targeted outreach to members in need of a reset or catch-up HRA 1e. QR Codes on HRA cover letters 2a. Quarterly tracking of initial ICP completion rate 2b. Monthly Communication to Health Networks on ICP Development 3. Monthly tracking of ICT to Health Network 4. Quarterly tracking and trending HRA Star Status and annual face-to-face 5. CalOptima Health D SNP 2027 MOC revision submission 1-3: Barrier analysis with strategies identified to address. 1-3: Implement two strategies to address identified barriers and monitor response.	1a-e. Q4 2025 by 3/31/2026; Q1 2026 by 6/30/2026; Q2 2026 by 9/30/2026; Q3 by 12/31/2026 1f. 6/30/2026 1g. 12/31/2026 2a. Q4 2025 by 3/31/2026; Q1 2026 by 6/30/2026; Q2 2026 by 9/30/2026; Q3 by 12/31/2026 2b. Monthly through 2026 2c. 6/31/2026 2d. 12/31/2026 3. Monthly through 2026. 4. Q4 2025 by 3/31/2026; Q1 2026 by 6/30/2026; Q2 2026 by 9/30/2026; Q3 by 12/31/2026 5. 5/29/2026	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Megan Dankmyer	QI Nurse Specialist	Medical Management	Yes - Program Oversight

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32	Quality of Clinical Care	Behavioral Health	Behavioral Health Services	Improve from the HEDIS MY2024 final rate to meet the HEDIS MY2025 goal by September 30, 2026, for the following measures: 1. MC Diabetes Screening for People with Schizophrenia or Bipolar Disorder (SSD) (Medicaid only) 2. MC Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) 3. MC Pharmacotherapy for Opioid Use Disorder (POD) 4. MC and OC Depression Screening and Follow-up for Adolescents and Adults Total (DSF-E) 5. MC Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) 6. MC Prenatal Depression Screening and Follow-Up (PND-E) 7. MC Postpartum Depression Screening and Follow-Up (PDS-E) (Please refer to the attached HEDIS MY2025 Medicare and Medicaid goal sheets for the 2026 HEDIS goals)	Medi-Cal and OneCare	SSD 1. Continue to track members in need of a glucose screening test 2. Use the provider portal to communicate follow-up best practices and guidelines for follow-up visits. 3. Continue to follow up on the data pull for the text messaging campaign. 4. Mail out member health rewards flyers to eligible members. 5. Continue to mail out to all PCP offices the following: - Best Practice PCP Letter - Provider Tool Tip Sheet - Member Reward Flyer 6. Schedule listening sessions with Providers to educate/train on how to obtain BH data. Pending report availability. APP 1. In 2026, we will continue to send out monthly provider mailouts. We also hope to send out an APP text message campaign to members starting in January 2026. POD 1. Educate providers on measures and best practice guidelines. DSF-E 1. Continue distributing HEDIS Tool Tip Sheets, ensuring they are accessible through provider portals and our website. 2. Offer virtual training or review DSF-E requirements and documentation tips. 3. Collaborate office visits with Provider relations for Provider Outreach and education. 4. Targeted Social Media Campaign to members that may need a depression screening. 5. Partner with community-based organizations to amplify importance of depression screenings APM 1. Share aggregate performance data with provider groups to highlight trends and encourage alignment with quality goals. 2. Share provider-level performance reports to increase awareness and accountability. 3. Offer targeted training on the importance of metabolic monitoring. 4. Use stratified data to identify non-compliant members and prioritize outreach based on risk level or historical gaps in care.	SSD by: End of Q4 APP by: End of Q4 POD by: End of Q4 DSF-E by: End of Q4 APM by: End of Q4	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Diane Ramos / Natalie Zavala / Carmen Katsarov	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	Yes - Program Oversight; MC POD, SSD, APM, APP, and PDS-E - Prior Year Evaluation (goal not met);PND-E and PDS-E - Prior Year Evaluation (continued improvement, maintenance and monitoring)

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33	Quality of Clinical Care	Behavioral Health; PHM Strategy	Behavioral Health Services: Care Coordination and Follow-up Care Performance Improvement Projects (PIPs) Medi-Cal BH (Patient Safety or Outcomes Across Settings)	Improve from the HEDIS MY2024 final rate to meet the HEDIS MY2025 goal by September 30, 2026, for the following measures: 1. MC Follow-Up After Emergency Department Visit for Mental Illness (FUM): 30-Day and 7-day 2. MC Follow-Up After Emergency Department Visit for Substance Use (FUA): 30-Day and 7-day 3. MC Follow-up After High-Intensity Care for Substance Use Disorder (FUI):30-Day and 7-day PIP Meet and exceed goals set forth on all improvement projects (See individual projects for individual goals) FUM and FUA for complex case management. (Please refer to the attached HEDIS MY2025 Medicare and Medicaid goal sheets for the 2026 HEDIS goals)	Medi-Cal	FUM/FUA 1. Assess IVR Call Implementation - Explore and pilot automated Interactive Voice Response (IVR) calls to remind members who meet FUM/FUA criteria to schedule follow-up appointments after ED visits. 2. Continue Daily Text Campaign - Maintain ongoing text message outreach to encourage timely follow-up care. 3. Engage High-Volume EDs - Continue in-person meetings with high-volume emergency departments to ensure members are connected to services before discharge. - Reinforce partnerships with Telemed2U and NAMI By Your Side for immediate member support. 4. Provider Portal Enhancements - Continue sharing BH Measures Report and FUM/FUA Daily ED reports via the Provider Portal to improve provider visibility and accountability. 5. Collaboration Projects - Maintain active participation in DHCS/OCHCA Behavioral Health Collaboration Project to improve FUA/FUM HEDIS outcomes. 6. Health Network Engagement - Continue attending HN Quality Meetings to provide updates, education, and performance feedback. 7. Provider Relations Coordination - Implement in-person visits with Provider Relations teams using a drafted outline of Behavioral Health discussion points to strengthen provider engagement. 8. Member Journey Magnets Distribution - Share BH Medi-Cal Member Journey magnets with QA team for distribution to Transtreme and At-Home Visit providers. - Magnets will outline key steps in the member care journey to reinforce engagement and follow-up. FUI 1. This measure was added for monitoring purposes. Opportunities for improvement and/or interventions will be considered for 2026. PIP 1. Conduct member outreach through the behavioral health telehealth provider to coordinate follow-up appointments post-ED visit. 2. Facilitate monthly collaboration meetings with key stakeholders to design and refine workflows for member outreach and engagement. 3. Ongoing Partnership with OC HCA and CalOptima Health IT teams to support the exchange of data files.	FUM/FUA/FUI by: End of Q4 PIP: by End of Q4	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Diane Ramos / Natalie Zavala / Carmen Katsarov	Program Specialist of Behavioral Health Integration	Behavioral Health Integration	Yes - Regulatory / Contractual and Prior Year Evaluation (goal not met)

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34	Quality of Clinical Care	Program Oversight	Medication Adherence	Improve from the HEDIS MY2024 final rate to meet the HEDIS MY2025 goal by September 30, 2026 for the following measures: 1. Medication adherence for Cholesterol (Statins) 2. Hypertension (RAS Antagonists) 3. Diabetes (Non-insulin)	OneCare members	1. Member outreach calls 2. Provider outreach calls 3 Pharmacy outreach calls 4 Health Network report support 5. IVRs 6. Mail order sign-up outreach	12/31/2026 (all)	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Dr. Nicki Ghazanfarpour	Clinical Pharmacist	Pharmacy Management	Yes - Program Oversight
35	Quality Data	Initiative	Cozeva PayerOne Software Solution	Deploy the Cozeva PayerOne software solution to advance the completeness and timeliness of quality data exchange. Goals include: 1. Achieve automatic bidirectional data exchange with Health Network partners by February 2026. 2. Onboard 20 high-volume provider offices to the Cozeva user interface by July 2026. 3. Integrate at least 5 high-volume CHCN provider EMR systems with Cozeva to automatically extract quality data by December 2026.	N/A	1. Launch the Cozeva Bridge solution to obtain quality data from Health Network partners. 2. Provide Cozeva with the file set needed to support HEDIS measure computation and weekly refresh (i.e. medical claims, pharmacy claims). 3. Provide Cozeva with the file set needed to support Risk Adjustment activities (i.e. MAO/MMR/MOR files). 4. Complete measure validation. 5. Enable natural language processing (NLP) in support of automated chart review and improved quality care gap closure. 6. Launch computation tenancy. 7. Begin provider onboarding activities. 8. Begin EMR integration activities.	1. By 01/16/2026 2. By 02/09/2026 3. By 02/09/2026 4. By 02/28/2026 5. By 02/28/2026 6. By 03/31/2026 7. By 04/01/2026 8. By 04/01/2026	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Kelli Glynn	Program Manager (Quality Incentives)	Quality Analytics	New - Program Oversight
36	Program Oversight/Quality of Clinical Care	Initiative	At-Home Visit Program	Goal: Implement an at-home visit program and report key findings and activities, analyze barriers and improvement efforts, and compare program data against the following goals: 1. By December 31, 2026, connect 40% of eligible members to an at-home visit provider. 2. By December 31, 2026, complete at least 500 at-home annual wellness visits (AWVs) for eligible members. 3. By December 31, 2026, improve HEDIS measure performance for Care for Older Adults, Controlling Blood Pressure, and Diabetes Care - Blood Sugar Control by at least 5%.	CalOptima Health Community Network (CHCN) members across all lines of business who have not had an Annual Wellness Visit (AWV) within the last 12 months, and/or have multiple open quality care gaps.	1. Complete all contracting-related activities in Q1 2026. 2. Launch multi-modal outreach campaigns to eligible members in Q1 2026; utilize text, email, and phone to encourage AWV scheduling. 3. Implement reporting tools to track AWV completion, member engagement, member satisfaction, and quality care gap closure. 4. Compare program data against target goals quarterly. Highlight trends and barriers in reports to leadership and QIHEC.	1. By 02/20/2026 2. By 02/27/2026 3. By 03/20/2026 4. Ongoing 12/31/2026	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Kelli Glynn	Supervisor, Quality Analytics	Quality Analytics	New - Program Oversight
37	Program Oversight/Quality of Clinical Care	Initiative	At-Home Lab Testing	Goal: Implement an at-home lab testing program and report key findings and activities, analyze barriers and improvement efforts, and compare program data against the following goals: 1. By December 31, 2026, achieve a 20% kit return rate for Colorectal Cancer Screening, Hemoglobin A1c testing, and kidney health testing. 2. By December 31, 2026, improve HEDIS measure performance for Colorectal Cancer Screening, Diabetes Care - Blood Sugar Control, and Kidney Health Evaluation for Patients with Diabetes by at least 5%.	CalOptima Health Community Network (CHCN) members across all lines of business are due for Colorectal Cancer Screening, Diabetes Care - Blood Sugar Control, or	1. Launch multi-modal outreach campaigns to eligible members; utilize text, email, and phone to encourage completion of lab testing. 2. Implement reporting tools to track test completion, member engagement, member satisfaction, and quality care gap closure. 3. Compare program data against target goals quarterly. Highlight trends and barriers in reports to leadership and QIHEC.	1. 12/31/2026 2. By Q2 2026 3. 12/31/2026	Report to QIHEC: Q1: 02/10/2026 Q2: 05/12/2026 Q3: 08/11/2026 Q4: 11/10/2026	Kelli Glynn	Manager of Quality Analytics	Quality Analytics	New - Program Oversight

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					Kidney Health Evaluation for Patients with Diabetes HEDIS measures.							
38	Quality of Service	Network Adequacy	Improve Network Adequacy: Reducing Gaps In Provider Network	1. For primary care providers: • Meet or exceed the MPL of 1:2000 (practitioner to member) ratio • Meet or exceed the 99% of practitioners being within ten (10) miles or thirty (30) minutes from any Member or anticipated Member's residence 2. For high-volume specialists: • Meet or exceed the MPL practitioner-to-member ratios in GG.1600 and MA.7007. • Meet or exceed the 99% of practitioners being within fifteen (15) miles or thirty (30) minutes from any Member or anticipated Member's residence 3. Participate and comply with regulatory submissions/audits: • Annual Network Certification (ANC) • Subdelegate Network Certification (SNC) • Network Adequacy Validation (NAV) Audit	Medi-Cal and OneCare Provider Network	Assess and report the following activities: 1. Conduct gap analysis of our network to identify opportunities with providers and expand the provider network 2. Conduct outreach and implement recruiting efforts to address network gaps to increase access for Members 3. Annual participation of ANC, SNC and NAV to DHCS with AAS or CAP 4. Communicate monitoring results and the remediation process to HN	1) Quarterly gap analysis 03/31/2026 06/30/2026 09/30/2026 12/31/2026 2) Completion will vary depending on the quarter that results in a gap 3) Submission- ANC by end of Q1 SNC by DHCS designated deadline NAV audit - date TBD by DHCS 4) Quarterly 03/31/2026 06/30/2026 09/30/2026 12/31/2026	Report to MEMx Q1: 01/27/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/06/2026	Quynh Nguyen	Manager, Provider Operations	Provider Data Operations	Yes - Regulatory / Contractual

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39	Quality of Service	Network Adequacy	Improve Timely Access: Appointment Availability/Telephone Access	1. Reach DHCS threshold appointment compliance rate of 70% MPL for all provider types by December 31, 2026. 2. Decrease the survey non-participation rate with individual providers by 10%.	Medi-Cal and OneCare Providers	1. Offer two training sessions per year on appointment and telephone access. 2. Provide Health Networks with a list of their noncompliant (including non-participating) providers for further action. 3. Resurvey non-compliant providers up to three times within a survey period. 4. Include individual provider survey results through multiple communication channels.	1. Q2 2026 2. Q1-Q3 2026 3. Q4 2026 4. Q4 2026	Report to MEMx Q1: 01/27/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/06/2026	Kelli Glynn	Manager of Quality Analytics / Project Manager of Quality Analytics	Quality Analytics	Yes - Regulatory / Contractual and Prior Year Evaluation (focus area = Psychiatrist Urgent and Psychiatrist Follow-up Appointments)
40	Quality of Service	Member Experience	Improve Member Experience/CAHPS	Improve CAHPS performance as follows:For OneCare:1. Annual Flu Vaccine: maintain or exceed 4 Stars2. Getting Needed Care: improve from 1 Star to 3 Stars3. Getting Appointments and Care Quickly: improve from 1 Star to 3 Stars4. Customer Service: improve from 1 Star to 3 Stars5. Rating of Health Care Quality: improve from 2 Stars to 3 Stars6. Rating of Health Plan: improve from 3 Stars to 4 Stars7. Care Coordination: improve from 1 Star to 3 Stars8. Rating of Drug Plan: improve from 3 Stars to 4 Stars9. Getting Needed Prescription Drugs: improve from 1 Star to 3 StarsFor Medi-Cal: Achieve or exceed the 33rd percentile for the following measures:1. Rating of All Health Care2. Rating of Health Plan3. Getting Needed Care4. Getting Care Quickly	All CalOptima Health Members	Assess and report on the following activities: 1. Execute the 'Just in Time' campaign in Q1 2026 to connect with members likely to respond negatively to the CAHPS survey to address unmet needs, as well as encourage survey completion amongst members who are likely to respond positively.2. Launch several Listening Post campaigns via two-way SMS across both lines of business and provide year-round service recovery in collaboration with multiple departments.3. Hold recurring meetings with Health Network Member Experience teams dedicated to MEMX improvement strategy.4. Provide Health Network partners with member-level predictive CAHPS analytics to inform targeted outreach campaigns.5. Partner with multiple departments to complete multi-modal outreach to members upon referral inquiry and post-referral authorization for impacted specialties such as Neurology, Rheumatology, and Urology.6. Distribute CAHPS playbooks and tip sheets to Health Network partners and provider offices.7. Launch member-facing digital educational campaigns regarding accessing care and the specialty referral process.	1. Q1 20262. Ongoing 12/31/20263. Ongoing 12/31/20264. Q2 20265. Ongoing 12/31/20266. Ongoing 12/31/20267. Q2 2026	Report to MEMxQ1: 01/27/2026Q2: 04/14/2026Q3: 07/14/2026Q4: 10/06/2026	Kelli Glynn	Manager of Quality Analytics / Project Manager of Quality Analytics / Quality Improvement Specialist	Quality Analytics	Yes - Program Oversight: CAHPS - Prior Year Evaluation (goal not met)

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41	Quality of Service	Member Experience	Grievance and Appeals Resolution Services	Implement grievance and appeals and resolution process, and report key findings and/or activities, analyze barriers, and improvement efforts. Maintain the grievance, appeals, and resolution process while meeting all regulatory requirements for timely processing of appeals and grievances, with a target goal of 95%.	OneCare members Medi-Cal members	1. Track and trend appeals and grievance data and implement process improvements and remediations as needed. 2. Comply with regulatory standards and compliance.	1. Ongoing 12/31/2026 2. Ongoing 12/31/2026	Report to GARS: Q1: 03/12/2026 Q2: 05/19/2026 Q3: 08/18/2026 Q4: 11/17/2026	Heather Sedillo	Manager of Grievance and Appeals	GARS	Yes - Regulatory / Contractual
42	Quality of Service	Member Experience	Customer Service Call Center	Implement customer service process and monitor against the following standards: 1. OC Call Center Abandonment Rate 5% or lower 2. OC Call Center Average Speed of Answer 2 minutes or lower 3. MC Call Center Average Speed of Answer 10 minutes or lower Report key findings and/or activities, analyze barriers, and improvement efforts.	OneCare members Medi-Cal members	Track and trend customer service call center data Comply with regulatory standards Improve the process for handling customer service calls	Report to MEMx Q1: 01/27/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/06/2026	Report to MEMx Q1: 01/27/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/6/2026	Andrew Tse	Managers of Customer Service (Medi-Cal and OneCare)	Customer Service	Yes - Regulatory / Contractual

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43	Safety of Clinical Care	PHM Strategy	Emergency Department Program (Patient Safety or Outcomes Across Settings)	Enhance care coordination and member outcomes by: 1. Maintaining real-time member outreach in ED. 2. Expand to at least 2 additional ED locations by the end of Q4 2026. 3. Assisting OneCare members discharged from ED with follow-up appointments within 7 days. 4. Tracking service utilization, reporting key findings, and analyzing barriers for continuous improvement.	Adults At Risk for Avoidable Hospital or ED Utilization	1. Maintain Real-Time Member Outreach in Emergency Departments (ED) a. Continue proactive engagement with members during ED visits. b. Monitor and adjust outreach strategies as needed. 2. Sustain Weekly Workgroup Meetings and Continuous Improvement a. Hold regular workgroup sessions to review interventions and recommendations. b. Implement ongoing refinements to processes and workflows. 3. Implement ED Post-Discharge Follow-Up for OC Members a. Begin scheduling post-discharge follow-up appointments for OC members. b. Finalize and optimize workflows for member identification and appointment scheduling. c. Continuously refine processes based on feedback and outcomes. 4. Expand Onsite Staff Presence Across Additional Emergency Departments a. Identify new ED locations for program expansion. b. Develop and implement strategies for scaling onsite activities. c. Continue process improvements to support expansion efforts.	Activities 1-3 March 30, 2026; Activities 4a-c Dec 31, 2026	Report to UMC: Q1: 02/19/2026 Q2: 05/21/2026 Q3: 08/20/2026 Q4: 11/19/2026	Michelle Evans		Utilization Management	Yes - Program Oversight
44	Safety of Clinical Care	PHM Strategy	Transitional Care Services (TCS) (Patient Safety or Outcomes Across Settings)	1. UM/CM/LTC to improve care coordination by increasing successful interactions for TCS high-risk members within 7 days of their discharge by 10% by 12/31/2026. 2. Achieve the 2026 Goal for the following measures: a. MC and OC: Plan All-Cause Readmissions 18-64 (PCR). For MC, the goal is to decrease the Observed to Expected Ratio (O/E) from 0.8983 to 0.8937 by 12/31/2026; for OC, the goal is to decrease readmissions from 10% to 8% by 12/31/2026. b. OC: Transitions of Care (TRC)	• Adults At Risk for Avoidable Hospital or ED Utilization • Pregnant and Postpartum Women; • Individuals experiencing homelessness; • Members experiencing a transition; • High-risk members. OneCare members	1a. TCS: Develop and Implement Reporting Dashboards: Create a dashboard for DHCS reporting requirements in collaboration with IT. b. Implement a real-time dashboard to identify opportunities for member outreach within 7 days of discharge. c. TCS; Continue refining workflows to improve operational efficiency. d. Implement process improvements that support timely interventions. e. TCS:Automate Jiva System Enhancements for TCS activity creation linked to inpatient episode creation. f. Reduce manual processes through system integration and automation. g. Automate ECM Reporting: Transition ECM successful interaction reporting from manual to automated processes. h. Ensure accurate and timely reporting for compliance and performance tracking. 2a-b i). Collaborating on Readmission Strategies: Attend Health Network (HN) Joint Operating Meetings (JOMs). ii). Request and document strategies HNs are using to reduce readmissions. a iii) Identify best practices for integration into workflows. iii). Share Readmission Rates for Transparency: Provide quarterly updates on facility-level and HN readmission rates during JOMs. iv). Use shared data to highlight opportunities for improvement. v). Report Post-Discharge Ambulatory Follow-Up Rates: Share quarterly reports on follow-up rates within 7 days of discharge with HNs and facilities during JOMs.	1a. March 30, 2026; 1b-h Dec 31, 2026 2. Dec 31, 2026; 3. Sept 30, 2026; 4. June 30, 2026;	Report to UMC: Q1: 02/19/2026 Q2: 05/21/2026 Q3: 08/20/2026 Q4: 11/19/2026	Michelle Evans	Project Manager, Medical Management	Utilization Management	Yes - Program Oversight and Prior Year Evaluation (PCR and TRC)

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						vi). Continue TCS activities and program enhancements to support member outreach and engagement. vii). Support Member Engagement and PCP Follow-Up; Maintain TCS activities focused on connecting members with their PCP after discharge. viii). Assisting OneCare members discharged from ED with follow-up appointments within 7 days. ix). Case Management will continue to outreach to all members admitted. x). UM notification to PCP of all admissions and discharges xi). Implement post-discharge program with Papa and share with all health networks xii). PointClickCare discharge sharing (implemented 9/18/2025) xiii). PointClickCare admission notifications (live 12/15/2025) xiv). Provider Portal enhancement- PCP notification for admissions and discharges (implemented 10/2025)						
45	Quality of Clinical Care and Safety of Clinical Care	Program Oversight	Facility Site Review (including Medical Record Review and Physical Accessibility Review) Compliance	Monitor PCPs, High Volume Specialists, and ancillary sites using the DHCS audit tool and methodology, and report any findings, barriers, and improvement efforts. 1. 95% of subsequent site reviews will be conducted at least every three years from the previous FSR/MRR. 2. 95% of Initial FSRs to be completed on relocated PCP sites within 60 days of notification or discovery of the move. 3. 95% of PARS will be conducted at least every three years from the previous PARS	Medi-Cal Providers	Q1-Q4 2026:. 1. Complete periodic site reviews by assigned due dates. 2. Complete annual site reviews on sites with failed scores on previous FSR and/or MRR audits. 3. Monitor and evaluate critical element criteria on all PCP sites between regularly scheduled site reviews. 4. Provide extensive training, education, and technical assistance on all sites with scores less than 80%.	1. Ongoing 2. Ongoing 3. Ongoing 4. 12/31/2026	Report to CPRC: Q1: 02/26/2026 Q2: 05/28/2026 Q3: 08/27/2026 Q4: 11/19/2026	Marsha Choo	Manager of Quality Improvement	Quality Improvement	Yes - Regulatory / Contractual

TOC	2026 Evaluation Category/Program	2026 Domain	2026 QIHETP Work Plan Element Description	2026 Goal(s)	2026 Population of Focus	2026 Planned Activities	2026 Specific date of completion for each activity (i.e. MM/DD/YYYY)	2026 Reporting (i.e. MM/DD/YYYY)	Responsible Business Owner	Support Staff	Department	Areas Carried Over From 2025
46	Quality of Clinical Care and Safety of Clinical Care	Program Oversight	Potential Quality Issues Review	1. Close 80% of PQIs within 90 days. 2. Close 80% of declined grievances within 30 days.	Medi-Cal and OneCare Program	1. Review and report on quality-of-care cases for peer review (CPRC), determine appropriate severity level and make recommendations for actions based on findings. 2. In Q1, collaborate with IT to develop a report to monitor TAT. 3. Monthly, monitor the TAT of PQIs and declined grievances. 4. Develop and implement an IRR process for RNs for QOC grievances. 5. Review the current training in Customer Service and GARS of PQI and update materials as needed.	1. Ongoing - Monthly 2. March 30, 2026 3. Ongoing - Monthly 4. December 31, 2026 5. December 31, 2026	Report to CPRC: Q1: 01/29/2026 Q2: 04/23/2026 Q3: 07/23/2026 Q4: 10/22/2026	Marsha Choo	Manager of Quality Improvement	Quality Improvement	Yes - Program Oversight
47	Quality of Clinical Care and Safety of Clinical Care	Program Oversight	Sentinel Event Monitoring and Disease Surveillance	1. Screen claims and encounter data for Provider Preventable Conditions (PPCs) monthly. 2. Report to DHCS PPCs when identified.	Medi-Cal and OneCare Program	1. Screen claims and encounter data monthly. 2. Present PPC findings quarterly to CPRC.	1. Ongoing - Monthly 2. Ongoing - Quarterly	Report to CPRC: Q1: 03/10/2026 Q2: 06/09/2026 Q3: 09/08/2026 Q4: 12/08/2026	Marsha Choo	Manager of Quality Improvement	Quality Improvement	New - Regulatory / Contractual

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48	Quality of Clinical Care and Safety of Clinical Care	Program Oversight	Quality Assurance Performance Improvement (QAPI) for Long-Term Care Services	1. Develop and implement an LTSS QAPI Program 2. Develop and implement an LTC Performance Improvement Project (PIP) as part of the QAPI	LTC Facilities	1. Develop an annual QAPI Program and submit to DHCS 2. Implement the QAPI and report, at a minimum but not limited to the following: - Potential Quality Issues (PQIs) - Critical Incidents (CIs) - Skilled Nursing Facility (SNF) QAPI Oversight including audits - LTC PIP	1. 01/31/2026 2. Ongoing 12/31/2026	Report to QIHEC: Q1: 03/10/2026 Q2: 06/09/2026 Q3: 09/08/2026 Q4: 12/08/2026	Scott Robinson	Manager of Long-Term Support Services	Long Term Support Services	Yes - Regulatory / Contractual and Program Oversight
49	Quality of Clinical Care and Safety of Clinical Care	Program Oversight	Provider Credentialing and Recredentialing	All providers are credentialed and recredentialed according to regulatory and accreditation timeframe requirements: 1. A credentialing decision will be rendered for 90% of credentialing files within 120 days from receipt of a complete application 2. 90% of providers are recredentialed within 36 months from the last credentialing or recredentialing decision date	Medicaid, Medicare, Exchange	1. Review and report providers are credentialed according to regulatory requirements: 2. CVO and technology RFP release in Q1 2026 3. CVO and technology implementation by Q4 2026 (consistent with vendor availability to go live in 2026)	1. Ongoing 2. 03/31/2026 3. 12/31/2026	Report to CPRC: Q1: 02/26/2026 Q2: 05/28/2026 Q3: 08/27/2026 Q4: 11/19/2026	Sharlee LeBleu	Manager of Quality Improvement	Quality Improvement	Yes - Regulatory / Contractual

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50	Cultural and Linguistic Appropriate Services	CLAS	Language Services: Cultural and Linguistics and Language Accessibility	Provide interpreter and translation services and report key findings and/or activities, analyze barriers, and identify improvements. 1. By December 31, 2026, CalOptima Health will evaluate its language services experience by collecting feedback from 6% to 10% of members and from 4% to 80% of staff using surveys and will analyze the results to identify improvements to language services. 2. Member experience with language services will maintain a satisfaction rate of 90% or above by December 31, 2026. 3. Staff experience with language services will maintain a satisfaction rate of 90% or above by December 31, 2026.	CalOptima Health employees and CalOptima Health LEP members who utilize language services	1. Review and revamp CalOptima Health member and staff survey. 2. Launch surveys to LEP members who utilized language services within the previous 6 months. 3. Distribute surveys to CalOptima Health member-facing staff/departments. 4. Collect and analyze response data and identify gaps/opportunities for improvement 5. Complete the 2026 Experience with Language Services and Utilization Analysis Report	1. 02/16/2026 2. 04/15/2026 3. 04/15/2026 4. 06/30/2026 5. 07/31/2026	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Albert Cardenas	Manager of Cultural and Linguistics	Cultural and Linguistic Services	Yes - Regulatory / Contractual and Program Oversight and Prior Year Evaluation (member and staff low response rate)
51	Cultural and Linguistic Appropriate Services	CLAS	Data Collection on Member Demographic Information	1. By September 30, 2026, CalOptima Health will update the current data system to receive, store and retrieve the following: disability function and identity, physical accommodations, auxiliary aides or services, geographic classification, age, and veteran/military status 2.By Dec. 31st, 2026, CalOptima Health will increase the collection of member disability function data from 0 to 5% through focused outreach and education, ensuring better representation and inclusion of members.	CalOptima Health Members	1. Work with IT to update Facet to accept/store disability function, identity and physical accommodations, auxiliary aides or services, geographic classification, age, and veteran/military status. 2. Develop/modify member surveys to collect disability function, identity and physical accommodations, auxiliary aids or services, geographic classification, age, and veteran/military status. 3. Develop scripting and training for Customer Service staff to capture disability function, identity and physical accommodations, auxiliary aids or services, geographic classification, age, and veteran/military status during phone interaction. Begin the mailing of surveys to collect disability function, identity and physical accommodations, auxiliary aids or services, geographic classification, age, and veteran/military status.	1.09/20/2026 2.03/30/2026 3.06/30/2026	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Albert Cardenas	Manager of Cultural and Linguistics	Cultural and Linguistic Services	New - Program Oversight

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52	Cultural and Linguistic Appropriate Services	CLAS	Data Collection on Practitioner Demographic Information	1. By Dec. 31st, 2026, CalOptima Health will increase the collection of provider race/ethnicity/languages (REL) data through focused outreach and education, ensuring better representation and inclusion of providers as follows: • Race/Ethnicity – 18% • Language – 7%	N/A	1. Outreach to medical groups to collect REL data 2. Load REL data into the provider data system to ensure it can be retrieved and used for CLAS improvement	1. 02/28/2026 2. 12/31/2026	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Quynh Nguyen	Manager, Provider Data Operations	Provider Data Operations	Yes - Program Oversight and Prior Year Evaluation (low response rate)
53	Cultural and Linguistic Appropriate Services	CLAS	Network Cultural Responsiveness: Provider Trainings to Improve Care or Service Delivery	2. By December 31, 2026, CalOptima Health will provide at least one continuing education training to providers on the unique health or health care needs of: 1. At least one racial, ethnic or cultural subgroup that represents CalOptima Health members. 2. At least one gender or sexual orientation subgroup relevant to CalOptima Health members 3. Members with disabilities 4. Members in rural geographies	Healthcare Providers	1. Collaborate with a selected ethnic group to co-develop a presentation. 2. Identity presenter, determine presentation component, design relevant content and schedule training date. 3. Consult with the Dayle McIntosh Center on training opportunities for members with disabilities. 4. Incorporate strategies to improve access to care for members in rural geographies within at least one continuing education training.	1. 06/30/2026 2. 12/31/2026 3. 12/31/2026 4. 12/31/2026	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Jane Flanegan-Brown / Rocio Valencia	Manager of Provider Relations	Provider Relations and Equity and Community Health	New - Program Oversight

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54	Cultural and Linguistic Appropriate Services	CLAS	Network Cultural Responsiveness: Building and Maintaining a Responsive Work Force	1. By Dec. 31st, 2026, CalOptima Health will offer at least one training or education to employees focused on improving the quality of or experience with health care or services or reducing disparities.	CalOptima Health employees	1. Assess whether the Dec 2025 DEI training module, which had 100% active employee participation, has met this goal. 2. Identify SME's for developing or selecting training content to be hosted by CalOptima University LMS.	1. 09/30/2026 2. 12/31/2026	Report to QIHEC Q1: 01/13/2026 Q2: 04/14/2026 Q3: 07/14/2026 Q4: 10/13/2026	Michael Coringrato	Lead Training and Education Specialist	Human Resources	Yes - Program Oversight

HEDIS MY2025 Medicaid Goals

Abbrev	Medicaid HEDIS Measures	Method	HEDIS MY2024 Rpt Rate	HEDIS MY2025 Goal	Long Term Goal (90th)	Medicaid 10th percentile	Medicaid 25th percentile	Medicaid 33rd percentile	Medicaid 50th percentile	Medicaid 66th percentile	Medicaid 75th percentile	Medicaid 90th percentile
WCC	Weight Assessment and Counseling for Children/Adolescents (BMI)	H	90.83%	**91.24%**	91.24%	66.91%	75.00%	76.89%	82.73%	86.20%	87.59%	91.24%
	Nutrition	H	83.84%	**84.37%**	84.37%	51.70%	63.87%	65.94%	71.78%	76.40%	79.08%	84.37%
	Physical Activity	H	83.41%	**82.16%**	82.16%	46.23%	59.85%	62.29%	68.33%	73.97%	77.13%	82.16%
CIS	Childhood Immunization Status (comb10)	H	38.69%	**42.34%**	42.34%	18.25%	22.87%	24.39%	27.49%	31.32%	34.79%	42.34%
IMA	Immunization for Adolescents (comb2)	H	45.50%	**48.66%**	48.66%	25.41%	29.72%	31.39%	34.30%	38.69%	41.61%	48.66%
LSC	Lead Screening in Children	H	70.80%	**63.84%**	79.51%	36.22%	53.12%	58.30%	63.84%	68.74%	71.11%	79.51%
BCS-E	Breast Cancer Screening	E	59.13%	**59.51%**	0.6348	42.86%	47.93%	49.24%	52.68%	56.66%	59.51%	63.48%
CCS	Cervical Cancer Screening	H	57.86%	**60.10%**	67.46%	43.31%	49.64%	52.07%	57.18%	60.10%	61.56%	67.46%
CHL	Chlamydia Screening in Women	A	76.66%	**67.39%**	67.39%	42.61%	49.65%	51.39%	56.04%	61.07%	62.90%	67.39%
COL-E	Colorectal Cancer Screening	A	47.60%	**49.35%**	49.35%	27.27%	31.58%	34.30%	38.07%	41.59%	43.71%	49.35%
CWP	Appropriate Testing for Pharyngitis	A	52.38%	**76.71%**	89.17%	61.35%	73.85%	76.71%	80.68%	85.11%	86.26%	89.17%
PCE	Pharmacotherapy management of COPD exacerbations (Corticosteroid)	A	72.37%	**71.36%**	82.88%	55.28%	63.48%	66.86%	71.36%	74.78%	77.35%	82.88%
	Bronchodilator		88.92%	**86.54%**	89.96%	67.25%	78.79%	80.19%	83.56%	86.54%	87.93%	89.96%
AMR	Asthma Medication Ratio (5-64 years)	A	66.08%	**70.56%**	76.65%	54.56%	59.47%	62.35%	66.24%	70.56%	72.22%	76.65%
CBP	Controlling High-Blood Pressure	H	67.54%	**72.75%**	72.75%	54.61%	59.73%	61.43%	64.48%	67.40%	69.37%	72.75%
PBH	Persistence of Beta Blocker Treatment after a Heart Attack	A	62.57%	**57.39%**	67.21%	40.74%	50.82%	53.57%	57.39%	61.90%	63.12%	67.21%
SPC	Statin Therapy for Patients with Cardiovascular Disease - Therapy		81.13%	**81.42%**	85.89%	66.64%	77.92%	79.82%	81.42%	83.00%	83.86%	85.89%
	Statin Therapy for Patients with Cardiovascular Disease - Adherence	A	77.89%	**81.79%**	81.79%	59.95%	65.19%	67.42%	70.52%	74.07%	76.48%	81.79%
CRE	Cardiac Rehabilitation - initiation (MY2020)	A	0.62%	**1.72%**	13.60%	0.00%	1.11%	1.72%	2.92%	3.95%	4.91%	13.60%
	Engagement 1	A	2.69%	**4.24%**	11.88%	0.00%	1.20%	2.38%	4.24%	6.01%	7.06%	11.88%
	Engagement 2	A	3.31%	**3.81%**	9.03%	0.11%	1.39%	2.30%	3.81%	4.98%	5.81%	9.03%
	Achievement	A	1.45%	**1.28%**	4.15%	0.00%	0.30%	0.68%	1.28%	1.87%	2.34%	4.15%
GSD	HbA1c Control for Patients with Diabetes - Poor Control (>9.0%)	H	30.92%	**27.01%**	27.01%	47.65%	40.15%	37.47%	33.33%	30.90%	29.93%	27.01%
	HbA1c Control (<8.0%)	H	61.60%	**59.64%**	63.50%	44.25%	51.58%	54.50%	57.42%	59.64%	60.83%	63.50%
EED	Eye Exam for patient with Diabetes	H	64.34%	**64.06%**	64.06%	40.39%	45.74%	49.15%	53.53%	57.09%	59.41%	64.06%
BPD	Blood Pressure Controlled for Patients with Diabetes	H	70.07%	**77.37%**	77.37%	58.15%	62.53%	65.32%	68.75%	71.78%	73.59%	77.37%
KED	Kidney Health Evaluation for Patients with Diabetes		51.02%	**45.11%**	49.72%	26.79%	30.63%	33.00%	36.46%	42.10%	45.11%	49.72%
SPD	Statin Therapy for Patients with Diabetes - therapy	A	73.15%	**71.41%**	71.41%	51.96%	60.83%	62.66%	65.28%	67.01%	68.12%	71.41%
	Statin Therapy for Patients with Diabetes - adherence		73.20%	**73.39%**	79.73%	53.23%	61.38%	64.18%	68.06%	70.91%	73.39%	79.73%
AMM	Antidepressant Medications Management (Acute Phase Treatment)	A	67.21%	**68.35%**	76.76%	49.86%	56.34%	58.37%	62.43%	65.60%	68.35%	76.76%
	Continuation Phase Treatment		50.64%	**48.16%**	61.06%	31.52%	38.63%	41.00%	44.25%	48.16%	50.14%	61.06%
ADD-E	Follow-up Care for Children Prescribed ADHD Medication (Initiation Phase)	A	50.35%	**48.96%**	55.40%	34.62%	41.30%	42.51%	45.72%	47.74%	48.96%	55.40%
	Continuation Phase		58.69%	**53.90%**	63.49%	37.19%	45.78%	48.94%	53.90%	56.83%	59.13%	63.49%
DMH	Diagnosed Mental Health Disorders	A	18.98%	**23.90%**	39.71%	17.78%	21.65%	23.90%	27.69%	31.55%	33.77%	39.71%
DSU	Diagnosed Substance Use Disorders (any)	A	3.43%	**4.97%**	11.47%	2.11%	4.30%	4.97%	6.44%	8.02%	8.90%	11.47%
FUI	Follow-up After High-Intensity Care for Substance Use Disorder (30-day) - (MY2019)	A	30.69%	**44.53%**	69.82%	31.71%	40.07%	44.53%	53.28%	59.90%	63.69%	69.82%
	Follow-up After High-Intensity Care for SUD (7-day)		13.65%	**26.90%**	50.80%	15.91%	23.08%	26.90%	32.34%	37.64%	41.53%	50.80%
FUM	Follow-up After ED visit for Mental Illness (30-day)	A	52.33%	**53.82%**	73.12%	36.32%	46.05%	49.22%	53.82%	59.65%	63.06%	73.12%
	Follow-up After ED visit for Mental Illness (7-day)	A	32.96%	**33.01%**	59.95%	21.19%	29.99%	33.01%	38.62%	44.33%	49.49%	59.95%
FUA	Follow-up After ED visit for Alcohol and Other Drug Dependence 30-day		28.63%	**36.18%**	49.40%	21.41%	26.79%	29.07%	36.18%	39.35%	41.86%	49.40%
	Follow-up After ED visit for Alcohol and Other Drug Dependence 7-day	A	16.81%	**18.76%**	37.47%	12.73%	16.74%	18.76%	24.00%	27.62%	29.09%	37.47%
POD	Pharmacotherapy for Opioid Use Disorder (MY2019)	A	4.93%	**21.36%**	36.71%	12.05%	18.18%	21.36%	25.28%	29.01%	31.78%	36.71%
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are using Antipsychotic medications	A	76.86%	**79.51%**	87.27%	75.46%	78.06%	79.51%	81.42%	83.51%	84.63%	87.27%
SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia	A	76.33%	**75.47%**	79.49%	60.89%	66.75%	68.75%	71.27%	73.74%	75.47%	79.49%
SMC	Cardiovascular Monitoring for People with Cardiovascular and Schizophrenia	A	80.82%	**79.55%**	87.50%	67.39%	74.30%	76.36%	79.55%	81.40%	83.44%	87.50%
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	A	69.86%	**74.83%**	74.83%	44.65%	56.14%	58.60%	62.56%	66.15%	68.08%	74.83%
APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Glucose	A	55.57%	**58.64%**	68.79%	46.17%	50.74%	52.20%	56.59%	58.64%	61.05%	68.79%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics - cholesterol		35.76%	**43.06%**	54.29%	27.42%	30.97%	32.99%	37.62%	43.06%	44.70%	54.29%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics - Total		34.58%	**41.41%**	52.57%	25.86%	29.41%	30.92%	35.59%	41.41%	43.58%	52.57%
NCS	Non-Recommended CCS in Adolescent Females	A	N/A	**0.15%**	0.05%	0.83%	0.53%	0.45%	0.31%	0.21%	0.15%	0.05%
URI	Appropriate Treatment for URI	A	86.38%	**89.13%**	94.15%	80.14%	86.50%	87.38%	89.13%	91.27%	92.47%	94.15%
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis*	A	39.70%	**56.76%**	77.66%	49.48%	54.94%	56.76%	62.14%	67.03%	69.28%	77.66%
LBP	Use of Imaging Studies for Low Back Pain*	A	72.21%	**74.09%**	78.72%	64.77%	67.07%	67.84%	70.55%	72.74%	74.09%	78.72%
HDO	Use of Opioids at High Dosage	A	2.08%	**2.14%**	0.75%	13.18%	7.73%	6.15%	3.95%	2.14%	1.51%	0.75%
UOP	Use of Opioids From Multiple Providers - multiple Prescribers	A	20.47%	**18.61%**	12.85%	26.98%	23.01%	21.50%	18.61%	16.67%	15.79%	12.85%
	Multiple Pharmacies		1.88%	**3.14%**	1.44%	6.27%	4.29%	3.74%	3.14%	2.27%	1.95%	1.44%

	Multiple Prescribers and Pharmacies		1.39%	**1.83%**	0.63%	4.21%	2.73%	2.44%	1.83%	1.22%	1.02%	0.63%
COU	Risk of Continued Opioid Use (MY2018) - 15 days	A	6.18%	**6.04%**	2.46%	10.37%	7.98%	7.23%	6.04%	4.80%	3.92%	2.46%
	Risk of Continued Opioid Use - 31 days	A	2.77%	**2.79%**	1.17%	6.06%	4.85%	4.14%	3.39%	2.79%	2.29%	1.17%
AAP	Adults' Access to Preventive/Ambulatory Health Services (20-44)	A	N/A	**67.52%**	80.42%	57.20%	65.41%	67.52%	71.68%	75.08%	76.68%	80.42%
	Adults' Access to Preventive/Ambulatory Health Services (45-64)	A	N/A	**77.77%**	87.18%	69.81%	75.97%	77.77%	81.07%	83.79%	84.89%	87.18%
	Adults' Access to Preventive/Ambulatory Health Services (65+)	A	N/A	**80.72%**	93.29%	67.01%	73.46%	75.67%	80.72%	86.11%	89.17%	93.29%
	Adults' Access to Preventive/Ambulatory Health Services (Total)	A	62.94%	**71.01%**	83.25%	62.61%	69.16%	71.01%	74.88%	78.35%	79.54%	83.25%
PPC	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	H	88.15%	**88.58%**	91.85%	73.48%	79.81%	81.94%	84.55%	86.89%	88.58%	91.85%
	Prenatal and Postpartum Care (Postpartum Care)	H	81.11%	**80.23%**	86.62%	68.63%	75.67%	77.37%	80.23%	82.48%	83.33%	86.62%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	A	53.10%	**54.55%**	74.14%	41.57%	48.98%	54.55%	60.22%	64.10%	67.06%	74.14%
W30	Well-Child Visits in the First 30 Months of Life (MY2020) 0-15 months	A	70.28%	**60.38%**	69.67%	46.98%	54.46%	57.15%	60.38%	63.29%	64.99%	69.67%
	Well-Child Visits in the First 30 Months of Life - 15-30 months	A	74.40%	**73.09%**	79.94%	59.69%	65.53%	66.79%	69.43%	71.93%	73.09%	79.94%
WCV	Child and Adolescent Well-Care Visits (MY2020) 3-11 years	A	N/A	**62.76%**	70.95%	49.07%	53.50%	55.27%	59.40%	62.76%	65.39%	70.95%
	Child and Adolescent Well-Care Visits (MY2020) 12-17 years	A	N/A	**58.92%**	65.37%	41.90%	46.77%	48.09%	52.39%	56.22%	58.92%	65.37%
	Child and Adolescent Well-Care Visits (MY2020) 18-21 years	A	N/A	**30.69%**	42.37%	19.73%	23.24%	25.08%	27.90%	30.69%	33.78%	42.37%
	Child and Adolescent Well-Care Visits (MY2020) Total	A	55.46%	**55.29%**	64.74%	41.83%	46.57%	48.15%	51.81%	55.29%	58.07%	64.74%
AXR	Antibiotic Utilization for Respiratory Conditions		N/A	**24.21%**	33.84%	16.70%	21.98%	24.21%	26.62%	29.47%	30.89%	33.84%
PCR	Plan All-Cause Readmissions 18-64 (new in 2018)		N/A	**0.8937**	0.8188	1.1783	1.0652	1.029	0.9619	0.9124	0.8937	0.8188
DSF-E	Depression Screening and Follow-up for Adolescents and Adults - Screening 12-17	E	N/A	**15.28%**	15.28%	0.00%	0.00%	0.03%	0.16%	1.20%	2.69%	15.28%
	Depression Screening and Follow-up for Adolescents and Adults - Screening 18-64	E	N/A	**16.48%**	16.48%	0.00%	0.09%	0.32%	1.39%	3.30%	4.71%	16.48%
	Depression Screening and Follow-up for Adolescents and Adults - Screening 65+	E	N/A	**27.33%**	27.33%	0.00%	0.26%	0.63%	1.83%	4.98%	9.14%	27.33%
	Depression Screening and Follow-up for Adolescents and Adults -Screening Total		8.65%	**16.22%**	16.22%	0.00%	0.09%	0.32%	1.03%	2.67%	4.52%	16.22%
DSF-E	- Follow up 12-17	E	N/A	**93.49%**	93.49%	71.61%	78.32%	80.67%	83.03%	87.37%	89.03%	93.49%
	- Follow up 18-64	E	N/A	**84.14%**	84.14%	47.37%	56.76%	62.50%	70.76%	77.03%	78.32%	84.14%
	- Follow up 65+	E	N/A	**45.85%**	82.24%	32.50%	41.03%	45.85%	52.51%	61.36%	65.85%	82.24%
	- Follow up Total		82.12%	**77.07%**	87.39%	48.28%	58.11%	65.70%	70.91%	77.07%	78.82%	87.39%
DMS-E	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Period 1	E	N/A	**17.60%**	17.60%	0.00%	0.04%	0.33%	1.38%	3.21%	6.12%	17.60%
	Period 2	E	N/A	**17.26%**	17.26%	0.00%	0.00%	0.09%	0.87%	4.55%	6.77%	17.26%
	Period 3	E	N/A	**18.76%**	18.76%	0.00%	0.00%	0.10%	0.79%	2.96%	5.22%	18.76%
	Total	E	N/A	**18.91%**	18.91%	0.00%	0.08%	0.34%	0.93%	3.95%	6.95%	18.91%
DRR-E	Depression Remission or Response for Adolescents and Adults - Follow-up	E	N/A	**50.00%**	50.00%	3.17%	8.29%	14.81%	26.68%	39.71%	43.42%	50.00%
	remission		N/A	**12.55%**	12.55%	0.00%	1.06%	2.23%	4.17%	5.56%	7.02%	12.55%
	Response		N/A	**14.05%**	18.09%	0.00%	2.70%	4.39%	7.89%	11.91%	14.05%	18.09%
AIS-E	Adult Immunization Status - influenza 19-65	E	N/A	**24.63%**	24.63%	7.39%	10.77%	12.40%	14.75%	17.16%	18.34%	24.63%
	Adult Immunization Status - influenza 66+		N/A	**40.88%**	50.10%	16.67%	25.49%	28.57%	35.15%	40.88%	43.21%	50.10%
	Adult Immunization Status - influenza Tota		17.98%	**26.40%**	26.40%	7.39%	10.98%	12.55%	15.53%	17.91%	19.80%	26.40%
	Adult Immunization Status - Tdap 19-65		N/A	**33.84%**	57.96%	22.14%	30.59%	33.84%	38.39%	47.72%	50.74%	57.96%
	Adult Immunization Status - Tdap 66+		N/A	**23.01%**	49.82%	14.73%	20.25%	23.01%	27.90%	35.23%	39.52%	49.82%
	Adult Immunization Status - Tdap Total		38.36%	**33.40%**	57.67%	21.26%	30.35%	33.40%	38.12%	47.30%	50.31%	57.67%
	Adult Immunization Status - Zoster 50-65		N/A	**19.39%**	19.39%	2.20%	4.72%	6.38%	9.75%	13.35%	14.18%	19.39%
	Adult Immunization Status - Zoster 66+		N/A	**19.13%**	31.32%	3.85%	8.45%	10.22%	14.69%	19.13%	21.72%	31.32%
	Adult Immunization Status - Zoster Tota		18.49%	**20.56%**	20.56%	2.23%	5.30%	7.15%	10.67%	13.49%	15.79%	20.56%
	Adult Immunization Status - Pneumococcal 66+		N/A	**38.73%**	68.07%	21.04%	35.13%	38.73%	44.41%	55.03%	58.18%	68.07%
PRS-E	Prenatal Immunization Status - Influenza		21.75%	**29.96%**	38.51%	11.45%	17.30%	19.74%	25.10%	29.14%	31.99%	38.51%
	Prenatal Immunization Status - Tdap	E	45.82%	**53.86%**	76.54%	29.65%	43.16%	48.95%	56.53%	63.41%	67.22%	76.54%
	Prenatal Immunization Status - Comb		18.03%	**25.81%**	35.60%	8.42%	13.37%	15.96%	20.85%	24.92%	27.64%	35.60%
PND-E	Prenatal Depression Screening and Follow-up - Screening	E	13.98%	**16.03%**	41.38%	0.00%	0.24%	1.13%	5.62%	12.29%	16.03%	41.38%
	Follow-up	E	77.53%	**53.33%**	66.67%	31.82%	41.90%	45.21%	50.98%	53.33%	57.68%	66.67%
PDS-E	Postpartum Depression Screening and Follow-up - screening		9.24%	**29.84%**	29.84%	0.00%	0.08%	0.25%	1.30%	5.75%	8.80%	29.84%
PDS-E	Postpartum Depression Screening and Follow-up - follow-up	E	87.14%	**61.70%**	84.44%	40.85%	51.30%	54.69%	61.70%	69.68%	71.88%	84.44%
RDM	Race/Ethnicity Diversity of Membership - Race Direct Tota	A	N/A	**70.92%**	99.97%	43.11%	62.41%	70.92%	79.15%	90.44%	93.86%	99.97%
	Race/Ethnicity Diversity of Membership - Ethinicity Direct Tota	A	N/A	**67.53%**	100.00%	4.33%	24.64%	44.96%	67.53%	91.23%	97.32%	100.00%

HEDIS MY2025 Medicare Goals

Abbrev	Medicare HEDIS Measures	Method	MY2024 HEDIS Reported Rate	MY2025 HEDIS Goals	Long Term HEDIS Goal (90th)	Medicare 33rd percentile	Medicare 50th percentile	Medicare 66th percentile	Medicare 75th percentile	Medicare 90th percentile	3-Star	4-Star	5-Star
BCS-E	Breast Cancer Screening	E	68.52%	75%	82%	67.84%	71.88%	75.65%	78.57%	82.80%	67%	75%	82%
COL-E	Colorectal Cancer Screening - Total		N/A	70.33%	82.33%	65.21%	70.33%	74.94%	77.86%	82.33%			
	Colorectal Cancer Screening - aged 50-75 (C02)	H	66.94%	75%	83%	66.37%	70.95%	75.56%	78.35%	82.44%	65%	75%	83%
COA	Care for Older Adults (SNP) - Medication Review (C09)	H	N/A	92%	98%						80%	92%	98%
	Care for Older Adults (SNP) - Pain assessment (C11)	H	N/A	92%	96%						81%	92%	96%
CWP	Appropriate Testing for Pharyngitis	A	N/A	72.5%	85.60%	72.51%	75.18%	78.10%	80.65%	85.60%			
SPR	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	A	N/A	23.42%	35.92%	23.42%	26.38%	28.96%	31.09%	35.92%			
PCE	Pharmacotherapy management of COPD exacerbations (Corticosteroid)	A	73.88%	71.19%	83.81%	71.19%	74.17%	77.07%	78.44%	83.81%			
	Bronchodilator		93.28%	91.70%	91.70%	82.57%	85.00%	87.18%	88.15%	91.70%			
CBP	Controlling High-Blood Pressure	H	77.26%	80%	85%	72.51%	75.18%	78.10%	80.65%	85.60%	74%	80%	85%
SPC	Disease - Therapy	A	86.13%	88%	92%	84.90%	86.25%	87.50%	88.48%	91.11%	85%	88%	92%
	Statin Therapy for Patients with Cardiovascular Disease - Adherence	A	81.95%	84.18%	92.45%	84.18%	85.93%	87.99%	89.12%	92.45%			
CRE	Cardiac Rehabilitation - initiation (MY2020)	A	1.25%	2.27%	15.95%	2.27%	3.38%	5.63%	6.90%	15.95%			
	Engagement 1	A	5.00%	2.90%	21.37%	2.90%	5.53%	8.61%	11.29%	21.37%			
	Engagement 2	A	6.25%	3.05%	17.77%	3.05%	5.99%	8.99%	10.23%	17.77%			
	Achievement	A	3.75%	2.90%	21.37%	2.90%	5.53%	8.61%	11.29%	21.37%			
GSD	HbA1c Control for Patients with Diabetes - Poor Control (>9.0%) (C15)	H	15.52%	10%	10%	21.17%	17.03%	13.54%	12.24%	9.60%	28%	16%	10%
	HbA1c Control for Patients with Diabetes - Control (<8.0%)	H	72.84%	72.99%	81.02%	69.28%	72.99%	75.86%	77.68%	81.02%			
EED	Eye Exam for Patients with Diabetes(C13)	H	77.61%	77%	83%	69.10%	74.70%	78.59%	81.03%	85.89%	70%	77%	83%
BPD	Blood Pressure Control for patients with Diabetes (C16)	H	75.22%	78.00%	85.96%	71.43%	74.45%	78.00%	80.05%	85.96%			
KED	Kidney Health Evaluation for Patients with Diabetes (MY2020)	A	59.30%	59%	72%	45.73%	52.73%	58.85%	63.04%	72.00%			
SPD	Statin Therapy for Patients with Diabetes - Therapy	A	83.01%	83.05%	85.74%	77.73%	79.65%	81.85%	83.05%	85.74%			
	Statin Therapy for Patients with Diabetes - Adherence	A	79.64%	82.42%	91.72%	82.42%	84.43%	86.52%	87.85%	91.72%			
OMW	Osteoporosis Management in Women Who Had a Fracture (C12)	A	43.64%	39%	71%	34.00%	43.81%	52.72%	57.09%	71.62%	39%	52%	71%
OSW	Osteoporosis Screening in Older Women (MY2020)	A	49.33%	49.08%	68.41%	43.24%	49.08%	57.30%	59.58%	68.41%			
AMM	Antidepressant Medications Management (Acute Phase Treatment)	A	73.71%	78.39%	88.71%	78.39%	81.14%	84.09%	85.65%	88.71%			
	Continuation Phase Treatment		58.22%	62.58%	76.27%	62.58%	65.08%	69.02%	70.53%	76.27%			
FUH	Follow-up After Hospitalization for Mental Illness (30-day)	A	61.61%	56.55%	71.46%	41.27%	48.48%	56.55%	60.38%	71.46%			
	Follow-up After Hospitalization for Mental Illness (7-day)		38.39%	33.52%	50.78%	22.58%	26.67%	33.52%	36.91%	50.78%			
FUI	Follow-up After High-Intensity Care for Substance Use Disorder (30-day)	A	N/A	34.69%	59.38%	34.69%	38.89%	44.12%	47.39%	59.38%			
	Follow-up After High-Intensity Care for SUD (7-day)		N/A	15.79%	37.07%	15.79%	19.60%	24.53%	27.19%	37.07%			
FUM	Follow-up After ED visit for Mental Illness (30-day)		51.16%	49.23%	71.63%	43.17%	49.23%	55.56%	59.06%	71.63%			
	Follow-up After ED visit for Mental Illness (7-day)	A	25.58%	32.57%	57.58%	26.74%	32.57%	39.31%	44.68%	57.58%			
FUA	Follow-up After ED visit for Alcohol and Othe Drug Dependence (new 2017) - 30-day	A	43.75%	38.00%	51.61%	33.54%	38.00%	42.57%	44.71%	51.61%			
	Follow-up After ED visit for Alcohol and Othe Drug Dependence (new 2017) - 7-day	A	18.75%	26.90%	36.67%	20.00%	23.21%	26.90%	29.82%	36.67%			
SAA	Adherence to Antipsychotic medications for Individuals with Schizophrenia	A	79.47%	77.90%	87.32%	75.00%	77.90%	80.91%	82.64%	87.32%			
TRC	Transitions of Care (new 2018) - Notification Admission	H	23.60%	30%	78.87%	29.93%	41.73%	56.69%	65.45%	78.87%			
	Receipt Discharge Info	H	14.84%	15%	61.80%	15.09%	24.33%	33.65%	39.91%	61.80%			
	Engmt after discharge	H	82.24%	86%	93.92%	82.14%	85.54%	89.05%	90.83%	93.92%			
	Med Reconciliation	H	57.42%	73%	87%	63.02%	73.27%	81.57%	84.43%	91.73%	57%	73%	87%
	Average		N/A	52%	77%						52%	63%	77%
FMC	Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions		55.62%	53%	69%	52.96%	56.44%	59.75%	62.19%	72.09%	53%	60%	69%
ACP	Advance Care Planning (MY2022)		N/A	42.62%	85.07%	32.56%	42.62%	53.52%	60.32%	85.07%			
PSA	Non-Recommended PSA-Based Screening in Older Men	A	40.33%	35.10%	11.90%	35.10%	29.32%	24.16%	20.75%	11.90%			
URI	Appropriate Treatment for URI (MY2019)	A	N/A	65.16%	84.00%	59.37%	65.16%	71.72%	74.57%	84.00%			
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis (MY2019)	A	N/A	47.50%	47.50%	27.45%	30.77%	35.07%	37.16%	47.50%			
DDE	Potentially Harmful Drug-Disease Interactions in Old Adults	A	35.27%	25.79%	25.79%	34.80%	32.36%	29.80%	28.68%	25.79%			
DAE	Use of high-risk medications in Old Adults		15.46%	13.75%	9.96%	19.55%	16.19%	13.75%	12.73%	9.96%			
HDO	Use of Opioids at High Dosage	A	2.19%	3.00%	1.19%	5.73%	4.13%	3.00%	2.33%	1.19%			
UOP	Use of Opioids From Multiple Providers - multiple Prescribers	A	17.80%	13.92%	7.41%	16.45%	13.92%	11.48%	10.00%	7.41%			
	Multiple Pharmacies	A	1.09%	1.16%	0.00%	2.13%	1.62%	1.16%	0.85%	0.00%			

	Multiple Prescribers and Pharmacies	A	0.47%	0.96%	0.00%	0.96%	0.61%	0.39%	0.21%	0.00%			
COU	Risk of Continued Opioid Use (MY2018) >= 15 days	A	N/A	13.64%	8.86%	15.30%	13.64%	12.22%	11.38%	8.86%			
	Risk of Continued Opioid Use >= 31 days	A	N/A	6.88%	4.76%	9.16%	7.86%	6.88%	6.17%	4.76%			
AAP	Adults' Access to Preventive/Ambulatory Health Services (age 20-44)	A	N/A	91.03%	96.26%	89.51%	91.03%	92.31%	93.46%	96.26%			
	Adults' Access to Preventive/Ambulatory Health Services (age 45-64)		N/A	95.89%	99.70%	94.60%	95.89%	96.95%	97.44%	99.70%			
	Adults' Access to Preventive/Ambulatory Health Services (age 65+)		N/A	93.77%	99.83%	93.77%	95.48%	96.68%	97.27%	99.83%			
	Adults' Access to Preventive/Ambulatory Health Services (Total)		92.24%	93.67%	99.69%	93.67%	95.44%	96.55%	97.13%	99.69%			
IET	Initiation of Alcohol and Other Drug Dependence Treatment	A	29.38%	30.54%	52.89%	30.54%	36.44%	41.88%	45.00%	52.89%			
	Engagement of Alcohol and Other Drug Dependence Treatment		4.84%	4.24%	10.07%	2.81%	4.24%	5.84%	6.67%	10.07%			
PCR	Plan All-Cause readmissions - 18+	A	N/A	10%	8%	1.0848	1.0244	0.9665	0.9371	0.8357	12%	10%	8%
HFS	Hospitalization following discharge From a Skilled Nursing Facility - 30 rehospitalization 65+		N/A	1.0319	0.7202	1.116	1.0319	0.9275	0.8822	0.7202			
	Hospitalization following discharge From a Skilled Nursing Facility - 60 rehospitalization 65+		N/A	0.9648	0.7994	1.1294	1.0651	0.9648	0.923	0.7994			
HPC	Hospitalization for Potentially Preventable Complications - DMC15		N/A	0.4114	0.338	0.6399	0.5341	0.4631	0.4114	0.338			
DSF-E	Depression Screening and Follow-up for Adolescents and Adults -screening	E	N/A	54.28%	54.28%	0.00%	1.03%	5.34%	9.79%	54.28%			
	follow-up		N/A	52.17%	89.23%	52.17%	64.31%	71.29%	75.00%	89.23%			
DMS-E	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults - Period 1	E	N/A	5.72%	43.34%	0.00%	1.36%	5.72%	10.49%	43.34%			
AIS-E	Adult Immunization Status - influenza 19-65	E	N/A	55.02%	55.02%	22.42%	28.86%	36.97%	41.54%	55.02%			
	Adult Immunization Status - influenza 66+	E	44.10%	53.11%	66.07%	25.53%	35.72%	46.54%	53.11%	66.07%			
	Adult Immunization Status - influenza Total	E	N/A	49.12%	64.00%	24.16%	33.40%	44.73%	49.12%	64.00%			
	Adult Immunization Status - Tdap 19-65	E	N/A	34.03%	56.03%	15.43%	23.74%	34.03%	39.84%	56.03%			
	Adult Immunization Status - Tdap 66+	E	41.24%	28.79%	49.31%	13.74%	20.13%	28.79%	34.56%	49.31%			
	Adult Immunization Status - Tdap Total	E	N/A	31.56%	51.37%	14.35%	21.25%	31.56%	35.97%	51.37%			
	Adult Immunization Status - Zoster 50-65	E	N/A	33.34%	33.34%	2.03%	6.86%	15.19%	19.55%	33.34%			
	Adult Immunization Status - Zoster 66+	E	24.43%	24.38%	42.39%	1.98%	8.07%	18.49%	24.38%	42.39%			
	Adult Immunization Status - Zoster Total	E	N/A	40.94%	40.94%	2.07%	7.70%	17.78%	23.46%	40.94%			
	Adult Immunization Status - Pneumococcal 66+	E	45.08%	56.76%	75.29%	30.00%	42.29%	56.76%	62.32%	75.29%			

2026 Population Health Management (PHM) Strategy & Work Plan

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INTRODUCTION

Organization Overview

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

Our Mission

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

Our Vision

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

CalOptima Health's Strategic Plan

The organization's 2025–2027 Strategic Plan prioritizes population health by leveraging technology and data to strengthen health equity, implementing consistent care models, expanding preventive services for vulnerable groups, and annually assessing member needs to guide targeted interventions. Health equity is integrated throughout all initiatives, ensuring proactive, data-driven approaches to close care gaps and improve outcomes for every member.

Strategy Purpose

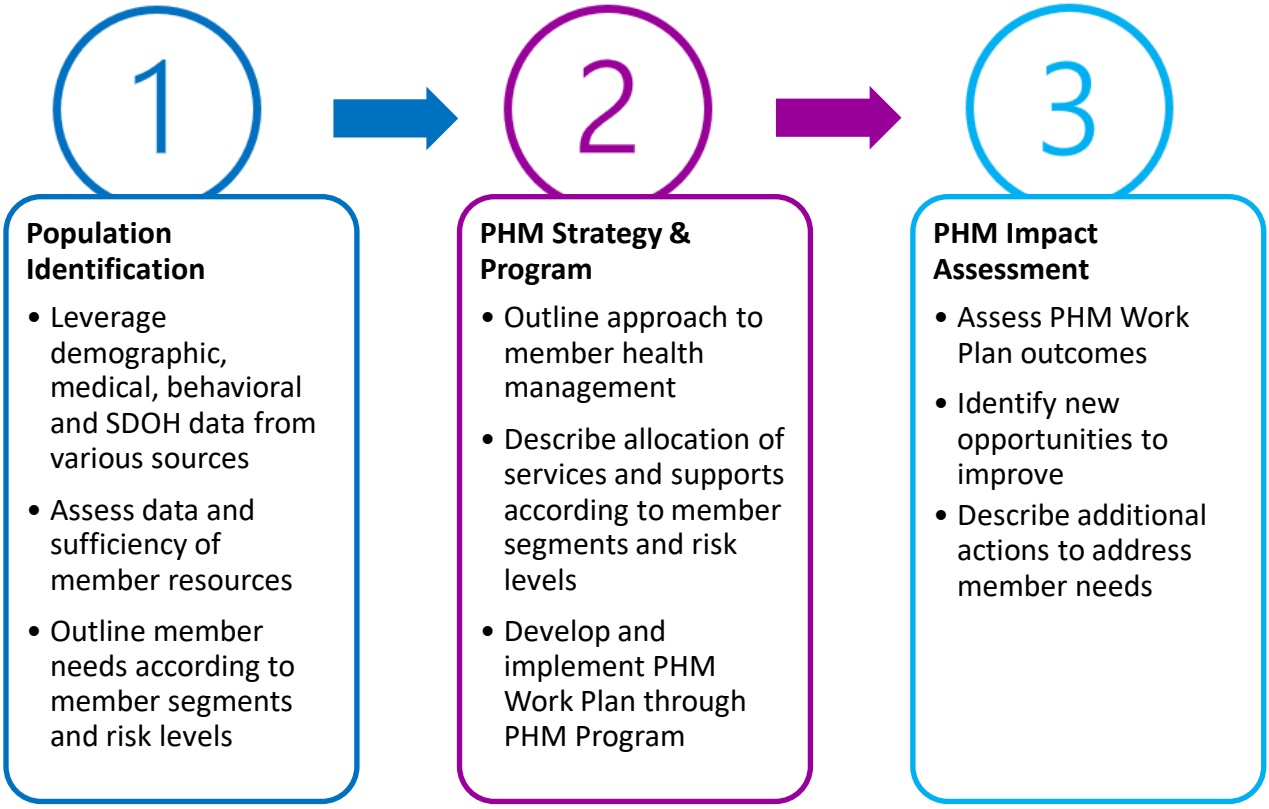
The PHM Strategy outlines CalOptima Health's cohesive plan of action to address the needs of our members across the continuum of care. Through the PHM Strategy and our commitment to health equity, CalOptima Health also incorporates an upstream approach to address social determinants of health (SDOH) and close gaps in care that lead to health disparities among our members. For each focus area, CalOptima Health establishes annual measurable goals based on member needs and aligned with Department of Health Care Services (DHCS) and National Committee for Quality Assurance (NCQA) quality priorities.

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

1. Keeping members healthy
2. Managing members with emerging risks
3. Increasing patient safety or outcomes across settings
4. Managing members with multiple chronic conditions

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.

Member Screenings and Assessments

Screening and assessment activities are conducted for newly enrolled Medi-Cal members within 90 days of enrollment. Outreach includes three attempts: mailing the Health Information Form/Member Evaluation Tool (HIF/MET), followed by two reminders.

The Initial Health Appointment (IHA) is a comprehensive assessment conducted during the members' first visit with their assigned or selected PCP and must be delivered in a culturally and linguistically appropriate manner. In accordance with DHCS guidance, primary care visits and screenings serve as proxy measures for IHA and HIF/MET completion. IHA Text and interactive voice response (IVR) campaigns reached thousands of new members monthly.

In addition, CalOptima Health works to understand a member's risk. Based on the results of the risk stratification algorithm and the analysis of the identified high-risk population, members are outreached to complete a Health Risk Assessment (HRA) survey, which includes three phone calls and a follow-up letter if contact is unsuccessful. When obtained, the HRA results are shared with the Health Network. Health Networks are required to share the HRA with the Primary Care Provider (PCP).

High-risk members without an identified intervention remain a priority for completing HRAs and Health Needs Assessments (HNAs), to ensure that no member falls through the cracks. These assessments help identify members who may benefit from wellness services such as health coaching, disease management, or referrals to behavioral health and social support programs. Screening and assessment activities are tracked through CalOptima Health's medical management platform, which monitors completion rates and supports timely outreach.

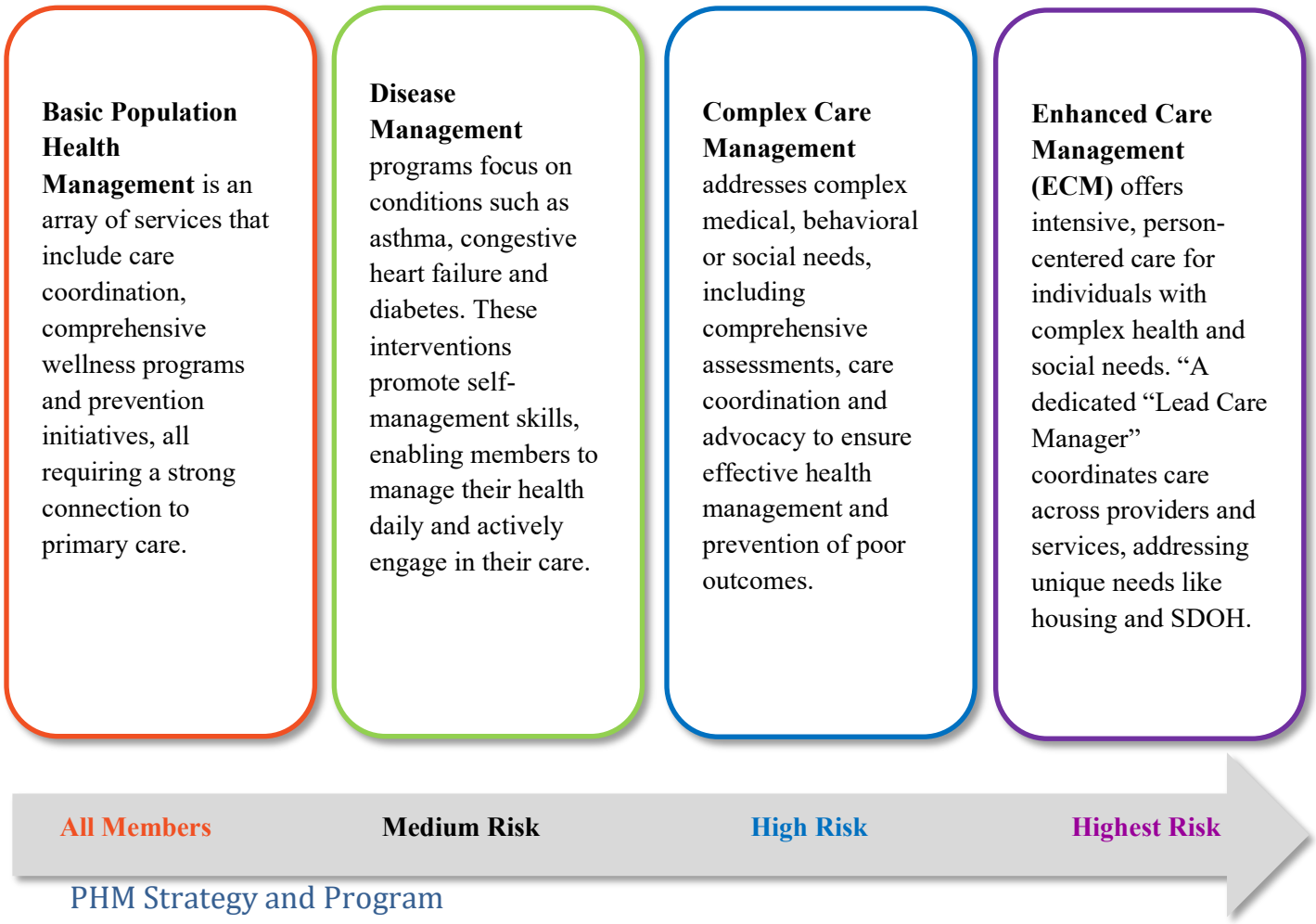
Population Segmentation and Care Coordination

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 Section of the Quality Improvement (QI) Work Plan

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

The following outlines CalOptima Health's 2026 PHM section of the QI Work Plan:

Keeping Members Healthy

- Keeping Children Healthy
- Maternal Health Program

Emerging Risk

- Disease Management Program

Patient Safety or Outcomes Across Settings

- CalAIM Enhanced Case Management and Community Supports
- Street Medicine Program
- Behavioral Health Services
- Transitional Care Services
- Emergency Department Pilot Program

Managing Multiple Chronic Conditions

- Complex Case Management Program

PHM Program

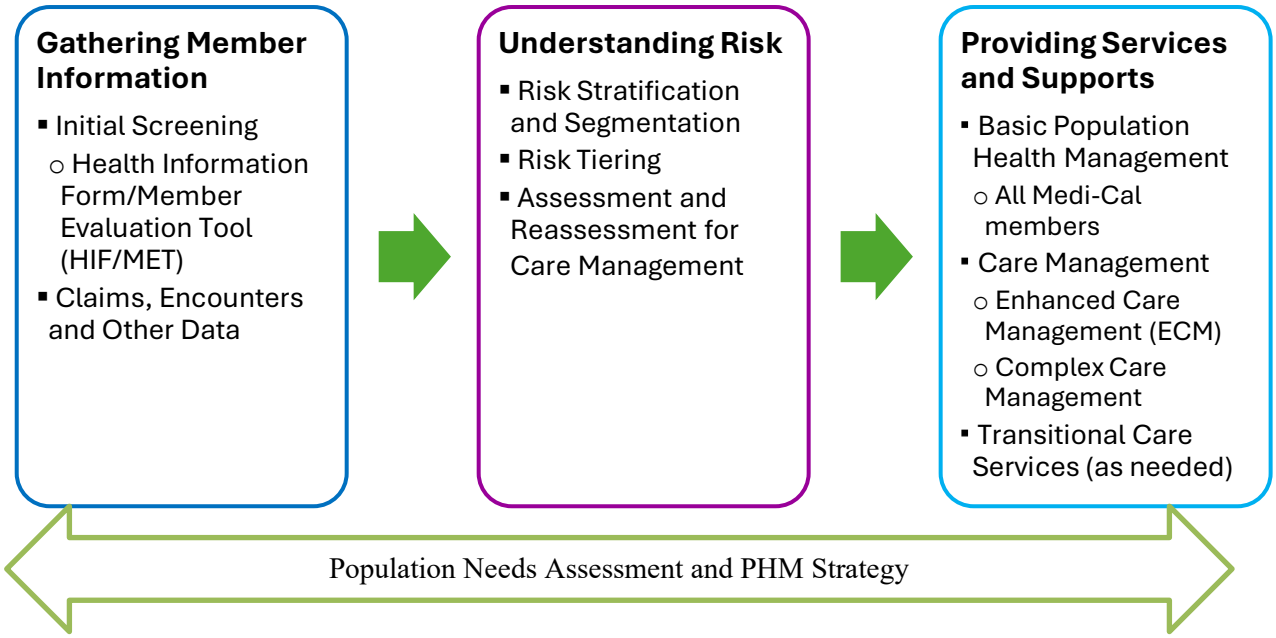
The PHM Strategy guides CalOptima Health's PHM Program. Our PHM Program and related services are developed by a multidisciplinary team of health professionals, community partners and stakeholders. Together, we ensure that our PHM Program is committed to health equity, member involvement and accountability.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

- Building trust and meaningful engagement with members.
- Using data-driven risk stratification and predictive analytics to address gaps in care.
- Revising and standardizing assessment processes.
- Offering care management services for all high-risk members.
- Creating robust transitional care services (TCS) to ensure members are supported from discharge planning to obtain needed services and supports.
- Developing effective strategies to address health disparities, SDOH and upstream drivers of health.
- Implementing interventions to support health and wellness for all members, including health education supports and self-management tools.

PHM Framework

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

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



PHM Program Coordination

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

- Behavioral Health Integration
- Case Management
- Long-Term Support Services (LTSS)
- Program of All-Inclusive Care for the Elderly (PACE)
- Pharmacy
- Utilization Management

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

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

Additionally, CalOptima Health uses real-time information on hospital and emergency department admissions and discharges, enabling care teams to act swiftly and effectively to identify high-risk individuals in need of follow-up, prioritizes outreach and supports seamless care transitions. This proactive approach helps reduce readmissions and ensures timely, targeted engagement for members with complex care needs.

Informing Members and Practitioners About PHM Programs

CalOptima Health uses multiple interactive methods to inform both members and practitioners about PHM programs, including program eligibility and how to access services. Practitioners are informed through provider news alerts, the CalOptima Health website, regular meetings and office visits.

Members receive information based on their language preferences through various channels: the Member Welcome Packet, newsletters, program letters, benefit manuals, the member website, text messages, personal phone calls, robocalls and in-person outreach. All PHM programs are voluntary.

Key elements include:

- Eligibility: Medi-Cal and OneCare members who meet program criteria are referred to appropriate staff for enrollment support.
- Service Use: Instructions are provided in multiple languages and tailored to appropriate health literacy levels.
- Voluntary Participation: Members may self-refer or opt out at any time. Outreach efforts clearly state that participation is voluntary.

PHM Impact Assessment

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

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

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

PROMOTING HEALTH EQUITY AND ADDRESSING HEALTH DISPARITIES

CalOptima Health is committed to advancing health equity and serving members with the excellence, dignity and care they deserve. This commitment extends into the heart of the communities our members call home. To advance health outcomes and drive meaningful impact, our health equity strategic framework is anchored in five focus areas:

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

CalOptima Health has operationalized our health equity efforts through a broad range of programs and services. Based on health outcomes identified in the 2025 Population Needs Assessment and 2025 PHM Impact Report, the 2026 PHM section of the QI Work Plan will focus on addressing the following health disparities:

- Increasing Childhood Immunizations and Well Child Visits for Black, White, and Native Hawaiian/Other Pacific Islander members through multi-modal outreach, member education, vaccine hesitancy resources, proactive engagement before HEDIS milestones, automated data exchange via Cozeva, and culturally tailored campaigns.
- Increasing Cervical Cancer Screening rates for Native Hawaiian/Other Pacific Islander members through targeted cancer screening mailers, enhanced text messaging campaigns, in-person engagement with Cancer Program grantees, impactful success story sharing, clinic partnerships with mobile mammogram services, program effectiveness evaluation, and robust reporting on cancer detection and stages.
- Increasing access and engagement to primary care, ECM, and housing services for members experiencing homelessness through integrated Street Medicine, coordinated ECM and housing navigation, and streamlined support for continuity of care and housing readiness.

Additional details about these goals and interventions can be found in the 2026 PHM section of the QI Work Plan.

PHM Activities and Resources

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

In addition, CalOptima Health conducts activities that are designed to support the PHM Strategy, including activities not directed at individual members. Building partnerships with community-based organizations, local health care agencies, hospitals and clinics, universities and others to streamline efforts and leverage resources. Examples of these activities are described below:

Continuous Provider Education, Training and Professional Development

CalOptima Health advances patient care by equipping providers with the knowledge and skills needed to deliver culturally responsive, person-centered care. Our Continuing Medical Education (CME) and Continuing Education (CE) programs offer in-person and virtual training for health networks, providers, community partners, and CalOptima Health staff. These evidence-based sessions not only fulfill regulatory requirements but also promote health equity by addressing disparities and strengthening collaboration between healthcare organizations and community-based agencies—bridging clinical and community efforts to improve outcomes and quality of care.

In addition, CalOptima Health provides a comprehensive suite of services designed to enhance patient experience and engagement. These include interactive workshops for clinicians and staff that build effective care teams, improve patient-provider communication, and support service excellence. Providers

also benefit from our shadow coaching program, which offers personalized feedback and actionable plans based on real-time observation, followed by ongoing reinforcement to ensure lasting skill development.

Performance and Quality Improvement Initiatives

CalOptima Health leverages Performance Improvement Projects (PIPs) and Quality Improvement Projects (QIPs) as strategic tools to enhance member care indirectly by improving system-level processes and outcomes. These initiatives focus on identifying gaps, implementing evidence-based interventions, and fostering collaboration across providers and partners to drive measurable improvements in health quality and access. Recent improvement projects have targeted critical areas of care, including:

- Increasing Well-Child Visit Rates to support early detection and preventive care.
- Improving Blood Sugar Control for members with diabetes to reduce complications and enhance long-term health outcomes.
- Enhancing Follow-Up Care for members who visited the emergency department for severe mental illness or substance use disorder, ensuring continuity of care and reducing readmissions.

Interventions within these projects are multifaceted and designed to remove barriers to care while promoting engagement. Key strategies include direct member outreach, streamlined access to care through telehealth options and scheduling support, data exchange and workflow integration with provider networks and community partners to improve coordination and efficiency. By addressing systemic challenges and optimizing care delivery processes, these improvement projects create a ripple effect that enhances member experience, promotes health equity, and drive better outcomes across populations.

Collaboration to Support Providers and Community Partners

CalOptima Health, in collaboration with Kaiser Permanente and the Orange County Health Care Agency, is committed to protecting children's health by increasing blood lead screenings across Orange County. Through a collaborative, equity-driven approach, the partners co-designed an initiative to address screening gaps in specific neighborhoods with the greatest disparities. The collaborative developed evidence-based resources and training programs that equip Community Health Workers (CHWs) to guide families through blood lead screening and related preventive services. These tools emphasize environmental health education, navigation support, and advocacy, ensuring parents receive culturally responsive, high-quality information. Examples of resources developed include:

- **Data Dashboard**: A Tableau dashboard that overlaid quality data and public health risk factors which identified neighborhoods in Santa Ana, San Juan Capistrano, and Fullerton as priority areas of focused outreach and engagement.
- **Education Toolkit**: A Blood Lead Screening Toolkit enabling CHWs to educate families on the importance of blood lead screenings and assist in accessing these critical services.
- **CHW Training Curriculum**: A CHW training curriculum on Blood Lead that leveraged the Toolkit and used outreach scripts and role-play scenarios to strengthen CHW communication and scheduling support for families in need of blood lead screening.

DELIVERY SYSTEM SUPPORTS

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

Information Sharing

CalOptima Health ensures timely and comprehensive sharing of member-level information with providers and practitioners to support care coordination, quality improvement, and population health management. This process spans multiple programs and processes, including Case Management, utilization of services (including new Medi-Cal members due for their Initial Health Appointment), and programs to ensure high quality care.

1. **Case Management:** CalOptima Health has a comprehensive care management framework which gathers member preferences, strengths, and needs through initial screenings, claims, and encounter data. Risk stratification and segmentation guide individualized care plans, which are shared with providers to ensure alignment and continuity of care. Provider letters and individualized care plans are distributed to practitioners, reinforcing collaboration and adherence to evidence-based guidelines.

2. **Utilization of Initial Health Appointment (IHA):** The Initial Health Appointment (IHA) is a requirement for newly enrolled Medi-Cal members that must be completed within 120 days of enrollment. The IHA allows a member and their primary care physician (PCP) to meet, identify, and address current care needs and form a working partnership toward managing the member's health. The CalOptima Health Provider Portal gives primary care providers access to a list of their assigned newly enrolled Medi-Cal members for outreach and IHA scheduling.

3. **Quality Data**: CalOptima Health shares member-level data with providers to support the Pay for Value (P4V) program, improve health outcomes, and enhance compliance with quality measures. Actionable gaps-in-care reports are available through the Provider Portal and are provided monthly to assist with preventive care outreach and engagement. CalOptima Health remains committed to improving information sharing through integrated and actionable data.

Data Integration and Exchange

CalOptima Health integrates a variety of data sources in accordance with the National Committee for Quality Assurance (NCQA) Population Health Management (PHM) standards to assess the needs and characteristics of all members. Additionally, CalOptima Health meets data exchange and information-sharing requirements through a comprehensive data-sharing policy that aligns with contractual obligations and key interoperability standards, such as the US Core Data for Interoperability (USCDI) and the Data Exchange Framework (DxF). This policy clearly defines the administrative, clinical, and encounter data provided to DHCS, ensuring compliance with information requests by leveraging secure, efficient systems and processes.

Having already signed the DxF, CalOptima Health is actively progressing toward full operational compliance, including participation in a Qualified Health Information Organization (QHIO) through Cozeva. This initiative builds upon the organization's solid interoperability foundation, which is evidenced by its current compliance with CMS interoperability regulations, facilitated by the use of Edifecs for mandated data exchange functions.

By participating in a QHIO through Cozeva, CalOptima Health will not only extend its compliance with DxF guidelines but also strengthen its ability to enhance data exchange, improve care coordination and achieve population health goals and quickly adapt to evolving regulatory requirements.

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

Comprehensive Provider Training and Support

CalOptima Health offers an ongoing program of Continuing Medical Education (CME) and Continuing Education (CE) trainings for medical providers, covering a wide range of clinical and behavioral health topics, such as hypertension, diabetes, trauma-informed care, substance use and asthma management. Trainings are delivered in-person and virtually to enhance clinical knowledge, support best practices, improve patient outcomes and fulfill licensure requirements.

Through its Culture and Health Conversations, CalOptima Health also provides culturally responsive education, enhancing understanding of physical and mental health needs and culturally specific practices for populations of focus. These efforts foster collaboration between health care organizations and community-based agencies, with partner agencies selected for their cultural expertise, alignment with

health and wellness goals, community leadership, and service to CalOptima Health members in Orange County.

Additionally, CalOptima Health supports providers with workshops and coaching programs focused on improving patient experience and engagement. These services help build effective care teams, strengthen communication, manage challenging situations and promote service excellence. Providers benefit from personalized feedback and ongoing support to reinforce new skills.

Through these efforts, CalOptima Health equips providers with up-to-date information, practical skills, and continuous support to better serve the health and well-being of our diverse members.

Transformation Support

CalOptima Health's Orange County Population Health and Value-Based Care Initiative (PHVBC) is a five-year, $50 million initiative aimed at helping community health centers transform care delivery and strengthen the local safety net. Through this initiative, participating clinics will implement projects that enhance population health capabilities and prepare for value-based care models. The focus is on improving access, equity and quality — particularly for communities disproportionately impacted by health disparities.

The Institute for High Quality Care (IHCQ) will provide tailored technical assistance, including training, coaching and best practice sharing. The Center for Community Health and Evaluation (CCHE) will lead evaluation efforts. CalOptima Health will also use provider profiles to identify care gaps and align financial incentives with quality improvement goals. These supports will help clinics shift from volume-based to value-based, whole-person care by enabling better care coordination, preventive services and staffing aligned with member needs.

Additionally, in 2025 CalOptima Health launched the Equity and Practice Transformation (EPT) Program, an initiative funded by DHCS to advance health equity and transform primary care for Medi-Cal members. CalOptima Health supports 14 Orange County practices with targeted coaching, training, and data support to help them meet rigorous milestones and earn incentive payments. The program focuses on improving access, reducing disparities and building patient-centered, value-based care models. EPT is closely aligned with CalOptima Health's PHM strategy, reinforcing our commitment to data-driven equity, quality improvement and sustainable transformation across our provider network.

Pay for Value (P4V)

CalOptima Health's Pay for Value (P4V) program recognizes outstanding performance and supports ongoing improvement to strengthen CalOptima Health's mission of serving members with excellence and providing quality health care. Health networks and CalOptima Health Community Network (CHCN) primary care providers are eligible to participate in the P4V programs.

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

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

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

PHM Structure

Population Health Management (PHM) operations at CalOptima Health are supported by a multidisciplinary leadership team, allied health professionals and administrative staff. In 2025, oversight of PHM transitioned from the Equity and Community Health (ECH) department to Clinical Operations. This strategic realignment was implemented to better integrate health education and disease management programs within the broader care continuum. Under Clinical Operations, PHM efforts are now more closely aligned with care coordination, case management and utilization management. While ECH previously led strategic initiatives to identify and address member health and wellness needs, Clinical Operations now assumes responsibility for these functions in accordance with DHCS and NCQA requirements. The following describes the current roles and responsibilities for PHM across the organization.

Team Roles and Responsibilities

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

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

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

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

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

Executive Director, Clinical Operations (ED CO) is responsible for overseeing all clinical operations functions, including the Utilization Management, Care Coordination, Complex Case Management,

Disease Management, Health Education and Managed LTSS (MLTSS) programs, along with all new program implementations related to initiatives in these areas.

Medical Director, Population Health Management (MD PHM) provides clinical leadership for CalOptima Health's population health strategies. This role oversees PHM programs, including Transitional Care Services, ensuring members are supported from discharge through connection to needed services. The MD also guides staff and provider education, ensures clinical accuracy of interventions, and promotes equitable, evidence-based care across the delivery system.

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

Executive Director, Equity and Community Health (ED ECH) is responsible for the management and oversight of CalOptima Health's Equity and Community Health department. The ED ECH oversees development and implementation of organizational strategies to advance health outcomes, strengthen community partnerships, and promote equitable access to care that improves health outcomes for all members. The ED ECH serves as a member of the executive team, reporting to the CHEO, and in partnership with the CMO, DCMO and Executive Director of Clinical Operations, supports efforts to promote adherence to established quality improvement and health equity strategies. The ED ECH also collaborates with leaders across the organization to integrate community health priorities into the delivery system and populations served.

Executive Director, Medi-Cal/CalAIM leads the strategic implementation and oversight of California Advancing and Innovating Medi-Cal (CalAIM), a transformative, person-centered initiative aimed at improving health outcomes and care delivery for vulnerable populations. This role is responsible for aligning operational execution with the broader vision of whole-system reform, integrating medical, behavioral and social services to address the full spectrum of member needs.

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

Executive Director, Operations (ED O) is responsible for overseeing and guiding the following operational departments: Claims Administration, Customer Service and Grievance & Appeals Resolution Services. The ED Ops works closely with top-level leadership to establish policies and implement procedures for the management of departments to accomplish the goals and objectives of CalOptima Health within budget and within applicable legal requirements.

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

Executive Director, Strategic Development (ED SD) is responsible for the oversight and implementation of CalOptima Health's strategic development programs. Under the general guidance of the Chief Administrative Officer (CAO), the ED SD works closely with top-level leadership to plan, develop and implement strategies and carry out organizational goals and priorities to effectively promote and implement CalOptima Health's mission and vision with internal and external contacts, including employees, the public, members, government officials and the media.

Sr. Director, Equity and Community Health (Sr. ECH Director) is responsible for leading the development and implementation of strategies designed to address identified health inequities. The Sr. ECH Director is responsible for assisting the ED ECH and CHEO in developing, implementing, analyzing, and refining the CalOptima Health goals and objectives related to health equity. The Sr. ECH Director partners with leaders across the organization to strengthen the organization's commitment and strategy to advance health equity, promote health literacy and reduce health disparities. The Sr. Director also engages with community partners on health equity initiatives that improve health outcomes.

Sr. Director and Directors, Case Management, lead the development and implementation of CalOptima Health's PHM strategies. They oversee departmental operations, ensure regulatory and accreditation compliance, and coordinate cross-functional initiatives with internal teams, health networks, providers and community stakeholders. These leaders are responsible for aligning care management programs with organizational goals to improve quality outcomes, cost efficiency and member experience.

The following staff support the implementation of PHM strategies:

- *Sr. Managers and Managers, Case Management*: The Sr. Managers and Managers develop PHM goals; oversee case, maternal and disease management programs; and ensure compliance and efficiency. Managers support daily operations, staff development and project execution under the Director's guidance. They monitor reports, ensure policy adherence, participate in operational and community meetings, and report key findings to leadership and relevant committees.
- *Supervisors, Case Management* oversee the daily operations of case management activities, ensuring compliance with regulatory requirements and internal policies. These roles provide leadership and guidance to staff, manage complex referrals directly, and support the implementation of new programs. Supervisors are responsible for monitoring team productivity and quality standards, addressing complex member and provider needs, and serving as a key resource for CalOptima Health's providers, health networks and community partners.
- *Program Managers:* Lead cross-organization initiatives and regulatory compliance, develop and evaluate new interventions, and stay informed on health care policy impacts.
- *Health Educators and Coaches:* Deliver member-focused health education, coaching, group classes and self-management support for chronic conditions, sharing progress with care teams.
- *Registered Dietitians:* Provide nutrition counseling, develop education materials and collaborate on member care planning.
- *Personal Care Coordinators:* Conduct assessments and coordinate care to ensure timely services and smooth transitions. They collaborate with members, PCPs, and care teams to address barriers and improve access across all levels of care.
- *Medical Case Managers/Care Managers:* Provide ongoing case management services for CalOptima Health's members. The Medical Case Manager facilitates communication and coordination among all participants of the health care team and the member to ensure the services

provided promote quality and cost-effective outcomes. Social Workers provide administrative case management and coordination of benefits for carved-out services. Social Workers serve as a departmental resource regarding benefits and available resources for the aged, behavioral health, foster care and the disabled population. Social Workers also serve as a liaison to Orange County-based community agencies.

PHM Oversight

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

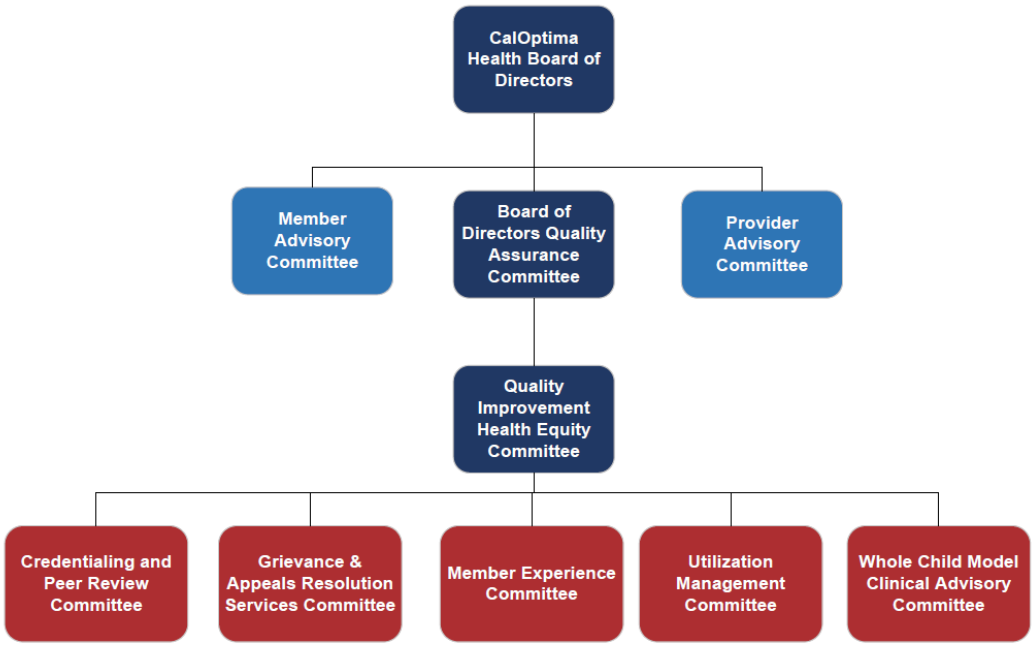
PHM Oversight Responsibilities

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

Committee Approval Descriptions

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

PHM Oversight Structure



Quality Improvement Health Equity Committee (QIHEC)

The purpose of the QIHEC is to provide overall direction for continuous, health equity-centered quality improvement processes, oversee activities consistent with CalOptima Health's strategic goals and priorities, and monitor compliance with regulatory and licensing requirements related to QI projects and activities.

Utilization Management Committee (UMC)

The UMC at CalOptima Health is led by a Medical Director and oversees the implementation, supervision and evaluation of the UM Program. It ensures optimal utilization of health care services, protects member rights, and monitors medical necessity and quality. The UMC meets quarterly, coordinates annual reviews, and reports to the Quality Improvement Health Equity Committee and the Board of Directors.

Board of Directors' Quality Assurance Committee (QAC)

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

CalOptima Health Board of Directors (BOD)

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

2026 Culturally and Linguistically Appropriate Services (CLAS) Program Description

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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 Medi-Cal, Medicare and Program of All-Inclusive Care for the Elderly (PACE) members deserve the highest quality care and service throughout the health care continuum. CalOptima Health collaborates with providers, community stakeholders and government agencies to achieve our mission and vision while upholding our values.

Our Mission

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

Our Vision

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

Who We Serve

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

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

Membership Demographics

Membership Data (as of November 30, 2025)

Total CalOptima Health Membership 877,271	Program	Members
	Medi-Cal	858,441
	OneCare (HMO D-SNP)	18,287
	Program of All-Inclusive Care for the Elderly (PACE)	543
	*Based on unaudited financial report and includes prior period adjustment	

Member Demographics (as of November 30, 2025)

Member Age

0 to 5	**8%**
6 to 18	**22%**
19 to 44	**34%**
45 to 64	**20%**
65+	**16%**

Language Preference

English	**56%**
Spanish	**29%**
Vietnamese	**9%**
Korean	**2%**
Other	**2%**
Farsi	**1%**
Chinese	**<1%**
Arabic	**<1%**
Russian	**<1%**

Medi-Cal Aid Category

Expansion	**38%**
Temporary Assistance for Needy Families	**36%**
Seniors	**13%**
Optional Targeted Low-Income Children	**7%**
People With Disabilities	**5%**
Long-Term Care	**<1%**
Other	**<1%**

Our Commitment to Culturally and Linguistically Appropriate Services (CLAS)

As a health care organization in the diverse community of Orange County, CalOptima Health strongly believes in the importance of providing culturally and linguistically appropriate services

to members. CalOptima Health is committed to providing effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. To ensure effective communication regarding treatment, diagnosis, medical history and health education, CalOptima Health has developed a Culturally and Linguistically Appropriate Services Program (CLAS Program), a component of the Quality Improvement and Health Equity Transformation Program (QIHETP), which integrates culturally and linguistically appropriate services at all levels of planning and operation.

Objectives for culturally and linguistically diverse membership include:

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

Authority and Accountability

Board of Directors (Board)

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

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

Board of Directors' Quality Assurance Committee

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

Member Advisory Committee

CalOptima Health is committed to delivering member-focused care through active engagement with members and the community. The Member Advisory Committee (MAC) has 20 voting members, with each seat representing a constituency served by CalOptima Health. The MAC ensures that the values and needs of CalOptima Health members are integrated into the design, implementation, operations and evaluation of the overall QIHETP. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, and preventive services. The MAC meets on a bimonthly basis and reports directly to the CalOptima Health Board of Directors. MAC meetings are open to the public.

The MAC membership includes representatives from the following constituencies:

- Behavioral/mental health
- Children
- Dental provider
- Developmental Disabilities
- Family/Caregiver support
- Foster children
- Local Education Agency
- Medi-Cal beneficiaries or authorized family members (four seats)
- Member advocate
- OneCare member or authorized family members (four seats)
- People with disabilities
- Recipients of CalWORKs
- Seniors
- County of Orange Social Services Agency (SSA) (standing seat)

One of the 20 positions, held by SSA, is a standing seat. Each of the remaining 19 appointed members may serve two consecutive three-year terms.

Provider Advisory Committee

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

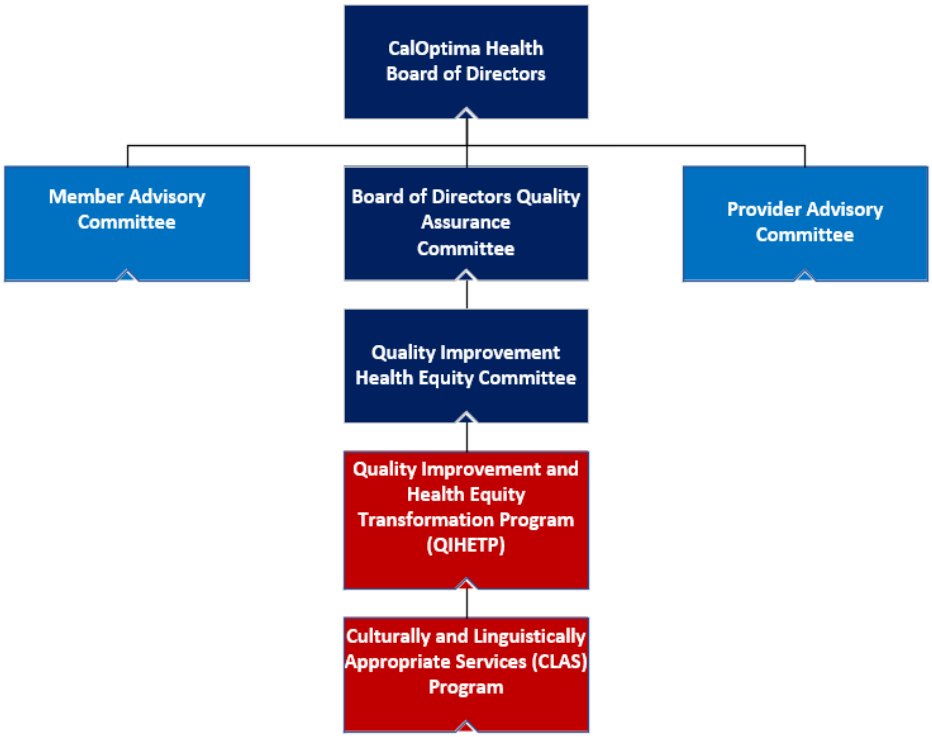
- Health networks
- Hospitals
- Physicians (three seats)
- Nurse
- Allied health services (two seats)
- Community health centers
- Orange County Health Care Agency (standing seat)
- LTSS (LTC facilities and CBAS) (one seat)
- Non-physician medical practitioner
- Safety net
- Behavioral/mental health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

Quality Improvement Health Equity Committee (QIHEC)

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

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

CLAS Reporting Structure



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

Community and Member Engagement

CalOptima Health is committed to providing member-focused care through active engagement with members and their communities. The organization engages members through the MAC and seeks input and advice related to cultural and linguistic, as well as health equity goals.

By actively seeking feedback and advice from the community, CalOptima Health ensures that its services are tailored to meet the diverse needs of its members. The MAC represents the diversity of its membership, including individuals from ethnic and language groups that represent at least 5% of the population.

Ethnicity	Ethnicity Membership Percentage	Language	Language Membership Percentage	Number of Members	Corresponding Seats
Hispanic	15%	Spanish	15%	3	1 OneCare Member/Family Member 1 Behavioral/Mental Health Representative 1 SSA Representative
White	50%	English	50%	10	1 Children

					1 Family/Caregiver Rep. 1 Foster Children 2 Medi-Cal Beneficiaries/ Family Members 1 Developmental Disabilities 1 Recipient of CalWORKS 1 Senior 2 OneCare Members/ Family Members
Vietnamese	5%	Vietnamese	5%	1	1 Person With Disabilities
Korean	5%	Korean	5%	1	1 Member Advocate

In addition to engaging MAC members, CalOptima Health gathers member input through community events, meetings and/or surveys.

Goals

The following are the 2026 areas of focus for the CLAS Program:

1. Language Services: Cultural and Linguistic and Language Accessibility: Provide interpreter and translation services and report key findings and/or activities, analyze barriers, and identify improvements.
    - By December 31st, 2026, CalOptima Health will evaluate its language services experience by collecting feedback from 6% to 10% of members and from 4% to 80% of staff using surveys and will analyze the results to identify improvements to language services.
    - Maintain a member and CalOptima Health staff satisfaction rate or above by December 31st, 2026
2. Data Collection of Member Demographic Information.
    - By September 30, 2026, CalOptima Health will update the current data system to receive, store and retrieve the following: disability function and identity, physical accommodations, auxiliary aids or services, geographic classification, age, and veteran/military status.
    - By December 31st, 2026, CalOptima Health will increase the collection of member disability function data from 0 to 5% through focused outreach and education, ensuring better representation and inclusion of members.
3. Data Collection on Practitioner Demographic Information.
    - By December 31st, 2026, CalOptima Health will increase the collection of provider race/ethnicity/languages (REL) from 2% to 5% through focused outreach and education, ensuring better representation and inclusion of providers.
4. Provider Trainings to Improve Care or Service Delivery.
    - By December 31st, 2026, CalOptima Health will implement and train 90% of health networks and providers on how to improve care or service delivery on at least one: racial, ethnic or cultural subgroups, gender or sexual orientation subgroups or patients with disabilities, use of physical accommodation and use of auxiliary aids or services.
    - By December 31st, 2026, conduct a CME on unique health or health care needs of at least one: racial, ethnic or cultural subgroup, gender or sexual orientation

subgroup or patients with disabilities, use of physical accommodation and use of auxiliary aids or services.

5. Building and Maintaining a Responsive Work Force
    - By December 31st, 2026, CalOptima Health will implement and train 90% of staff on how to improve care or service delivery on at least one: racial, ethnic or cultural subgroups, gender or sexual orientation subgroups or patients with disabilities, use of physical accommodation and use of auxiliary aids or services.

CLAS Work Plan

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

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

- Network cultural responsiveness
- Language services
- Program scope
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the CLAS Program

The CLAS Work Plan supports the comprehensive annual evaluation and planning process, which includes reviewing and revising the CLAS Program as well as applicable policies and procedures. The 2026 CLAS Work Plan encompasses all cultural and linguistic focus areas, including goals, improvement activities, progress toward these goals, and associated timeframes. Planned activities include strategies to continue to enhance the collection, storage, retrieval, and sharing of data on race/ethnicity, language and sexual orientation. Additionally, new activities include implementing a process for collecting, storing, retrieving, and sharing data on disability status, disability-related accommodations and accessible digital content. All goals will be measured and monitored in the CLAS Work Plan, reported to QIHEC on a quarterly basis and evaluated annually. A copy of the QIHETP (and CLAS) Work Plans is also available to the public on the CalOptima Health website.

For more details on the 2026 CLAS Work Plan, see Appendix A: 2026 QIHETP Work Plan

CLAS Monitoring Progress

To ensure that the CLAS Program meets the needs of our diverse member population, CalOptima Health conducts ongoing assessments of CLAS-related activities and integrates CLAS-related measures into measurement and continuous quality improvement activities. The QIHEC continuously monitors progress against CLAS goals. At least quarterly, dedicated staff

from the Cultural & Linguistic Services (C&L) department, in collaboration with multidisciplinary work teams throughout the organization, collect and track indicators and activities specific to CLAS goals, outcomes and outputs. C&L staff prepare quarterly findings and identify potential risks to share with CalOptima Health leadership at QIHEC meetings. CalOptima Health's QIHEC reviews, offers feedback and approves quarterly CLAS monitoring reports. QIHEC summarizes the CLAS monitoring reports and shares them with CalOptima Health's Board of Directors' QAC.

CLAS Evaluation

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

- A description of completed and ongoing CLAS activities that address the cultural and linguistic needs of our members, including achievements and progress toward goals, as outlined in the CLAS Work Plan, and identification of opportunities for improvement.
- Trending of measures to assess performance in the quality, accuracy and utilization of translation and interpreter services.
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions.
- An evaluation of the effectiveness of CLAS activities, including Quality Improvement Projects (QIPs), Performance Improvement Projects (PIPs), Plan-Do-Study-Act cycles (PDSAs).
- An evaluation of the effectiveness of member experience surveys related to cultural and linguistic services.
- A report to the QIHEC and QAC summarizing all CLAS measures and identifying significant trends.
- A critical review of the organizational resources involved in the CLAS Program through CalOptima Health's strategic planning process.
- Recommended changes included in the revised CLAS Program Description for the subsequent year for QIHEC, QAC and the Board of Directors' review and approval.

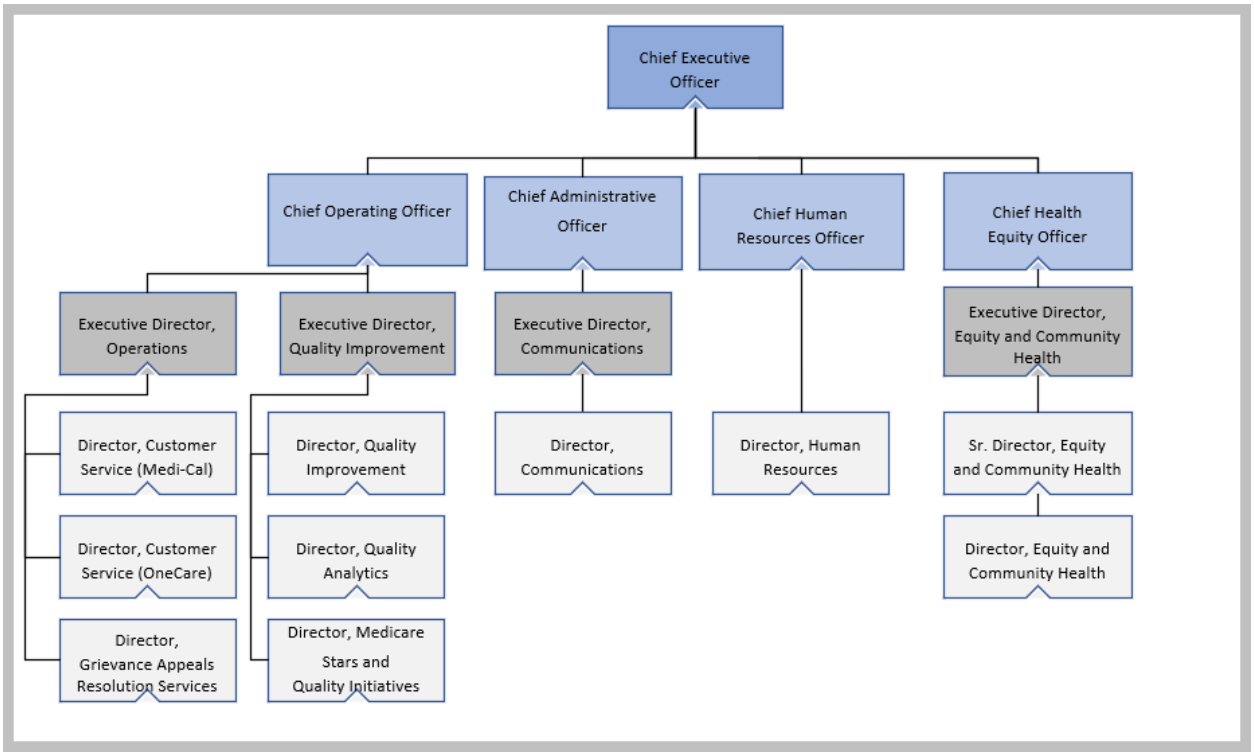
A copy of the CLAS Evaluation is also available to the public on the CalOptima Health website.

The C&L department consists of the Director of Customer Service/Cultural & Linguistics, the Manager of Cultural & Linguistics, a Supervisor, 10 Translation Specialists, and two Program Specialists, who are responsible for translating documents and coordinating cultural and linguistic services with contracted vendors. The C&L department is supported by CalOptima Health departments, including but not limited to:

- Communications
- Utilization Management
- Grievance and Appeals Resolution Services

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

Cultural & Linguistic Services Organizational Chart Structure



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

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

Chief Administrative Officer (CAO) has overall responsibility and accountability for the activities of the Clerk of the Board, Communications & Marketing, Government Affairs, Strategic Development, and Enterprise Project Management. The CAO creates a shared sense of purpose to achieve an aligned mission and vision executed through CalOptima Health's

strategic plan and CEO initiatives. The CAO is expected to lead by example and influence others by exhibiting the highest professional and ethical behaviors.

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

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

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

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

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

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

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

Executive Director, Network Operations (ED NO) is responsible for the plan's provider delivery system; leads delivery system operations across multiple models; implements strategies that achieve the established program objectives and leverage the core competencies of the plan's existing administrative infrastructure; directs the integrated operations of the provider network contracted under the various programs and coordinates organizational efforts;

responsible for the overall success of network operations for the planning and implementation to fulfill the plan's strategic objectives as related to contracting and operations of the provider delivery system; and responsible for provider relations and support, including provider education and problem resolution.

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

Director, Customer Service (Medi-Cal) is responsible for day-to-day management, strategic direction and support to CalOptima Health Customer Service operations, including Medi-Cal Call Center, Behavioral Health Call Center, Member Liaison, Customer Service Data Analysts, member-facing sections of the CalOptima Health website and the CalOptima Health Member Portal.

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

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

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

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

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

The position provides coordination and support to the QIHEC and other committees to ensure compliance with regulatory and accreditation agencies.

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

Director, Contracting is responsible for the development and implementation of contracting strategies for providers and other business entities, management and monitoring of contractual relationships with existing provider networks and contractors. The Director of Contracting also conducts and coordinates financial analysis to determine and design contracting strategies for CalOptima Health and negotiates provider contracts.

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

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

Director, Human Resources leads, oversees, and manages the administration of Human Resources (HR) services, policies, and programs for CalOptima which may include benefits and wellness programs, classification and compensation, employee engagement, employee relations, human resources information systems (HRIS), leaves programs, performance management, Workers' Compensation as determined by the Chief Human Resources Officer. Provides highly responsible and complex guidance to executives and management.

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

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

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

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

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

- Language Interpreting Services poster in the reception area
- Member Handbook/Evidence of Coverage
- Summary of Benefits
- Quarterly/Annual Newsletters
- New Member Orientations
- Customer Service Call Center
- Health education workshops
- CalOptima Health website
- Member Portal
- Presentations/trainings at community-based organizations and public agencies

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

- Eligible beneficiaries residing in CalOptima Health's service area who indicate their primary language as a language other than English and who meet a numeric threshold of 3,000 or 5% of the eligible beneficiary population, whichever is lower (Threshold Standard Language); and

- Eligible beneficiaries residing in CalOptima Health's service area who indicate their primary language as a language other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes (Concentration Standard Language).

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

Cultural & Linguistic Services Language Competency Testing

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

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

Cultural Competency and Training

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

- **Race:** Any of the different varieties or populations of human beings distinguished by physical traits such as hair color and texture, eye color, skin color or body shape.
- **Ethnicity:** A group having a common cultural heritage or nationality, as distinguished by customs, language, common history, etc.
- **Culture:** The ideas, customs, skills, arts, etc. of a people or group that are transferred, communicated or passed along to current or succeeding generations.

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

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

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

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

Promotion of Diversity, Equity and Inclusion

CalOptima Health is committed to reducing bias and promoting diversity, equity and inclusion (DEI), and supports initiatives that advance health equity for Medi-Cal members.

CalOptima Health is committed to maintaining a workforce that reflects the cultural and linguistic diversity of the communities it serves. This includes the following:

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

CalOptima Health is also committed to creating and fostering better relationships and connectivity with its diverse community members. The organization supports initiatives to create an inclusive environment within CalOptima Health and with network providers, as well as other community-based contractors and staff with lived experience. CalOptima Health ensures CalOptima Health staff, contracted health networks (including subdelegates), and network providers receive DEI training that includes the following up-to-date and evidence-based DEI training topics:

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

Data Collection and Analysis

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

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

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

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

- Overall member population, including Social Determinants of Health
- Children and adolescent members ages 2–19
- Members with disabilities
- Member clinical and utilization trends, including analysis by racial and ethnic groups
- Members with limited English proficiency
- Relevant focus populations, including members who are pregnant or experiencing homelessness

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

Attachment 1

CalOptima Health Measurement Year (MY) 2026
Pay for Value Programs

MY 2026 Medi-Cal Pay for Value (P4V)

The Medi-Cal P4V program incentivizes performance on all Healthcare Effectiveness Data and Information Set (HEDIS®) that are included in the Department of Health Care Services (DHCS) Managed Care Accountability Set (MCAS) measures required to achieve a minimum performance level (MPL). The Medi-Cal P4V programs also includes incentives for Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction measures. Health networks (HNs) and CalOptima Health primary care providers are eligible to participate in the Medi-Cal P4V program.

MY 2026 Medi-Cal P4V Program Components

1. Include measures held to a DHCS MPL or quality withhold in the MY2026 MCAS measure set.

MY 2026 Medi-Cal Pay for Value Program Measurement Set	
Follow-up After ED Visit for Mental Illness- 30 days	Prenatal and Postpartum Care: Postpartum Care
Follow-Up After ED Visit for Substance Abuse- 30 days	Prenatal and Postpartum Care: Timeliness of Prenatal Care
Depression Screening and Follow-Up for Adolescents and Adults	Postpartum Depression Screening and Follow Up
Child and Adolescent Well-Care Visits	Prenatal Depression Screening and Follow Up
Childhood Immunization Status- Combination 10	Breast Cancer Screening
Development Screening in the First Three Years of Life*	Cervical Cancer Screening
Immunizations for Adolescents- Combination 2	Colorectal Cancer Screening
Lead Screening in Children	CAHPS- Rating of Health Network: Adult and Child
Topical Fluoride in Children*	CAHPS- Rating of Health Care: Adult and Child
Well-Child Visits in the First 30 Months of Life- 0 to 15 Months- Six or More Well-Child Visits	CAHPS- Rating of Personal Doctor: Adult and Child
Well-Child Visits in the First 30 Months of Life- 15 to 30 Months- Six or More Well-Child Visits	CAHPS- Rating of Specialist Seen Most Often: Adult and Child
Controlling High Blood Pressure	CAHPS- Getting Needed Care: Adult and Child
Glycemic Status Assessment for Patients with Diabetes (>9%)	CAHPS- Getting Care Quickly: Adult and Child
	CAHPS- Coordination of Care: Adult and Child

- Utilize both Child and Adult CAHPS scores proportional to the age distribution of the assigned member population. For example, if a HN's membership is 30% children ages 0 to 18 and 70% adults, the CAHPS rate would be 30% from the child CAHPS score and 70% from the adult CAHPS score.

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN.
   - Attainment and Improvement scores are calculated for each measure. The better of the two scores is used.
   - Scoring
     - Attainment Points
       - Scale of 1-10 points

- Points based on performance between 50th percentile and 95th percentile.
- $1 + \left(\frac{(MY2026\ Rate - 50th\ Percentile)}{((95th\ Percentile - 50th\ Percentile)/9)} \right)$

- Improvement Points
  - Scale of 0-10 points
  - Points reflect performance in the prior year compared to the current year.
  - $\left(\frac{(MY2026\ Rate - MY2025\ Rate)}{((95th\ Percentile - MY2025\ Rate)/10)} \right)$

3. Prior year (MY2025) National Committee for Quality Assurance (NCQA) Quality Compass National Medicaid percentiles used as benchmarks. *Developmental Screening in the First Three Years of Life and Topical Fluoride are CMS measures where the only benchmark is the 50th percentile. For these two measures, CMS percentiles will be used and HNs will earn 10 points for performance at or above the 50th percentile and 1 point for performance below the 50th percentile.
4. Measure weighting
   - HEDIS measures weighted 1.0
   - CAHPS measures weighted 1.5
5. Maintain program funding at ten percent (10%) of professional capitation (base rate only).
6. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance.
7. HNs that score below the 50th percentile will be required to submit an improvement plan for that measure to CalOptima Health.
8. DHCS quality withhold penalties will be deducted from each HN's earned P4V program payment.

Attachment 1

CalOptima Health Measurement Year (MY) 2026
Pay for Value Programs

OneCare Pay for Value Program (P4V)

The OneCare P4V program focuses on select Centers for Medicare and Medicaid Services (CMS) Star Part C and Part D measures. Measures are developed from industry standards including HEDIS, CAHPS member experience, and Pharmacy Quality Alliance. Health networks (HNs) and CalOptima Health primary care physicians (PCPs) are eligible to participate in the OneCare P4V program.

MY 2026 OneCare P4V Program Components

Alignment with the CMS Star program and the following components- CMS Star Part C and Part D measures, measure weights, and Star cut points as benchmarks:

1. Utilize a subset of CMS Star measures

MY 2026 OneCare Pay for Value Program Measurement Set	
Measure Category	**Measure**
Part C HEDIS	Breast Cancer Screening
	Colorectal Cancer Screening
	Care for Older Adults- Medication Review
	Care for Older Adults- Functional Status Assessment
	Osteoporosis Management in Women who had a Fracture
	Comprehensive Diabetes Care – Eye Exam
	Comprehensive Diabetes Care – Blood Sugar Controlled
	Kidney Health Evaluation for Patients with Diabetes
	Controlling Blood Pressure
	Transitions of Care
	Follow-Up After ED Visit for Patients with Multiple Chronic Conditions
	Plan All-Cause Readmission
	Statin Therapy for Patients with Cardiovascular Disease
Part C Member Experience	Care Coordination
	Getting Care Quickly
	Getting Needed Care
	Customer Service
	Rating of Health Network Quality
	Rating of Health Network
Part D	Medication Adherence for Diabetes
	Medication Adherence for Hypertension
	Medication Adherence for Cholesterol
	Statin Use in Persons with Diabetes
	Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults
	Concurrent Use of Opioids and Benzodiazepines

2. Adopt IHA scoring methodology to assess overall quality rating score based on performance for each HN
   - Attainment and Improvement score calculated for each measure. The better of the two scores is used.

   - Scoring
     - Attainment Points

- Scale of 1-5 points
- Points based on performance between 3-Star and 5-Star cut points.
- $1 + \left(\frac{(MY2026\ Rate - 3\ Star\ cut\ point)}{((5\ Star\ cut\ point - 3\ Star\ cut\ point)/4)} \right)$

▪ Improvement Points
- Scale of 0-5 points
- Points reflect performance in the prior year compared to the current year.
- $\left(\frac{(MY2026\ Rate - MY2025\ Rate)}{((5\ Star\ cut\ point - MY2025\ Rate)/5)} \right)$

3. MY2026 CMS Star cut points used as benchmarks. These benchmarks will be released by CMS in Q4 2027 in the 2028 Star Rating Technical Notes.
4. Measure weighting
   - HEDIS process measures weighted 1
   - CAHPS measures weighted 2
   - Outcome measures weighted 3
5. Apply a program funding methodology of $20 PMPM
6. Available Incentive Pool: the OneCare incentive pool will be determined by each HN's Stars performance as described in the table below. Actual OneCareP4V incentives will be based on performance as described in this section.

OneCare P4V Performance	MY2026 Incentive Percentage SY2028
Below 3.0 stars	0%
3 Stars	20%
3.5 Stars	40%
4.0 Stars	60%
4.5 Stars	80%
5.0 Stars	100%

Note: MY = measurement year, SY= Star rating display year

7. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance
8. HNs that score below 3.0 Stars will be required to submit an improvement plan for that measure to CalOptima Health.

Attachment 1

CalOptima Health Measurement Year (MY) 2026
Pay for Value Programs

Covered California Pay for Value Program (P4V)

The Covered California P4V program focuses on measures included in the Quality Transformation Initiative. Health networks (HNs) are eligible to participate in the Covered CA P4V program.

MY 2027 Covered CA P4V Program Components

Alignment with the Covered CA Quality Transformation Initiative (QTI) and the following components:

1. CalOptima Health will adopt the 2027 QTI measures for the MY2027 P4V Program.

MY 2027 Covered CA Pay for Value Program Measurement Set
Controlling High Blood Pressure
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)
Colorectal Cancer Screening
Childhood Immunization Status (Combo 10)
Depression Screening and Follow-Up for Adolescents and Adults

2. Utilize an attainment scoring methodology where rates that meet designated benchmarks qualify for percentages of incentives per measure
3. MY2026 National Committee for Quality Assurance (NCQA) Quality Compass National Exchange percentiles used as benchmarks
4. Measures will be weighted equally
5. Establish program funding at ten percent (10%) of professional capitation (base rate only)
6. Covered CA P4V incentives will be based on performance compared to benchmarks as described below:

NCQA Quality Compass National Exchange Percentile	% of Incentive Earned per Measure
75th	100%
66th	75%
50th	50%
33rd	25%

7. Performance incentive allocations will be distributed upon final calculation and validation of each health network's performance

CalOptima Health Measurement Year (MY) 2026
Behavioral Health Integration (BHI) Department Pay for Value Programs

The Behavioral Health Integration Department has implemented two Pay-for-Value programs designed to improve quality of care and incentivize performance among directly contracted providers: one for Applied Behavior Analysis (ABA) and another for non-ABA mental health provider groups.

1) Applied Behavior Analysis Pay-for-Value Program (ABA P4V)

Behavioral Health Integration Department proprietary designed Applied Behavior Analysis (ABA) Pay-for-Value (P4V) Program approved by the Board of Directors and applies to measurement periods from **July 1, 2024, through June 30, 2026.**

- **ABA P4V Program Metrics**

CalOptima Health developed a proprietary ABA Pay-for-Value (P4V) Program using a structured approach that incorporated clinical best practices into the program metric selection.

	Category	Program Metric	Metric Weight %
1	Quality	Client Received Monthly Direct Services	2.0%
2	Quality	Client Received 10% or More Supervision	2.0%
3	Quality	Client Received Monthly In-Person BCBA/BMC Field Visits	2.0%
4	Care Experience	Client Received Timely Treatment	2.0%
5	Care Experience	Client Received Monthly Parent Training Visits	2.0%
		Total Percentage	**10%**

- **ABA P4V Program Methodology**
  - Measurement Period: Every 6 months
  - Data Source: Claims and encounter submissions
  - Review Frequency: Semi-annual performance review
  - Incentive Opportunity: Providers can qualify for up to a 10% incentive applied to adjudicated paid claims during the payout period

Measurement Period	Review Period	Payout Period
Jul – Dec 2024	Jan – Jun 2025	July– Dec 2025
Jan – Jun 2025	Jul – Dec 2025	Jan – Jun 2026
Jul – Dec 2025	Jan – Jun 2026	Jul – Dec 2026
Jan– Jun 2026	Jul – Dec 2026	Jan – Jun 2027

2) Mental Health Provider Pay-for-Value Program (MH P4V)

Behavioral Health Integration's proprietary program incentivizes mental health provider/group contracted directly with CalOptima Health. The program was approved by the Board of Directors and applies to measurement periods from **January 1, 2025, through December 31, 2026.**

- **MH P4V Program Metrics**

This is a proprietary program developed by CalOptima Health. The measures listed in the table align with a combination of standards, including select Healthcare Effectiveness Data and Information Set (HEDIS) quality metrics, Department of Managed Health Care (DMHC) timely access requirements, and clinical best practices.

	Category	Program Metric	Metric Weight Percentage
1	Quality	Timely Follow-up After BH/SUD ED visit	2.5 %
2	Quality	Follow–up After Initial Visits	2.5%
3	Quality	Effective Ongoing Care	1.0%
4	Capacity/Growth	Capacity/Panel Growth	1.0%
5	Care Effectiveness	Quality Monitoring of Essential Labs and Diagnostics	1.0%
6	Care Effectiveness	Clinical Measurement of Care	1.0%
		Total Percentage:	**10%**

- **MH P4V Program Methodology**
  - Measurement Period: Every 6 months
  - Data Collection: Claims and encounter submissions and provider attestation forms
  - Review Frequency: Semi-annual performance review
  - Incentive Opportunity: Providers can qualify for up to a 10% incentive applied to adjudicated paid claims during the payout period

Measurement Period	Review Period	Payout Period
Jan – Jun 2025	Jul – Dec 2025	Jan – Jun 2026
July – Dec 2025	Jan – Jun 2026	Jul – Dec 2026
Jan – Jun 2026	Jul – Dec 2026	Jan – Jun 2027
July – Dec 2026	Jan – Jun 2027	Jul – Dec 2027