



Kaiser Foundation Health Plan, Inc.

Medi-Cal Managed Care — California Medicaid Line of Business

Northern California and Southern California Regions

2026 Quality Improvement and Health Equity Annual Plan

Submitted pursuant to
Exhibit A, Attachment III, Section 2.2.7 of the Medi-Cal Managed Care Contract

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Section 0 • Requirements Crosswalk

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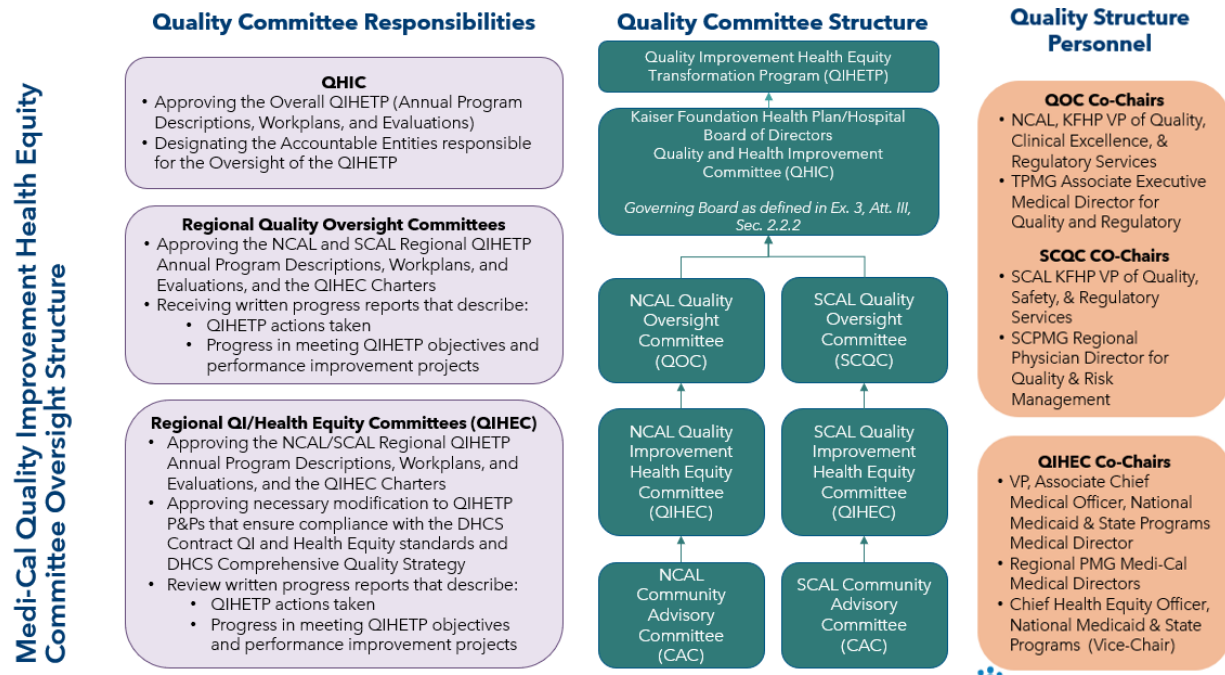
Section 1 • Program Governance and Structure

Kaiser Foundation Health Plan, Inc. (KFHP; hereafter the Plan) develops and submits this Quality Improvement and Health Equity (QIHE) Annual Plan for its California Medicaid line of business pursuant to Exhibit A, Attachment III, Section 2.2.7 of the Medi-Cal Managed Care Contract (the Medi-Cal Contract). This document is the Plan's single, consolidated QIHE Annual Plan for the 2026–2027 cycle, covering both the Northern California (NCAL) and Southern California (SCAL) regions (collectively, the Annual Plan).

Regional Quality and Health Equity Teams. Per Section 2.2.7 of the Medi-Cal Contract and All Plan Letter (APL) 24-004, the Plan maintains regional quality and health equity teams in NCAL and

SCAL. A Quality and Safety Oversight Director leads each team and carries responsibility for the quality improvement and health equity infrastructure of the Medi-Cal Contract: quality oversight, outcomes evaluation and monitoring, facility site and medical record review, oversight of contracted-provider quality, and data-driven improvement.

Committee oversight structure. The Plan's Medi-Cal QIHE program operates under a four-tier oversight structure in each region.



Quality Improvement and Health Equity Committee (QIHEC). The Medi-Cal Medical Director and the appointed Permanente Medical Group Medical Director co-chair the QIHEC, and the Chief Health Equity Officer serves as Vice-Chair. The QIHEC operates under the Medi-Cal Quality Improvement and Health Equity Committee Policy and meets bi-monthly in each region. In 2026, the Plan will strengthen statewide coordination and alignment by convening two of the six sessions as combined statewide meetings of the NCAL and SCAL QIHECs.

Scope. This Annual Plan governs KFHP's California Medi-Cal line of business. Unless otherwise specified, all performance data, analyses, findings, and reported outcomes apply exclusively to the Medi-Cal population. When a broader population denominator informs an analysis, the Plan explicitly identifies the denominator and documents the methodology used to isolate and evaluate the Medi-Cal population.

Section 2 · Comprehensive Assessment of Quality Improvement and Health Equity Activities — Section 2.2.7(A)(1)

2.1 The assessment method

The Plan evaluates quality improvement (QI) and health equity (HE) interventions through a standardized assessment process against three key questions:

- (1) Did the intervention improve the targeted performance measure?
- (2) Did it reach and benefit the intended member population?
- (3) Based on the results, should the intervention be continued, adapted, adopted as a standard practice, discontinued or abandoned?

Interventions are reviewed through the QIHEC oversight process using performance-monitoring reports, stratified analyses, utilization and encounter-data reviews, program evaluations, and intervention-specific outcome measures. When available, results are evaluated by race and ethnicity, language, geography, and other relevant demographic characteristics to assess health equity impact and identify opportunities to reduce disparities.

2.2 Effectiveness findings — principal interventions

Non-Clinical PIP — provider notification within seven days of an Emergency Department (ED) visit for members with Substance Use Disorder (SUD) or Specialty Mental Health (SMH) diagnoses. Pursuant to 42 CFR Section 438.330(d) and Department of Health Care Services (DHCS) requirements, Medi-Cal Managed Care Plans (MCPs) are required to conduct Performance Improvement Projects (PIPs) designed to achieve meaningful improvement across clinical and non-clinical areas. The Plan's three-year statewide Non-Clinical Behavioral Health PIP focused on strengthening administrative processes for provider notification to increase the percentage of notifications completed within seven days of an ED visit for members with a substance use disorder (SUD) or specialty mental health (SMH) diagnosis. Interventions included identifying non-Kaiser Permanente ED visits and routing provider notifications following qualifying external ED encounters to support timely follow-up care and care coordination.

From the Measurement Year (MY) 2023 baseline to Remeasurement 1 (MY 2024), the California aggregate rate improved from 47.67% to 50.34% ($p=0.0033$), a statistically significant improvement. The initial 2024 intervention focused on improving identification of encounters that took place outside of Kaiser Permanente (KP) facilities; however, it was not adopted because evaluation findings showed the need for a more targeted process redesign. In 2025, the Plan implemented a standardized workflow to route identified outside ED encounter notifications to providers, creating a more reliable process from encounter identification through provider notification. This redesigned intervention produced greater improvement, with performance reaching 57.00% at Remeasurement 2 (MY 2025; $p<0.0001$). The sustained statistically significant

improvement across both remeasurement periods demonstrates the effectiveness of the enhanced notification and routing process. **Disposition: Adopted** (see also Section 9.2).

Clinical PIP — Well-Child Visits (W30-6), Black/African American members. Pursuant to 42 CFR Section 438.330(d) and DHCS direction, the Plan operates a state-mandated clinical PIP addressing the W30-6 measure among Black/African American Medi-Cal members, a population and topic selected by DHCS based on state performance data. Interventions included generation of targeted monthly outreach lists, telephone and secure-message outreach, scheduling the next visit at the current visit, reminder letters at 10 months to encourage completion of the 12-month well-child visit, and text/call outreach at 14 months for members who had not yet completed the 12-month visit, while maintaining standard care processes for all members.

From the MY 2023 baseline to Remeasurement 1 (MY 2024), the California aggregate W30-6 rate for Black/African American members improved from 71.45% to 76.27% ($p=0.0444$), a statistically significant improvement. At Remeasurement 2 (MY 2025), performance remained above baseline at 73.34%, although the improvement was no longer statistically significant ($p=0.3718$). Regional variation contributed to the statewide result: SCAL sustained improvement at 78.81% (+4.81 percentage points from baseline), while NCAL declined to 65.24%. Performance remained above the Minimum Performance Level in every measurement period. The Plan identified a documentation and data capture gap in Northern California, where nursing staff completed an estimated 38 eligible well-child visits that were not captured in the W30-6 numerator. Recognizing that inclusion of these visits would have increased the MY 2025 rate to 73.81%, the Plan standardized documentation workflows across service areas to improve reporting accuracy and optimize quality measure performance. **Disposition: Adopted** (see also Section 9.1).

Non-Specialty Mental Health Services (NSMHS) outreach and education. Pursuant to DHCS All Plan Letter (APL) 24-012, *Non-Specialty Mental Health Services: Member Outreach, Education, and Experience Requirements*, the Plan developed and implemented an annual outreach and education strategy to increase member awareness, access, and utilization of covered NSMHS. The strategy is informed by the annual NSMHS Utilization Assessment and other data sources, including member and stakeholder feedback and population assessment findings. Together, these inputs enable the Plan to move beyond general communications and conduct targeted outreach to members experiencing lower utilization or identified barriers to care.

Key activities include:

- **Member and provider education.** In the fourth quarter of 2025, the Plan distributed the *NSMHS Covered Services and How to Access Care* flyer in 13 languages to approximately 1.2 million Kaiser Permanente Medi-Cal members. The flyer was also distributed at Community Advisory Committee and Quality Improvement and Health Equity Committee meetings and shared with primary care providers, county behavioral health plans, and other community partners. Feedback from the Community Advisory Committee and Quality Improvement and Health Equity Committee was incorporated into the outreach strategy, resulting in targeted member and provider education designed to improve awareness of covered services, clarify access pathways, and address identified barriers to care.

- **Digital and community-based resources.** The Plan maintains a dedicated [Medi-Cal Resource Center](#) on kp.org, including a mental health services webpage with digital versions of the educational materials distributed in 2025.

Building on these activities, the Plan will continue to address identified utilization gaps, promote equitable access to NSMHS, and strengthen the member experience through coordinated, co-designed approaches across stakeholder groups. These efforts will emphasize clear, culturally and linguistically appropriate information about covered services and how to access care; simplified service navigation; enhanced digital experience; and outreach and educational messaging designed to reduce stigma and support members in seeking care. **Disposition: Continued** — the 2026 Outreach and Education Plan carries the strategy forward, with utilization results evaluated at Section 6.2.

Performance against the DHCS Bold Goals. The Plan evaluates its performance against DHCS’s five Comprehensive Quality Strategy “Bold Goals,” including the reduction of health disparities. At year-end 2025, statewide performance was progressing towards established targets across all five goals. For reducing disparities in well-child visits and immunizations, the Plan exceeded its targets on four of five measures in both regions. For reducing disparities in maternity care, both regions performed above the Minimum Performance Level on both measures. For maternal and adolescent depression screening, NCAL met three of four measure targets, while SCAL met all four. For follow-up after mental health and substance use care, NCAL met all four measure targets and SCAL met all six. For the goal of achieving at least the 50th percentile on children’s preventive care measures, NCAL exceeded its targets on five of nine measures and SCAL on six of nine. Lead screening and topical fluoride application were the lowest-performing measures in both regions and are addressed in the plan of action in Section 3.3.

Lead Screening in Children (LSC) Interventions. Lead-screening performance remained a priority for improvement. Both regions achieved substantial year-over-year gains but remained below the rapidly increasing Minimum Performance Level. In NCAL, performance improved from 53.25% to 62.93%, a 9.68 percentage-point increase. Targeted telephone outreach reached 381 members with clinical gaps and resulted in 55 completed screenings, a 14% completion rate among members contacted. In SCAL, performance was 65.61%, below the MPL of 69.96%. Interventions included automated STAT blood-lead laboratory orders and parent notification letters, care-gap alerts during well-child visits, provider education, and collaboration with local health jurisdictions and community health workers.

Regional findings indicate that targeted outreach, clinical decision-support tools, care-gap identification, and streamlined laboratory workflows contributed to improved screening completion. **Disposition: Continued and expanded.** In 2026, the Plan will expand outreach, improve access to in-clinic laboratory services, explore point-of-care blood-lead testing during well-child visits, and evaluate broader statewide strategies to reduce barriers and improve performance (Section 3.3).

Topical fluoride (TFL-CH) Oral Health Initiative. A statewide Oral Health Initiative workgroup, established in the first quarter of 2025, coordinated efforts to increase topical fluoride application and dental-home referrals. In NCAL, performance improved by 6.55 percentage points year over

year to 20.91% but remained below the Minimum Performance Level. In SCAL, performance exceeded the Minimum Performance Level in five of seven counties.

Targeted member outreach was a central component of the initiative, educating families about the importance of fluoride application and encouraging them to establish a dental home with a Denti-Cal provider. A Modesto-area pilot contacted 113 families and generated 23 appointments. Additional Oral Health Initiative activities included engaging DHCS leadership on opportunities to strengthen Denti-Cal network access (supported by access data from NCAL); improving TFL-CH data capture and reporting workflows; consulting with Federally Qualified Health Centers regarding coding practices (including within School Based Health Centers); and developing a community-based dental event strategy with qualified vendors, including Smile Dental Services.

Disposition: Discontinued and replaced. The localized Modesto pilot was discontinued and will be replaced in 2026 by a comprehensive statewide campaign using targeted text and telephone outreach, complemented by continued data, provider, and network improvement activities and the planned launch of community-based dental events in several counties (Section 3.3 and Section 4.3.17).

DHCS/IHI Child Health Equity Collaborative. The Plan's participation in the DHCS/Institute for Healthcare Improvement (IHI) Child Health Equity Collaborative was evaluated as effective. The Plan's SCAL region completed Phase 1 of the Collaborative (2024-2025), which focused on improving well-care visits among members ages 18-21 through a series of improvement interventions. Building on this work, the NCAL region assumed leadership for Phase 2 (2025-2026), a statewide quality improvement initiative focused on improving Well-Child Visits in the First 30 Months of Life (W30-6 and W30-2). IHI required selection of a population with significant clinical disparity, which for KP, based on a review of baseline and stratified performance data, included the Black/AA Medi-Cal population in Sacramento County.

Sacramento County was chosen due to its large Medi-Cal pediatric population and diverse member demographics, providing an opportunity to implement and evaluate targeted interventions designed to improve well-child visit engagement and completion. NCAL initiated its first PDSA cycle to establish a baseline for the existing outreach process and evaluate opportunities to improve member engagement, appointment scheduling, and visit completion. Early findings demonstrated the value of proactive outreach while identifying opportunities to strengthen member engagement and support completion of scheduled well-child visits. **Disposition: Continued and expanded** participation in the Collaborative, with ongoing evaluation of PDSA findings to inform future improvement efforts, sustainability, and spread of effective practices (Section 9.4).

DHCS/IHI Behavioral Health Collaborative. The Plan is participating in the DHCS/Institute for Healthcare Improvement (IHI) Behavioral Health Quality Improvement Collaborative, with the SCAL region engaged in Phase 2 (August 2025 to September 2026) alongside DHCS, IHI, San Diego County Behavioral Health Services, and other Medi-Cal Managed Care Plans. The collaborative focuses on improving Follow-Up After Emergency Department Visits for Mental Illness (FUM) and Substance Use Disorder (FUA) through activities such as process mapping, PDSA cycles, data monitoring, storyboard submissions, and participation in learning sessions, coaching calls, and

action period meetings. Early efforts have focused on partnership development, assessment of existing workflows, review of baseline data, and identification of opportunities to strengthen care coordination, communication, data sharing, and member follow-up after behavioral health-related emergency department encounters. Evaluation of intervention effectiveness is pending due to HEDIS/MCAS reporting schedule; outcome data are not yet available for analysis. **Disposition: Continued** through September 2026; results monitored as data become available (see also Section 9.4).

Network Lead Entity quality oversight. The Plan's oversight of its Network Lead Entities for Enhanced Care Management (ECM) and Community Supports (CS) identified inconsistent compliance with DHCS and KFHP ECM, CS, and community-health-worker service delivery requirements at one entity; the Plan escalated through a mitigation plan and issued a formal corrective action plan in January 2026 — the oversight function operating as designed. **Disposition: Escalated**, corrective action in progress.

2.3 What the assessment changed

The 2025 evaluation informed program and monitoring priorities for 2026–2027. The Plan will monitor performance at the statewide, regional, and county levels and expand stratified analyses by geographic and socio-demographic factors to identify disparities and assess intervention effectiveness. Standardized documentation and numerator-capture workflows developed through the Well-Child Visit (W30-6) Clinical PIP will improve measure reliability and reporting consistency, while revised National Committee for Quality Assurance (NCQA) MY 2025 FUM and FUA specifications will be incorporated into behavioral health monitoring and workflow design. Children's health initiatives, including Lead Screening in Children and Topical Fluoride for Children, will continue with expanded outreach, workflow improvements, and evaluation of additional strategies. The Plan will also implement updated Office of Management and Budget race and ethnicity reporting standards as data become available.

Beginning with MY 2025/RV 2026, all Plan counties became subject to Minimum Performance Level accountability and APL 23-012 enforcement requirements, heightening the need for timely monitoring, intervention, and corrective action. Accordingly, the 2026–2027 work plan (Appendix A) establishes accountable owners, implementation timelines, and monitoring methodologies while continuing interventions demonstrated to be effective.

Section 3 • Performance Measure Analysis and Plan of Action — Section 2.2.7(A)(2)

3.1 Measure set and method

The Plan reported the Managed Care Accountability Set (MCAS) for Measurement Year 2025/Reporting Year 2026 per the DHCS Medi-Cal Managed Care Contract and APL 24-004. Analysis compares each measure against the DHCS Minimum Performance Level (MPL or the 50th percentile nationwide) and High Performance Level (HPL or the 90th percentile nationwide) and examines stratified results for disparities between member populations.

3.2 Results analysis — MY 2025 final performance

Accomplishments. Across the 18 MCAS measures held to benchmarks in Measurement Year 2025, the Plan's statewide performance met or exceeded the MPL on 17 of 18 measures, and met or exceeded the High Performance Level (HPL) on ten: FUA (30-day follow-up after ED visit for substance use, 55.43%), CIS-10 (38.60%), IMA-2 (62.41%), W30-6 (79.49%), AMR (84.39%), CBP (83.67%), GSD (17.69%, lower is better), BCS-E (77.73%), CCS-E (75.52%), and PPC-Prenatal (94.48%). Per DHCS, FUM and BCS-E were excluded from MY 2025 sanctions determinations due to specification changes that expanded those measures' denominators.

Deficiencies. Three measures fell below MPL and carry plans of action (Section 3.3):

Measure	Where	MY 2025 rate	MPL	Gap
LSC Lead Screening in Children	NCAL, SCAL, statewide	64.48% statewide 62.93% NCAL 65.61% SCAL	69.96%	–5.48 pp statewide
TFL-CH Topical Fluoride for Children	NCAL only	20.91% NCAL 25.46% statewide met 28.71% SCAL met	21.60%	–0.69 pp NCAL
WCV Child and Adolescent Well-Care Visits	SCAL only	54.18% SCAL 56.84% statewide met 60.59% NCAL met	55.41%	–1.23 pp SCAL

Stratified analysis and disparities. The Plan stratifies MCAS results per APL 24-004 and responds to identified disparities across all populations with interventions per Section 2.2.7(A)(5). The clearest current example: while the Plan's total W30-6 rate of 79.49% exceeds the HPL, the rate for Black/African American members was 73.34% (MY 2025; Section 9.1) — a 6.15-point gap against the total population. DHCS identified this disparity and selected the population for the state-mandated clinical PIP, and the Plan's own stratified assessment confirmed and prioritized the same gap — the response at Section 9.1 follows the model the Plan applies to disparities generally: a measured gap, a targeted intervention available to all clinically eligible members, and evaluation against the number.

The broader stratified review also identified pediatric care as the recurring opportunity across regions. In SCAL, the MY 2025 health equity analysis identified WCV below MPL for American Indian/Alaska Native, Black/African American, Hispanic/Latino, and White populations, and identified the White population as an LSC opportunity. In NCAL, disparities analysis identified recurring below-MPL county findings for WCV and W30 among Black/African American members and several other subpopulations. Taken together, these findings support continued stratified monitoring and targeted pediatric outreach while preserving access to interventions for all clinically eligible members.

Small-denominator note: Race and ethnicity results with fewer than 30 eligible members were not used to identify or rank disparities because the rates are too small for stable interpretation.

3.3 Plan of action

Each measure below-MPL carries an action with an accountable role, a specific date, and a monitoring data source (full grid at Appendix A):

- **LSC (the statewide priority, 5.48 below MPL).** In effect throughout MY 2025 and continuing: expanded EHR Care Gap alert criteria targeting members at both 12 and 24 months (SCAL); automated LSC lab orders with parent outreach letters, converted to STAT orders to reduce wait time at presentation; added care-gap alerts, best-practice advisories, and auto-generated screening orders in the EHR; expanded drop-in lab hours including evenings and weekends; began in-room blood draws during well-care visits at select NCAL clinics; added lead-screening reminders in the After-Visit Summary; and a lab-access landscape review to identify and close proximity gaps (NCAL). MY 2025 Q1 data indicated statewide LSC improvement. Closing the statewide gap to the current MPL requires approximately 935 additional screenings among eligible members; outreach and operational improvements planned for 2026 are sized to meet and exceed that gap.
- **TFL-CH (NCAL, 0.69 below MPL).** Mobile-clinic fluoride varnish in rural Amador County (launched 2024); community engagement including the Santa Clara County Oral Health Program "Happy Teeth" event; data-collection enhancements covering school-based clinics and Community Based Organizations (CBOs); clinical collaboration to improve delivery and EHR documentation of fluoride application; and the Stanislaus County TFL-CH outreach project (Modesto pediatrics).
- **WCV (SCAL, 1.23 below MPL).** Reminder letters to parents/caregivers to schedule well-care visits; KP.org member-portal Online Personal Action Plan reminders targeting members 18–21 to schedule an annual visit (SCAL).

Monitoring: Progress is monitored through the QIHEC review cycle using routine measure-level reporting, intervention monitoring, and regional performance reviews. Performance trends are evaluated to determine whether implemented interventions are producing the expected increases in screening and visit completion rates needed to close identified MPL gaps. Findings are reviewed with regional and operational leaders, and measures that do not demonstrate sufficient progress are subject to corrective action planning, enhanced monitoring, and escalation in accordance with the corrective-action and escalation process described in Section 5.2.

3.4 Fully Delegated Subcontractors

The Plan has no Fully Delegated Subcontractors and no Downstream Fully Delegated Subcontractors for its Medi-Cal line of business. The analyses required by Section 2.2.7(A)(2) for such entities are therefore not applicable. Subcontractor performance of delegated quality activities is assessed in Section 10.2.

Section 4 • Actions Taken on External Quality Review Recommendations — Section 2.2.7(A)(3)

The three recommendations from the 2023–24 EQR cycle were addressed in the Plan's 2025–2026 QIHE Annual Plan; the interventions adopted in response continue and are carried in the plans of action at Section 3.3.

2024–25 EQR cycle. In April 2026 Health Services Advisory Group (HSAG) finalized the 2024–25 Medi-Cal Managed Care Physical Health EQR Technical Report, which DHCS posted publicly; Volume 2 directed one recommendation to the Plan, and the Plan submitted its response to HSAG in August 2026 for incorporation into the 2025–26 EQR technical report.

1. Below-MPL measure performance, factors, and county-specific improvement.

Recommendation. The Plan will prioritize improvement in **Lead Screening in Children (LSC)** and **Topical Fluoride for Children (TFL-CH)**, the two measures that performed below the Minimum Performance Level in Measurement Year 2024. To improve performance, the Plan will conduct targeted analyses to identify the key drivers and barriers affecting outcomes, implement data-informed quality improvement strategies, and monitor the effectiveness of interventions. The Plan will also evaluate county-level performance to identify variation, focus improvement efforts, and develop targeted county-specific interventions. In addition, the Plan will assess the effectiveness of member- and provider-focused interventions and refine, replace, or discontinue strategies that do not demonstrate measurable impact.

Action taken. The Plan identified the root-cause factors for each measure — for LSC, laboratory access and operating-hour mismatches, distance between clinics and labs, competing priorities during the well-child visit, and limited parent/guardian awareness; for TFL-CH, Denti-Cal access barriers and provider-directory inaccuracies, limited benefit awareness and fluoride-safety misconceptions, single rather than the required two varnish applications, and variation in clinical workflow and documentation — and implemented targeted strategies against them. For **LSC**: expanded drop-in and in-clinic phlebotomy (including blood draws during the well-child visit), EHR automation (automated lab orders, best-practice advisories, care-gap alerts, and after-visit-summary education), and pre-second-birthday outreach calls and reminder letters. For **TFL-CH**: oral-health coalition and learning-collaborative participation with DHCS and dental-leadership advocacy for Denti-Cal network access, secure-message and telephonic dental-home campaigns, mobile-health-vehicle fluoride varnish in rural and underserved communities, and reporting-logic and coding enhancements (the Z29.3 diagnosis code and D1206A procedure code, with standardized documentation) to capture varnish delivered in medical encounters.

The Plan assessed county-level performance and scaled successful local practices across the integrated delivery system — for LSC, county telephonic outreach, a point-of-care-versus-finger-stick testing pilot, and county-specific toolkits and handbooks (Orange, San Diego, San Bernardino, Kern, and Contra Costa counties); for TFL-CH, the Stanislaus County TFL-CH improvement project, whose lessons informed the statewide automated oral-health outreach campaign for 2026–2028, plus dental-screening questionnaires and community and mobile delivery. The Plan also continued participation in statewide quality-improvement initiatives and

collaborative efforts designed to improve preventative-care access, reduce barriers to care, and advance health-equity outcomes among Medi-Cal members.

On the revise-or-abandon question, the Plan's evaluation found its interventions continuing to demonstrate value; none were abandoned, and the finding supports refining and expanding those with demonstrated results — earlier, more strategic in-year outreach, expanded automated tools, scaling county interventions to persistent-gap areas, EHR optimization, and broader community and mobile delivery. Evaluation findings also supported ongoing workflow standardization, documentation enhancements, and continued monitoring of intervention effectiveness to guide future quality-improvement activities.

Result. The Plan's identified below-MPL priorities for improvement remain LSC and TFL-CH with concrete plans of actions outlined in Section 3.3. The EQR assessment supported the continuation, refinement, and expansion of interventions designed to improve preventative-service utilization, address identified barriers and improve performance across counties and populations.

Section 5 · Analysis of Service Delivery and Quality of Care — Section 2.2.7(A)(4)

5.1 Quality performance results

Summarized in Section 3; stratified MCAS results are the backbone of the Plan's service-delivery analysis.

5.2 Encounter data and utilization review

The QIHEC oversees encounter data and utilization review activities to monitor whether Medi-Cal members receive appropriate, timely, and equitable care and to identify potential under-utilization, over-utilization, or access barriers requiring corrective action. Oversight includes bi-annual over/under utilization measurement performance reports, behavioral health utilization reporting, utilization analyses, and quarterly Utilization Management denial timeliness reporting. Findings are incorporated into annual work planning and quality-improvement activities and are used to assess performance across preventive care, maternal health, behavioral health, and hospital-based services.

The committee's review incorporated stratified health equity, access, and utilization analyses to identify potential disparities and opportunities for targeted interventions. In SCAL, primary care utilization was generally consistent across reported racial and ethnic groups, with no significant disparities identified. However, members with unknown race represented a notable opportunity area, with 95.4% reporting no primary care visit within the prior 12 months, compared with a regional average of 20.2%. Language-stratified analyses identified Korean-speaking members as a subgroup warranting continued monitoring, with 23.8% reporting no primary care visit during the prior year. Similarly, in NCAL primary care utilization was generally consistent across reported racial and ethnic groups, with no clear disparities identified. Members with unknown race also represented an opportunity area, with 64.4% reporting no primary care visit within the prior 12 months, compared with a regional average of 21.6%. Language-stratified analyses identified

opportunities for further evaluation among Hmong-speaking (26.0%) and Russian-speaking (24.6%) members, while Punjabi-speaking members demonstrated the highest primary care engagement at 10.0% reporting no primary care visit during the prior year. QIHEC also reviewed SCAL Behavioral Health Treatment (BHT) utilization and access findings, including Applied Behavioral Analysis (ABA) assessment timeliness, developmental-screening performance, member experience measures, and grievance trends, as well as NCAL utilization-review findings related to follow-up after emergency department visits, maternal and postpartum care, well-child visits, readmissions, and primary care engagement. These findings informed committee discussion regarding demographic-data completeness, language-specific utilization patterns, member engagement, and equitable access to care.

What changed because of utilization review. Utilization-review findings were incorporated into performance-improvement planning, behavioral health quality oversight, readmissions-reduction activities, and ongoing health-equity monitoring. QIHEC used these findings to identify priority populations, monitor corrective actions, and evaluate whether existing interventions were effectively addressing identified utilization patterns and disparities. Across both NCAL and SCAL, utilization-review findings informed leadership discussions, ongoing monitoring activities, and regional quality-improvement efforts related to primary care engagement, follow-up after emergency department visits, maternal health services, well-child care, behavioral health utilization, and hospital readmissions. In SCAL, utilization monitoring included developmental and behavioral health services, where all 13 service areas met the ABA initial-assessment access standard and developmental-screening performance exceeded DHCS minimum performance thresholds across counties. In NCAL, utilization-review findings established baselines for ongoing monitoring of primary care engagement, supported evaluation of follow-up care and readmissions performance, and informed regional improvement activities focused on emergency department transitions, maternal health services, well-child care, and equitable access to care. Findings from both regions were incorporated into ongoing health equity monitoring and quality-improvement planning to promote equitable access and health outcomes for Medi-Cal members. Taken together, the 2025 encounter-data and utilization-review findings demonstrate strong performance across preventive care, maternal health, behavioral health, developmental screening, and hospital utilization measures, while identifying opportunities to improve primary care engagement, follow-up care, readmissions reduction, and demographic-data completeness. The QIHEC will continue using utilization and encounter data to monitor disparities, oversee corrective actions, and evaluate whether interventions improve equitable access and health outcomes for Medi-Cal members.

Utilization Management denial timeliness (DHCS target $\geq 95\%$). SCAL achieved the timeliness standard by year-end 2025, with decision timeliness at 95.3%, practitioner notification at 99.1%, and member notification at 98.1%. Urgent member-notification timeliness also improved substantially, increasing from 71.4% in Q2 to 93.8% in Q4. NCAL met the routine-decision timeliness standard at 96.9% but did not meet the target for urgent determinations, with urgent decision and notification timeliness at 55% against the 95% standard. Corrective actions are underway and include implementation of a centralized denial-review unit, establishment of a durable medical equipment reviewer work queue in August 2025, automation of decision due dates within the care-management system, and quarterly monitoring until performance is sustained at or above the standard for three to four consecutive months. New CMS-0057-F requirements, effective

January 1, 2026, mandate standard decisions within seven calendar days and expedited decisions within 72 hours and have been incorporated into the Plan's timeliness-monitoring processes. When performance monitoring identifies a significant negative trend, the regional team promptly engages key stakeholders, develops and implements corrective action plans, and provides senior leadership with regular progress updates against established targets. This structured escalation process reinforces accountability, accelerates performance recovery, and supports achievement of quality objectives. The team also uses stratified findings from these reports to inform and support the analyses and improvement strategies outlined in Section 6.

5.3 Complaints, Grievances and Appeals

The Plan analyzes complaints, grievances, and appeals as a direct service-delivery signal, identifying where members encountered barriers to care, coverage, or service. The Consumer Experience and Local Member Services departments in each region compile and trend this data, and the QIHEC reviews findings quarterly and annually through the Member Concerns Committee structure. Analysis is conducted at the regional, service-area, department, and complaint-category levels, and is used to identify systemic patterns, prioritize corrective action, and evaluate whether interventions improve the member experience.

Rate and volume performance. The Plan's primary complaint rate Key Performance Indicator (KPI) (cases per 1,000 members) showed improvement through year-end in 2025, where complaint rates decreased in both regions. NCAL decreased from 2.69 in January 2025 to 2.41 in December 2025 (-10.4%), while SCAL decreased from 2.15 to 1.92 (-10.7%). These reductions achieved the National Member Relations goal of a 4% annual reduction established under its three-year improvement strategy.

Although member complaint case volume increased year over year, growth was proportional to underlying membership growth. Compared to 2024 year-end volumes, NCAL recorded 16,112 cases in 2025, an increase of 9.6% compared with 8.2% membership growth. SCAL recorded 18,303 cases, an increase of 6.5% compared with 6.8% membership growth. Taken together, these results indicate that member complaint performance remained stable relative to enrollment growth while the KPI improved meaningfully during the 2025 year.

Leading categories. Members reported concerns most often in the categories of quality of care and service, as well as access. Within those categories, complaints most commonly referenced treatment plans and diagnosis quality, appointment scheduling timeliness, referral authorization, staff communication, and returned calls and messages. On the health plan side, members reported concerns most often in quality of service, benefits and coverage, and administrative processes, with complaints commonly referencing prescription coverage, durable medical equipment, dental benefits, digital tools, and telephone service. Transportation complaints are tracked separately and reviewed through vendor oversight.

Across both areas, access and benefits navigation were the categories reported most consistently throughout the year. These results are consistent with member responses on access and timeliness in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, reported in Section 5.4.

Discrimination-related complaints. The Plan tracks grievances alleging discrimination as a distinct category and reviews them through a multidisciplinary process that includes the Civil Rights Discrimination Officer or designated discrimination grievance coordinator, the Area Compliance Officer, the department chief, and the operational director or manager. This process supports review of each allegation, application of corrective action where an allegation is substantiated, and adherence to applicable regulatory requirements. Discrimination-related grievances are tracked as a distinct category and reviewed through the Plan's multidisciplinary process — 1,266 statewide, of which 496 (39.2%) were Medi-Cal and 24.2% alleged disability-related denial of access.

Appeals. The Plan tracks appeals separately from complaints and grievances. Consistent with 42 CFR §438.400, an appeal is the Plan's review of an adverse benefit determination. Appeal activity is monitored through request volume and requests per 1,000 members. In 2025, appeal activity increased in both regions. NCAL recorded 647 requests, compared with 448 in 2024, and its rate increased from 0.94 to 1.24 requests per 1,000 members. SCAL recorded 562 requests, compared with 495 in 2024, and its rate increased from 0.77 to 0.82. Statewide volume increased from 943 requests in 2024 to 1,209 in 2025.

Leading appeal drivers. Requests involving internal benefits or services were the largest category, increasing from 376 in 2024 to 501 in 2025, or 33%. Requests for payment following a denied claim increased from 267 to 280, or 5%, while requests involving external benefits or services increased from 124 to 171, or 38%. Together, these three categories accounted for 952 requests, or approximately 79% of 2025 appeal activity. The increase was concentrated in requests involving benefits and services, while payment-related appeals remained comparatively stable.

Resolution timeliness. Against the 95% standard, 93% of appeals were resolved timely statewide in 2025, compared with 94% in 2024. NCAL met the standard at 95%, unchanged from 2024, while SCAL declined from 94.1% to 92.0%.

What changed because of the complaints, grievances and appeals. The following actions responded to the leading categories identified above:

- **Access and appointment availability.** A restructured primary care model is in place across all service areas to support timely appointments with preferred providers. Changes include expanded same day capacity, redesigned urgent and online booking templates, self-booking pilots, and daily access data huddles. Referral authorization to contracted behavioral health providers is expedited, and contracted specialty providers are engaged to expand appointment availability. Complaint volume decreased by 10% between January and December 2025.
- **Service behavior and communication.** Regional member experience committees oversees real time complaint reporting to leadership that support service recovery and resolutions. Interventions include teach back methods, empathy and communication training, manager rounding, and standardized after visit summaries. Call center teams tightened callback standards, upgraded interactive voice response routing to reduce misdirected transfers, and standardized response scripts. Complaint volume decreased by 19% between January and December 2025.
- **Pharmacy coverage display.** A defect in how drug coverage and copays displayed in the Plan's pharmacy systems drove member complaints and was escalated to a statewide priority;

regional Consumer Experience and pharmacy-technology leaders established a joint action-plan in mid-2025 for remediation efforts. Formulary status is now visible to prescribers within the electronic health record, with direct links to the Medi-Cal Contract Drug List to support prescribing accuracy. Complaint volume decreased by 30% between January and December 2025.

- **Transportation.** Biweekly grievance reviews and monthly oversight with the Plan's non-emergency medical transportation vendor, the vendor's addition to the Plan's complaint-tracking platform, and a new statewide transportation program-manager role lifted on-time performance above 95% against a 90% service-level agreement — with no findings in the 2024 DHCS audit.
- **Benefits navigation and continuity of coverage.** Complaints involving dental services, durable medical equipment, Enhanced Care Management, Community Supports, and disenrollment prompted escalation protocols, service recovery, and direct outreach on unresolved issues. Staff training and cross training support accuracy of benefit information and responsiveness to equipment requests. Continuation of care protocols cover coverage changes and provider transitions, including appointment scheduling, medical record transfer, and case management. Complaint volume decreased by 34% between January and December 2025.
- **Discrimination and service behavior.** The Plan operates a multidisciplinary review process (Civil Rights, Compliance, and department leadership) and requires cultural-competency training within 90 days of hire; over the same period, discrimination complaints filed in the emergency-department setting decreased 25.6% from January to December 2025 — a reduction in complaints the Plan monitors as one signal among several, not by itself a measure of underlying conduct. A statewide service-behavior training program reached organization-wide completion by year-end.
- **Digital access.** Secure messaging navigation was simplified, with fewer steps to reach messaging, clearer menu terminology, and stated response time expectations. Additional work addressed scheduling, privacy notices, prescription refills, notifications, proxy process, and website content accuracy. Complaint volume decreased by 33% between January and December 2025.

Taken together, the 2025 results show modest growth in complaint volume alongside declining complaint rates and measurable improvement in several identified problem areas. The Plan will continue using complaint, grievance, and appeal trends to identify disparities and service failures, prioritize corrective action, and monitor whether interventions improve members' access and experience.

5.4 Consumer satisfaction — Medi-Cal CAHPS

The Plan fields Medi-Cal-specific CAHPS surveys and publishes results annually; Medi-Cal CAHPS results for Measurement Years 2023, 2024, and 2025 are publicly available on the Plan's Medi-Cal Quality Improvement website. The most recent results — the MY 2025 Medicaid Adult and Child CAHPS 5.1H surveys, benchmarked against NCQA Quality Compass (All Plans 2024) and presented to the QIHEC — are reported across four survey populations (Adult and Child in each region), which the Plan reads together as an input into its statewide member-experience picture.

Statewide response was 628 of 6,000 sampled members (10.6%). Race/ethnicity variances against plan are visible and were reviewed, however, small sample sizes across many race/ethnicity categories render variance data non-reportable. The Plan has secured a doubling of the sample (2× oversampling) for the 2026 cycle to sharpen the survey signal and is pairing it with response-method outreach to lift the response rate itself (Section 7.3).

Strengths. Overall health plan rating met or exceeded the NCQA 50th percentile in all four populations. Care coordination for children scored at the 99th percentile in both regions, and child experience was strong on personal-doctor and getting-needed-care measures (NCAL Child rating of personal doctor 97th, getting needed care 90th, ease of filling out forms 98th). Adults rated provider relationships highly (SCAL Adult rating of personal doctor 90th; specialist care 88th SCAL / 82nd NCAL). Against the Plan's commercial line — a comparison available for adults only — Medi-Cal rated comparably on overall health-plan rating (64th–82nd percentile vs. commercial 67th–75th) and higher on overall health care, personal doctor, specialist care, and getting needed care, with the widest advantage on specialist care (82nd–88th percentile vs. commercial 33rd).

Areas of improvement. "Getting Care Quickly" is the Plan's clearest service-delivery deficiency: below the 25th percentile in three of the four populations (NCAL Adult 23rd, NCAL Child 21st, SCAL Adult 16th; SCAL Child 33rd), with the constraint concentrated in routine rather than urgent appointment access — and it is one of the two composites (with Getting Needed Care) scored in DHCS's Quality Withhold and Incentive Program. Both the Medi-Cal and commercial lines score below the 50th percentile on getting care quickly, doctor communication, and adult care coordination — a system-level pattern the Plan is addressing for all members. Its access-timeliness response — expanded same-day clinic capacity, redesigned scheduling templates for urgent and online appointments, standardized after-visit summaries, and clinician-communication training — is monitored through joint Care-Experience operational workgroups and carried in the work plan (Appendix A).

Adult Coordination of Care. MY 2025 Medi-Cal CAHPS identified Adult Coordination of Care as a statewide member-experience priority. The measure scored 76.1% in NCAL, at the 1st national Medicaid percentile, and 78.9% in SCAL, at the 2nd percentile, compared with the 99th percentile for Child Coordination of Care in both regions. The item measures whether members perceived their personal doctor as informed and up to date about care received from other providers. The adult-child difference indicates an opportunity to strengthen how connected care is experienced and communicated across the adult care journey.

The Plan's improvement approach will focus on strengthening care-coordination practices and making coordinated care more visible and understandable to members. Planned activities include identifying successful practices through medical-center review; translating those practices into clinician playbooks, videos, and local action tools; engaging regional leaders and service-area teams to spread effective practices and address implementation barriers; and strengthening clinician communication so members understand that relevant information from other specialties and departments has been reviewed and incorporated into their care. The Plan will adapt these activities to regional care-delivery settings through continued collaboration among Health Plan and medical-group partners. The documented improvement framework includes medical-center deep

dives, clinician and local action tools, accountable service-area teams, and communication strategies that demonstrate awareness of the member’s broader care journey.

Progress will be monitored through future Medi-Cal CAHPS results, with NCAL and SCAL Care-Experience operational workgroup leads reporting progress to QIHEC. The 2026 Medi-Cal CAHPS cycle uses a doubled sample to strengthen the survey signal, support more reliable year-over-year assessment, and improve the ability to evaluate subgroup results.

5.5 Synthesis

Across the five sources, three conclusions govern the 2026–2027 program: (1) clinical quality, preventive care, and behavioral health follow-up are the Plan's principal strengths — HPL-level performance on ten MCAS measures, strong child care-coordination and personal-doctor experience, FUA above HPL and FUM above MPL; (2) the consistent gaps are access-timeliness ("Getting Care Quickly"), adult care coordination, and the named below-MPL measures (Section 3.2), each carried in the work plan with an owner; (3) stratified analyses repeatedly identify the same populations and geographic areas as opportunities for improvement, making equity-focused intervention the through-line of the service-delivery response described in Section 6.

Section 6 • Equity-Focused Interventions: Utilization Patterns in Physical and Behavioral Health — Section 2.2.7(A)(5)

Pursuant to Section 2.2.7(A)(5), the Plan implements and maintains interventions to improve health outcomes for populations with disparities addressing identified patterns of over- and under-utilization in both physical and behavioral health services. Each intervention below is grounded in a measured utilization pattern or disparity, targets it under state or federal mandate, and is available to all clinically eligible members.

6.1 Physical health

Well-child visit completion (under-utilization). The Plan monitors utilization patterns and disparities through ongoing quality, utilization, and health equity reporting processes. DHCS stratified analyses and the Plan’s own monitoring identified lower completion of Well-Child Visits in the First 30 Months of Life (W30) among Black/African American children. In response, the Plan implemented a statewide Clinical Performance Improvement Project focused on reducing this disparity. Interventions include monthly population-specific outreach lists; telephone, secure-message, and text outreach; scheduling the next well-child visit before the current visit concludes; and reminder letters at 10 months and telephone and text reminders at 14 months. The Plan monitors performance by all socio-demographic factors to evaluate intervention effectiveness, identify emerging disparities, and guide additional improvement activities. Further details and results are provided in Section 2.2 and 9.1.

Perinatal care — postpartum and prenatal visit completion (under-utilization). While Southern California (SCAL) utilization monitoring primarily identified opportunities related to well-child visits and primary care engagement, Northern California (NCAL) over-and under-utilization monitoring

identified disparities in prenatal and postpartum care utilization among Native Hawaiian and Other Pacific Islander (NHPI) members. In NCAL, overall Medi-Cal performance remained strong, with prenatal care completion at 95.4% and postpartum care completion at 88.2%; however, NHPI members were the lowest performing racial and ethnic subgroup for both measures. Prenatal care completion among NHPI members was 85.1%, and postpartum care completion was 76.1%, compared with 92.4% postpartum care completion among Asian members. Similar disparities were observed for the Well-Child Visits in the First 30 Months of Life (15-30 months) measure, where NHPI performance was 68.9% compared with 84.2% among Asian members. In response, NCAL implemented standardized prenatal scheduling workflows, including a 36-week scheduling checklist with backup scheduling at 38- and 40-week visits, daily outreach lists managed by medical center care teams, timely patient education, and ongoing process monitoring. These findings were incorporated into ongoing regional health equity monitoring activities, with continued stratified reporting and review of performance by socio-demographic and geographic factors to identify opportunities for disparity reduction.

Primary-care engagement (under-utilization). The Plan monitors primary-care engagement through ongoing Medi-Cal utilization and access oversight. Using the DHCS Enrollees with No Primary Care Visit (ENPC) measure, NCAL and SCAL assessed primary-care utilization by geography, age, gender, race, ethnicity, and language. Results were generally aligned across regions: 21.6% of NCAL members and 20.2% of SCAL members had no primary-care visit in the prior 12 months. Although utilization patterns were largely consistent across reported racial and ethnic groups, both regions identified opportunities related to members with unknown race and to language-specific utilization trends. Utilization-review findings informed discussions about demographic-data completeness, member engagement, and potential barriers to primary-care access. Findings were shared with regional quality and clinical leadership to establish baselines for continued monitoring and evaluation of equitable access to care. In 2026, the Plan will conduct outreach to members with no primary-care visit in the prior 12 months through the Basic Population Health Management care-gap process and the Initial Health Appointment outreach process for new members. These efforts will support member engagement, improve primary-care utilization, and create opportunities to collect and validate race, ethnicity, and language information to strengthen future stratified analyses.

6.2 Behavioral health

Non-specialty mental health services utilization (under-utilization). Pursuant to DHCS APL 24-012, as further described in Section 2.2, the Plan conducts an annual NSMHS Utilization Assessment to evaluate utilization by race, ethnicity, language, age, and gender and identify populations experiencing lower utilization of covered NSMHS. Additional demographic fields are under development. The assessment measures the number of Medi-Cal members with at least one covered NSMHS encounter during the lookback period and provides a data-driven foundation for identifying utilization patterns and informing targeted outreach and education priorities.

Findings from the 2025 NSMHS Utilization Assessment, covering October 1, 2024, through September 30, 2025, were considered with other data inputs in developing the Plan's 2026 NSMHS Outreach and Education Plan for Medi-Cal members and primary care physicians. Key findings include:

- **Volume:** A total of 985,282 Medi-Cal members had at least one covered NSMHS encounter during the lookback period, an increase of approximately 86,700 members from the prior assessment period.
- **Age:** Members ages 0–21 accounted for 371,687 members with at least one covered NSMHS encounter. This group had the lowest year-over-year growth among the three age bands at 16.4%, compared with 25.0% for members ages 22–64 and 30.3% for members ages 65 and older.
- **Race and ethnicity:** Hispanic or Latino members represented the largest group with at least one covered NSMHS encounter (408,468), followed by Asian (117,101), Black or African American (114,989), and White (109,518) members.

The 2026 Community Health Assessment and Community Health Improvement Plan behavioral health findings, considered alongside Behavioral Health Transformation and Behavioral Health Services Act statewide goals, further clarified areas of concentrated need. Youth mental health access emerged as a shared priority across 13 counties in both regions, reinforcing the importance of improving NSMHS and Specialty Mental Health Services (SMHS) utilization among Medi-Cal members younger than age 21. Progress is linked to measures BH-1 and BH-2, which assess receipt of at least one core clinical service, and BH-11, which assesses the NSMHS care experience.

The [NSMHS Utilization Assessment Reports and Outreach and Education Plans](#) are available on the Plan’s Medi-Cal Quality Improvement and Health Equity webpage.

Behavioral-health follow-up after ED visits (under-utilization among a subgroup despite statewide benchmark attainment). Final MY 2025 statewide performance met applicable benchmarks for both 30-day behavioral-health follow-up measures. Follow-Up After Emergency Department Visit for Substance Use (FUA) was 55.43% (1,752/3,161), above the 53.27% High Performance Level. Follow-Up After Emergency Department Visit for Mental Illness (FUM) was 63.93% (5,853/9,155), above the 57.13% Minimum Performance Level. Regional performance varied. NCAL FUA was 58.84% (789/1,341), above the High Performance Level, while SCAL FUA was 52.91% (963/1,820), above the Minimum Performance Level but slightly below the High Performance Level. FUM met the Minimum Performance Level in both regions, at 59.56% (2,856/4,795) in NCAL and 68.74% (2,997/4,360) in SCAL.

Despite statewide benchmark attainment, final race-stratified results identified lower follow-up utilization among Black/African American members. For FUA, the statewide Black/African American follow-up rate was 46.90% (219/467), which was 8.53 percentage points below the statewide overall rate and 15.40 percentage points below the White-member rate of 62.30% (780/1,252). The direction of the difference was consistent in both regions. Black/African American FUA performance was 44.44% (100/225) in NCAL and 49.17% (119/242) in SCAL, compared with regional overall rates of 58.84% and 52.91%, respectively. Although the Black/African American subgroup met the 39.10% Minimum Performance Level in both regions and statewide, the persistent difference across regions identifies a statewide equity opportunity in follow-up utilization.

FUM showed a similar but smaller difference. The statewide Black/African American FUM rate was 58.49% (940/1,607), which was 5.44 percentage points below the statewide overall rate and 7.56

percentage points below the White-member rate of 66.05% (1,979/2,996). In NCAL, the Black/African American FUM rate was 53.71% (478/890), or 3.42 percentage points below the Minimum Performance Level. In SCAL, the corresponding rate was 64.44% (462/717) and met the Minimum Performance Level. The Plan therefore interprets the FUM finding as a statewide relative utilization difference, with a specific below-MPL opportunity among Black/African American members in NCAL. FUM underwent a MY 2025 specification change that substantially expanded the eligible population and limits direct year-over-year comparison. DHCS excluded FUM from MY 2025 sanctions determinations because of this denominator-expanding specification change. The Plan will therefore use the final MY 2025 results as the baseline for subsequent monitoring under the revised specification rather than attributing year-over-year movement solely to changes in care delivery.

The Plan addresses behavioral-health follow-up through statewide and region-specific activities. The statewide non-clinical Performance Improvement Project uses a standardized workflow to identify qualifying non-KP emergency department encounters, assess existing behavioral-health or addiction-medicine involvement, and route notifications to the appropriate treating provider within seven days. This intervention supports the care-transition pathway but measures timely provider notification, which is distinct from the FUA and FUM measures of completed member follow-up within 30 days. In NCAL, related activities include standardized emergency department transition workflows, structured outreach through mental-health and addiction-medicine partnerships, integration of Emergency Prospective Review Program information into the Care Coordination Transitions Dashboard, and care-coordinator support for transitions to Kaiser Permanente or county resources. In SCAL, activities include the Emergency Prospective Review Program provider-notification process and participation in the DHCS/IHI Behavioral Health Collaborative focused on strengthening communication, data exchange, care coordination, and follow-up after behavioral-health emergency department visits.

Interventions in this section are planned and operated under Section 2.2.7(A)(5), APL 24-004 (stratification and health equity promotion), and 42 CFR Section 438.330. Where a specific population is named, the focus responds to a DHCS-identified disparity or DHCS/CMS reporting mandate; all services and interventions remain available to all clinically eligible members.

Section 7 • Member and Family Engagement — Section 2.2.7(A)(6)

The Plan incorporates member, family, and community perspectives into quality and health-equity oversight through Community Advisory Committees (CACs), member listening activities, feedback surveys, community partnerships, and documented feedback loops connecting findings to responsible operational and governance bodies.

7.1 The engagement structure

In 2025, the Plan expanded from two CACs to nine—five in Northern California (NCAL) and four in Southern California (SCAL)—in accordance with All Plan Letter (APL) 25-009. Each committee represents a cluster of the Plan’s service-area counties:

- **NCAL** — North Bay (Marin, Napa, Sonoma, Solano); East Bay (Alameda, Contra Costa); San Francisco Bay Area (San Francisco, San Mateo, Santa Clara, Santa Cruz); Sacramento

Region (Amador, El Dorado, Placer, Sacramento, Sutter, Yolo, Yuba); and Central Valley (Fresno, Kings, Madera, Mariposa, Tulare, San Joaquin, Stanislaus).

- **SCAL** — Central Valley South (Kern, Ventura); Greater Los Angeles; Inland Desert (Imperial, Riverside, San Bernardino); and South SoCal (Orange, San Diego).

Each committee is designed to include approximately 25 Medi-Cal members and three community-based organization (CBO) representatives, recruited to reflect the Plan’s Medi-Cal population, including hard-to-reach populations. Combined participation increased from 65 members in 2024 (NCAL 34; SCAL 31) to 208 in 2025 (NCAL 113; SCAL 95). The committees met quarterly in 90-minute sessions, for 36 meetings during 2025—20 in NCAL and 16 in SCAL.

Meetings were conducted virtually; an in-person pilot began in Q3 2025, with one in-person meeting per quarter in each region. CAC findings are reported through the Medi-Cal Quality Improvement and Health Equity Committee (QIHEC) oversight structure described in Section 1, together with findings from member listening activities, post-meeting surveys, and community partnerships.

7.2 How member input is analyzed

CAC feedback is coded and analyzed using qualitative thematic analysis and quantitative coding across seven primary themes: access to care; member experience; communication and respect; system navigation; community-specific needs; support services and resources; and Medi-Cal experience. Documented feedback increased from 177 items in 2024 to 1,263 items statewide in 2025. Analyses for Q1 (290 items), Q2 (365 items), Q3 (317 items), and Q4 (289 items) were reviewed by the CAC Feedback Committee on June 2, August 21, November 19, 2025, and February 13, 2026.

The Plan supplemented this CAC analysis with a statewide review of seven 2025 member-experience reporting sources: NCAL and SCAL care experience; Civil Rights and Section 1557; Medi-Cal Consumer Assessment of Healthcare Providers and Systems (CAHPS); Medi-Cal Voice of the Consumer; and NCAL and SCAL language access. Each contributing group identified up to three priority opportunities, producing 15 themes categorized as access to care, benefits navigation, quality, or reputation. Access to care and benefits navigation were the most consistently identified areas of opportunity.

7.3 How input informs decisions: closed feedback loops

- **Benefits and CalAIM navigation.** CAC input on the Community Supports website informed planned updates to member communications. The broader Voice of the Consumer analysis confirmed opportunities to improve awareness of Medi-Cal benefits, timeliness of CalAIM services, and understanding of how CalAIM providers are assigned. Responsive actions included coordination with CAC and stakeholder teams, identification of additional Permanente Medical Group education needs, placement of one NLE on a performance improvement plan, and frequent checkpoints with NLEs to resolve escalations.
- **Care access and coordination.** CAC feedback prompted a commitment to document Medi-Cal care-coordination workflows and share that information with members. The 2025 Medi-Cal CAHPS survey, completed by 628 of 6,000 sampled members (10.6%),

subsequently identified Getting Care Quickly—below the 25th national percentile in three of four surveyed populations—and adult Coordination of Care—at the 1st percentile in NCAL and 2nd percentile in SCAL—as priorities. Access-timeliness actions are documented at Section 5.4; the Plan’s statewide improvement approach for Adult Coordination of Care is described in Section 5.4 and will be adapted to regional care-delivery settings. The Plan secured twice the sample for the 2026 survey cycle and began exploring outreach tailored to members’ preferred response methods.

- **Member communications and policy information.** Feedback prompted review of how the Plan develops, approves, and distributes member communications and consideration of a Patient Advisory Council round-robin format for more focused engagement. In response to member concerns about Medi-Cal program changes, the Plan also added a policy-update segment to CAC agendas for the remainder of 2025.
- **Closing the loop and sustaining participation.** The Plan presents findings and resulting actions back to CAC members and connects individual members with information or resources when feedback identifies a specific need. Attendance data also prompted graduated outreach by email, text, and telephone; an in-person meeting pilot; and replacement of four CBO representatives that had not attended during 2025—one in NCAL and three in SCAL.

7.4 Culturally and linguistically appropriate engagement

The Plan designs its engagement processes to be culturally and linguistically responsive at the point of input. Under APL 25-009, CACs advise on the cultural and linguistic appropriateness of the Plan’s policies, communications, partnerships, services, and diversity, equity, and inclusion training. Committee recruitment is intended to reflect the Medi-Cal populations represented.

In 2025, feedback concerning community-specific needs identified priorities affecting all members, including immigrant subpopulations, members with limited English proficiency, LGBTQIA+ members, older adults, and families of members with special health care needs. Member input informed Spanish-language Community Supports materials in the Sacramento region and Vietnamese translations in Greater Los Angeles. Members also identified digital access barriers affecting older adults and members with limited internet access; the Plan incorporated these concerns into its review of member communications.

7.5 Community provider participation in quality improvement

Community-based organizations and other community partners participate in quality improvement through three distinct channels:

- **CAC participation.** CBO representatives serve as CAC members and contribute community and population-specific perspectives, including the experiences of hard-to-reach Medi-Cal populations. Their input informs the Plan’s consideration of opportunities related to care, access, member experience, health equity, communications, policies, and procedures.
- **QIHEC governance.** Medi-Cal Members and CBO Representatives serve as voting members of QIHEC, which oversees Medi-Cal quality and health-equity performance and

compliance with the Plan’s DHCS contract. QIHEC evaluates quality-improvement and health-equity activities, identifies performance deficiencies, initiates or recommends responsive actions, and monitors follow-up.

- **Service-delivery.** Community organizations participate as Network Lead Entities or as sub-providers of Enhanced Care Management, Community Supports, and Community Health Worker services across the Plan’s 32-county Medi-Cal service area. These partners contribute geographic, cultural, population-specific, and operational knowledge to the design, delivery, monitoring, and improvement of services through applicable contract and quality-oversight processes.

Together, these roles incorporate community perspectives into both formal quality governance and the delivery and improvement of services for Medi-Cal members.

7.6 Health Education

The Plan provides health education through individual support, coaching, classes, digital tools, and written materials. Depending on the service, members may participate in person, virtually, by telephone, online, or through print resources; SCAL also offers text-message education. Services are available at no cost and are designed to accommodate members’ language, literacy, accessibility, readiness, and learning preferences. Members may access services directly or through care-team referrals, with individual encounters documented in the electronic health record. Qualified Health Educators review written health education materials against the DHCS Readability and Suitability Checklist under APL 18-016 and assess sixth-grade readability, plain language, cultural and linguistic appropriateness, and evidence-based accuracy.

Health Education programs monitor enrollment and attendance by class date, location, and language and use the findings to adjust schedules and offerings. For example, NCAL identified the “DM Basics” class for testing and refinement based on member feedback, including expanded self-directed learning options. Health Education materials also connect members with relevant community, public health, and government resources, with contact information reviewed for continued accuracy.

Section 8 • Population Health Management Activities and Findings — Section 2.2.7(A)(7)

This section addresses each subsection of Exhibit A, Attachment III, Section 4.3 in order, stating the Plan's activities and the year-end 2025 findings or status for each.

4.3.1 • PHM Program Requirements

The Plan's population health management framework aligns with the DHCS Comprehensive Quality Strategy and NCQA PHM standards, and the Plan retains responsibility for the quality and health equity of all covered services, including those delivered by network providers and subcontractors. PHM activities are subject to continuous quality improvement, with oversight by the Medi-Cal QIHEC (a chartered subcommittee of the regional Quality Oversight Committee, co-

chaired by the Medi-Cal Medical Director, a Permanente Medical Group director, and the Chief Health Equity Officer) and Board-level approval per Section 1.

The Plan's 2025 PHM Evaluation concludes that the program is operating effectively and in compliance: PHM is run through integrated enterprise processes and monitored through standardized dashboards, intake forms, referral trackers, escalation logs, and regulatory repositories, which the QIHEC reviews to identify performance gaps and direct corrective action, with findings feeding annual work planning and MOU updates. The evaluation carries six named enhancements into the 2026–2027 cycle: expanded IHSS data exchange, support for Justice-Involved expansion, increased Indian Health Care Provider participation in Enhanced Care Management, finalized LEA MOUs, dashboard enhancement, and standardized QIHEC governance documentation.

4.3.2 · Local Planning

Local Planning is grounded in the Plan's participation in each Local Health Jurisdiction's (LHJs) Community Health Assessment / Community Health Improvement Plan (CHA/CHIP) process through designated county leads. (DHCS discontinued the standalone "Population Needs Assessment"; the activity now runs through the LHJ's CHA/CHIP framework.) In 2025 the Plan took part in 700+ CHA/CHIP meetings across 35 LHJs (32 counties and three cities), helping shape health improvement efforts through committee leadership, strategic funding opportunities, and data-sharing support aligned to local health priorities. The Plan also submitted 35 PHM Strategy Deliverables, one for each LHJ, to DHCS in Q1 2026.

The 2025 assessment identified the Plan's leading statewide priority conditions — access to behavioral healthcare (the new top priority, named in 22 of 35 jurisdictions), housing, healthy-food access, preventive care, and health communications — and the populations disproportionately affected: low-income members, racial and ethnic minorities, limited-English-proficient members, rural residents, youth and older adults, people experiencing homelessness, LGBTQIA+ members, and justice-involved and immigrant populations. Social-driver findings named behavioral-health provider shortages, housing instability, food deserts, transportation gaps, the digital divide, and interpreter-service gaps (limited-English proficiency exceeding one in seven members in Napa; majority-Spanish or non-English populations in Imperial and Tulare).

4.3.3 · Data Integration and Exchange

Against Section 4.3.3's lettered requirements:

(A) Data-source integration per NCQA PHM standards — the Plan provides MIS capabilities within core Health Information Technology (HIT) systems to integrate additional data sources in accordance with the amended Medi-Cal contract and NCQA PHM standards to assess the needs and characteristics of all members. HIT guidelines for MIS include the Plan and Care Delivery systems that electronically capture enrollment data, identify cohort and risk stratification data, clinical decision support tools, electronic capture of clinical quality measures, reporting regulatory data to DHCS, and maintaining patient and provider portals.

(B) Interoperability with HIT/HIE — the Plan participates in national interoperability frameworks and health information exchange networks, enabling data exchange as DHCS specifies.

(C) Medi-Cal Connect data ingestion — the Plan ingests data from Medi-Cal Connect via secure file transfer protocol (sFTP) downloads and application programming interfaces (APIs). These data include, but are not limited to, risk stratification, segmentation, and tiering (RSST) and behavioral health transformation (BHT) performance measures.

(D) Data provision to DHCS — the Plan provides and certifies administrative, clinical, and other data as specified.

(E) CalHHS Data Exchange Framework — the Plan complies with the Framework's data-sharing agreements per H&S Section 130290.

(F) CMS Interoperability and Patient Access Final Rule — the Plan maintains a Medi-Cal Interoperability and Patient Access Policy compliant with CMS-9115-F.

4.3.4 • Medi-Cal Connect

The Plan supports connectivity to Medi-Cal Connect, DHCS's population health data platform, by establishing secure API and SFTP-based data exchanges that enable the integration of member-level data into KP systems to support reporting, analytics, and care management workflows.

4.3.5 • Risk Stratification, Segmentation, and Tiering

The Plan uses population risk stratification and segmentation to identify and assess Medi-Cal member-level risks and needs, and to connect members to appropriate services in accordance with DHCS requirements and NCQA Population Health Management (PHM) standards. This includes members who are required to receive an assessment according to Federal standards and those who require additional supports during a care transition. In addition, the Plan is currently developing processes to use Medi-Cal Connect RSST risk information to identify members who may benefit from preventive services, care management, and other interventions; validate needs through outreach and engagement; and connect members to appropriate supports designed to improve health outcomes and reduce future risk.

4.3.6 • Screening and Assessments

(A) Screenings: The Plan sends a Health Information Form (HIF)/Member Evaluation Tool (MET) to all new Medi-Cal members within 90 days of enrollment. The Plan monitors completion and reviews responses to identify member needs, support appropriate follow-up, and facilitate care coordination. The Plan also conducts outreach and scheduling efforts to support completion of an Initial Health Appointment (IHA) within 120 days of enrollment. During the IHA, members receive a comprehensive assessment of their health needs and are connected to appropriate services and care management resources; however, an IHA may not be necessary when the member's medical record contains complete and current information from the previous 12 months.

(B) Assessments: The Plan conducts targeted assessments for Medi-Cal members with specialized needs, including those requiring Long-Term Services and Supports (LTSS), individuals enrolled in Complex Care Management (CCM) or Enhanced Care Management (ECM), Children and Youth with Special Health Care Needs (CSHCN), pregnant individuals, and other high-risk populations. Assessments are performed by appropriate providers, documented in the electronic medical record, and followed by care team interventions as needed.

4.3.7 · Care Management Programs (Complex and Enhanced)

Complex Care Management (CCM) and Enhanced Care Management (ECM) operate along the Plan's care-management continuum. ECM serves members with the highest needs who meet DHCS-defined Population of Focus criteria, while CCM supports members with higher or rising risk. ECM is administered in accordance with the DHCS ECM Policy Guide and Model of Care requirements; CCM operates separately under Plan-established criteria consistent with NCQA standards.

ECM is available to eligible members across all DHCS-defined Populations of Focus, including justice-involved members (Section 4.3.23). The Plan also works with Indian Health Care Providers to strengthen the ECM provider network and improve access for eligible American Indian and Alaska Native members (Section 4.3.22). Members eligible for both ECM and 1915(c) waiver services must select one program, consistent with DHCS requirements, to prevent duplication of services (Section 4.3.20).

CCM eligibility criteria incorporate locally identified needs from the Community Health Assessment and Community Health Improvement Plan process, helping align care-management resources with populations experiencing elevated risk and unmet needs.

4.3.8 · Basic Population Health Management (BPHM)

The Plan's BPHM program is available to all Medi-Cal members and provides whole-person, population-based support to improve health outcomes and advance health equity. The program connects members with primary and preventive care, chronic disease management, health education, wellness resources, and services addressing physical, behavioral, developmental, and health-related social needs. It also coordinates care across healthcare providers, community-based organizations, and social service partners. Data are used to identify care gaps, disparities, and populations—including children—that may benefit from targeted preventive services, care navigation, or enhanced care management.

4.3.9 · Other Population Health Requirements for Children (EPSDT)

The Plan's Medi-Cal for Kids and Teens program implements the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit in accordance with DHCS APL 23-005 and other applicable federal and state requirements. In 2025, both regions updated their well-child periodicity schedules and blood-lead screening policies, including alignment with the blood-lead screening requirements in DHCS APL 20-016 (Revised). Dental screenings and oral health assessments are conducted at each periodic visit for members under age 21 (Section 4.3.17). Developmental screening performance exceeded the 37.40% Minimum Performance Level in both regions, reaching 83.12% in SCAL and 62.60% in NCAL, 74.57% statewide.

Through QIHEC oversight, the Plan prioritizes children's Population Health Management measures performing below the Minimum Performance Level: Lead Screening in Children and Topical Fluoride for Children. Both measures are subject to stratified performance monitoring and targeted interventions (Section 3.3). The Well-Child Visits in the First 30 Months of Life measures, W30 and W30-6, performed above the Minimum Performance Level; W30-6 is also the focus of the statewide Clinical Performance Improvement Project addressing racial disparities (Section 9.1).

4.3.10 · Transitional Care Services

The Plan provides Transitional Care Services (TCS) to support safe, timely transitions between care settings, including hospital-to-home, facility-to-community, and health plan transitions, and to reduce readmissions through the Plan All-Cause Readmissions workstream (Section 5.2). Each transitioning member is classified as high or lower risk in accordance with the PHM Policy Guide. High-risk members receive a single point of contact throughout the transition, while lower-risk members have access to a dedicated TCS team for at least 30 days after discharge. TCS includes member outreach, risk assessment, discharge planning and coordination, medication reconciliation, follow-up care, and referrals to Complex Care Management, Enhanced Care Management, Community Supports, and other needed services. The Plan coordinates with discharging and post-discharge providers to support continuity of care and connect members with necessary medical, behavioral health, long-term services and supports, and community-based services.

In 2026, TCS will expand to include moderate- and high-intensity pregnancy and postpartum services. Program targets include outreach to 75% of high-risk members and completion of a follow-up provider appointment by 60% of discharged members within seven days of discharge.

4.3.11 · Targeted Case Management

The Plan identifies populations eligible for Targeted Case Management (TCM), including members at risk and members with developmental disabilities, maintains referral procedures, and coordinates with Local Government Agencies (LGAs) when members receive county-administered TCM. This coordination includes arranging medically necessary covered services identified in TCM care plans, including referrals and prior authorization for out-of-network services, and continues until the LGA confirms that TCM is no longer needed.

The Managed Care Liaison (Section 4.3.24) serves as the Plan’s designated contact for sharing provider and care-manager information, resolving operational issues, and notifying members’ PCPs and care managers of TCM participation and LGA contacts. The Plan also prevents duplication between TCM and Basic Population Health Management, Complex Care Management, Enhanced Care Management, and Community Supports. For members under age 21, the Plan remains responsible for timely delivery of all medically necessary services under the Early and Periodic Screening, Diagnostic, and Treatment benefit.

4.3.12 · Mental Health Services (Non-Specialty)

The Plan uses DHCS-approved screening and transition tools to connect members with the appropriate mental health delivery system in accordance with No Wrong Door requirements. The Plan provides timely NSMHS, including during assessment and before a diagnosis or service-eligibility determination, and for members with co-occurring mental health and substance use disorders. NSMHS may be provided concurrently with SMHS when the services are coordinated and not duplicative. Under APL 26-002, NSMHS are available to adults aged 21 and older with mild-to-moderate distress or impairment and to members under age 21 regardless of diagnosis or level of distress or impairment. Covered services include individual, group, family, and dyadic psychotherapy; psychological and neuropsychological testing; outpatient drug-therapy monitoring;

psychiatric consultation; and related outpatient laboratory services, medications, supplies, and supplements.

Members meeting SMHS criteria are referred to the applicable county Mental Health Plan (MHP). The Plan coordinates services with each MHP through an MOU and continues appropriate NSMHS during transitions to SMHS. Disputes do not delay medically necessary care and are resolved within 15 working days—or one working day when expedited review is warranted—in accordance with APL 21-013. The Plan annually updates and publicly posts its DHCS-approved member and PCP [NSMHS Utilization Assessment Reports and Outreach and Education Plans](#), as described in Section 6.2.

4.3.13 · Alcohol and Substance Use Disorder Treatment Services

Under APL 26-002, the Plan provides or arranges covered alcohol and substance use disorder (SUD) services, including:

- Screening, assessment, brief intervention, and referral to treatment for members aged 11 and older, including pregnant members;
- Preventive tobacco, alcohol, and illicit-drug screening consistent with USPSTF and Bright Futures recommendations;
- Medications for Addiction Treatment (MAT), including buprenorphine and other prescribed medications, in primary care, emergency departments, hospitals, and other contracted medical settings; and
- Emergency and post-stabilization services.

The Plan identifies and refers members needing additional treatment to county Drug Medi-Cal and Drug Medi-Cal Organized Delivery System programs, community resources, or applicable Medi-Cal Fee-for-Service opioid-treatment providers. The Plan assists members in locating services, including outside its service area when necessary, and continues to provide all medically necessary covered services and coordinate care across providers and treatment programs.

MOUs with county SUD agencies define responsibilities for timely care coordination and prevention of service gaps or duplication. Related data-sharing agreements comply with 42 CFR Part 2 and DHCS authorization requirements, including identifying the Plan and DHCS as authorized recipients for payment and health care operations and incorporating applicable redisclosure provisions (*APL 21-014; Section 13*).

4.3.14 · California Children's Services

The Plan identifies members with potential California Children's Services (CCS)-eligible conditions through baseline health assessments, diagnostic evaluations, internal reporting, and provider or Plan referrals. In non-Whole Child Model counties, network providers submit initial referrals to the local CCS Program on the same day and provide supporting clinical documentation. Providers are informed that CCS reimburses only CCS-paneled providers and CCS-approved hospitals, beginning on the referral date. For emergency admissions, notification occurs by the next working day. The Plan continues all medically necessary covered services while eligibility is determined. Once eligibility is established, the Plan coordinates joint case management among the member's PCP, CCS providers, and county CCS Program; provides services not authorized by CCS; and

arranges authorized in-home nursing hours when requested. If CCS eligibility or a requested service is denied, the Plan remains responsible for medically necessary covered services.

MOUs with each county CCS Program define responsibilities for care coordination and prevention of service duplication. A designated liaison (Section 4.3.24) coordinates the Plan-county interface, while risk stratification (Section 4.3.5) supports integration of CCS and non-CCS care. At least 12 months before a member ages out of CCS, the Plan develops a transition plan addressing the member's qualifying condition, potential eligibility for other programs, transition needs, member communication, and appropriate primary and specialty care. The Plan continues assessing the member's needs throughout the first 12 months after transition.

4.3.15 • Services for Persons with Developmental Disabilities

The Plan maintains policies and procedures to identify and track members with developmental disabilities and the medical, behavioral health, Regional Center, and other supportive services they receive. Member care plans incorporate Regional Center services and support coordination among primary care, specialty care, mental health, and Regional Center providers, including transition planning and follow-up. A trained Regional Center Liaison serves as the central point of contact for the 19 Regional Centers operating within the Plan's service area. The liaison assists members and families in understanding and accessing services, coordinates referrals, provides training and technical assistance, manages escalations, and supports resolution of access and care concerns.

The Plan refers members to Regional Centers for evaluation and access to non-medical services, including respite, out-of-home placement, and supportive living services. Coordination with Regional Center staff supports development and implementation of the member's individual developmental services plan, timely information exchange, and prevention of service duplication. The Plan continues providing all medically necessary covered services, including medical care, non-specialty mental health services, and Behavioral Health Treatment. The Plan also identifies and refers eligible members to Home and Community-Based Services programs administered by the Department of Developmental Services and coordinates those services in accordance with Section 4.3.20. In 2025, the Plan continued MOU development with its 19 Regional Center partners. In 2026, the Plan will further operationalize referral and data-exchange protocols, strengthen joint care-coordination workflows, and use quarterly partner meetings to identify and address access and quality-improvement opportunities.

4.3.16 • School-Based Services

The Plan covers medically necessary mental health and substance use disorder (SUD) services delivered by eligible school-linked behavioral health providers to members aged 25 or younger under the Children and Youth Behavioral Health Initiative (CYBHI) Multi-Payer School-Linked Fee Schedule. Services are reimbursed at DHCS-established rates and administered in accordance with applicable DHCS guidance and agreement requirements. During 2025, the Plan established the operational capabilities necessary to support implementation of the CYBHI Fee Schedule, including claims administration, member eligibility identification, data exchange, contracting, and related operational processes. The CYBHI Interim Memorandum of Understanding (MOU) was executed in August 2025.

In 2025, the Plan:

- Successfully completed participation in the School-Based Behavioral Health Incentive Program (SBHIP) across all 32 service-area counties and supported distribution of more than \$7 million to advance school-based behavioral health services and infrastructure;
- Served as a key SBHIP partner, with accountability for reporting and fund distribution for 12 counties and 58 participating school entities;
- Supported participating school entities in strengthening school-linked behavioral health infrastructure through technical assistance and service and information technology expansion efforts, including support across 10 counties; and
- Collaborated with LEAs, County Offices of Education (COEs), DHCS, and other implementation partners to support the transition from SBHIP to the CYBHI Fee Schedule and strengthen school-linked behavioral health infrastructure.

Through its school-based behavioral health initiatives, including SBHIP participation and CYBHI implementation activities, the Plan has supported efforts to strengthen access to behavioral health services for children and youth in school settings while collaborating with educational partners to advance school-linked service infrastructure and implementation readiness.

In 2026, the Plan will continue advancing implementation of the Children and Youth Behavioral Health Initiative (CYBHI) Multi-Payer School-Linked Fee Schedule, including the processing and payment of eligible school-linked behavioral health claims and continued operationalization of claims administration, member eligibility identification, data exchange, and related operational processes. The Plan will maintain coordination across cross-functional teams and education partners to support implementation activities and advancement of the long-term Fee Schedule operating model. Following the State's delay of the Local Education Agency (LEA) MOU requirement until January 1, 2027, the Plan will continue engaging LEAs and County Offices of Education (COEs) to support implementation readiness and strengthen collaboration between health care and education partners. These efforts include development of an LEA-Health Plan Roadshow designed to build shared understanding of roles and responsibilities, identify local implementation considerations, strengthen relationships between managed care and education partners, and support future LEA MOU execution and implementation.

4.3.17 • Dental

The Plan ensures that all members receive appropriate dental screenings and oral health assessments and are referred to Medi-Cal dental providers. The Plan covers medically necessary Federally Required Adult Dental Services, fluoride varnish, and dental-related services that may be performed by medical professionals; services available exclusively through dental providers are provided through the Medi-Cal Dental Program. For members under age 21, dental screening and oral health assessment are incorporated into every periodic health assessment, with annual dental referrals beginning at the eruption of the first tooth or 12 months of age, whichever occurs first.

A designated dental liaison assists Medi-Cal dental providers with referrals and access to related covered services, including laboratory testing, pre-admission examinations, facility-based care, and inpatient or outpatient anesthesia. When prior authorization is required, the Plan maintains

and publishes DHCS-reviewed procedures to support timely access and coordinates those procedures with the DHCS Medi-Cal Dental Services Division.

In 2025, the Plan launched the Statewide Oral Health Initiative to assess fluoride-varnish and dental-home-referral workflows, identify gaps, and improve consistency across care settings. The initiative supports the Plan’s strategy to improve Topical Fluoride for Children performance (Section 3.3). In 2026, the Plan will conduct four to six community-based dental events offering fluoride varnish, screenings, and oral health education. The Plan will also strengthen education for staff and dental providers regarding Medi-Cal dental benefits, care coordination, and prior authorization for dental anesthesia.

4.3.18 · Directly Observed Therapy for Tuberculosis

The Plan arranges and coordinates timely outpatient diagnostic and treatment services for members with suspected or active tuberculosis (TB), including examinations, drug therapy, laboratory testing, and radiology. For each member requiring anti-tuberculosis drug therapy, the Plan assesses the risk of treatment resistance or nonadherence across the risk groups identified in Section 4.3.18(A). Members with active TB or an identified risk are referred to the Local Health Department (LHD) TB Control Officer for Directly Observed Therapy (DOT) in accordance with Section 4.3.18(B). Joint case management and care coordination are governed by the LHD MOU required under Section 5.6, which establishes referral pathways, responsibilities, information-sharing processes, quality-improvement activities, and ongoing oversight. The Plan provides all medically necessary covered services for members receiving DOT.

4.3.19 · Women, Infants, and Children (WIC)

The Plan identifies and refers eligible members to county Women, Infants, and Children (WIC) programs. Eligible members include those who are pregnant, breastfeeding, or postpartum and parents or legal guardians of members under age five. Referrals are made during the initial evaluation of newly pregnant members and at other appropriate care encounters. As of January 2026, the Plan has executed 40 of 63 MOUs with county WIC agencies and third-party entities across its 32 counties, with the remainder in progress. A dedicated WIC liaison and MOU implementation team coordinate referral workflows, quarterly partner meetings, intake and triage processes, and member or provider escalations. In 2026, the Plan will continue refining referral and escalation workflows to support timely access to medically necessary formula and human donor milk and will expand donor-milk contracting to address access gaps.

4.3.20 · Home and Community-Based Services

The Plan identifies members who may benefit from Home and Community-Based Services (HCBS) through screenings, assessments, and referrals and connects them with the appropriate administering entity. Referral and coordination activities include the Medi-Cal Waiver Program, Assisted Living Waiver, Home and Community-Based Alternatives Waiver, Multipurpose Senior Services Program, Developmental Disabilities Waiver, and Self-Determination Program across the Plan’s 32-county service area. Members remain enrolled in the Plan while applying for or receiving HCBS. The Plan continues providing all medically necessary covered services and coordinates with state agencies, waiver agencies, Regional Centers, care managers, providers, and other authorized

entities. Designated staff serve as a central point of contact, assist members in understanding and accessing services, and support the timely exchange of health and medical information in accordance with HIPAA and applicable data-sharing requirements. To prevent duplicative case management, members enrolled in 1915(c) HCBS waivers are excluded from Enhanced Care Management while continuing to receive Plan-covered services and care coordination. The Plan has also recruited Consumer Advisory Committee members representing HCBS programs to incorporate member perspectives into program oversight.

In 2026, the Plan will expand staff education, strengthen coordination and information exchange with HCBS entities, and improve data identifying members enrolled in HCBS programs to support continuity of care and prevent service duplication.

4.3.21 · In-Home Supportive Services (IHSS)

The Plan identifies members who may benefit from In-Home Supportive Services (IHSS) through screenings, assessments, and referrals and refers them to the county IHSS program for eligibility determination. The Plan tracks members receiving IHSS using available county and member-reported information, contacts county agencies regarding members identified by DHCS, and continues coordination until notified that IHSS is no longer needed. Coordination includes reviewing IHSS participation when determining eligibility for Enhanced Care Management, Personal Care Services and other Community Supports, and related services to prevent duplication; consulting county assessments when available; conducting case conferences; and maintaining communication regarding unresolved medical and social needs. The Plan reassesses members' risk tiers upon referral, approval, or receipt of IHSS (Section 4.3.5) and continues Basic Population Health Management and care coordination for all medically necessary services.

A designated IHSS/LTSS liaison serves as the day-to-day contact with county IHSS agencies. The liaison is trained on IHSS eligibility, assessment and referral processes; coordination across IHSS, medical care, and long-term services and supports; and referrals supporting transitions from inpatient and skilled nursing settings to home and community-based care. The Plan continues executing MOUs with IHSS agencies across its 32-county service area. In 2026, the Plan will develop operational guidelines, direct data-exchange pathways, and discontinuation-notification processes to strengthen timely, coordinated, and nonduplicative care.

4.3.22 · Indian Health Care Providers

The Plan maintains a dedicated Tribal Liaison who works with contracted and non-contracted Indian Health Care Providers (IHCPs) across the Plan's service area. The liaison coordinates referrals, care navigation, provider relations, claims resolution, and timely payment for services provided to eligible American Indian and Alaska Native members. In 2025, the Plan continued working with Network Lead Entities to expand culturally responsive Enhanced Care Management capacity and refined billing and claims workflows to reduce administrative barriers for IHCPs. In 2026, the Plan will develop bidirectional referral pathways and warm handoffs between IHCPs and Plan providers, expand access to culturally appropriate behavioral health services, provide staff education focused on cultural humility and trauma-informed care, and continue participating in the statewide Tribal Liaisons Workgroup.

4.3.23 · Justice-Involved Reentry

The Justice-Involved Enhanced Care Management (ECM) Population of Focus launched January 1, 2024, and the Justice-Involved Pre-Release Initiative launched October 1, 2024, making California the first state to implement pre-release services of this kind. The initiative is being implemented county by county through September 30, 2026, and supports eligible individuals during the 90 days before release. A designated Justice-Involved Liaison processes correctional-facility referrals, coordinates ECM provider assignment through the Plan’s Network Lead Entity, and serves as an escalation point. Pre-release care managers coordinate behavioral health linkages, information exchange, and warm handoffs to post-release ECM providers. The Plan ensures access to medically necessary covered services, including physical and behavioral health care, ECM, Community Supports, non-emergency medical transportation, and non-medical transportation.

At year-end 2025, pre-release services were operational in eight counties—Kern, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Sutter, and Yuba—and statewide within California Department of Corrections and Rehabilitation facilities. A single Network Lead Entity served Justice-Involved ECM providers. DHCS released the county Justice-Involved MOU in December 2025, while the CDCR-specific MOU remained pending. In 2026, the operational footprint expands to 13 counties: Alameda, El Dorado, Imperial, Kern, Los Angeles, Orange, San Diego, San Francisco, San Joaquin, San Mateo, Santa Clara, Sutter, and Yuba. The Plan continues phased implementation in the remaining counties and collaboration with other Medi-Cal managed care plans on a statewide data-sharing strategy for reentry coordination.

4.3.24 · Managed Care Liaisons

The Plan maintains designated Tribal, Long-Term Services and Supports (LTSS), Transportation, California Children’s Services, County Child Welfare, Justice-Involved, Regional Center (RC), Dental, and In-Home Supportive Services (IHSS) Liaisons, who serve as day-to-day points of contact for their respective services and programs. The Plan also maintains liaison support for transitional care management. Liaisons receive domain-specific training on applicable requirements, referrals, care management, authorization, payment, and coordination processes. Partner entities are notified of liaison changes no later than the effective date, and DHCS is notified within five days.

Domain-specific responsibilities include:

- The LTSS Liaison supports coverage, payment, claims, provider-resolution, care-management, and transition processes.
- The Transportation Liaison provides direct, real-time assistance and urgent triage for unresolved, time-sensitive transportation issues; this function is not delegated to the transportation broker.
- The CCS Liaison coordinates services with county CCS programs, facilitates quarterly meetings, and supports referral, annual review, care-management, and authorization processes.
- The Child Welfare Liaison advocates for members involved with county child welfare, supports Child and Family Team participation, coordinates covered and county services, provides

technical assistance to ECM providers, and addresses operational or intercounty-transition barriers.

- The Justice-Involved Liaison supports correctional facilities, pre-release care managers, and ECM providers with reentry planning, referrals, provider assignment, and escalation.
- Tribal, Regional Center, dental, and IHSS liaisons perform the coordination responsibilities described in subsections 4.3.15, 4.3.17, 4.3.21, and 4.3.22.

In 2025, liaisons managed member-care and data escalations, supported county initiatives, provided training and technical assistance, and participated in MOU development. In 2026, the Plan will continue advancing MOUs with all 32 counties and 19 Regional Centers; develop referral, data-exchange, and operational workflows; use quarterly partner meetings to identify improvement opportunities; and leverage liaison expertise to increase appropriate access to Enhanced Care Management, Community Supports, and Community Health Worker services (Section 13).

Section 9 • Performance Improvement Projects, Survey Outcomes, and Collaborative Initiatives — Section 2.2.7(A)(8)

The Plan operates two statewide PIPs per 42 CFR Section 438.330(d) and APL 24-004.

9.1 Clinical PIP — W30-6 among Black/African American members

The DHCS-mandated Clinical Performance Improvement Project (PIP), conducted pursuant to APL 24-004, focused on improving Well-Child Visits in the First 30 Months of Life (W30-6) among Black/African American members, a population selected by DHCS based on identified disparities. Performance increased from 71.45% (553/774) in MY 2023 to 76.27% in MY 2024, a statistically significant improvement ($p=0.0444$). In MY 2025, performance remained above baseline at 73.34%, although the difference was no longer statistically significant ($p=0.3718$). Performance exceeded the minimum performance level in all measurement periods despite a 42% increase in the eligible population, from 774 to 1,099 members. Regional results diverged in MY 2025: SCAL improved to 78.81%, while NCAL declined to 65.24%.

Root-cause analysis identified an NCAL documentation and numerator-capture issue affecting eligible nursing-staff visits. Pediatric leadership implemented standardized workflows to improve encounter capture. Beyond the capture correction, NCAL continues the PIP's outreach interventions — monthly population-specific outreach lists, the 10-month reminder letter, and 14-month text and call outreach — and the Sacramento County IHI Collaborative PDSA (Section 9.4) tests refinements to that outreach for the same population. During the 2024–2025 validation cycle, HSAG assigned the PIP High Confidence ratings for both Acceptable Methodology and Significant Improvement based on MY 2024 remeasurement results, with 100% of evaluation and critical elements met. Sustained improvement cannot yet be assessed because HSAG requires an additional remeasurement period after significant improvement is demonstrated. The PIP will continue in 2026–2027 with region-specific adaptations to address remaining variation between NCAL and SCAL.

9.2 Non-Clinical PIP — 7-day provider notification, SUD/SMH ED encounters

The DHCS-mandated Non-Clinical Performance Improvement Project (PIP), conducted pursuant to APL 24-004, focused on improving provider notification following Emergency Department (ED) visits by members with a Substance Use Disorder (SUD) or Specialty Mental Health (SMH) diagnosis. Performance increased from 47.67% (2,737/5,741) in MY 2023 to 50.34% in MY 2024, a statistically significant improvement ($p=0.0033$), and to 57.00% in MY 2025, demonstrating further statistically significant improvement ($p<0.0001$). Performance increased 9.33 percentage points above baseline despite the eligible population more than doubling, from 5,741 to 12,303 qualifying ED visits.

Root-cause analysis identified challenges in detecting and routing information from external ED encounters. In response, the Plan implemented the 2025 Outside Encounter Notification Routing to Providers intervention, establishing a standardized workflow from encounter identification through timely provider notification. During the 2024–2025 validation cycle, HSAG initially assigned the PIP a Low Confidence rating, with 78% of critical methodology elements met. Following corrective action and incorporation of all required methodological components, the final 2025 validation achieved High Confidence ratings for both Acceptable Methodology and Significant Improvement, with 100% of evaluation and critical elements met. These results resolved the prior validation findings and achieved the PIP's provider-notification improvement objective.

9.3 Consumer satisfaction surveys

Consumer-satisfaction outcomes are analyzed at Section 5.4 and summarized here as A(8) requires: on the MY 2025 Medi-Cal CAHPS, overall health-plan rating met or exceeded the NCQA 50th percentile in all four survey populations, child care coordination reached the 99th percentile in both regions, and Medi-Cal rated comparably to or better than the Plan's commercial line on overall rating and specialist access; "Getting Care Quickly" and adult care coordination are the named improvement priorities.

9.4 Collaboratives and Initiatives

Collaboratives, initiatives, and outcomes for the period:

- **Oral Health Initiative.** Continued advancement with improved data capture, targeted outreach, and collaboration with TPMG, community dental sites, and county partners; 2026 MCAS accountability preparation including plan-initiated outreach, care coordination, and family messaging to support dental-home establishment (See Sections 3.3 and 4.3.17)
- **DHCS/IHI Child Health Equity Collaborative.** The Plan's NCAL region participated in Phase 2 of the DHCS/IHI Child Health Equity Collaborative, focused on improving W30-6 and W30-2 performance among Black/African American Medi-Cal members in Sacramento County. During the audit period, the team initiated a PDSA cycle to evaluate the existing outreach process and establish a baseline for future improvement activities. The collaborative remains ongoing, with findings informing future interventions and health equity improvement efforts. (See Sections 2.2 and 6.1)
- **DHCS/IHI Behavioral Health Demonstration Collaborative.** The Plan's SCAL region participated in Phase 2 of the DHCS/IHI Behavioral Health Collaborative, focused on improving

care coordination, reducing behavioral health disparities, and strengthening follow-up after emergency department visits for Medi-Cal members with mental illness and substance use disorder diagnoses. During the audit period, the team conducted PDSA cycles to assess existing workflows, establish cross-system partnerships, review baseline performance, and identify opportunities to improve FUA and FUM outcomes. The collaborative remains ongoing, with findings informing sustainability planning and future interventions. Final outcomes data are pending due to HEDIS reporting timelines and claims lag. (See Sections 2.2 and 6.2)

Section 10 • Subcontractor Performance — Delegated QI and Health Equity Activities

10.1 Fully Delegated Subcontractors — Section 2.2.7(A) delegation clause

The Plan has no Fully Delegated Subcontractors and no Downstream Fully Delegated Subcontractors for its Medi-Cal line of business; the delegation-specific evaluation requirements of Section 2.2.7(A) are therefore not applicable for this reporting period.

10.2 Subcontractor assessment — Section 2.2.7(C)

American Specialty Health (ASH) performs delegated quality activities on behalf of the Plan, subject to Plan oversight. The annual statewide Quality Oversight audit, conducted in October 2025 for the January 1–December 31, 2024 review period, evaluated ASH’s quality assurance program across six delegation agreement elements: quality assurance structure, Quality Assurance Review Committee, practitioner contract requirements, continuity and coordination of care, timeliness, and communication services. **ASH met 100% of the delegation agreement requirements for 2024**, supported by consistent quarterly quality assurance reporting, adherence to appointment-access standards, and robust language-assistance services.

Opportunities to strengthen race and ethnicity reporting and expand clinical outcome measurement beyond utilization and timeliness will be carried into the 2026 oversight cycle through the quarterly ASH–KP Joint Oversight Committee and the KP Statewide Quality Oversight Delegation Workgroup. The KP audit tool will also be updated in 2026 to align with current NCQA and DHCS standards. The next annual ASH audits, covering the January–December 2025 measurement period, will be conducted from September through November 2026.

Section 11 • Accreditation — Section 2.2.7(B)

The Plan maintains NCQA Health Plan Accreditation and NCQA Health Equity Accreditation for its Medicaid line of business in both Northern and Southern California. Accreditation findings and recommendations are reviewed through the Plan’s Quality Improvement and Health Equity Program and incorporated into monitoring and improvement activities, as applicable.

11.1 Northern California

NCQA Health Plan Accreditation: The Plan completed a Standards Year 2023 Renewal Survey and remains Accredited, effective October 21, 2025, through May 29, 2027. Of the 151 scored elements, 150 were either Met or Not Applicable; one—QI 1B, Annual Work Plan—was Not Met as the reviewed work plan did not identify the staff responsible for each activity. NCQA identified no must-pass failures, and the score summary did not designate any element as subject to corrective action.



NCQA Health Plan Accreditation certificate — Kaiser Foundation Health Plan, Inc., Northern California, Medicaid HMO; Accredited; Standards Year 2023; granted October 21, 2025, expiring May 29, 2027.

NCQA Health Equity Accreditation: The Plan remains Accredited under Standards Year 2023, granted December 13, 2023, through December 13, 2026. Twenty scored elements were Met and one—HE 1B, Promoting Diversity, Equity and Inclusion Among Staff—was Partially Met. The finding related to demonstrating that training on culturally and linguistically appropriate practices, bias reduction, or inclusion was provided to all employees at least annually. NCQA recommended aligning the employee-training approach with the annual requirement, and the Plan moved to annual delivery of this training as a result; the score summary did not designate the element as subject to corrective action.



NCQA Health Equity Accreditation certificate — Kaiser Foundation Health Plan, Inc., Northern California, Medicaid HMO; Accredited; granted December 13, 2023, expiring December 13, 2026.

11.2 Southern California

NCQA Health Plan Accreditation: The Plan completed a Standards Year 2025 First Survey and was Accredited, effective November 19, 2025, through November 19, 2028. Of the 160 scored elements, 159 were either Met or Not Applicable; one—NET 5C, Assessment of Physician Directory Accuracy—was Not Met. NCQA identified no must-pass failures, and the score summary did not designate the element as subject to corrective action.



NCQA Health Plan Accreditation certificate — Kaiser Foundation Health Plan, Inc., Southern California, Medicaid HMO; Accredited; Standards Year 2025; granted November 19, 2025, expiring November 19, 2028.

NCQA Health Equity Accreditation: The Plan remains Accredited under Standards Year 2023, granted July 17, 2024, through July 17, 2027. All 21 scored elements were Met, with four delegation elements scored Not Applicable. NCQA identified no recommended actions or corrective-action requirements.



NCQA Health Equity Accreditation certificate — Kaiser Foundation Health Plan, Inc., Southern California, Medicaid HMO; Accredited; granted July 17, 2024, expiring July 17, 2027.

The Plan currently holds NCQA Health Equity Accreditation — the program Section 2.2.8 names — in both regions. For surveys on or after July 1, 2026, NCQA's 2026 standards restructure this program into Health Outcomes Accreditation and Community-Focused Care Accreditation.

Copies of the applicable accreditation certificates, score summaries, and final submission overview or state regulatory reports for both regions accompany this annual submission. Pursuant to 42 CFR Section 438.332, the Plan authorizes NCQA to provide DHCS a copy of its most recent accreditation review annually.

Section 12 • Public Availability — Section 2.2.7(D)

This QIHE Annual Plan is made publicly available on the Plan's website and is updated annually. The Annual Plan is reviewed and approved through the organization's Quality Improvement and Health Equity governance structure, including regional quality oversight committees and the Plan/Hospitals Board Quality and Health Improvement Committee (QHIC). Upon approval, the QIHE Annual Plan is published on the Plan's website in an accessible format consistent with applicable accessibility requirements and is available to the public.

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Section 13 · Regional Collaborative Participation — Section 2.2.7(E)

The Plan participates in regional collaborative meetings at least quarterly, as required by APL 24-004. Participants include other Medi-Cal managed care plans, county Mental Health Plans, Drug Medi-Cal and Drug Medi-Cal Organized Delivery System agencies, Local Government Agencies, local health departments, public hospitals, providers, community-based organizations, and other regional partners. Depending on the forum, engagement occurs weekly, monthly, or quarterly through behavioral health forums, health equity collaboratives, community health initiatives, stakeholder workgroups, and local agency meetings.

Participation is supported through a structured Local Health Jurisdiction assignment model. Each county in the Plan’s 32-county service area has designated Quality leads, including primary and secondary Accreditation, Regulatory and Licensing leads, responsible for maintaining collaborative participation and coordination. These leads work with Local Engagement, Community Health, Local Planning, MOU coordinators, county partners, providers, and community-based organizations. The Chief Health Equity Officer and Chief Medical Officer also participate in applicable DHCS and regional forums for their areas of expertise and oversight.

In 2025, the Plan participated in more than 500 collaborative meetings and forums statewide. These partnerships supported implementation of Medi-Cal initiatives, identification of community needs and barriers to care, coordination of services and resources, and advancement of regional quality-improvement and health-equity priorities. Attendance is documented through regional collaborative records and representative collaborative outcomes appear in Section 9.4.

Appendix A • 2026–2027 Quality Improvement and Health Equity (QIHE) Work Plan

#	Activity	Objective	Accountable role	Date(s)	Monitoring	Data source
1	LSC improvement bundle (Section 3.3)	LSC ≥ MPL (69.96) statewide	Regional Quality and Safety Oversight Directors (NCAL, SCAL)	Monitored monthly; reported at QIHEC quarterly	Monthly → QIHEC	MCAS/EHR care-gap reports
2	TFL-CH NCAL actions (Section 3.3)	TFL-CH ≥ MPL (21.60) NCAL	NCAL Quality and Safety Oversight Director	Monitored monthly; reported at QIHEC quarterly	Monthly → QIHEC	MCAS
3	WCV SCAL actions (Section 3.3)	WCV ≥ MPL (55.41) SCAL	SCAL Quality and Safety Oversight Director	Monitored monthly; reported at QIHEC quarterly	Monthly → QIHEC	MCAS
4	Clinical PIP continuation (Section 9.1)	W30-6 B/AA gap closure	Regional Quality and Safety Oversight Directors (NCAL, SCAL)	August 2026 (HSAG PIP submission); August 2027	Monthly outreach-list cycle	Stratified W30-6 reports
5	Non-clinical PIP continuation (Section 9.2)	7-day notification rate	Regional Quality and Safety Oversight Directors (NCAL, SCAL)	August 2026 (HSAG PIP submission); August 2027	Monthly	Notification reports
6	Member experience — Getting Care Quickly and adult Coordination of Care (Section 5.4, Section 9.3)	Improve the two member-experience priorities named by the MY 2025 Medi-Cal CAHPS (Section 9.3): Getting Care Quickly, below the 25th percentile in three of four survey populations, and adult Coordination of Care, at the 1st percentile in NCAL and 2nd in SCAL, by at least 2 percentage points from the MY 2025 baseline in each region and improve national Medicaid percentile rank, with a stretch goal of reaching at least the 10th percentile.	Care-Experience operational workgroup leads (NCAL, SCAL)	Reported to QIHEC quarterly	Quarterly → QIHEC; Care-Experience operational workgroups	Medi-Cal CAHPS (doubled 2026 sample, Section 5.4); Care-Experience workgroup reports
7	NCAL Utilization Management: urgent DME referrals and DME denial timeliness (Section 5.2)	Urgent decision and notification timeliness ≥95%, sustained for three to four consecutive months	Sr. Director, Health Plan Utilization Management (NCAL)	Q1–Q4 2026 (quarterly reporting until the standard is sustained)	Quarterly UM denial-timeliness report → QIHEC	UM denial timeliness reports
8	Prior-year issue monitoring: LSC, TFL-CH, WCV, NCAL W30-6 numerator capture	No repeat deficiency	QIHEC co-chairs	Reported to QIHEC quarterly	Quarterly → QIHEC	Section 3.2 sources

#	Activity	Objective	Accountable role	Date(s)	Monitoring	Data source
9	Facility site review and medical record review cycle (Section 1)	Review cycle completed; findings and corrective actions reported	NCAL Quality and Safety Oversight Director; Sr. Manager, DHCS FSR Program (SCAL)	Reported December 2026	QIHEC	FSR/MRR results
10	CAC feedback-loop cycle (Section 7)	Coded analysis + closed loops each quarter	Chief Health Equity Officer; CAC Coordinators	Q1–Q4 2026 CAC meetings; CAC Feedback Committee reviews	Feedback Committee review	Thematic analysis reports
11	Regional collaborative participation (Section 13)	Quarterly minimum per APL 24-004	Quality Improvement and Health Equity Team Members (NCAL, SCAL)	Mar · Jun · Sep · Dec 2026 (quarterly minimum)	Attendance record	LHJ attendance log
12	Annual QIHE program evaluation	Evaluate this Plan's effectiveness; feed 2027–28 plan	Medi-Cal Medical Director, with the Chief Health Equity Officer	February 2027 QIHEC	QIHEC → QOC/SCQC → QHIC	This Plan's measures
13	Annual plan public posting (Section 12)	Posted, ADA-compliant	Regional Quality and Safety Oversight Directors (NCAL, SCAL)	Q3 2026	QHIC approval date	Posted URL