Chief Medical Officer

Leadership Profile

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THE OPPORTUNITY

Community Health Group seeks a forward-thinking, dynamic, and seasoned physician executive to serve as its Chief Medical Officer (CMO). The CMO is a key member of the executive management team, engaged in helping define the overall business strategy and direction of the organization. The CMO provides medical oversight, expertise, and leadership to ensure the delivery of affordable, high quality healthcare services. The CMO will be responsible for the strategic development and implementation of innovative clinical programs, while overseeing all medical management functions to ensure the quality and cost-effectiveness of healthcare services received by Community Health Group members.

The CMO provides strategic clinical leadership for both the Medi-Cal and Medicare lines of business, working closely with executive leadership, the medical staff, regulatory agencies, providers, and community partners to ensure high-quality, cost-effective, and equitable care for the populations served. They will be joining a high performing health plan with over 40 years of success in San Diego County.

The CMO must be passionate about leadership, service, and provider collaboration. Community Health Group (CHG) seeks a CMO who wants to make a difference in the communities they serve, and is committed to serving their Medi-Cal and Medicare members through superior service and quality. The CMO is a crucial position in CHG requiring a mature physician executive who can work in a nimble, unpretentious culture that has high expectations for leadership.

CHG seeks someone who will embrace working in a highly diverse and collaborative team environment. The CMO will have highly developed executive skills and a track record of successful project management and execution as well as engaging internal and external stakeholders in a variety of different settings. The CMO must understand managed Medicaid/Medicare products, and have strong knowledge of medical and behavioral health utilization, medical loss ratios, pharmacy, quality, claims, and disease management.

THE COMPANY

Organizational Overview

Community Health Group (CHG) is a nonprofit, community-based managed care organization serving more than 328,000 members throughout San Diego County for more than 40 years. The organization operates through two affiliated nonprofit entities that work together to deliver comprehensive government-sponsored health care programs while maintaining separate legal, regulatory, and licensing structures. CHG has nearly $2 billion in annual revenue.

CHG Foundation, doing business as Community Health Group Partnership Plan, was established in 1982 as a 501(c)(3) nonprofit organization. It holds Knox-Keene License and contracts directly with the California Department of Health Care Services (DHCS) to administer the organization's Medi-Cal line of business. Community Health Group, established in 1994, is a 501(c)(4) nonprofit organization and serves as the sole corporate member of CHG Foundation, providing strategic governance and oversight. CHG holds Knox-Keene License and contracts directly with the Centers for Medicare & Medicaid Services (CMS) to operate its Medicare Advantage Special Needs Plans, including both the Chronic Condition Special Needs Plan (C-SNP) and the Dual Eligible Special Needs Plan (D-SNP).

To promote operational efficiency while preserving the independence of each licensed entity, Community Health Group provides administrative and management services to CHG Foundation through a comprehensive Administrative Services Agreement (ASA). CHG is also responsible for contracting with the organization's provider network and vendor partners and

serves as the employer of all personnel across the enterprise. Beginning January 1, 2026, CHG began providing administrative services for another organization through a separate Administrative Service Agreement.

Although the two organizations (CHG and CHG Foundation) maintain separate licenses and regulatory obligations, they function as an integrated enterprise with shared executive leadership, clinical operations, finance, compliance, and administrative infrastructure. This structure enables the organization to effectively manage multiple government-sponsored health programs while ensuring compliance with both state and federal regulatory requirements.

The 2026 Strategic Plan emphasizes preparing for the 2029 Medi-Cal procurement by strengthening quality, health equity, regulatory performance, provider partnerships, and operational readiness. CHG is also advancing a human-centered digital transformation through the responsible use of artificial intelligence to improve efficiency, clinical operations, and member experience.

Despite challenges including healthcare policy changes, Medi-Cal funding uncertainty, and enrollment pressures, CHG continues to build on its longstanding strengths—industry-leading quality performance, strong community partnerships, and an unwavering commitment to delivering high-quality, equitable care. This strategic focus positions the organization to remain a trusted leader in serving the diverse communities of San Diego County.

CalAIM Implementation

California's Medi-Cal program entered a period of rapid evolution in 2022, as major policy and delivery system reforms moved from design to implementation. California Advancing and Innovating Medi-Cal (CalAIM) is a transformative five-year initiative by the California Department of Health Care Services (DHCS) redefining Medi-Cal to enhance members' health outcomes and quality of life. By addressing social drivers of health and delivering comprehensive whole-person care, CalAIM provides coordinated services for physical, behavioral and long-term care needs. With a focus on equity and prevention, it extends critical support into communities, better serving California's most vulnerable populations, including those experiencing homelessness, senior and children with complex medical needs. This shift redefines how plans partner with counties, providers, and the state to serve high-need populations. The major components of CalAIM build upon successful outcomes of various pilots from the previous federal waivers and will result in better quality of life for Medi-Cal members as well as long-term cost savings/avoidance.

CalAIM was launched by California Department of Health Care Services (DHCS) In January 2022 with a phased implementation and is currently in phase 3 of a 4-phased implementation through 2027.

Phase 1 was the foundational roll out involving statewide go-live of Enhanced Care Management (ECM) and Community Supports (housing, meals, recuperative care, etc.) transitioning away from Whole Person Carer and Health Homes Program.

Phase 2 (2023-2024) involved the adding of new populations as well as expanded benefits. New individuals included children & youth, long-term care transitions, and just justice involved populations. Expanded benefits include behavioral health reforms and additional Community Supports.

Phase 3 (current phase 2024-2026) involves system transformation and standardization which includes statewide scaling and normalization of ECM and Community Supports to be fully embedded in Medi-Cal managed care. Managed care contract overhaul began in 2024 to standardize benefits, access and accountability.

Phase 4 is the "prove value and lock-it-in" phase. The federal waiver renewal is underway with submission in late 2026 to move toward permanent authorization of key elements including ECM and In Lieu of Services (ILOS) as well as value-based payment alignment.

Mission Statement

Community Health Group is dedicated to maintaining and improving the health of our members by providing access to quality care and offering exceptional service to diverse populations.

Vision Statement

Community Health Group will be the leading health plan by delivering exceptional service to all of our customers.

CHG Financial Performance Highlights

	CY 2026 (6 months)	CY 2025 (12/31/2025)	CY 2024 (12/31/2024)
Revenue	1,020,662,342	1,930,992,227	1,953,707,110
Medical Costs	1,047,554,246	1,944,175,195	1,718,089,942
Medical Loss Ratio	103%	101%	88%
Administrative Costs	39,789,295	72,097,796	81,008,039
Administrative Cost Ratio	3.89%	3.73%	4.15%
Total Expenses (Medical, Labor, Non-Labor)	1,087,343,541	2,016,272,991	1,999,097,981
Operating Surplus/(Deficit)	(66,681,199)	(85,280,764)	154,609,129
Other Income/(Expense)	19,580,076	47,787,792	48,586,303
Net Surplus	(47,101,123)	(37,492,972)	203,195,432
Cash on Hand	1,143,264,095	1,310,222,967	1,361,934,108
Receivables	291,649,778	294,487,759	442,862,289
Current Assets	1,474,243,624	1,609,690,333	1,812,918,224
Current Liabilities	454,648,794	544,508,466	712,799,015
Tangible Net Equity/Capital Reserves	1,034,434,072	1,081,535,196	1,119,028,168
TNE/Reserves Minimum Required	83,000,000	79,443,382	70,898,459
Current Ratio	3.24	2.96	2.54

THE ROLE

Location Chula Vista, CA
Reports directly to the Chief Executive Officer with a dotted line to the Chief Operating Officer for administrative and operational matters
Company Website https://www.chgsd.com

Position Summary

The Chief Medical Officer (CMO) is responsible for developing and implementing medical policy for the organization that is consistent with community standards of patient care and the contract requirements of Community Health Group's managed care programs. The CMO has oversight responsibility for daily clinical operations of utilization management.

The CMO is responsible for ensuring that a quality improvement process is followed and is compliant with NCQA standards, applicable state and federal regulations, and any specific requirements set forth by DMHC, DHCS and CMS. The CMO shall work with the Director of Quality Improvement to ensure the design and implementation of studies, audits and reviews as directed by the Quality Improvement, Utilization Management, or Credentials Committees, or by the Board as it relates to utilization, case or chronic care management.

Primary Responsibilities

- Establishes, develops, and implements medical policy consistent with applicable standards of care.to guide medical and health care service decisions.
- Participates in the development of the organization's budget, strategic and operational plans, and risk management activities.
- Ensures that medical decisions are rendered by qualified medical personnel, and ensures that other health care services are not influenced by fiscal or administrative management considerations.
- Oversees the development of utilization management and quality improvement programs, as well as medical necessity definition and criteria.

- Serves as the Chair for the Quality Improvement and Utilization Management Committees, e.g., Quality Improvement Health Equity Committee (QIHEC), Credentialing and Peer Review, Utilization Management Committee, and Pharmacy and Therapeutics Committee, Behavioral Health Quality Improvement Committee and serves on the Board's QIHEC. Directly participates in the implementation of Quality Improvement activities.
- Oversees the development and implementation of the health plan's clinical guidelines and protocols that can be utilized through the quality improvement, utilization management, and case management processes to positively impact the delivery of care.
- Ensures that policy and procedures are established for purposes of monitoring and assuring that the medical and other health care providers meet acceptable standards of care.
- Ensures that Community Health Group's medical personnel follow medical protocols and rules of conduct.
- Ensures division management and staff competency and compliance with applicable responsibilities and statues and regulations.
- Resolves and actively participates in the execution of Grievance and Appeals procedures in all clinically related aspects, including grievances related to Quality of Care, and for acting as the ultimate authority for determining whether a grievance should be processed as a potential quality issue, or whether or not a grievance and/or appeals requires clinical review and determination.
- Ensures the grievance system is in concert with all medical necessity decision making processes, including review, monitoring and tracking of all potential or confirmed quality of care or service issues.
- Recommends medical and ancillary service providers and hospitals for contract development.
- Presents and participates in educational programs, reviews current literature and trends, participates on committees and in meetings as assigned.
- Develops and maintains positive relationships with contracted physicians, community clinics, and hospital networks.
- Promotes a positive image of the organization and the department in all aspects of communication and contact.

General Responsibilities

Process

- Establishes a framework for ongoing assessments of each functional area to identify opportunities for improvement, document the process and analyze possible solutions prior to implementation.
- Creates structures and systems to evaluate, update and change current processes that no longer contribute to the organization's efficiency or efficacy.
- Establishes performance and productivity standards for each direct report within the division.
- Works closely with direct reports to ensure data is collected, collated, analyzed and distributed to providers as a means to provide and improve cost effective care and services.
- Provides leadership and mentoring as necessary to ensure all managers and staff are educated and trained in their respective roles, including ensuring that each manager and staff have an understanding of the impact of their role on downstream functions.

Communication

- Ensures that all areas are kept current in terms of strategies and practices used to make determinations, coordinate care and services, and process workflow.
- Ensures that communication within all aspects of health services is conducted in a timely and professional manner.
- Establishes a work environment conducive to open communication, allowing staff participation in identifying and resolving problems.
- Ensures all functional areas are compliant with HIPAA regulations, and that appropriate security measures are in place to prevent inappropriate disclosure.
- Ensures that providers have relevant and timely information.
- Ensures communication linkages with all departments to ensure smooth upstream and downstream processes, including the coordination of delay, modification, and denial determinations and notifications.

Confidentiality and Compliance

- Participates in departmental and organization wide activities and programs to promote compliance with state and federal statutes (including CMS and/or Medicare Part D, DHCS and DMHC), and health plan and organizational policies and standards.
- Keeps individual information, as well as clinical information, confidential and ensures that requests for information are responded to in an appropriate fashion.
- Notifies the Chief Executive Officer immediately of any potential or real breach in confidentiality or compliance.
- Establishes division-wide policy related to fraud and abuse, and monitors compliance on an ongoing basis.
- Ensures that all staff members are educated relative to fraud and abuse, privacy, protected information and related security measures.

Information Management

- Works with the Utilization Management Manager to ensure timely procedures and practices, and to implement a philosophy of "one and done" throughout the division.
- Works with contracting and provider relations to ensure early detection of, and possible prevention of, a decrease in provider performance.
- Reviews systems and processes that track specific and aggregate cases and utilization patterns that may adversely impact care, services or cost.
- Ensures development, along with the Chief Information Officer, databases specific to population targets to facilitate effective case management and chronic care coordination.

Goals and Objectives

The following goals and objectives have been identified as priorities for this position:

- **Integrate successfully into the Organization:** Must get to know the organization's history, programs, employees, board, providers, the communities served and be sincerely interested in the various constituents. The CMO must maintain high visibility at all levels and develop strong collaborative relationships and be viewed as a trustworthy, confident and effective leader.
- **Optimize Quality:** Responsible for optimizing the quality of the care delivery system for plan members. Continue to maximize HEDIS and STARS scores and other proactive quality

programs. Develop strong quality improvement, population health management programs linked to disease management, and enhance predictive modeling.

- **External Relationships:** Responsible for developing outstanding working relationships and being visible with the physician and provider communities, area hospitals, and federally qualified health centers. Establish a strong working relationship with the provider community based on trust. The individual must be relationship driven, partnering in nature, yet able to advocate on behalf of CHG as appropriate. As the chief medical spokesperson, inform and educate the marketplace on healthcare policies, strategies and programs.
- **Successful Analytics and Care Management Oversight:** Provide strategic and operational guidance in maximizing the effectiveness of core clinical operations with a particular focus on enhancing day-to-day clinical operations of authorizations, utilization and care management, and care coordination. Embrace, establish and utilize clinical data analytics to drill down on trends and ensure that the health plan will improve care oversight and integration, increase efficiencies, and provide the highest quality care possible to the members with an eye towards financial impact.
- **Teamwork:** Must serve as the leader of the clinical organization while taking the division to a new level of performance. Establish oneself as an approachable, open, visible, self-confident leader who is inclusive and can effectively influence change and set new direction. The CMO must evaluate the effectiveness of the team members, develop annual goals and objectives, ensure accountability for performance, mentor and develop team members as needed, and look to succession planning. The CMO will establish collegial, trusting, credible relationships with all parties, remove silos and create cross department integration.
- **Change Management:** Be an agent for change through innovation and inspiration by working through others to achieve enhancements in the healthcare delivered to members by creating standardization, utilizing technology and improving processes for maximum efficiency. Develop and implement process improvement programs that will focus on quality, cost, and efficiency as the desired outcome.

THE PROFILE

Candidate Qualifications

The ideal candidate for the Chief Medical Officer position will possess the following qualifications, experience, and personal characteristics.

Experience, Knowledge, and Skills

- Minimum of three years, preferably five years, of experience in Medicaid managed care in a health plan.
- Progressive physician leadership experience with responsibility for medical management, quality improvement, population health, utilization management, care management, and provider engagement.
- Experience working with state Medicaid agencies, regulators, and other external stakeholders, with a strong understanding of Medicaid regulations, accreditation standards, and healthcare policy.
- Minimum of five years of clinical experience in a primary care or specialty field of practice.
- Strong preference for prior experience as a Chief Medical Officer.
- Deep understanding of Medicaid programs, managed care delivery systems, quality improvement, utilization management, care management, and value-based care models.
- Experience with NCQA accreditation, quality improvement programs, and regulatory compliance activities within a managed care environment.
- Experience with value-based care arrangements, risk-based contracting, and alternative payment models preferred.
- Must enjoy working with a Medicaid population and comfortable working with diverse populations who speak many languages.

- Must be willing to go out in the community and meet, face-to-face, with key providers including the CMOs of larger organizations, FQHCs, hospitals and with key primary care providers.
- Demonstrated ability to build collaborative relationships and credibility with physicians, community organizations, and other healthcare stakeholders.
- Excellent communication and interpersonal skills, with the ability to influence and build consensus among physicians, provider organizations, executive leadership, Board members, regulators, and community partners.
- Must appreciate being part of a multicultural and multilingual team to include executive team, Board members and staff at all levels of the organization.

Education/Certification

- A graduate of an accredited school of medicine.
- An advanced degree such as an MHA, MPH or MBA is preferred.
- Must be licensed or eligible to be licensed with an unrestricted and unencumbered California license.
- Board Certified in a recognized medical practice specialty

Compensation

- An attractive compensation package will be created to attract the right Individual to this opportunity.

All qualified applicants will receive consideration for employment based on merit, without regard to race, color, religion, sex, national origin, disability, protected Veteran Status, or any other characteristic protected by applicable federal, state, or local law.

THE COMMUNITY

San Diego, California

San Diego is a world-class destination city in Southern California, on the coast of the Pacific Ocean, approximately 120 miles south of Los Angeles, driving distance to many mountains and hiking trails, and adjacent to the border with Mexico. By population, Metropolitan San Diego is the eighth largest city in America and the second largest in California. As the birthplace of California, San Diego is known for its mild year-round climate, natural deep-water harbor, 70 miles of coastline, long association with the U.S. Navy, and recent emergence as a healthcare and biotechnology development center.

Often called “America’s Finest City’ San Diego is recognized for its quality of life, culture, and combination of urban amenities with a strong, outdoor lifestyle. It is a top U.S. destination known for its beautiful beaches, attractions such as the San Diego Zoo, Sea World, Balboa Park and its numerous activities for people to enjoy year-round. San Diego’s main economic engines are military and defense-related activities, tourism, international trade, and manufacturing. The presence of the University of California, San Diego (UCSD) has helped make the area a center of research in biotechnology. In total, San Diego is home to 11 colleges and/or universities, three of which earned places on U.S. News & World Report's Best Colleges rankings. San Diego encompasses 294 public elementary, middle and high schools and also has 106 private schools. Fifty high schools are recognized on U.S. News & World Report's Best High Schools rankings.

For more information about San Diego, please visit: https://www.sandiego.gov/

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