NOTICE OF A
REGULAR MEETING OF THE
WHOLE-CHILD MODEL
FAMILY ADVISORY COMMITTEE

TUESDAY, FEBRUARY 24, 2026
9:30 A.M.

CalOptima Health
505 City Parkway West, Room 109-N
Orange, California 92868

AGENDA

This agenda contains a brief, general description of each item to be considered. The Committee may take any action on all items listed. Except as otherwise provided by law, no action shall be taken on any item not appearing in the following agenda. To speak on an item during the public comment portion of the agenda, please register using the Webinar link below. Once the meeting begins, the Question-and-Answer section of the Webinar will be open for those who wish to make a public comment, and registered individuals will be unmuted when their name is called. You must be registered to make a public comment.

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

The Regular Whole-Child Model Family Advisory Committee's meeting agenda and supporting materials are available for review at CalOptima Health, 505 City Parkway West, Orange, CA 92868, 8 a.m. – 5:00 p.m., Monday-Friday, and online at www.caloptima.org.

Register to Participate via Zoom at:
https://us02web.zoom.us/webinar/register/WN_Xpk43HfTRAGgrIKFvmyiEg and Join the Meeting.

Webinar ID: 842 9505 0912

Passcode: 556126 -- Webinar instructions are provided below.

1. **CALL TO ORDER**
   Pledge of Allegiance

2. **ESTABLISH QUORUM**

3. **APPROVE MINUTES**
   Approve Minutes of the October 28, 2025 Regular Meeting of the Whole-Child Model Family Advisory Committee

4. **PUBLIC COMMENT**
   At this time, members of the public may address the Whole-Child Model Family Advisory Committee on matters not appearing on the agenda but within the Committee's subject-matter jurisdiction. Speakers will be limited to three (3) minutes.

5. **INFORMATIONAL ITEMS**
   A. Children's Hospital of Orange County Adolescent to Adult Bridge (A2B) Program
   B. California Children's Services (CCS) Transition Planning
   C. CalAIM Transitional Rent Overview
   D. Committee Member Updates

6. **MANAGEMENT REPORTS**
   A. Chief Operating Officer
   B. Chief Medical Officer
   C. Chief Executive Officer

7. **COMMITTEE MEMBER COMMENTS**

8. **ADJOURNMENT**

TO JOIN THE MEETING

Please register for the Regular Meeting of the Whole-Child Model Family Advisory Committee on February 24, 2026, at 9:30 a.m. (PST)

Join from a PC, Mac, iPad, iPhone or Android device:
Please use this link to register prior to the meeting date:

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On the day of the meeting, please use this link to join the meeting:

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+16699009128,,84295050912#,,,,*556126# US (San Jose)

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+1 646 558 8656 US (New York)
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+1 689 278 1000 US
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MINUTES

REGULAR MEETING OF THE
CALOPTIMA HEALTH
WHOLE CHILD MODEL
FAMILY ADVISORY COMMITTEE

October 28, 2025

A Regular Meeting of the Whole-Child Model Family Advisory Committee (WCM FAC) was held on October 28, 2025, at CalOptima Health, 505 City Parkway West, Orange, California, via in-person and teleconference (Zoom).

CALL TO ORDER

Chair Lori Sato called the meeting to order at 9:34 a.m. and led the committee in the Pledge of Allegiance.

ROLL CALL

Members Present: Lori Sato, Chair;; Katya Aguilar; Jody Bullard (remote); Cally Johnson (remote); April Johnston (Remote) Jennifer Heavener; Mayra Ortiz; Jessica Putterman; Kristen Rogers (Remote) (9:51 AM)

Members Absent: Erika Jewell, Vice-Chair, Fabiana Avendano,

Others Present: Michael Hunn, Chief Executive Officer; Richard Pitts, DO., Ph.D., Chief Medical Officer; Veronica Carpenter, Chief Administrative Officer; Michaell S. Rose, Dr.PH, LCSW, Chief Health Equity Officer; Carmen Katsarov, Executive Director, Behavioral Health; Dr. Michelle Laba, California Children's Services; Cheryl Simmons, Staff to the Advisory Committees; Ruby Nunez, Executive Assistant;

MINUTES

Approve the Minutes of the August 26, 2025 Regular Meeting of the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

Action: ***On motion of Member Kristen Rogers, seconded and carried, the WCM FAC Committee approved the minutes of the August 26, 2025, meeting. (Motion carried 9-0-0)***

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PUBLIC COMMENTS

There were no public comments.

INFORMATION ITEMS

California Children's Services Update

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

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

OneCare Update

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

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

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

Chief Operating Officer Update

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

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

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

Committee Member Updates

Chair Lori Sato informed the committee that the Board approved a stipend increase of up to $100 at its October meeting. Additionally, Chair Sato requested that any proposed agenda items be submitted to Cheryl Simmons.

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CEO AND MANAGEMENT REPORTS

Deputy Chief Medical Officer Report

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

Dr. Dabbah also provided an update on the Respiratory Syncytial Virus (RSV), and that prevention has expanded significantly. She noted that for infants, a single intramuscular dose is recommended for all babies aged 8 months or younger during the RSV season (October–March). This provides protection for up to five months, and a second dose is advised for high-risk infants aged 8–19 months, including those with chronic lung disease, congenital heart disease, or who are immunocompromised. For pregnant individuals, the maternal RSV vaccine is now recommended between 32-36 weeks of gestation during RSV season. This approach, endorsed by the American College of Obstetrics and Gynecology, helps transfer immunity to the unborn child. If the maternal vaccine is given, the infant dose is not needed except for high-risk infants. Dr. Dabbah also discussed the new updated catch-up schedules, which are available for children with interrupted vaccine series, immunocompromised children, and those with uncertain vaccination histories, such as refugees and immigrants.

Chief Administrative Officer Report

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

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

Chief Executive Officer Report

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

ADJOURNMENT

Hearing no further business, Chair Lori Sato adjourned the meeting at 11:15 a.m.

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Cheryl Simmons
Staff to the Advisory Committees

CAL OPTIMA WHOLE CHILD MODEL FAMILY ADVISORY COMMITTEE

CCS PROGRAM UPDATES

Michelle Laba MD | California Children's Services

February 24, 2026

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OC health CARE AGENCY
SPECIALIZED MEDICAL SERVICES

CCS PROGRAM IMPROVEMENTS

- Newly designed CCS Phone Tree
  - Updated scripting
  - Simplified prompts for ease of use
  - Expected Go Live: February or March 2026

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CCS OPERATIONAL UPDATES

- Medical Therapy Program Leadership
  - Diana Weber (formerly Interim Chief Therapist) named Chief Therapist in November 2025.

- Staffing
  - State underfunding of Orange County CCS program is ongoing.
  - County of Orange continues to monitor program staffing needs to meet mandated program requirements.
  - CCS Administrative (Medical) Program given approval to fill PHN vacancy and some office support vacancies.
  - Medical Therapy Program (MTP) given approval to fill Supervising Therapist vacancy and an office support vacancy.
  - This helps to offset previous March 2025 FTE reductions (40% decrease/Admin; 12% decrease/MTP).

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OC health CARE AGENCY

STAY CONNECTED

OC Health Care Agency

@ochealthinfo

@ochealth

@oc_hca

@ochealth

www.ochealthinfo.com

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ADOLESCENT TO ADULT BRIDGE (A2B) PROGRAM

February 24, 2026

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What We Know About Peds to Adult Health Care Transition

Time between pediatric and adult care is marked by risk & poor health outcomes

86% of California parents report their teen has never received services needed to transition to adult care

Transition is a multi-year process across ages 12-26, not a discrete event

In 2020, only 10% of a study cohort at RCH-OC transferred successfully

Rady Children's Health

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What is Care Transition?

Health care transition, or HCT, is the planned, purposeful process of moving from a child/family-centered model of health care to an adult/patient-centered model of health care.

TRANSITION	≠	TRANSFER
• Starts at age 12 • Promotes patient engagement and autonomy • Increase knowledge, skills, and abilities • Move through a structured transition curriculum		• Discrete, planned event • Health summary and transfer packet • Warm hand-off to receiving adult provider • Aim for transfer by age 21 with disease-specific exceptions

Consequences of *Unstructured* Transition

Increased morbidity, mortality, and care utilization

- Type 1 diabetes
  - serious complications increased from 3% to 37% post-transfer
- Sickle Cell patients
  - 22–24-year-olds: 3x more likely to die during hospitalization than 16–18-year-olds
- Spina bifida
  - 3.6x more ED visits post
  - 1.7x more hospitalizations post-transfer
- Cerebral Palsy
  - 12.5% of young adults had 3+ ED visits compared to 5.9% of adults (40+ years old)

Rady Children's Health

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Evidence-Based Models

Dedicated Time Matters

- Structured transition programs
  - Endorsed by AAP, AAFP, and ACP
  - Improves health outcomes, patient experience, and care utilization
- Assessing Transition Readiness
  - Annual assessment starting at age 12 years
  - Paired with tailored education & support
- Dedicated Transition Navigators
  - Fewer ER visits for patients with medical & mental health diagnoses
  - Patients report more support, increased self-management skills, and greater continuity of care
  - Greater success transferring patients with care complexities
- While the DHCS requirements acknowledge transition, they do not address the specific evidence-based interventions

Who Delivers Transition Education & Care?

A Role for Everyone

Parents	• Modeling self-management skills • Emotional support • Advocate and coach • Coordinating care between peds & adult services • Engagement with available transition services
Primary Care Team(s)	• Anticipatory Guidance • Disease education • Medical summaries • Warm Handoff
Dedicated Transition Teams	• Holistic, whole person care • Complex care planning • Coordination across multiple specialists • Specialized health systems and complex insurance navigation

What do OC Doctors Recommend?

OC Primary & Specialty Care Focus Groups

- Patients & families are not prepared to navigate the adult healthcare system
- Adult providers are not prepared to care for young adults with intellectual and developmental disorders
- Lack of a formal transition process meant key interventions and supports are missing (i.e. medical summaries)

Gray, Wendy, et al. "Adult provider perspectives on transition and transfer to adult care: a multi-specialty, multi-institutional exploration." Journal of Pediatric Nursing 59 (2021): 173-180.

Not Unique to Orange County

- Transition through regular care is challenging:
  - Lack of time
  - Lack of funding
  - Lack of training on transition interventions
- Transition is most successful when there is a formal, dedicated program

A2B Transition at RCH-OC

SYSTEM WIDE

System-wide culture of transition readiness

Research that drives best practices

A2B Clinic for patients at high risk of poor transition outcomes

A2B TEAM

Dr. Alexandra Roche
Adolescent Medicine

Dr. Mike Weiss,
A2B Program Sponsor

Erin Benekos, FNP
Clinical Lead

Reny Sims,
LCSW/MPH
Program Manager

Courtney Malave
LCSW

Dr. Wendy Gray
Research Lead

Mayumi Kaneko
RN Care Manager

Parasto Dorriz, MPH
QI Advisor

Sandra Hollist
Patient Access
Coordinator

METRICS

1,500 Patients assessed for transition readiness annually

17 Primary & specialty transition pilot projects

375 Patients seen in A2B Clinic annually

75 Medically complex patients successfully transferred all care

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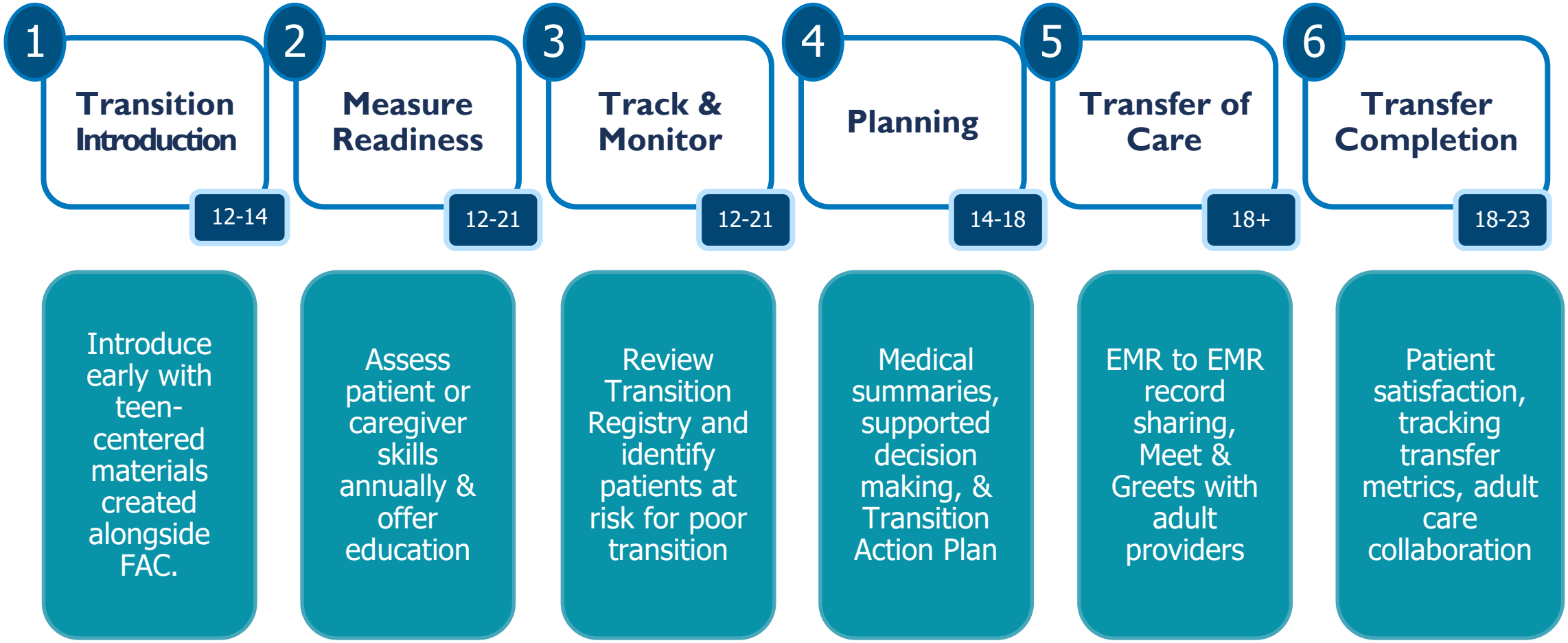
GotTransition 6 Core Elements in Practice



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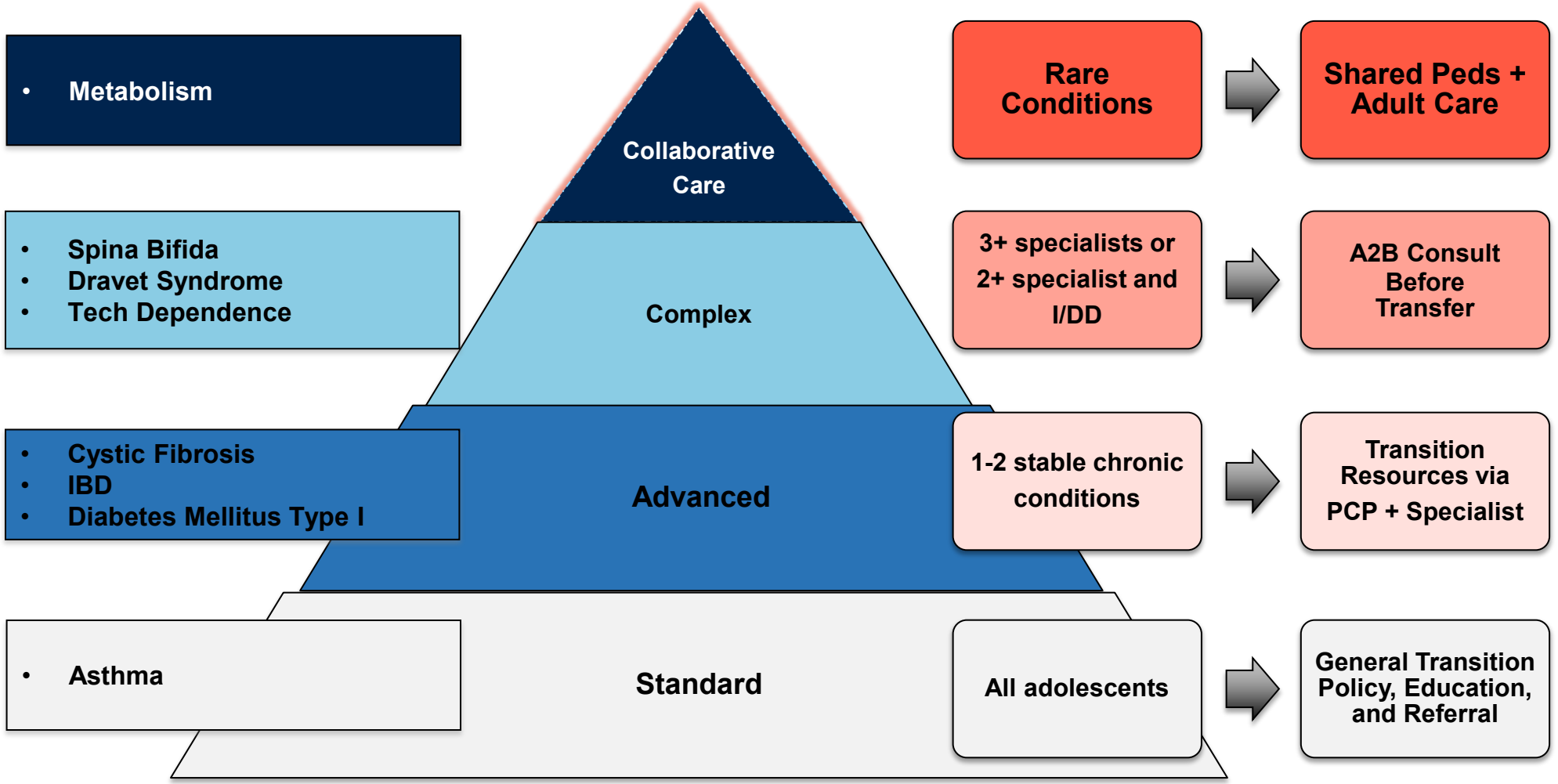
Transition Pathways at RCH-OC



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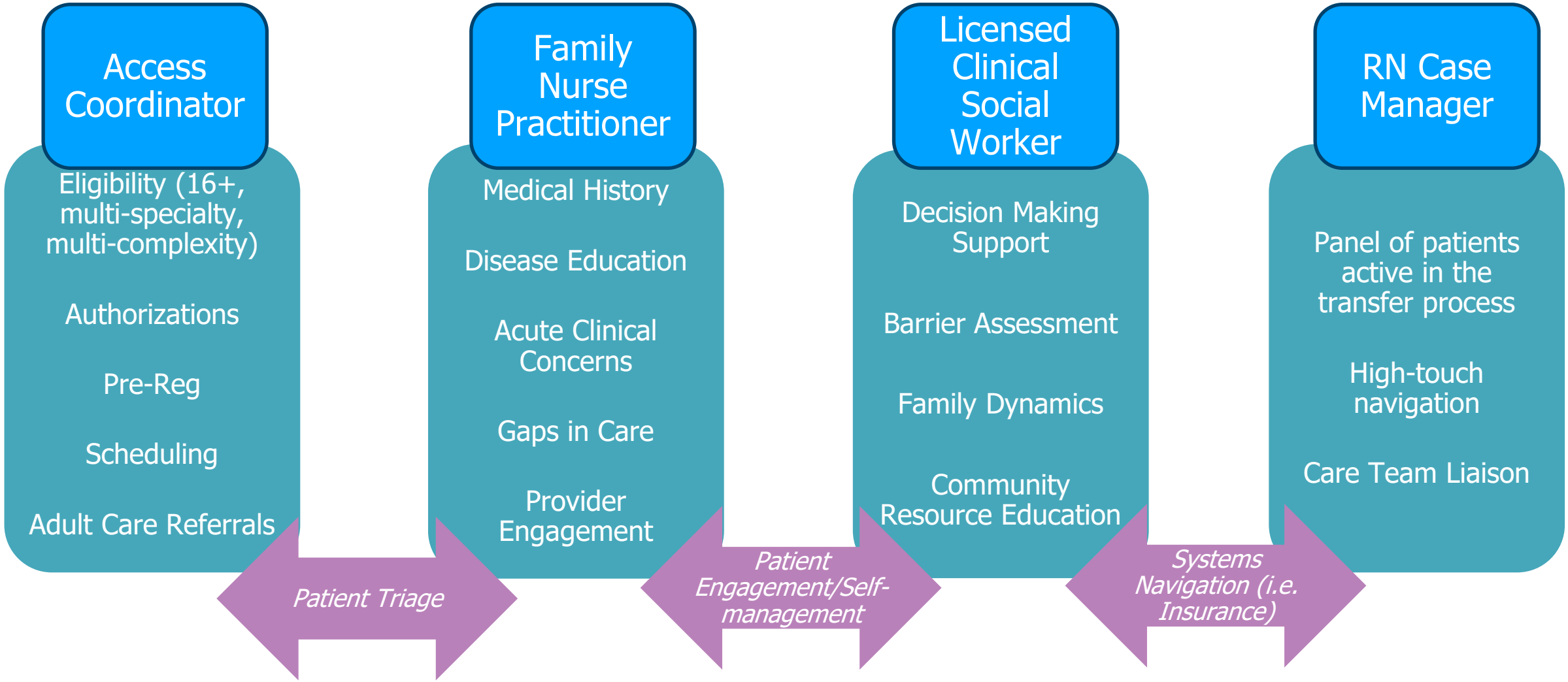
A2B Clinical Team



Benefits of A2B Transition Clinic

Specialized, Multidisciplinary Team
Access to transition medicine specialists, social work and case management for comprehensive care.

Individualized Transition Plans
Personalized plans tailored to the patient's condition and readiness for self-management.

Seamless Transition of Care
Ensures continuity from pediatric to adult care, reducing gaps in treatment.

Improved Outcomes: Enhance adherence to treatment, reduce hospitalizations, and improve disease management.

Early Success in A2B Clinic

In 3 years, clinic volume has grown from 148 visits to 375 visits annually

90% of caregivers report high satisfaction, saying they learned something new

Serves a diverse patient population, 57% with IDD, 76% on Medicaid, and 46% Latinx

73 patients have transferred ALL care successfully, 64% within 6 months

Rady Children's Health

Developing a specialty transition clinic: Inaugural clinical and financial operations. (Gray 2023, Health Care Transitions, 1)

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A2B Program Success

- Disease Agnostic Approach
  - Patients with any diagnosis can receive tailored services
    - 100+ patients with rare diseases have received formal transition support

- Pediatric & Adult Provider Meet & Greets
  - Neurology, Gastroenterology, and ENT
  - Collaborative meetings with pulmonary, rheumatology, palliative, and internal medicine

- Pilots with FQHCs
  - Trained adult primary care on patients with Autism and Intellectual & Developmental Disorders
  - Formal warm referral workflows pilot with Share Ourselves & AltaMed Clinics

A2B Program Success Continued

- Legal Partnership
  - Monthly conservatorship clinics
  - Launching financial planning for families with adults with disabilities

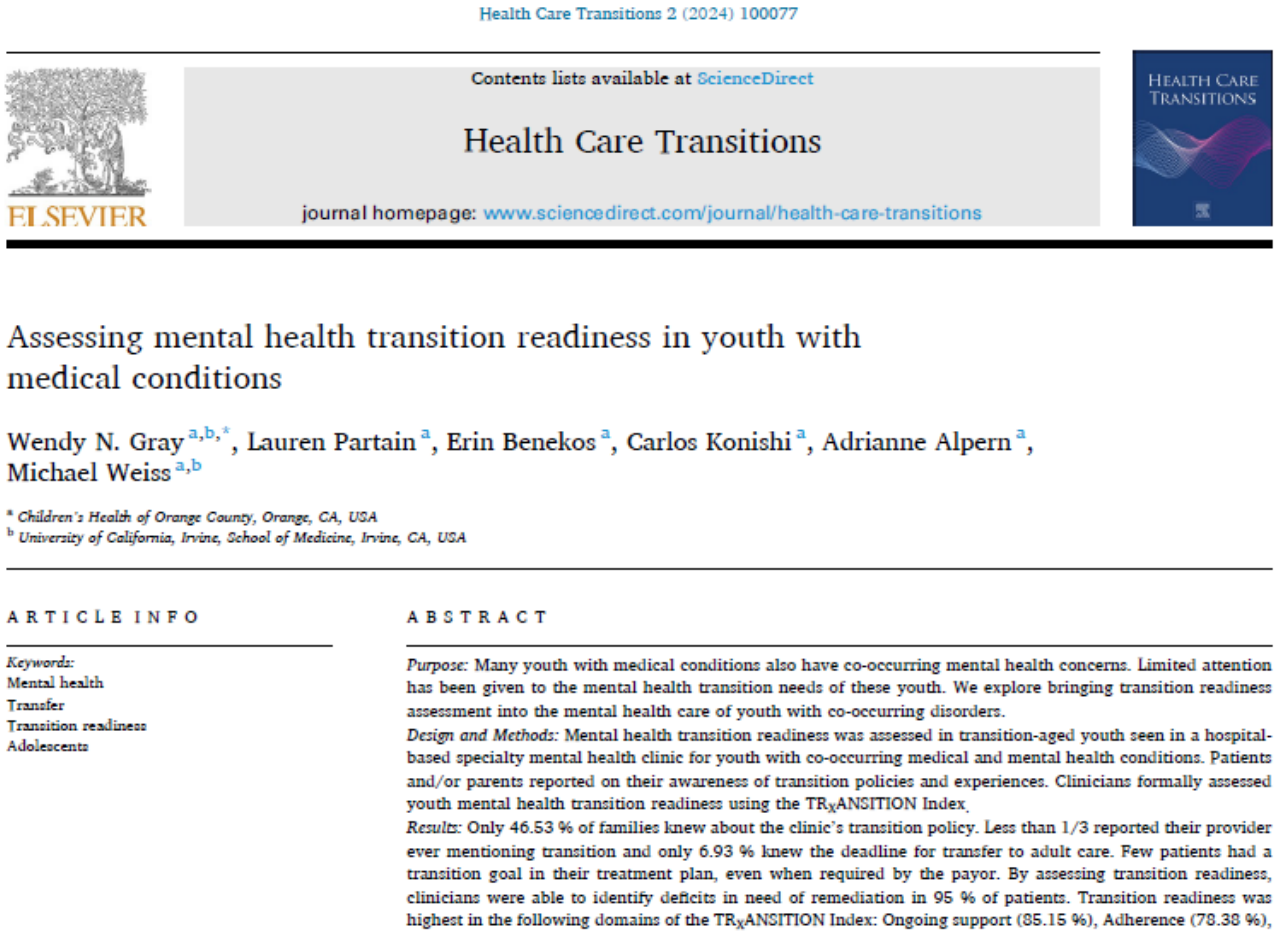
- Payor Contracts
  - Heritage St. Joseph, Molina, and CHA
  - Remains a major opportunity with little CalOptima Health Network engagement. Annual case rate is minimal and covers a full year of services

- Inpatient Services launching Summer 2026
  - A2B Team consults for older patients with complex care needs

Evidence-Based Program

Publications to Date

- Adult provider perspectives on transition and transfer to adult care: A multi-specialty, multi-institutional exploration. (Gray 2021, *J Pediatr Nurs*, *59,* 173-180)
- Developing a specialty transition clinic: Inaugural clinical and financial operations. (Gray 2023, *Health Care Transitions*, *1*)
- Integrating transition readiness assessment into clinical practice: Adaptation of the UNC TR$_X$ANSITION Index into the Cerner electronic medical record.(Gray 2023, *J Pediatr Nurs*, *71,* 127-134)
- Assessing mental health transition readiness in youth with medical conditions. (Gray 2024, *Health Care Transitions*, *2*)



Health Care Transitions 2 (2024) 100077

Contents lists available at ScienceDirect

Health Care Transitions

journal homepage: www.sciencedirect.com/journal/health-care-transitions

Assessing mental health transition readiness in youth with medical conditions

Wendy N. Gray [a,b,*], Lauren Partain [a], Erin Benekos [a], Carlos Konishi [a], Adrianne Alpern [a], Michael Weiss [a,b]

[a] Children's Health of Orange County, Orange, CA, USA
[b] University of California, Irvine, School of Medicine, Irvine, CA, USA

ARTICLE INFO

Keywords:
Mental health
Transfer
Transition readiness
Adolescents

ABSTRACT

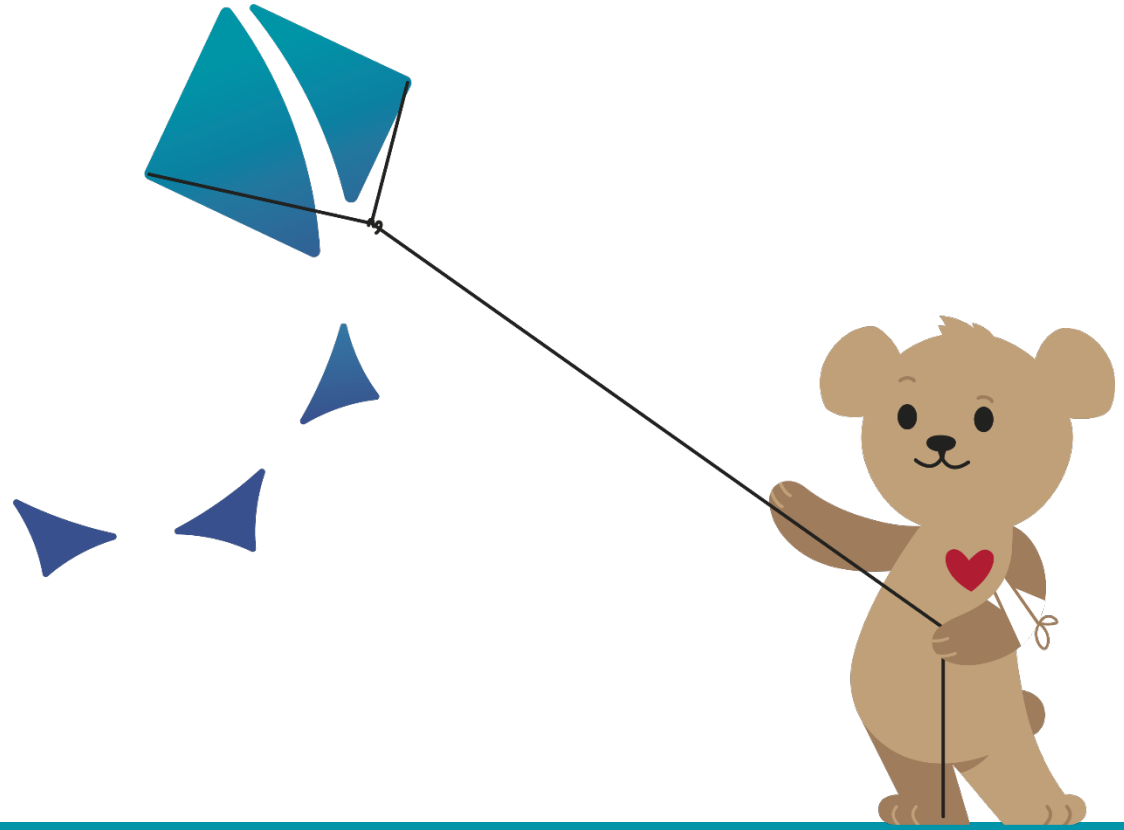
Purpose: Many youth with medical conditions also have co-occurring mental health concerns. Limited attention has been given to the mental health transition needs of these youth. We explore bringing transition readiness assessment into the mental health care of youth with co-occurring disorders.
Design and Methods: Mental health transition readiness was assessed in transition-aged youth seen in a hospital-based specialty mental health clinic for youth with co-occurring medical and mental health conditions. Patients and/or parents reported on their awareness of transition policies and experiences. Clinicians formally assessed youth mental health transition readiness using the TR$_X$ANSITION Index.
Results: Only 46.53 % of families knew about the clinic's transition policy. Less than 1/3 reported their provider ever mentioning transition and only 6.93 % knew the deadline for transfer to adult care. Few patients had a transition goal in their treatment plan, even when required by the payor. By assessing transition readiness, clinicians were able to identify deficits in need of remediation in 95 % of patients. Transition readiness was highest in the following domains of the TR$_X$ANSITION Index: Ongoing support (85.15 %), Adherence (78.38 %),

Presentations & Conferences

- Healthcare Transition Research Consortium Research Symposium (2021, 2022, 2023, 2024, 2025)
  - A Machine Learning Approach for Predicting Care Transition Risk
  - Quantifying Success: Evaluating Transfer Metrics in a Specialty Transition Clinic
  - Bridging Gaps in Emergency Care: A Clinical Pathway to Improve HCT for Medically Complex Adults
- Camden Coalition (2025)
  - A2B: A Model for Healthcare Transition
- Society for Adolescent Health & Medicine (2026)
  - Optimizing Healthcare Transition Through a Pediatric ED-Based Clinical Pathway for Medically Complex Young Adults
- GotTransition Learning Collaborative
  - Member at large
- Social Work Advisory on Transition
  - Founding member

Advocating for Improved Transition Services: Call to Action

Understand the Needs:	• Conduct patient- and family-centered assessments to tailor transition services • Identify barriers such as lack of resources, insurance coverage, or provider readiness
Implement Best Practices:	• Incorporate clinical pathways for transition into routine care • Adopt evidence-based tools like transition readiness assessments • Have dedicated transition navigators to support families
Advocate Within Adult Practices:	• Build capacity for supporting young adults with pediatric-onset conditions • Champion a culture of shared decision-making and patient empowerment
Community Collaboration:	• Partner with local organizations to build networks • Raise awareness of transition issues in the broader healthcare community



Contact:
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www.choc.org/A2B

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California Children's Services (CCS) Transition Planning

Jennifer Claros, Manager, Case Management

Alice Cheng, Director, Provider Relations

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CCS Transition Planning

- Transition Planning Playbook:
  - Outlines necessary information to successful transition planning for impending CCS age-out.
    - Includes the following: insurance information; medical conditions and medications; case management information from Health Network; care coordination such as transportation or caregiver needs;
  - Currently in draft state pending additional feedback from WCM FAC members.
  - Reviewed with internal teams with Medical Director and Executive Leadership, County CCS, CHOC Health Network, RCOC, Home and Community Based Alternatives Waiver Agencies: Access TLC and Libertana, and Director Maura Byron.

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CCS Transition PCP Incentive

- **Purpose**
  - Ensure timely, high-quality transition of CCS members (ages 20–21) to adult primary care by aligning Adult PCP incentives with access, coordination, and outcomes.
- **Key Design Elements**
  - Establishes Adult PCP accountability for transition success
  - Leverages fee-schedule–based enhancements
  - Limits incentives to first 24 months post-transition
- **Incentive Structure**
  - **One-Time Transition Payment (Adult PCP Only)**
    - Transition plan completed and first adult visit within 90 days
    - Drives rapid acceptance and care establishment

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CCS Transition PCP Incentive

- **Ongoing Incentives (Up to 2 Years)**
  - Transition visit add-ons (new and established E/M)
  - Care management codes and volume-based incentives

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CalOptima Health

Transitional Rent Overview

Our Mission

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

Our Vision

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

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Transitional Rent

Provides up to six months of rental assistance in interim and permanent settings to Members who are experiencing or at risk of homelessness, have certain clinical risk factors and have either recently undergone a critical life transition or who meet other specified eligibility criteria.

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Transitional Rent Eligibility Criteria

- Behavioral Health POF:
  - Meet the access criteria for Medi-Cal Specialty Mental Health Services (SMHS);
  - Meet the access criteria for Drug Medi-Cal (DMC) or Drug Medi-Cal Organized Delivery System (DMC-ODS)

And

  - Experiencing or at-risk of homelessness;

And

  - Included in any Transitioning Population.

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Transitional Rent Eligibility Criteria

- Transitioning Population Requirement:
  - Transitioning out of an institutional or congregate residential setting.
  - Transitioning out of a carceral setting.
  - Transitioning out of interim housing.
  - Transitioning out of recuperative care or short-term post hospitalization housing.
  - Transitioning out of foster care.

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Other Eligibility Criteria

- Member has not exhausted the global cap (DHCS restriction of 182 days of room and board services).
- Member has a “viable” housing plan, which includes:
  - Development of a permanent housing solution
  - Identified payment sources to maintain housing after the 6 months of transitional rent.

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Appropriate Housing Settings

- **Permanent**: homes, duplexes, apartments, ADUs, shared housing, SRO units, recovery housing, etc.
- **Interim**: SRO units, tiny homes, hotel/motels, transitional and recovery housing.

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Implementation Strategy

- CalOptima Health is contracting with **Orange County Health Care Agency (OC HCA)** to be the provider for Transitional Rent.
  - Members with a qualifying SMI condition will be connected to BHSA housing opportunities for months 7 and beyond.
- OC HCA will be responsible for issuing payment and administering the service.
- Housing Navigation providers will continue to support members with identifying housing options and developing the member's housing support plan.

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Additional Supportive CalAIM Services

- When a member is authorized for Transitional Rent, they will automatically be authorized for ECM and the Housing Trio of Community Supports.
  - ECM providers conduct weekly in-person outreach visits to the Member as soon as feasible and acceptable to the member.
  - Members can receive both Transitional Rent and Housing Deposits at the same time.

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How to make referrals

- The Transitional Rent referral form will be available on the CalOptima Health website and is posted on CalOptima Connect for contracted providers.
- The referral form will be submitted on behalf of the member with the member's housing support plan.
- If the member does not have a viable housing support plan, the member will be connected to Housing Transition Navigation services first.

Questions

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Stay Connected With Us

www.caloptima.org

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US Measles Outbreak 2025

Whole-Child Model Family Advisory Committee

February 24, 2026

Richard Pitts, D.O., Ph.D.

Our Mission

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

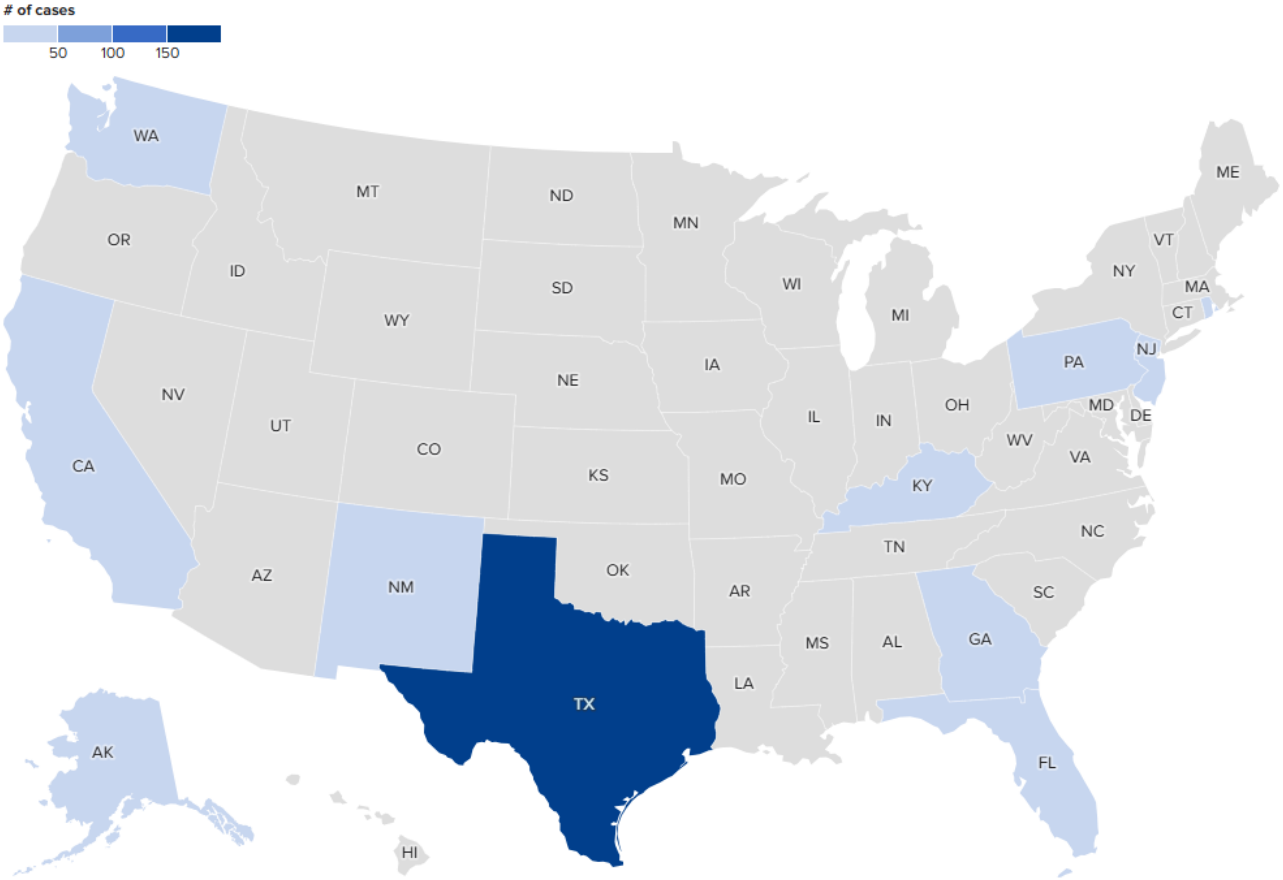
Our Vision

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

Back to Agenda

States with measles in 2025

So far this year, the U.S. has reported **222** cases. Click or hover over a state for more details.



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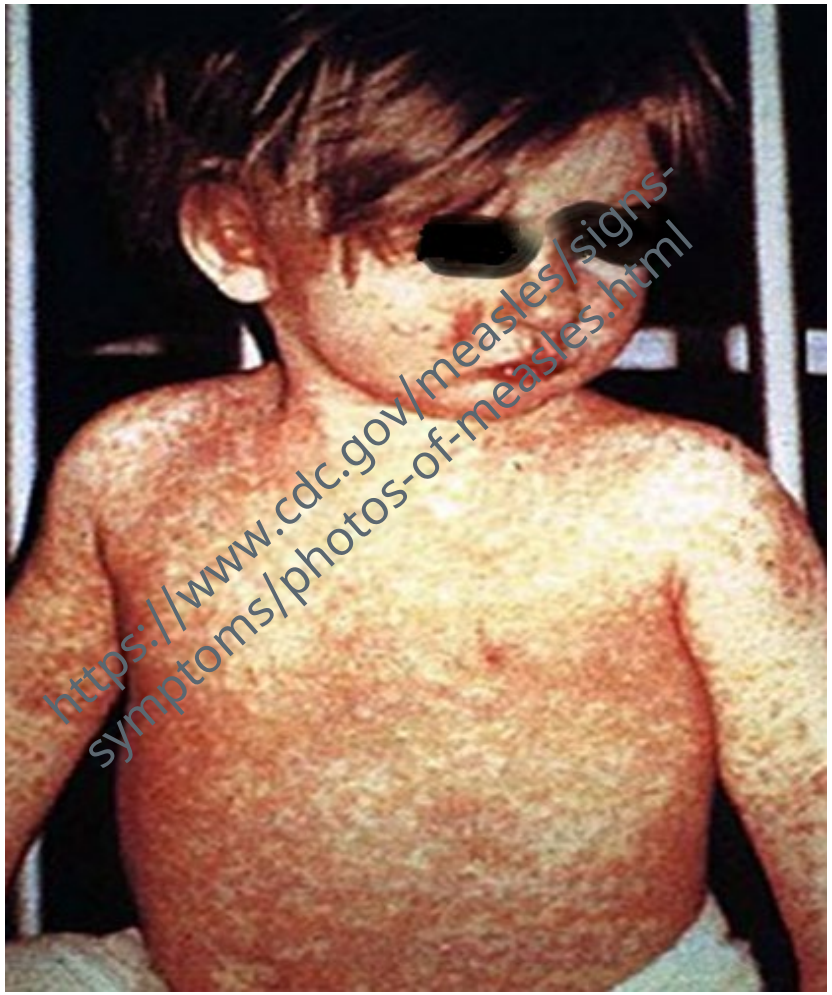
CalOptima Health



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https://www.cdc.gov/measles/signs-symptoms/photos-of-measles.html

CalOptima Health

Complications of measles

- Ear infections.
- Scarring of the cornea.
- Pneumonia.
- Encephalitis (inflammation of the brain) which occurs in about one in every 1,000 people with measles.

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CalOptima Health

In All of 2023
What was the total number of Measles cases in the US? **59**

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CalOptima Health

In All of 2024
What was the total number of Measles cases in the US? **285**

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CalOptima Health

COUNTY HEALTH OFFICER
LOCAL MEDICAL LEADERS MONTHLY MEETING
2026

Regina Chinsio-Kwong, DO
County Health Officer (moderator)

Presenters:

Anissa Davis, MD, MPH
Deputy Health Officer/Communicable Disease Controller

Mindy Winterswyk, DPT, PCS
Director of Specialized Medical Services

February 2, 2026

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health CARE AGENCY

MEASLES

IT ISN'T JUST A LITTLE RASH

Measles can be dangerous, especially for babies and young children.

Measles symptoms typically include:

- **High fever** (may spike to more than 104°F)
- **Cough**
- **Runny nose**
- **Red and/or watery eyes**
- **Rash** (breaks out 3-5 days after symptoms begin)

HTTPS://WWW.CDC.GOV/MEASLES/DOWNLOADS/MEASLES-ISNT-JUST-A-LITTLE-RASH-INFOGRAPHIC-508.PDF

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Measles can be serious.

Measles can cause severe health complications, including pneumonia, swelling of the brain (encephalitis) and death.

1 out of 5 people who get measles will be hospitalized.

1 out of every 20 children with measles will get pneumonia, the most common cause of death from measles in young children.

1 out of every 1,000 people with measles will develop brain swelling, which may lead to brain damage.

1 to 3 out of 1,000 people with measles will die.

Long-term complications

A very rare, but deadly disease called subacute sclerosing panencephalitis can develop 7 to 10 years after a person has recovered from measles.

CDC

www.cdc.gov/measles

You have the power to protect your child.

Provide your children with safe and long-lasting protection against measles by making sure they get the measles-mumps-rubella (MMR) vaccine. Talk to your healthcare provider.

HTTPS://WWW.CDC.GOV/MEASLES/DOWNLOADS/MEASLES-ISNT-JUST-A-LITTLE-RASH-INFOGRAPHIC-508.PDF

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CDC MEASLES DATA FROM 2025-2026

U.S. Cases

	2026 To date	2025 Full year
Total Cases	**588**	**2267**
Age		
Under 5 years	157 (27%)	581 (26%)
5-19 years	343 (58%)	1002 (44%)
20+ years	66 (11%)	671 (30%)
Age unknown	22 (4%)	13 (1%)
Vaccination Status		
Unvaccinated or Unknown	94%	93%
One MMR dose	2%	3%
Two MMR doses	4%	4%

U.S. Hospitalizations

	2026	2025
Total Hospitalized	**3%** (17 of 588 cases)	**11%** (244 of 2267 cases)
Percent of Age Group Hospitalized		
Under 5 years	5% (8 of 157)	18% (106 of 581)
5-19 years	1% (5 of 343)	6% (56 of 1002)
20+ years	6% (4 of 66)	12% (82 of 671)
Age unknown	0% (0 of 22)	0% (0 of 13)

U.S. Deaths

	2026	2025
Total Deaths	**0**	**3**

Note: The total number of cases includes cases among international visitors to the U.S.

FROM HTTPS://WWW.CDC.GOV/MEASLES/DATA-RESEARCH/INDEX.HTML ACCESSED 2.2.2026 (LAST UPDATED JANUARY 30, 2026)

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RARE COMPLICATION OF SSPE FROM MEASLES CAUSED FATALITY IN A CHILD IN 2025

LINK : HTTP://PUBLICHEALTH.LACOUNTY.GOV/PHCOMMON/PUBLIC/MEDIA/MEDIAPUBHPDETAIL.CFM?PRID=5135

NEWS RELEASE

County of Los Angeles Public Health

313 N. Figueroa Street, Room 806 | Los Angeles, CA 90012 | (213) 288-8144 |
media@ph.lacounty.gov

For Immediate Release:

September 11, 2025

Public Health Reminds Residents About the Importance of Measles Vaccination Following the Death of a Child from a Measles-Related Complication

The Los Angeles County Department of Public Health encourages residents to make sure that all members of their families are protected against measles following the recent tragic death of a school-aged LA County resident from a complication of measles infection acquired during infancy. The child was originally infected with measles as an infant before they were eligible to receive the measles vaccine which is routinely recommended to be administered between 12 and 15 months. Although they recovered from the initial measles illness, the child developed and ultimately died from subacute sclerosing panencephalitis (SSPE)—a rare but universally fatal complication that can occur in individuals who had measles early in life.

SSPE is a rare, progressive brain disorder that is a late complication of infection from the measles virus. SSPE usually develops seven to ten years after the initial measles infection after the patient seemed to fully recover. It is characterized by a gradual and worsening loss of neurological function with death occurring one to three years after the initial diagnosis. There is no cure or effective treatment. It is rare, affecting about 1 in 10,000 people with measles, but the risk may be much higher — about 1 in 600 — for those who get measles as infants.

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PRESS RELEASES- RECENT MEASLES CASES CONFIRMED IN CALIFORNIA

Napa County

January 21, 2026

- Child returning from South Carolina

Orange County

January 28, 30, 31, 2026

- Young Adult who recently returned from international travel
- Toddler (no travel)
- LA case who traveled to Disneyland on January 28 (infectious period)

Los Angeles

January 30 and 31, 2026

- Resident who recently travelled internationally
- International traveler

Shasta County

January 31, 2026

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MEASLES- ORANGE COUNTY CASES AND EXPOSURES

- Adult who recently traveled internationally
  - Sites case visited during infectious period:
    - Eos gym in Ladera Ranch
    - AFC UC in Ladera Ranch
    - Mission Hospital
  - 134 known exposures
- Toddler without travel or known exposure
  - No known exposures
- Los Angeles County Case-
  - International traveler who visited Disneyland while infectious 1/28/26
  - 65 known exposures

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CDPH Health Advisor to Healthcare Providers
Suspect Measles?
Isolate, Report to Local Public Health and Test
3/25/2025

CDPH Recommendations

Suspect measles in patients with:

- Fever, rash, and any of the "3 Cs" – cough, coryza, or conjunctivitis
- In the prior 3 weeks, any of: attendance at an event or location with a known measles exposure, international travel, transit through airports, or interaction with international visitors (including at U.S. tourist attractions)

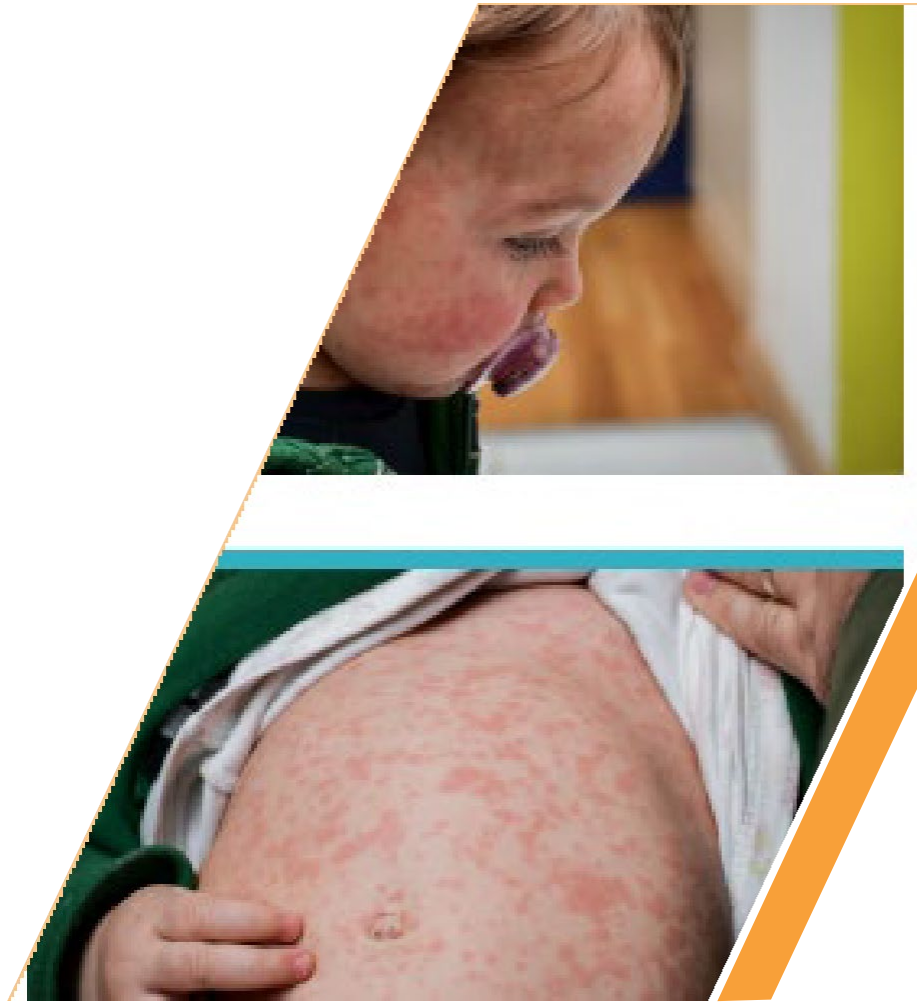
Steps for providers to take when patients present with febrile rash illness:

- Mask the patient immediately, if possible.
- Bypass the waiting room: keep patients out of common areas.
- Isolate patient immediately, in an airborne infection isolation room (AIIR) if possible. See CDC and CDPH (PDF) infection control guidance. People with measles are contagious from 4 days before rash onset through 4 days after rash onset.
- All healthcare personnel entering the patient room, regardless of immune status, should use respiratory protection at least as effective as an N95 respirator per Cal/OSHA requirements.
- Assess for risk factors and measles immunization status.
- Promptly telephone the local health department (LHD) to report suspected measles cases, even before laboratory confirmation, to discuss measles testing and control measures.
- Collect throat or NP swab and urine for polymerase chain reaction (PCR) testing. See Measles testing guidance. PCR is the preferred method for diagnosis.

Importance of immunization: Ensure all patients are up to date on MMR vaccine per ACIP recommendations. For patients planning international travel:

- Infants 6 to 11 months old need 1 dose of MMR vaccine.
- Children 12 months and older need 2 doses of MMR vaccine.
- Adults born during or after 1957 without evidence of immunity against measles need documentation of two doses of MMR vaccine at least 28 days apart.

LINK :
HTTPS://WWW.CDPH.CA.GOV/PROGRAMS/OPA/PAGES/CAHAN/-SUSPECT-MEASLES-ISOLATE-REPORT-TO-LOCAL-PUBLIC-HEALTH-AND-TEST.ASPX



Images
- CDC Be Ready for Measles
- https://www.cdc.gov/measles/media/pdfs/2024/08/measles-clinical-diagnosis-fs.pdf

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WHAT HAPPENS IF THERE'S A CASE

- **72 hour** to **6 day** window to provide **prophylaxis** (MMR or IG)
- Need to document **when and where** patient was in facility
- **Line list of exposed staff and their immunity documentation**
  - If they do not have documented immunity by day 5 after exposure they will be excluded from work for up to 21 days
  - Employer's responsibility
- Line list of **exposed patients and visitors**
- Particularly concerned for **infants**, **pregnant** people, **severely immunocompromised**
- We may need assistance reaching patients

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WHAT PROVIDERS & FACILITIES CAN DO

- **Document staff immune status NOW**
  - This will help avoid work exclusions
  - Give people time to find their documentation or to get titers drawn
- **Prepare for potential increased staffing needs to respond**
  - A single case linked to your facility can require significant effort and coordination with local officials for rapid notification and to ensure safety and health of staff and visitors.
- **Plan for patient triage**
  - Educate staff on how to quickly identify patients with fever + rash
  - Consider:
    - Waiting outside
    - Isolation protocols

HTTPS://WWW.CDPH.CA.GOV/PROGRAMS/CID/DCDC/CDPH%20DOCUMENT%20LIBRARY/IMMUNIZATION/MEASLES-HCFACILITYICRECS.PDF

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FOLLOW US ON SOCIAL MEDIA AND SHARE OUR POSTS!

Click on Image to start Video of Dr. Anissa Davis's message About Measles

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FOLLOW US ON SOCIAL MEDIA!

www.ochealthinfo.com

FACEBOOK | **INSTAGRAM** | **LINKEDIN** | **X** | **YOUTUBE**

HEALTH CORNER

WHY MATERNAL HEALTH MATTERS

January 23, 2026

Michele Cheung, MD MPH, FAAP
MEDICAL DIRECTOR, MATERNAL, CHILD AND ADOLESCENT HEALTH
HEALTH CORNER

In the early years of our lives, mothers are the center of our universe. They bring us life, they kiss our boo-boos, they read to us and tell us stories, they support our families emotionally and often financially, they shape us into the functioning adults we are today. Healthy moms lead to healthier children, who grow up to be healthier adults, and then the cycle repeats, building the foundation of our society.

And yet somehow, the health of our mothers has fallen by the wayside. Despite being in one of the wealthiest countries of the world, our maternal mortality rates in the United States are higher (=worse) than most other high-income countries.

Maternal health overall is an indicator of a nation's overall health, reflecting the strength of the health care system, the status of women, and their socioeconomic well-being. Differences in rates of adverse pregnancy and birth outcomes among race/ethnic groups are especially important to address to improve maternal health overall. The Centers for Disease Control and Prevention (CDC) estimates that more than 80% of deaths during and after pregnancy are preventable.

January 23 – Maternal Health Awareness Day is a Reminder that Your Health Matters

Whether you are pregnant, thinking about becoming pregnant, just had a baby, or in between babies, remember that

www.ochealthinfo.com/healthcorner

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MEMORANDUM

DATE:	January 29, 2026
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — February 5, 2026, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; and Whole-Child Model Family Advisory Committee

A. Covered California Monthly Update

CalOptima Health continues to prepare for the launch of a Covered California line of business, effective January 1, 2027. Following the Board's approval on June 5, staff submitted an initial filing on June 16 to the California Department of Managed Health Care (DMHC) to expand the scope of CalOptima Health's current Knox-Keene Act license, which is required to offer a commercial insurance product. Since then, we have engaged with DMHC to respond to comments and provide additional information. On October 31, staff submitted our second filing, including provider network rosters. Staff continue to collaborate with our provider network and execute amendments with several existing vendors to include Covered California in their scopes of service. In addition, operational workstreams are actively addressing program solutions to achieve operational readiness during the next year. Our teams are also preparing to file a Letter of Intent to Apply to Covered California as well as responses to the 2027 Qualified Health Plan application, which is due in April 2026. We have engaged with Covered California's Plan Management Advisory Group to maintain alignment on CalOptima Health's application. Finally, staff are actively monitoring regulatory and policy impacts on the Marketplace landscape in California resulting from the enactment of H.R. 1 and the recent expiration of the enhanced Advance Premium Tax Credits (eAPTCs), which have increased prices for consumers across all metal tiers. So far, preliminary results of 2026 open enrollment show a decrease in new enrollments in Orange County, with renewals remaining steady. CalOptima Health will have a better sense of the impact of policy changes on enrollment in early February.

B. CalOptima Health Earns National Committee for Quality Assurance (NCQA) Health Outcomes Accreditation

The NCQA has awarded CalOptima Health an "Accredited" status in our first submission for Health Outcomes Accreditation, previously known as Health Equity Accreditation. This recognition took effect on December 16, 2025, and remains valid through December 16, 2028. CalOptima Health met all standards and received 100% (full points). This accomplishment is a testament to our collective commitment to advancing health equity and delivering quality, inclusive care to the communities we serve. Achieving full points in every category reflects the dedication, collaboration and hard work of our entire team.

C. Get Care Now Campaign Launched

With Medi-Cal changes coming in the future, CalOptima Health's mission to keep members healthy has not changed. To address the shifting environment and reassure members about their coverage, we launched the Get Care Now campaign in late 2025 to encourage members to continue seeking care. The campaign features print ads, digital and social media ads, radio ads, outdoor transit shelter and bus interior ads, and place-based ads. Ads for this campaign will run through March 2026. Further, this campaign will serve as a bridge to our future Medi-Cal eligibility campaign. In addition, CalOptima Health created a toolkit for use by community partners to help us spread the message that members have options for care, including virtual doctor visits and medication home delivery. A flyer, FAQ and social media content can be downloaded here. Staff are raising awareness of the toolkit with community partners and providers, seeking support in distributing the messages.

D. PACE Expansion Application Includes Support Letters

Following the Board's approval on December 4, staff prepared an application to the California Department of Health Care Services (DHCS) to establish a second PACE center. Included in the submission were 26 letters of support from elected officials, providers and community-based organizations in Orange County.

E. Transitional Rent Becomes 15th Community Support

Mandated by DHCS, Transitional Rent is now the 15th CalAIM Community Support. Launched January 1, 2026, this new service will provide up to six months of rental assistance in interim and permanent settings to members who are: 1) experiencing or at risk of homelessness, 2) have certain clinical risk factors, and 3) have either recently undergone a critical life transition or who meet other specified eligibility criteria. CalOptima Health is contracted with the Orange County Health Care Agency as the sole provider for the Transitional Rent benefit. The initial rollout of this service will be specifically for members with significant behavioral health needs, aligning with the Behavioral Health Services Act interventions.

F. Government Affairs Updates

FY 2026–27 Proposed State Budget Is Released

On January 9, Governor Gavin Newsom released the Fiscal Year (FY) 2026–27 Proposed State Budget, effective July 1, 2026. While state tax revenue has come in higher than expected recently increased state program costs and the loss of significant federal funding to the state government will result in a modest $2.9 billion budget shortfall. As anticipated, the Medi-Cal program will be particularly affected as policy changes from H.R. 1 and last year's enacted state budget are implemented. Notably, Medi-Cal enrollment is projected to decrease by 3.5% in the upcoming fiscal year due to more restrictive eligibility requirements, such as minimum work obligations and semiannual redeterminations. Also effective in FY 2026–27 are direct reductions to federal match dollars for the Managed Care Organization (MCO) tax, Hospital Quality Assurance Fee (HQAF) and emergency Medicaid services for undocumented adults. Fortunately, this proposed state budget does not include any major new spending cuts beyond what was previously announced or expected. Most existing Medi-Cal initiatives, including CalAIM, would continue to be fully funded. However, this budget proposal is largely viewed as a placeholder and is still subject to change as the state updates its revenue projections and receives further guidance from the federal government in the coming months. Governor Newsom will release a revised state budget proposal by May 14 before a final budget must be negotiated with the State Legislature and enacted by July 1.

CalOptima Health Leads eAPTC Advocacy Coalition Letter
Ahead of the expiration of the enhanced Advance Premium Tax Credits (eAPTCs) on December 31, 2025, CalOptima Health led a coalition letter to Orange County's federal delegation advocating for at least a one-year clean extension of the eAPTCs. Since 2026 open enrollment was already underway, a clean extension would have avoided any further uncertainty for Orange County residents — especially as CalOptima Health prepares for Covered California marketing and enrollment activities this year ahead of our proposed January 1, 2027, plan launch. Other signatories of the coalition letter included the Hospital Association of Southern California, Orange County Medical Association, Orange County Business Council and several individual hospital systems. The eAPTCs ultimately expired on December 31, but the U.S. Congress continues to consider proposals that could include a retroactive extension and/or other related reforms. While there is no clear consensus or outcome at this time, Government Affairs staff continue to monitor ongoing negotiations.

Judge Allows CMS to Share Medicaid Data with ICE
On December 29, U.S. District Judge Vince Chhabria ruled that the U.S. Centers for Medicare & Medicaid Services (CMS) can resume sharing personal data about undocumented immigrants receiving Medicaid benefits with Immigration and Customs Enforcement (ICE), starting on January 6. ICE had been blocked from doing so for months amid a legal challenge from California and several other states. Chhabria's order is narrowly tailored to six categories of "basic" personal information: citizenship, immigration status, address, phone number, date of birth and Medicaid ID. CMS remains barred from sharing personal health records and other potentially sensitive medical information. Furthermore, CMS is prohibited from sharing any Medicaid data about immigrants who are lawfully residing in the United States. In response to the ruling, DHCS issued a statement reiterating its commitment to protecting the privacy of Medi-Cal beneficiaries.

G. Modivcare Chapter 11 Restructure Approved

On December 29, 2025, Modivcare announced it had successfully emerged from its financial restructuring. Earlier this month, Modivcare subsequently announced that Chief Executive Officer Heath Sampson will be departing the company but remain on the board. To support the company's continued success, the Board and Heath agreed he will remain in his role through this transition. Board Vice Chairman Scott McCarty will provide executive oversight of the company throughout this transition period. There has been no impact to member provided transportation at CalOptima Health – the current satisfaction performance is 99.7%.

H. Annual Medical Loss Ratio (MLR) Audit of Contracted Health Networks Is Complete

CalOptima Health completed the annual MLR audit of our contracted health networks for Calendar Year (CY) 2024. In accordance with contract requirements, health networks must maintain a minimum MLR of 85% for each measurement year. CalOptima Health combines results for Medi-Cal and OneCare members to assess compliance. The CY 2024 audit results show that all health networks have met the MLR requirement. CalOptima Health also finalized the CY 2024 MLR reporting template and submitted it to DHCS.

I. CalOptima Health Receives Robust Media Coverage

- On December 12, Spectrum News ran a feature on seniors and homelessness, with Kelly Bruno-Nelson, DSW, Executive Director of Medi-Cal/CalAIM, as a key interview. Kelly connected the reporter with Jamboree Housing and their resident to bring this story to life. In addition, the reporter also interviewed Supervisor Vicente Sarmiento.

- On December 17, the Orange County Register ran an article syndicated by KFF Health News featuring CalOptima Health titled, "Medicaid health plans step up outreach efforts ahead of GOP changes."
- On December 22, the Voice of OC published a brief op-ed piece I wrote about our dedication to members despite challenges similar to those faced 30 years ago when CalOptima Health was founded.
- On December 29, I was interviewed by CBS LA News regarding the changes to Medi-Cal as of January 1, including the enrollment freeze on undocumented adults.
- On January 7, PACE Medical Director Dr. Donna Frisch was interviewed by KTLA for a recurring segment called "The Doctor Will See You Now." The live, in-studio segment featured Dr. Frisch giving advice on caring for aging loved ones.
- On January 14, the Voice of OC ran an article titled, "CalOptima Health Braces for Health Insurance Eligibility Changes For OC's Neediest Families." It featured an interview with Chief Operating Officer Yunkyung Kim.
- On January 21, the OC Register ran a feature article about my plans to retire at the end of 2026.
- On January 22, the OC Register covered the groundbreaking for Casa Colibri, a new housing development funded in part by a CalOptima Health grant.

CalOptima Health

Fast Facts
February 2026

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

Membership Data* (as of December 31, 2025)

Total CalOptima Health Membership

865,746

Prior month: 877,271

Program	Members
Medi-Cal	846,603
OneCare (HMO D-SNP)	18,599
Program of All-Inclusive Care for the Elderly (PACE)	544

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

Key Financial Indicators (for the month ended December 31, 2025)

	Dashboard	YTD Actual	Actual vs. Budget ($)	Actual vs. Budget (%)
Operating Income/(Loss)	●	$62.4M	$48.8M	359.4%
Non-Operating Income/(Loss)	●	$59.2M	$10.0M	20.4%
Covered California Start-up Expenses	●	($2.3M)	$2.9M	56.5%
Bottom Line (Change in Net Assets)	●	$119.3M	$61.8M	107.3%
Medical Loss Ratio (MLR) *(Percent of every dollar spent on member care)*	●	92.5%	---	(0.7%)
Administrative Loss Ratio (ALR) *(Percent of every dollar spent on overhead costs)*	●	5.1%	---	1.3%

Notes:
- For additional financial details, refer to the financial packages included in the Board of Directors meeting materials.
- Adjusted MLR (without the estimated provider rate increases funded by reserves) is 88.3%.

Reserve Summary (as of December 31, 2025)

	Amount (in millions)
Board Designated Reserves*	$1,623.6
Statutory Designated Reserves	$135.8
Capital Assets (Net of depreciation)	$111.8
Unspent Balance of Allocated Resources	$349.4
Unspent Balance of Board Approved Provider Rate Increase**	$210.5
Unallocated Resources*	$488.9
Total Net Assets	$2,919.9

* Total of Board-designated reserves and unallocated resources can support approximately 194 days of CalOptima Health's current operations.

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

Total Annual Budgeted Revenue **$4.7 Billion**

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

CalOptima Health Fast Facts

February 2026

Personnel Summary (as of January 10, 2026, pay period)

	Filled	Open	Vacancy % Medical	Vacancy % Administrative	Vacancy % Combined
Staff	1,347.25	86	38.77%	61.23%	6%
Supervisor	82	5	60%	40%	5.75%
Manager	114	12	16.67%	83.33%	9.52%
Director	80	8.5	29.41%	70.59%	9.60%
Executive	21	1	---%	100%	4.55%
Total FTE Count	1,644.25	112.5	28.97%	71.03%	6.40%

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

Provider Network Data (as of January 23, 2026)

	Number of Providers
Primary Care Providers	1,307
Specialists	7,994
Pharmacies	493
Acute and Rehab Hospitals	42
Community Health Centers	71
Long-Term Care Facilities	243

Treatment Authorizations (as of November 30, 2025)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	38.71 hours
Prior Authorization – Urgent	72 hours	6.02 hours
Prior Authorization – Routine	5 days	0.74 days

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

Member Demographics (as of December 31, 2025)

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

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

Medi-Cal Aid Category	
Expansion	37%
Temporary Assistance for Needy Families	36%
Seniors	13%
Optional Targeted Low-Income Children	8%
People With Disabilities	5%
Long-Term Care	<1%
Other	<1%

CalOptima Health

Provider Network Trend

February 2026

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

CHCN and Health Networks

Total Providers [1]

Provider Type	2024 – Q4	2025 – Q1	2025 – Q2	2025 – Q3	2025 – Q4	YOY Net Δ
PCP [2]	1,313	1,312	1,301	1,281	1,306	-7
Specialist (Physicians)	7,017	7,070	7,479	7,685	8,246	1,229
Hospitals [3]	41	41	41	43	42	1
Community Health Centers [4]	65	65	68	68	68	3
Long Term Care	206	207	207	225	241	35
Behavioral Health [5]	2,273	2,529	2,579	2,791	3,023	750
ECM	32	31	32	34	34	2
Community Support	103	102	103	107	107	4

Medi-Cal

Provider Type	2024 – Q4	2025 – Q1	2025 – Q2	2025 – Q3	2025 – Q4	YOY Net Δ
PCP [2]	1,087	1,087	1,076	1,057	1,090	3
Specialist (Physicians)	6,420	6,464	7,173	7,394	7,987	1,567
Hospitals [3]	37	37	37	40	39	2
Community Health Centers [4]	63	63	66	66	68	5
Long Term Care	202	203	203	221	237	35
Behavioral Health [5]	2,177	2,436	2,495	2,695	2,926	749
ECM	32	31	32	34	34	2
Community Support	103	102	103	107	107	4

OneCare

Provider Type	2024 – Q4	2025 – Q1	2025 – Q2	2025 – Q3	2025 – Q4	YOY Net Δ
PCP [2]	1,099	1,096	1,082	1,074	1,088	-11
Specialist (Physicians)	5,437	5,488	5,844	6,047	6,270	833
Hospitals [3]	36	36	36	40	39	3
Community Health Centers [4]	58	58	62	62	62	4
Long Term Care	206	203	207	224	240	34
Behavioral Health [5]	649	668	713	851	952	303

PACE

Provider Type	2024 – Q4	2025 – Q1	2025 – Q2	2025 – Q3	2025 – Q4	YOY Net Δ
PCP [2]	3	3	4	3	3	0
Specialist (Physicians)	3,457	3,549	4,033	4,256	4,446	989
Hospitals [3]	29	29	29	31	30	1
Community Health Centers [4]	0	0	0	0	0	0
Long Term Care	66	67	69	76	91	25
Behavioral Health [5]	103	106	116	119	132	29

Provider Network Trend

February 2026

CHCN Only

Total Providers [1]

Provider Type	2024 – Q4	2025 – Q1	2025 – Q2	2025 – Q3	2025 – Q4	YOY Net Δ
PCP [2]	678	677	671	671	685	7
Specialist (Physicians)	6,335	6,384	6,841	7,058	7,330	995
Hospitals [3]	37	37	37	40	39	2
Community Health Centers [4]	56	56	58	58	59	3
Long Term Care	202	203	203	221	237	35
Behavioral Health [5]	2,247	2,500	2,541	2,767	2,975	728
ECM	32	31	32	34	34	2
Community Support	103	102	103	107	107	4

Medi-Cal

Provider Type	2024 – Q4	2025 – Q1	2025 – Q2	2025 – Q3	2025 – Q4	YOY Net Δ
PCP [2]	656	653	650	650	514	-142
Specialist (Physicians)	5,988	6,026	6,791	7,000	7,269	1,281
Hospitals [3]	34	34	34	38	37	3
Community Health Centers [4]	56	56	58	58	59	3
Long Term Care	202	203	203	221	237	35
Behavioral Health [5]	2,155	2,411	2,471	2,673	2,879	724
ECM	32	31	32	34	34	2
Community Support	103	102	103	107	107	4

OneCare

Provider Type	2024 – Q4	2025 – Q1	2025 – Q2	2025 – Q3	2025 – Q4	YOY Net Δ
PCP [2]	569	571	565	567	581	12
Specialist (Physicians)	4,706	4,746	5,136	5,359	5,575	869
Hospitals [3]	31	31	31	33	32	1
Community Health Centers [4]	46	46	48	48	49	3
Long Term Care	202	203	203	220	236	34
Behavioral Health [5]	634	652	699	836	936	302

PACE

Provider Type	2024 – Q4	2025 – Q1	2025 – Q2	2025 – Q3	2025 – Q4	YOY Net Δ
PCP [2]	3	3	4	3	3	0
Specialist (Physicians)	3,457	3,549	4,033	4,256	3	989
Hospitals [3]	29	29	29	31	4,446	1
Community Health Centers [4]	0	0	0	0	30	0
Long Term Care	66	67	69	76	91	25
Behavioral Health [5]	103	106	116	119	132	29

Footnotes:

[1] Unique count of Provider by NPI (does not include count of each practice location per provider)

[2] Includes Primary Care Physicians, FQHCs and Long Term Care facilities acting as Primary Care Providers

[3] Includes Acute, Rehab and Long Term Acute Care Hospitals

[4] Community Health Centers includes FQHCs, FQHC look-alike and Community Clinics

[5] Includes Practitioners and Behavioral Health Groups