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

AUGUST 6, 2026
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

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Isabel Becerra
Norma García Guillén
Brian Helleland
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Michael Hunn	James Novello Kennaday Leavitt	Tina Knapp

This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda. To speak on an item, complete a Public Comment Request Form identifying the item and submit to the Clerk of the Board. To speak on a matter not appearing on the agenda, but within the subject matter jurisdiction of the Board of Directors, you may do so during Public Comments. Public Comment Request Forms must be submitted prior to the beginning of the Consent Calendar and/or the beginning of Public Comments. When addressing the Board, it is requested that you state your name for the record. Address the Board as a whole through the Chair. Comments to individual Board Members or staff are not permitted. Speakers are limited to three (3) minutes per item.

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

The Board Meeting Agenda and supporting materials are available for review at CalOptima Health, 505 City Parkway West, Orange, CA 92868, Monday-Friday, 8:00 a.m. – 5:00 p.m. These materials are also available online at www.caloptima.org. Board meeting audio is streamed live on the CalOptima Health website at www.caloptima.org.

Members of the public may attend the meeting in person. Members of the public also have the option of participating in the meeting via Zoom Webinar (see below).
To Make a Public Comment, Participate via Zoom Webinar at
https://us02web.zoom.us/s/84574235040?pwd=UyZG57n3eKEJprI5ew5r3aGyvtgMnX.1
To Register and Join the Meeting.
Webinar ID: **845 7423 5040**
Passcode: **787769**
To Listen in Only, Participate via Vimeo at:
https://vimeo.com/event/6083391/1a81a2a7e9

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS
1. National Opinion Research Center on Member and Population Health Needs Assessment

2. Health Equity Updates

MANAGEMENT REPORTS
3. Chief Executive Officer Report

ADVISORY COMMITTEE UPDATES
4. Member Advisory and Provider Advisory Committees Report to the Board

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

CONSENT CALENDAR
5. Minutes
   a. Approve Minutes of the June 4, 2026 Regular Meeting of the CalOptima Health Board of Directors and Approve Minutes of the June 18, 2026 Special Meeting of the CalOptima Health Board of Directors

6. Approve Reappointments and Appointments to the CalOptima Health Board of Directors' Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee

7. Approve the Further Revision of CalOptima Health's Position on Assembly Bill 2194

8. Approve CalOptima Health's Opposition to Proposed State Budget Trailer Bill Language

9. Ratify Execution of License Agreement with Avanta Properties City Parkway LLC and Orange City Mills Mall Limited Partnership

10. Approve Modifications to CalOptima Health Policy: GG.1611

11. Approve Reallocation of Remaining Non-monetary Gift Cards

12. Receive and File – *Monthly Financial, Compliance, and Government Affairs Reports*
    a. 2026 Financial Summary (May & June 2026)
    b. Compliance Report
    c. Government Affairs Reports

13. Receive and File – *Monthly Community Events and Sponsorship Reports*
    a. CalOptima Health Community Outreach Summary (July & August 2026)
    b. Sponsorships and Community Participation Including Upcoming Events (July & August 2026)

14. Receive and File – *Quarterly Reports*
    a. Board Approved Initiative Impact Summary (April-June 2026)
    b. Strategic Plan Performance Quarterly Report CY 2026 (Q2 April-June)
    c. Grievances and Appeals Quarterly Report

REPORTS/DISCUSSION ITEMS

15. Approve Actions Related to the Street Medicine Program City Collaborative Expansion

16. Approve Actions Related to the Housing and Homelessness Incentive Program – Funding Allocations

17. Approve Actions Related to CalOptima Health's Qualified Health Plan Contract with Covered California

18. Approve Actions Related to CalOptima Health's Community Reinvestment Plan

19. Approve Actions Related to New Provider Services Contract Template and Associated Exhibits

20. Approve the three-year pilot Whole Child Model Transition Program, inclusive of an Adult Primary Care Provider Incentive Payment Model, to support California Children's Services Members Transitioning from Pediatric to Adult Care

21. Authorize Actions Related to Contracting for Hair Removal Services for Transgender and Gender Diverse Members in the CalOptima Health Direct Medi-Cal Program- *to follow closed session*

CLOSED SESSION

CS-1 HEALTH PLAN TRADE SECRETS – GOVERNMENT CODE SECTION 54956.87(b)
Provider Contract Rates

CS-2 HEALTH PLAN TRADE SECRETS – GOVERNMENT CODE SECTION 54956.87(b)
Program of All-Inclusive Care for the Elderly

CS-3 PUBLIC EMPLOYEE APPOINTMENT – GOVERNMENT CODE SECITION 54957(b)(1)
General Counsel

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

NORC at the University of Chicago

Member and Population Health Needs Assessment (MPHNA)

Presentation to the CalOptima Health Board of Directors

08.06.2026

Lisa Shugarman, Senior Fellow

Back to Agenda

Agenda

01 MPHNA Background and Areas of Focus

02 Key Findings by Area of Focus

03 Priority Areas and Recommendations

Back to Agenda

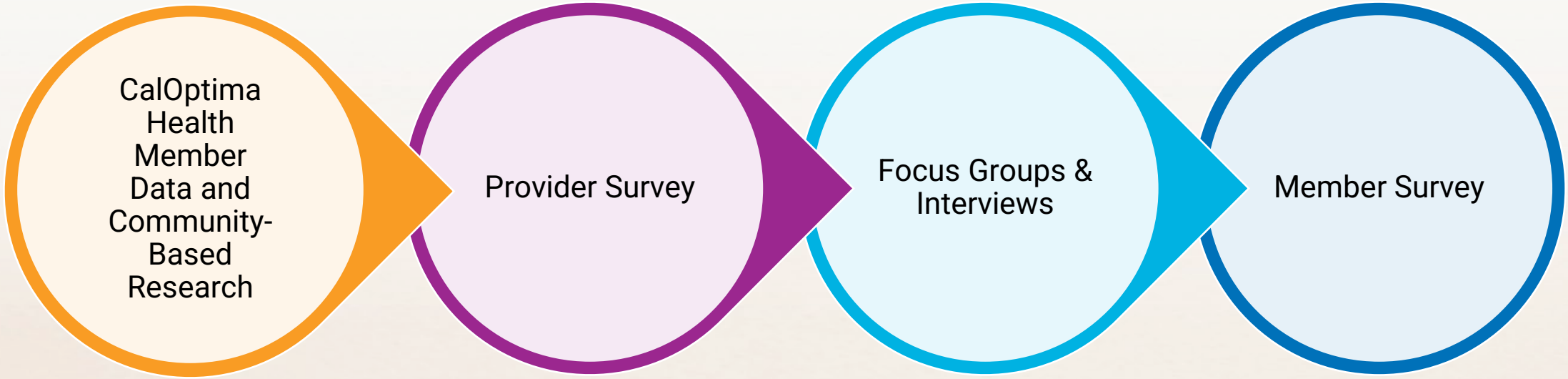
CalOptima Health MPHNA Background

- Board-approved strategic initiative started in March 2025 with selected vendor NORC at the University of Chicago (NORC)
- **MPHNA Objectives:**
  - Gain a comprehensive understanding of the health needs and preferences of CalOptima Health members
  - Inform the development of effective programs and strategic initiatives that address the health needs and preferences of CalOptima Health members



Back to Agenda

MPHNA Process



March – September 2025

- Developed study design with collaborative review
- Analyzed administrative datasets providing detail on member characteristics, health, and quality measures
- Reviewed community research to gain insights into local health and social needs

July 21, 2025 - August 29, 2025

- Assessed provider views on members' access to care and health outcomes

October – December 2025

- Conducted in-person and virtual focus groups and interviews with members and community stakeholders representing all geographic regions of Orange County

November 4, 2025 - January 26, 2026

- Conducted a web-based member survey distributed through postcards with unique survey links via mail, community events, Street Medicine, and PACE location.

Back to Agenda

MPHNA Areas of Focus

The MPHNA explored health and social needs across several domains, identifying key issues and opportunities in each of these areas.

- **Health Status & Conditions**
- **Health Care Use**
- **Health Care Access, Coverage, & Navigation**
- **Care Experience & Quality**
- **Health Behaviors**
- **Health Related Social Needs**

Back to Agenda

MPHNA Data Sources and Methods

NORC and its partners used multiple data sources to understand the needs of CalOptima Health members and the Orange County community.



1,858
Member Survey Responses



301
Provider Survey Responses



10
Reports Reviewed (e.g., CHA/CHIP)



11
Member Focus Groups



22
Member and Caregiver Interviews



Analysis of CalOptima Health Administrative Data

Back to Agenda

Health Status and Conditions

Bright Spots

- Most members (68%) rated their health as good to excellent.

Areas of Opportunity

- Behavioral health emerged as an important area for continued member support and engagement, based on 2025 CalOptima Health data and from providers' perspectives.*
- Variation in the prevalence of chronic conditions across racial/ethnic groups and sex highlighted opportunities for targeted member support.



About 1 in 10 members had anxiety or mood disorders.

Source: 2025 CalOptima Health administrative member data



About two-thirds of providers viewed substance use as a problem among Medi-Cal patients.

Source: 2025-2026 CalOptima Health MPHNA Provider Survey

*CalOptima Health provides behavioral health services for mild-to-moderate behavioral health needs, while the county provides services for more severe needs.

Back to Agenda

Health Care Use

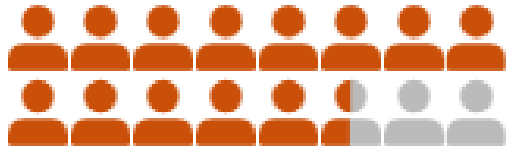
Bright Spots

- Most members (81%) used a doctor's office or medical clinic as their primary source of care.
- More than 8 in 10 members had at least one primary care visit in the past year.

Areas of Opportunity

- Opportunities exist to further support access to and utilization of routine dental services.
- Members described using urgent care because of convenience, same-day access, and shorter waits, highlighting these influential factors for care-seeking behavior.
- Certain member populations had higher rates of emergency room use, identifying opportunities to better understand and address their care needs.

84% of members had a primary care visit within the past year



Source: 2025-26 CalOptima Health MPHNA Member Survey

Back to Agenda

Health Care Access, Coverage, & Navigation

Bright Spots

- Birth outcomes were better than statewide averages for low-weight birth (51 per 1,000 live births vs. 75 statewide) and pre-term birth (54 vs. 92).
- Members enrolled in OneCare reported fewer challenges than dually eligible members enrolled in Medicare outside CalOptima Health.

Areas of Opportunity

- Access to needed care represented an opportunity to further support members, particularly with respect to timely appointment availability.
- Member feedback identified specialty care access as an area where improvements in wait times and referrals for appointments could further support positive experiences.
- Findings highlighted opportunities to improve understanding of available services and how to access them effectively.

4 in 10 members said they needed help understanding covered services or how to use their benefits.



Source: 2025-26 CalOptima Health MPHNA Member Survey

Back to Agenda

Care Experience and Quality

Bright Spots

- The majority of members agreed that their doctor addressed their concerns.
- The majority of members agreed their doctor listened to them.
- Most members said their cultural and individual needs were met during care.

Areas of Opportunity

- Among members who speak a language other than English at home, there are opportunities to invest in more strategies to help them understand their health concerns and after-visit follow-up.
- Opportunities exist to foster an environment where members feel comfortable sharing their cultural and religious preferences.

3 in 4 members agreed their cultural and individual needs were met.



Source: 2025-26 CalOptima Health MPHNA Member Survey

Back to Agenda

Health Behaviors

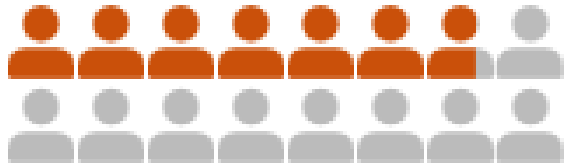
Bright Spots

- Nearly half (46%) of members were interested in support with access to fruits and vegetables.

Areas of Opportunity

- The most requested support for physical activity was free or low-cost fitness classes, suggesting that cost may be a barrier and removing this barrier may encourage physical activity.
- Opportunities exist to further support safe and inclusive environments for physical activity among LGBTQ+ members.
- Member feedback suggested opportunities to strengthen nutrition-related support and education for populations with greater health needs.

About 2 in 5 members wanted free or low-cost fitness classes



Source: 2025-26 CalOptima Health MPHNA Member Survey

Back to Agenda

Health Related Social Needs

Bright Spots

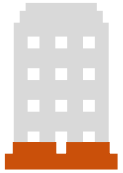
- Nearly 80% of adult members said they feel safe where they live and 90% said they feel safe in their home.
- Most adult members (78%) reported no difficulty accessing community services or resources.

Areas of Opportunity

- Members' experiences of financial strain pointed to opportunities to address factors related to economic stability to support overall health and well-being.
- Housing stability emerged as a key area of focus, based on both member experiences and provider perspectives.
- Opportunities exist to strengthen connections between providers and community-based resources that support social needs.



45% of members experienced financial strain.



15% of members had insecure housing.

Source: 2025-26 CalOptima Health MPHNA Member Survey

Back to Agenda

Priority Areas and Recommendations

NORC examined the findings that emerged within and across each area of focus by data source to identify priority areas and recommendations for future action.

- **Behavioral Health**
- **Access to Care and Care Navigation**
- **Health Related Social Needs**
- **Cultural, Linguistic, And Identity Responsive Care**

Back to Agenda

Priority Areas and Recommendations: **Behavioral Health**

Recommendations

- Expand and promote behavioral health-specific care navigation, ensuring members are aware of and connected to supports.
- Deepen integration of behavioral health within primary care settings by supporting co-located services, warm handoffs, and collaborative care models.

Current Initiatives

- Since 2022, CalOptima Health expanded access and community partnerships, including peer support with NAMI Orange County, the allcove youth center, and Telemed2U telehealth services.
- Additional efforts strengthened integration of behavioral health into primary care, including a First 5 partnership to train clinics to deliver early childhood mental health services.



Back to Agenda

Priority Areas and Recommendations: Access to Care and Care Navigation

Recommendations

- Continue to conduct member outreach to build awareness and utilization of navigation and case management services.
- Address specialty care access bottlenecks due to long appointment wait times through coordinated, multi-pronged strategy focused on both provider practices and system-level alternatives.
- Promote appropriate care pathways by educating members on when and how to use care.



Current Initiatives

- In 2023, CalOptima Health committed $50 million in investments to increase the health care workforce in Orange County. The initiative focuses on education, training, recruitment and retention of health care providers to improve access to care for the Medi-Cal population.

Back to Agenda

Priority Areas and Recommendations: Health Related Social Needs

Recommendations

- Continue to invest in the development of affordable housing.
- Explore new referral pathways to social services by expanding provider screening for social needs and enhance closed-loop referral pathways.
- Partner with community and workforce development organizations, community colleges, and local employers to support job training, employment opportunities, and economic opportunity.



Current Initiatives

- In early 2026, CalOptima Health awarded grants totaling $10 million to six Orange County community organizations to support new affordable housing developments.
- Since 2022, CalOptima Health has invested $93.3 million in affordable housing, with over 1,250 new units developed or in development.

Back to Agenda

Priority Areas and Recommendations: Cultural, Linguistic, and Identity Responsive Care

Recommendations

- Conduct targeted outreach campaigns for both members and providers to increase awareness of available cultural and linguistic services and how to access them.
- Encourage a trust-building and patient-centered communication strategy focused on culturally safe care conversations.

Current Initiatives

- CalOptima Health's Cultural and Linguistics (C&L) team coordinates interpreter services for CalOptima Health members, offering face-to-face, telephonic, and video options to ensure access for all languages.
- CalOptima Health's Community Health Team also offers a variety of trainings related to Cultural Competency for providers.



Back to Agenda

Behavioral Health

- Strategic goal focused on improving BH quality scores and access to care (Goal 2.4)
- Close collaboration with the Orange County Health Care Agency (HCA), including data sharing, joint workgroups, and aligned quality measures
- SBHIP and CYBHI initiatives
- Partnerships with NAMI, the allcove youth drop-in center, and First 5 Orange County
- TeleMed2U behavioral health telehealth services
- Cognoa autism screening partnership

Access to Care & Care Navigation

- Strategic goal focused on access to care (Goal 2.2)
- Provider Workforce Development Initiative $50 million investment
- Focused contracting efforts to expand access to care
- Provider rate increases
- Care management and navigation programs focused on highest risk members
- Specific care initiatives focused on maternal health, diabetes management, and obesity
- Health education and promotion programs
- Skilled Nursing Facility access program

Back to Agenda

Health Related Social Needs

- Strategic goal focused on expanding social supports (Goal 3.1)
- Enhanced Care Management (ECM) and Community Supports (CS) initiatives
- Street Medicine program
- $93.3 million in investments in capital projects to increase affordable housing units
- Supplemental Food Assistance initiative
- CalFresh member outreach and awareness campaign
- FindHelp social needs referral tool

Cultural, Linguistic, & Identity Responsive Care

- Strategic goal focused on access to care for vulnerable populations in pursuit of health equity (Goal 1.4)
- Member materials available in all threshold languages
- Translation and interpretation services and supports
- Health education in multiple languages and formats
- Cultural Competency training for providers
- Community Listening Sessions
- Community partnerships

Back to Agenda

Thank you.

Lisa Shugarman
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Research You Can Trust™

NORC at the University of Chicago

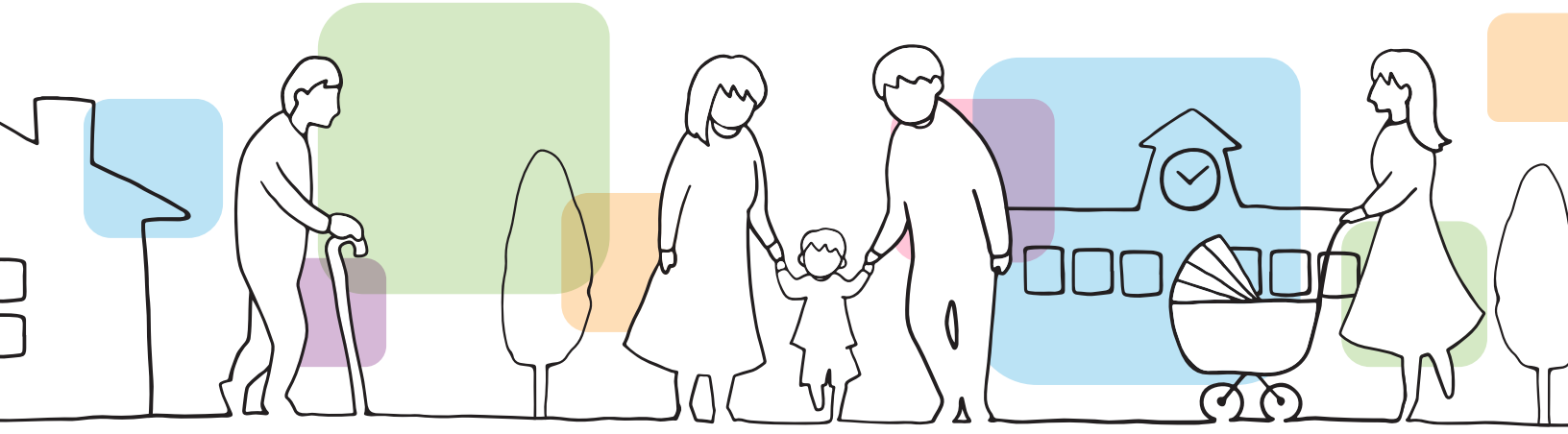
Back to Agenda

CalOptima Health

Member and Population Health Needs Assessment

EXECUTIVE SUMMARY

August 2026



Back to Agenda

Executive Summary

From mid-2025 to mid-2026, CalOptima Health conducted one of its most comprehensive and inclusive Member and Population Health Needs Assessments (MPHNA). This initiative highlighted our commitment to improving well-being and fostering a healthier, more resilient community. Building on prior efforts, the assessment engaged thousands of members, service providers and community partners to ensure a thorough understanding of the evolving needs of the populations we serve. The MPHNA delivers critical data that supports CalOptima Health's mission to provide high quality care and accessible services delivered with excellence, dignity and respect. Insights from this assessment will guide our organization in addressing current challenges and advancing equitable, member centered and whole-person care across Orange County.

CalOptima Health and its research partner, NORC at the University of Chicago (NORC), embarked on a comprehensive Member and Population Health Needs Assessment (MPHNA) from mid-2025 to mid-2026. This report summarizes what CalOptima Health learned about the health needs, care experiences and daily challenges facing its members across Orange County. The MPHNA examined both health needs and the social factors that shape health, such as housing, food, transportation, safety and financial stress. The goal of the assessment was to provide practical, data-driven information that CalOptima Health can use to strengthen services, improve member experience, guide community partnerships and support health equity.

Methods and Data Sources

NORC and its partners used multiple sources of information to complete this assessment. The study included a web-based member survey that was available in eight languages; a web-based provider survey; 11 member focus groups held in-person and virtually in English, Spanish and Vietnamese; 22 in-person interviews with members and caregivers; input from community partners representing 12 organizations; a review of CalOptima Health administrative data; and reviews of Orange County and community-level needs assessments, population health and other reports. Together, these data provide a broad view of CalOptima Health member needs, highlight important differences across groups, and point to where future investments may have the greatest impact.

At a Glance

1,858
Member Survey Responses

11
Member Focus Groups

22
Member and Caregiver Interviews

301
Provider Survey Responses

8
Languages

Back to Agenda

We invited a sample of 25,253 CalOptima Health members to participate so we could better understand their health care experiences and health and social needs. The survey was fielded from November 4, 2025, to January 26, 2026, through mail, email and postcard reminders, and targeted outreach with the Program of All-Inclusive Care for the Elderly (PACE), the Street Medicine Program, and postcard distribution at member and community events. A total of 1,858 members completed the survey, as shown in **Exhibit 1** by race and ethnicity, enrollment status, and survey language.

Exhibit 1. Number and Percent of Completed Surveys

	Number of Completed Surveys	Percent of Completed Surveys
Total Population	**1,858**	**100%**
By Race/Ethnicity		
Hispanic/Latino	611	33%
White, Non-Hispanic/Latino	362	19%
Vietnamese	308	17%
Other	577	31%
By Enrollment Status		
Medi-Cal only	1,370	74%
OneCare	288	16%
Dually eligible for Medi-Cal and Medicare (not enrolled in OneCare)	173	9%
Other	27	1%
By Survey Language		
English	1,341	72%
Spanish	252	14%
Vietnamese	119	6%
Other	146	8%

Source: 2025–26 CalOptima Health MPHNA Member Survey

With the support of strong community partnerships, the NORC team conducted a series of focus groups and interviews with members and community stakeholders to gain detailed qualitative insights into members' experiences of accessing care, what works well, and opportunities for improvement. Twenty-one community stakeholders representing 12 organizations from the Orange County Health Care Agency Population Health Collaborative validated the assessment framework, which informed the discussion guides and strengthened the questionnaire design. This facilitated in-depth conversations with 80 members or their caregivers with a total of 11 focus groups and 22 interviews held, reflecting a diverse range of perspectives, representing the following 10 distinct populations:

- Adults with disabilities or their caregivers
- Black/African American members
- English-speaking members residing in North and South County
- Members who are unhoused
- Members with behavioral health needs
- Older adult members and PACE members or their caregivers
- Parents of children participating in the Whole Child Model (children enrolled in California Children's Services [CCS])
- Pregnant or postpartum women and parents of children under 5 years of age
- Spanish-speaking members residing in North and South County
- Vietnamese-speaking members

The NORC team also surveyed CalOptima Health contracted providers to understand their perspectives on members' health needs, health-related social needs, and the services and resources available to address those needs. A total of 2,252 providers were invited to participate by email, and CalOptima Health promoted the survey through its provider network forums and newsletters. The survey was conducted July 21–August 29, 2025, and received 301 completed responses. **Exhibit 2** summarizes the characteristics of survey respondents. They provided valuable insights into the health and social needs of CalOptima Health members and the resources available to support them.

Exhibit 2. Summary of Provider Survey Respondents

Respondent Type	Number of Completed Surveys	Percent of Completed Surveys
Physician	102	34%
Behavioral health professional	92	31%
Other clinical staff	44	15%
Other administrative staff	29	10%
Office or clinic manager	19	6%
Case manager	15	5%

Source: 2025 CalOptima Health MPHNA Provider Survey

Assessment Areas

By integrating evidence from multiple data sources, including surveys, focus groups, interviews, administrative data and past research, the MPHNA provides a comprehensive understanding of opportunities, priorities and stakeholder needs. The MPHNA assessed health and social needs across several domains, identifying key findings and opportunities in each domain.

Assessment Domain	Description
Health Status and Health Conditions	Members' health status, including chronic conditions, and how healthy they feel.
Health Care Use	How often and where members use health care services, and the risk of health problems when care is delayed, fragmented or does not meet clinical needs.
Health Care Access, Coverage and Navigation	Members' ability to get needed care, including finding in-network providers, making appointments, understanding their coverage and knowing where to get care or help.
Care Experience and Quality	Members' experiences with the care they receive, such as communication with providers, respect, cultural responsiveness and whether care meets their needs.
Health Behaviors	Daily actions that affect health, such as eating habits, physical activity and tobacco use.
Health-Related Social Needs	Basic needs that affect health, such as having stable housing, enough food, reliable transportation and personal safety.

Summary of Findings

The findings of this assessment show that CalOptima Health members are connected to important parts of the health care system. Most members described their health positively, demonstrating that they have consistent access to their primary care providers, feel they can speak with providers in a language that is comfortable to them and that their cultural and personal needs were met during care. In terms of opportunities, the assessment identified that members face access barriers in behavioral health, specialty care, dental care and care navigation, and have unmet health-related social needs (HRSN). Members also reported meaningful differences in experience by age, language, health status, and in some cases, race and ethnicity. The assessment points to several strengths that CalOptima Health can build on, while also identifying areas where members would benefit from clearer communication, stronger service coordination, and better alignment between need and available resources.

Back to Agenda

Health Status and Health Conditions

- Overall, many members described their health positively, and about two-thirds of survey respondents (68%) rated their health as good, very good or excellent.
- The assessment found a substantial burden of chronic disease and behavioral health needs across the membership. Chronic conditions were especially common among older adults, who had much higher rates of hypertension, high cholesterol, diabetes, arthritis and other ongoing health concerns than working-age adults. The data also showed meaningful variation across demographic groups.
- Behavioral health emerged as a key concern throughout the assessment. CalOptima Health administrative data, survey results, provider input and community feedback all pointed to elevated need related to anxiety, depression, serious mental illness and substance use.

Health Care Use

- Members reported strong use of primary care, and most identified a doctor's office or clinic as their usual source of care. This is an important strength because it suggests that many members are connected to routine and preventive care rather than relying only on urgent or emergency settings.
- Specialty care use was higher among members in poorer health, which indicates that members with greater need are reaching higher levels of care at least some of the time. However, the assessment also found gaps in the use of other important services.
- Dental care use was low, with fewer than half of members reporting a dental visit in the past year. While CalOptima Health does not provide dental care, care navigation to these providers can be strengthened.
- Behavioral health service use also appeared lower than expected given the level of documented need.
- Emergency department use was not uniformly high across the membership, but some groups showed elevated rates, including certain middle-aged adults and young children.

Health Care Access, Coverage and Navigation

- While members reported strong connections to primary care providers, members most often reported challenges with obtaining timely specialty care and behavioral health care.
- Roughly one-third reported delaying needed care, and the most common reasons include not being able to get appointments, long waits, providers not accepting insurance and providers not accepting new patients. Members in poorer health were especially likely to report delayed care.
- Many members said they needed additional help understanding what services were covered, how to use their benefits and how to find the right providers. Focus groups and interviews added important detail to these findings.
- Older adults enrolled in OneCare reported fewer mental health access issues than similar members outside the program, suggesting that more integrated coverage and navigation support can make a difference.

Care Experience and Quality

- Members generally described their interactions with providers positively. Many said their providers listened to them, answered questions and treated them with respect.
- Most members also said they were able to speak with providers in a language that felt comfortable to them and that their cultural and personal needs were met during care.
- Fewer than half of members said they consistently left medical visits fully understanding what to do next.
- Interpreter availability and understanding of the availability of these supports was uneven, and many members with limited English proficiency still reported barriers in communication.
- Members were also less likely to say they felt comfortable discussing cultural, religious or personal preferences with their providers.

Health Behaviors

- Members expressed strong interest in practical supports that would help them be more active, eat healthier foods and sleep better.
- Common requests for support included free or low-cost fitness classes, safe places to exercise, better access to fruits and vegetables, guidance on healthy eating, and help managing stress that affects sleep.
- The results also indicated that some groups may face greater barriers than others, especially members in poorer health and members who reported wanting safer and more welcoming environments for physical activity.

Health-Related Social Needs

- Most members reported feeling safe at home and in their community. However, the provider survey found that over half of providers (54%) reported that domestic violence is a problem for members, indicating that a lack of personal safety may have been underreported in the member survey.
- Financial strain was widespread, and many members reported difficulty paying bills, concern about income loss, food insecurity and housing insecurity. Nearly half of the members said food did not last the whole month at least some of the time, and a meaningful share reported housing insecurity. Providers and community data reinforced these findings.
- Housing and utility requests made up a large share of 2-1-1 OC calls, and providers frequently described a lack of affordable housing as a major issue affecting their patients.

Back to Agenda

Priority Areas for Action and Recommendations

Based on the combined findings, four areas stand out as the strongest opportunities for CalOptima Health to improve outcomes, reduce barriers and better align services with member need. These priority areas are interconnected. Progress in one area, such as stronger care navigation, is likely to improve results in others, such as behavioral health access or connection to community resources.

1. Behavioral Health and Substance Use Care Gaps
2. Access to Care and Care Navigation
3. Health-Related Social Needs, Especially Housing and Financial Strain
4. Cultural, Linguistic and Identity-Responsive Care

1 Behavioral Health and Substance Use Care Gaps

Behavioral health needs were prevalent across the assessment, highlighting the strain on the existing system of care, including the number of facilities across the county, increased need for services and continued workforce shortages. To address these challenges, CalOptima Health has expanded access and strengthened community partnerships through targeted investments, including a peer support partnership with NAMI Orange County; the development of the allcove youth drop-in center; and expanded virtual behavioral health services. Additional investments have advanced integration of behavioral health into primary care, notably through a First 5 partnership to operate the Dyadic Services Academy, a training program that helps pediatric and primary care clinics integrate early childhood mental health services into routine medical care. NORC offers the following recommendations to strengthen efforts in this area:

1. Expand and promote behavioral health-specific care navigation, ensuring members are aware of and connected to supports that can assist with appointment scheduling, referral tracking and ongoing engagement, particularly for members with co-occurring conditions or complex needs.
2. Deepen integration of behavioral health within primary care settings by supporting co-located services, warm handoffs and collaborative care models that normalize behavioral health treatment, reduce stigma and lower logistical barriers to access.
3. Continue to invest in expanding the behavioral health workforce in Orange County, building upon the accomplishments from the existing Workforce Development Initiative.

2 Access to Care and Care Navigation

While members identified strong relationships with primary care providers, they also described difficulty getting appointments, understanding referrals, knowing which services were covered, and navigating a complex system, particularly for specialty care. CalOptima Health can use these findings to improve outreach, strengthen trust in underused services, and make it easier for members to understand where to go, what is available, and how to get help when needs arise. NORC offers the following recommendations to strengthen efforts in this area:

1. Continue to educate members through ongoing communications and member materials and conduct member outreach to build awareness and utilization of navigation and case management services by clearly communicating their availability and purpose.
2. Address specialty care access bottlenecks due to long appointment wait times through a coordinated, multipronged strategy focused on both provider practices and system-level alternatives.
3. Enhance the promotion of appropriate care pathways by educating members on when and how to use primary care, dental care, urgent care and behavioral health services, helping align care-seeking behavior with the most appropriate and effective settings.

3 Health-Related Social Needs, Especially Housing and Financial Strain

Social needs are central to member well-being and are closely connected to health care use, stress and quality of life. CalOptima Health can build existing partnerships by targeting community investments in areas with the greatest unmet need, improving referral pathways to housing and food supports, and using community data to align resources with member realities. CalOptima Health has already made considerable investments in affordable housing and food security, and a continued commitment to these efforts aligns well with member needs. NORC offers the following recommendations to strengthen efforts in this area:

1. Continue to invest in the development of affordable housing, prioritizing locations that are accessible to health care facilities, grocery stores, public transportation and employment centers to further improve members' access to resources that meet their basic needs and reduce barriers to care.
2. Explore new referral pathways to social services by expanding provider screening for social needs and enhancing closed-loop referral pathways to social services to help members successfully connect to support services that meet their needs. Partner with providers to assist with navigation to these services.
3. Partner with community and workforce development organizations, community colleges and local employers to support job training and employment opportunities and economic opportunity to improve members' long-term financial wellbeing and help them prepare for new Medi-Cal eligibility requirements, as applicable.

4 Cultural, Linguistic and Identity-Responsive Care

While many members reported respectful treatment by providers, the assessment found ongoing concerns about interpreter access, communication clarity and comfort discussing personal preferences in care settings. Continued investment in language access, culturally responsive communication, provider support and trust-building practices would help members feel better supported. CalOptima Health can also continue to actively educate members and providers about the services and supports that are already available to them. NORC offers the following recommendations to strengthen efforts in this area:

1. Conduct targeted outreach campaigns for members, providers and community partners to increase awareness of available cultural and linguistic services and how to access them.
2. Encourage a trust-building and patient-centered communication strategy focused on culturally safe care conversations.

Conclusion

Overall, the assessment shows that CalOptima Health has a strong foundation to build on, including broad connections to primary care, many positive member experiences with providers, and a rich set of data to guide action. At the same time, the findings make clear that many members continue to face barriers related to behavioral health, specialty care, care navigation, language access and basic needs such as food and housing. CalOptima Health has many programs and community investments in place that help address these challenges and can continue to expand these efforts to address the assessment's findings. Addressing these challenges will require both system-level improvements and continued collaboration with providers, community organizations and county partners. The findings in this report offer a roadmap for where focused action is most likely to improve member health, strengthen member experience and advance community health across Orange County.

CalOptima Health

CalOptima Health, A Public Agency
505 City Parkway West
Orange, CA 92868

caloptima.org

Back to Agenda

Health Equity Updates

Board of Directors Meeting

August 6, 2026

Michaell Silva Rose, DrPH, LCSW

Chief Health Equity Officer

Our Mission

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

Our Vision

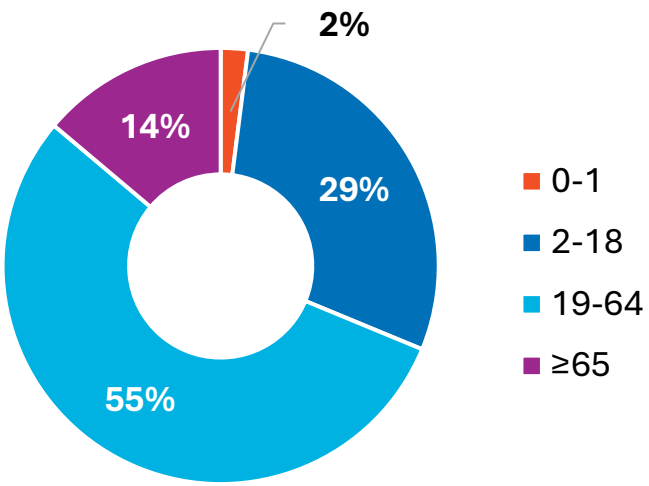
Provide all members with access to care and supports to achieve optimal health and well-being through an equitable and high-quality health care system.

CalOptima Health Membership

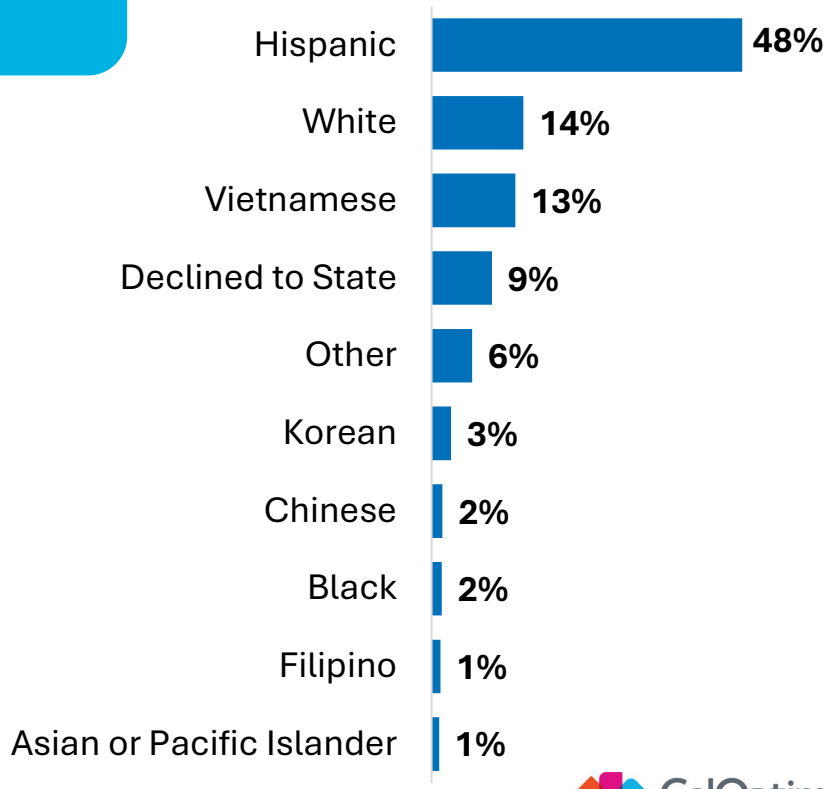
779,979
Total Membership

760,382
Medi-Cal

Age

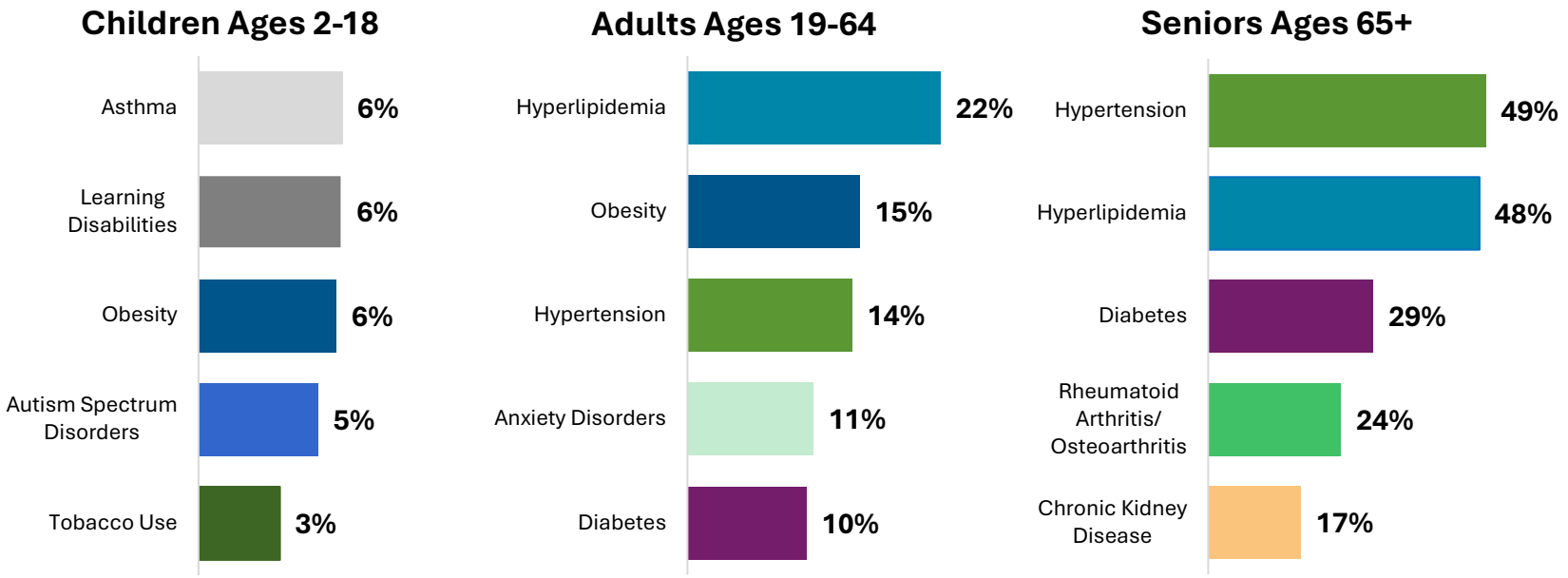


Race/Ethnicity



Source: CalOptima Health Membership Dashboard. Data pulled July 20, 2026

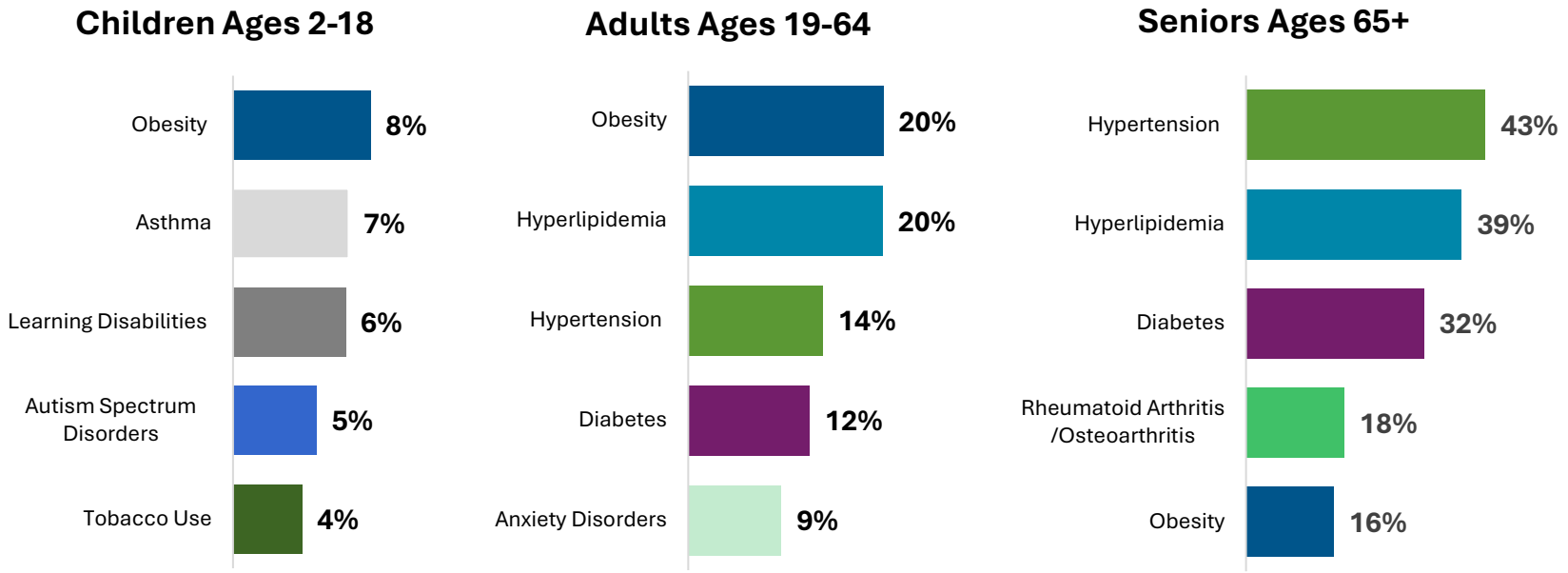
Top 5 Chronic Conditions: Medi-Cal Members



- Prevalence of chronic conditions such as hypertension, hyperlipidemia and diabetes more than doubled by age 65

Sources: CalOptima Health CMS Chronic Conditions Dashboard. Data pulled July 17, 2026

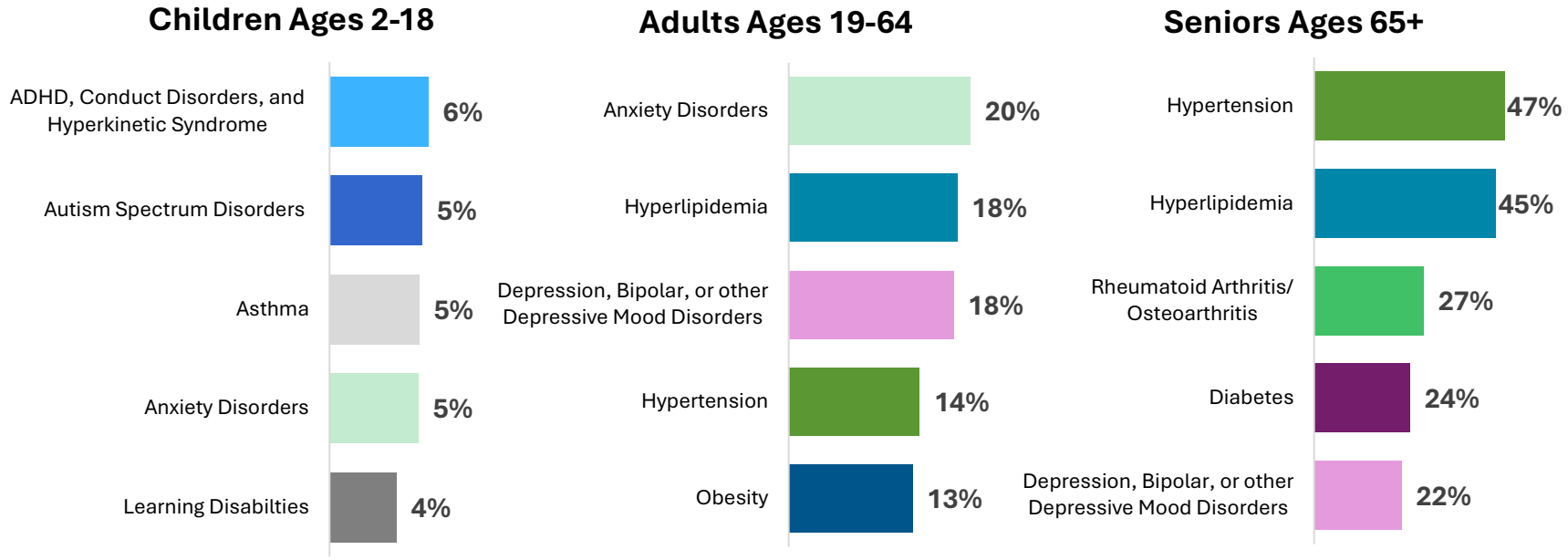
Top 5 Chronic Conditions: Medi-Cal Hispanic Members



- Obesity is the top condition for children and adults
- Like the overall population, the prevalence of chronic conditions such as hypertension, hyperlipidemia and diabetes more than doubled by age 65

Sources: CalOptima Health CMS Chronic Conditions Dashboard. Data pulled July 17, 2026

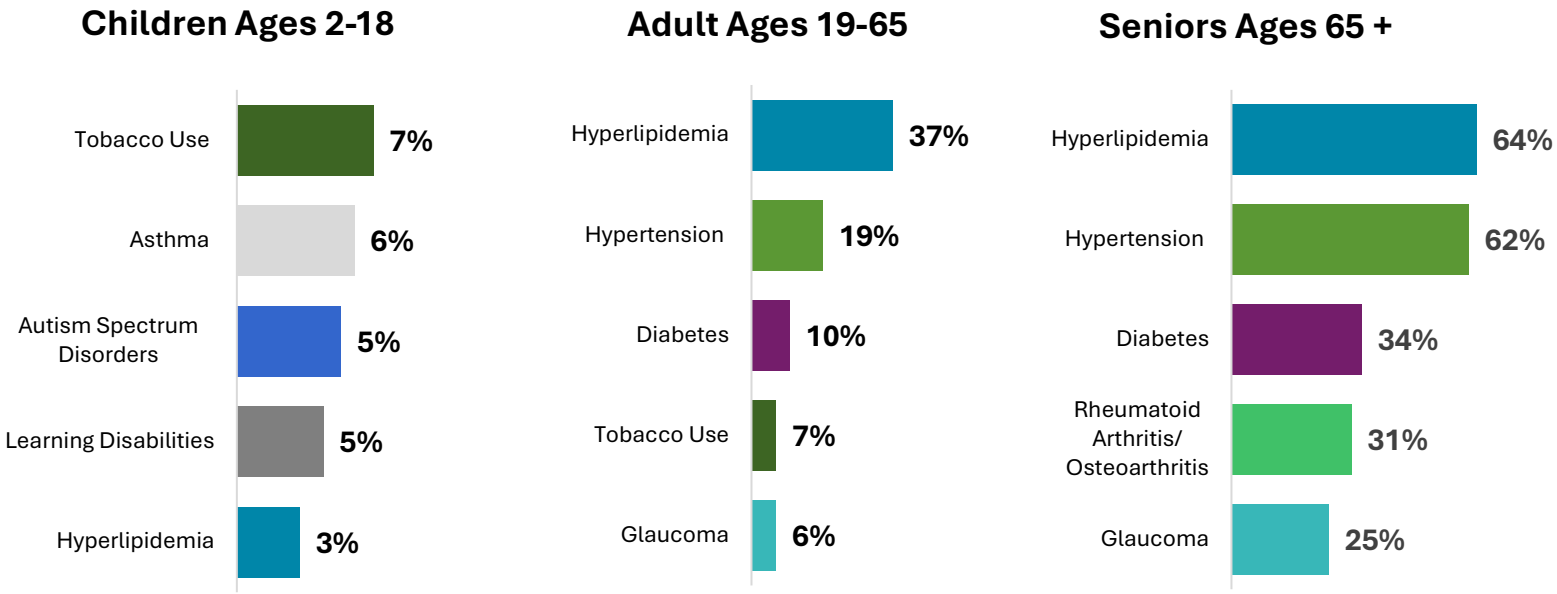
Top 5 Chronic Conditions: Medi-Cal White Members



- Anxiety and depression are among the top three conditions for adults
- Prevalence of hypertension and hyperlipidemia increased by 33% and 27%, respectively, by age 65

Source: CalOptima Health CMS Chronic Conditions Dashboard. Data pulled July 17, 2026

Top 5 Chronic Conditions: Medi-Cal Vietnamese Members

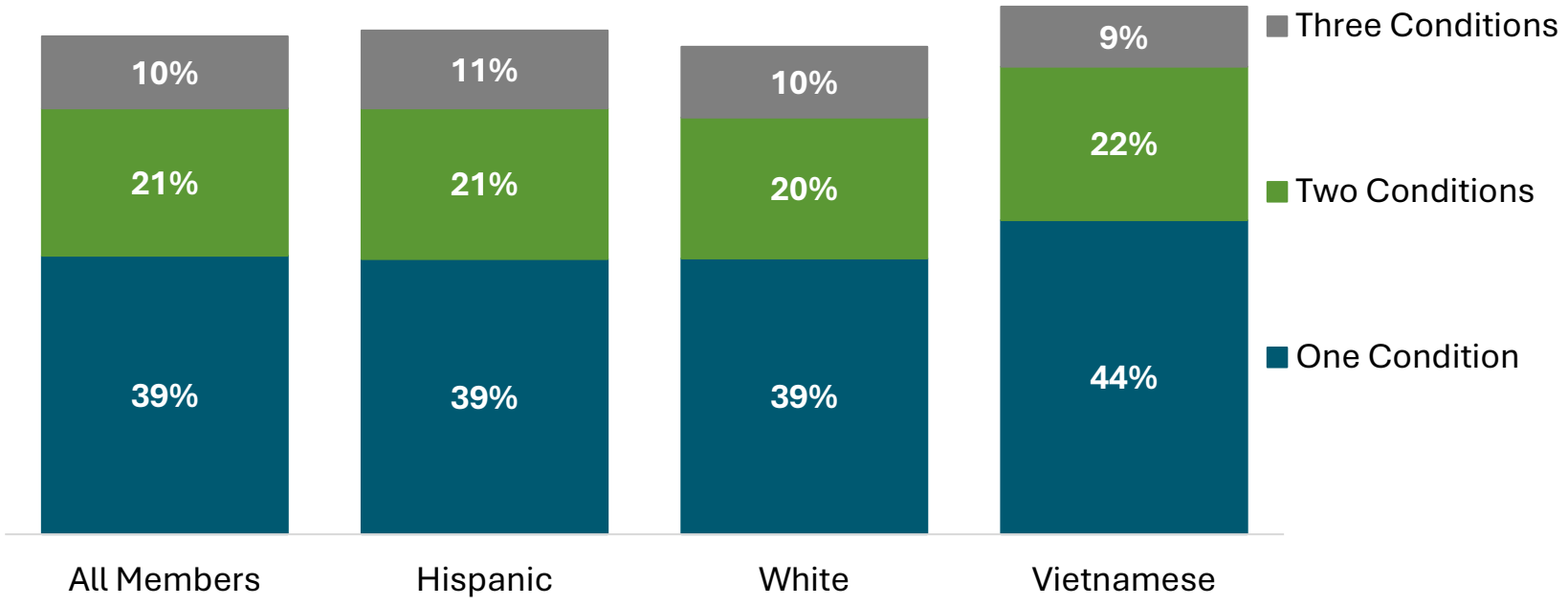


- Unlike the other populations analyzed, hyperlipidemia is found in the top five conditions for children
- Tobacco use is the top condition for children
- Highest prevalence of hyperlipidemia and hypertension in adults and seniors

Source: CalOptima Health CMS Chronic Conditions Dashboard. Data pulled July 17, 2026

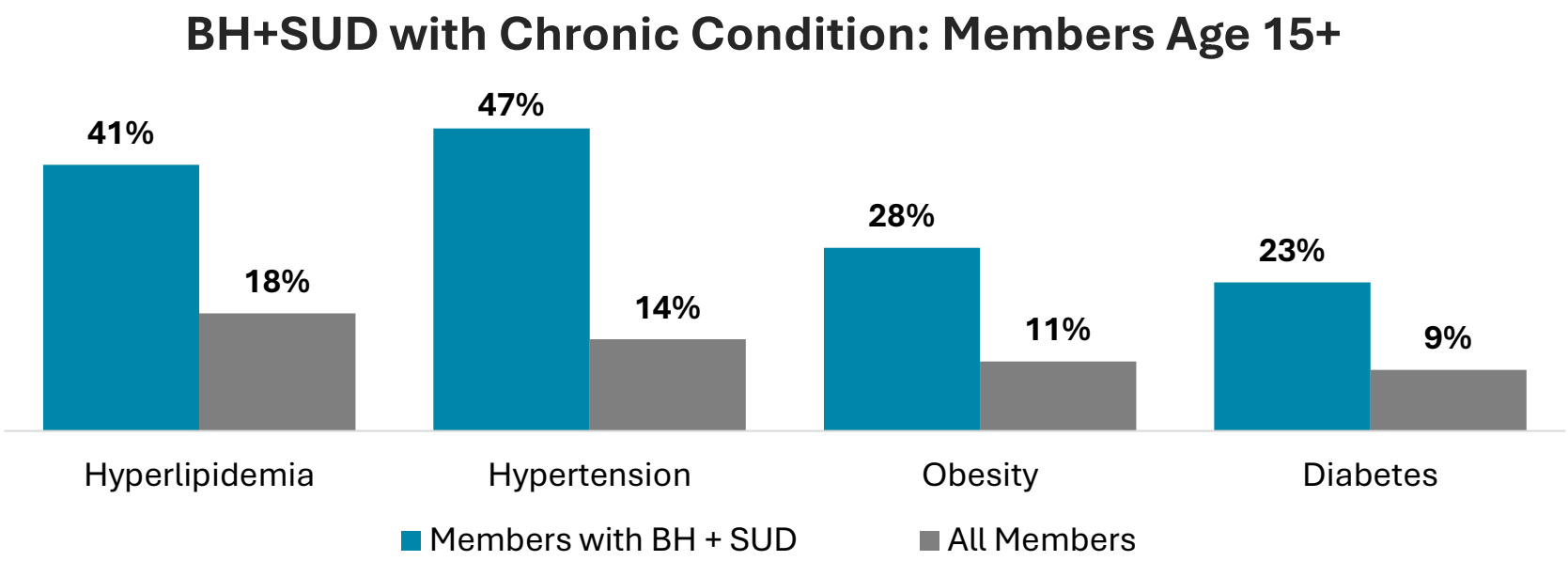
Chronic Disease Burden: Medi-Cal Members Age 19-64

- 70% of all members have one of the top five chronic conditions
- More than 30% of all members have two or more



Source: CalOptima Health CMS Chronic Conditions Dashboard. Data pulled July 2026;
*CalOptima Health Members with at least one of these Conditions: Obesity, Hypertension, Hyperlipidemia, Diabetes, Anxiety Disorders

Behavioral Health and Top Chronic Conditions: Medi-Cal Members



- Members with co-occurring behavioral health and substance use disorders (BH+SUD) have a higher prevalence of chronic conditions

Source: CalOptima Health CMS Chronic Conditions Dashboard. Data pulled February 2026

Drivers of Health Outcomes



CalOptima Health

Meeting Our Members Where They Are

- An accessible, person-centered, community space that extends support beyond clinical care:
  - Connecting members to preventative health education
  - Social services and community resources
  - Culturally responsive supportive programming

CalOptima Health

Community Resource Center: Organizational Priority Alignment

- Alignment with:
  - CalOptima Health Organizational Strategic Goals
  - Health Equity mandates
  - MPHNA* member focus groups
- Improved member:
  - Health outcomes
  - Experience, satisfaction and retention
- Advancement of quality measures and reduction of health disparities

*MPHNA – Member and Population Health Needs Assessment

CalOptima Health

Co-Creating: Insights on Community Resource Center

- 446 responses to surveys, 105 focus group participants and 22 CBO* and stakeholder interviews:
  - Members envision a safe, community-based space that provides support across the lifespan
  - Culturally and linguistically appropriate health education:
    - Preventive and wellness programs
    - Nutritional education
    - Physical activity
  - Mental health support and stress management
  - Chronic disease management support
  - Healthcare and benefit navigation

*CBO – Community Based Organization

CalOptima Health

Community Resource Center: Proposed Goals

- Improve Health Outcomes and Prevention
- Strengthen Chronic Disease Management
- Close Quality Care Gaps
- Enhance Maternal and Early Childhood Wellness
- Improve Member Experience, Satisfaction and Retention
- Address Social Drivers of Health

CalOptima Health

A CalOptima Health Opportunity: Community Resource Center

- Located across from Customer Service
- 7,000 square feet on 1st floor
  - Training kitchen
  - Fitness room
  - Training rooms
  - Meeting rooms
  - Clinical rooms



CalOptima Health

Community Resource Center: Next Steps

- Gather feedback from CalOptima Health Board
- Continued community engagement
- Finalize plans for the CRC building, infrastructure, and programming

CalOptima Health

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www.caloptima.org

MEMORANDUM

DATE:	July 30, 2026
TO:	CalOptima Health Board of Directors
FROM:	Michael Hunn, Chief Executive Officer
SUBJECT:	CEO Report — August 6, 2026, Board of Directors Meeting
COPY:	Tina Knapp, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; and Whole-Child Model Family Advisory Committee

A. Covered California Monthly Update

CalOptima Health is continuing to prepare to launch a Covered California plan, effective January 1, 2027. CalOptima Health was officially announced as a new entrant to the marketplace as part of Covered California's annual rate announcement on July 21 and will be the lowest-cost Silver plan in Orange County. Staff expect to receive the Covered California contract at the end of July for approval and execution by the end of August. CalOptima Health's filing with the California Department of Managed Health Care (DMHC) to expand the scope of our current Knox-Keene Act license also continues to progress. As the regulatory filings move forward, staff are engaging with Covered California's Plan Management Advisory Group to prepare for upcoming system testing between Covered California and CalOptima Health that will begin on August 3. In addition, staff has finalized the logo and brand identity for the CalOptima Health Covered product and continues to develop educational materials for member and broker audiences. Operational implementation activities are also progressing, including information technology solutions and regular onboarding sessions with delegated health networks.

B. Member and Population Health Needs Assessment Is Complete

CalOptima Health has completed its 2025–26 Member and Population Health Needs Assessment (MPHNA), reaffirming our commitment to improving well-being and fostering a healthier, more resilient community. In partnership with NORC at the University of Chicago, this project expanded on earlier efforts that engaged thousands of members, providers and community partners to ensure a thorough understanding of the evolving needs of the populations we serve. The assessment involved 1,858 member survey responses, 11 focus groups, 22 in-person interviews with members and caregivers, 301 provider survey responses, analysis of CalOptima Health administrative data, and reviews of Orange County and community-level needs assessments, population health and other relevant reports. Key findings focused on themes across behavioral health access, navigation challenges, social needs, culturally responsive care and service utilization. These insights point to strengths we can continue to build on and areas where additional focused strategies will meaningfully support our members. The final report summarizes what CalOptima Health learned about the health needs, care experiences and daily challenges facing our members across Orange County, which will

guide our organization in addressing current issues and advancing equitable, member-centered and whole-person care. The Executive Summary, along with a presentation of key findings and current strategies to address findings, will be shared at the Board meeting on August 6, and the full report will be posted on the CalOptima Health website in late August.

C. Governor Signs Fiscal Year 2026–27 Enacted State Budget

On June 29, Governor Gavin Newsom signed into law the Fiscal Year 2026–27 Enacted State Budget, which includes several budget bills and associated trailer bills that implement related policy changes. Earlier that day, both houses of the California State Legislature passed the final budget package, which the governor and legislative leadership had announced a few days earlier. While the final budget includes some improvements over the governor's revised budget proposal (May Revision) based on the State Legislature's counterproposal and advocacy efforts by CalOptima Health's trade associations and other partners, several finalized provisions are still anticipated to result in negative impacts on our members, providers and stakeholders.

Most notably and unfortunately, the final budget includes the transition of individuals with Unsatisfactory Immigration Status (UIS) from Medi-Cal managed care plans (MCPs) to the Medi-Cal fee-for-service system, effective January 1, 2027. While the final budget includes $31 million to support care coordination related to the transition, additional details are still pending. CalOptima Health's state trade association, Local Health Plans of California (LHPC), is engaging with the California Department of Health Care Services (DHCS) and legislative leadership to advocate for maximum transparency during the transition as well as MCP involvement in post-transition care coordination. LHPC also established a dedicated workgroup that includes key CalOptima Health clinical and operational leaders to coordinate implementation, share insights and make ongoing recommendations to DHCS. On one positive note, DHCS and the U.S. Centers for Medicare & Medicaid Services (CMS) have determined that UIS individuals may remain enrolled in the Program for All-Inclusive Care for the Elderly (PACE).

For more information, please reference the impact analysis prepared by staff that follows this report. In the coming months, DHCS will issue guidance to Medi-Cal MCPs on implementing applicable budget provisions, and the governor and State Legislature may enact budget cleanup bills.

D. CMS Releases Medicaid Community Engagement Requirements Rule

On June 1, CMS released its long-awaited Interim Final Rule (IFR) to implement community engagement requirements (i.e., work requirements) for certain Medicaid beneficiaries ages 19 to 64, effective January 1, 2027, pursuant to H.R. 1. To comply with the IFR, applicable beneficiaries must demonstrate at least 80 hours per month of work, community service or participation in a work program; a monthly income equivalent to at least minimum wage for 80 hours; or part-time enrollment in an educational program. The IFR also provides additional details on exemptions, including but not limited to beneficiaries who satisfy the following:

- Medically frail
- Participating in a drug/alcohol treatment program
- Pregnant or entitled to postpartum coverage
- Former foster children
- Dually eligible for Medicare
- Experiencing short-term hardship
- Parents with dependents under the age of 14
- Other caregivers/caretakers

In addition, the IFR outlines documentation requirements to demonstrate a beneficiary's compliance with, or exemption from, the community engagement requirements. Contrary to initial expectations, the

IFR does not list specific conditions that may qualify as "medically frail," but requires each state to develop its own list. Further, the IFR requires everyone with a qualifying condition to ***prove*** that it impairs their ability to comply with the community engagement requirements. Self-attestations for medical frailty will be accepted in the first year of implementation (2027), but additional proof/documentation will be required starting on January 1, 2028. CalOptima Health leadership recently traveled to Washington, D.C., to express concerns about several of these provisions to Members of Congress. Since then, all five U.S. House Democrats representing Orange County have signed on to a letter to CMS outlining significant concerns about the rule's strict definition of medical frailty. CalOptima Health will also submit a public comment letter to CMS before the July 31, 2026, deadline, but CMS is not required to issue another final rule in response to feedback.

E. CalOptima Health Hosts Fourth Annual Back-to-School Health and Wellness Fair

CalOptima Health, in partnership with the Orange Unified School District, is hosting the Fourth Annual Back-to-School Health and Wellness Fair on Saturday, August 1, from 9 a.m.–1 p.m. at El Modena High School in Orange.

F. Care Traffic Control to Hold Grand Opening Celebration

On Thursday, August 13, at 10–11 a.m., CalOptima Health is hosting a grand opening for the new Care Traffic Control Center on the third floor of the 500 building. In addition to CalOptima Health leadership and staff, other attendees will include our Street Medicine Program providers and city officials from Anaheim, Costa Mesa, Garden Grove and Santa Ana, as well as U.S. Representatives Lou Correa and Young Kim, who successfully sponsored a $2 million federal earmark to support construction costs.

G. Medi-Cal Dental Benefit Changes Delayed

The Medi-Cal dental benefit changes previously expected to take place this year have been delayed to July 1, 2027, for UIS adult members ages 19 and older. This means these members will continue to receive full dental benefits until July 1, 2027. Full details can be found here.

H. Expanded Telehealth Reports Early Success

CalOptima Health has recently expanded our contract with TeleMed2U (our behavioral health telehealth vendor) to improve and expand access to physical health specialty care for our members, starting with our OneCare CalOptima Health Community Network (CHCN). The specialties include Endocrinology, Rheumatology, Urology and Neurology. The initial pilot for Endocrinology began in mid-April, focusing on OneCare CHCN members with diabetes and an A1c greater than 9%. As of May 21, 2026, 38 appointments (including 21 initial visits) have been completed, and the number continues to grow. The pilot's ability to provide rapid access to specialists has been vital in ensuring timely connection to care. In some cases, members received same-week appointments for stabilization. The telehealth specialty access pilot serves as a bridge, supporting primary care providers (PCPs) and promoting interdisciplinary care and education. Additionally, written consults and progress notes are made available to PCPs within 48 hours, enhancing communication and continuity of care.

I. Chief Medical Officer Dr. Richard Pitts to Retire

CalOptima Health's Chief Medical Officer Richard Pitts, D.O., Ph.D., is retiring. We have been fortunate to have his leadership in serving our mission and members for almost five years, and we wish to congratulate him on a job well done! Thank you, Dr. Pitts, on behalf of members and their families, medical directors and staff, providers, community partners, and all those whose lives you have touched

while at CalOptima Health. Going forward, Richard Lopez, M.D., will act as the Interim Chief Medical Officer. Dr. Lopez is the medical director in charge of our transplant program.

J. CalOptima Health Distributes Three Press Releases

- On June 9, CalOptima Health announced an investment of $429.6 million in rate increases for hospitals and specialists.
- On July 1, CalOptima Health announced $3.6 million in grant funding to seven Orange County community-based organizations to expand Medi-Cal enrollment and retention outreach.
- On July 21, CalOptima Health announced plans to join Covered California as an affordable plan for Orange County.

K. Media Coverage Raises CalOptima Health's Visibility

- CalOptima Health's provider rate increase news garnered considerable coverage from a variety of outlets, including:
  - Fierce Healthcare — "CalOptima Health approves $430M rate increase to keep safety-net providers afloat" (June 9)
  - Orange County Business Journal — "CalOptima Invests $430M to Boost Provider Reimbursement" (June 10)
  - Becker's Payer Issues — "CalOptima approaches $1B in provider rate increases since 2024" (June 10)
  - Hospital Association of Southern California (HASC) — "CalOptima Health invests $429.6 million in rate increases for hospitals, specialists" (June 15)
  - Orange County Register — "CalOptima Invests $430 Million in Reserves to Boost Hospital, Specialist Payments" (July 15)
- Announced July 21, our entrance into Covered California for the 2027 benefit year drew attention from the media. Selected clips include:
  - Orange County Register
  - Becker's Payer Issues
  - LAist
  - KPCC
- Other media coverage included:
  - On July 8, KFF News published "California defends using Medicaid money for housing and food, as GOP cries fraud" The story included a quote from Chief Operating Officer Yunkyung Kim on the impact of CalAIM on members experiencing homelessness.
  - On July 9, New Santa Ana ran a story about the Youth Connected Program, a partnership among Orangewood, CalOptima Health and OC Probation Department.

CalOptima Health

Fast Facts
August 2026

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

Membership Data* (as of June 30, 2026)

Total CalOptima Health Membership

806,971

Prior month: 819,485

Program	Members
Medi-Cal	787,436
OneCare (HMO D-SNP)	18,958
Program of All-Inclusive Care for the Elderly (PACE)	577

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

Key Financial Indicators (for the month ended June 30, 2026)

	Dashboard	YTD Actual	Actual vs. Budget ($)	Actual vs. Budget (%)
Operating Income/(Loss)	●	$189.9M	$174.3M	1,117.3%
Non-Operating Income/(Loss)	●	$131.5M	$37.3M	39.7%
Covered California Start-up Expenses	●	($5.1M)	$5.6M	52.2%
Bottom Line (Change in Net Assets)	●	$316.3M	$217.3M	219.5%
Medical Loss Ratio (MLR) *(Percent of every dollar spent on member care)*	●	91.3%	---	(2.1%)
Administrative Loss Ratio (ALR) *(Percent of every dollar spent on overhead costs)*	●	5.2%	---	1.4%

Notes: For additional financial details, refer to the financial packages included in the Board of Directors meeting materials.

Reserve Summary (as of June 30, 2026)

	Amount (in millions)
Board Designated Reserves*	$1,637.0
Statutory Designated Reserves	$141.6
Capital Assets (Net of depreciation)	$110.4
Unspent Balance of Allocated Resources	$335.6
Unspent Balance of Board Approved Provider Rate Increase	
Increase from 7/1/24 – 12/31/26	$105.2
Increase from 7/1/26 – 12/31/28	$429.6
Unallocated Resources*	$357.5
Total Net Assets	$3,116.8

* Total Designated Reserves and Unallocated Resources can support about 183 days of CalOptima Health's current operations.

Notes: 5/2/24 meeting: Board of Directors committed $526.2 million for provider rate increases from 7/1/24–12/31/26.
6/4/26 meeting: Board of Directors committed $429.6 million for provider rate increases from 7/1/26 – 12/31/28.

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

August 2026

Personnel Summary (as of July 11, 2026, pay period)

	Filled	Open	Vacancy Administrative	Vacancy Medical	Vacancy % Combined
Staff	1,345.5	87.25	48.5	38.75	6.09%
Supervisor	85	3	2	1	3.41%
Manager	116	9	8	1	7.2%
Director	86	3	2	1	3.37%
Executive	21	1	1	--	4.55%
Total FTE Count	1,653.5	103.25	61.5	41.75	5.88%

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

Provider Network Data (as of July 23, 2026)

	Number of Providers
Primary Care Providers	1,290
Specialists	8,617
Pharmacies	502
Acute and Rehab Hospitals	47
Community Health Centers	73
Long-Term Care Facilities	255

Treatment Authorizations (as of May 31, 2026)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	37.30 hours
Prior Authorization – Urgent	72 hours	6.44 hours
Prior Authorization – Routine	5 days	1.04 days

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

Member Demographics (as of June 30, 2026)

Member Age

0 to 5	8%
6 to 18	22%
19 to 44	33%
45 to 64	20%
65+	17%

Language Preference

English	57%
Spanish	28%
Vietnamese	9%
Korean	2%
Other	1%
Farsi	1%
Chinese	1%
Arabic	<1%
Russian	<1%

Medi-Cal Aid Category

Expansion	37%
Temporary Assistance for Needy Families	35%
Seniors	13%
Optional Targeted Low-Income Children	8%
People With Disabilities	6%
Other	<1%
Long-Term Care	<1%

Back to Agenda

CalOptima Health

Provider Network Trend

August 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	2025 – Q2	2025 – Q3	2025 – Q4	2026 – Q1	2026 – Q2	YOY Net Δ
PCP [2]	1,301	1,281	1,306	1,337	1,327	26
Specialist (Physicians)	7,479	7,685	8,246	8,501	8,819	1,340
Hospitals [3]	41	43	42	41	46	5
Community Health Centers [4]	68	68	68	68	68	0
Long Term Care	207	225	241	242	250	43
Behavioral Health [5]	2,579	2,791	3,023	3,148	3,364	785
ECM	32	34	34	34	34	2
Community Support	103	107	107	106	106	3

Medi-Cal

Provider Type	2025 – Q2	2025 – Q3	2025 – Q4	2026 – Q1	2026 – Q2	YOY Net Δ
PCP [2]	1,076	1,057	1,090	1,126	1,131	55
Specialist (Physicians)	7,173	7,394	7,987	8,248	8,556	1,383
Hospitals [3]	37	40	39	38	43	6
Community Health Centers [4]	66	66	68	68	68	2
Long Term Care	203	221	237	238	246	43
Behavioral Health [5]	2,495	2,695	2,926	3,075	3,293	798
ECM	32	34	34	34	34	2
Community Support	103	107	107	106	106	3

OneCare

Provider Type	2025 – Q2	2025 – Q3	2025 – Q4	2026 – Q1	2026 – Q2	YOY Net Δ
PCP [2]	1,082	1,074	1,088	1,083	1,062	-20
Specialist (Physicians)	5,844	6,047	6,270	6,494	6,306	462
Hospitals [3]	36	40	39	39	43	7
Community Health Centers [4]	62	62	62	62	61	-1
Long Term Care	207	224	240	240	249	42
Behavioral Health [5]	713	851	952	1,020	1,159	446

PACE

Provider Type	2025 – Q2	2025 – Q3	2025 – Q4	2026 – Q1	2026 – Q2	YOY Net Δ
PCP [2]	4	3	3	3	6	2
Specialist (Physicians)	4,033	4,256	4,446	4,713	4,932	899
Hospitals [3]	29	31	30	30	34	5
Community Health Centers [4]	0	0	0	0	0	0
Long Term Care	69	76	91	96	106	37
Behavioral Health [5]	116	119	132	127	147	31

Provider Network Trend

August 2026

CHCN Only

Total Providers [1]

Provider Type	2025 – Q2	2025 – Q3	2025 – Q4	2026 – Q1	2026 – Q2	YOY Net Δ
PCP [2]	671	671	685	690	694	23
Specialist (Physicians)	6,841	7,058	7,330	7,602	7,949	1,108
Hospitals [3]	37	40	39	36	41	4
Community Health Centers [4]	58	58	59	60	60	2
Long Term Care	203	221	237	238	246	43
Behavioral Health [5]	2,541	2,767	2,975	3,098	3,318	777
ECM	32	34	34	34	33	1
Community Support	103	107	107	106	105	2

Medi-Cal

Provider Type	2025 – Q2	2025 – Q3	2025 – Q4	2026 – Q1	2026 – Q2	YOY Net Δ
PCP [2]	650	650	514	532	538	-112
Specialist (Physicians)	6,791	7,000	7,269	7,549	7,879	1,088
Hospitals [3]	34	38	37	36	41	7
Community Health Centers [4]	58	58	59	60	60	2
Long Term Care	203	221	237	238	246	43
Behavioral Health [5]	2,471	2,673	2,879	3,026	3,248	777
ECM	32	34	34	34	33	1
Community Support	103	107	107	106	105	2

OneCare

Provider Type	2025 – Q2	2025 – Q3	2025 – Q4	2026 – Q1	2026 – Q2	YOY Net Δ
PCP [2]	565	567	581	584	584	19
Specialist (Physicians)	5,136	5,359	5,575	5,789	5,412	276
Hospitals [3]	31	33	32	30	34	3
Community Health Centers [4]	48	48	49	51	50	2
Long Term Care	203	220	236	236	245	42
Behavioral Health [5]	699	836	936	1,006	1,143	444

PACE

Provider Type	2025 – Q2	2025 – Q3	2025 – Q4	2026 – Q1	2026 – Q2	YOY Net Δ
PCP [2]	4	3	3	3	6	2
Specialist (Physicians)	4,033	4,256	4,446	4,713	4,932	899
Hospitals [3]	29	31	30	30	34	5
Community Health Centers [4]	0	0	0	0	0	0
Long Term Care	69	76	91	96	106	37
Behavioral Health [5]	116	119	132	127	147	31

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. Removed LOA Hospitals, effective Q1 2026

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

[5] Includes Practitioners and Behavioral Health Groups

Fiscal Year 2026–27 Enacted State Budget
Impact Analysis
July 15, 2026

Background

On January 9, 2026, Governor Gavin Newsom released the Fiscal Year (FY) 2026–27 Proposed State Budget, reflecting a minor $2.9 billion budget shortfall due to increased state program costs and the loss of significant federal funding, despite state tax revenue coming in higher than expected. While the proposed budget did not include any major new commitments or spending reductions, the Medi-Cal program would still be particularly affected as policy changes from federal H.R. 1 legislation, enacted on July 4, 2025, and the previous FY 2025–26 enacted state budget continue to be implemented.

On May 14, Governor Newsom released the FY 2026–27 Revised State Budget Proposal, known as the May Revision, which reflects updated economic forecasts and revenue projections. After accounting for budget solutions, the May Revision proposed $349.4 billion in total funding ($246.6 billion General Fund [GF]). Revenues are projected to be $16.5 billion higher than estimated in January's proposed budget across the three-year budget window, primarily driven by stronger-than-expected personal income tax collections and a spike in capital gains realizations associated with the artificial intelligence boom.

On June 15, the State Senate and State Assembly both passed a counterproposal — Assembly Bill (AB) 109 — as a placeholder budget to meet the June 15 constitutional deadline while negotiations with the governor on a final budget continued.

On June 26, Gov. Newsom and legislative leaders announced a final budget agreement. After both houses of the State Legislature passed the agreed-upon revisions as Senate Bill (SB) 111 on June 29, Gov. Newsom signed both AB 109 and SB 111 into law that same day. Additionally, the Legislature passed and the governor signed the consolidated Health Trailer Bill (SB 164), which contains policy changes needed to implement health-related budget expenditures. Together, these bills — along with additional trailer bills covering other policy areas — represent the FY 2026–27 Enacted State Budget.

Summary

The FY 2026–27 Enacted State Budget includes $351.7 billion in total spending ($251.1 billion GF) to support a balanced budget for FY 2026–27 and positive year-end balances and reserves over the next two FYs through a combination of revenue and spending solutions. New revenue streams include a sales tax on pre-written software projects, limits on business tax credits and a new Managed Care Organization (MCO) tax, as discussed later. However, the final budget agreement mitigates several spending reductions proposed in the May Revision by rejecting or delaying them until the following budget year. Still, significant cutbacks in the Medi-Cal program remain included, in part due to new federal Medicaid requirements under H.R. 1 and ongoing guidance from the U.S. Centers for Medicare & Medicaid Services (CMS). Both the State Senate and the State Assembly aim to revisit any included reductions and consider additional delays, restorations or modifications of those reductions as part of the FY 2027–28 budget process, consistent with the state's fiscal condition at that time.

The following are significant provisions in the FY 2026–27 Enacted State Budget that may impact CalOptima Health and its members, providers and stakeholders:

Medi-Cal Eligibility & Enrollment

- Transition the Unsatisfactory Immigration Status (UIS) population from Medi-Cal managed care plans to the Medi-Cal fee-for-service system, effective January 1, 2027.
    - The California Department of Health Care Services (DHCS) claims that this is required in response to a State Medicaid Director Letter issued by CMS in September 2025 that disallows coverage of federally eligible emergency Medicaid services within a risk-based managed care delivery system for the UIS population.
    - Program of All-Inclusive Care for the Elderly (PACE) participants are exempt from the transition and are therefore allowed to maintain enrollment in PACE.
    - $39 million has been appropriated to support the transition, including $31 million for care coordination, such as language access, integrated care planning, member outreach, and provider coordination, as well as $8 million for contracts with clinics and community-based organizations to provide navigation services.
    - In total, approximately 117,000 CalOptima Health members will be transitioned, including 295 vulnerable children enrolled in the Whole Child Model program.
- Delay the transition of the Qualified Non-Citizen (QNC) population to restricted-scope Medi-Cal from October 1, 2026, through July 1, 2027. In the meantime, the QNC population will be transitioned alongside the UIS population to Medi-Cal FFS on January 1, 2027.
- Require the next governor's FY 2027–28 May Revision to set a Medi-Cal premium between $30 and $50 per month for UIS adults ages 19–59, effective July 1, 2027. A $30-per-month premium was already set to take effect on the same date, pursuant to the FY 2025–26 enacted state budget.
- Further reduce the asset limit for seniors and disabled adults to $21,000 per individual or $31,000 per couple, effective July 1, 2027. An asset limit of $130,000 per individual was recently implemented on January 1, 2026.
- Augment funding by $197 million GF in FY 2026–27 to support increased county workload as a result of H.R. 1 changes to Medi-Cal eligibility and enrollment.
- Appropriate $1.5 million GF in FY 2026–27 to clear the Medi-Cal Home and Community Based Alternatives (HCBA) Waiver waitlist and serve all eligible individuals seeking enrollment in the HCBA Waiver program.

Medi-Cal Benefits

- Renew the California Advancing and Innovating Medi-Cal (CalAIM) initiative from January 1, 2027, through December 31, 2031, with the following new components subject to federal approval:
    - **Employment Supports**: A county opt-in benefit to provide employment support services, including job readiness assessments, individualized employment planning, job placement assistance, and post-employment retention services.
    - **BridgeCare Pilots**: A county opt-in benefit to provide home- and community-based services and caregiver supports to individuals enrolled in Medicare who meet the near-dual eligibility criteria.
- Delay the elimination of UIS adult dental benefits until July 1, 2027.
- Maintain the community-based mobile crisis services benefit until July 1, 2027, despite the expiration of enhanced federal funding.

Medi-Cal Efficiencies

- Strengthen utilization management controls for applied behavior analysis (ABA)/behavioral health treatment (BHT) and transportation services, including non-medical transportation

(NMT) and non-emergency medical transportation (NEMT). More details can be found in this DHCS fact sheet. CalOptima Health currently requires prior authorization for ABA/BHT and NEMT services (with exceptions), but not for NMT services.

- Eliminate the incentive component of the Quality Withhold and Incentive Program, which would effectively result in a rate cut to Medi-Cal managed care plans.
- Refine eligibility criteria, referral pathways, service definitions and utilization management criteria for Enhanced Care Management (ECM) and Community Supports, effective January 1, 2027. More details can be found in this DHCS fact sheet. CalOptima Health has already adopted or has recommended adopting several of these proposed reforms to improve the quality and sustainability of the CalAIM program.

Rates and Financing

- Delay the elimination of Proposition 56 dental supplemental payments until July 1, 2027.
- Delay elimination of Prospective Payment System (PPS) rates to community clinics for UIS beneficiaries until July 1, 2027.
- Submit a new MCO Tax model, effective January 1, 2027, due to the expiration of the existing MCO tax on that same date. The new model would consist of two components:
    - The first component would comply with Proposition 35 (2024) but is expected to be rejected by CMS due to noncompliance with the provider tax uniformity requirements under H.R. 1.
    - The second component would comply with H.R. 1 but would not be tied to Proposition 35. Under this component, an $8.85 per member per month (PMPM) tax would be imposed on both Medi-Cal and non-Medi-Cal plans to sustain the Medi-Cal targeted rate increases (TRI) for primary care, maternal health and non-specialty mental health services that were implemented on January 1, 2024. However, this would effectively sweep remaining MCO Tax revenues into the GF to support existing Medi-Cal costs, rather than additional provider rate increases as intended by Proposition 35.
- Appropriate $90 million GF to the California Department of Health Care Access and Information (HCAI) in FY 2026–27 to provide one-time grants to hospitals in immediate and significant financial distress, and authorize the California Department of Finance to augment up to an additional $50 million.
- Appropriate $250 million GF to DHCS in FY 2026–27 to support designated public hospitals.
- Appropriate $30 million GF in FY 2026–27 to support rate increases for private duty nursing.
- Appropriate $26 million to maintain access to gender affirming care through a provider network stabilization program.
- Appropriate $40 million to support uncompensated care and continued access for reproductive health services.

Miscellaneous

- Initiate process to develop and release a proposed "fair share" tax on large corporations whose employees are enrolled in Medi-Cal by April 1, 2027.
- Appropriate $800,000 annually ongoing to hire additional DHCS nursing staff to evaluate PACE enrollment applications and make level-of-care determinations more timely.
- Increase ongoing funding from $190,000 to $300,000 annually to expand the state premium subsidy program for Covered California enrollees up to 200% of the Federal Poverty Level, effective July 1, 2026, to partially offset the expiration of the federal enhanced Advance Premium Tax Credits (eAPTCs) on December 31, 2025.

- Augment funding by $223 million GF in FY 2026–27 to support increased county workload as a result of H.R. 1 changes to CalFresh eligibility and enrollment.
- Redirect the state's share of Medical Loss Ratio (MLR) remittances from the Medi-Cal Physician and Dentists Loan Repayment Program to the GF, which would reduce GF costs by $25 million annually ongoing. For context, Medi-Cal managed care plans that fall below the minimum 85% MLR requirement must remit the difference to DHCS.
- Appropriate additional one-time funding of $100 million to food banks in FY 2026–27 as part of the CalFood program.
- Appropriate one-time funding of $16.5 million for diaper banks.

Rejected Proposals

The following notable proposals in the May Revision were ***not*** included in the final budget:

- Eliminate the adult acupuncture benefit, effective January 1, 2027.
- Implement a rate cap for PACE organizations at the lower bound of the actuarial rate range, effective January 1, 2027. A rate cap at the midpoint of the rate range is already set to take effect on the same date. Since CalOptima Health's PACE rates are currently at the midpoint of the rate range, this new proposal would have resulted in an effective rate cut to CalOptima Health.
- Shift the costs of growth in In-Home Supportive Services (IHSS) to counties, eliminate the IHSS Backup Provider System and align IHSS termination with Medi-Cal termination.

Next Steps

State agencies, including DHCS, will begin implementing the policies included in the enacted budget. In addition, the Legislature may consider additional clean-up budget bills and will continue to advance policy bills through the legislative process. The Legislature has until August 31, 2026, to pass legislation, and Gov. Newsom has until September 30, 2026, to either sign or veto that passed legislation. Policy bills with funding allocated in the enacted budget are more likely to be passed and signed into law.

Government Affairs staff will continue to monitor policies included in the enacted budget, engage in any additional necessary advocacy efforts and provide updates on issues that have a significant impact on CalOptima Health. If you have any questions, please contact GA@caloptima.org.

Board of Directors Meeting
August 6, 2026

Regular Joint Meeting of the Member Advisory and Provider Advisory Committees

Report to the Board

The Member Advisory Committee (MAC) and the Provider Advisory Committee (PAC) held a regular joint meeting on June 11, 2026.

The MAC and PAC reviewed their individual ad hoc recommendations for candidates to fill open seats on both committees. Both committees voted in favor of the MAC and PAC ad Hoc committees' recommendations and have submitted information to the Board for the appointment and reappointment of the recommended candidates.

Michael Hunn, Chief Executive Officer, notified the MAC and PAC that they would soon receive an email from Ruby Nunez, Executive Assistant and Interim Clerk of the Board, inviting them to provide confidential feedback on the CEO search led by the executive recruiting firm Witt Kiefer. Participants could share input in person, via Zoom, or through a written questionnaire. Their feedback would help shape a leadership profile, which would be summarized for the Board's search committee. He noted that the goal was to select and announce a new CEO at the October CalOptima Health Board meeting, allowing time for a smooth transition through the end of the year.

Mr. Hunn expressed his appreciation to the Board for approving the $4.8 billion annual budget, which included higher reimbursement rates. He also noted that, thanks to careful financial management, CalOptima Health remained stable, avoided layoffs and service cuts, and continued reinvesting in Orange County's healthcare system.

Janis Rizzuto, Director of Communications, outlined the extensive, research-driven process behind the upcoming launch of the CalOptima Health Covered plan (Covered California). She noted that for more than six months, the communications team conducted broad discovery efforts, including 14 internal working groups, multiple provider and broker organizations, and extensive consumer engagement. CalOptima Health also built on its long-standing collaboration with its award-winning marketing agency, leveraging the agency's expertise in Covered California plan launches. The goal throughout was to ensure a deeply informed, well-grounded marketing campaign that reflects the needs and expectations of the local Orange County community.

Following the initial discovery phase, CalOptima Health conducted 10 diverse focus groups with 75 participants across English, Spanish, and Vietnamese-speaking communities. Participants were either current Covered California members or individuals familiar with CalOptima Health's Medi-Cal program. The purpose was to test six campaign concepts, each of which had to be supportive, emotionally resonant, culturally cohesive, action-oriented, and unmistakably tied to Orange County. The team ensured that the concepts reassured "churners," individuals shifting between Medi-Cal and Covered California coverage and avoided unintended negative messages.

Ms. Rizzuto discussed how across many of the focus groups, participants identified affordability and provider networks as the top factors in choosing a plan. She noted that many expressed anxiety about navigating insurance changes and emphasized the need for trust, clarity, and confidence in messaging. Some participants were also confused about whether CalOptima Health Covered was limited to Medi-Cal members, underscoring the need to clearly communicate that the product is open to all eligible residents. These insights guided the selection of a single, strongly favored campaign concept, which is now moving into full creative development.

The marketing rollout will occur in two phases: a plan-launch announcement beginning August 15, 2026, followed by a full campaign aligned with Covered California's open enrollment period, starting October 15, 2026. The campaign will be large-scale and multi-channel, including television, radio, outdoor, digital, print, and website enhancements. Ms. Rizzuto noted that CalOptima Health aims to bring a trusted, locally grounded option to the market and is preparing to finalize network arrangements. It will rely on delegated health network partners during the plan's first year while evaluating future adjustments.

Michelle Nielsen, Director of Strategic Development, presented preliminary findings from CalOptima Health's Member and Population Health Needs Assessment (MPHNA). She explained that the multi-year project aimed to provide an updated, comprehensive understanding of CalOptima Health members' evolving needs across Orange County and that the final report was scheduled for release in August 2026. Using surveys, focus groups, interviews, and secondary data, the assessment examined health status, health-related social needs, behaviors, access to care, navigation, utilization, and care experience. More than 36,000 members were contacted, yielding nearly 2,000 survey responses, complemented by provider input from 301 respondents and qualitative insights from diverse focus groups and interviews.

Ms. Nielsen noted that the respondent profiles reflected broad representation across service lines, languages, demographics, and health conditions. Member surveys were offered in all threshold languages, and targeted outreach increased participation among Hispanic/Latino and Filipino members. Provider responses captured perspectives from both outpatient and inpatient settings, with strong representation from physicians and behavioral health professionals. Focus groups and interviews provided deeper insights from older adults, caregivers, unhoused members, behavioral health populations, and culturally diverse groups. Community partners and the Population Health Collaborative helped shape and validate assessment tools and frameworks.

Ms. Nielsen also noted that preliminary findings revealed four priority areas: behavioral health, health-related social needs, access and care navigation, and cultural and linguistically responsive care. Behavioral health needs were pronounced as members reported anxiety and depression

symptoms at nearly twice the national average, with barriers such as stigma, language, long waits, unclear follow-up, and low awareness of available services. Social needs, including housing instability, food insecurity, financial strain, and social isolation, significantly impacted health outcomes, delayed care, and increased reliance on emergency services. She also noted that members also described difficulties navigating the health system, including confusion about coverage, referrals, provider networks, and long wait times for primary, specialty, and mental health care.

While members generally reported positive care experiences, gaps surfaced in language access and identity-responsive care. Some were unaware of available language services, and others did not feel fully comfortable discussing cultural or identity-related needs with providers. Opportunities include strengthening multilingual staffing, culturally tailored programs, provider training, and coordinated care across services. Ms. Nielsen concluded by noting that the MPHNA will guide future program development, community investments, and strategic planning, while helping CalOptima Health build on its strengths and address persistent barriers. The full report and detailed recommendations will be presented at the August board meeting.

Yunkyung Kim, Chief Operating Officer, invited Veronica Carpenter, Chief Administrative Officer, who attended via Zoom, to provide an update from Sacramento regarding the state budget process. Ms. Carpenter thanked outgoing committee members before summarizing the recent developments in Sacramento. She noted that the Senate and Assembly have each released responses to the governor's May budget revision, with key differences outlined in a comparative document. A major issue is the governor's proposal to shift approximately 130,000 undocumented members with unsatisfactory immigration status out of CalOptima Health and into the Medi-Cal fee-for-service program due to federal restrictions on funding for this population. In response, associations have developed a "lift and shift" alternative to allow these members to remain in managed care under a new, federally compliant contract. Legislative leaders must finalize a unified proposal under the 72-hour rule, with a vote expected June 15. Veronica noted ongoing advocacy efforts and meetings with key offices, including the Speaker, and committed to keeping the committee informed.

During this discussion, members acknowledged the uncertainty and anticipated that these questions would be answered once decisions were finalized. Ms. Carpenter added that the Centers for Medicare & Medicaid Services (CMS) recently released the federal work-requirement rule and that CalOptima Health will prepare its response and participate in association-level feedback. She noted that an update on that process will be provided at the August joint MAC and PAC meeting.

Yunkyung Kim continued with her report and discussed how CalOptima Health would distribute a summary to stakeholders and the board once the governor finalizes the state legislative budget proposal. She also noted that the organization recently received board approval for its FY 2026-2027 budget. Revised budget assumptions are expected to be ready around October, with updated budget materials likely to be presented in November. The Board also approved allocating reserve funds to support providers, and leadership expressed gratitude to PAC members and providers for their strong support, including those who offered public comments. Contracts related to these provider investments are now being issued and signed.

Additionally, she noted that the board approved moving forward with the purchase of a property in Irvine to establish a second Program of All-Inclusive Care for the Elderly (PACE) program site, as the Garden Grove location has been operating near full capacity. She noted that due diligence on the property is underway, with further details expected by the end of summer.

Ms. Kim also told the committees that the Physician Representative on the Board, Dr. Jose Mayorga, announced plans to resign at the end of June, which will open a physician seat affiliated with one of CalOptima Health's delegated groups. The county will manage the recruitment process, and provider partners will be asked to help encourage qualified physicians to apply.

Michaell Silva Rose, DrPH, LCSW, Chief Health Equity Officer, alerted the MAC and PAC to an email they would receive containing a link to a survey about the new Community Resource Center planned for the 500-building next door. She noted that the center is being designed based on prior feedback from members and the community, and the MAC and PAC are invited to share additional insights into programming, needs they've observed, and ideas to enhance services for members. She noted that their input will help ensure the center reflects the community's priorities.

Richard Pitts, D.O., Ph.D., Chief Medical Officer, provided an update on current respiratory illnesses, noting that influenza, RSV, and COVID-19 continue to circulate, with COVID-19 briefly peaking in September before declining. He highlighted growing concerns about Ebola abroad, emphasizing that while Ebola is extremely dangerous, the U.S. is now far better prepared than during the 2014 outbreak, with stricter airport entry controls and improved safety protocols to prevent spread. He explained the significant challenges of caring for Ebola patients, including large volumes of hazardous medical waste and high risks during the removal of protective gear. Dr. Pitts stressed that Ebola prevention and border containment remain critical and that the public should generally not be fearful unless traveling to affected areas.

Dr. Pitts also encouraged ongoing vaccination advocacy, praising California's high childhood immunization rates, while noting that measles cases are rising nationwide following the pandemic. He reminded the group that strong vaccination coverage remains essential to protecting vulnerable populations and preventing outbreaks.

The MAC and PAC said farewell to members whose terms were expiring and to those who decided not to apply for reappointment.

The members of the MAC and PAC appreciate the opportunity to update the Board on their current activities. The next joint MAC/PAC meeting is scheduled for August 13, 2026. We welcome assignments from the Board for items they would like the MAC and PAC to provide feedback on.

REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS

June 4, 2026

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on June 4, 2026, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar, as allowed under the Brown Act as amended by Senate Bill 707 (2025). The meeting recording is available on CalOptima Health's website under View Past Meeting Materials. Chair Vicente Sarmiento called the meeting to order at 2:02 p.m., and Director Jose Mayorga led the Pledge of Allegiance.

ROLL CALL

Members Present: Supervisor Vicente Sarmiento, Chair; Maura Byron, Vice Chair; Norma García Guillén; Catherine Green, R.N.; Brian Helleland; Jose Mayorga, M.D.; Supervisor Janet Nguyen (In at 2:07 pm), Blair Contratto; Isabel Becerra; Veronica Kelley (non-voting)

(All Board members participated in person)

Members Absent:

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

The Clerk noted for the record that staff would like to reorder the agenda to hear agenda items 16 and 17 at the top of the agenda and reorder the agenda to hear agenda item 15 immediately after 13, and agenda item 19 immediately after 14. Additionally, after the board materials were posted last Friday, CalOptima Health received additional clarification on agenda item 19. The purchase and sale agreement listed as Attachment 2 of the board action was finalized with some minor changes from what was posted publicly. Those changes include added information for Exhibit A, a description of the land, which provides an official legal description of the property. Added that there are no items to report for Exhibits B, C, I, and J, and clarified in Exhibit D list of environment reports the date and vendor that performed the Phase One environmental site assessment. The board has also received hard copies of the amended and final PSA, and staff will update the archive and the amendment attachment after the meeting.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Michael Hunn, Chief Executive Officer, provided the monthly Fast Facts update, reporting that as of April 30, 2026, CalOptima Health had $726.4 million in unallocated resources. With the approval of proposed rate increases and the acquisition of a new property for the Program of All-Inclusive Care for the Elderly (PACE), the balance in the unallocated resource fund will decrease to about $266 million. Mr. Hunn referenced the State of California's May revise and noted that if the final state budget resulted in material changes or amendments related to the undocumented immigration status members, an amended budget may be brought to the November board meeting. Mr. Hunn also commended the Communications team for their exceptional outreach work and highlighted recent achievements, including 10 Telly Awards

and 32 additional awards for excellence in communications, marketing and advertising. Mr. Hunn concluded his remarks by inviting questions from the board.

ADVISORY COMMITTEE UPDATES

2. Provider Advisory Committee Update

Chair Sarmiento noted that the Advisory Committee Updates were included in the meeting materials for the board's review and that no official presentation was provided.

PUBLIC COMMENTS

- Remi De La Rocha, AltaMed; oral report on agenda item 15
- Michael Weiss, M.D, Rady Children's Health, Orange County; oral report on agenda items 13,14, & 15
- Phuc Nguyen, M.D., Family Choice; oral report on agenda item 15
- Jacob Sweidan, M.D., Noble OC; oral report on agenda item 15
- Nahla Kayali, Access California Services; Oral report on agenda item 17
- Sara May, Hospital Association of Southern California; oral report on agenda item 13
- Tiffany Alva, First Five OC; oral report on agenda item 17

CONSENT CALENDAR

3. Minutes

a. Approve Minutes of the May 7, 2026 Special Meeting of the CalOptima Health Board of Directors

b. Receive & File Minutes of the February 19, 2026 Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee

4. Approve Modifications to CalOptima Health Policy FF.1007: Health Network Reinsurance Coverage

5. Adopt Resolution No. 26-0604-01 Authorizing and Directing Execution of Contract MS-2627-41 with the California Department of Aging for the Multipurpose Senior Services Program

6. Authorize and Direct Execution of Amendment 12 to Agreement 16-93274 Care Coordination Agreement with the California Department of Health Care Services in Order to Continue Operation of the Dual Eligible Special Needs Plan OneCare Program

7. Authorize Amendments to the Contracts with Investment Managers and Investment Advisor to Extend the Contracts

8. Adopt Resolution No. 26-0604-02 Approving Updated CalOptima Health Human Resources Policies

9. Authorize the Chief Executive Officer to Execute a Contract Amendment with HealthEdge Software, Inc. for Continued Use of Source (Claims Pricing Software)

Back to Agenda

10. Receive and File:
   a. April 2026 Financial Summary
   b. Compliance Report
   c. Government Affairs Reports
   d. CalOptima Health Community Outreach and Program Summary

Action: ***On motion of Director Green, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 3 through 10, as presented. (Motion carried 9-0-0)***

REPORTS/DISCUSSION ITEMS

16. Approve Actions Related to the City Health Improvement Grant Program

Director Janet Nguyen expressed appreciation to staff, noting that CalOptima Health assisted members during evacuations following the Chemical leak incident in Garden Grove in May 2026. She also asked staff, as they develop proposals for the use of funds, to focus support on the neighborhood affected by the chemical leak.

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors: 1.) Directed the Chief Executive Officer to create a one-year grant program to support Orange County cities to enhance community-based health promotion for Medi-Cal members. 2.) Authorized CalOptima Health staff to proceed with development of a Scope of Work to be used in Notice of Funding Opportunity process for the City Health Improvement Grant Program. 3. Approve an allocation from the remaining unallocated Intergovernmental Transfer 1-7 balance in an amount not to exceed $5.2 million to fund the City Health Improvement Grant Program. (Motion carried 9-0-0)***

17. Approve Actions Related to the Community Enrollers Notice of Funding Opportunity Round 3

Vice Chair Maura Byron did not participate in agenda item 17 due to her role as Executive Director at Family Support Network, and she left the room during the discussion and vote. Director Isabel Becerra did not participate in this item due to her role as CEO of the Coalition of Orange County Community Health Centers. She also left the room and did not participate in the discussion or vote. Director Jose Mayorga did not participate in this item due to his role as Senior Vice President and Chief Quality Officer at AltaMed Health Services and left the room during the discussion and vote. Director Helleland did not participate in the item due to his role as Chief Executive at Providence St. Joseph Hospital & Orange County and High Desert Service Area and left the room during the discussion and vote.

The Board heard two public comments on this item as noted under the Public Comments section above.

Action: ***On motion of Director Green, seconded and carried, the Board of Directors: 1.) Approved CalOptima Health staff's recommendations to administer grant agreements and award payments totaling $3,572,399 to selected grant recipients (listed in Attachment 4) from Round 3 of the Community Enrollers Notice of Funding Opportunity. 2.) Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose. (Motion carried 5-0-0; Vice Chair Byron Recused; Director Becerra recused; Director Mayorga recused and Director Helleland recused)***

Back to Agenda

11. Approve the CalOptima Health Fiscal Year 2026-27 Operating Budget

Director Becerra reported that the Finance and Audit Committee reviewed the operating and capital budgets for the upcoming fiscal year at its May 28 meeting. She noted that the committee held a three-hour session to discuss key budget components and assumptions. The committee concluded that staff prepared the budgets thoughtfully and responsibly. Ms. Becerra stated that, given ongoing uncertainties at the state level, the proposed budget, along with the board's additional commitment to provider rate increases. She would support CalOptima Health's mission, vision, and the county's overall safety net in the coming year. Director Becerra also thanked Nancy and her team for their work and, on behalf of the Finance and Audit Committee, recommended that the full board approve the budgets.

Nancy Huang, Chief Financial Officer, provided a report highlighting key components of CalOptima Health's Fiscal Year 2026-27 Operating Budget. She noted that the budget is based on the best finalized information currently available and reiterated that if major program changes occur after state or federal decisions are finalized, staff will return to the board with revised recommendations. She reported that the budget incorporates enrollment forecasts that still include undocumented members because the proposed carve-out in the State's May Revise is not scheduled until January 2027. The budget also includes Medi-Cal rebasing, health network rate adjustments, and the planned provider rate increase totaling $426 million. She added that the assumptions for Proposition 35 are not included because CalOptima Health is awaiting guidance from the Department of Health Care Services (DHCS). Ms. Huang presented the fiscal year 2026–27 Operating budget. She stated that revenue was $4,859,603,087 and expenses for 2026-27 were $4,818,248,081. That left the operating margin at $41,355,006. Ms. Huang also reviewed enrollment projections showing an enrollment forecast of 749,396, a 15 percent decrease from the current fiscal year, and explained that revenue increases are driven by member acuity and the addition of the Private Hospital Direct Payment program, which will add an estimated $427 million beginning January 2027. She outlined corresponding increases in medical costs and detailed the administrative budget request of $291 million, which includes $11 million to support the launch of the Covered California line of business. Ms. Huang emphasized that administrative costs remain essentially flat for existing lines of business, noting continued restraint in FTE growth and careful monitoring of expenditures. She reviewed major medical cost categories and provided a budget-to-budget comparison of administrative expenses, highlighting increases tied to IT infrastructure, software depreciation, and building-related costs. She concluded by noting that the overall medical loss ratio remains at 93 percent and the administrative loss ratio at 6 percent for the upcoming fiscal year.

Chair Sarmiento paused the presentation to invite board members to ask questions, noting the volume of material being reviewed and thanked Nancy Huang for her detailed walk-through of the charts. He referenced slide 16, which compared the current year's actual administrative costs with the proposed fiscal year 2026–27 budget, and asked for clarification on the difference between the $246 million actual administrative cost for FY 2025–26 and the proposed $291 million, beyond the $11 million attributed to the new Covered California line of business. In response, Nancy Huang directed the board to slide 29 and explained that the $44–45 million variance is primarily due to two factors: the current year's $34 million in savings from unfilled positions and underspending relative to the approved administrative budget, and the additional $11 million needed to support Covered California. She then reviewed slide 30, outlining the major drivers behind the increase, including merit increases, capitalization of certain IT-related staffing costs, rising healthcare premiums, expanded professional services, new broker and sales commissions for Covered California, increased claims editing and call center support, significant software licensing and maintenance costs tied to digital transformation projects, and building maintenance and related operating expenses. She summarized that these factors collectively account for the proposed administrative budget growth and paused to address any further questions. Director Blair Contratto emphasized the importance

of rate rebasing and requested a one-page fact sheet for board members and the provider networks, then moved approval of the item.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Approved the CalOptima Health Fiscal Year 2026-27 Operating Budget and Non-Operating Items and authorized expenditures and appropriate funds for the items in Attachment A: Fiscal Year 2026-27 Operating Budget for All Lines of Business and Non-Operating Items and Attachment B: Administrative Budget Details. 2.) Approved the CalOptima Health Fiscal Year 2026-27 Covered California Budget, allocating up to $7.7 million from existing reserves to fund pre-implementation expenditures related to Covered California, and authorized expenditures and appropriate funds for the items in Attachment B1: Covered California Start-up Administrative Budget Details. 3.) Approved the CalOptima Health Fiscal Year 2026-27 Digital Transformation Budget and authorized expenditures and appropriate funds for the items in Attachment B2: Digital Transformation Administrative Budget Details. 4.) Directed the Chief Executive Officer, or Designee, to make a commitment of up to $429.6 million from existing reserves to support provider rates to ensure longer-term provider network stability, network adequacy, and access to care for CalOptima Health members throughout Orange County for a 2.5-year period (i.e., July 1, 2026, through December 31, 2028). (Motion carried 9-0-0)***

12. Approve the CalOptima Health Fiscal Year 2026-27 Routine Capital and Digital Transformation Year Five Capital Budgets

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors: 1.) Approved the CalOptima Health Fiscal Year 2026-27 Routine Capital Budget and authorized expenditures and appropriate funds for the items in Attachment A: Fiscal Year 2026-27 Routine Capital Budget by Project. 2.) Approved the CalOptima Health Fiscal Year 2026-27 Digital Transformation Year Five Capital Budget to complete ongoing and new projects and authorized expenditures and appropriate funds for the items in Attachment A1: Fiscal Year 2026-27 Digital Transformation Year Five Capital Budget by Project. (Motion carried 9-0-0)***

Back to Agenda

13. Authorize Amendments to the CalOptima Health Medi-Cal Fee-for-Service Hospital Services Contracts

Director Helleland did not participate in the item due to his role as Chief Executive at Providence St. Joseph Hospital & Orange County and High Desert Service Area and left the room during the discussion and vote.

The Board heard two public comments on this item as noted under the Public Comments section above.

Chair Vicente Sarmiento thanked the public for their comments, expressed appreciation to staff for bringing the recommendation forward, and thanked the hospitals that submitted letters of support, noting correspondence from HASC and other hospital partners. He acknowledged that the provider rate enhancement would not fully offset federal and state funding reductions but emphasized that it would help mitigate ongoing challenges. Chair Sarmiento requested clarification on how much of the $576 million provider rate enhancement was allocated to hospitals. Ms. Huang stated that approximately $100 million of the annual $210 million spent was allocated to hospitals. Chair Sarmiento confirmed that this proportionality aligned with the current proposed $429.6 million enhancement. He noted the importance of supporting hospitals, primary care providers and community clinics across the network. Director Jose Mayorga then expressed support for the item and underscored the critical partnership between inpatient and outpatient providers, urging hospitals to elevate quality performance across the board as CalOptima Health enters a challenging period with rising uninsured populations. He encouraged collaboration with outpatient partners and affirmed his support before moving the item.

Action: ***On motion of Director Mayorga, seconded and carried, the Board of Directors: 1.) Pending approval of a separate Board action, authorized the Chief Executive Officer, or designee, to execute amendments to existing CalOptima Health Medi-Cal Fee-for-Service Hospital Services Contracts to update rates for outpatient hospital services, effective July 1, 2026. (Motion carried 8-0-0; Director Helleland recused))***

15. Authorize Amendments to the CalOptima Health Medi-Cal Shared-Risk Group, Physician-Hospital Consortia, and Health Maintenance Organization Health Network Contracts

The Board heard three public comments on this item as noted under the Public Comments section above.

Director Mayorga did not participate in this item, due to his role as Senior Vice President and Chief Quality Officer at AltaMed Health Services and left the room during the discussions and vote. Director Helleland did not participate in this item due to his role as Chief Executive at Providence St. Joseph Hospital & Orange County and High Desert Service Area and left the room during the discussion and vote

Director Becerra added that she appreciated the comments received during the meeting, particularly those describing improvements made because of prior incentive program funding. She emphasized the importance of understanding where those investments had a meaningful impact, noting that such insight helps inform the case for continued funding.

Back to Agenda

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors 1.) Pending approval of separate Board actions, authorized the Chief Executive Officer, or designee, to execute amendments to the CalOptima Health Medi-Cal Shared-Risk Group, Physician-Hospital Consortia, and Health Maintenance Organization Contracts, effective July 1, 2026, to reflect: a. Changes to capitation base rates, supplemental maternity kick payments, and reinsurance, as developed by the recent Milliman rebasing analysis; and b. Additional capitation funding commensurate for planned enhancements to hospital outpatient and specialist physician rate increases. (Motion carried 7-0-0; Director Helleland recused and Director Mayorga recused)***

14. Authorize Amendments to the CalOptima Health Fee-for-Service Professional Services Contracts for Contracted Specialist Physicians for the Medi-Cal, OneCare, and Program of All-Inclusive Care for the Elderly Programs

Director Mayorga did not participate in this item due to his role as Senior Vice President and Chief Quality Officer at AltaMed Health Services and left the room during the discussions and vote.

Action: ***On motion of Director Green, seconded and carried, the Board of Directors 1.) Pending approval of a separate Board action, authorized the Chief Executive Officer, or designee, to execute amendments to existing CalOptima Health Fee-for-Service contracts with contracted specialist physicians, effective July 1, 2026. (Motion carried 8-0-0; Director Mayorga recused)***

19. Authorize Purchase and Sale Agreement for Real Property at 17838 Gillette Avenue, Irvine, California

Director Mayorga did not participate in this item due to his role as Senior Vice President and Chief Quality Officer at AltaMed Health Services and left the room during the discussions and vote.

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors:1.) Authorized the Chair of the CalOptima Health Board of Directors, with the assistance of legal counsel, to execute the Purchase and Sale Agreement (PSA) for real property at 17838 Gillette Avenue, Irvine, California (the Subject Property) and to negotiate and execute all documentation necessary to complete the transaction for purchase of the Subject Property. 2.) Authorized unbudgeted expenditures in an amount not to exceed $29,309,500 from existing reserves for the purchase price of the Subject Property. a. Authorized the payment of two (2) deposits, that will be applied to the purchase price of the Subject Property, for a total deposit amount of $850,000 as follows: i. $425,000 payable to the seller upon mutual execution of the PSA; and ii. $425,000 payable to the seller at the end of the sixty (60) day due diligence period. 3.) Authorized unbudgeted expenditures in the amount of up to $100,000 from existing reserves for consulting services related to due diligence inspections for the Subject Property. 4.) Authorized unbudgeted expenditures in an***

Back to Agenda

amount up to $100,000 from existing reserves for estimated escrow and closing costs. (Motion carried 8-0-0; Director Mayorga recused)

18. Authorize the Chief Executive Officer or Designee to Exercise the Third Renewal Option to Extend the Term of the Contract with Ankura Consulting Group, LLC.

Action: ***On motion of Vice Chair Byron, seconded and carried, the Board of Directors:1.) Authorized the Chief Executive Officer or designee to execute a contract amendment with Ankura Consulting Group, LLC, to exercise the third optional renewal, extending the contract term through July 31, 2027, to continue the grant close-out and review processes. (Motion carried 9-0-0)***

CLOSED SESSION

The Board adjourned to Closed Session at 3:34 p.m. HEALTH PLAN TRADE SECRETS, Pursuant to Government Code section 54956.87, subdivision (b): Covered California; CONFERENCE WITH LEGAL COUNSEL- ANTICIPATED LITIGATION. Significant exposure to litigation pursuant to Government Code section 54956.9(d)(2): up to 1 potential case; PUBLIC EMPLOYEE APPOINTMENT- General Counsel Pursuant to Government Code Section 54957 (b) (1)

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The Board returned to Open Session at 4:45 p.m. and the Clerk reestablished a quorum.

ROLL CALL

Members Present: Supervisor Vicente Sarmiento, Chair; Maura Byron, Vice Chair; Norma García Guillén; Catherine Green, R.N.; Brian Helleland; Jose Mayorga, M.D.; Blair Contratto; Isabel Becerra; Veronica Kelley (non-voting)

(All Board members participated in person)

Members Absent: Supervisor Janet Nguyen;

Chair Sarmiento noted that the Board met in Closed Session and turned it over to Troy Szabo, Outside General Counsel, Kennaday Leavitt, for the report on the items discussed in Closed Session.

Mr. Szabo reported on item number one, the board authorized staff to submit revised rates to Covered California and the Department of Managed Healthcare that aim to achieve the lowest cost premium position for the Covered California program for calendar year 2027.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Chair Sarmiento opened the floor for board member comments, beginning with Director Brian Helleland. Director Helleland reported on behalf of the PACE Expansion Ad Hoc Committee, stating that the committee had completed its assigned scope of work and recommended adjourning. He summarized that the ad hoc committee, had been established on December 4, 2025 and composed of Vice Chair Byron and Directors Becerra, Director Garcia-Guillen, and himself. It convened on January 16 2025 and met biweekly to provide guidance and direction on securing property for the PACE expansion. The committee met twelve times and provided monthly updates to the full board. He noted that the board had just approved the purchase and sale agreement for the site reviewed and recommended by the committee,

and that the committee also reviewed the due diligence steps included in the staff's requested budget. He thanked fellow committee members, staff, and legal counsel for their diligence throughout the process, acknowledging the extensive work and robust review involved. Director Helleland added that while this approval marked the beginning of the substantive PACE expansion effort, the committee is no longer needed to guide the work and looks forward to regular staff updates as the project progresses.

Director Mayorga thanked the Chair and reflected on the significance of the critical decisions made earlier in the meeting. He noted that the nation is experiencing an unprecedented period in healthcare and shared his perspective as someone involved with CalOptima Health since its early days. Director Mayorga emphasized the powerful impact CalOptima Health has had on the community and described how board decisions translate directly into meaningful improvements he witnesses in the clinic exam room. He expressed gratitude for the opportunity to advocate for members and to represent the physicians who care for them, acknowledging the collaborative efforts of hospital partners and community organizations. Director Mayorga also announced that he would step away from his duties as a board member effective June 30, 2026. He thanked the Orange County Board of Supervisors for his appointment, his fellow board members for their collegiality and mentorship, and CalOptima Health staff for their dedication and hard work. Director Mayorga also extended appreciation to the thousands of patients and families he has cared for, noting that they have been his greatest teachers and a constant reminder of his purpose in medicine. He concluded by encouraging current and future board members to continue making decisions in the best interest of CalOptima Health's members and stated that he will remain a strong advocate for the community.

ADJOURNMENT

Hearing no further business, Chair Sarmiento adjourned the meeting at 4:54 p.m.

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Ruby Nunez
Interim, Clerk of the Board

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 6, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

6. Approve Reappointments and Appointments to the CalOptima Health Board of Directors' Member Advisory Committee, Provider Advisory Committee, and Whole-Child Model Family Advisory Committee

Contact

Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

1. Reappoint the following individuals to the Member Advisory Committee, effective August 6, 2026, for three-year terms ending June 30, 2029:
    a. Kim Goll as the Family Support/Caregiver Representative;
    b. Linda Adair Pugh as Medi-Cal Beneficiary or Authorized Family Member Representative; and
    c. Peter Hersh as the OneCare Member or Authorized Family Member Representative.

2. Appoint the following individuals to the Member Advisory Committee, effective August 6, 2026, for three-year terms ending June 30, 2029:
    a. Joyce Large as a Medi-Cal Beneficiary or Authorized Family Member Representative;
    b. Jennifer Heavener as a OneCare Member or Authorized Family Member Representative;
    c. Ana Guerrero as a Recipients of CalWORKs Representative; and
    d. Kawon (Kay) Lee as a Seniors Representative.

3. Appoint the following individuals to the Provider Advisory Committee, effective August 6, 2026, for three-year terms ending June 30, 2029:
    a. Jonathon Myers, DPT, as an Allied Health Services Representative;
    b. Jeremy Elkins as a Community Health Centers Representative;
    c. Kyle Kim as a Hospital Representative;
    d. Paul Lubinsky, M.D., as a Physician Representative; and
    e. Jina Lawler as a Safety Net Representative.

4. Reappoint the following individuals to the Whole-Child Model Family Advisory Committee, effective August 6, 2026, for two-year terms ending on June 30, 2028:
    a. Jody Bullard as an Authorized Family Member Representative;
    b. Jessica Putterman as an Authorized Family Member Representative; and
    c. Erika Jewell as a Community-Based Organization Representative.

5. Appoint Yvette Lavery as a Consumer Advocate Representative to the Whole-Child Model Family Advisory Committee, effective August 6, 2026, for a two-year term ending June 30, 2028.

Back to Agenda

Background

The CalOptima Health Board of Directors (Board) established the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) by resolution on February 14, 1995, to provide input to the Board. The MAC comprises twenty voting members, and the PAC comprises fifteen voting members. Pursuant to the resolution, MAC and PAC members serve three-year terms, except for one standing seat for a representative from the County of Orange Social Services Agency on the MAC and a standing seat for a representative from the Orange County Health Care Agency on the PAC. The Board is responsible for appointing all MAC and PAC members.

Senate Bill 586 (SB 586), signed into law on September 25, 2016, authorized the establishment of the Whole-Child Model (WCM) program, incorporating California Children's Services (CCS)-covered services for Medi-Cal eligible children and youth into specified County Organized Health System plans. A provision of the WCM program requires each participating health plan to establish a family advisory committee. Accordingly, the Board established the WCM Family Advisory Committee (WCM FAC) by resolution on November 2, 2017, to report on the WCM program and provide input and recommendations to the Board.

The WCM FAC comprises eleven voting members, including: (i) nine members designated as family representatives and (ii) two members designated as community seats who represent the interests of children receiving CCS services. While the WCM FAC must include two community members, the Board may appoint up to two additional community members to the WCM FAC if it lacks enough family representative candidates to fill the nine designated seats. The Board is responsible for appointing all WCM FAC members.

Discussion

CalOptima Health staff conducted comprehensive outreach, including notifying community-based organizations (CBOs), conducting targeted outreach to agencies and CBOs about open positions on the MAC, PAC, and WCM FAC, and posting recruitment materials on the CalOptima Health website and social media.

The MAC Nominations Ad Hoc Subcommittee, comprised of Chair Christine Tolbert, Vice Chair Meredith Chillemi, and member Dr. Junie Lazo-Pearson, evaluated each applicant for the upcoming openings and forwarded the recommended candidates to the MAC.

The PAC Nominations Ad Hoc Subcommittee, comprised of Chair John Nishimoto, O.D., and committee members Andrew Inglis, M.D., and Jena Jensen, evaluated each applicant and forwarded the recommended candidates to the PAC.

At the June 11, 2026, joint meeting, the MAC and PAC each approved the recommended slate of candidates proposed by the individual MAC and PAC Nominations Ad Hoc Subcommittees and requested staff to forward the proposed slate for each committee to the Board for its consideration at the August 6, 2026, meeting. Staff will continue recruiting for the open Persons with Disabilities seat on MAC until it is filled.

Back to Agenda

The WCM FAC Nominations Ad Hoc Subcommittee, comprised of Chair Lori Sato, members Jennifer Heavener and Katya Aguilar, evaluated each applicant for the open seats and recommended that the Board appoint and reappoint the recommended candidates. Staff will continue recruiting for the open Consumer Advocate seat and the Authorized Family Member seats.

Member Advisory Committee

The recommended MAC candidates for the open positions are as follows:

Family Support/Caregiver Representative

Kim Goll – Reappointment

Kim Goll is the President/Chief Executive Officer (CEO) of First 5 Orange County. As CEO, Ms. Goll has firsthand experience working with CalOptima Health families. This includes identifying gaps in the care system, conducting outreach to better understand these gaps and the barriers to services, and identifying opportunities for improvement, funding, and impact monitoring. These efforts have contributed to supporting pregnant families, increasing compliance with developmental and well-child visits, enhancing access to developmental interventions, and expanding access to new CalAIM benefits. Ms. Goll has served as a member of the MAC since 2024, with an existing term ending on June 30, 2026.

Medi-Cal Beneficiary or Authorized Family Member Representative (two seats)

Linda Adair Pugh – Reappointment

Linda Adair Pugh is retired and currently a CalOptima Health Medi-Cal member. Ms. Adair Pugh has lived in Orange County for more than 50 years. She currently serves on two City of Anaheim boards: the Residential Advisory Board and the Housing and Community Development Commission. Since 2021, she has served as a Medi-Cal Beneficiaries Representative on the MAC, with an existing term ending on June 30, 2026.

Joyce Large – New Appointment

Joyce Large is an active CalOptima Health Medi-Cal member with extensive experience serving the Medi-Cal population. She volunteers with the Salvation Army, leading sobriety support groups and connecting individuals to resources, particularly those recently released from prison. In addition, Ms. Large is a member of Clarvida's Wellness Center in Orange, which serves many Medi-Cal members throughout Orange County.

OneCare Member or Authorized Family Member Representative (two seats)

Peter Hersh – Reappointment

Peter Hersh is an advocate for his father, a OneCare Member. Mr. Hersh provides consulting services in planning, development, and government relations. He is an elected member of the Chamber of Commerce for the City of Laguna Niguel. Mr. Hersh has served on the MAC since 2025, appointed to fill an existing term which ends on June 30, 2026.

Jennifer Heavener – New Appointment

Jennifer Heavener has navigated the Medi-Cal and CCS systems for the past 20 years on behalf of her special needs child. Ms. Heavener's experience as an advocate and caregiver gives her a unique

Back to Agenda

perspective that will help other families in the OneCare program. Ms. Heavener previously served on the WCM FAC as an Authorized Family Member Representative and currently serves as a Consumer Advocate. Ms. Heavener's daughter has transitioned from the CCS and WCM program and is now a OneCare member. Ms. Heavener would like to continue her advocacy by representing OneCare members as an Authorized Family Member Representative.

Recipients of CalWORKS Representative

Ana Guerrero – New Appointment

Ana Guerrero is a Social Services Supervisor II at the Orange County Social Services Agency, where she serves on the CalWORKs Operations and Policy Team. Ms. Guerrero has 13 years of experience supporting CalOptima Health members, helping numerous families with Medi-Cal eligibility and guiding them through the benefits process. Ms. Guerrero was raised and resides in Orange County, giving her a deep understanding of the county's diverse cultural groups. These lifelong experiences have strengthened her knowledge of the county's rich cultural diversity. As both a resident and a servant leader, she is well acquainted with the challenges Orange County communities face, including language access barriers and cultural differences that make navigating public services difficult.

Seniors Representative

The MAC received two applicants for this seat, Linda Cardoza and Kay Lee. The MAC Nominations Ad Hoc Subcommittee recommends the appointment of Kay Lee.

Kawon (Kay) Lee – New Appointment

Kay Lee serves as the Executive Director and Administrator of the Healthy Aging Center: Laguna Woods, where she leads the facility's management and daily operations for the adult day health care program. Since assuming this role in August 2024, Ms. Lee has focused on strengthening organizational effectiveness, enhancing the participant experience, and ensuring full regulatory compliance across all program areas. She has extensive experience serving a multicultural senior population.

Linda Cardoza

Linda Cardoza recently retired but has devoted her career to supporting older adults and vulnerable community members through extensive service in Medicare counseling, advocacy, and volunteer work. Ms. Cardoza began as a volunteer state-registered counselor, assisting Orange County residents and their caregivers with Medicare and insurance issues across five counties with appeals and enrollment events.

Provider Advisory Committee

The recommended PAC candidates for the open seats are as follows:

Allied Health Services Representative

The PAC received two applicants for this seat: Carina Biddle and Jonathan Myers. The PAC Nominations Ad Hoc Subcommittee recommends the appointment of Jonathan Myers to this seat.

Jonathon Myers, DPT – New Appointment

Dr. Jonathon Myers is the President and CEO of Southland Physical Therapy, with offices in Santa Ana and Stanton. Drawing on his experience across the financial divide, Dr. Myers seeks to ensure that

underserved communities receive high-quality physical therapy care. Dr. Myers understands the financial challenges faced by patients and by CalOptima Health and strives to balance these realities to deliver compassionate, effective, and sustainable care. Dr. Myers holds a Doctorate in Physical Therapy and is a licensed physical therapist who serves a large CalOptima Health patient population at both of his practice locations.

Carina L. Biddle, MS, LMFT
Carina L. Biddle is a Licensed Marriage and Family Therapist and the owner of Tune Therapy in Irvine. Ms. Biddle specializes in trauma-informed, evidence-based psychotherapy for individuals seeking meaningful, measurable change. Her clinical approach integrates acceptance and commitment therapy, cognitive behavioral therapy, person-centered therapy, solution-focused therapy, psychodynamic principles, and family systems work. Before opening her practice, Ms. Biddle served as a therapist at Forward Wellness and spent several years at Child Guidance Center, where she provided comprehensive assessments and treatment for children, teens, and young adults. Ms. Biddle commits to creating a supportive, collaborative space where clients can build resilience, gain insight, and move toward personal healing and growth.

Community Health Centers Representative
Jeremy Elkins – New Appointment
Jeremy Elkins has worked directly and indirectly with the CalOptima Health population for 20 years. From 2005 to 2015, he provided direct patient care as a Physician Assistant at a Federally Qualified Health Center (FQHC), serving uninsured individuals and CalOptima Health members. Since 2010, Mr. Elkins has also contributed through administrative and leadership roles, providing strategic and business development oversight for Medi-Cal populations statewide, including CalOptima Health members. Since 2022, Mr. Elkins has served as CEO of Camino Health Center, which serves more than 20,000 CalOptima Health members.

Hospital Representative
Kyle Kim – New Appointment
Kyle Kim serves as Vice President of Finance for University of California Irvine (UCI) Health's Medical Centers, guiding systemwide initiatives and supporting the growth and integration of UCI Health's expanding clinical enterprise. Mr. Kim played a key leadership role in opening UCI Health's new Irvine medical center in 2025, ensuring a smooth activation and alignment with the organization's academic and clinical mission. He seeks to serve as the Hospital Representative because CalOptima Health is essential to Orange County's safety net, and hospitals must be active partners in improving access and outcomes. Mr. Kim brings experience across academic medicine, community hospitals, payer strategy, and performance improvement, and commits to advocating for all CalOptima Health members and providers.

Physician Representative
The PAC received four applicants for this seat: Paul Lubinsky, M.D.; Sabrina Cooley, M.D.; Yong (Andy) Han, M.D.; and K. Louis Kamel, M.D.. The PAC Nominations Ad Hoc Subcommittee recommends the appointment of Paul Lubinsky, M.D..

Back to Agenda

Paul Lubinsky, M.D. – New Appointment
Dr. Paul Lubinsky, is a pediatric intensive care physician, providing care at Rady Children's Hospital of Orange County (RCHOC) and Mission Hospital. Dr. Lubinsky also offers pediatric burn and trauma consultation at UCI. He also serves as a Professor of Health Sciences at UCI and as the Children's Specialist Medical Director for RCHOC, splitting his full-time role between clinical care and administrative leadership. He is board-certified in Pediatrics and Pediatric Critical Care.

Sabrina Cooley, M.D.
Dr. Sabrina Cooley is a board-certified Family Medicine physician committed to whole-person care. She trained at Ohio State University and Kaiser Permanente, served as a Medical Officer in the U.S. Navy, and later worked in psychiatric emergency services and urgent care. Dr. Cooley has also served as Site Medical Director at Share Ourselves Community Health Center. Since 2021, Dr. Cooley has been with Celebrating Life Community Health Center, where she provides integrated, community-focused care. She enjoys the arts, Zumba, paddleboarding, and time with loved ones.

Yong (Andy) Han, M.D.
Dr. Yong (Andy) Han is a vitreoretinal surgeon and ophthalmologist serving patients in Orange County. He is an Associate Physician at Orange County Ophthalmology Medical Group and previously practiced at South Coast Retina Center. Dr. Han completed his ophthalmology residency and retinal fellowship at the University of Southern California Roski Eye Institute. He earned his M.D. from the Yale School of Medicine and completed an internship at MedStar Harbor Hospital. Dr. Han is dedicated to providing expert, patient-centered retinal care grounded in advanced surgical training and clinical excellence.

K. Louis Kamel, M.D.
Dr. K. Louis Kamel is an experienced neuropsychiatrist and the founder of Noble Neuropsychiatric Medical Group, where he has provided care to geriatric and adult patients in skilled nursing and retirement homes since 1988. He has led major clinical and regulatory initiatives, including developing a medication-management strategy for the California Department of Corrections and Rehabilitation that significantly reduced psychiatric drug misuse, which became a national model.

Safety Net Representative
The PAC received two applicants for this seat: Jina Lawler and Mela Rodriguez. The PAC Nominations Ad Hoc Subcommittee recommends the appointment of Jina Lawler.

Jina Lawler, MSW – New Appointment
Jina Lawler is the President and CEO of Hurtt Family Health Clinic, an FQHC serving underserved communities throughout Orange County. Since assuming the role in 2023, she has expanded services and achieved more than 40% growth in the organization while maintaining full compliance with federal, state, and managed care requirements. Ms. Lawler has improved access to care by adding optometry, chiropractic, dental, and behavioral health services, and by establishing a Community Programs Department focused on the social drivers of health. Under Ms. Lawler's leadership, the clinic has enhanced operational efficiency, improved care coordination, and advanced health equity through integrated, patient-centered services.

Back to Agenda

Mela Rodriguez
Mela Rodriguez is a healthcare operations leader at Serve the People Health Center, with extensive experience overseeing multidisciplinary medical, dental, behavioral health, vision, and administrative services. She partners closely with executive and clinical leadership to strengthen workflows, improve coordination, and ensure high-quality, compliant care. Ms. Rodriguez leads policy development, supports regulatory and audit readiness, advances behavioral health integration, manages key grants and community partnerships, and drives cross-functional initiatives that expand access and enhance services for diverse and underserved populations.

Whole-Child Model Family Advisory Committee
The WCM FAC Nominations Ad Hoc Subcommittee recommends the following candidates for the open seats:

Authorized Family Member Representatives
Jody Bullard - Reappointment
Jody Bullard is a former social worker and the current caregiver for her 16-year-old son, who was born with a rare genetic syndrome. Before leaving her employment to become her son's full-time caregiver, Ms. Bullard used her social work skills to advocate within the CCS system and would like to assist other WCM participants. She has served as a member of the WCM FAC since 2024, with an existing term ending on June 30, 2026.

Jessica Putterman - Reappointment
Jessica Putterman is the mother of a child with special needs who currently receives CCS and Medi-Cal services. After ten years of navigating CCS with her son, Ms. Putterman would like to assist other parents with her knowledge and expertise in this area, as she has made it a point to learn as much as possible to advocate for her child. Ms. Putterman has served as a member of the WCM FAC since 2022, with an existing term ending on June 30, 2026.

Community-Based Organization Representative
Erika Jewell - Reappointment
Erika Jewell is the manager of case management and social services at RCHOC, where she works closely with RCHOC's Health Alliance and with other Medi-Cal patients and families to ensure they receive the social services support they need. Ms. Jewell is a licensed clinical social worker with more than 22 years of experience working with CCS patients and participates in local stakeholder groups that benefit CCS patients. She also serves on the Tustin Unified School District's Special Education Advisory Committee. Ms. Jewell currently serves as Vice-Chair of the WCM FAC and has served as a member of the WCM FAC since 2022, with an existing term ending on June 30, 2026.

Consumer Advocate Representative
Yvette Lavery - New Appointment
Yvette Lavery brings both lived and professional expertise in navigating Medi-Cal, CalOptima Health, RCHOC Health Alliance, and CCS as the parent of a child with multiple rare conditions. Her career includes roles with Healthy Smiles for Kids of Orange County, United Way of California and Orange County, Beyond Blindness, and First 5 Orange County, where she worked to improve access and

coordination for children with complex medical needs. A former First 5 Orange County Commissioner, she consistently advocated for the CCS population, drawing on firsthand caregiving experience. Ms. Lavery seeks to serve on the WCM FAC to advance integrated, family-centered care and strengthen care coordination and access for vulnerable children.

Fiscal Impact

The following representatives may receive a stipend of up to $100 in the form of a check or gift card per committee meeting attended: (1) MAC Medi-Cal Beneficiary or Authorized Family Member Representative; (2) MAC OneCare Member or Authorized Family Member Representative; (3) WCM FAC Member or Authorized Family Member Representative.

Funding for the stipends is a budgeted item under the CalOptima Health Fiscal Year 2026-27 Operating Budget. Management will include funding for the stipends for July 1, 2027, and after in future operating budgets. There is no additional fiscal impact from the recommended actions.

Rationale for Recommendation

As stated in policies AA.1219a, AA.1219b, and AA.1271, the MAC, PAC, and the WCM FAC each established a Nominations Ad Hoc Subcommittee to review potential candidates for vacancies on the committees. The MAC and PAC each approved their respective Nominations Ad Hoc Subcommittee's recommended slate of candidates at the joint MAC and PAC meeting held on June 11, 2026. The MAC and PAC forward their recommended slate of candidates to the Board for consideration and appointment. The WCM FAC Nominations Ad Hoc Subcommittee has reviewed the applicants and forwards its recommended slate of candidates to the Board for consideration and appointment.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt
Member Advisory Committee Nominations Ad Hoc Subcommittee
Member Advisory Committee
Provider Advisory Committee Nominations Ad Hoc Subcommittee
Provider Advisory Committee
Whole-Child Model Family Advisory Committee Nominations Ad Hoc Subcommittee

Attachments

None

/s/ Michael Hunn — *07/29/2026*
Authorized Signature — **Date**

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 6, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Approve the Further Revision of CalOptima Health's Position on Assembly Bill 2194

Contact

Veronica Carpenter, Chief Administrative Officer, (657) 900-1161

Recommended Action

Approve the further revision of CalOptima Health's formal position on Assembly Bill 2194 (2026) in response to additional amendments, dated July 2, 2026.

Background

On February 19, 2026, California State Assemblymember Avelino Valencia introduced Assembly Bill (AB) 2194, sponsored by the County of Orange, to implement two significant reforms regarding the governance of CalOptima Health. After advancing through the Assembly Health Committee and Assembly Appropriations Committee, AB 2194 unanimously passed the full Assembly on April 16, 2026.

On May 7, 2026, CalOptima Health's Board of Directors (Board) adopted a position of "Support If Amended" regarding AB 2194 by a vote of 6–1 (see Attachment 1). The Board expressed broad support for the provision that would implement staggered terms for the seven Board seats with four-year terms (*i.e.*, all seats except those represented by two members of the Orange County Board of Supervisors [BOS], who serve one-year terms). This provision would become effective for the new terms expected to begin in August 2028. Notably, the staggered Board terms was a reform recommended by the Board's former Governance Ad Hoc Committee, which was dissolved on December 4, 2025. By preventing a potential wholesale turnover of the Board, this provision is a positive reform that would improve oversight and continuity in CalOptima Health's governance. However, the Board voiced concerns and requested an amendment to remove another provision of AB 2194 that would have provided the alternate member of the Board with the same right of access to CalOptima Health materials – including confidential closed-session information – as all other Board members.

On June 15, 2026, Assemblymember Valencia introduced significant amendments to AB 2194. As amended, AB 2194 would replace the two Board seats held by the BOS with the Director of the Orange County Health Care Agency and the Director of the Orange County Social Services Agency. As such, the Board composition would change from 10 members (nine voting and one non-voting) to nine members, with no non-voting member or alternate member. In addition, a new selection committee would appoint all Board members, rather than the BOS. CalOptima Health would administer this new selection committee, which would comprise of federal and state legislators, health care representatives, and other community members. Lastly, the amendments would retain the provision to implement staggered terms on the Board, but that amendment would set initial term lengths by lottery beginning at the first meeting after the start of the new Board terms. Since these amendments to AB 2194 would significantly change the Board structure, and since the Board previously approved a position on an earlier version of AB 2194, the Board adopted a revised position of "Oppose" at a special meeting on June 18, 2026 (see Attachment 2).

Back to Agenda

Discussion
Following significant advocacy efforts by CalOptima Health's Board members, staff, and state lobbyists at Clear Advocacy, the County of Orange, and several other local organizations, the Senate Health Committee introduced committee amendments to AB 2194 on June 23, 2026, that reversed the significant amendments introduced by Assemblymember Valencia on June 15, 2026, and incorporated a few other modifications. Specifically, the Senate Health Committee amendments remove the newly proposed Board structure and selection committee, maintain the staggered-terms language, keep out the alternate access language, and add an independent external audit requirement to address Assemblymember Valencia's concerns about CalOptima Health's governance.

Subsequently, Orange County Supervisors Vicente Sarmiento and Janet Nguyen spoke in support of the amendments at the Senate Health Committee hearing on June 24, 2026, and Assemblymember Valencia agreed to the amendments. Then, the Senate Health Committee unanimously passed AB 2194, recommending adoption of the amendments and re-referring the bill to the Senate Local Government Committee. On July 1, 2026, the Senate Local Government Committee formally adopted the amendments and unanimously passed and re-referred AB 2194 to the Senate Appropriations Committee, where it is scheduled for a hearing on August 3, 2026. The current version of the bill, incorporating the adopted amendments, was subsequently published on July 2, 2026 (see Attachment 3). CalOptima Health was and remains unable to submit an updated position at these three Senate committee hearings in response to the latest amendments, pending further Board direction.

As such, in order to accurately reflect the Board's position on the current, amended version of AB 2194, staff recommends that the Board formally remove CalOptima Health's position of "Oppose." In doing so, CalOptima Health would no longer have a position on the bill. While the Board will not consider this revised position until after the Senate Appropriations Committee hearing on August 3, 2026, staff would communicate the revised position when AB 2194 is expected to be ordered back to the Assembly for concurrence in Senate amendments.

Should the Board approve the recommended revised position, staff would still retain the ability to coordinate technical amendments to AB 2194 but would no longer advocate on the substantive policy of the legislation. To that end, staff has identified a few inconsistencies in the latest Senate Health Committee amendments, which have been acknowledged as unintended drafting errors by both the Senate Health Committee and Assemblymember Valencia's office (see Attachment 4). Staff expects consideration of corrections at the Senate Appropriations Committee hearing on August 3, 2026.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Proactive engagement with public officials is critical to influencing policy decisions that are likely to impact CalOptima Health. Since the latest amendments to AB 2194 would address the Board's previously approved position on an earlier version of the bill, staff recommends that the Board adopt a revised position.

Back to Agenda

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
1. CalOptima Health's Support If Amended Letter on AB 2194 (dated May 19, 2026)
2. CalOptima Health's Oppose Letter on AB 2194 (dated June 19, 2026)
3. AB 2194 Current Text (as amended on July 2, 2026)
4. AB 2194 Potential Drafting Errors

/s/ Michael Hunn *07/28/2026*
Authorized Signature **Date**

Back to Agenda

CalOptima Health
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May 19, 2026

The Honorable Avelino Valencia
California State Assembly
1021 O Street, Suite 5510
Sacramento, CA 95814

RE: Assembly Bill 2194 (Valencia): Medi-Cal: special commissions — SUPPORT IF AMENDED

Dear Assemblymember Valencia:

On May 7, 2026, CalOptima Health's Board of Directors (Board) adopted a position of "Support If Amended" regarding Assembly Bill (AB) 2194 by a vote of 6–1.

The Board expressed broad support for the provision that would implement staggered terms for the seven Board seats with four-year terms (*i.e.*, all seats except those represented by two members of the Orange County Board of Supervisors, who serve one-year terms). This provision would become effective for the new terms expected to begin in August 2028. Notably, staggering Board terms was a recommended reform of the Board's former Governance Ad Hoc Committee that was dissolved on December 4, 2025. By preventing a potential wholesale turnover of the Board, this provision is a positive reform that would improve oversight and continuity in CalOptima Health's governance.

However, the Board expressed several concerns about the provision that would grant the alternate Board member the same right of access to CalOptima Health materials — including confidential closed-session information — as all other Board members. Based on staff research, this would likely be an unprecedented departure from long-standing Brown Act practice. In addition, the provision raises concerns regarding confidentiality, attorney-client privilege and protected health information under the Health Insurance Portability and Accountability Act of 1996.

For these reasons, the Board has directed staff to seek an amendment to remove the latter provision, and if such an amendment is adopted, to advocate in support of AB 2194. If you have any questions, please contact Kevin Bassett, Senior Director, State Government Affairs, at kevin.bassett@caloptima.org. I appreciate your consideration of this request.

Sincerely,

Vicente Sarmiento
Chair, CalOptima Health Board of Directors
Orange County Supervisor, Second District

Back to Agenda Back to Item

cc: Members, Orange County Legislative Delegation
Members, Senate Health Committee
Members, Senate Local Government Committee
Jen Flory, Principal Consultant, Senate Health Committee
Joe Parra, Policy Consultant, Senate Republican Caucus
Anton Favorini-Csorba, Chief Consultant, Senate Local Government Committee
Ryan Eisberg, Policy Consultant, Senate Republican Caucus

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June 19, 2026

The Honorable Akilah Weber Pierson, M.D.
Chair, Senate Health Committee
1021 O Street, Suite 7310

Sacramento, CA 95814

RE: Assembly Bill 2194 (Valencia): Medi-Cal: special commissions — OPPOSE

Dear Senator Weber Pierson:

On June 18, 2026, the CalOptima Health Board of Directors (Board) unanimously voted (7-0) to oppose AB 2194, as amended on June 15, 2026.

The Board was grateful that Assemblymember Valencia chose to carry the bill's original proposal to establish staggered terms for appointed Board members, a reform that would have strengthened continuity and governance stability.

Unfortunately, the CalOptima Health Board was surprised by the late substantive amendments made to AB 2194 on June 15, 2026. As amended, AB 2194 removes Orange County Board of Supervisors' representation from the CalOptima Health Board, eliminates the alternate member structure, and replaces a longstanding governance framework that has successfully served Orange County's Medi-Cal population for decades. These changes would make Orange County the only County Organized Health System (COHS) in California without direct representation from elected County Supervisors on its governing board, effectively eliminating local accountability and oversight.

This proposal comes at a time when counties, health plans, and providers are navigating significant challenges to the Medi-Cal program, including federal policy changes that threaten coverage stability and place new demands on local health care systems. The focus should be on preserving continuity, strengthening coordination, and maintaining accountability - not disrupting a governance structure that is working.

County Supervisors provide direct public accountability to the residents, taxpayers, and CalOptima Health members they serve. They also bring a countywide perspective across health care, behavioral health, public health, social services, and housing - coordination essential to supporting Orange County's most vulnerable residents. Notably, AB 2194 would remove two County Supervisors of color who represent the supervisorial districts with the highest concentrations of CalOptima Health members, including significant Vietnamese and Latino communities. As a result, the communities most reliant on Medi-Cal and other safety-net services would lose direct representation on the governing board of their health plan. The longstanding statutory framework allowing Supervisors to serve on both governing bodies has been instrumental in aligning County services with CalOptima Health's mission, and supporting many of the priorities this Committee has been tasked with addressing.

Back to Agenda Back to Item

As revised, AB 2194 would weaken that connection late in the legislative cycle without compelling justification. There has been no governance failure, operational breakdown, or demonstrated deficiency warranting such a significant restructuring. Yet the bill would replace a proven governance model with an unprecedented structure found nowhere else in California, effectively removing local control and accountability.

CalOptima Health is committed to serving its members with respect and dignity and would welcome the opportunity to discuss and consider any issues that may have prompted the significant amendments that were introduced on June 15, 2026. At this time, however, we write in strong opposition to AB 2194 as amended as we urge the committee to defeat this measure.

If you have any questions, please contact Kevin Bassett, Senior Director, State Government Affairs, at kevin.bassett@caloptima.org. I appreciate your consideration of this request.

Sincerely,



Vicente Sarmiento
Chair, CalOptima Health Board of Directors
Orange County Supervisor, Second District

AB-2194 Medi-Cal: special commissions. (2025-2026)

As Amends the Law Today

SECTION 1. Section 14087.59 of the Welfare and Institutions Code is amended to read:

14087.59. (a) (1) Notwithstanding subdivision (d) of Section 14087.54, governance of the commission in the County of Orange established pursuant to Section 14087.54, known as the Orange County Health Authority, shall be vested in a governing body consisting of 10 members: 9 voting members and 1 nonvoting member. The nonvoting member shall be the Director of the Orange County Health Care Agency. The nine voting members shall be nominated by the Orange County Health Care Agency and appointed by a majority vote of the Board of Supervisors of the County of Orange and shall consist of the following:

(A) Two members shall each be a member of the Board of Supervisors of the County of Orange, with one additional member of the Board of Supervisors of the County of Orange to serve as an alternate.

(B) One member shall be a current or former hospital administrator.

(C) One member shall be a representative of a community clinic, which may include, but is not limited to, a representative of a federally qualified health center, as defined in Section 1396d(l)(2)(B) of Title 42 of the United States Code.

(D) One member shall be a member of the public who is a legal resident of the County of Orange.

(E) One member shall be a practicing licensed medical provider who is not an owner or officer, or a member of the board of directors, of a contracted independent physician's association or provider network.

(F) One member shall be a current ~~CalOptima~~ *Orange County Health Authority* member or a family member of a current ~~CalOptima~~ *Orange County Health Authority* member.

(G) One member shall be an accounting or public finance professional, or an attorney who is an active member of the State Bar.

(H) One member shall be a practicing licensed physician who is a representative of a contracted independent physician's association or provider network.

(2) For purposes of identifying qualified individuals to be considered as members of the governing body, the Board of Supervisors of the County of Orange shall consult with stakeholders in the County of Orange, including, but not limited to, providers who serve CalOptima members, consumers, and advocates.

(b) Each member of the governing body shall reside in, or be employed in, the County of Orange and shall be generally representative of the diverse backgrounds, interests, and demography of persons residing in the County of Orange. Each member of the governing body shall have a commitment to a health care system that seeks to improve access to high-quality health care for persons served by the commission and that in fact delivers high-quality care and is financially viable. Each member shall possess the requisite skills and knowledge necessary to design and operate a quality publicly assisted health care delivery system.

~~(c) (1) Members of the governing body of the commission shall serve four-year terms, except for those members who are members of the Board of Supervisors of the County of Orange who shall serve a one-year term.~~

~~(2)~~ *(c)* ~~A~~ *(1)* ~~member~~ *Members* of the governing body *of the commission shall serve four-year terms, which shall be staggered, except for those members who are members of the Board of Supervisors of the County of Orange, who shall serve a one-year term. The term of office of members of the governing body* described in any of subparagraphs ~~(B) to (H), inclusive,~~ *(B), (D), (F), and (H)* of paragraph (1) of subdivision (a) ~~shall serve no more than two consecutive terms. An individual who served a one-year term on~~ *duly serving prior to January 1, 2027, shall remain unchanged. The term of office for members of* the governing body ~~as~~ described in ~~paragraph (1) may not be appointed to serve a four-year term under any of subparagraphs (B) to (H), inclusive,~~ *subparagraphs (C), (E), and (G) of paragraph (1) of subdivision (a) serving a term beginning prior to January 1, 2027, shall be a two-year term. Thereafter, members described in subparagraphs (C), (E), and (G)* of paragraph (1) of subdivision (a) ~~within 12 months of the expiration of their one-year term. The limitations set forth in this paragraph apply only to service for consecutive terms. No other limitation on the number of terms a person may serve is intended.~~ *shall serve a four-year term and are subject to the limitations provided for in paragraph (2) of this subdivision. Members who are appointed to fill the unexpired term of a vacant seat shall have an initial term that corresponds to the unexpired term of the vacant seat. A vacancy that occurs in the last 90 days of a term shall not be filled until the expiration of the term.*

(2) A member of the governing body shall serve no more than two consecutive terms. The limitations set forth in this paragraph apply only to service for consecutive terms. No other limitation on the number of terms a person may serve is intended.

(3) A member of the governing body of the commission may be removed from the governing body by a vote in favor of that removal of at least two-thirds of the full membership of the Board of Supervisors of the County of Orange.

(d) The governing body of the commission, subject to a two-thirds vote of the full membership, may increase the number of public members, or the number of members who are current ~~CalOptima~~ *Orange County Health Authority* members or family members of current ~~CalOptima~~

Orange County Health Authority members who may serve as a member of the governing body, subject to an affirmative vote by a majority of the Board of Supervisors of the County of Orange, provided, however, that a change in the composition of the governing body under this subdivision shall not result in the elimination of any member described in paragraph (1) of subdivision (a).

(e) Each member of the governing body shall have the responsibility and duty to follow the requirements of applicable federal and state laws and regulations, including Section 1090 of the Government Code, the applicable provisions of Sections 87100 to 87500, inclusive, of the Government Code, and Section 14047.6 of this code, to serve the public interest of the members of ~~CalOptima,~~ *the Orange County Health Authority,* and to ensure the operational well-being and fiscal solvency of the Orange County Health Authority. Members of the governing body shall further strive to improve health care quality, promote prevention and wellness, ensure the provision of cost-effective health and behavioral health care services, reduce health disparities, address the needs of Medi-Cal members who are affected by homelessness and housing instability, improve quality outcomes, and manage the risk and needs of Medi-Cal beneficiaries through whole-person care approaches and addressing social determinants of health. The Orange County Health Authority shall work to earn the public's trust through its commitment to accountability, responsiveness, transparency, reliability, and cooperation.

(f) A member of the governing body who has a financial interest, within the meaning of Section 87100 of the Government Code, in a decision before the governing body shall, upon identifying a conflict of interest or a potential conflict of interest and immediately prior to the consideration of the matter, do all of the following:

(1) Publicly identify the financial interest that gives rise to the conflict of interest or potential conflict of interest in detail sufficient to be understood by the public, except that disclosure of the exact street address of a residence is not required.

(2) Recuse the member's own self from discussing and voting on the matter.

(3) Leave the room until after the discussion, vote, and any other disposition of the matter is concluded, unless the matter has been placed on the portion of the agenda reserved for uncontested matters.

(4) Notwithstanding paragraph (3), the member may speak on the issue during the time that the general public speaks on the issue.

(g) (1) A member of the governing body shall not, for a period of one year after leaving office, act as an agent or attorney for, or otherwise represent, for compensation, any other person, by making any formal or informal appearance before, or by making any oral or written communication to, the commission, or any committee, subcommittee, or present member of the commission, or any officer or employee of the commission, if the appearance or communication is made for the purpose of influencing administrative action or influencing any action or proceeding involving the issuance, amendment, awarding, or revocation of a permit, license, grant, or contract, or the sale or purchase of goods or property.

(2) In addition to paragraph (1), a member of the governing body described in subparagraphs (A) and (G) of paragraph (1) of subdivision (a) shall not, for a period of one year after leaving office, serve as an employee, agent, or attorney, or otherwise represent, for compensation, the Orange County Health Authority or any other entity that received an expenditure of Medi-Cal funds from the Orange County Health Authority during the prior five years. This paragraph does not apply to expenditures of Medi-Cal funds from the Orange County Health Authority for routine administrative expenses for reimbursement for travel, continuing education costs, routine office expenses, and other ongoing routine administrative expenses. This paragraph does not prevent any member from returning to or continuing the role that they held when they were appointed to the governing body.

SEC. 2. *Section 14087.591 is added to the Welfare and Institutions Code, to read:*

14087.591. *(a) The governing body of the Orange County Health Authority shall authorize and pay for an independent external audit of the Orange County Health Authority's governance procedures and practices. The audit shall be conducted by an independent entity with demonstrated expertise in health care governance, board oversight, and managed care operations. The entity conducting the audit shall be announced at an Orange County Health Authority board meeting and opportunity for interested stakeholders to submit input to the entity for particular actions to be reviewed shall be permitted.*

(b) The independent external audit shall evaluate, at a minimum, all of the following:

(1) The Orange County Health Authority's conflict-of-interest policies and procedures, including policies governing disclosures, recusals, and potential conflicts involving members of the governing body, officers, employees, and individuals participating in contracting or procurement decisions.

(2) The roles and responsibilities of the governing body, executive leadership, and staff to ensure appropriate separation between governance and oversight functions and the day-to-day operations and management of the Orange County Health Authority.

(3) The Orange County Health Authority's policies and practices governing contracting, procurement, and vendor selection to ensure decisions are made consistent with applicable laws, regulations, fiduciary obligations, and established governance practices. In reviewing the governing practices, the independent audit shall review particular actions identified by interested stakeholders as described in subdivision (a).

(4) The Orange County Health Care Agency's policy for nominating members to the governing body. The audit shall determine if the policy sufficiently prioritizes strategies to attract and retain professionals with a background in health care to be nominated to the board and provide suggestions on recruitment as necessary.

(5) Whether the Orange County Health Authority's governance structure, policies, or practices appropriately preserve the ability of executive leadership and staff to independently conduct contracting and procurement functions consistent with the governing body's oversight role.

(6) Recommendations to strengthen governance practices, accountability, transparency, and appropriate oversight by the governing body.

(c) In order to evaluate the items in subdivision (b), the independent audit shall conduct interviews with staff of the Orange County Health Authority and provide anonymous opportunities to share feedback.

(d) The independent external audit shall be completed and the governing body shall submit the audit report to the Legislature and the department no later than July 1, 2027.

Back to Agenda
Back to Item

(1) The requirement for submitting a report imposed under this subdivision is inoperative on July 1, 2031, pursuant to Section 10231.5 of the Government Code.

(2) A report to be submitted pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

(e) The governing body of the Orange County Health Authority shall review the findings and recommendations of the independent external audit and develop a corrective action plan, as appropriate, to address any identified deficiencies.

(f) The Orange County Health Authority shall make the audit report and any corrective action plan available to the public, consistent with applicable confidentiality and proprietary information requirements.

SEC. 3. *The Legislature finds and declares that a special statute is necessary and that a general statute cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because of the unique circumstances applicable to the County of Orange with respect to the operation and governance of the Orange County Health Authority, which is a county-organized health system known as CalOptima.*

SEC. 4. *No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district are the result of a program for which legislative authority was requested by that local agency or school district, within the meaning of Section 17556 of the Government Code and Section 6 of Article XIII B of the California Constitution.*

AB 2194 (Valencia) — Potential Drafting Errors

The most recent committee amendments to AB 2194 (Valencia) that were recommended by the Senate Health Committee on June 24 and adopted by the Senate Local Government Committee on July 1 may have resulted in the following three (3) unintentional drafting errors:

1. As it relates to the bill's implementation of staggered terms, the committee amendments now apply the transitional two-year terms for seats (C), (E) and (G) to their ***current terms before January 1, 2027****,* rather than their *next terms* beginning *after* January 1, 2027, as was in the original bill language. This is problematic because all current seats were appointed in August 2024 for a four-year term through August 2028, so the new transitional two-year seats will already be past the two-year mark by the time this bill becomes effective on January 1, 2027. The original bill language is cleaner from an implementation perspective, as the next appointments in August 2028 would be either two-year or four-year terms.

2. The committee amendments ***no longer exempt the Supervisorial seats from the two consecutive term limit***, which only applies to the *non*-Supervisorial seats under existing law. Since the non-Supervisorial seats serve four-year terms, those seats are limited to eight consecutive years under existing law. However, since the Supervisorial seats only serve a one-year term, the term limits do not apply to them under existing law. The current bill language is problematic because it would now limit the Supervisorial seats to two consecutive years, which could create a frequent revolving door of Supervisors who may not want to serve on the CalOptima Health Board.

3. The committee amendments ***remove a good-governance provision*** that was recently incorporated into existing law by AB 498 (Quirk-Silva, 2022), which prohibits Supervisors from being appointed to a *non*-Supervisorial seat (four-year term) within 12 months of the expiration of their Supervisorial seat (one-year term).

Back to Agenda Back to Item

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 6, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

8. Approve CalOptima Health's Opposition to Proposed State Budget Trailer Bill Language

Contact

Veronica Carpenter, Chief Administrative Officer, (657) 900-1161

Recommended Actions

1. Approve CalOptima Health's formal position in opposition to proposed Fiscal Year 2026–27 California State Budget trailer bill language regarding local health plan governance; and
2. Authorize the Chief Executive Officer, or designee, to implement legislative advocacy efforts in alignment with the approved position and in collaboration with Local Health Plans of California.

Background/Discussion

On June 29, 2026, the California State Legislature passed, and Governor Gavin Newsom signed into law, the Fiscal Year (FY) 2026–27 Enacted State Budget, effective July 1, 2026. As is typical, the State Legislature is now preparing to consider additional legislation as part of its budget cleanup process before the current 2025–26 legislative session adjourns on August 31, 2026.

On July 9, 2026, CalOptima Health's state trade association, Local Health Plans of California (LHPC), shared budget trailer bill language (TBL) proposed by the County of Santa Clara that would allow it to assume control of the locally operated Medi-Cal plan, Santa Clara Family Health Plan (SCFHP), thereby integrating it into the county government and removing its status as an independent public agency (see Attachment 1).

In response, LHPC adopted an "Oppose" position, primarily due to the proposal's precedent-setting nature for all locally operated Medi-Cal plans. Key arguments in LHPC's opposition letter include the following (see Attachment 2):

- The TBL bypasses critical oversight and regulatory processes designed to protect Medi-Cal members and health care consumers. Allowing this statutory shortcut may negatively impact providers and Medi-Cal members.
- The separation of governance between local health plans and counties is intentional and protective. Authorizing county control of the local health plan is short-sighted and creates uncertainty about the local health plan's long-term viability in serving Medi-Cal members by:
    - Eliminating a governance structure that protects against the diversion of local health plan resources to solve county financial challenges.
    - Eroding the local health plan model under the false premise that the financial pressures faced by the County of Santa Clara are unique.
- The TBL creates a dangerous statewide precedent and runs counter to California's transparent and rigorous review process to evaluate significant changes to local health plan structure.

For the reasons articulated in LHPC's opposition letter, as well as the potential risk to the fundamental statutory protections for the County Organized Health System (COHS) model that governs CalOptima

Back to Agenda

Health under state law, staff recommends that the CalOptima Health Board of Directors (Board) similarly adopt a formal position in opposition to the proposed SCFHP Integration TBL. Of note, the FY 2026–27 Public Policy Priorities approved by the Board on May 7, 2026, authorize the Chief Executive Officer to adopt this position pursuant to the following provision: *"Preserve the COHS and delegated managed care delivery models."*

Fiscal Impact
There is no additional fiscal impact.

Rationale for Recommendation
Proactive engagement with public officials is critical to influencing policy decisions that are likely to impact CalOptima Health. If enacted, the proposed SCFHP Integration TBL could ultimately negatively impact the governance of CalOptima Health.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachment
1. Proposed SCFHP Integration TBL Text (dated June 10, 2026)
2. LHPC's Oppose Letter on Proposed SCFHP Integration TBL (dated July 17, 2026)

/s/ Michael Hunn *07/28/2026*
Authorized Signature **Date**

Back to Agenda

An act to add Section 14087.381 to the Welfare and Institutions Code, relating to Medi-Cal.

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Back to Item

Back to Agenda

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 14087.381 is added to the Welfare and Institutions Code, immediately following Section 14087.38, to read:

14087.381. (a) Notwithstanding any other law, at the election of the County of Santa Clara, and effective 30 calendar days after that county provides written notice to the department, the health authority created by the Board of Supervisors of that county pursuant to Section 14087.38 shall hereby become part of, and not independent from, the county.

(b) If the election described in subdivision (a) is made, all of the following conditions apply:

(1) All existing contracts between the health authority and its payors, payees, and vendors, including the Medi-Cal contract between the state and the health authority, shall remain in place notwithstanding the County of Santa Clara's assumption of control of the health authority.

(2) The health authority, including all of its assets, liabilities, and licenses, shall be assumed by and become the responsibility of the County of Santa Clara.

(3) The health authority governing board shall be dissolved and the powers of the health authority governing board shall be returned to the Board of Supervisors of the County of Santa Clara.

(4) The County of Santa Clara shall coordinate with the department to ensure continuity of care and benefits for all Medi-Cal beneficiaries enrolled with the health authority in the county.

SEC. 2. The Legislature finds and declares that a special statute is necessary and that a general statute cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because of the unique circumstances relating to the County of Santa Clara's interest in creating efficiencies and reducing bureaucratic redundancies in providing Medi-Cal managed care for county residents with minimal disruption to the experience of patients by not terminating the health authority before consolidation. Unique circumstances exist within the County of Santa Clara in that two county-created public plans under the Knox-Keene Health Care Service Plan of 1975 are operating within the county and serving the Medi-Cal managed care population within the county.

- 0 -

261528437959ILL

Back to Item
Back to Agenda

LEGISLATIVE COUNSEL'S DIGEST

Bill No.
as introduced, _____.
General Subject: Medi-Cal: County of Santa Clara: health authority.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services through different delivery systems, including managed care or fee-for-service. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions.

Existing law authorizes the board of supervisors of a county to establish a health authority for the purposes of providing health care services under the Medi-Cal program. Under existing law, the health authority, under the direction of its governing board, is considered an entity separate from the county with its own specified powers and authorities.

Under this bill, at the election of the County of Santa Clara, and effective 30 calendar days after the county provides written notice to the department, the health authority created by the Board of Supervisors of the County of Santa Clara would become part of, and not independent from, the County of Santa Clara. The bill would impose specified conditions if the health authority becomes part of the county, including that all existing contracts between the health authority and its payors, payees, and vendors remain in place and that the county coordinate with the department to ensure continuity of care and benefits for all Medi-Cal beneficiaries.

This bill would make legislative findings and declarations as to the necessity of a special statute for the County of Santa Clara.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

2615284379593111

Back to Item

Back to Agenda

July 17, 2026

Honorable Monique Limón
President Pro Tempore California Senate
1021 O Street, Suite 8518
Sacramento, CA 95814

Honorable Robert Rivas
Speaker of the California State Assembly
1021 O Street, Room 219
Sacramento, CA 95814

RE: Opposition to Proposed Trailer Bill Exempting Santa Clara County from Medi-Cal Statutory Safeguards

Dear Pro Tem Limón and Speaker Rivas:

On behalf of the Local Health Plans of California (LHPC), representing California's community-based and public Medi-Cal managed care plans, we write in strong opposition to proposed trailer bill language (TBL) which exempts Santa Clara County from statutory safeguards that establish local health plans (i.e., health authorities) as entities separate and independent from the counties. The statutory safeguard ensures that local plan resources are utilized for paying for their members' health care rather than solving a county financial crisis. LHPC's position reflects strong opposition by the Association though we acknowledge the local health plan from Santa Clara County, Santa Clara Family Health Plan, is supporting the proposal. **The Santa Clara County proposal establishes a statewide precedent allowing the statutory independence of local health plans to be set aside through county-specific legislation that bypasses key regulatory processes and is motivated by the county's financial troubles. We urge the Legislature to reject this statutory language as a part of budget trailer bill or any other legislative vehicle.**

The proposed trailer bill:

- **Circumvents Critical Oversight and Regulatory Processes.** As regulatory agencies, DHCS and DMHC possess the expertise and statutory responsibility to evaluate significant changes in ownership, governance, solvency, licensing, member protections, and organizational control before they occur. Rather than engaging in those established review processes, this proposal seeks legislative authority to circumvent them. The fact that the regulatory process may require significant time or resources should not justify creating a statutory exception. If the proposed integration can satisfy existing legal and regulatory standards, it should proceed through those established processes. If it cannot, the Legislature and Administration should not support an alternative pathway that weakens longstanding protections applicable to every other Medi-Cal managed care plan in California. Advancing this TBL would authorize a significant restructuring outside the regulatory and oversight

frameworks administered by DHCS and DMHC. This would diminish the role of both agencies in reviewing such transactions and in ensuring that processes designed to protect Medi-Cal members, plan solvency, and the integrity of the Medi-Cal program are followed.

- **Eliminates a Governance Structure that Protects Against Local Plan Resources Being Diverted to Solve County Financial Challenges.** The Legislature intentionally established local health authorities as independent public entities, separate from county government, to ensure independent governance and protect Medi-Cal resources from being used to address broader county financial pressures. Welfare and Institutions Code Section 14087.38(a)(2) defines a health authority as "an entity separate from the county," while Section 14087.38(k) reinforces this separation by providing that "a county shall not be liable for any act or omission of the health authority." Together, these provisions create a deliberate governance and financial firewall that preserves the independence of local health plans, prevents conflicts of interest, and ensures that plan resources are used to serve Medi-Cal members.

  The proposed TBL dismantles this statutory framework by authorizing Santa Clara Family Health Plan's integration into county government, effectively placing the county in the roles of purchaser, provider, and governing authority. This concentration of authority under the county infrastructure threatens the independence of the local plans that preserves neutrality in provider contracting and ensures that resources dedicated to Medi-Cal remain focused on ensuring access to care, improving quality, and supporting improved health outcomes. By contrast, the legislation would allow the county to redirect plan resources with little to no oversight. From a member choice and access perspective, the integration could influence decision-making about where Medi-Cal members receive care, favoring county providers over other community-based providers.

- **Erodes the Local Plan Model Under the False Premise that the Financial Pressures Faced by the County are Unique.** LHPC does not dispute that Santa Clara County's public health system is experiencing significant financial pressures. Unfortunately, those pressures are shared across California's safety-net delivery system. Public hospitals, county health systems, federally qualified health centers, community providers, and Medi-Cal managed care plans throughout the state are confronting unprecedented financial uncertainty driven by federal Medicaid funding reductions under H.R. 1, California's structural budget deficit, inflationary pressures, workforce shortages, and increasing demand for services. No single county is uniquely affected by these statewide challenges. Any solution to county financial challenges should not jeopardize the ability for local plans to continue to provide care to millions of Californians.

Protecting the statutory independence of local health plans is ultimately about preserving public confidence that decisions affecting millions of Californians will continue to be guided by the health and well-being of the communities they serve. Beyond the legal and regulatory concerns, this proposal threatens the public trust that local health plans have earned over decades as community-based and independently governed organizations dedicated to providing comprehensive, coordinated care to Medi-Cal members. Members, providers, and local communities rely on the assurance that local health plan decisions are made in the best interests of patient care and community needs and are not influenced by the broader fiscal pressures or operational priorities of county government.

LHPC supports continued collaboration between counties, public health systems, and local health plans to address the significant fiscal challenges confronting California's safety net. However, this collaboration should not come at the expense of independent local plan governance. **California has established a deliberate statutory framework for local health plans that balances local flexibility with independent control and governance, and we urge the Legislature to protect that framework by rejecting the proposed trailer bill language.**

Sincerely,



Linnea Koopmans
Chief Executive Officer
Local Health Plans of California

cc: Marjorie Swartz, Consultant, Office of the Senate Pro Tempore
Rosielyn Pulmano, Consultant, Office of the Assembly Speaker
Scott Ogus, Principal Consultant, Senate Budget Sub 3, Health & Human Services
Patrick Le, Consultant, Assembly Budget Sub 1, Health
Julie Cravatto, Assembly Member Dawn Addis, Chief of Staff
Kimberly Fuentes, Senator Menjivar, Policy Analyst
Jen Flory, Consultant, Senate Health Committee
Lisa Murawski, Consultant, Assembly Health Committee
Jason Constantouros, Principle Fiscal & Policy Analyst, Legislative Analyst's Office
Karina Hendren, Senior Fiscal & Policy Analyst, Legislative Analyst's Office

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 6, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

9. Ratify Execution of License Agreement with Avanta Properties City Parkway LLC and Orange City Mills Mall Limited Partnership

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action

Ratify the execution of the license agreement for use of parking areas to hold public events for a three-year term with automatic one-year renewals unless terminated by CalOptima Health, Avanta Properties City Parkway LLC, or Orange City Mills Mall Limited Partnership.

Background

CalOptima Health owns a four-story commercial office building located at 500 City Parkway West, Orange, California (500 Building) and a ten-story commercial office building at 505 City Parkway West, Orange, California. Avanta Properties City Parkway LLC (Avanta) owns the commercial office building located at 600 City Parkway West, Orange, California. Orange City Mills Mall Limited Partnership (Mills) owns the real property that has been improved with, among other uses, retail and entertainment facilities with surface parking lots (Shopping Center).

On May 7, 2026, the Board of Directors (Board) authorized the Chief Executive Officer (CEO), with the assistance of legal counsel, to execute a license agreement for the use of parking areas to hold public events for a five-year term with automatic one-year renewals unless terminated by CalOptima Health or Mills. The license agreement will allow CalOptima Health to use certain portions of the parking areas subject to the Cross Parking Easement to hold public events from time-to-time associated with CalOptima Health's mission and purpose.

Discussion

After the May Board action and prior to execution of the license agreement, Mills revised the initial term of the agreement from the Board-approved five-year term to a three-year term with automatic one-year renewals. Mills indicated they could only offer a three-year initial commitment for the purpose of the license agreement.

Vicente Sarmiento, the Chair of the Board, signed the license agreement on June 18, 2026, incorporating the revised three-year initial term. Staff requests the Board ratify the Chair's execution of the license agreement with Mills based on this substantive change from the prior Board action.

Fiscal Impact

There is no fiscal impact.

Back to Agenda

Rationale for Recommendation

The recommended action will ensure that CalOptima Health can provide adequate space for public events, including event layouts and member parking.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. License Agreement for Use of Parking Areas

/s/ Michael Hunn *07/29/2026*
Authorized Signature **Date**

Back to Agenda

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
CalOptima Health	505 and 500 City Parkway West	Orange	CA	92868
Avanta Properties City Parkway LLC	2211 Michelson Drive, Suite 220	Irvine	CA	92612
Orange City Mills Mall Limited Partnership	225 West Washington Street	Indianapolis	IN	46204

Docusign Envelope ID: 243C5D71-56C8-8E59-833A-E46D82B44652

LICENSE AGREEMENT FOR USE OF PARKING AREAS

SUMMARY OF BASIC TERMS

Parties:

Licensee: CalOptima ("CalOptima")

CalOptima Health, A Public Agency
505 City Parkway West, Orange, CA 92868
Attention: Director, Facilities

Licensor No. 1: Avanta Properties City Parkway LLC: ("Avanta")

Avanta Properties City Parkway LLC
c/o Greenlaw
2211 Michelson Drive #220
Irvine, CA 92612

Licensor No. 2: Orange City Mills Limited Partnership ("Mills")

c/o M.S. Management Associates Inc.
225 West Washinton Street
Indianapolis, Indiana 46204-3438
Attention: Jocelyn Gubler and Kristen Elfring

LICENSEE and each LICENSOR may be referred to as a "Party" and collectively as the "Parties" and Licensor No. 1 and Licensor No. 2 collectively shall be referred to as "LICENSOR".

Term: Three (3) years with automatic one year renewal year-after-year unless terminated by LICENSOR upon thirty (30) days written notice to LICENSEE.

Insurance: Insurance Certificates due no less than five (5) calendar days before each Event and in types and amounts set forth in Section 9.

RECITALS

WHEREAS, CalOptima owns the real property commonly known as 500 and 505 City Parkway West and AVANTA owns 600 City Parkway, Orange, California (collectively, the "Parkway Properties");

WHEREAS, the Parkway Properties and Orange City Mills Limited Partnership ("Mills") are subject to that certain Declaration of Cross Parking Easement, dated as of November 25, 1997, by and between Mills and Spieker, and recorded in the Official Records of Orange County, California, on January 21, 1998, as Instrument No. 19980033262, as amended ("Cross-Parking Easement"), wherein the Parkway Properties and Mills have certain rights to parking areas within the Parkway Properties; and

WHEREAS, CalOptima wishes from time-to-time to hold public events associated with its services (an "Event") within the parking areas of the Parkway Properties subject to the Cross-Parking Easement and therefore, CalOptima, as Licensee and Mills and CGL, collectively as Licensor, hereby enter into this License Agreement For Use Of Parking Areas ("Agreement") permitting CalOptima to use certain portions of the Parkway Properties parking areas under the terms and conditions set forth herein.

Back to Agenda Back to Item

Docusign Envelope ID: 243C5D71-56C8-8E59-833A-E46D82B44652

LICENSE PROVISIONS

1. The License Property:

That portion of the parking areas within the Parkway Properties as shown on **Exhibit "A"** attached hereto and made a part of this Agreement ("Licensed Area"). The Licensed Area may for any Event be adjusted downward for each Event per the Event Notice (as defined in Section 2 below) provided to LICENSOR by LICENSEE.

2. Use of License Property:

LICENSOR hereby grants to LICENSEE the exclusive right to use the Licensed Area as designated on Exhibit A for an Event upon providing to LICENSORS at least thirty (30) days written advance notice of each Event setting forth the date and time period for the Event, including any move-in and move-out activity (the "Event License Period") and briefly describing the Event taking place (collectively, "Event Notice"). Each LICENSOR shall have five (5) business days to object to the Event or Event License Period, and the if an objection is received, the objecting party and LICNSEE shall meet and confer and negotiate in good faith to resolve any objection to an Event or the Event License Period. LICENSEE, its guests, exhibitors, patrons or invitees, shall have the exclusive right to use the Licensed Area in connection with an Event. Event activity must be limited to the Event License Period. LICENSEE understands and agrees that this Agreement is a license for use of the specified Licensed Area and that it is not and does not constitute a lease or other rental agreement that would confer on LICENSEE any rights as a tenant under California landlord-tenant laws, including any rights to prior notice or cure under such laws, and LICENSEE's right to occupy and use the Licensed Area may be terminated in accordance with the terms set forth in this Agreement.

3. Commencement Date:

This Agreement is made effective as of the date on which all parties have signed this Agreement.

4. Term:

The term ("Term") of this Agreement shall commence on the Commencement Date and continue in full force and effect until the end of the Term set forth in the Summary of Basic terms unless terminated by either LICENSOR upon thirty (30) written notice to LICENSEE.

5. Termination:

LICENSOR acknowledges that LICENSEE shall expend time, money and other resources organizing, advertising and preparing for the EVENT and thus, LICENSOR, or any of them, may only terminate this Agreement upon at least thirty (30) days' prior written notice to LICENSEE unless there is a substantial risk to public health and safety, in which, case, LICENSOR, or any of them, may terminate this Agreement in their sole discretion, effective immediate upon delivery of written notice.

6. Scope of Use.

LICENSEE shall be responsible to perform and pay for all costs of move-in, move-out, clean-up, repair, and maintenance caused by an Event. The Licensed Area must be cleared, cleaned and all items removed from the Licensed Area by the end of the Event License Period. The use of the Licensed Area shall not damage or alter the parking area in any manner. LICENSEE shall pay the actual cost to replace, repair and/or restore, in LICENSOR's reasonable discretion, any part of the Licensed Area or Parkway Properties that was defaced or damaged by LICENSEE, its agents, employees, exhibitors, or invitees during the EVENT.

Back to Agenda Back to Item

7. Breach.

In the event of a default by either party to this Agreement, the non-defaulting party shall have available all remedies at law or equity, and such remedies shall be cumulative and not exclusive of one another and the exercise of any one or more of said remedies shall not constitute a waiver or election with respect to any other available remedy.

8. Indemnity.

LICENSEE shall indemnify, hold harmless and defend each LICENSOR and their respective members, officers, directors, agents and employees from and against any and all claims, suits, damages, actions, costs, and expenses (including reasonable attorneys' fees) arising out of or connected with, whether directly or indirectly, LICENSEE's operations on or in the Licensed Area associated with an Event, or the use or occupancy of the Licensed Area by LICENSEE during the EVENT, its employees, agents, contractors, patrons, guests, exhibitors, licensees, or invitees unless the claim or suit arises out of the sole negligence or willful misconduct of the party to be indemnified, their employees or agents.

9. Insurance.

Notwithstanding the indemnification requirements of Section 8, LICENSEE shall, at its sole cost and expense, procure and maintain the following types and limits of insurance, containing the additional insured endorsements and cancellation clause set forth herein. At a minimum, said insurance coverage shall be in effect for the Event License Period. LICENSEE shall deliver certificates of insurance evidencing the following coverage and endorsements on or before the date set forth in the Summary of Basic Terms and shall confirm the same in writing in each Event Notice to Licensor:

(a) **Commercial General Liability** policy with coverage in occurrence form providing coverage against claims for bodily injury or death and property damage occurring in or upon or resulting from LICENSEE's use or occupancy of the Licensed Property. Such insurance shall be primary and not require contribution from any of the additional insureds other insurance coverages, and shall afford immediate defense and indemnification of any named additional insureds, to the limit of not less than ONE MILLION DOLLARS ($1,000,000.00) per occurrence; and

(b) **Automobile Liability** insurance for owned, hired, and non-owned autos with limits of not less than ONE MILLION DOLLARS ($1,000,000.00) for bodily injury and property damage, in combined or equivalent split limits, for each single accident. Insurance shall cover liability arising out of LICENSEE's use of vehicles in connection with this License Agreement, including owned, leased, hired, and/or non-owned autos, as each may be applicable; and

(c) **Worker's Compensation Insurance** as required by law.

All insurance policies provided by LICENSEE in satisfaction of this Section 9, other than Worker's Compensation insurance, shall include the following additional insured endorsement language: Avanta Properties City Parkway LLC and Orange City Mills Limited Partnership and their members, officers, directors, and employees.

The parties agree and LICENSEE understands that the specified coverage or limits of insurance in no way limit the liability of the LICENSEE. LICENSEE shall maintain, with respect to each such policy or agreement, evidence of such insurance coverage and endorsements required by this Agreement.

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10. Compliance with Laws.

LICENSEE agrees to comply with all rules and regulations in existence as of the date of this Agreement that apply to areas of the Parkway Properties. LICENSEE shall comply and cause its agents, servants, employees, contractors, patrons, guests, licensees or invitees to promptly comply with all applicable laws, ordinances, rules, and regulations of all federal, state, county and city governments for an Event. LICENSEE shall obtain any licenses and permits required by federal, state, county, or city laws in connection with its Event and shall permit inspection by appropriate agencies or departments. LICENSOR shall have the right to refuse entrance to or remove and eject from an Event any person associated with LICENSEE or present at LICENSEE's Event whose conduct is objectionable, disorderly, disruptive, or in violation of any law.

11. Lost or Misplaced Property.

Any equipment or personal property belonging to LICENSEE, its agents, servants, employees, contractors, invitees, patrons or guests, which remains in Parkway Properties or the Licensed Area after the License Period for the EVENT, shall be deemed abandoned and may be disposed of by LICENSOR at LICENSEE's sole expense. LICENSOR shall assume no responsibility for losses caused by theft, disappearance or abandonment of equipment or personal property.

12. Assignment.

LICENSEE shall not assign this Agreement or any right, obligation or interest herein or permit the use of the Licensed Area or any part thereof by any other party, except that LICENSEE shall have the right to permit its exhibitors to use the Licensed Area in conjunction with LICENSEE's Event. Any substantive change in the nature of LICENSEE's Event, without Licensor's prior written consent, shall constitute a material breach of this Agreement.

13. Notices.

All notices and demands which either party is required to or desires to give to the other shall be made in writing by email, personal delivery, overnight delivery by a recognized national courier, or certified mail, return receipt requested, postage prepaid, and addressed to contacts set forth in the Summary of Basic Terms. Either party may change its contact information for the receipt of notice by giving written notice thereof to the other party in the manner herein provided. Notices shall be effective on the date delivered.

14. Governing Law.

This Agreement shall be governed by the laws of the State of California.

15. Amendment.

This Agreement may be amended at any time by the written agreement of the parties. All amendments, changes, revisions, and discharges of this Agreement in whole or in part, and from time to time, shall be binding upon the parties, so long as the same shall be in writing and executed by the parties hereto.

16. Entire Agreement.

This Agreement and Exhibit "A" hereto constitute the entire agreement between the Parties with respect to the subject matter hereof and supersede all prior verbal or written agreements and understandings between the Parties with respect to the items set forth herein.

Back to Agenda Back to Item

17. Signatures

This Agreement may be signed in counterparts, and the counterparts taken together shall be deemed an original executed Agreement. A signature may be delivered to the parties by fax or scanned and e-mailed document, and such fax or scanned signature shall be accepted and effective as an original signature.

18. Effective Date

The effective date of this Agreement shall be the date it is executed by all Parties.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives.

Avanta Properties City Parkway LLC:

AVANTA PROPERTIES CITY PARKWAY LLC,
a California limited liability company

By: _____ Date: _____
Name:
Title:

Mills:

ORANGE CITY MILLS LIMITED PARTNERSHIP,
a Delaware limited company

By: ORANGE CITY MILLS MALL GP, L.L.C.,
a Delaware limited liability company,
its general partner

By: SIMON-MILLS II, LLC,
a Delaware limited liability company,
its manager

DocuSigned by:
By: John Rulli Date: May 29, 2026
Name: John Rulli
Title: Chief Administrative Officer

CalOptima:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency, dba Orange Prevention and
Treatment Integrated Medical Assistance dba CalOptima

By: _____ Date: _____
Name:
Title:

16. Entire Agreement.

This Agreement and Exhibit "A" hereto constitute the entire agreement between the Parties with respect to the subject matter hereof and supersede all prior verbal or written agreements and understandings between the Parties with respect to the items set forth herein.

17. Signatures

This Agreement may be signed in counterparts, and the counterparts taken together shall be deemed an original executed Agreement. A signature may be delivered to the parties by fax or scanned and e-mailed document, and such fax or scanned signature shall be accepted and effective as an original signature.

18. Effective Date

The effective date of this Agreement shall be the date it is executed by all Parties.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives.

Avanta Properties City Parkway LLC:

AVANTA PROPERTIES CITY PARKWAY LLC,
a California limited liability company

By: _____ Date:
Name: Chi Luong
Title: CEO

Mills:

ORANGE CITY MILLS LIMITED PARTNERSHIP,
a Delaware limited company

By: ORANGE CITY MILLS MALL GP, L.L.C.,
a Delaware limited liability company,
its general partner

By: SIMON-MILLS II, LLC,
a Delaware limited liability company,
its manager

By: _____
Name:
Title:

CalOptima:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency, dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima

By: _____
Name:
Title:

Back to Agenda Back to Item

16. Entire Agreement.

This Agreement and Exhibit "A" hereto constitute the entire agreement between the Parties with respect to the subject matter hereof and supersede all prior verbal or written agreements and understandings between the Parties with respect to the items set forth herein.

17. Signatures

This Agreement may be signed in counterparts, and the counterparts taken together shall be deemed an original executed Agreement. A signature may be delivered to the parties by fax or scanned and e-mailed document, and such fax or scanned signature shall be accepted and effective as an original signature.

18. Effective Date

The effective date of this Agreement shall be the date it is executed by all Parties.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed by their duly authorized representatives.

Avanta Properties City Parkway LLC:

AVANTA PROPERTIES CITY PARKWAY LLC,
a California limited liability company

By: _____ Date:
Name:
Title:

Mills:

ORANGE CITY MILLS LIMITED PARTNERSHIP,
a Delaware limited company

By: ORANGE CITY MILLS MALL GP, L.L.C.,
a Delaware limited liability company,
its general partner

By: SIMON-MILLS II, LLC,
a Delaware limited liability company,
its manager

By: _____
Name:
Title:

CalOptima:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency, dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima

By: _____ 6-18-26
Name: Vicente Sarmiento
Title: Supervisor, Second District

Back to Agenda Back to Item

Docusign Envelope ID: 243C5D71-56C8-8E59-833A-E46D82B44652

EXHIBIT A

[Subject Property and Licensed Area Map]



Event Licensed Areas: A (Green), B (green) and C (Orange)

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 6, 2026
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar
10. Approve Modifications to CalOptima Health Policy: GG.1611

Contacts
Linda Lee, Executive Director, Quality Improvement, (657) 900-1069
Marsha Choo, Director, Quality Improvement, (714) 246-8670

Recommended Action
Approve modifications to CalOptima Health Policy GG.1611: Potential Quality Issue Review Process in connection with CalOptima Health's regular review process and consistent with regulatory requirements.

Background/Discussion
CalOptima Health regularly reviews its policies and procedures to ensure they are up to date and aligned with federal and state health care program requirements, contractual obligations, and laws, as well as CalOptima Health operations.

Below are the proposed modifications to Policy GG.1611:

Policy Section	Proposed Changes
II.E. and III.C.1.	Clarifies that reporting under section 805.01 is included when submitting actions to state licensing boards.
II.J.	Adds criteria directing when letters must be issued based on the Medical Director or Credentialing and Peer Review Committee's (CPRC) recommendations: • Contracted CalOptima Health Community Network (CCN) providers receive a letter summarizing investigation findings. • Providers not contracted with CCN but contracted with a CalOptima Health Network receive a letter; a copy may also be sent to their Health Network requesting case review and a response to CPRC after investigation. • For non-contracted providers, a non-805-reportable letter may be sent to the state licensing board requesting review of the identified issue.
III.B.3.	Extends the target potential quality issue (PQI) case closure timeline from 90 days to 120 days to align with turnaround times used by other Medi-Cal health plans.
III.B.3.c.	Clarifies that two QI Nurse RNs must jointly close Quality-of-Service PQI cases.
Attachment A	Removes the Provider Resolution Letter attachment from the policy and procedure.

Back to Agenda

Fiscal Impact

The recommended action is operational nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2026-27 Operating Budget.

Rationale for Recommendation

To ensure CalOptima Health's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, rules, and accreditation standards, CalOptima Health staff recommends that the Board of Directors approve and adopt the presented CalOptima policy and procedure. The updated policy and procedure will supersede prior versions.

Concurrence

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

Attachments

1. Policy GG.1611: Potential Quality Issue Review Process
2. QI Policy Updates: GG.1611 Presentation

/s/ Michael Hunn *07/28/2026*
Authorized Signature **Date**

Back to Agenda

Policy:	GG.1611
Title:	**Potential Quality Issue Review Process**
Department:	Quality Improvement~~Medical Management~~
Section:	Not Applicable~~Quality Improvement~~
CEO Approval:	*/s/*
Effective Date:	12/01/1999
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☐ PACE

For 20260806 POD Review Only

I. PURPOSE

This policy defines the procedure for reviewing and processing of a Potential Quality Issue (PQI) referred to the CalOptima Health Quality Improvement (QI) Department for any Provider servicing Members.

II. POLICY

A. CalOptima Health departments, Health Networks and Providers shall refer a PQI to the CalOptima Health QI Department for review and investigation.

B. The QI Department shall log a PQI in CalOptima Health's care management system and appropriately trained and qualified staff, including QI Nurses and CalOptima Health Medical Directors, shall review all PQIs. Goals for the PQI review include improving Member outcomes, reducing errors, and/or enhancing efficiency.

C. The QI Department shall conduct an investigation on the PQI and obtain pertinent documentation as needed to conduct the investigation.

D. CalOptima Health's Chief Medical Officer (CMO) or Designee may refer PQI cases to the CalOptima Health Credentialing and Peer Review Committee (CPRC) for evaluation and action, pursuant to the CalOptima Health Quality Improvement Health Equity Transformation Program (QIHETP).

E. CalOptima Health shall comply with the reporting requirements of the National Practitioner Data Bank, and, as applicable, CalOptima Health's CMO or Designee shall file an 805 or 805.01 Report with the relevant Agency within fifteen (15) days after the effective date of an action of the CPRC, as further described in CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

F. The QI Department shall track, trend, and analyze Provider and Health Network PQI data by issue, action(s), and level of severity monthly to identify emerging patterns.

1. A pattern is defined as two (2) or more Quality of Care (QOC) PQIs, with severity levels one (1), two (2), or three (3) within a six (6) month period.

2. This data shall be reviewed by the CMO or Designee, who shall report any issues and/or emerging patterns to the CalOptima Health CPRC for further evaluation and action, as necessary.

Back to Agenda Back to Item

G. The QI Department shall prepare a summary report of all QI case activities monthly and submit the report for review to the CalOptima Health CPRC.

H. The CPRC shall report a summary of trends and activities to the CalOptima Health Quality Improvement Health Equity Committee (QIHEC) and to the Board of Directors Quality Assurance Committee (QAC) quarterly.

I. CalOptima Health shall maintain confidentiality of QI case review information, in accordance with this policy and applicable privacy and confidentiality laws.

J. PQI cases given a severity level 3 shall send a letter per the following criteria as the recommendation of the Medical Director or CPRC:

1. The Providers contracted with CCN shall receive a letter outlining the findings of the investigation.

2. The Providers who are not contracted with CCN but are contracted with a CalOptima Health Network, shall receive a letter and a letter may be sent to their contracted Health Network requesting its review of the case and a request to provide a response to CPRC at the conclusion of their investigation.

3. For non-contracted Providers, a non-805-reportable letter may be submitted to the State Licensing Board requesting its review of the issue identified by CPRC.

III. PROCEDURE

A. Case Referral and Identification

1. In addition to PQI referrals to CalOptima Health by Providers and Health Networks, a PQI may also be identified and referred to the QI Department from multiple internal sources. Internal sources, include but are not limited to CalOptima Health departments, ~~QI committees~~QIHEC and subcommittees, and QOC related activities such as monitoring, analyzing, and improving processes to enhance Member outcomes, reduce errors, or improve efficiency.

2. For Grievances related to potential QOC issues received from the Grievance and Appeals Resolution Services (GARS) Department, the QI Department shall immediately refer such Grievances to the CMO or Designee for review. This includes declined Grievances where the Member declines to file a Grievance, but a QOC issue is identified in the complaint.

3. Supporting documentation (*e.g.*, correspondence, Grievances, claims data, case management notes) shall accompany the referral.

a. Any entity referring a PQI case shall specify whether the Member chooses to remain anonymous.

B. Process, Review, and Evaluation of PQI Cases

1. PQI cases shall be opened by the CalOptima Health QI Department PQI team to review QOC issues, system issues, and/or administrative issues. PQI cases shall be documented in CalOptima Health's care management system.

a. If the Member chooses to remain anonymous, the case will be flagged as confidential in the care management system.

For 20260206 BOD Review Only

b. The QI Nurse shall request pertinent medical records and a response to the PQI from the appropriate Provider(s) and/or Health Network that rendered medical services or were involved in rendering medical service(s) related to the PQI.

i. Medical records and a response may or may not be able to be obtained for confidential cases to maintain the Member's anonymity.

ii. If a Provider or Health Network fails to respond:

a) CalOptima Health's QI Department, in consultation with a CalOptima Health Medical Director, may take any and all reasonable actions it deems to be in the best interest of the Member, including the issuance of a corrective action plan, pursuant to CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Providers.

iii. Data may also be collected from surveys, incident reports, and other sources to assess QOC and performance.

2. CalOptima Health's QI Department may deem it appropriate to deploy CalOptima Health's copying vendor to copy and obtain medical records.

3. CalOptima Health's QI Department shall analyze medical records and other data~~,~~ and will target case closure within ~~ninety (90~~one hundred and twenty (120) calendar days of receipt of the PQI. The case will be considered closed when it is given an outcome score.

a. QI Nurses may close cases when the following is determined:

i. The case is deemed service-related only; and/or

ii. No QOC or Quality of Service (QOS) issue is identified.

b. Declined Grievances shall be preliminarily reviewed by a CalOptima Health Medical Director within thirty (30) days of when the PQI is opened.

~~.~~c. If the QI Nurse RN does not identify a QOC issue, the case will be reviewed by a second QI Nurse RN, and if the second QI Nurse RN concurs, the case will be given an outcome score, ~~and no further action regarding the PQI review shall occur~~designated with the Action of "No Further Action Required" and/or "Track and Trend" and the case will be closed.

~~5.~~4. If the QI Nurse identifies a QOC issue, the case shall be referred to and reviewed by the CalOptima Health Medical Director, who must address service elements, including accessibility, availability, and continuity of care, and assess whether the provision and utilization of services ~~meets~~meet professionally recognized standards of practice. Based upon the outcome of the review, the reviewer shall assign an outcome score that reflects the severity of the issue and determine if any further action will be taken. The case may be closed by the CalOptima Health Medical Director or be presented to CalOptima Health CPRC for further review and consideration(s).

a. Cases assigned severity Outcome Score 3 will be presented to CPRC for consideration and recommendation of action.

b. Other cases may be presented to CPRC upon CalOptima Health Medical Director's discretion.

For 2026 0206 BOD Review Only

Outcome Score	Description of Outcome Score
0	No Quality-of-Care or Quality-of-Service issue identified.
1	Mild clinical judgment or operational issue with or without an adverse outcome.
2	Moderate clinical judgment or operational issue with or without an adverse outcome.
3	Severe clinical judgment or operational issue with or without an adverse outcome.
S0	Service-related issue, unable to verify.
S1	Service-related issue, verified, resulting in inconvenience or dissatisfaction to the Member.

6. CalOptima Health shall utilize an external review entity when the following occurs:

   a. A specific specialty is required for PQI review and the specialty is not represented by a CalOptima Health Medical Director.

   b. A second opinion is determined to be needed.

7. A CalOptima Health Medical Director or CPRC may recommend and approve further action, including but not limited to:

   ~~.~~a. A corrective action, which may require the Provider to attend a course, provide training to their staff, and/or update policies and procedures;

   ~~.~~b. An educational or best practice letter, which may reference an ~~all plan letter~~All Plan Letter or other regulatory requirement, a CalOptima Health policy, and/or national standard of practice;

   ~~.~~c. An on-site audit of the facility and/or medical records;

   ~~.~~d. Medical records review;

   ~~.~~e. Referral to CalOptima Health Fraud, Waste & Abuse, Contracting, or another internal department;

   ~~.~~f. Referral to a regulatory Agency, including but not limited to a state licensing Agency, the California Department of Public Health, and/or The Joint Commission.

   ~~.~~g. Require other appropriate action(s) as recommended by the CPRC, up to and including the recommendation for administrative or for cause termination per CalOptima Health Policy GG.1616: Fair Hearing Process.

8. The QI Nurse will implement the action(s) under the guidance of a CalOptima Health Medical Director and report back to a CalOptima Health Medical Director when the action is completed.

For 20260806 BOD Review Only

9. Once the PQI review process is completed, a resolution letter will be sent to the Provider or Health Network.

    a. If the case was a confidential case, the Member information will be blinded in the Provider/ Health Network resolution letter.

    b. If the Provider/Health Network disagrees with the determination, the Provider/Health Network may notify CalOptima Health by contacting the QI Department and/or by filing a complaint pursuant to CalOptima Health Policies CC.1202: CalOptima Health Provider Complaint, HH.1101: CalOptima Health Provider Complaint, and MA.9006: Contracted Provider Complaint Process.

C. Reporting Requirements and Follow-up Actions

1. CalOptima Health's CMO or Designee shall file an 805 or 805.01 Report with the relevant agency within fifteen (15) days after the effective date on which any of the following occurs as a result of an action of the CPRC per CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network:

    a. A Licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason.

    b. A Licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.

    c. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more within any twelve (12)-month period, for a medical disciplinary cause or reason.

2. CalOptima Health shall comply with the reporting requirements of the National Practitioner Data Bank in accordance with CalOptima Health policy CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

3. The QI Department shall use statistical methods and quality improvement models to identify trends, gaps, and potential cause(s) of issue(s) to generate trend reports of PQI cases and shall report to the CPRC at least every six (6) months.

4. Patterns that are identified in the trend reports will be presented to CPRC, including any action recommended such as developing strategies to address deficiencies, policy changes, staff training, or new technologies.

5. The QI Department shall submit a report to CPRC of all QOC Practitioner-specific complaint cases referred to QI by the GARS Department, evaluating the Practitioner's history of complaints, every six (6) months.

6. The QI Department shall submit a monthly report to CPRC of all PQI case findings of PQIs closed the previous month, trend reports, and recommended actions to the ~~CalOptima Health~~ CPRC quarterly. The report will include the date opened and closed, date of incident, Provider name, specialty, quality issue, date reported to CPRC, action(s), and level of severity. Cases regarding Practitioners will be blinded on the monthly report.

7. The QI Department shall follow- up on all actions that the CPRC recommends, track compliance (including requesting evidence that corrective actions have been implemented), and report to the CPRC.

For 20260305 BOD Review Only

8. The CalOptima Health QIHEC shall submit quarterly summary reports on behalf of the CPRC to the CalOptima Health Board of Directors' QAC, in accordance with the CalOptima Health QIHETP Plan.

9. The QI Department may extract relevant information from case reviews, including those where no quality issues were identified, for trending, future study, and monitoring impact on health care quality, continuously assessing improvements, and to adjust strategies as needed.

10. The QI Department shall include a summary of the case review findings in the Provider's Credentialing file in accordance with CalOptima Health Policies GG.1650: Credentialing and Recredentialing of Practitioners and GG.1651: Assessment and Reassessment of Organizational Providers.

11. The QI Department shall submit a quarterly report to the Health Networks, reporting all closed PQIs affiliated with the specific Health Network. Members who choose to remain confidential will have their information blinded in the report.

IV. ATTACHMENT(S)

Not Applicable
~~A. Peer Review Conclusion Letter~~

V. REFERENCE(S)

A. California Business and Professions Code, §805 and 1000
B. California Health and Safety Code § 1370
C. CalOptima Health 2025 Quality Improvement Health Equity Transformation Plan
~~B.~~D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
~~C.~~E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for OneCare
~~D.~~F. CalOptima Health Contract with Covered California
~~E.~~G. Covered California Physician Group Services Contract
~~F.~~H. CalOptima Health Policy CC.1202: CalOptima Health Provider Complaint
~~G.~~I. CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Providers
~~H.~~J. CalOptima Health Policy GG.1616: Fair Hearing Process
~~I.~~K. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
~~J.~~L. CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers
~~K.~~M. CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting
~~L.~~N. CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network
~~M.~~O. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
~~N.~~P. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
~~O.A. CalOptima Health 2025 Quality Improvement Health Equity Transformation Plan~~
~~P.~~Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates (Supersedes APL 17-006) (Revised 08/31/2022)
R. Peer Review Conclusion Letter
~~Q.A. California Health and Safety Code § 1370~~
~~R.~~S. Title 22, California Code of Regulations (C.C.R.), § 51051
~~S.~~T. Title 28~~.~~, California Code of Regulations (C.C.R~~.~~.), §§ 1300.70(a)(1) and (3), 1300.70(b)(1)(B) and (C), 1300.70(b)(2)(C), 1300.70(c)
~~T.~~ Title 42, Code of Federal Regulations (C.F.R), § 422.152
U. ~~42 C.F.R. §~~ and 438.330

For 2026 0206 BOD Review Only

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
11/23/2015	Department of Health Care Services (DHCS)	Approved as Submitted
03/28/2016	Department of Health Care Services (DHCS)	Approved as Submitted
06/11/2021	Department of Health Care Services (DHCS)	Approved as Submitted
03/03/2022	Department of Health Care Services (DHCS)	File and Use
10/23/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
03/04/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	05/01/2007	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	01/01/2009	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/2013	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	08/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	11/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	05/01/2017	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	03/04/2021	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	02/01/2022	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	10/01/2023	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	10/01/2024	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	04/01/2025	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare

Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	05/01/2025	GG.1611	Potential Quality Issue Review Process	Covered California Medi-Cal OneCare
Revised		GG.1611	Potential Quality Issue Review Process	Covered California Medi-Cal OneCare

1

For 20260806 BOD Review Only

IX. GLOSSARY

Term	Definition
805 Report	The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body: 1. A Licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason. 2. A Licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.
Agency	The relevant state licensing agency having regulatory jurisdiction over the Licentiates.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider's professional or technical competence, and may include registration, certification, licensure, and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services.
Credentialing Peer Review Committee (CPRC)	The CPRC is CalOptima Health's peer review body and makes decisions, provides guidance, and provides peer input into the CalOptima Health provider selection process and determines corrective action necessary to ensure that all Practitioners and Organizational Providers who provide services to CalOptima Health Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Health Quality Improvement Health Equity Committee.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	Covered California: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.

For 20260806 BOD Review Only

Term	Definition
	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.
Health Network	A physician hospital consortium, physician group under a shared risk contract, health care service plan, such as a health maintenance organization, subcontractor, or first tier entity, that contracts with CalOptima Health to provide covered services to Members.
Licentiate	Physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, licensed midwife, physician assistant, or nurse practitioner practicing pursuant to BPC §§ 2837.103 or 2837.104. Licentiate also includes a person authorized to practice medicine pursuant to BPC §§ 2113 or 2168.
Member	An individual enrolled in a CalOptima Health program.
Organizational Provider	Medi-Cal: Organizations or institutions that are contracted to provide medical services such as hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, end-stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers. OneCare: Hospitals, Intermediate Care Facilities (ICF), Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H), Skilled Nursing Facilities (SNF), sub-acute facilities-adult, sub-acute facilities-pediatric, home health agencies, extended care facility, nursing home, free-standing surgical center, seating clinic, urgent care centers, radiology facilities, laboratory facilities, pathology facilities, and Durable Medical Equipment (DME) vendors.
Peer Review	A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of

For 20260806 BOD Review Only

Term	Definition
	Licentiates to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following: 1. Determine whether a Licentiate may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, determine the parameters of that practice. 2. Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services. 3. Any other activities of a peer review body as specified in the definition of "Peer Review Body" in Business and Professions Code Section 805(a)(1)(b).
Potential Quality Issue (PQI)	For the purposes of this policy, means any issue whereby a Member's quality of care may have been compromised. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Practitioner	For purposes of this Policy, Practitioner means a "Licentiate" as that term is defined in BPC § 805 and specifically a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant and persons authorized to practice medicine pursuant to BPC §§ 2113 or 2168. Practitioner also means an individual who is licensed or otherwise authorized by a state to provide health care services; or any individual who, without authority, holds himself or herself out to be so licensed or authorized as that term is defined in the Health Care Quality Improvement Act of 1986 and its implementing regulations.
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare Members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the Providers of Covered Services under Medicare Part B.
Quality Improvement Health Equity Committee (QIHEC)	A committee facilitated by CalOptima Health's Medical Director, or the Medical Director's Designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.
Quality Improvement (QI) Nurse	For the purposes of this policy, a QI Nurse may be a CalOptima Health QI Registered Nurse (RN) or a CalOptima Health QI Licensed Vocational Nurse (LVN).
Quality of Care (QOC)	The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Quality of Service (QOS)	Medi-Cal: Defined as, adequate access and availability to primary, behavioral health services, specialty health care, and long-term services and supports (LTSS) Providers and services; continuity and coordination of care across all

For 20260806 BOD Review Only

Term	Definition
	care and services settings, and for transitions in care; and Member experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum. OneCare: Service issue resulting in inconvenience or dissatisfaction to Member.
Recredentialing	The process by which the qualifications of Providers is verified in order to make determinations relating to their continued eligibility for participation in CalOptima Health's programs.

1

For 20260806 BOD Review Only

Policy:	GG.1611
Title:	**Potential Quality Issue Review Process**
Department:	Quality Improvement
Section:	Not Applicable
CEO Approval:	*/s/*
Effective Date:	12/01/1999
Revised Date:	
Applicable to:	☐ Administrative ☒ Covered California [Effective 2027] ☒ Medi-Cal ☒ OneCare ☐ PACE

For 20260806 POD Review Only

I. PURPOSE

This policy defines the procedure for reviewing and processing of a Potential Quality Issue (PQI) referred to the CalOptima Health Quality Improvement (QI) Department for any Provider servicing Members.

II. POLICY

A. CalOptima Health departments, Health Networks and Providers shall refer a PQI to the CalOptima Health QI Department for review and investigation.

B. The QI Department shall log a PQI in CalOptima Health's care management system and appropriately trained and qualified staff, including QI Nurses and CalOptima Health Medical Directors, shall review all PQIs. Goals for the PQI review include improving Member outcomes, reducing errors, and/or enhancing efficiency.

C. The QI Department shall conduct an investigation on the PQI and obtain pertinent documentation as needed to conduct the investigation.

D. CalOptima Health's Chief Medical Officer (CMO) or Designee may refer PQI cases to the CalOptima Health Credentialing and Peer Review Committee (CPRC) for evaluation and action, pursuant to the CalOptima Health Quality Improvement Health Equity Transformation Program (QIHETP).

E. CalOptima Health shall comply with the reporting requirements of the National Practitioner Data Bank, and, as applicable, CalOptima Health's CMO or Designee shall file an 805 or 805.01 Report with the relevant Agency within fifteen (15) days after the effective date of an action of the CPRC, as further described in CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

F. The QI Department shall track, trend, and analyze Provider and Health Network PQI data by issue, action(s), and level of severity monthly to identify emerging patterns.

1. A pattern is defined as two (2) or more Quality of Care (QOC) PQIs, with severity levels one (1), two (2), or three (3) within a six (6) month period.

2. This data shall be reviewed by the CMO or Designee, who shall report any issues and/or emerging patterns to the CalOptima Health CPRC for further evaluation and action, as necessary.

Back to Agenda Back to Item

G. The QI Department shall prepare a summary report of all QI case activities monthly and submit the report for review to the CalOptima Health CPRC.

H. The CPRC shall report a summary of trends and activities to the CalOptima Health Quality Improvement Health Equity Committee (QIHEC) and to the Board of Directors Quality Assurance Committee (QAC) quarterly.

I. CalOptima Health shall maintain confidentiality of QI case review information, in accordance with this policy and applicable privacy and confidentiality laws.

J. PQI cases given a severity level 3 shall send a letter per the following criteria as the recommendation of the Medical Director or CPRC:

1. The Providers contracted with CCN shall receive a letter outlining the findings of the investigation.

2. The Providers who are not contracted with CCN but are contracted with a CalOptima Health Network, shall receive a letter and a letter may be sent to their contracted Health Network requesting its review of the case and a request to provide a response to CPRC at the conclusion of their investigation.

3. For non-contracted Providers, a non-805-reportable letter may be submitted to the State Licensing Board requesting its review of the issue identified by CPRC.

III. PROCEDURE

A. Case Referral and Identification

1. In addition to PQI referrals to CalOptima Health by Providers and Health Networks, a PQI may also be identified and referred to the QI Department from multiple internal sources. Internal sources, include but are not limited to CalOptima Health departments, QIHEC and subcommittees, and QOC related activities such as monitoring, analyzing, and improving processes to enhance Member outcomes, reduce errors, or improve efficiency.

2. For Grievances related to potential QOC issues received from the Grievance and Appeals Resolution Services (GARS) Department, the QI Department shall immediately refer such Grievances to the CMO or Designee for review. This includes declined Grievances where the Member declines to file a Grievance, but a QOC issue is identified in the complaint.

3. Supporting documentation (*e.g.*, correspondence, Grievances, claims data, case management notes) shall accompany the referral.

a. Any entity referring a PQI case shall specify whether the Member chooses to remain anonymous.

B. Process, Review, and Evaluation of PQI Cases

1. PQI cases shall be opened by the CalOptima Health QI Department PQI team to review QOC issues, system issues, and/or administrative issues. PQI cases shall be documented in CalOptima Health's care management system.

a. If the Member chooses to remain anonymous, the case will be flagged as confidential in the care management system.

For 20260806 BOD Review Only

b. The QI Nurse shall request pertinent medical records and a response to the PQI from the appropriate Provider(s) and/or Health Network that rendered medical services or were involved in rendering medical service(s) related to the PQI.

i. Medical records and a response may or may not be able to be obtained for confidential cases to maintain the Member's anonymity.

ii. If a Provider or Health Network fails to respond:

a) CalOptima Health's QI Department, in consultation with a CalOptima Health Medical Director, may take any and all reasonable actions it deems to be in the best interest of the Member, including the issuance of a corrective action plan, pursuant to CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Providers.

iii. Data may also be collected from surveys, incident reports, and other sources to assess QOC and performance.

2. CalOptima Health's QI Department may deem it appropriate to deploy CalOptima Health's copying vendor to copy and obtain medical records.

3. CalOptima Health's QI Department shall analyze medical records and other data and will target case closure within one hundred and twenty (120) calendar days of receipt of the PQI. The case will be considered closed when it is given an outcome score.

a. QI Nurses may close cases when the following is determined:

i. The case is deemed service-related only; and/or

ii. No QOC or Quality of Service (QOS) issue is identified.

b. Declined Grievances shall be preliminarily reviewed by a CalOptima Health Medical Director within thirty (30) days of when the PQI is opened.

c. If the QI Nurse RN does not identify a QOC issue, the case will be reviewed by a second QI Nurse RN, and if the second QI Nurse RN concurs, the case will be given an outcome score, designated with the Action of "No Further Action Required" and/or "Track and Trend" and the case will be closed.

4. If the QI Nurse identifies a QOC issue, the case shall be referred to and reviewed by the CalOptima Health Medical Director, who must address service elements, including accessibility, availability, and continuity of care, and assess whether the provision and utilization of services meet professionally recognized standards of practice. Based upon the outcome of the review, the reviewer shall assign an outcome score that reflects the severity of the issue and determine if any further action will be taken. The case may be closed by the CalOptima Health Medical Director or be presented to CalOptima Health CPRC for further review and consideration(s).

a. Cases assigned severity Outcome Score 3 will be presented to CPRC for consideration and recommendation of action.

b. Other cases may be presented to CPRC upon CalOptima Health Medical Director's discretion.

For 20260206 BOD Review Only

Outcome Score	Description of Outcome Score
0	No Quality-of-Care or Quality-of-Service issue identified.
1	Mild clinical judgment or operational issue with or without an adverse outcome.
2	Moderate clinical judgment or operational issue with or without an adverse outcome.
3	Severe clinical judgment or operational issue with or without an adverse outcome.
S0	Service-related issue, unable to verify.
S1	Service-related issue, verified, resulting in inconvenience or dissatisfaction to the Member.

6. CalOptima Health shall utilize an external review entity when the following occurs:

   a. A specific specialty is required for PQI review and the specialty is not represented by a CalOptima Health Medical Director.

   b. A second opinion is determined to be needed.

7. A CalOptima Health Medical Director or CPRC may recommend and approve further action, including but not limited to:

   a. A corrective action, which may require the Provider to attend a course, provide training to their staff, and/or update policies and procedures;

   b. An educational or best practice letter, which may reference an All Plan Letter or other regulatory requirement, a CalOptima Health policy, and/or national standard of practice;

   c. An on-site audit of the facility and/or medical records;

   d. Medical records review;

   e. Referral to CalOptima Health Fraud, Waste & Abuse, Contracting, or another internal department;

   f. Referral to a regulatory Agency, including but not limited to a state licensing Agency, the California Department of Public Health, and/or The Joint Commission.

   g. Require other appropriate action(s) as recommended by the CPRC, up to and including the recommendation for administrative or for cause termination per CalOptima Health Policy GG.1616: Fair Hearing Process.

8. The QI Nurse will implement the action(s) under the guidance of a CalOptima Health Medical Director and report back to a CalOptima Health Medical Director when the action is completed.

9. Once the PQI review process is completed, a resolution letter will be sent to the Provider or Health Network.

For 20260806 BOD Review Only

a. If the case was a confidential case, the Member information will be blinded in the Provider/ Health Network resolution letter.

b. If the Provider/Health Network disagrees with the determination, the Provider/Health Network may notify CalOptima Health by contacting the QI Department and/or by filing a complaint pursuant to CalOptima Health Policies CC.1202: CalOptima Health Provider Complaint, HH.1101: CalOptima Health Provider Complaint, and MA.9006: Contracted Provider Complaint Process.

C. Reporting Requirements and Follow-up Actions

1. CalOptima Health's CMO or Designee shall file an 805 or 805.01 Report with the relevant agency within fifteen (15) days after the effective date on which any of the following occurs as a result of an action of the CPRC per CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network:

   a. A Licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason.

   b. A Licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.

   c. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of thirty (30) days or more within any twelve (12)-month period, for a medical disciplinary cause or reason.

2. CalOptima Health shall comply with the reporting requirements of the National Practitioner Data Bank in accordance with CalOptima Health policy CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting.

3. The QI Department shall use statistical methods and quality improvement models to identify trends, gaps, and potential cause(s) of issue(s) to generate trend reports of PQI cases and shall report to the CPRC at least every six (6) months.

4. Patterns that are identified in the trend reports will be presented to CPRC, including any action recommended such as developing strategies to address deficiencies, policy changes, staff training, or new technologies.

5. The QI Department shall submit a report to CPRC of all QOC Practitioner-specific complaint cases referred to QI by the GARS Department, evaluating the Practitioner's history of complaints, every six (6) months.

6. The QI Department shall submit a monthly report to CPRC of all PQI case findings of PQIs closed the previous month, trend reports, and recommended actions to the CPRC quarterly. The report will include the date opened and closed, date of incident, Provider name, specialty, quality issue, date reported to CPRC, action(s), and level of severity. Cases regarding Practitioners will be blinded on the monthly report.

7. The QI Department shall follow up on all actions that the CPRC recommends, track compliance (including requesting evidence that corrective actions have been implemented), and report to the CPRC.

For 20260806 BOD Review Only

8. The CalOptima Health QIHEC shall submit quarterly summary reports on behalf of the CPRC to the CalOptima Health Board of Directors' QAC, in accordance with the CalOptima Health QIHETP Plan.

9. The QI Department may extract relevant information from case reviews, including those where no quality issues were identified, for trending, future study, and monitoring impact on health care quality, continuously assessing improvements, and to adjust strategies as needed.

10. The QI Department shall include a summary of the case review findings in the Provider's Credentialing file in accordance with CalOptima Health Policies GG.1650: Credentialing and Recredentialing of Practitioners and GG.1651: Assessment and Reassessment of Organizational Providers.

11. The QI Department shall submit a quarterly report to the Health Networks, reporting all closed PQIs affiliated with the specific Health Network. Members who choose to remain confidential will have their information blinded in the report.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Business and Professions Code, §805 and 1000
B. California Health and Safety Code § 1370
C. CalOptima Health 2025 Quality Improvement Health Equity Transformation Plan
D. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
E. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for OneCare
F. CalOptima Health Contract with Covered California
G. Covered California Physician Group Services Contract
H. CalOptima Health Policy CC.1202: CalOptima Health Provider Complaint
I. CalOptima Health Policy GG.1615: Corrective Action Plan for Practitioners and Organizational Providers
J. CalOptima Health Policy GG.1616: Fair Hearing Process
K. CalOptima Health Policy GG.1650: Credentialing and Recredentialing of Practitioners
L. CalOptima Health Policy GG.1651: Assessment and Reassessment of Organizational Providers
M. CalOptima Health Policy GG.1657: State Licensing Board and the National Practitioner Data Bank (NPDB) Reporting
N. CalOptima Health Policy GG.1658: Summary Suspension or Restriction of Practitioner Participation in CalOptima Health's Network
O. CalOptima Health Policy HH.1101: CalOptima Health Provider Complaint
P. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates (Supersedes APL 17-006) (Revised 08/31/2022)
R. Peer Review Conclusion Letter
S. Title 22, California Code of Regulations (C.C.R.), § 51051
T. Title 28, California Code of Regulations (C.C.R.), §§ 1300.70(a)(1) and (3), 1300.70(b)(1)(B) and (C), 1300.70(b)(2)(C), 1300.70(c)
U. Title 42, Code of Federal Regulations (C.F.R), § 422.152 and 438.330

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
11/23/2015	Department of Health Care Services (DHCS)	Approved as Submitted

For 20260205 BOD Review Only

03/28/2016	Department of Health Care Services (DHCS)	Approved as Submitted
06/11/2021	Department of Health Care Services (DHCS)	Approved as Submitted
03/03/2022	Department of Health Care Services (DHCS)	File and Use
10/23/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
03/04/2021	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	12/01/1999	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	05/01/2007	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	01/01/2009	GG.1611	Potential Quality Issue Review Process	Medi-Cal
Revised	03/01/2013	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	08/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	11/01/2015	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	05/01/2017	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	03/04/2021	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	02/01/2022	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare OneCare Connect
Revised	12/31/2022	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	10/01/2023	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	10/01/2024	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	04/01/2025	GG.1611	Potential Quality Issue Review Process	Medi-Cal OneCare
Revised	05/01/2025	GG.1611	Potential Quality Issue Review Process	Covered California Medi-Cal OneCare
Revised		GG.1611	Potential Quality Issue Review Process	Covered California Medi-Cal OneCare

Only

F

IX. GLOSSARY

Term	Definition
805 Report	The written report required under BPC § 805 (b), which requires that the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body: 1. A Licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason. 2. A Licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason. Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.
Agency	The relevant state licensing agency having regulatory jurisdiction over the Licentiates.
Credentialing	Covered California: The initial process by which the qualifications of a Provider is verified in order to make a determination relating to the Provider's eligibility for participation in CalOptima Health's programs. Medi-Cal: The process of determining a Provider's professional or technical competence, and may include registration, certification, licensure, and professional association membership. OneCare: The process of obtaining, verifying, assessing, and monitoring the qualifications of a Provider to provide quality and safe patient care services.
Credentialing Peer Review Committee (CPRC)	The CPRC is CalOptima Health's peer review body and makes decisions, provides guidance, and provides peer input into the CalOptima Health provider selection process and determines corrective action necessary to ensure that all Practitioners and Organizational Providers who provide services to CalOptima Health Members meet generally accepted standards for their profession in the industry. The CPRC meets at least quarterly and reports to the CalOptima Health Quality Improvement Health Equity Committee.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Grievance	Covered California: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance.

For 20260806 BOD Review Only

Term	Definition
	Medi-Cal: Any expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD), and may include, but is not limited to the Quality of Care or services provided, aspects of interpersonal relationships with a Provider or CalOptima Health's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima Health to make an authorization decision. A complaint is the same as Grievance. An inquiry is a request for more information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other CalOptima Health processes. If CalOptima Health is unable to distinguish between a Grievance and an inquiry, it must be considered a Grievance. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.
Health Network	A physician hospital consortium, physician group under a shared risk contract, health care service plan, such as a health maintenance organization, subcontractor, or first tier entity, that contracts with CalOptima Health to provide covered services to Members.
Licentiate	Physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, licensed midwife, physician assistant, or nurse practitioner practicing pursuant to BPC §§ 2837.103 or 2837.104. Licentiate also includes a person authorized to practice medicine pursuant to BPC §§ 2113 or 2168.
Member	An individual enrolled in a CalOptima Health program.
Organizational Provider	Medi-Cal: Organizations or institutions that are contracted to provide medical services such as hospitals, home health agencies, nursing facilities (includes skilled nursing, long term care, and sub-acute), free standing ambulatory surgical centers, hospice services, community clinics including Federally Qualified Health Centers, urgent care centers, end-stage renal disease services (dialysis centers), Residential Care Facility for the Elderly (RCFE), Community Based Adult Services (CBAS), durable medical equipment suppliers, radiology centers, clinical laboratories, outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, diabetes centers, portable x-ray suppliers. OneCare: Hospitals, Intermediate Care Facilities (ICF), Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H), Skilled Nursing Facilities (SNF), sub-acute facilities-adult, sub-acute facilities-pediatric, home health agencies, extended care facility, nursing home, free-standing surgical center, seating clinic, urgent care centers, radiology facilities, laboratory facilities, pathology facilities, and Durable Medical Equipment (DME) vendors.
Peer Review	A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of Licentiates to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following:

For 20260805 BOD Review Only

Term	Definition
	1. Determine whether a Licentiate may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, determine the parameters of that practice. 2. Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services. 3. Any other activities of a peer review body as specified in the definition of "Peer Review Body" in Business and Professions Code Section 805(a)(1)(b).
Potential Quality Issue (PQI)	For the purposes of this policy, means any issue whereby a Member's quality of care may have been compromised. PQIs require further investigation to determine whether an actual quality issue or opportunity for improvement exists.
Practitioner	For purposes of this Policy, Practitioner means a "Licentiate" as that term is defined in BPC § 805 and specifically a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant and persons authorized to practice medicine pursuant to BPC §§ 2113 or 2168. Practitioner also means an individual who is licensed or otherwise authorized by a state to provide health care services; or any individual who, without authority, holds himself or herself out to be so licensed or authorized as that term is defined in the Health Care Quality Improvement Act of 1986 and its implementing regulations.
Provider	Covered California: A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services. Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare Members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the Providers of Covered Services under Medicare Part B.
Quality Improvement Health Equity Committee (QIHEC)	A committee facilitated by CalOptima Health's Medical Director, or the Medical Director's Designee, in collaboration with the Health Equity officer, that meets at least quarterly to direct all Quality Improvement and Health Equity Transformation Program (QIHETP) findings and required actions.
Quality Improvement (QI) Nurse	For the purposes of this policy, a QI Nurse may be a CalOptima Health QI Registered Nurse (RN) or a CalOptima Health QI Licensed Vocational Nurse (LVN).
Quality of Care (QOC)	The degree to which health services for Members and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Quality of Service (QOS)	Medi-Cal: Defined as, adequate access and availability to primary, behavioral health services, specialty health care, and long-term services and supports (LTSS) Providers and services; continuity and coordination of care across all care and services settings, and for transitions in care; and Member experience

For 20260806 BOD Review Only

Term	Definition
	and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum. OneCare: Service issue resulting in inconvenience or dissatisfaction to Member.
Recredentialing	The process by which the qualifications of Providers is verified in order to make determinations relating to their continued eligibility for participation in CalOptima Health's programs.

1

For 20260806 BOD Review Only

CalOptima Health, A Public Agency
Quality Improvement Department
505 City Parkway West
Orange, CA 92868
Fax: 657-900-1615
Email: qualityofcare@caloptima.org

Quality Improvement Department

Potential Quality of Care Issue

[date printed]

[name]
[address]
[city, state, zip]

Case Number: XXXXXXX

Peer Review Conclusion

Dear [name],

The CalOptima Health recently reviewed the case below. After reviewing the member complaint and your response, the case was leveled [severity code and severity code and severity code description] and was closed on [date].

Member Name	Member DOB	Member ID	

PQI Type	PQI Category	PQI Sub-category	Date of Incident	Place of Incident	Severity	Action	Resolution Date/Time

Confidential Case*: [ ]

Please contact Laura Guest, RN, ANP, Quality Improvement Manager, if you have any questions at **(657) 900-1122**. Thank you for your commitment and continued efforts to deliver quality service to the communities we serve.

Sincerely,
Mohini Sinha, M.D.
Medical Director, Quality
qualityofcare@caloptima.org

* Confidential cases are those cases where the member chooses to remain anonymous, or the member does not want to file a grievance. CalOptima Health

Attachment Retired - Moved to References

CalOptima Health, A Public Agency
Quality Improvement Department
505 City Parkway West
Orange, CA 92868
Fax: 657-900-1615
Email: qualityofcare@caloptima.org

representatives believe there is a quality-of-care component to the issue, so the case is referred to Quality Improvement for review.

Attachment Retired - Moved to References

Quality Policy Updates

CalOptima Health Board of Directors

August 6, 2026

Linda Lee, Executive Director, Quality Improvement

Our Mission

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

Our Vision

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

Annual Policy Review of GG.1611: Potential Quality Issue (PQI) Review Process

- Summary of key updates:
  - Expanded language to clarify policy covers “805.01,” reporting, ensuring alignment with regulatory requirements for reporting and oversight
  - Target PQI case closure timeframe extended from 90 days to 120 days.
  - Clarified that Quality of Service (QOS) cases closed by QI Nurses undergo review by two RNs prior to closure
  - Updated contact from a named individual to a centralized inbox: qualityofcare@caloptima.org

CalOptima Health

Annual Policy Review of GG.1611: Potential Quality Issue Review Process Continued

- Summary of key updates continued:
  - For Severity Level 3 potential quality issues, notification processes were clarified:
    - Contracted CHCN providers: Receive a formal letter outlining investigation findings.
    - Non-CHCN providers contracted with a CalOptima Health network: Receive a letter, and their network is formally requested to review the case and respond to the Credentialing and Peer Review Committee (CPRC) upon completion.
    - Non-contracted providers: A non-805-reportable letter is submitted to the appropriate State Licensing Board requesting review of the concern

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 6, 2026
Regular Meeting of the CalOptima Health Board of Directors'

Report Item

11. Approve Reallocation of Remaining Non-monetary Gift Cards

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Actions

1. Approve the reallocation of the remaining non-monetary gift cards totaling $16,425 from the Medi-Cal COVID-19 Member Vaccination Incentive Program to the Calendar Year 2026 Medi-Cal Member Health Rewards Program.
2. Approve the reallocation of the remaining non-monetary gift cards totaling $2,750 from the OneCare COVID-19 Member Vaccination Incentive Program and $65,600 from the OneCare Calendar Year 2024 Member Health Rewards Program to the Calendar Year 2026 OneCare Member Health Rewards Program.

Background

On November 3, 2022, the Board of Directors (Board) approved extending CalOptima Health's Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP) for Medi-Cal, OneCare (OC) and OneCare Connect (OCC), and authorized expenditures for additional $25 non-monetary gift cards for the program. The program ended on December 31, 2023. An inventory of $25 gift cards remains unused from the program as follows:

- 657 gift cards totaling $16,425 for Medi-Cal; and
- 110 gift cards totaling $2,750 for OC.

On November 2, 2023, the Board approved CalOptima Health's Calendar Year (CY) 2024 Member Health Rewards (MHR) for Medi-Cal and OC. The OC MHR Program included rewards for annual wellness visit (AWV), breast cancer screening, colorectal cancer screening, diabetes A1c test, diabetes eye exam, osteoporosis management, and Health Risk Assessment.

For CY 2024, the OC MHR Program utilized physical gift cards to incentivize member participation. In 2024, the AWV MHR was based on passive identification, meaning members who completed the AWV were automatically recognized and qualified for the reward through claim and encounter data. In Quarter 4 of 2024, staff were notified of data enhancements that could increase the number of eligible members, prompting the purchase of additional gift card inventory in anticipation of higher participation. This measure was taken to ensure that the OC MHR Program maintained adequate inventory to reward all eligible and participating members in a timely manner. An inventory of 2,624 gift cards totaling $65,600 remains unused from the program.

On August 1, 2024, the Board approved CalOptima Health's CY 2025 MHR for Medi-Cal and OC, which maintained the same OC rewards as CY 2024. For CY 2025, efforts were made to transition the

Back to Agenda

OC MHR Program to a flex card model to minimize the turnaround time for rewarding members.

On November 6, 2025, the Board approved the CY 2026 MHR for Medi-Cal and OC, which continued the OC rewards from the year prior with minor revisions to expand qualifying criteria and enhance ease of participation for members. The flex card reward model adopted in CY 2025 remains the primary reward mechanism in CY 2026.

Discussion

Staff recommends the Board approve the following:

- Medi-Cal: Staff requests reallocation of the remaining Medi-Cal COVID-19 VIP non-monetary gift card inventory to the CY 2026 Medi-Cal MHR Program, approved by the Board on November 6, 2025.
- OneCare: Staff requests reallocation of the remaining non-monetary gift card inventory from the OC COVID-19 VIP program and the CY 2024 OC MHR Program to the CY 2026 OC MHR Program.

The gift cards will be utilized by staff and/or vendor partners to provide member incentives pursuant to the type and amount of the member health rewards in the Board-approved CY 2026 Medi-Cal and OC MHR Program. These member incentives include completion of plan-approved quality services and screenings, such as completion of an AWV, completion of a Health Risk Assessment, or completion of a quality care gap, such as a breast cancer screening mammogram, blood lead test, diabetes A1c test and eye exam, cervical cancer screening, colorectal cancer screening, osteoporosis screening, and postpartum checkup.

Staff will oversee the gift card inventory and monitor program activity and completion, ensuring all cards issued for these services are closely tracked and reconciled.

Table 3. Release and Distribution

From:	To:	Number of Gift Cards	Total
Medi-Cal COVID-19 VIP Program	CY 2026 Medi-Cal MHR Program	657	$16,425
	Medi-Cal Subtotal	***657***	***$16,425***
OC COVID-19 VIP Program	CY 2026 OC MHR Program	110	$2,750
CY 2024 OC MHR Program	CY 2026 OC MHR Program	2,624	$65,600
	OC Subtotal	**2,734**	***$68,350***

Fiscal Impact

The reallocation of the remaining Medi-Cal and OC non-monetary gift card inventory will have no net fiscal impact on CalOptima Health Operating Budgets.

Back to Agenda

Rationale for Recommendation

The non-monetary gift cards were previously designated for programs that have since concluded. To maximize organizational resources and enhance member engagement, staff recommends that the remaining gift card inventory be repurposed for the current, Board-approved MHR Program. This strategic realignment will directly support efforts to improve member experience, strengthen the primary care provider-patient relationship, and improve the quality of care delivered to CalOptima Health members. By incentivizing preventive care, early detection, chronic disease management, and facilitating opportunities to coordinate care through AWV, this approach aligns with CalOptima Health's commitment to delivering comprehensive, high-quality healthcare.

Concurrence

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

Attachment

1. Approve Modifications to CalOptima Health's Coronavirus (COVID-19) Member Vaccination Incentive Program
2. Approve CalOptima Health's CY 2024 Member Health Rewards
3. Approve CalOptima Health's CY 2025 Member Health Rewards
4. Approve CalOptima Health's CY 2026 Member Health Rewards

Prior Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
January 7, 2021	Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for CY 2021	CY 2021	$20 million
March 4, 2021	Consider Ratification and Authorization of Additional Unbudgeted Expenditures Related to COVID-19 Member VIP + fiscal impact	CY 2022	$695,974
December 20, 2021	Consider Authorizing an Extension of CalOptima Health's Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP) for CY 2022	CY 2022	Original funding level of $35 million
November 3, 2022	Approve Modifications to CalOptima Health's Coronavirus (COVID-19) Member Vaccination Incentive Program	CY 2023	$550,000
November 2, 2023	Approve CalOptima Health's Calendar Year 2024 Member Health Rewards for Medi-Cal and OneCare.	CY 2024	Medi-Cal: $4.76 million, OneCare: $550,000

Back to Agenda

August 1, 2024	Approve CalOptima Health's Calendar Year 2025 Member Health Rewards for Medi-Cal and OneCare.	CY 2025	Medi-Cal: $4.87 million, OneCare: $660,000
November 6, 2025	Approve CalOptima Health's CY 2026 Member Health Rewards for Medi-Cal and OneCare	CY 2026	Medi-Cal: $6.3 million, OneCare: $1.0 million

/s/ Michael Hunn *07/28/2026*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2022
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

5. Approve Modifications to CalOptima Health's Coronavirus (COVID-19) Member Vaccination Incentive Program

Contacts

Marie Jeannis, RN, Executive Director, Quality & Population Health Management, (714) 246-8591
Katie Balderas, Director, Population Health Management, (657) 235-6907

Recommended Actions

1. Authorize extending CalOptima Health's Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP) for Medi-Cal, One Care (OC) and One Care Connect (OCC) members through end of the fiscal year, June 30, 2023;
2. Authorize modification to CalOptima Health's COVID-19 Member VIP to provide up to four (4) $25 non-monetary gift cards to eligible Medi-Cal, OC, and OCC members for receiving up to four (4) required doses of the COVID-19 vaccine; and;
3. Authorize unbudgeted expenditures in an amount up to $550,000 from existing reserves for the COVID-19 Member VIP for eligible OC and OCC members.

Background

On January 7, 2021, the CalOptima Health Board of Directors allocated $35 million in IGT 10 funds for CalOptima Health's COVID-19 VIP. The program included member health rewards for eligible members to receive a $25 gift card per vaccine, for a maximum of $50 per member. On March 4, 2021, the Board authorized unbudgeted expenditures in an amount up to $695,974 from existing reserves to include OC and OCC members in the COVID-19 VIP.

On December 20, 2021, the Board extended the COVID-19 VIP through calendar year (CY) 2022 and included provisions for $25 non-monetary gift cards for members receiving the two required doses of the COVID-19 vaccine (one gift card per shot) and receiving a single COVID-19 booster shot.

The Food and Drug Administration (FDA) has continued to authorize the COVID-19 vaccine to include additional age groups:

- In June 2022, the FDA approved a primary three dose series of the Pfizer vaccine for children six months to four years old.
- In August 2022, the FDA approved one dose of the bivalent booster for ages 12 years and older.

Discussion

Since the COVID-19 vaccine approval in 2021, CalOptima Health has engaged in multi-faceted outreach strategies to close vaccination gaps for members. Activities to engage and motivate members have included outbound calls to targeted populations and homebound members, hosting vaccination clinics in collaboration with Orange County Health Care Agency (OCHCA), social media, direct mail, texting campaigns, and partnering with trusted messengers to address vaccine hesitancy. The non-monetary gift cards have promoted vaccine adherence and motivated members to participate in

Back to Agenda

Back to Item

vaccination clinics. Although the CalOptima Health has made great strides in vaccination, staff believes that CalOptima Health must continue outreach to the community to increase awareness and encourage vaccination.

CalOptima Health members are currently eligible for a maximum of two $25 non-monetary gift cards and a booster (one gift card per shot) based on current Board approvals. However, that does not include an additional $25 non-monetary gift card for the third primary dose approved for children 6 months to 4 years and bivalent booster. Staff recommends the approval of up to four gift cards per eligible member and extending the COVID-19 VIP until the end of the fiscal year, June 30, 2023. A CalOptima Health member who receives a primary COVID-19 vaccine dose on or before June 30, 2023, will be eligible to receive $25 non-monetary incentives for COVID-19 vaccine doses received by December 31, 2023, up to four (one per dose). The current recommendations are budget neutral because the funds are already allocated, and staff will continue to monitor COVID-19 vaccinations trends and available funding.

OC and OCC populations are not eligible for IGT dollars as Medicare is their primary health insurance coverage. Staff recommends application of the same program modifications and the extension of the program end date through June 30, 2023, to eligible members within the OC and OCC programs. The total estimated cost is $550,000 through June 30, 2023. Staff requests that the Board authorize the use of existing reserves to fund these additional costs. Of note, OC and OCC members residing in long-term care settings and PACE members are excluded from the COVID-19 Member VIP.

Fiscal Impact

Medi-Cal Program Fiscal Impact:
The recommended action to authorize revisions to and extension of the CalOptima Health Member VIP through June 30, 2023, has no net fiscal impact to the CalOptima Health Fiscal Year 2022-23 Operating Budget approved by the Board on June 2, 2022.

As of September 30, 2022, approximately $27.9 million of the $35 million in IGT 10 funds allocated by the Board for the CalOptima Health Member VIP program has been spent. Staff anticipates the remaining $7.1 million in IGT 10 funds will be sufficient to cover program expenses through June 30, 2023. Expenditure of these IGT funds is for covered services to Medi-Cal members and does not commit CalOptima Health to future budget allocations.

OC and OCC Program Fiscal Impact:
The recommended action to authorize revisions to and extension of the CalOptima Health Member VIP for eligible OC and OCC members is an unbudgeted item. An allocation of up to $550,000 from existing reserves will fund these actions.

Rationale for Recommendation

CalOptima Health is committed to improving COVID-19 vaccination rates and promoting member engagement. The recommended actions will allow staff to continue outreaching to unvaccinated members, provide member incentives, and support overall vaccination efforts.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Back to Agenda

Back to Item

Attachments
None.

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
January 7, 2021	Consider Authorizing Coronavirus (COVID-19) Vaccination Member Incentive Program for Calendar Year 2021	Calendar Year (CY) 2021	$20 million
March 4, 2022	Consider Ratification and Authorization of Additional Unbudgeted Expenditures Related to COVID-19 Member VIP + fiscal impact	Calendar Year 2022 (CY 2022)	$695,974
December 20, 2021	Consider Authorizing an Extension of CalOptima Health's Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP) for Calendar Year 2022	Calendar Year 2022 (CY 2022)	Original funding level of $35 million

/s/ Michael Hunn *10/27/2022*
Authorized Signature **Date**

Back to Agenda

Back to Item

CalOptima Health Board Action Agenda Referral

Action To Be Taken November 2, 2023
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

4. Approve CalOptima Health's Calendar Year 2024 Member Health Rewards

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Action

1. Approve CalOptima Health's Calendar Year 2024 Member Health Rewards for Medi-Cal and OneCare.

Background

CalOptima Health provides health rewards and incentives in the form of physical gift cards to eligible members to improve member health and quality outcomes. In calendar year 2023, CalOptima Health provided members with health rewards for preventive services in both Medi-Cal and OneCare, including breast cancer screening, cervical cancer screening, colorectal cancer screening, diabetes tests, postpartum care, osteoporosis testing, and annual wellness visits.

Discussion

Health rewards and incentives (R&I) motivate members to establish primary care relationships and get recommended preventive care and screenings. Rewards may encourage members to receive important tests and reinforce health behaviors. Incentives were selected based on clinical areas with the largest opportunity for improvement and those measures where CalOptima Health had performed below established benchmarks.

Staff recommends maintaining the following incentives from 2023 for calendar year 2024:

Medi-Cal	OneCare
Annual Wellness Visit- $50	Annual Wellness Visit- $50
Breast Cancer Screening- $25	Breast Cancer Screening- $25
Cervical Cancer Screening- $25	Colorectal Cancer Screening (colonoscopy)- $50
Diabetes A1c Test- $25	Diabetes A1c Test- $25
Diabetes Eye Exam- $25	Diabetes Eye Exam- $25
Postpartum Check Up- $50	Osteoporosis Management for Members with a Fracture- $25

Back to Agenda

Back to Item

Staff also recommends adding incentives for the following:

Medi-Cal	OneCare
Colorectal Cancer Screening (colonoscopy)- $50	Health Risk Assessment- $25
Lead Screening- $25	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications-$25	
Follow-Up Care for Children Prescribed ADHD Medication- $25	

Members will receive R&I gift cards contingent upon complete member encounters with appropriate and complete coding. At the time of budgeting, staff assumed a member participation rate of 15% based on past participation rates and an anticipated increase in member participation. In the event participation rates are higher than assumed and exceed the budgeted amounts, staff will return to the Board for additional funding requests at future meetings.

Fiscal Impact

The total estimated cost for the calendar year 2024 member health reward program is $4.76 million for Medi-Cal and $550,000 for OneCare. Funding for the recommended action for the period of January 1, 2024, through June 30, 2024, is a budgeted item under the CalOptima Health Fiscal Year (FY) 2023-24 Operating Budget. Management will include expenses for the period of July 1, 2024, through December 31, 2024, in the FY 2024-25 Operating Budget.

Rationale for Recommendation

A member health reward program will strengthen the primary care provider-patient relationship, improve the quality of care delivered to CalOptima Health members by promoting preventive care, early identification, chronic care management, and identify opportunities to coordinate care based on an annual wellness visit.

Concurrence

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

Attachment

None.

/s/ Michael Hunn *10/27/2023*
Authorized Signature **Date**

Back to Agenda

Back to Item

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 1, 2024
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

5. Approve CalOptima Health's Calendar Year 2025 Member Health Rewards

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Action

Approve CalOptima Health's Calendar Year 2025 Member Health Rewards for Medi-Cal and OneCare.

Background

CalOptima Health provides health rewards to members in the form of physical gift cards and plans to explore providing digital e-card and flex card reward options to eligible members to improve member health and quality outcomes. In calendar year (CY) 2024, CalOptima Health provided Medi-Cal and OneCare members with health rewards for preventive services, including annual wellness visit, blood lead test(s), breast cancer screening, cervical cancer screening, colorectal cancer screening, diabetes tests (multiple), postpartum care, osteoporosis testing, and follow-up care for children prescribed ADHD medication. Member incentives are awarded based on provider attestations using an incentive form and passive rewards based on qualifying claims and encounter data.

Medi-Cal

The Medi-Cal member health rewards program utilizes both provider attestations and passive rewards to issue incentives. Annual wellness visits, health risk assessment, and diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications are historically passively rewarded incentives. The remaining member incentives require a provider attestation.

OneCare

For OneCare members, staff has discussed leveraging a preloaded "flex card" (debit card), to directly reward members for their participation in health rewards program activities. Currently, the OneCare member health rewards program is a passively rewarded program, where members are identified through claims and encounters data and are automatically issued a member health reward. Since there is no provider attestation and form submission required, adapting the reward process to payout through the flex card will increase health reward processing efficiency and minimize turnaround time for members to receive their rewards. CalOptima Health's OneCare flex benefit vendor has the capability to include member health rewards in the flex card for CY 2025. CalOptima Health plans to implement member health rewards in the flex card starting 2025 and will evaluate program effectiveness.

Discussion

Health rewards motivate members to establish primary care relationships and get recommended preventive care and screenings. Rewards may encourage members to receive important tests and reinforce health behaviors. Health rewards were selected based on clinical areas with the largest opportunity for improvement and those measures where CalOptima Health has performed below established benchmarks.

Back to Agenda

Back to Item

Staff recommends maintaining the following health rewards from CY 2024 for CY 2025:

Current	
Medi-Cal	**OneCare**
Annual Wellness Visit- $50	Annual Wellness Visit- $50
Blood Lead Test 12 Months of Age- $25	Breast Cancer Screening- $25
Blood Lead Test 24 Months of Age- $25	Colorectal Cancer Screening- $50
Breast Cancer Screening- $25	Diabetes A1c Test- $25
Cervical Cancer Screening- $25	Diabetes Eye Exam- $25
Colorectal Cancer Screening- $50	Health Risk Assessment- $25
Diabetes A1c Test- $25	Osteoporosis Screening- $25
Diabetes Eye Exam- $25	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications- $25	
Follow-up Care for Children Prescribed ADHD Medication- $25	
Postpartum Checkup- $50	

Staff also recommends revising the following health rewards for CY 2025. This includes piloting the change from attestation-based to passive identification and rewarding to enhance member experience for Blood Lead Test and to reduce the reward amount from $50 to $25 for Postpartum Checkup to align with other Medi-Cal rewards.

Changes	
Medi-Cal	**OneCare**
Blood Lead Test 12 Months of Age (change rewarding to passive)	N/A
Blood Lead Test 24 Months of Age (change rewarding to passive)	
Postpartum Checkup- $25 (decrease reward value)	

Members will receive health reward gift cards contingent upon completed member encounters with appropriate and complete coding. At the time of budgeting, staff assumed a member participation rate of 15%* based on past participation rates and an anticipated increase in member participation. In the event participation rates are higher than assumed and exceed the budgeted amounts, staff will return to the Board of Directors for additional funding requests at future meetings.

**For passive health rewards: Blood Lead Test 12 and 24 Months (Medi-Cal) participation rate is assumed at 62.79%, which is the current DHCS minimum performance level. Health Risk Assessment (OneCare) participation rate is assumed at 75% as aligned with the current CMS 4-star rating. Annual Wellness Visit (Medi-Cal and OneCare) participation rate is assumed at 15% as aligned with Medi-Cal DHCS Member Incentive goal and previous year's participation rate. Diabetes Screening for People*

with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (Medi-Cal) participation rate is assumed at 79.05%, which is the current DCHS minimum performance level.

Fiscal Impact

Medi-Cal:

The estimated cost for CY 2025 Medi-Cal Member Health Rewards program is $4.87 million. Funding included in the proposed CalOptima Health Fiscal Year (FY) 2024-25 Operating Budget and unearned funds from the Measurement Year 2023 Medi-Cal Pay for Value Performance program will be sufficient to fund the program.

OneCare:

The estimated cost for CY 2025 OneCare Member Health Rewards program is $660,000 and is a budgeted item in the proposed FY 2024-25 Operating Budget. Management will include expenses for the period of July 1, 2025, through December 31, 2025, in the FY 2025-26 Operating Budget.

Rationale for Recommendation

A member health reward program will strengthen the primary care provider-patient relationship, improve the quality of care delivered to CalOptima Health members by promoting preventive care, early identification, chronic care management, and identify opportunities to coordinate care based on an annual wellness visit.

Concurrence

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

Attachment

1. Calendar Year 2025 Member Health Rewards for Medi-Cal and OneCare Presentation

/s/ Michael Hunn *07/25/2024*
Authorized Signature **Date**

Back to Agenda

Back to Item

Calendar Year 2025 Member Health Rewards for Medi-Cal and OneCare

Quality Assurance Committee Meeting

June 12, 2024

Linda M. Lee, Executive Director, Quality Improvement

Our Mission

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

Our Vision

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.

Current 2024 Member Health Reward Program

- CalOptima Health provides health rewards and incentives to members for completing preventive services
- Rewards in the form of retailer physical gift cards
  - Exploring digital e-cards and flex card reward options
- OneCare member health rewards are passively rewarded
  - Reward is based on identified claims and encounters
  - Health Risk Assessment (OC only), Annual Wellness Visit (MC and OC), and Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (MC only) are passively rewarded.
- Medi-Cal member health rewards are attestation-based
  - Reward is based on provider attestation and form submission

MC: Medi-Cal

OC: OneCare

Back to Agenda

Back to Item

2024 Program and 2025 Proposed Changes

Medi-Cal	OneCare
Annual Wellness Visit- $50	Annual Wellness Visit- $50
Blood Lead Test 12 Months of Age- $25 *Change from Attestation-based to Passive Rewarding	Breast Cancer Screening- $25
Blood Lead Test 24 Months of Age- $25 *Change from Attestation-based to Passive Rewarding	Colorectal Cancer Screening- $50
Breast Cancer Screening- $25	Diabetes A1c Test- $25
Cervical Cancer Screening- $25	Diabetes Eye Exam- $25
Colorectal Cancer Screening- $50	Health Risk Assessment- $25
Diabetes A1c Test- $25	Osteoporosis Screening- $25
Diabetes Eye Exam- $25	
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications- $25	
Follow-up Care for Children Prescribed ADHD Medication- $25	
Postpartum Check Up- $25 *Change from $50 to $25	

*Proposed changes for 2025

Back to Agenda

Back to Item

2025 Proposed Revisions

- Retain all member health rewards from calendar year 2024 with the following changes:
  - **Blood Lead Test 12 and 24 Months of Age**
    - Pilot to change from attestation-based to passive identification and rewarding to enhance member experience.
  - **Postpartum Checkup**
    - Reduce amount from $50 to $25 reward to align with other Medi-Cal rewards.

Summary of Fiscal Impact

- Estimated Cost at 15% Response Rate*
  - Medi-Cal: approximately $4,870,000
  - OneCare: approximately $660,000

	2024	2025	Budget Difference
Medi-Cal	$4,665,000	$4,865,244	$200,244
OneCare	$530,625	$656,130	$125,505

*For passive rewarded incentives: Blood Lead Test 12 and 24 Months (Medi-Cal) participation rate is assumed at 62.79% which is DHCS minimum performance level. Health Risk Assessment (OneCare) participation rate is assumed at 75% as aligned with CMS 4-star rating. Annual Wellness Visit (Medi-Cal and OneCare) participation rate is assumed at 15% as aligned with Medi-Cal DHCS Member Incentive goal and previous year's participation rate. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (Medi-Cal) participation rate is assumed at 79.05% which is the DHCS minimum performance level.

Back to Agenda

Back to Item

CalOptima Health

Appendix

Back to Agenda

Back to Item

CalOptima Health

2025 Proposed Incentives Cost Projections

Member Health Reward	Amount	Medi-Cal Eligible Members	OneCare Eligible Members	Estimated Cost at 5% Response Medi-Cal	Estimated Cost at 5% Response OneCare	Estimated Cost at 15% Response Medi-Cal	Estimated Cost at 15% Response OneCare
Annual Wellness Visit**	$50	198,562	17,233	$496,405	$43,083	$1,489,215[A]	$129,248
Blood Lead Test at 12 Months of Age**	$25	11,584	-	$176,830[B]	-	$181,840[C]	-
Blood Lead Test 24 Months of Age**	$25	11,584	-	$176,830[B]	-	$181,840[C]	-
Breast Cancer Screening	$25	78,524	5,466	$98,155	$6,833	$294,465	$20,498
Cervical Cancer Screening	$25	229,229	-	$286,536	-	$859,609	-
Colorectal Cancer Screening	$50	196,563	10,995	$491,408	$27,488	$1,474,223	$82,463
Diabetes A1C Test	$25	44,566	3,949	$55,708	$4,936	$167,123	$14,809
Diabetes Eye Exam	$25	44,566	3,949	$55,708	$4,936	$167,123	$14,809
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications**	$25	1,659	-	$2,074	-	$32,790[G]	-
Follow-up Care for Children Prescribed ADHD Medication	$25	1,265	-	$1,581	-	$4,744	-
Health Risk Assessment	$25	-	17,583	-	$272,537[D]	-	$329,681[E]
Osteoporosis Screening	$25	-	17,233[F]	-	$21,541	-	$64,624
Postpartum Checkup	$25	3,273	-	$4,091	-	$12,274	-
Totals				$1,845,325	$381,353	$4,865,244	$656,130

Eligible members are identified using the February 2024 Prospective Rate HEDIS denominator, but reward is not limited to condition or diagnosis. Annual Wellness Visit, Health Risk Assessment, and Osteoporosis Screening eligible population is based on health reward program eligibility criteria.
**Passive identification and rewarding. (continued next slide)

Back to Agenda

Back to Item

CalOptima Health

2025 Proposed Incentives Cost Projections (Continued)

A. Medi-Cal Annual Wellness Visit goal is 15% response rate.
B. Lead Screening estimated response rate is calculated based on administrative compliance rate for MY2023, 61.06%.
C. Lead Screening estimated response rate is calculated based on minimum performance level for MY2024, 62.79%.
D. Health Risk Assessment estimated for 3 STARs at 62% participation rate.
E. Health Risk Assessment estimated for 4 STARs at 75% participation rate.
F. Osteoporosis Screening eligible population is based on all OneCare members who are eligible and not restricted to specifications dictated in the HEDIS measure requirements for: Osteoporosis Management in Women Who Had a Fracture (OMW).
G. Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications Follow-up Care for Children Prescribed ADHD Medication estimated response rate is calculated based on minimum performance level for MY2024, 79.05%.

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 6, 2025
Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Approve CalOptima Health's Calendar Year 2026 Member Health Rewards

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491
Linda Lee, Executive Director, Quality Improvement, (657) 900-1069

Recommended Action

1. Approve CalOptima Health's Calendar Year 2026 Member Health Rewards for Medi-Cal and OneCare.

Background

In Calendar Year (CY) 2025, CalOptima Health offers health rewards to eligible members through physical gift cards for Medi-Cal and &more flex card rewards for OneCare, to enhance member health and quality outcomes. CalOptima Health provides Medi-Cal and OneCare members with health rewards for preventive services, including annual wellness visit, blood lead test(s), breast cancer screening, cervical cancer screening, colorectal cancer screening, diabetes tests, postpartum care, osteoporosis testing, and follow-up care for children prescribed ADHD medication.

Medi-Cal

The Medi-Cal member health rewards program has both provider attestation and automated claims-based rewarding. Annual wellness visits, health risk assessment, and diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications have historically been automated reward incentives. The remaining member incentives require provider attestations.

OneCare

The OneCare member health rewards program has both self-attestation and automated claims-based rewards. Annual wellness visits and health risk assessment are automated rewards. The remaining member incentives require a self-attestation form. In CY 2025, the OneCare &more flex benefit card is being used as the vehicle for member health rewards, which can be used for any purchases permissible through the &more card. The transition to digital self-attestation forms and automated rewards in CY 2025 has increased health reward processing efficiency and minimized turnaround time for members to receive their rewards.

Discussion

Health rewards may motivate members to establish primary care relationships and get recommended preventive care and screenings. Rewards may encourage members to receive important tests, reinforce health behaviors, and positively impact member experience. Health rewards were selected based on clinical areas with the largest opportunity for improvement and those measures where CalOptima Health has performed below established benchmarks.

Back to Agenda

Back to Item

Staff recommend maintaining the following health rewards from CY 2025 for CY 2026 as detailed in the table below:

Proposed CY2026 Member Incentives		
Medi-Cal		**OneCare**
Automated Reward		**Automated Reward**
Annual Wellness Visit- $50		Health Risk Assessment- $25
Blood Lead Test 12 Months of Age- $25		
Blood Lead Test 24 Months of Age- $25		
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications- $25		
Provider Attestation Reward		**Self-Attestation Reward**
Breast Cancer Screening- $25		Annual Wellness Visit- $50
Cervical Cancer Screening- $25		Breast Cancer Screening- $25
Colorectal Cancer Screening- $50*		Colorectal Cancer Screening- $50*
Diabetes A1c Test- $25		Diabetes A1c Test- $25
Diabetes Eye Exam- $25		Diabetes Eye Exam- $25
Postpartum Checkup- $25		Osteoporosis Screening- $25

*The reward amount will vary based on the type of colon cancer screening test completed: $15 for fecal occult blood test (FOBT) or fecal immunochemical test (sDNA FIT), $25 for CT colonography or flexible sigmoidoscopy, or $50 for colonoscopy.

Staff recommends the following revisions to the health rewards program for CY 2026. To align with the US Preventive Services Task Force (USPSTF) recommendations, the Colorectal Cancer Screening health reward will be expanded to include four types of colon cancer screening tests: FOBT, sDNA FIT, CT colonography, and flexible sigmoidoscopy.

Additionally, in accordance with USPSTF guidelines, the Medi-Cal member health rewards will recognize screenings, tests, or exams completed outside the standard age criteria. This adjustment acknowledges that members may require these screenings, tests, or exams at different intervals and may not adhere strictly to the recommended age criteria.

Staff recommend Osteoporosis Screening be revised to reward members who get a bone mineral density test or additionally those who fill a prescription for a drug to treat osteoporosis. This addition is in alignment with clinical practice guidelines which aim to reduce fracture risk by encouraging early intervention rather than waiting for adverse events such as falls.

Staff recommends revising the OneCare Annual Wellness Visit Member Health Reward from an automated, claims-based reward to self-attestation. In 2025, OneCare Member Health Rewards were upgraded to digital form submission, eliminating the need for members to bring a physical form to the provider's office and either mail or fax it to CalOptima Health. This proactive, streamlined approach is designed to enhance member engagement, reduce barriers, minimize inquiries and grievances, and increase member ownership of their health. The Annual Wellness Visit Health Reward has shown a

strong correlation as a gateway to complete other screenings such as breast cancer screening, colorectal cancer screening, and retinal eye exams for members with diabetes. By implementing self-attestation, members will not only become more aware of other health offerings but also learn how to access their rewards through the &more flex card. This change is expected to further improve member satisfaction and health outcomes.

Program Changes		
Medi-Cal		**OneCare**
Breast Cancer Screening - Update age criteria to 40-74 years old		Osteoporosis Screening - Expand criteria to allow medication treatment as a qualifying event
Colorectal Cancer Screening - Update to allow other colon cancer screening methods		Colorectal Cancer Screening - Update to allow other colon cancer screening methods
		Annual Wellness Visit - Change process for rewarding to self-attestation

For CY 2026, the Behavioral Health Department recommends discontinuing the Follow-Up Care for Children Prescribed ADHD Medication (ADD) health reward due to the low participation rate (fewer than 5 participants in CY 2024) and the unique qualifications required. In its place, the Behavioral Health Department has developed an ADD text campaign to remind members who qualify for the ADD measure to follow up with their provider within 30 days of filling their first prescription.

Retire		
Medi-Cal		**OneCare**
Follow-up Care for Children Prescribed ADHD Medication		N/A

Members will receive a health reward upon completing the qualifying event. At the time of budgeting, staff assumed a member participation rate of 15-20%* based on historical participation rates and an anticipated increase in member participation. Should the participation rates exceed these assumptions and budgeted amounts, staff will return to the Board of Directors for additional funding requests at future meetings. Other participation rate assumptions are as follows:

** **Automated Health Rewards:***

- *Annual Wellness Visit (OneCare): Participation rate is assumed at 45%, consistent with past participation.*
- *Blood Lead Test at 12 and 24 Months (Medi-Cal): Participation rate is assumed at 71.11% (75th percentile), which is the next benchmark following achievement of the DHCS minimum performance level for Measurement Year (MY) 2024.*
- *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (Medi-Cal): Participation rate is assumed at 84.63% (75th percentile), supporting alignment with Behavioral Health initiatives.*
- *Health Risk Assessment (OneCare): Participation rate is assumed at 76%, in line with the current CMS 4-star rating.*

Back to Agenda

Back to Item

**** Self-Attestation Rewards:***

- *Annual Wellness Visit (Medi-Cal): Participation rate is assumed at 25%, based on past participation.*
- *All other member health rewards participation rate is assumed at 15% for Medi-Cal and 20% for OneCare.*

Program Funding

Staff recommends utilizing unearned MY 2024 Pay for Value Performance Program (P4V Program) dollars to fund the member health reward program. MY 2024 Medi-Cal P4V rewards have been preliminarily calculated. The total Medi-Cal P4V pool was $101 million (based on 10% of professional capitation for Fiscal Year 2024-25) with $31 million earned and $70 million unearned. The MY 2024 OneCare P4V will be calculated in November 2025 pending results from member satisfaction surveys. Staff expects OneCare performance similar to Medi-Cal with 30% earned and 70% unearned.

Fiscal Impact

Medi-Cal:

The recommended action has no additional fiscal impact on the operating budget. The estimated cost for the CY 2026 Medi-Cal Member Health Rewards program is $6.3 million. Staff anticipates that unearned funds from the MY 2024 Medi-Cal P4V Program will be sufficient to fund the program.

OneCare:

The recommended action has no additional fiscal impact on the operating budget. The estimated cost for the CY 2026 OneCare Member Health Rewards program is $1.0 million. Staff anticipates that unearned funds from the MY 2024 OneCare P4V Program will be sufficient to fund the program.

Rationale for Recommendation

A member health reward program will strengthen the primary care provider-patient relationship, improve the quality of care delivered to CalOptima Health members by promoting preventive care, early identification, chronic care management, and identify opportunities to coordinate care based on an annual wellness visit.

Concurrence

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

Attachment

1. Calendar Year 2026 Member Health Rewards for Medi-Cal and OneCare Presentation

/s/ Michael Hunn *10/30/2025*
Authorized Signature **Date**

Back to Agenda

Back to Item

Calendar Year 2026 Member Health Rewards for Medi-Cal and OneCare

Quality Assurance Committee Meeting

October 8, 2025

Linda Lee, Executive Director, Quality Improvement

Our Mission

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

Our Vision

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

Current 2025 Member Health Rewards Program

- CalOptima Health provides health rewards and incentives to members for completing preventive services
- 11 Medi-Cal Health Rewards
  - Rewards are through physical cards
  - Provider attestation and passive reward mechanism
- 7 OneCare Health Rewards
  - Rewards are through the flex benefit card
  - Self attestation and passive reward mechanism

CalOptima Health

2026 Medi-Cal Program and Proposed Changes

Mechanism	Medi-Cal Health Reward	Reward Amount	Proposed Changes
Passive	Annual Wellness Visit	$50	
	Blood Lead Test 12 Months of Age	$25	
	Blood Lead Test 24 Months of Age	$25	
	Diabetes Screening for People with Schizophrenia or Bipolar…*	$25	
Provider Attestation	Breast Cancer Screening	$25	Update age criteria to 40-74 years old
	Cervical Cancer Screening	$25	
	Colorectal Cancer Screening	$15-50**	Expand to include other screening options
	Diabetes A1c Test	$25	
	Diabetes Eye Exam	$25	
	Postpartum Checkup	$25	

*Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications. **Reward varies: $15 for FIT or FOBT, $25 for CT colonography or flexible sigmoidoscopy, or $50 for colonoscopy .

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2026 OneCare Program and Proposed Changes

Mechanism	OneCare Health Reward	Reward Amount	Proposed Changes
Passive	Health Risk Assessment	$25	
Self Attestation	Annual Wellness Visit	$50	Change reward process to self-attestation
	Breast Cancer Screening	$25	
	Colorectal Cancer Screening	$15-50**	Expand to include other screening options
	Diabetes A1c Test	$25	
	Diabetes Eye Exam	$25	
	Osteoporosis Screening	$25	Expand criteria to allow medication treatment

**Reward varies: $15 for FIT or FOBT, $25 for CT colonography or flexible sigmoidoscopy, or $50 for colonoscopy .

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2026 Proposed Revisions

- Breast Cancer Screening, Medi-Cal:
  - Update age criteria to 40-74 years
- Osteoporosis Screening, OneCare:
  - Expand criteria to allow medication treatment
- Annual Wellness Visit, OneCare:
  - Change rewarding process to self-attestation

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2026 Proposed Revisions

- Colorectal Cancer Screening, Medi-Cal and OneCare:
  - Expand eligible screening options:
    - Health Reward 1:
      - $15 fecal occult blood test (FOBT), or
      - $15 fecal immunochemical test (sDNA FIT), or
      - $25 for CT colonography, or
      - $25 flexible sigmoidoscopy
    - Health Reward 2:
      - $50 for colonoscopy

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Retire

- Medi-Cal, Follow-up Care for Children Prescribed ADHD Medication

Summary of Fiscal Impact

- Estimated Cost at 15-20% Response Rate
  - Medi-Cal: approximately $6.25 million
  - OneCare: approximately $1.03 million

	2025	2026	Budget Difference
Medi-Cal	$4,865,244	$6,250,382	$1,385,138
OneCare	$656,130	$1,026,665	$370,535

Passive health rewards were calculated based on Quality Compass Benchmarks or Star goals.

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Appendix

Medi-Cal 2026 Projected Cost

Member Health Rewards	Reward Value	2026 Projected Expenditure
Annual Wellness Visit (AWV)	$50.00	$3,125,000.00
Blood Lead Test at 12 Months of Age (BLT12)	$25.00	$175,161.71
Blood Lead Test at 24 Months of Age (BLT24)	$25.00	$175,161.71
Breast Cancer Screening (BCS)	$25.00	$254,250.00
Cervical Cancer Screening (CCS)	$25.00	$756,255.00
Colorectal Cancer Screening (COL)	$50.00	$1,292,520.00
Diabetes A1C Test (GSD)	$25.00	$172,875.00
Diabetes Eye Exam (EED)	$25.00	$172,875.00
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)	$25.00	$105,152.78
Postpartum Checkup (PPC)	$25.00	$21,131.25
	Total	$6,250,382.44

AWV projected at 25% participation rate. BLT 12, BLT 24 and SSD projected at the 75th percentile. All other health rewards projected at 15% participation rate.

OneCare 2026 Projected Cost

Member Health Rewards	Reward Value	2026 Projected Expenditure
Annual Wellness Visit (AWV)	$50.00	$450,000.00
Breast Cancer Screening (BCS)	$25.00	$27,680.00
Colorectal Cancer Screening (COL)	$50.00	$109,580.00
Diabetes A1C Test (GSD)	$25.00	$21,380.00
Diabetes Eye Exam (EED)	$25.00	$21,380.00
Health Risk Assessment (HRA)	$25.00	$380,000.00
Osteoporosis Screening (OSW, OMW)	$25.00	$16,645.00
		$1,026,665.00

AWV projected at 45% participation rate. HRA projected at 4 Stars Goal. All other health rewards projected at 20% participation rate.

CalOptima Health

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UNAUDITED FINANCIAL STATEMENTS

May 31, 2026

Back to Agenda

Table of Contents

Financial Highlights 3
Full-Time Equivalent (FTE) Data 4
Statement of Revenues and Expenses – Consolidated Month to Date 5
Statement of Revenues and Expenses – Consolidated Year to Date 6
Statement of Revenues and Expenses by LOB – Consolidated Month to Date 7
Statement of Revenues and Expenses by LOB – Consolidated Year to Date 8
Highlights – Consolidated 9
Enrollment Summary 10
Enrollment Trend by Network 11
Highlights – Enrollment 12
Statement of Revenues and Expenses – Medi-Cal 13
Highlights – Medi-Cal 14
Statement of Revenues and Expenses – OneCare 15
Highlights – OneCare 16
Statement of Revenues and Expenses – PACE 17
Statement of Revenues and Expenses – MSSP 18
Statement of Revenues and Expenses – Covered CA 19
Statement of Revenues and Expenses – 505 City Parkway 20
Statement of Revenues and Expenses – 500 City Parkway 21
Statement of Revenues and Expenses – 7900 Garden Grove Blvd 22
Highlights – PACE, MSSP, Covered CA, 500 City Parkway and 7900 Garden Grove Blvd 23
Balance Sheet 24
Highlights – Balance Sheet 25
Board Designated Reserve and, TNE Analysis 26
Statement of Cash Flow 27
Spending Plan 28
Key Financial Indicators 29
Digital Transformation Strategy 30
Homeless Health Initiatives 31
Housing and Homelessness Incentive Program 32
Budget Allocation Changes 33
Budget Allocation Changes (cont.) 34

Back to Agenda

CalOptima Health - Consolidated
Financial Highlights
For the Eleven Months Ending May 31, 2026

May 2026					July 2025 - May 2026			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
819,485	868,566	(49,081)	(5.7%)	Member Months	9,500,322	9,749,132	(248,810)	(2.6%)
394,340,059	385,305,128	9,034,931	2.3%	Revenues	4,773,225,245	4,307,551,705	465,673,540	10.8%
354,221,227	367,960,192	13,738,965	3.7%	Medical Expenses	4,365,546,851	4,018,782,741	(346,764,110)	(8.6%)
21,279,723	25,865,028	4,585,305	17.7%	Administrative Expenses	238,676,079	280,486,148	41,810,069	14.9%
18,839,109	(8,520,092)	**27,359,201**	**321.1%**	**Operating Margin**	**169,002,315**	**8,282,816**	**160,719,499**	**1,940.4%**
				Non-Operating Income (Loss)				
9,113,067	8,333,341	779,726	9.4%	Net Investment Income/Expense	132,893,182	91,666,749	41,226,433	45.0%
(55,000)	-	(55,000)	(100.0%)	Grant Expense	(23,369,124)	-	(23,369,124)	(100.0%)
(2,514,756)	-	(2,514,756)	(100.0%)	Community Reinvestment	29,647,026	-	29,647,026	100.0%
(122,021)	(138,610)	16,589	12.0%	Other Income/Expense	(7,044,801)	(1,524,710)	(5,520,091)	(362.0%)
6,421,290	**8,194,731**	(1,773,442)	(21.6%)	**Total Non-Operating Income (Loss)**	**132,126,283**	**90,142,039**	**41,984,244**	**46.6%**
25,260,398	(325,361)	**25,585,759**	**7,863.8%**	**Change in Net Assets**	**301,128,598**	**98,424,855**	**202,703,743**	**205.9%**
89.8%	*95.5%*	(5.7%)		*Medical Loss Ratio*	*91.5%*	*93.3%*	(1.8%)	
5.4%	*6.7%*	*1.3%*		*Administrative Loss Ratio*	*5.0%*	*6.5%*	*1.5%*	
4.8%	(2.2%)	*7.0%*		*Operating Margin Ratio*	*3.5%*	*0.2%*	*3.3%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		

Back to Agenda

CalOptima Health - Consolidated
Full Time Equivalent (FTE) Data
For the Eleven Months Ending May 31, 2026

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1,322	1,411	89
OneCare	172	182	10
PACE	113	119	6
CCA	12	20	8
MSSP	22	24	2
Total	1,641	1,756	115

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	14,571	15,485	914
OneCare	1,850	2,001	151
PACE	1,243	1,309	66
CCA	63	186	123
MSSP	243	261	18
Total	17,970	19,242	1,272

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	605	602	(3)
OneCare	108	100	(8)
PACE	5	5	0
CCA	0	0	0
MSSP	0	23	23
Consolidated	499	495	(5)

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	638	616	(22)
OneCare	109	99	(10)
PACE	5	5	0
CCA	0	0	0
MSSP	24	23	(1)
Consolidated	529	507	(22)

Open FTE			
	Total	Medical	Admin
Medi-Cal	95	48	47
OneCare	11	6	5
PACE	6	5	1
CCA	14	0	14
MSSP	0	0	0
Total	126	59	67

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending May 31, 2026

MEMBER MONTHS		819,485		868,566		(49,081)
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$352,652,622	$440.67	$339,140,113	$399.06	$13,512,509	$41.61
OneCare	36,072,834	1,934.30	40,675,068	2,241.05	(4,602,234)	(306.75)
PACE	5,372,182	9,424.88	5,240,893	9,210.71	131,289	214.17
MSSP	242,421	413.69	249,054	446.33	(6,633)	(32.64)
Total Operating Revenue	394,340,059	481.20	385,305,128	443.61	9,034,931	37.59
MEDICAL EXPENSES						
Medi-Cal	313,375,546	391.59	325,005,116	382.43	11,629,570	(9.16)
OneCare	36,156,572	1,938.79	38,147,611	2,101.80	1,991,039	163.01
PACE	4,479,337	7,858.49	4,535,389	7,970.81	56,052	112.32
MSSP	209,771	357.97	227,092	406.97	17,321	49.00
Covered CA			44,984		44,984	
Total Medical Expenses	354,221,227	432.25	367,960,192	423.64	13,738,965	(8.61)
GROSS MARGIN	40,118,832	48.95	17,344,936	19.97	22,773,896	28.98
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	13,104,607	15.09	14,349,841	16.52	1,245,235	1.43
Professional Fees	1,473,344	1.70	2,513,145	2.89	1,039,800	1.19
Purchased Services	1,798,875	2.07	2,635,275	3.03	836,400	0.96
Printing & Postage	325,528	0.37	591,870	0.68	266,342	0.31
Depreciation & Amortization	1,070,249	1.23	949,334	1.09	(120,915)	(0.14)
Other Expenses	3,074,676	3.54	4,337,795	4.99	1,263,119	1.45
Indirect Cost Allocation, Occupancy	432,445	0.50	487,768	0.56	55,323	0.06
Total Administrative Expenses	21,279,723	25.97	25,865,028	29.78	4,585,305	3.81
NET INCOME (LOSS) FROM OPERATIONS	18,839,109	22.99	(8,520,092)	(9.81)	27,359,201	32.80
INVESTMENT INCOME						
Interest Income	13,286,942	16.21	8,735,956	10.06	4,550,986	6.15
Realized Gain/(Loss) on Investments	(948,131)	(1.16)	-	-	(948,131)	(1.16)
Unrealized Gain/(Loss) on Investments	(3,027,963)	(3.69)	-	-	(3,027,963)	(3.69)
Investment Fees	(197,781)	(0.24)	(402,615)	(0.46)	204,834	0.22
Total Investment Income	9,113,067	11.12	8,333,341	9.59	779,726	1.53
NET BUILDING INCOME/EXPENSE	(123,535)	(0.15)	(138,610)	(0.17)	15,075	0.02
GRANT EXPENSE	(55,000)	(0.07)	-	-	(55,000)	(0.07)
COMMUNITY REINVESTMENT	(2,514,756)	(3.07)	-	-	(2,514,756)	(3.07)
OTHER INCOME/EXPENSE	1,514	-	-	-	1,514	-
CHANGE IN NET ASSETS	**25,260,398**	**30.82**	(325,361)	(0.37)	**25,585,759**	**31.19**
MEDICAL LOSS RATIO	**89.8%**		**95.5%**		(5.7%)	
ADMINISTRATIVE LOSS RATIO	**5.4%**		**6.7%**		**1.3%**	

Back to Agenda

CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2026

MEMBER MONTHS		9,500,322		9,749,132		(248,810)
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$4,309,747,051	$463.81	$3,822,773,479	$400.46	$486,973,572	$63.35
OneCare	405,162,251	2,002.53	427,152,094	2,166.96	(21,989,843)	(164.43)
PACE	55,589,404	9,292.78	54,886,538	9,088.68	702,866	204.10
MSSP	2,726,540	431.96	2,739,594	446.33	(13,054)	(14.37)
Total Operating Revenue	4,773,225,245	502.43	4,307,551,705	441.84	465,673,540	60.59
MEDICAL EXPENSES						
Medi-Cal	3,938,165,302	423.82	3,564,865,728	373.44	(373,299,574)	(50.38)
OneCare	377,065,375	1,863.66	403,556,328	2,047.26	26,490,953	183.60
PACE	47,916,350	8,010.09	47,367,849	7,843.66	(548,501)	(166.43)
MSSP	2,399,825	380.20	2,498,012	406.97	98,188	26.77
Covered CA			494,824		494,824	
Total Medical Expenses	4,365,546,851	459.52	4,018,782,741	412.22	(346,764,110)	(47.30)
GROSS MARGIN	407,678,394	42.91	288,768,964	29.62	118,909,430	13.29
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	143,797,918	14.75	156,262,916	16.03	12,464,998	1.28
Professional Fees	16,802,253	1.72	22,613,776	2.32	5,811,523	0.60
Purchased Services	22,374,024	2.29	30,195,081	3.10	7,821,056	0.81
Printing & Postage	5,181,085	0.53	6,775,370	0.69	1,594,285	0.16
Depreciation & Amortization	10,558,289	1.08	10,442,674	1.07	(115,615)	(0.01)
Other Expenses	35,256,697	3.62	48,866,283	5.01	13,609,586	1.39
Indirect Cost Allocation, Occupancy	4,705,813	0.48	5,330,048	0.55	624,235	0.07
Total Administrative Expenses	238,676,079	25.12	280,486,148	28.77	41,810,069	3.65
NET INCOME (LOSS) FROM OPERATIONS	169,002,315	17.79	8,282,816	0.85	160,719,499	16.94
INVESTMENT INCOME						
Interest Income	150,113,003	15.80	95,203,089	9.77	54,909,914	6.03
Realized Gain/(Loss) on Investments	5,527,930	0.58	-	-	5,527,930	0.58
Unrealized Gain/(Loss) on Investments	(20,628,579)	(2.17)	-	-	(20,628,579)	(2.17)
Investment Fees	(2,119,172)	(0.22)	(3,536,340)	(0.36)	1,417,168	0.14
Total Investment Income	132,893,182	13.99	91,666,749	9.40	41,226,433	4.59
NET BUILDING INCOME/EXPENSE	(1,003,482)	(0.11)	(1,524,710)	(0.16)	(43,029)	0.05
GRANT EXPENSE	(23,369,124)	(2.46)	-	-	(23,369,124)	(2.46)
COMMUNITY REINVESTMENT	29,647,026	3.12	-	-	29,647,026	3.12
OTHER INCOME/EXPENSE	(6,041,320)	(0.64)	-	-	(6,041,320)	(0.64)
CHANGE IN NET ASSETS	**301,128,598**	**31.70**	**98,424,855**	**10.10**	**202,703,743**	**21.60**
MEDICAL LOSS RATIO	**91.5%**		**93.3%**		(1.8%)	
ADMINISTRATIVE LOSS RATIO	**5.0%**		**6.5%**		**1.5%**	

Back to Agenda

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending May 31, 2026

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	800,266	18,649	570	586		819,485
REVENUES						
Capitation Revenue	$ 352,652,622	$ 36,072,834	$ 5,372,182	$ 242,421	$ -	$ 394,340,059
Total Operating Revenue	**352,652,622**	**36,072,834**	**5,372,182**	**242,421**	**-**	**394,340,059**
MEDICAL EXPENSES						
Provider Capitation	106,721,577	14,477,805				121,199,381
Facility and Professional Claims	140,373,671	8,746,453	2,316,366			151,436,490
MLTSS	48,192,074		66,125	19,942		48,278,142
Prescription Drugs		10,891,349	609,991			11,501,340
Case Mgmt & Other Medical	18,088,224	2,040,965	1,486,855	189,829		21,805,874
Total Medical Expenses	**313,375,546**	**36,156,572**	**4,479,337**	**209,771**	**-**	**354,221,227**
Medical Loss Ratio	*88.9%*	*100.2%*	*83.4%*	*86.5%*	*0.0%*	*89.8%*
GROSS MARGIN	**39,277,076**	(83,738)	**892,844**	**32,650**	**-**	**40,118,832**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	11,550,183	1,036,024	179,209	110,285	228,905	13,104,607
Non-Salary Operating Expenses	2,784,703	585,201	134,764	1,458	91,621	3,597,747
Depreciation & Amortization	1,069,181		1,068			1,070,249
Other Operating Expenses	2,981,627	77,358	7,720	7,865	105	3,074,676
Indirect Cost Allocation, Occupancy	(670,081)	1,078,093	17,150	7,283		432,445
Total Administrative Expenses	**17,715,614**	**2,776,677**	**339,911**	**126,891**	**320,631**	**21,279,723**
Administrative Loss Ratio	*5.0%*	*7.7%*	*6.3%*	*52.3%*	*0.0%*	*5.4%*
Operating Income/(Loss)	**21,561,462**	(2,860,415)	**552,933**	(94,241)	(320,631)	**18,839,109**
Investments and Other Non-Operating	(2,513,243)					6,421,290
CHANGE IN NET ASSETS	**$ 19,048,220**	$ (2,860,415)	**$ 552,933**	$ (94,241)	$ (320,631)	**$ 25,260,398**
BUDGETED CHANGE IN NET ASSETS	(7,138,425)	(706,976)	383,007	(121,400)	(936,298)	(325,361)
Variance to Budget - Fav/(Unfav)	$ 26,186,645	$ (2,153,439)	$ 169,926	$ 27,159	$ 615,667	$ 25,585,759

Back to Agenda

CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Eleven Months Ending May 31, 2026

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	9,292,015	202,325	5,982	6,312		9,500,322
REVENUES						
Capitation Revenue	$ 4,309,747,051	$ 405,162,251	$ 55,589,404	$ 2,726,540	$ -	$ 4,773,225,245
Total Operating Revenue	**4,309,747,051**	**405,162,251**	**55,589,404**	**2,726,540**	**-**	**4,773,225,245**
MEDICAL EXPENSES						
Provider Capitation	1,222,812,070	160,525,336				1,383,337,406
Facility and Professional Claims	1,520,386,026	85,506,388	24,442,712			1,630,335,126
MLTSS	509,089,828		700,401	332,770		510,122,999
Prescription Drugs		108,519,842	6,387,115			114,906,957
Case Mgmt & Other Medical	685,877,378	22,513,809	16,386,122	2,067,054		726,844,363
Total Medical Expenses	**3,938,165,302**	**377,065,375**	**47,916,350**	**2,399,825**	**-**	**4,365,546,851**
Medical Loss Ratio	*91.4%*	*93.1%*	*86.2%*	*88.0%*	*0.0%*	*91.5%*
GROSS MARGIN	**371,581,748**	**28,096,876**	**7,673,054**	**326,716**	**-**	**407,678,394**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	127,915,753	11,378,199	2,004,452	1,166,151	1,333,363	143,797,918
Non-Salary Operating Expenses	33,621,902	6,462,016	1,127,286	16,066	3,130,093	44,357,363
Depreciation & Amortization	10,547,751		10,538			10,558,289
Other Operating Expenses	33,768,128	1,281,706	119,500	86,932	431	35,256,697
Indirect Cost Allocation, Occupancy	(7,413,602)	11,859,026	180,280	80,109		4,705,813
Total Administrative Expenses	**198,439,932**	**30,980,947**	**3,442,056**	**1,349,257**	**4,463,887**	**238,676,079**
Administrative Loss Ratio	*4.6%*	*7.6%*	*6.2%*	*49.5%*	*0.0%*	*5.0%*
Operating Income/(Loss)	**173,141,817**	(2,884,071)	**4,230,998**	(1,022,541)	(4,463,887)	**169,002,315**
Investments and Other Non-Operating	23,605,707					132,126,283
CHANGE IN NET ASSETS	**$ 196,747,523**	$ (2,884,071)	**$ 4,230,998**	$ (1,022,541)	$ (4,463,887)	**$ 301,128,598**
BUDGETED CHANGE IN NET ASSETS	27,206,800	(11,767,996)	3,986,125	(1,321,283)	(9,820,830)	98,424,855
Variance to Budget - Fav/(Unfav)	$ 169,540,723	$ 8,883,925	$ 244,873	$ 298,742	$ 5,356,943	$ 202,703,743

Back to Agenda

CalOptima Health

Highlights – Consolidated, for Eleven Months Ending May 31, 2026

MONTH TO DATE RESULTS:

- Change in Net Assets is $25.3 million, favorable to budget $25.6 million
- Operating surplus is $18.8 million, with a surplus in non-operating income of $6.4 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $301.1 million, favorable to budget $202.7 million
- Operating surplus is $169.0 million, with a surplus in non-operating income of $132.1 million

Change in Net Assets by Line of Business (LOB) ($ millions):

May 2026				July 2025 - May 2026		
Actual	Budget	Variance	Operating Income (Loss)	Actual	Budget	Variance
21.6	(7.1)	28.7	Medi-Cal	173.1	27.2	145.9
(2.9)	(0.7)	(2.2)	OneCare	(2.9)	(11.8)	8.9
0.6	0.4	0.2	PACE	4.2	4.0	0.2
(0.1)	(0.1)	0.0	MSSP	(1.0)	(1.3)	0.3
(0.3)	(0.9)	0.6	Covered CA	(4.5)	(9.8)	5.4
18.8	**(8.5)**	**27.4**	**Total Operating Income (Loss)**	**169.0**	**8.3**	**160.7**
			Non-Operating Income (Loss)			
9.1	8.3	0.8	Net Investment Income/Expense	132.9	91.7	41.2
(2.7)	(0.1)	(2.6)	Other Income/Expense	0.0	(0.8)	(1.5)
6.4	**8.2**	**(1.8)**	**Total Non-Operating Income/(Loss)**	**132.1**	**90.1**	**42.0**
25.3	**(0.3)**	**25.6**	**TOTAL**	**301.1**	**98.4**	**202.7**

CalOptima Health - Consolidated
Enrollment Summary
For the Eleven Months Ending May 31, 2026

May 2026					July 2025 - May 2026			
Actual	**Budget**	**$ Variance**	**%Variance**	**Enrollment (by Aid Category)**	**Actual**	**Budget**	**$ Variance**	**%Variance**
110,392	123,571	(13,179)	(10.7%)	Adult	1,321,960	1,393,839	(71,879)	(5.2%)
236,930	253,939	(17,009)	(6.7%)	Child	2,720,389	2,827,476	(107,087)	(3.8%)
292,169	311,188	(19,019)	(6.1%)	Expansion	3,454,995	3,564,957	(109,962)	(3.1%)
2,958	2,504	454	18.1%	LTC	33,222	27,606	5,616	20.3%
149,149	149,631	(482)	(0.3%)	SPD	1,664,484	1,632,366	32,118	2.0%
8,668	9,014	(346)	(3.8%)	Whole Child Model	96,965	99,729	(2,764)	(2.8%)
800,266	**849,847**	(49,581)	(5.8%)	**Medi-Cal Total**	**9,292,015**	**9,545,973**	(253,958)	(2.7%)
18,649	**18,150**	**499**	**2.7%**	**OneCare**	**202,325**	**197,120**	**5,205**	**2.6%**
570	**569**	**1**	**0.2%**	**PACE**	**5,982**	**6,039**	(57)	(0.9%)
586	**558**	**28**	**5.0%**	**MSSP**	**6,312**	**6,138**	**174**	**2.8%**
819,485	**868,566**	(49,081)	(5.7%)	**CalOptima Health Total**	**9,500,322**	**9,749,132**	(248,810)	(2.6%)
				Enrollment (by Network)				
305,441	330,466	(25,025)	(7.6%)	HMO	3,649,914	3,755,092	(105,178)	(2.8%)
151,522	156,503	(4,981)	(3.2%)	PHC	1,748,037	1,773,463	(25,426)	(1.4%)
72,225	77,637	(5,412)	(7.0%)	Shared Risk Group	782,180	793,449	(11,269)	(1.4%)
271,078	285,241	(14,163)	(5.0%)	Fee for Service	3,111,884	3,223,969	(112,085)	(3.5%)
800,266	**849,847**	(49,581)	(5.8%)	**Medi-Cal Total**	**9,292,015**	**9,545,973**	(253,958)	(2.7%)
18,649	**18,150**	**499**	**2.7%**	**OneCare**	**202,325**	**197,120**	**5,205**	**2.6%**
570	**569**	**1**	**0.2%**	**PACE**	**5,982**	**6,039**	(57)	(0.9%)
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819,485	**868,566**	(49,081)	(5.7%)	**CalOptima Health Total**	**9,500,322**	**9,749,132**	(248,810)	(2.6%)

Note:* Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2026

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	YTD Actual	YTD Budget	Variance
HMOs															
Adult	67,587	67,579	68,311	68,508	68,160	66,645	65,123	63,288	62,002	60,344	58,934		716,481	729,406	(12,925)
Child	73,203	72,978	72,855	72,899	72,345	70,973	70,328	69,430	68,850	67,919	66,518		778,298	842,272	(63,974)
Expansion	182,912	181,318	182,080	181,632	179,847	175,204	173,049	169,517	166,654	162,993	159,346		1,914,552	1,947,712	(33,160)
LTC	3	12	(1)			1	1						16	11	5
SPD	20,739	20,738	20,896	20,798	20,700	21,213	20,857	20,168	19,960	19,703	19,304		225,076	219,988	5,088
Whole Child Model	1,508	1,526	1,499	1,371	1,449	1,399	1,403	1,393	1,326	1,278	1,339		15,491	15,703	(212)
Total	345,952	344,151	345,640	345,208	342,501	335,435	330,761	323,796	318,792	312,237	305,441		3,649,914	3,755,092	(105,178)
PHCs															
Adult	3,936	3,870	3,761	3,668	3,632	3,526	3,423	3,296	3,230	3,135	3,068		38,545	39,302	(757)
Child	129,804	128,525	127,408	126,859	126,480	124,703	124,033	122,561	121,702	120,678	119,504		1,372,257	1,382,018	(9,761)
Expansion	21,807	21,373	20,988	20,479	20,259	20,012	19,772	19,316	19,098	18,884	18,495		220,483	235,415	(14,932)
SPD	4,775	4,791	4,754	4,517	4,510	4,699	4,654	4,541	4,511	4,533	4,516		50,801	50,640	161
Whole Child Model	6,119	5,909	5,992	5,913	5,972	5,982	6,044	6,069	6,088	5,924	5,939		65,951	66,088	(137)
Total	166,441	164,468	162,903	161,436	160,853	158,922	157,926	155,783	154,629	153,154	151,522		1,748,037	1,773,463	(25,426)
Shared Risk Groups															
Adult	11,382	11,126	10,872	10,652	13,363	13,277	13,129	12,927	12,770	12,645	12,573		134,716	138,216	(3,500)
Child	18,444	18,179	17,845	17,764	21,036	20,822	20,848	20,685	20,631	20,587	20,379		217,220	211,881	5,339
Expansion	34,473	33,658	33,030	32,525	37,053	36,360	36,073	35,866	35,685	35,301	34,939		384,963	401,185	(16,222)
LTC		1				1							2	9	(7)
SPD	3,418	3,327	3,355	3,268	4,042	4,109	4,123	3,999	4,041	3,996	3,967		41,645	37,431	4,214
Whole Child Model	226	252	301	265	396	385	406	404	334	298	367		3,634	4,727	(1,093)
Total	67,943	66,543	65,403	64,474	75,890	74,954	74,579	73,881	73,461	72,827	72,225		782,180	793,449	(11,269)
Fee for Service (Dual)															
Adult	876	859	867	846	861	758	783	769	789	797	761		8,966	12,429	(3,463)
Child		1											1		1
Expansion	3,187	3,126	3,065	3,171	3,382	2,453	2,669	3,045	3,012	2,746	2,798		32,654	49,694	(17,040)
LTC	2,311	2,446	2,667	2,763	2,833	2,793	2,800	2,791	2,756	2,750	2,634		29,544	24,448	5,096
SPD	107,827	107,645	108,097	108,113	108,327	108,940	108,174	108,276	107,965	107,467	107,465		1,188,296	1,146,920	41,376
Whole Child Model	15	26	15	13	23	11	10	10	24	24	12		183	155	28
Total	114,216	114,103	114,711	114,906	115,426	114,955	114,436	114,891	114,546	113,784	113,670		1,259,644	1,233,646	25,998
Fee for Service (Non-Dual - Total)															
Adult	44,785	43,246	41,276	39,488	38,439	37,065	36,162	36,335	35,976	35,424	35,056		423,252	474,486	(51,234)
Child	35,975	34,671	34,330	33,798	30,558	30,303	30,169	31,158	30,811	30,311	30,529		352,613	391,305	(38,692)
Expansion	93,242	89,170	85,738	83,769	79,512	79,262	78,979	79,964	78,856	77,260	76,591		902,343	930,951	(28,608)
LTC	286	305	350	340	359	326	347	344	329	350	324		3,660	3,138	522
SPD	15,643	15,501	14,961	14,481	13,920	14,407	14,263	14,015	13,759	13,819	13,897		158,666	177,387	(18,721)
Whole Child Model	1,296	1,252	1,231	1,155	983	974	887	947	1,024	946	1,011		11,706	13,056	(1,350)
Total	191,227	184,145	177,886	173,031	163,771	162,337	160,807	162,763	160,755	158,110	157,408		1,852,240	1,990,323	(138,083)
Grand Totals															
Total MediCal MM	**885,779**	**873,410**	**866,543**	**859,055**	**858,441**	**846,603**	**838,509**	**831,114**	**822,183**	**810,112**	**800,266**		**9,292,015**	**9,545,973**	(253,958)
OneCare	**17,971**	**17,873**	**18,242**	**18,211**	**18,287**	**18,599**	**18,617**	**18,593**	**18,573**	**18,710**	**18,649**		**202,325**	**197,120**	**5,205**
PACE	**528**	**529**	**529**	**536**	**543**	**544**	**537**	**546**	**557**	**563**	**570**		**5,982**	**6,039**	(57)
MSSP	**553**	**551**	**556**	**571**	**582**	**582**	**573**	**583**	**591**	**584**	**586**		**6,312**	**6,138**	**174**
Grand Total	**904,278**	**891,812**	**885,314**	**877,802**	**877,271**	**865,746**	**857,663**	**850,253**	**841,313**	**829,385**	**819,485**		**9,500,322**	**9,749,132**	(248,810)

Note:* Total membership does not include MSSP

Back to Agenda

ENROLLMENT– MAY MONTH:

Overall, May enrollment was 819,485

- Unfavorable to budget 49,081 or 5.7%
- Decreased 9,900 or 1.2% from Prior Month (PM) (April 2026)
- Decreased 85,337 or 9.4% from Prior Year (PY) (May 2025)

Medi-Cal enrollment was 800,266

- Unfavorable to budget 49,581 or 5.8% due to freeze of enrollment for members 19 years or older with Unsatisfactory Immigration Status (UIS) and asset test reinstatement
- Medi-Cal Expansion (MCE) enrollment unfavorable to budget 19,019
- Child (CHD) enrollment unfavorable to budget 17,009
- Adult (FAM) enrollment unfavorable to budget 13,179
- Seniors and Persons with Disabilities (SPD) enrollment unfavorable to budget 482
- Whole Child Model (WCM) enrollment unfavorable to budget 346
- Long-Term Care (LTC) enrollment favorable to budget 454
- Decreased 9,846 or 1.2% from PM

OneCare enrollment was 18,649

- Favorable to budget 499 or 2.7%
- Decreased 61 or 0.3% from PM

PACE enrollment was 570

- Favorable to budget 1or 0.2%
- Increased 7 or 1.2% from PM

MSSP enrollment was 586

- Favorable to budget 28 or 5.0%
- Increased 2 or 0.3% from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2026

May 2026					July 2025 - May 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
800,266	**849,847**	(49,581)	(5.8%)	**Member Months**	**9,292,015**	**9,545,973**	(253,958)	(2.7%)
				Revenues				
352,652,622	339,140,113	13,512,509	4.0%	Capitation Revenue	4,309,747,051	3,822,773,479	486,973,572	12.7%
352,652,622	**339,140,113**	**13,512,509**	**4.0%**	**Total Operating Revenue**	**4,309,747,051**	**3,822,773,479**	**486,973,572**	**12.7%**
				Medical Expenses				
106,721,577	108,843,720	2,122,143	1.9%	Provider Capitation	1,222,812,070	1,227,734,841	4,922,771	0.4%
65,767,829	66,638,733	870,904	1.3%	Facilities Claims	734,298,170	724,804,991	(9,493,179)	(1.3%)
74,605,841	76,059,585	1,453,744	1.9%	Professional Claims	786,087,856	818,514,069	32,426,213	4.0%
48,192,074	51,295,525	3,103,451	6.1%	MLTSS	509,089,828	547,770,465	38,680,637	7.1%
7,259,370	9,445,750	2,186,380	23.1%	Incentive Payments	59,368,920	104,563,322	45,194,402	43.2%
8,169,281	10,952,120	2,782,839	25.4%	Medical Management	97,317,103	121,529,091	24,211,988	19.9%
2,659,573	1,769,683	(889,890)	(50.3%)	Other Medical Expenses	529,191,355	19,948,949	(509,242,406)	(2552.7%)
313,375,546	**325,005,116**	**11,629,570**	**3.6%**	**Total Medical Expenses**	**3,938,165,302**	**3,564,865,728**	(373,299,574)	(10.5%)
39,277,076	**14,134,997**	**25,142,079**	**177.9%**	**Gross Margin**	**371,581,748**	**257,907,751**	**113,673,997**	**44.1%**
				Administrative Expenses				
11,550,183	12,431,799	881,616	7.1%	Salaries, Wages & Employee Benefits	127,915,753	135,860,903	7,945,150	5.8%
1,335,859	1,963,905	628,045	32.0%	Professional Fees	12,598,592	16,563,344	3,964,752	23.9%
1,264,878	2,109,600	844,722	40.0%	Purchased Services	17,283,290	23,908,942	6,625,652	27.7%
183,966	467,845	283,879	60.7%	Printing & Postage	3,740,021	5,232,445	1,492,425	28.5%
1,069,181	947,712	(121,469)	(12.8%)	Depreciation & Amortization	10,547,751	10,424,832	(122,919)	(1.2%)
2,981,627	4,088,037	1,106,409	27.1%	Other Operating Expenses	33,768,128	46,836,121	13,067,993	27.9%
(670,081)	(735,476)	(65,395)	(8.9%)	Indirect Cost Allocation, Occupancy	(7,413,602)	(8,125,636)	(712,034)	(8.8%)
17,715,614	**21,273,422**	**3,557,808**	**16.7%**	**Total Administrative Expenses**	**198,439,932**	**230,700,951**	**32,261,019**	**14.0%**
21,561,462	(7,138,425)	**28,699,887**	**402.0%**	**Income (Loss) From Operations**	**173,141,817**	**27,206,800**	**145,935,016**	**536.4%**
				Non-Operating Income (Loss)				
(2,514,756)	-	(2,514,756)	0.0%	Community Reinvestment	29,647,026	-	29,647,026	100.0%
1,514	-	1,514	0.0%	Other Income /Expense	(6,041,320)	-	(6,041,320)	(100.0%)
(2,513,243)	-	(2,513,243)	(100.0%)	**Total Non-Operating Income/(Loss)**	**23,605,707**	-	**23,605,707**	**100.0%**
19,048,220	(7,138,425)	**26,186,645**	**366.8%**	**Change in Net Assets**	**196,747,523**	**27,206,800**	**169,540,723**	**623.2%**
88.9%	***95.8%***	(7.0%)		***Medical Loss Ratio***	***91.4%***	***93.3%***	(1.9%)	
5.0%	***6.3%***	***1.2%***		***Admin Loss Ratio***	***4.6%***	***6.0%***	***1.4%***	

Back to Agenda

MEDI-CAL INCOME STATEMENT– MAY MONTH:

REVENUES are $352.7 million, favorable to budget $13.5 million:

- Unfavorable volume-related variance of $19.8 million
- Favorable price-related variance of $33.3 million
  - $33.9 million due to favorable Calendar Year (CY) 2026 capitation rates and member mix by the Department of Health Care Services (DHCS)

MEDICAL EXPENSES are $313.4 million, favorable to budget $11.6 million:

- Favorable volume-related variance of $19.0 million
- Unfavorable price-related variance of $7.3 million
  - Provider Capitation expense unfavorable variance of $4.2 million
  - Facilities Claims expense unfavorable variance of $3.0 million
  - Professional Claims expense unfavorable variance of $3.0 million
  - Other Medical Expenses unfavorable variance of $1.0 million
  - All other expense categories favorable variance of $3.9 million

ADMINISTRATIVE EXPENSES are $17.7 million, favorable to budget $3.6 million:

- Non-Salary expense favorable to budget $2.7 million
- Salary expense favorable to budget $0.9 million

NON-OPERATING INCOME/(LOSS) is ($2.5) million, unfavorable to budget $2.5 million

CHANGE IN NET ASSETS is $19.0 million, favorable to budget $26.2 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2026

May 2026					July 2025 - May 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
18,649	**18,150**	**499**	**2.7%**	**Member Months**	**202,325**	**197,120**	**5,205**	**2.6%**
				Revenues				
25,843,475	29,257,500	(3,414,025)	(11.7%)	Medicare Part C	290,807,852	312,780,726	(21,972,874)	(7.0%)
10,229,359	11,417,568	(1,188,209)	(10.4%)	Medicare Part D	114,354,398	114,371,368	(16,970)	(0.0%)
36,072,834	**40,675,068**	(4,602,234)	(11.3%)	**Total Operating Revenue**	**405,162,251**	**427,152,094**	(21,989,843)	(5.1%)
				Medical Expenses				
14,477,805	17,077,956	2,600,151	15.2%	Provider Capitation	160,525,336	182,374,178	21,848,842	12.0%
6,067,285	5,415,016	(652,269)	(12.0%)	Facilities Claims	59,316,162	56,874,659	(2,441,503)	(4.3%)
2,679,168	2,098,474	(580,694)	(27.7%)	Professional Claims	26,190,226	22,154,652	(4,035,574)	(18.2%)
10,891,349	11,330,549	439,200	3.9%	Prescription Drugs	108,519,842	117,377,471	8,857,630	7.5%
313,880	617,276	303,396	49.2%	Incentive Payments	3,986,472	6,966,736	2,980,264	42.8%
1,234,304	1,493,669	259,365	17.4%	Medical Management	12,295,262	16,563,290	4,268,028	25.8%
492,781	114,671	(378,110)	(329.7%)	Other Medical Expenses	6,232,075	1,245,342	(4,986,733)	(400.4%)
36,156,572	**38,147,611**	**1,991,039**	**5.2%**	**Total Medical Expenses**	**377,065,375**	**403,556,328**	**26,490,953**	**6.6%**
(83,738)	**2,527,457**	(2,611,195)	(103.3%)	**Gross Margin**	**28,096,876**	**23,595,766**	**4,501,110**	**19.1%**
				Administrative Expenses				
1,036,024	1,227,665	191,641	15.6%	Salaries, Wages & Employee Benefits	11,378,199	13,315,334	1,937,135	14.5%
34,479	115,466	80,987	70.1%	Professional Fees	931,162	1,279,126	347,964	27.2%
424,620	396,613	(28,007)	(7.1%)	Purchased Services	4,286,941	4,926,657	639,716	13.0%
126,103	106,817	(19,286)	(18.1%)	Printing & Postage	1,243,914	1,321,437	77,523	5.9%
77,358	189,705	112,347	59.2%	Other Operating Expenses	1,281,706	1,341,371	59,665	4.4%
1,078,093	1,198,167	120,074	10.0%	Indirect Cost Allocation, Occupancy	11,859,026	13,179,837	1,320,811	10.0%
2,776,677	**3,234,433**	**457,756**	**14.2%**	**Total Administrative Expenses**	**30,980,947**	**35,363,762**	**4,382,815**	**12.4%**
(2,860,415)	(706,976)	(2,153,439)	(304.6%)	**Change in Net Assets**	(2,884,071)	(11,767,996)	**8,883,925**	**75.5%**
100.2%	***93.8%***	***6.4%***		***Medical Loss Ratio***	***93.1%***	***94.5%***	(1.4%)	
7.7%	***8.0%***	***0.3%***		***Admin Loss Ratio***	***7.6%***	***8.3%***	***0.6%***	

Back to Agenda

ONECARE INCOME STATEMENT– MAY MONTH:

REVENUES are $36.1 million, unfavorable to budget $4.6 million:

- Favorable volume-related variance of $1.1 million
- Unfavorable price-related variance of $5.7 million due to CY 2026 Hierarchical Condition Category (HCC) estimate

MEDICAL EXPENSES are $36.2 million, favorable to budget $2.0 million:

- Unfavorable volume-related variance of $1.0 million
- Favorable price-related variance of $3.0 million
  - Provider Capitation expense favorable variance of $3.1 million
  - Prescription Drugs expense favorable variance of $0.8 million
  - Incentive Payments expense favorable variance of $0.3 million
  - Medical Management expense favorable variance of $0.3 million
  - Offset by:
    - Professional Claims expense unfavorable variance of $0.5 million
    - Facilities Claims expense unfavorable variance of $0.5 million
    - Other Medical expense unfavorable variance of $0.4 million

ADMINISTRATIVE EXPENSES are $2.8 million, favorable to budget $0.5 million

- Non-Salary expense favorable to budget $0.3 million
- Salaries, Wages & Employee Benefits expense favorable to budget $0.2 million

CHANGE IN NET ASSETS is ($2.9) million, unfavorable to budget $2.2 million

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2026

May 2026					July 2025 - May 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
570	**569**	1	0.2%	**Member Months**	**5,982**	**6,039**	(57)	(0.9%)
				Revenues				
3,974,941	3,931,344	43,597	1.1%	Medi-Cal Capitation Revenue	41,206,339	41,475,014	(268,675)	(0.6%)
1,037,379	953,450	83,929	8.8%	Medicare Part C Revenue	10,396,672	9,695,561	701,111	7.2%
359,861	356,099	3,762	1.1%	Medicare Part D Revenue	3,986,392	3,715,963	270,429	7.3%
5,372,182	**5,240,893**	**131,289**	**2.5%**	**Total Operating Revenue**	**55,589,404**	**54,886,538**	**702,866**	**1.3%**
				Medical Expenses				
1,486,855	1,576,893	90,038	5.7%	Medical Management	16,386,122	17,447,369	1,061,247	6.1%
1,120,478	918,268	(202,210)	(22.0%)	Facilities Claims	12,033,955	9,332,632	(2,701,323)	(28.9%)
877,488	868,184	(9,304)	(1.1%)	Professional Claims	9,147,036	8,815,757	(331,279)	(3.8%)
609,991	796,483	186,492	23.4%	Prescription Drugs	6,387,115	8,094,981	1,707,866	21.1%
66,125	53,446	(12,679)	(23.7%)	MLTSS	700,401	474,283	(226,118)	(47.7%)
318,400	322,115	3,715	1.2%	Patient Transportation	3,261,721	3,202,827	(58,894)	(1.8%)
4,479,337	**4,535,389**	**56,052**	**1.2%**	**Total Medical Expenses**	**47,916,350**	**47,367,849**	(548,501)	(1.2%)
892,844	**705,504**	**187,340**	**26.6%**	**Gross Margin**	**7,673,054**	**7,518,689**	**154,365**	**2.1%**
				Administrative Expenses				
179,209	186,879	7,670	4.1%	Salaries, Wages & Employee Benefits	2,004,452	2,040,766	36,314	1.8%
34,929	13,941	(20,988)	(150.5%)	Professional Fees	151,380	153,143	1,763	1.2%
84,376	77,062	(7,314)	(9.5%)	Purchased Services	778,755	787,482	8,727	1.1%
15,459	17,187	1,728	10.1%	Printing & Postage	197,151	221,257	24,106	10.9%
1,068	1,622	554	34.1%	Depreciation & Amortization	10,538	17,842	7,304	40.9%
7,720	8,312	592	7.1%	Other Operating Expenses	119,500	119,640	140	0.1%
17,150	17,494	344	2.0%	Indirect Cost Allocation, Occupancy	180,280	192,434	12,154	6.3%
339,911	**322,497**	(17,414)	(5.4%)	**Total Administrative Expenses**	**3,442,056**	**3,532,564**	**90,508**	**2.6%**
552,933	**383,007**	**169,926**	**44.4%**	**Change in Net Assets**	**4,230,998**	**3,986,125**	**244,873**	**6.1%**
83.4%	***86.5%***	(3.2%)		***Medical Loss Ratio***	***86.2%***	***86.3%***	(0.1%)	
6.3%	***6.2%***	(0.2%)		***Admin Loss Ratio***	***6.2%***	***6.4%***	***0.2%***	

Back to Agenda

CalOptima Health
MSSP
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2026

May 2026					July 2025 - May 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
586	**558**	28	5.0%	**Member Months**	**6,312**	**6,138**	**174**	**2.8%**
				Revenues				
242,421	249,054	(6,633)	(2.7%)	Medi-Cal Capitation Revenue	2,726,540	2,739,594	(13,054)	(0.5%)
242,421	**249,054**	(6,633)	(2.7%)	**Total Operating Revenue**	**2,726,540**	**2,739,594**	(13,054)	(0.5%)
				Medical Expenses				
189,829	194,133	4,304	2.2%	Medical Management	2,067,054	2,135,463	68,409	3.2%
19,942	32,959	13,017	39.5%	Waiver Services	332,770	362,549	29,779	8.2%
209,771	**227,092**	**17,321**	**7.6%**	**Total Program Expenses**	**2,399,825**	**2,498,012**	**98,187**	**3.9%**
32,650	**21,962**	**10,688**	**48.7%**	**Gross Margin**	**326,716**	**241,582**	**85,133**	**35.2%**
				Administrative Expenses				
110,285	125,759	15,474	12.3%	Salaries, Wages & Employee Benefits	1,166,151	1,369,232	203,081	14.8%
1,457	1,500	43	2.9%	Professional Fees	16,027	16,500	473	2.9%
1	-	(1)	(100.0%)	Purchased Services	39	-	(39)	(100.0%)
7,865	8,520	655	7.7%	Other Operating Expenses	86,932	93,720	6,788	7.2%
7,283	7,583	300	4.0%	Indirect Cost Allocation, Occupancy	80,109	83,413	3,304	4.0%
126,891	**143,362**	**16,471**	**11.5%**	**Total Administrative Expenses**	**1,349,257**	**1,562,865**	**213,608**	**13.7%**
(94,241)	(121,400)	**27,159**	**22.4%**	**Change in Net Assets**	(1,022,541)	(1,321,283)	**298,742**	**22.6%**
86.5%	***91.2%***	(4.6%)		***Medical Loss Ratio***	***88.0%***	***91.2%***	(3.2%)	
52.3%	***57.6%***	***5.2%***		***Admin Loss Ratio***	***49.5%***	***57.0%***	***7.6%***	

CalOptima Health
Covered California
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2026

May 2026					July 2025 - May 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
-	-	-	**0.0%**	**Member Months**	-	-	-	**0.0%**
				Revenues				
-	-	-	0.0%	Capitation Revenue	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Medical Expenses				
-	44,984	44,984	100.0%	Medical Management	-	494,824	494,824	100.0%
-	**44,984**	**44,984**	**100.0%**	**Total Medical Expenses**	**-**	**494,824**	**494,824**	**100.0%**
-	(44,984)	**44,984**	(100.0%)	**Gross Margin**	**-**	(494,824)	**494,824**	(100.0%)
				Administrative Expenses				
228,905	377,739	148,834	39.4%	Salaries, Wages & Employee Benefits	1,333,363	3,676,681	2,343,318	63.7%
66,621	418,333	351,712	84.1%	Professional Fees	3,105,093	4,601,663	1,496,570	32.5%
25,000	52,000	27,000	51.9%	Purchased Services	25,000	572,000	547,000	95.6%
-	21	21	100.0%	Printing & Postage	-	231	231	100.0%
105	43,221	43,116	99.8%	Other Operating Expenses	431	475,431	475,000	99.9%
320,631	**891,314**	**570,683**	**64.0%**	**Total Administrative Expenses**	**4,463,887**	**9,326,006**	**4,862,119**	**52.1%**
(320,631)	(936,298)	**615,667**	**65.8%**	**Income (Loss) From Operations**	(4,463,887)	(9,820,830)	**5,356,943**	**54.5%**
(320,631)	(936,298)	**615,667**	**65.8%**	**Change in Net Assets**	(4,463,887)	(9,820,830)	**5,356,943**	**54.5%**
0.0%	***0.0%***	***0.0%***		***Medical Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	

Back to Agenda

CalOptima Health
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2026

May 2026					July 2025 - May 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Building Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
106,215	29,708	(76,507)	(257.5%)	Purchased Services	854,065	326,788	(527,277)	(161.4%)
190,106	191,643	1,537	0.8%	Depreciation & Amortization	2,064,434	2,108,073	43,639	2.1%
21,938	25,124	3,186	12.7%	Insurance Expense	254,219	276,364	22,145	8.0%
147,078	219,809	72,731	33.1%	Repair & Maintenance	1,849,880	2,417,899	568,019	23.5%
38,755	59,093	20,338	34.4%	Other Operating Expenses	588,535	650,023	61,488	9.5%
(504,092)	(525,376)	(21,284)	(4.1%)	Indirect Cost Allocation, Occupancy	(5,611,132)	(5,779,136)	(168,004)	(2.9%)
-	**1**	**1**	**100.0%**	**Total Administrative Expenses**	**-**	**11**	**11**	**100.0%**
-	(1)	**1**	(100.0%)	**Change in Net Assets**	**-**	(11)	**11**	(100.0%)

Back to Agenda

CalOptima Health
Building 500 - City Parkway
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2026

May 2026					July 2025 - May 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
137,198	118,206	18,992	16.1%	Building Income	1,539,366	1,300,266	239,100	18.4%
137,198	**118,206**	**18,992**	**16.1%**	**Total Operating Revenue**	**1,539,366**	**1,300,266**	**239,100**	**18.4%**
				Administrative Expenses				
41,940	19,131	(22,809)	(119.2%)	Purchased Services	606,188	210,441	(395,747)	(188.1%)
59,004	75,663	16,659	22.0%	Depreciation & Amortization	649,075	832,293	183,218	22.0%
7,807	9,245	1,438	15.6%	Insurance Expense	93,010	101,695	8,685	8.5%
107,013	104,657	(2,356)	(2.3%)	Repair & Maintenance	642,016	1,151,227	509,211	44.2%
13,554	31,298	17,744	56.7%	Other Operating Expenses	219,291	344,278	124,987	36.3%
(24,285)	(25,416)	(1,131)	(4.4%)	Indirect Cost Allocation, Occupancy	(233,998)	(279,576)	(45,578)	(16.3%)
205,033	**214,578**	**9,545**	**4.4%**	**Total Administrative Expenses**	**1,975,582**	**2,360,358**	**384,776**	**16.3%**
(67,835)	(96,372)	**28,537**	**29.6%**	**Change in Net Assets**	(436,216)	(1,060,092)	**623,876**	**58.9%**

Back to Agenda

CalOptima Health
Building 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2026

May 2026					July 2025 - May 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Building Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
33,462	3,333	(30,129)	(904.0%)	Purchased Services	375,061	36,663	(338,398)	(923.0%)
9,397	9,651	254	2.6%	Depreciation & Amortization	103,372	106,161	2,789	2.6%
4,984	-	(4,984)	(100.0%)	Insurance Expense	52,660	-	(52,660)	(100.0%)
6,258	28,533	22,275	78.1%	Repair & Maintenance	30,906	313,863	282,957	90.2%
1,598	720	(878)	(122.0%)	Other Operating Expenses	5,267	7,920	2,653	33.5%
55,700	**42,237**	(13,463)	(31.9%)	**Total Administrative Expenses**	**567,265**	**464,607**	(102,658)	(22.1%)
(55,700)	(42,237)	(13,463)	(31.9%)	**Change in Net Assets**	(567,265)	(464,607)	(102,658)	(22.1%)

Back to Agenda

OTHER PROGRAM INCOME STATEMENTS – MAY MONTH:

PACE

- **CHANGE IN NET ASSETS** is $0.6 million, favorable to budget $0.2 million

MSSP

- **CHANGE IN NET ASSETS** is ($94,241), favorable to budget $27,159

Covered CA

- **CHANGE IN NET ASSETS** is ($0.3) million, favorable to budget $0.6 million

NON-OPERATING INCOME STATEMENTS – MAY MONTH:

BUILDING 500 City Parkway

- **CHANGE IN NET ASSETS** is ($67,835) million, favorable to budget $28,537

BUILDING 7900 Garden Grove Blvd

- **CHANGE IN NET ASSETS** is ($55,700), unfavorable to budget $13,463

INVESTMENT INCOME

- Net Investment Income of $9.1 million due to $4.0 million in unrealized loss on investments, offset by $13.1 million of net interest income

COMMUNITY REINVESTMENT

- Unfavorable variance of $2.5 million due to Community Reinvestment obligation estimates

CalOptima Health
Balance Sheet
May 31, 2026

		May-26	April-26	$ Change	% Change
ASSETS					
Current Assets					
	Operating Cash	274,730,860	186,430,035	88,300,825	47.4%
	Short-term Investments	1,835,320,651	1,837,200,374	(1,879,724)	(0.1%)
	Receivables - Other	15,809,461	16,256,385	(446,924)	(2.7%)
	Prepaid Expenses	17,404,444	18,311,690	(907,246)	(5.0%)
	Capitation Receivables	618,494,839	620,954,776	(2,459,937)	(0.4%)
	Total Current Assets	**2,761,760,255**	**2,679,153,260**	**82,606,995**	**3.1%**
	Total Capital Assets, Net	**108,981,068**	**109,126,426**	(145,358)	(0.1%)
Other Assets					
	Restricted Deposit & Other	300,000	300,000	-	0.0%
	Total Other Assets	**300,000**	**300,000**	**-**	**0.0%**
Board Designated Assets					
	Board Designated Reserves	1,635,396,290	1,632,536,535	2,859,755	0.2%
	Statutory Designated Reserves	141,432,587	136,279,926	5,152,662	3.8%
	Total Designated Assets	**1,776,828,877**	**1,768,816,461**	**8,012,416**	**0.5%**
TOTAL ASSETS		**4,647,870,200**	**4,557,396,146**	**90,474,054**	**2.0%**
Deferred Outflows	GASB 68 - PERS - Contributions	94,666	94,666	-	0.0%
	GASB 68 - PERS - Difference in Experience	20,669,960	20,669,960	-	0.0%
	GASB 68 - PERS - Changes in Assumptions	4,311,207	4,311,207	-	0.0%
	GASB 68 - PERS - Difference in Earnings	2,361,239	2,361,239	-	0.0%
	GASB 75 - OPEB - Contributions	637,000	637,000	-	0.0%
	GASB 75 - OPEB - Changes in Assumptions	552,000	552,000	-	0.0%
	GASB 53 - INVT - Changes in Fair Value	-	59,531	(59,531)	(100.0%)
	Advance Discretionary Payment			-	0.0%
TOTAL ASSETS & DEFERRED OUTFLOWS		**4,676,496,272**	**4,586,081,749**	**90,414,523**	**2.0%**
LIABILITIES					
Current Liabilities	Accounts Payable	159,917,521	112,172,478	47,745,042	42.6%
	Accrued Payroll Liabilities	23,476,431	25,952,475	(2,476,044)	(9.5%)
	Deferred Revenue	7,971,083	7,971,083	-	0.0%
	Due to State of California and CMS	793,732,113	777,141,284	16,590,829	2.1%
	Medical Claims Liabilities	345,288,653	352,194,165	(6,905,511)	(2.0%)
	Capitation and Withholds	136,136,895	128,473,188	7,663,706	6.0%
	Total Current Liabilities	**1,466,522,696**	**1,403,904,674**	**62,618,022**	**4.5%**
	GASB 96 Subscription Liabilities	21,952,296	21,952,296	-	0.0%
	Capital Lease Payable	200,903	205,075	(4,172)	(2.0%)
	Community Reinvestment, Capital Lease Payable	58,451,085	55,936,328	2,514,756	4.5%
	Post Employment Health Benefits Liability	17,506,482	17,480,965	25,518	0.1%
	Net Pension Liabilities	5,840,992	5,840,992	-	0.0%
TOTAL LIABILITIES		**1,570,474,454**	**1,505,320,330**	**65,154,124**	**4.3%**
Deferred Inflows					
	GASB 68 - PERS - Difference in Experience	1,321,519	1,321,519	-	0.0%
	GASB 75 - OPEB - Changes in Assumptions	1,322,000	1,322,000	-	0.0%
	GASB 75 - OPEB - Difference in Experience	1,666,000	1,666,000	-	0.0%
	GASB 53 - INVT - Changes in Fair Value	-	-	-	0.0%
	Required TNE	134,823,552	135,126,542	(302,989)	(0.2%)
	Funds in excess of TNE	2,966,888,746	2,941,325,359	25,563,387	0.9%
	Net Assets	**3,101,712,299**	**3,076,451,900**	**25,260,398**	**0.8%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION		**4,676,496,272**	**4,586,081,749**	**90,414,523**	**2.0%**

Back to Agenda

BALANCE SHEET – MAY MONTH:

ASSETS of $4.7 billion increased $90.4 million from April or 2.0%

- Operating Cash and Short-term Investments increased $86.4 million due primarily to the Managed Care Organization (MCO) tax payment not being due this month
- Total Designated Assets increased $8.0 million due to a $5 million transfer from the custody account and an overall increase in the value of the portfolio

LIABILITIES of $1.6 billion increased $65.2 million from April or 4.3%

- Accounts Payable increased $47.7 million due to the CY 2026 MCO tax accrual
- Due to State of California and CMS increased $16.6 million due primarily to CY 2025 MCO tax overpayment by DHCS
- Capitation and Withholds increased $7.7 million due to accrual of CalOptima Health's provider and hospital incentive program and shared risk pool

NET ASSETS of $3.1 billion, increased $25.3 million from April or 0.8%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of May 31, 2026

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	817,052,656				
MetLife Tier One	818,343,634				
Board Designated Reserves	1,635,396,290	1,087,444,350	1,739,910,960	547,951,940	(104,514,670)
Current Reserve Level (X months of average monthly revenue) [1]	*3.76*	*2.50*	*4.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	70,786,061				
MetLife Tier Two	70,646,526				
Statutory Designated Reserves	141,432,587	134,823,552	148,305,908	6,609,035	(6,873,320)
Current Reserve Level (X min. TNE) [1]	*1.05*	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

CalOptima Health
Statement of Cash Flow
May 31, 2026

	May 2026	July 2025 - May 2026
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	25,260,398	301,128,598
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation & Amortization	1,328,757	13,375,170
Changes in assets and liabilities:		
Prepaid expenses and other	907,246	(6,221,382)
Capitation receivable	2,906,860	114,807,435
Medical claims liability	(6,905,511)	(702,448,686)
Deferred revenue	-	(14,083,479)
Payable to health networks	7,663,706	(17,856,470)
Accounts payable	47,745,042	(74,068,986)
Accrued payroll	(2,450,526)	(6,111,874)
Other accrued liabilities	19,101,414	769,155,533
Net cash provided by/(used in) operating activities	95,557,385	377,675,857
GASB53, GASB 68, GASB 75 and Advance Discretionary Payment Adjustments	59,531	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES:		
Change in Investments	1,879,724	(494,394,050)
Change in Property and Equipment	(1,183,399)	(23,733,533)
Change in Restricted Deposit & Other	-	-
Change in Board Designated Reserve	(8,012,417)	(60,021,369)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	(7,316,092)	(578,148,952)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	88,300,825	(200,473,095)
CASH AND CASH EQUIVALENTS, beginning of period	186,430,035	475,203,955
CASH AND CASH EQUIVALENTS, end of period	**274,730,860**	**274,730,860**

Back to Agenda

CalOptima Health
Spending Plan
For the Eleven Months Ending May 31, 2026

Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
Total Net Position @ 5/31/2026	**$3,101.7**			**100.0%**
Resources Assigned				
Board Designated Reserve[1]	**$1,635.4**			**52.7%**
Statutory Designated Reserve[1]	**$141.4**			**4.6%**
Capital Assets, net of Depreciation	**$109.0**			**3.5%**
Resources Allocated				
Homeless Health Initiative (HHI)[2]	14.2	63.3	49.1	0.5%
Housing and Homelessness Incentive (HHIP)[2]	25.6	87.4	61.8	0.8%
Intergovernmental Transfers (IGTs)	34.9	52.1	17.2	1.1%
Digital Transformation and Workplace Modernization[3]	20.7	100.0	79.3	0.7%
CalFresh Outreach Strategy	1.7	6.0	4.3	0.1%
Coalition of Orange County Community Health Centers Grant	10.7	50.0	39.3	0.3%
Mind OC Grant (Irvine)	-	15.0	15.0	0.0%
General Awareness Campaign	0.1	4.7	4.6	0.0%
Member Health Needs Assessment	0.3	1.3	1.0	0.0%
Five-Year Hospital Quality Program	106.8	153.5	46.7	3.4%
Skilled Nursing Facility Access Program	10.0	10.0	-	0.3%
National Alliance for Mental Illness (NAMI) Orange County Peer Support Program Grant	2.0	5.0	3.0	0.1%
Stipend Program for Master of Social Works Grant	-	5.0	5.0	0.0%
Wellness & Prevention Program Grant	1.0	2.7	1.7	0.0%
CalOptima Health Provider Workforce Development Fund Grant	39.7	50.0	10.3	1.3%
Garden Grove Bldg Improvement	16.5	17.5	1.1	0.5%
Dyadic Services Program Academy	0.2	1.9	1.7	0.0%
Medi-Cal Provider Rate Increases	122.8	526.2	403.4	4.0%
Homeless Prevention and Stabilization Pilot Program	0.2	0.3	0.1	0.0%
OneCare Member Engagement and Education	0.1	0.3	0.2	0.0%
Medi-Cal Eligibility Outreach Strategy	20.7	21.8	1.1	0.7%
Supplemental Food Support for Medi-Cal Members	4.7	8.0	3.3	0.2%
Orange County Community Health Assessment and Improvement Plan	0.5	1.0	0.5	0.0%
Subtotal	**433.2**	**1,182.9**	**749.7**	**14.0%**
Resources Available for New Initiatives				
Unallocated/Unassigned[1]	**$782.7**			**25.2%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 219 days of CalOptima Health's current operations.

[2] See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.

[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

Back to Agenda

CalOptima Health
Key Financial Indicators
As of May 31, 2026

	Item Name	May 2026					July 2025 - May 2026				
		Actual	Budget	Variance	%		Actual	Budget	Variance	%	
Income Statement	*Member Months*	819,485	868,566	(49,081)	(5.7%)		9,500,322	9,749,132	(248,810)	(2.6%)	
	Operating Revenue	394,340,059	385,305,128	9,034,931	2.3%		4,773,225,245	4,307,551,705	465,673,540	10.8%	
	Medical Expenses	354,221,227	367,960,192	13,738,965	3.7%		4,365,546,851	4,018,782,741	(346,764,110)	(8.6%)	
	General and Administrative Expense	21,279,723	25,865,028	4,585,305	17.7%		238,676,079	280,486,148	41,810,069	14.9%	
	Non-Operating Income/(Loss)	6,421,290	8,194,731	(1,773,442)	(21.6%)		132,126,283	90,142,039	41,984,244	46.6%	
	Summary of Income & Expenses	25,260,398	(325,361)	25,585,759	7,863.8%		301,128,598	98,424,855	202,703,743	205.9%	
Ratios	Medical Loss Ratio (MLR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	89.8%	95.5%	(5.7%)			91.5%	93.3%	(1.8%)		
	Administrative Loss Ratio (ALR)	Actual	Budget	Variance			Actual	Budget	Variance		
	Consolidated	5.4%	6.7%	1.3%			5.0%	6.5%	1.5%		

Key:

> 0%
> -20%, < 0%
< -20%

Investment	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
	@5/31/2026	3,583,580,561	3,577,137,023	6,443,538	0.2%

Unallocated/Unassigned Reserve Balance	Current Month @May 2026	Fiscal Year Ending June 2025	Change	%
Consolidated	782,722,028	264,975,684	517,746,344	195.4%
*Days Cash On Hand**	211			

*Total Designated Reserves and unallocated reserve amount can support approximately 219 days of CalOptima Health's current operations.

Back to Agenda

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Eleven Months Ending May 31, 2026

Seg 6	May 2026 Actual Spend	May 2026 Approved Budget	May 2026 Variance $	May 2026 Variance %	July 2025 -May 2026 Actual Spend	July 2025 -May 2026 Approved Budget	July 2025 -May 2026 Variance $	July 2025 -May 2026 Variance %	All Time to Date Actual Spend	All Time to Date Approved Budget	All Time to Date Variance $	All Time to Date Variance %
Capital Assets (Cost, Information Only):												
Total Capital Assets	**75,880**	**(2,057,596)**	**(2,133,476)**	**103.7%**	**2,006,012**	**4,548,064**	**2,542,052**	**55.9%**	**17,616,964**	**31,318,180**	**13,701,216**	**43.7%**
Operating Expenses:												
Salaries, Wages & Benefits	-	-	-	0.0%	-	-	-	0.0%	17,826,058	17,826,058	-	0.0%
Professional Fees	228,137	250,000	21,863	8.7%	2,506,328	2,750,000	243,672	8.9%	9,307,139	9,550,811	243,672	2.6%
Purchased Services	-	-	-	0.0%	(141,754)	-	141,754	0.0%	1,190,915	1,332,669	141,754	10.6%
GASB 96 Amortization Expenses	-	-	-	0.0%	-	-	-	0.0%	2,563,169	2,563,169	-	0.0%
Other Expenses	25,259	182,292	157,033	86.1%	4,464,169	2,005,212	(2,458,957)	(122.6%)	25,559,910	23,100,953	(2,458,957)	(10.6%)
Medical Management	-	-	-	0.0%	-	-	-	0.0%	5,502,156	5,502,156	-	0.0%
Total Operating Expenses	**253,396**	**432,292**	**178,896**	**41.4%**	**6,828,743**	**4,755,212**	**(2,073,531)**	**-43.6%**	**61,949,349**	**59,875,818**	**(2,073,531)**	**-3.5%**

Funding Balance Tracking: July 2025	**Approved Budget**	**Actual Spend**	**Variance**
Beginning Funding Balance	100,000,000	100,000,000	-
Less:			
Capital Assets[1]	38,931,116	17,616,964	21,314,152
FY2023 Operating Budget[2]	8,381,011	8,381,011	-
FY2024 Operating Budget	22,788,092	22,788,092	-
FY2025 Operating Budget	24,289,000	23,951,502	337,498
FY2026 Operating Budget	5,187,500	6,828,743	(1,641,243)
Ending Funding Balance	**423,281**	**20,433,688**	**20,010,407**
Add: Prior year unspent Operating Budget	**337,498**		
Total available Funding	**760,779**		

[1] Staff will continue to monitor the project status of DTS' Capital Assets
[2] Unspent budget from this period is added back to available DTS funding
[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024

Note: 1. Report includes applicable transactions for GASB 96, Subscriptions - Based Information Technology Arrangements.

Back to Agenda

CalOptima Health
Summary of Homeless Health Initiatives (HHI) and Allocated Funds
As of May 31, 2026

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
HHI - IGT'S	61,496,005	61,496,005	49,125,580	12,370,425	-
HHI - Existing Reserves	1,800,000	1,800,000	-	1,800,000	-
HHIP	40,100,000	40,100,000	-	40,100,000	-
Total	**103,396,005**	**103,396,005**	**49,125,580**	**54,270,425**	**-**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-	IGT's
Recuperative Care	6,194,190	6,194,190	-	IGT's
Medical Respite	250,000	250,000	-	IGT's
Day Habilitation (County for HomeKey)[4]	-	-	-	IGT's
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-	IGT's
CalOptima Homeless Response Team	1,681,734	1,681,734	-	IGT's
Homeless Coordination at Hospitals	10,000,000	10,000,000	-	IGT's
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support[5]	925,540	925,540	-	IGT's
FQHC (Community Health Center) Expansion	21,902	21,902	-	IGT's
HCAP and CalOptima Health Days	9,888,914	4,985,310	4,903,604	IGT's
Vaccination Intervention and Member Incentive Strategy[2]	54,649	54,649	-	IGT's
Street Medicine[3]	14,279,077	9,736,241	4,542,836	IGT's & Existing Reserves
Outreach and Engagement	7,000,000	2,276,015	4,723,985	IGT's
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000	IGT's & Existing Reserves
Subtotal of Approved Initiatives	**103,396,005**	**49,125,580**	**54,270,425**	
Transfer of funds to HHIP[4]	(40,100,000)	-	(40,100,000)	
Program Total	**63,296,005**	**49,125,580**	**14,170,425**	

[1]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1 million from HHI to HHIP.

[2]On June 5, 2025, CalOptima Health's Board of Directors approved the close out of the Vaccination Intervention and Member Incentive Strategy program and transfer of the remaining funds of $68,699 to unallocated reserves for new initiatives.

[3]On August 7, 2025, CalOptima Health's Board of Directors approved $9.3 million to expand the Street Medicine Program ($3.2 million remaining from Street Medicine Initiative (from the Homeless Health Initiatives Reserve), $1.8 million from Existing Reserves, and $4.3 million from Intergovernmental Transfer balance resulting from a June 5, 2025, Board action), to fund 2-year grant agreements to Healthcare in Action (Anaheim), Celebrating Life Community Health Center (Costa Mesa), and AltaMed (Santa Ana).

[4] On February 5, 2026, CalOptima Health's Board of Directors approved the closeout of the Day Habilitation (County for HomeKey) and designated the remaining balance of $2.5 million as available for allocation to deliver enhanced services for Medi-Cal members.

[5]On April 2, 2026, CalOptima Health's Board of Directors approved the closeout of the CalOptima Days, HCAP and FQHC Administrative Support and make $37,721 in IGT 8 funds available toward future IGT initiatives to deliver covered services for Medi-Cal members.

CalOptima Health
Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds
As of May 31, 2026

Summary by Funding Source:	Total Funds[1]	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	65,931,189	65,931,189	34,733,595	31,197,594	-
Existing Reserves & HHI Transfer	87,384,530	87,384,530	61,793,542	25,590,988	-
Street Medicine Support Center - GG Building[2]	7,000,000	7,000,000	-	7,000,000	-
Total	**160,315,719**	**160,315,719**	**96,527,137**	**63,788,583**	-

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	1,400,000	909,650	490,350	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,821,311	800,001	HHI & DHCS
Infrastructure Projects	5,832,314	5,832,310	4	HHI
Capital Projects	126,247,564	73,140,270	53,107,294	HHI, DHCS & Existing Reserves
System Change Projects	19,314,530	9,968,205	9,346,325	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	**$160,315,719[1]**	**$96,527,137**	**$63,788,583**	
Transfer of funds to Street Medicine Support Center-GG Building	**#N/A**	**#N/A**	**#N/A**	Existing Reserves
Program Total	**$153,315,719**	**$96,527,137**	**$56,788,583**	

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments

[2]On October 7, 2025, CalOptima Health's Board of Directors approved up to $7.0 million for general contractor services & furniture, fixtures & equipment for the Street Medicine Support Center

CalOptima Health
Fiscal Year 2025-26 Budget Allocation Changes
Reporting Changes as of May 31, 2026

Transfer Month	Line of Business	From	To	Amount	Reason to Re-Allocate Funds
July	Medi-Cal	Human Resources - Training and Seminar - Participant Guides	Human Resources - Cert./Cont. Education - Educational Reimbursement	$90,000	For Educational Reimbursement
July	Medi-Cal	Human Resources - Professional Fees - Executive Recruiters, Direct Hire and Conversion Fees	Human Resources - Advertising - Combined: Recruitment and Job Postings Network	$90,000	For Job Posting Advertising
July	Medi-Cal	ITS - Infrastructure - Maintenance HW/SW - Software License	ITS - Infrastructure - Maintenance HW/SW - Server - Maintenance coverage for on-premises physical servers, storage and SAN switches	$28,150	For Server Maintenance Coverage
July	Medi-Cal	ITS - Application Development - Professional Fees - Development and QA Professional Services	ITS - Application Development - Purchased Services - General - Managed Services for Website Support	$120,250	For Website Maintenance Support
August	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Software License	ITS - Infrastructure - Other Operating Expenses - Server Connectivity Maintenance	$140,238	For Server Maintenance
August	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Maintenance for Firewalls and IPSEC VPNS	ITS - Infrastructure - Professional Fees - IT Advisory Subscription	$162,890	For Professional Services
August	Medi-Cal	ITS - Application Development - Automation Application for the Board and Committee Material Preparation	ITS - Application Development - Policies and Regulation Compliance Identification - Readily Compliance Project	$65,000	For Readily Compliance Project
September	Medi-Cal	ITS - Infrastructure - Maintenance HW/SW Network Connectivity Maintenance and Support	ITS - Infrastructure - Maintenance HW/SW Maintenance of Operations and Desktop Application Software and Hardware	$52,420	For Right Fax
September	Medi-Cal	Customer Service - Printing and Postage - Member Communication	Human Resources - Professional Fees - Employee Feedback	$70,000	For Leadership Development
October	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Annual Volume License Adjustment	ITS - Infrastructure - Other Operating Expenses - Enterprise Monitoring for On-premise and cloud instances	$34,415	For On-Premise and Cloud Database Monitoring Maintenance
October	Medi-Cal	ITS - Infrastructure - Other Operating Expense - Annual Volume Licenses Contract	ITS - Applications Management - Interest - GASB 96	$41,558	For License Agreement Renewal
October	Medi-Cal	ITS - Applications Management - Interest - GASB 96	ITS - Applications Management - Other Operating Expenses - Subscription-Based Information Technology Arrangements (SBITAs)	$41,558	For Increase Against Original Contract
October	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Annual Volume License Adjustment	ITS - Applications Management - Other Operating Expenses - TeamDynamix	$26,780	For TeamDynamix Solutions
November	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Annual Volume License Adjustment	ITS - Infrastructure - Other Operating Expenses - Data backup and protection	$249,999	For Infrastructure Maintenance
November	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Domain Names and IP Addresses	ITS - Infrastructure - Other Operating Expenses - Data backup and protection	$29,472	For Maintenance and Data Protection
December	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Network Firewall Upgrade and Enhancement	ITS - Infrastructure - Other Operating Expenses - Capital Software Expense	$15,000	For Capital Software
December	OneCare	Operations Management - Professional Fees - OneCare Consulting Services	ITS - Applications Management - Other Operating Expenses - Predictive Analytics Modeling	$18,000	For Application Development
December	OneCare	Communications - Purchased Services - Print Advertising	Communications - Printing and Postage - Direct Mail to Prospective Members	$75,000	For OneCare Direct Mail
December	Medi-Cal	ITS - Applications Management - Other Operating Expenses - Corporate Application SW	ITS - Applications Management - Other Operating Expenses - Writing assistance tool	$54,800	For Writing Assistance Tool
December	Medi-Cal	Accounting - Professional Fees - Investment Advisory Services	Accounting - Professional Fees - OPEB Valuation	$15,000	For Actuarial Services
January	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Additional Software License	ITS - Applications Management - Other Operating Expenses - CRM Licenses	$100,000	For Additional CRM Licenses
January	Medi-Cal	Human Resources - Other Operating Expenses - Employee Engagement Events and Logo Apparel	Human Resources - Professional Fees - Employee Feedback	$34,000	For Consulting Services
January	Medi-Cal	Human Resources - Purchased Services - Background Screening	Human Resources - Other Operating Expenses - Tuition Reimbursement	$20,000	For Educational Reimbursement
January	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Volume Licenses Contract	ITS - Infrastructure - Professional Fees - Consulting	$50,000	For Consulting Services
January	Medi-Cal	ITS - Application Development - Purchased Services to Med - Managed Service Support	ITS - Applications Management - Purchased Services to Med - Closed Loop Referral System and Support	$155,000	For Closed Loop Referral System and System
January	Medi-Cal	ITS - Applications Management - Maintenance HW/SW to Med - Software License	ITS - Applications Management - Purchased Services to Med - Closed Loop Referral System and Support	$22,000	For Closed Loop Referral System and System
January	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Additional Software License	Medi-Cal and CalAIM - Professional Fees - Grant Consulting	$50,000	For Grant Consulting Services
February	PACE	PACE Marketing - Printing and Postage - Member Communication - Direct Mail and Marketing Materials	PACE Marketing - Purchased Services - Advertising - Outdoor Ads	$23,000	For Advertising Campaigns
February	Medi-Cal	ITS - Application Development - Other Operating Expenses - Capital Software Expense	ITS - Application Development - Professional Fees - Development and QA Profession Services	$230,000	For Management Contractor for Operations
February	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Annual Volume License	ITS - Applications Management - Other Operating Expenses - GASB 96 Variable Expenses	$89,100	For Volume License Supplement
February	Medi-Cal	Facilities - Printing and Postage - General Postage for Outgoing Mail	Facilities - Other Operating Expenses - Purchases and Installation of Office Furniture	$50,000	For Supplies and Minor Equipment
February	Medi-Cal	Executive Office - Other Operating Expenses - Travel	Executive Office - Other Operating Expenses - Training and Seminar	$15,000	For Professional Development
February	Medi-Cal	ITS - Cyber Security - Professional Fees - AI Implementation Services for Security Controls	Accounting - Professional Fees - Accounting and Finance System Support	$100,000	For System Support

Back to Agenda

Fiscal Year 2025-26 Budget Allocation Changes
Reporting Changes as of May 31, 2026 (cont.)

Transfer Month	Line of Business	From	To	Amount	Reason to Re-Allocate Funds
March	Medi-Cal	Communications - Other Operating Expenses - Promotional Items	Communications - Purchased Services - Regulatory Compliance Remediation Services	$60,000	For Document Remediation Services
March	Covered California	IS - Enterprise Data and System - Regulatory Enrollment Transactions	ITS - Applications Management - Core System Configuration	$120,000	For Facets Implementation
March	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - User Licenses	ITS - Application Development - Other Operating Expenses - Office Software Suite License Costs	$50,000	For Office Software Suite License Costs
March	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - User Licenses	ITS - Applications Management - Other Operating Expenses - Finance Software Maintenance	$50,000	For Finance Software Maintenance
March	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Network Connectivity Expenses	ITS - Application Development - Other Operating Expenses - Application Software Maintenance	$75,000	For Testing Tool
March	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Network Connectivity Expenses	ITS - Infrastructure - Other Operating Expenses - Office Software Suite License Costs	$52,000	For Office Software Suite License Costs
March	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Network Connectivity Expenses	ITS - Applications Management - User Licenses for Customer Relationship Management Software	$52,000	For Customer Relationship Management Software
March	Medi-Cal	ITS - Infrastructure - Professional Fees - Process Enhancements	ITS - Application Development - Professional Fees - Development Enhancement	$200,000	For Development Enhancement
March	OneCare	Customer Service - Printing and Postage - Marketing Materials	Cultural and Linguistics Services - Purchased Services - Translations and Interpreter Services	$100,000	For Translations and Interpreter Services
March	Medi-Cal	IS - Enterprise Data and System - Other Operating Expenses - Application Software Maintenance	ITS - Infrastructure - Other Operating Expenses - User Licenses and Other Minor Computer Equipment	$15,855	For Computer Equipment
March	Medi-Cal	IS - Enterprise Data and System - Other Operating Expenses - Application Software Maintenance	IS - Enterprise Architecture - Professional Fees - External Consultant for Core Labor Work Support	$15,000	For External Consultant
April	Medi-Cal	ITS - Cyber Security - Other Operating Expenses - File Level Encryption	Human Resources - Professional Fees - Employee Feedback	$61,000	For Emergent Success
April	Medi-Cal	Procurement and Vendor Management - Purchased Services - Procurement Platform	Procurement and Vendor Management - Other Operating Expenses - Subscription Fees	$17,000	For Service Subscription
April	Medi-Cal	Claims Administration - Purchased Services - Change Healthcare EDI Clearinghouse	Claims Administration - Professional Fees - External Medical Review	$117,000	For Medical Reviews
April	Medi-Cal	IS - Enterprise Data and System - Other Operating Expenses - Software Maintenance	ITS - Application Development - Other Operating Expenses - Workflow Software Solution	$12,766	For Workflow Solution
April	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Maintenance for Replacements	ITS - Applications Management - Professional Fees - Facets Technical Support	$200,400	For Facets Technical Support Consulting
April	Medi-Cal	IS - Enterprise Data and System - Other Operating Expenses - Software Maintenance	ITS - Application Development - Other Operating Expenses - Subscription Service	$24,000	For IT Subscription Service
April	Medi-Cal	IS - Enterprise Data and System - Other Operating Expenses - Software Maintenance	ITS - Application Development - Other Operating Expenses - SurveyMonkey License	$31,432	For SurveyMonkey License
April	Medi-Cal	IS - Enterprise Data and System - Other Operating Expenses - Software Maintenance	ITS - Application Development - Other Operating Expenses - Management Training Software	$45,500	For Management Training Software
April	Medi-Cal	ITS - Cyber Security - Other Operating Expenses - Intrusion Prevention System	ITS - Application Development - Professional Fees - Cloud Platform Assistance	$100,000	For Cloud Platform Enhancement
April	Medi-Cal	Accounting - Other Operating Expenses - Training and Seminar	Accounting - Purchased Services - Tax Form Processing Fees	$20,000	For TIN Matching Add-On Services
May	Medi-Cal	ITS - Infrastructure - Purchased Services - Business Workflow Platform	ITS - Infrastructure - Professional Fees - External Consulting	$50,000	For Consulting Services
May	Medi-Cal	ITS - Applications Management - Other Operating Expenses - Licenses and Platform	ITS - Enterprise Architecture - Professional Fees - External Consulting	$45,000	For Consulting Services
May	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Network Connectivity Expenses	ITS - Infrastructure - Other Operating Expenses - Minor Computer Equipment	$40,000	For Hardware Equipment
May	Medi-Cal	Facilities - Other Operating Expenses - Office Supplies	Facilities - Other Operating Expenses - Purchases and Installation of Office Furniture	$60,000	For Minor Equipment
May	Medi-Cal	Facilities - Other Operating Expenses - Office Supplies	Facilities - Other Operating Expenses - Purchases and Installation of Office Furniture	$16,000	For Minor Equipment
May	Medi-Cal	ITS - Applications Management - Other Operating Expenses - Travel	ITS - Applications Management - Other Operating Expenses - Training and Seminar	$20,000	For Training and Seminar

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $250,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Financial Summary
May 31, 2026

Board of Directors Meeting

August 6, 2026

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

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

Financial Highlights Notes: May 2026

- CalOptima Health transferred $5.0 million from Short-Term Operating to the Statutory Reserve account in May, resulting in a month-end balance of $141.4 million, which brings the reserve to 105% of the DMHC minimum Tangible Net Equity (TNE) requirement. The board-approved TNE reserve policy range is between 100% to 110%.

Financial Highlights
May 2026

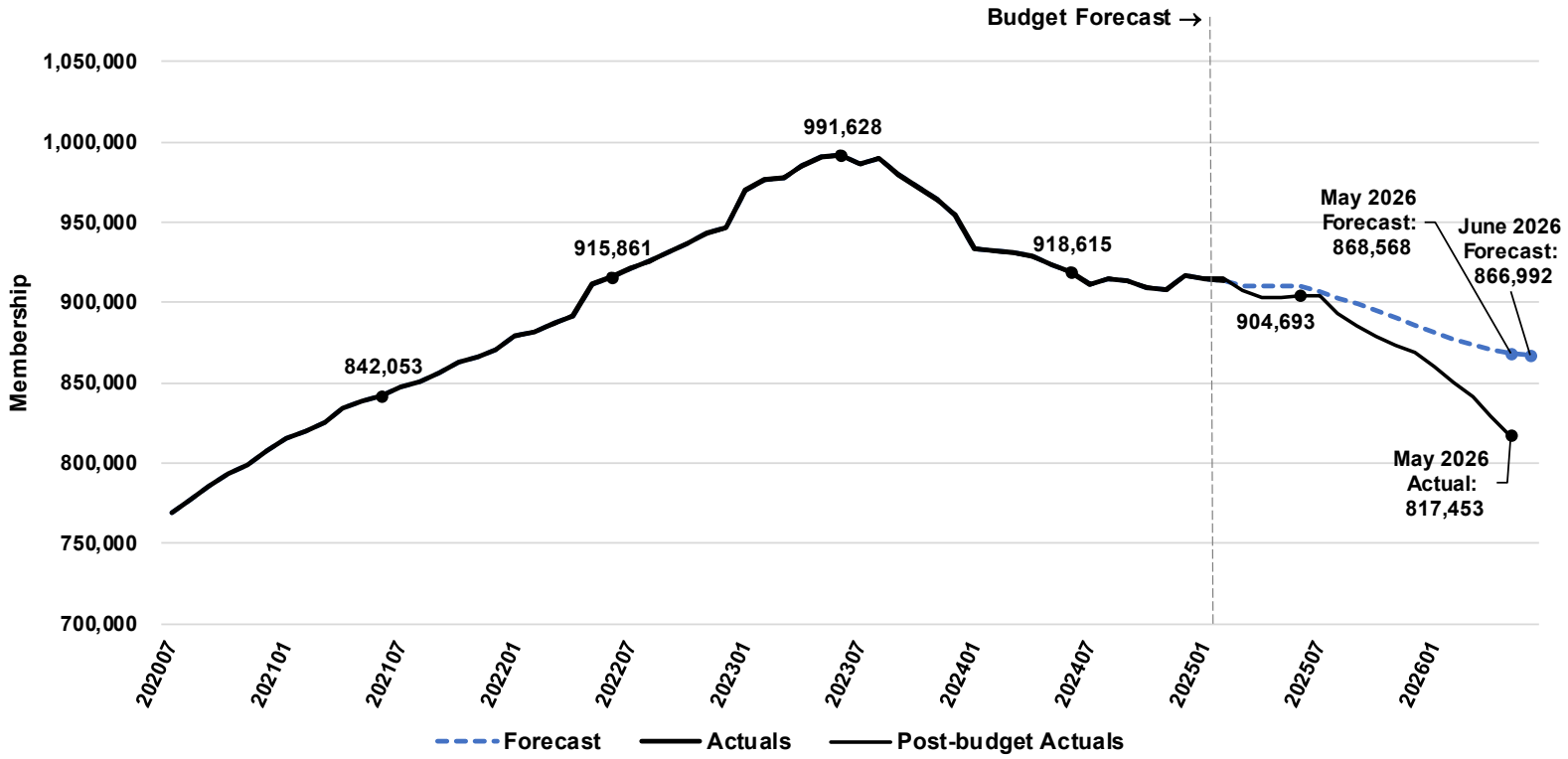
May 2026					July 2025 - May 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
819,485	868,566	(49,081)	(5.7%)	Member Months	9,500,322	9,749,132	(248,810)	(2.6%)
394,340,059	385,305,128	9,034,931	2.3%	Revenues	4,773,225,245	4,307,551,705	465,673,540	10.8%
354,221,227	367,960,192	13,738,965	3.7%	Medical Expenses	4,365,546,851	4,018,782,741	(346,764,110)	(8.6%)
21,279,723	25,865,028	4,585,305	17.7%	Administrative Expenses	238,676,079	280,486,148	41,810,069	14.9%
18,839,109	(8,520,092)	**27,359,201**	**321.1%**	**Operating Margin**	**169,002,315**	**8,282,816**	**160,719,499**	**1,940.4%**
				Non-Operating Income (Loss)				
9,113,067	8,333,341	779,726	9.4%	Net Investment Income/Expense	132,893,182	91,666,749	41,226,433	45.0%
(55,000)	-	(55,000)	(100.0%)	Grant Expense	(23,369,124)	-	(23,369,124)	(100.0%)
(2,514,756)	-	(2,514,756)	(100.0%)	Community Reinvestment	29,647,026	-	29,647,026	100.0%
(122,021)	(138,610)	16,589	12.0%	Other Income/Expense	(7,044,801)	(1,524,710)	(5,520,091)	(362.0%)
6,421,290	**8,194,731**	(1,773,442)	(21.6%)	**Total Non-Operating Income (Loss)**	**132,126,283**	**90,142,039**	**41,984,244**	**46.6%**
25,260,398	(325,361)	**25,585,759**	**7,863.8%**	**Change in Net Assets**	**301,128,598**	**98,424,855**	**202,703,743**	**205.9%**
89.8%	*95.5%*	(5.7%)		*Medical Loss Ratio*	*91.5%*	*93.3%*	(1.8%)	
5.4%	*6.7%*	*1.3%*		*Administrative Loss Ratio*	*5.0%*	*6.5%*	*1.5%*	
4.8%	(2.2%)	*7.0%*		*Operating Margin Ratio*	*3.5%*	*0.2%*	*3.3%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		

CalOptima Health

Actuals v. Budget – Total Membership

CalOptima Health

Consolidated



Notes:

- Data included in this report are based on member eligibility months rather than booked enrollment (as used in the financials).
- Includes data as of June 15, 2026

CalOptima Health

FY 2025-26: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) May 2026: $25.3 million, favorable to budget $25.6 million or 7,863.8% driven by:
    - Favorable Calendar Year (CY) 2026 capitation rates by Department of Health Care Services (DHCS) and Net Investment Income
    - Offset by unfavorable Community Reinvestment expense and Grant Expense
  - Year To Date (YTD) July 2025 – May 2026: $301.1 million, favorable to budget $202.7 million or 205.9% driven by Net Investment Income, favorable member mix and capitation rates, and Community Reinvestment

CalOptima Health

FY 2025-26: Management Summary (cont.)

- Enrollment
  - MTD: 819,485 members, unfavorable to budget 49,081 or 5.7% due to freeze on enrollment of new members 19 years or older with Unsatisfactory Immigration Status (UIS) and asset test reinstatement
  - YTD: 9,500,322 member months, unfavorable to budget 248,810 or 2.6%

CalOptima Health

FY 2025-26: Management Summary (cont.)

- Revenue
  - MTD: $394.3 million, favorable to budget $9.0 million or 2.3% driven by Medi-Cal (MC) Line of Business (LOB) due to favorable member mix and capitation rates, offset by lower enrollment
  - YTD: $4,773.2 million, favorable to budget $465.7 million or 10.8% due primarily to:
    - MC LOB CY 2023 and 2024 Hospital Directed Payments (DP), CY 2024 Quality Incentive Program (QIP), CY 2025 Skilled Nursing Facility Workforce and Quality Incentive (SNF WQIP), favorable member mix and capitation rates
    - Offset by OneCare (OC) LOB lower than anticipated Risk Adjustment Factor (RAF)

CalOptima Health

FY 2025-26: Management Summary (cont.)

- Medical Expenses
  - MTD: $354.2 million, favorable to budget $13.7 million or 3.7% due to decrease in utilization
  - YTD: $4,365.5 million, unfavorable to budget $346.8 million or 8.6% due to:
    - $514.2 million in Other Medical expenses primarily due to CY 2023 and 2024 Hospital DP, CY 2024 QIP and CY 2025 SNF WQIP

FY 2025-26: Management Summary (cont.)

- Medical Expenses (cont.)
  - Offset by favorable variances to budget:
    - $48.2 million in Incentive Payments primarily due to release of accrual for MC Pay-for-Value (P4V) Incentive Payments
    - $38.5 million in Managed Long-Term Services and Supports (MLTSS) expense
    - $30.1 million in Medical Management
    - $28.0 million in Professional Claims expense
    - $26.8 million in Provider Capitation expense
    - $10.6 million in Prescription Drug expense

CalOptima Health

FY 2025-26: Management Summary (cont.)

- Administrative Expenses
  - MTD: $21.3 million, favorable to budget $4.6 million or 17.7% due to the timing of administrative expense activities
  - YTD: $238.7 million, favorable to budget $41.8 million or 14.9% due to the timing of administrative expense activities

FY 2025-26: Management Summary (cont.)

- Non-Operating Income (Loss)
  - MTD: $6.4 million, unfavorable to budget $1.8 million or 21.6% due to:
    - $2.5 million unfavorable variance in Community Reinvestment
    - Offset by $0.8 million favorable variance in Net Investment Income
  - YTD: $132.1 million, favorable to budget $42.0 million or 46.6% due to:
    - $41.2 million favorable variance in Net Investment Income
    - $29.6 million favorable variance in Community Reinvestment
    - Offset by:
      - $23.4 million unfavorable variance in Grant Expense
      - $5.5 million net unfavorable variance in Other Income/Expense and Net Building Income/Expense

CalOptima Health

FY 2025-26: Key Financial Ratios

- Medical Loss Ratio (MLR)

	Actual	Budget	Variance (%)
MTD	89.8%	95.5%	(5.7%)
YTD	91.5%	93.3%	(1.8%)

- Administrative Loss Ratio (ALR)

	Actual	Budget	Variance (%)
MTD	5.4%	6.7%	1.3%
YTD	5.0%	6.5%	1.5%

CalOptima Health

FY 2025-26: Key Financials Ratios (cont.)

- Balance Sheet Ratios
  - Current ratio*: 1.9
  - Board Designated Reserve level: 3.76
  - Statutory Designated Reserve level: 1.05
  - Net-position: $3.1 billion, including required TNE of $134.8 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations.

CalOptima Health

Enrollment Summary: May 2026

May 2026					July 2025 - May 2026			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
110,392	123,571	(13,179)	(10.7%)	FAM	1,321,960	1,393,839	(71,879)	(5.2%)
236,930	253,939	(17,009)	(6.7%)	CHD	2,720,389	2,827,476	(107,087)	(3.8%)
292,169	311,188	(19,019)	(6.1%)	MCE	3,454,995	3,564,957	(109,962)	(3.1%)
2,958	2,504	454	18.1%	LTC	33,222	27,606	5,616	20.3%
149,149	149,631	(482)	(0.3%)	SPD	1,664,484	1,632,366	32,118	2.0%
8,668	9,014	(346)	(3.8%)	WCM	96,965	99,729	(2,764)	(2.8%)
800,266	**849,847**	(49,581)	(5.8%)	**Medi-Cal Total**	**9,292,015**	**9,545,973**	(253,958)	(2.7%)
18,649	**18,150**	**499**	**2.7%**	**OneCare**	**202,325**	**197,120**	**5,205**	**2.6%**
570	**569**	**1**	**0.2%**	**PACE**	**5,982**	**6,039**	(57)	(0.9%)
586	**558**	**28**	**5.0%**	**MSSP***	**6,312**	**6,138**	**174**	**2.8%**
819,485	**868,566**	(49,081)	(5.7%)	**CalOptima Health Total**	**9,500,322**	**9,749,132**	(248,810)	(2.6%)

*MSSP enrollment is included in Medi-Cal total

Consolidated Revenue & Expenses: May 2026 MTD

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	800,266	18,649	570	586		819,485
REVENUES						
Capitation Revenue	$ 352,652,622	$ 36,072,834	$ 5,372,182	$ 242,421	$ -	$ 394,340,059
Total Operating Revenue	**352,652,622**	**36,072,834**	**5,372,182**	**242,421**	**-**	**394,340,059**
MEDICAL EXPENSES						
Provider Capitation	106,721,577	14,477,805				121,199,381
Facility and Professional Claims	140,373,671	8,746,453	2,316,366			151,436,490
MLTSS	48,192,074		66,125	19,942		48,278,142
Prescription Drugs		10,891,349	609,991			11,501,340
Case Mgmt & Other Medical	18,088,224	2,040,965	1,486,855	189,829		21,805,874
Total Medical Expenses	**313,375,546**	**36,156,572**	**4,479,337**	**209,771**	**-**	**354,221,227**
Medical Loss Ratio	*88.9%*	*100.2%*	*83.4%*	*86.5%*	*0.0%*	*89.8%*
GROSS MARGIN	**39,277,076**	(83,738)	**892,844**	**32,650**	**-**	**40,118,832**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	11,550,183	1,036,024	179,209	110,285	228,905	13,104,607
Non-Salary Operating Expenses	2,784,703	585,201	134,764	1,458	91,621	3,597,747
Depreciation & Amortization	1,069,181		1,068			1,070,249
Other Operating Expenses	2,981,627	77,358	7,720	7,865	105	3,074,676
Indirect Cost Allocation, Occupancy	(670,081)	1,078,093	17,150	7,283		432,445
Total Administrative Expenses	**17,715,614**	**2,776,677**	**339,911**	**126,891**	**320,631**	**21,279,723**
Administrative Loss Ratio	*5.0%*	*7.7%*	*6.3%*	*52.3%*	*0.0%*	*5.4%*
Operating Income/(Loss)	**21,561,462**	(2,860,415)	**552,933**	(94,241)	(320,631)	**18,839,109**
Investments and Other Non-Operating	(2,513,243)					6,421,290
CHANGE IN NET ASSETS	**$ 19,048,220**	$ (2,860,415)	**$ 552,933**	$ (94,241)	$ (320,631)	**$ 25,260,398**
BUDGETED CHANGE IN NET ASSETS	(7,138,425)	(706,976)	383,007	(121,400)	(936,298)	(325,361)
Variance to Budget - Fav/(Unfav)	$ 26,186,645	$ (2,153,439)	$ 169,926	$ 27,159	$ 615,667	$ 25,585,759

CalOptima Health

Consolidated Revenue & Expenses: May 2026 YTD

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	9,292,015	202,325	5,982	6,312		9,500,322
REVENUES						
Capitation Revenue	$ 4,309,747,051	$ 405,162,251	$ 55,589,404	$ 2,726,540	$ -	$ 4,773,225,245
Total Operating Revenue	**4,309,747,051**	**405,162,251**	**55,589,404**	**2,726,540**	**-**	**4,773,225,245**
MEDICAL EXPENSES						
Provider Capitation	1,222,812,070	160,525,336				1,383,337,406
Facility and Professional Claims	1,520,386,026	85,506,388	24,442,712			1,630,335,126
MLTSS	509,089,828		700,401	332,770		510,122,999
Prescription Drugs		108,519,842	6,387,115			114,906,957
Case Mgmt & Other Medical	685,877,378	22,513,809	16,386,122	2,067,054		726,844,363
Total Medical Expenses	**3,938,165,302**	**377,065,375**	**47,916,350**	**2,399,825**	**-**	**4,365,546,851**
Medical Loss Ratio	*91.4%*	*93.1%*	*86.2%*	*88.0%*	*0.0%*	*91.5%*
GROSS MARGIN	**371,581,748**	**28,096,876**	**7,673,054**	**326,716**	**-**	**407,678,394**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	127,915,753	11,378,199	2,004,452	1,166,151	1,333,363	143,797,918
Non-Salary Operating Expenses	33,621,902	6,462,016	1,127,286	16,066	3,130,093	44,357,363
Depreciation & Amortization	10,547,751		10,538			10,558,289
Other Operating Expenses	33,768,128	1,281,706	119,500	86,932	431	35,256,697
Indirect Cost Allocation, Occupancy	(7,413,602)	11,859,026	180,280	80,109		4,705,813
Total Administrative Expenses	**198,439,932**	**30,980,947**	**3,442,056**	**1,349,257**	**4,463,887**	**238,676,079**
Administrative Loss Ratio	*4.6%*	*7.6%*	*6.2%*	*49.5%*	*0.0%*	*5.0%*
Operating Income/(Loss)	**173,141,817**	(2,884,071)	**4,230,998**	(1,022,541)	(4,463,887)	**169,002,315**
Investments and Other Non-Operating	23,605,707					132,126,283
CHANGE IN NET ASSETS	**$ 196,747,523**	$ (2,884,071)	**$ 4,230,998**	$ (1,022,541)	$ (4,463,887)	**$ 301,128,598**
BUDGETED CHANGE IN NET ASSETS	27,206,800	(11,767,996)	3,986,125	(1,321,283)	(9,820,830)	98,424,855
Variance to Budget - Fav/(Unfav)	$ 169,540,723	$ 8,883,925	$ 244,873	$ 298,742	$ 5,356,943	$ 202,703,743

CalOptima Health

Balance Sheet: As of May 2026

ASSETS	
Current Assets	
Operating Cash	$274,730,860
Short-term Investments	1,835,320,651
Capitation Receivable	618,494,839
Receivables - Other	15,809,461
Prepaid Expenses	17,404,444
Total Current Assets	**2,761,760,255**
Capital Assets	
Capital Assets	210,592,329
Less: Accumulated Depreciation	(101,611,261)
Capital Assets, Net of Depreciation	**108,981,068**
Other Assets	
Restricted Deposit & Other	300,000
Board Designated Reserves	1,635,396,290
Statutory Designated Reserves	141,432,587
Total Other Assets	**1,777,128,877**
TOTAL ASSETS	**4,647,870,200**
Deferred Outflows	**28,626,072**
TOTAL ASSETS & DEFERRED OUTFLOWS	**$4,676,496,272**

LIABILITIES & NET POSITION	
Current Liabilities	
Accounts Payable	$159,917,521
Medical Claims Liability	345,288,653
Accrued Payroll Liabilities	23,476,431
Deferred Revenue	7,971,083
Due to State of California and CMS	793,732,113
Capitation and Withholds	136,136,895
Total Current Liabilities	**1,466,522,696**
Other Liabilities	
GASB 96 Subscription Liabilities	21,952,296
Community Reinvestment	58,451,085
Capital Lease Payable	200,903
Post Employment Health Benefits Liability	17,506,482
Net Pension Liabilities	5,840,992
Total Other Liabilities	**103,951,758**
TOTAL LIABILITIES	**1,570,474,454**
Deferred Inflows	**4,309,519**
Net Position	
Required TNE	134,823,552
Funds in Excess of TNE	2,966,888,746
TOTAL NET POSITION	**3,101,712,299**
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**$4,676,496,272**

CalOptima Health

Board Designated Reserve and TNE Analysis: As of May 2026

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	817,052,656				
MetLife Tier One	818,343,634				
Board Designated Reserves	1,635,396,290	1,087,444,350	1,739,910,960	547,951,940	(104,514,670)
Current Reserve Level (X months of average monthly revenue) [1]	*3.76*	*2.50*	*4.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	70,786,061				
MetLife Tier Two	70,646,526				
Statutory Designated Reserves	141,432,587	134,823,552	148,305,908	6,609,035	(6,873,320)
Current Reserve Level (X min. TNE) [1]	*1.05*	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

CalOptima Health

Spending Plan: As of May 2026

Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
Total Net Position @ 5/31/2026	**$3,101.7**			**100.0%**
Resources Assigned				
Board Designated Reserve[1]	**$1,635.4**			**52.7%**
Statutory Designated Reserve[1]	**$141.4**			**4.6%**
Capital Assets, net of Depreciation	**$109.0**			**3.5%**
Resources Allocated				
Homeless Health Initiative (HHI)[2]	14.2	63.3	49.1	0.5%
Housing and Homelessness Incentive (HHIP)[2]	25.6	87.4	61.8	0.8%
Intergovernmental Transfers (IGTs)	34.9	52.1	17.2	1.1%
Digital Transformation and Workplace Modernization[3]	20.7	100.0	79.3	0.7%
CalFresh Outreach Strategy	1.7	6.0	4.3	0.1%
Coalition of Orange County Community Health Centers Grant	10.7	50.0	39.3	0.3%
Mind OC Grant (Irvine)	-	15.0	15.0	0.0%
General Awareness Campaign	0.1	4.7	4.6	0.0%
Member Health Needs Assessment	0.3	1.3	1.0	0.0%
Five-Year Hospital Quality Program	106.8	153.5	46.7	3.4%
Skilled Nursing Facility Access Program	10.0	10.0	-	0.3%
National Alliance for Mental Illness (NAMI) Orange County Peer Support Program Grant	2.0	5.0	3.0	0.1%
Stipend Program for Master of Social Works Grant	-	5.0	5.0	0.0%
Wellness & Prevention Program Grant	1.0	2.7	1.7	0.0%
CalOptima Health Provider Workforce Development Fund Grant	39.7	50.0	10.3	1.3%
Garden Grove Bldg Improvement	16.5	17.5	1.1	0.5%

Spending Plan: As of May 2026 (cont.)

Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
Dyadic Services Program Academy	0.2	1.9	1.7	0.0%
Medi-Cal Provider Rate Increases	122.8	526.2	403.4	4.0%
Homeless Prevention and Stabilization Pilot Program	0.2	0.3	0.1	0.0%
OneCare Member Engagement and Education	0.1	0.3	0.2	0.0%
Medi-Cal Eligibility Outreach Strategy	20.7	21.8	1.1	0.7%
Supplemental Food Support for Medi-Cal Members	4.7	8.0	3.3	0.2%
Orange County Community Health Assessment and Improvement Plan	0.5	1.0	0.5	0.0%
Subtotal	**433.2**	**1,182.9**	**749.7**	**14.0%**
Resources Available for New Initiatives				
Unallocated/Unassigned[1]	**$782.7**			**25.2%**

[1]Total Designated Reserves and unallocated reserve amount can support approximately 219 days of CalOptima Health's current operations.
[2]See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.
[3]On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

CalOptima Health

Homeless Health Initiative and Allocated Funds: As of May 2026

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
HHI - IGT'S	61,496,005	61,496,005	49,125,580	12,370,425	-
HHI - Existing Reserves	1,800,000	1,800,000	-	1,800,000	-
HHIP	40,100,000	40,100,000	-	40,100,000	-
Total	**103,396,005**	**103,396,005**	**49,125,580**	**54,270,425**	**-**

Funds Allocation, approved initiatives:	Amount	Utilized Amount	Approved Amount	Funding Source(s)
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-	IGT's
Recuperative Care	6,194,190	6,194,190	-	IGT's
Medical Respite	250,000	250,000	-	IGT's
Day Habilitation (County for HomeKey)[4]	-	-	-	IGT's
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-	IGT's
CalOptima Homeless Response Team	1,681,734	1,681,734	-	IGT's
Homeless Coordination at Hospitals	10,000,000	10,000,000	-	IGT's
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support[5]	925,540	925,540	-	IGT's
FQHC (Community Health Center) Expansion	21,902	21,902	-	IGT's
HCAP and CalOptima Health Days	9,888,914	4,985,310	4,903,604	IGT's
Vaccination Intervention and Member Incentive Strategy[2]	54,649	54,649	-	IGT's
Street Medicine[3]	14,279,077	9,736,241	4,542,836	IGT's & Existing Reserves
Outreach and Engagement	7,000,000	2,276,015	4,723,985	IGT's
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000	IGT's & Existing Reserves
Subtotal of Approved Initiatives	**103,396,005**	**49,125,580**	**54,270,425**	
Transfer of funds to HHIP[4]	(40,100,000)	-	(40,100,000)	
Program Total	**63,296,005**	**49,125,580**	**14,170,425**	

[1]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1 million from HHI to HHIP.

[2]On June 5, 2025, CalOptima Health's Board of Directors approved the close out of the Vaccination Intervention and Member Incentive Strategy program and transfer of the remaining funds of $68,699 to unallocated reserves for new initiatives.

[3]On August 7, 2025, CalOptima Health's Board of Directors approved $9.3 million to expand the Street Medicine Program ($3.2 million remaining from Street Medicine Initiative (from the Homeless Health Initiatives Reserve), $1.8 million from Existing Reserves, and $4.3 million from Intergovernmental Transfer balance resulting from a June 5, 2025, Board action), to fund 2-year grant agreements to Healthcare in Action (Anaheim), Celebrating Life Community Health Center (Costa Mesa), and AltaMed (Santa Ana).

[4]On February 5, 2026, CalOptima Health's Board of Directors approved the closeout of the Day Habilitation (County for HomeKey) and designated the remaining balance of $2.5 million as available for allocation to deliver enhanced services for Medi-Cal members.

[5]On April 2, 2026, CalOptima Health's Board of Directors approved the closeout of the CalOptima Days, HCAP and FQHC Administrative Support and make $37,721 in IGT 8 funds available toward future IGT initiatives to deliver covered services for Medi-Cal members.

CalOptima Health

Housing and Homelessness Incentive Program: As of May 2026

Summary by Funding Source:	Total Funds[1]	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	65,931,189	65,931,189	34,733,595	31,197,594	-
Existing Reserves & HHI Transfer	87,384,530	87,384,530	61,793,542	25,590,988	-
Street Medicine Support Center - GG Building[2]	7,000,000	7,000,000	-	7,000,000	-
Total	**160,315,719**	**160,315,719**	**96,527,137**	**63,788,583**	-

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	1,400,000	909,650	490,350	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,821,311	800,001	HHI & DHCS
Infrastructure Projects	5,832,314	5,832,310	4	HHI
Capital Projects	126,247,564	73,140,270	53,107,294	HHI, DHCS & Existing Reserves
System Change Projects	19,314,530	9,968,205	9,346,325	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	**160,315,719**	**$96,527,137**	**$63,788,583**	
Transfer of funds to Street Medicine Support Center-GG Building	**(7,000,000)**	**-**	**($7,000,000)**	Existing Reserves
Program Total	**$153,315,719**	**$96,527,137**	**$56,788,583**	

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments.

[2]On October 7, 2025, CalOptima Health's Board of Directors approved up to $7.0 million for general contractor services & furniture, fixtures & equipment for the Street Medicine Support Center.

CalOptima Health

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CalOptima Health

UNAUDITED FINANCIAL STATEMENTS

June 30, 2026

Preliminary Reports as of July 21, 2026

Final fiscal year report is subject to change following financial audit

Back to Agenda

Table of Contents

Financial Highlights 3
Full-Time Equivalent (FTE) Data 4
Statement of Revenues and Expenses – Consolidated Month to Date 5
Statement of Revenues and Expenses – Consolidated Year to Date 6
Statement of Revenues and Expenses by LOB – Consolidated Month to Date 7
Statement of Revenues and Expenses by LOB – Consolidated Year to Date 8
Highlights – Consolidated 9
Enrollment Summary 10
Enrollment Trend by Network 11
Highlights – Enrollment 12
Statement of Revenues and Expenses – Medi-Cal 13
Highlights – Medi-Cal 14
Statement of Revenues and Expenses – OneCare 15
Highlights – OneCare 16
Statement of Revenues and Expenses – PACE 17
Statement of Revenues and Expenses – MSSP 18
Statement of Revenues and Expenses – Covered CA 19
Statement of Revenues and Expenses – 505 City Parkway 20
Statement of Revenues and Expenses – 500 City Parkway 21
Statement of Revenues and Expenses – 7900 Garden Grove Blvd 22
Highlights – PACE, MSSP, Covered CA, 500 City Parkway and 7900 Garden Grove Blvd 23
Balance Sheet 24
Highlights – Balance Sheet 25
Board Designated Reserve and, TNE Analysis 26
Statement of Cash Flow 27
Spending Plan 28
Key Financial Indicators 29
Digital Transformation Strategy 30
Homeless Health Initiatives 31
Housing and Homelessness Incentive Program 32
Budget Allocation Changes 33
Budget Allocation Changes (cont.) 34

Back to Agenda

CalOptima Health - Consolidated
Financial Highlights
For the Twelve Months Ending June 30, 2026

June 2026					July 2025 - June 2026			
Actual	**Budget**	**$ Variance**	**% Variance**		**Actual**	**Budget**	**$ Variance**	**% Variance**
806,971	866,997	(60,026)	(6.9%)	Member Months	10,307,293	10,616,129	(308,836)	(2.9%)
384,125,364	384,432,922	(307,558)	(0.1%)	Revenues	5,157,350,610	4,691,984,627	465,365,983	9.9%
341,023,431	361,858,068	20,834,637	5.8%	Medical Expenses	4,706,570,282	4,380,640,809	(325,929,473)	(7.4%)
27,354,583	26,022,962	(1,331,620)	(5.1%)	Administrative Expenses	266,030,662	306,509,110	40,478,448	13.2%
15,747,351	(3,448,108)	**19,195,459**	**556.7%**	**Operating Margin**	**184,749,666**	**4,834,708**	**179,914,958**	**3,721.3%**
				Non-Operating Income (Loss)				
7,228,413	8,333,251	(1,104,839)	(13.3%)	Net Investment Income/Expense	140,121,594	100,000,000	40,121,594	40.1%
(199,656)	-	(199,656)	(100.0%)	Grant Expense	(23,568,780)	-	(23,568,780)	(100.0%)
(8,490,253)	-	(8,490,253)	(100.0%)	Community Reinvestment	21,156,773	-	21,156,773	100.0%
842,559	(4,311,375)	5,153,934	119.5%	Other Income/Expense	(6,202,242)	(5,836,085)	(366,157)	(6.3%)
(618,938)	**4,021,876**	(4,640,814)	(115.4%)	**Total Non-Operating Income (Loss)**	**131,507,345**	**94,163,915**	**37,343,430**	**39.7%**
15,128,413	**573,768**	**14,554,645**	**2,536.7%**	**Change in Net Assets**	**316,257,011**	**98,998,623**	**217,258,388**	**219.5%**
88.8%	*94.1%*	(5.3%)		*Medical Loss Ratio*	*91.3%*	*93.4%*	(2.1%)	
7.1%	*6.8%*	(0.4%)		*Administrative Loss Ratio*	*5.2%*	*6.5%*	*1.4%*	
4.1%	(0.9%)	*5.0%*		*Operating Margin Ratio*	*3.6%*	*0.1%*	*3.5%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		

CalOptima Health - Consolidated
Full Time Equivalent (FTE) Data
For the Twelve Months Ending June 30, 2026

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1,311	1,412	101
OneCare	173	182	9
PACE	113	119	6
CCA	14	20	6
MSSP	21	24	3
Total	1,632	1,757	125

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	15,881	16,897	1,016
OneCare	2,023	2,183	160
PACE	1,356	1,428	72
CCA	77	206	129
MSSP	264	285	21
Total	19,601	20,999	1,398

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	601	601	0
OneCare	109	100	(9)
PACE	5	5	0
CCA	0	0	0
MSSP	27	23	(4)
Consolidated	494	494	0

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	635	615	(20)
OneCare	109	99	(10)
PACE	5	5	0
CCA	0	0	0
MSSP	26	23	(3)
Consolidated	526	506	(20)

Open FTE			
	Total	Medical	Admin
Medi-Cal	96	47	49
OneCare	11	6	5
PACE	6	5	1
CCA	15	0	15
MSSP	1	1	0
Total	129	59	70

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending June 30, 2026

MEMBER MONTHS		806,971		866,997		(60,026)
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$351,766,616	$446.72	$338,368,868	$398.91	$13,397,748	$47.81
OneCare	26,863,824	1,417.02	40,547,313	2,228.73	(13,683,489)	(811.71)
PACE	5,255,243	9,107.87	5,267,687	9,193.17	(12,444)	(85.30)
MSSP	239,682	419.76	249,054	446.33	(9,372)	(26.57)
Total Operating Revenue	384,125,364	476.01	384,432,922	443.41	(307,558)	32.60
MEDICAL EXPENSES						
Medi-Cal	309,311,254	392.81	319,511,470	376.68	10,200,216	(16.13)
OneCare	26,351,426	1,389.99	37,564,374	2,064.77	11,212,948	674.78
PACE	5,156,722	8,937.13	4,510,166	7,871.14	(646,556)	(1,065.99)
MSSP	204,029	357.32	227,076	406.95	23,047	49.63
Covered CA			44,982		44,982	
Total Medical Expenses	341,023,431	422.60	361,858,068	417.37	20,834,637	(5.23)
GROSS MARGIN	43,101,934	53.41	22,574,854	26.04	20,527,080	27.37
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	14,234,494	16.42	14,507,876	16.73	273,382	0.31
Professional Fees	3,853,701	4.44	2,666,173	3.08	(1,187,528)	(1.36)
Purchased Services	1,827,731	2.11	2,619,404	3.02	791,673	0.91
Printing & Postage	636,861	0.73	483,900	0.56	(152,961)	(0.17)
Depreciation & Amortization	1,034,018	1.19	949,334	1.09	(84,684)	(0.10)
Other Expenses	5,089,555	5.87	4,308,504	4.97	(781,051)	(0.90)
Indirect Cost Allocation, Occupancy	678,223	0.78	487,771	0.56	(190,452)	(0.22)
Total Administrative Expenses	27,354,583	33.90	26,022,962	30.02	(1,331,620)	(3.88)
NET INCOME (LOSS) FROM OPERATIONS	15,747,351	19.51	(3,448,108)	(3.98)	19,195,459	23.49
INVESTMENT INCOME						
Interest Income	13,540,168	16.78	8,735,911	10.08	4,804,256	6.70
Realized Gain/(Loss) on Investments	(104,101)	(0.13)	-	-	(104,101)	(0.13)
Unrealized Gain/(Loss) on Investments	(6,006,643)	(7.44)	-	-	(6,006,643)	(7.44)
Investment Fees	(201,010)	(0.25)	(402,660)	(0.46)	201,650	0.21
Total Investment Income	7,228,413	8.96	8,333,251	9.61	(1,104,839)	(0.65)
NET BUILDING INCOME/EXPENSE	(278,414)	(0.35)	(138,606)	(0.17)	(139,808)	(0.18)
GRANT EXPENSE	(199,656)	(0.25)	-	-	(199,656)	(0.25)
NET QAF/IGT	(2,979)	-	-	-	(2,979)	-
COMMUNITY REINVESTMENT	(8,490,253)	(10.52)	-	-	(8,490,253)	(10.52)
OTHER INCOME/EXPENSE	1,123,952	1.39	(4,172,769)	(4.81)	5,296,721	6.20
CHANGE IN NET ASSETS	**15,128,413**	**18.75**	**573,768**	**0.66**	**14,554,645**	**18.09**
MEDICAL LOSS RATIO	**88.8%**		**94.1%**		(5.3%)	
ADMINISTRATIVE LOSS RATIO	**7.1%**		**6.8%**		(0.4%)	

CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2026

MEMBER MONTHS		10,307,293		10,616,129		(308,836)
	Actual		**Budget**		**Variance**	
REVENUE	**$**	**PMPM**	**$**	**PMPM**	**$**	**PMPM**
Medi-Cal	$4,661,513,666	$462.48	$4,161,142,347	$400.33	$500,371,319	$62.15
OneCare	432,026,075	1,952.37	467,699,407	2,172.18	(35,673,332)	(219.81)
PACE	60,844,646	9,276.51	60,154,225	9,097.74	690,421	178.77
MSSP	2,966,222	430.95	2,988,648	446.33	(22,426)	(15.38)
Total Operating Revenue	5,157,350,610	500.36	4,691,984,627	441.97	465,365,983	58.39
MEDICAL EXPENSES						
Medi-Cal	4,247,476,556	421.40	3,884,377,198	373.71	(363,099,358)	(47.69)
OneCare	403,416,801	1,823.08	441,120,702	2,048.74	37,703,901	225.66
PACE	53,073,072	8,091.64	51,878,015	7,846.04	(1,195,057)	(245.60)
MSSP	2,603,853	378.30	2,725,088	406.97	121,235	28.67
Covered CA			539,806		539,806	
Total Medical Expenses	4,706,570,282	456.63	4,380,640,809	412.64	(325,929,473)	(43.99)
GROSS MARGIN	450,780,328	43.73	311,343,818	29.33	139,436,510	14.40
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	158,032,412	14.89	170,770,792	16.09	12,738,380	1.20
Professional Fees	20,655,954	1.95	25,279,949	2.38	4,623,995	0.43
Purchased Services	24,201,755	2.28	32,814,485	3.09	8,612,730	0.81
Printing & Postage	5,817,946	0.55	7,259,270	0.68	1,441,324	0.13
Depreciation & Amortization	11,592,307	1.09	11,392,008	1.07	(200,299)	(0.02)
Other Expenses	40,346,252	3.80	53,174,787	5.01	12,828,535	1.21
Indirect Cost Allocation, Occupancy	5,384,036	0.51	5,817,819	0.55	433,783	0.04
Total Administrative Expenses	266,030,662	25.81	306,509,110	28.87	40,478,448	3.06
NET INCOME (LOSS) FROM OPERATIONS	184,749,666	17.92	4,834,708	0.46	179,914,958	17.46
INVESTMENT INCOME						
Interest Income	163,653,171	15.88	103,939,000	9.79	59,714,171	6.09
Realized Gain/(Loss) on Investments	5,423,828	0.53	-	-	5,423,828	0.53
Unrealized Gain/(Loss) on Investments	(26,635,222)	(2.58)	-	-	(26,635,222)	(2.58)
Investment Fees	(2,320,182)	(0.23)	(3,939,000)	(0.37)	1,618,818	0.14
Total Investment Income	140,121,594	13.59	100,000,000	9.42	40,121,594	4.17
NET BUILDING INCOME/EXPENSE	(1,281,896)	(0.12)	(1,663,316)	(0.16)	224,842	0.04
GRANT EXPENSE	(23,568,780)	(2.29)	-	-	(23,568,780)	(2.29)
NET QAF/IGT	(2,979)	-	-	-	(2,979)	-
COMMUNITY REINVESTMENT	21,156,773	2.05	-	-	21,156,773	2.05
OTHER INCOME/EXPENSE	(4,917,368)	(0.48)	(4,172,769)	(0.39)	(744,599)	(0.09)
CHANGE IN NET ASSETS	**316,257,011**	**30.68**	**98,998,623**	**9.33**	**217,258,388**	**21.35**
MEDICAL LOSS RATIO	**91.3%**		**93.4%**		(2.1%)	
ADMINISTRATIVE LOSS RATIO	**5.2%**		**6.5%**		**1.4%**	

Preliminary

Back to Agenda

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending June 30, 2026

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	787,436	18,958	577	571		806,971
REVENUES						
Capitation Revenue	$ 351,766,616	$ 26,863,824	$ 5,255,243	$ 239,682	$ -	$ 384,125,364
Total Operating Revenue	**351,766,616**	**26,863,824**	**5,255,243**	**239,682**	**-**	**384,125,364**
MEDICAL EXPENSES						
Provider Capitation	101,702,148	13,216,562				114,918,710
Facility and Professional Claims	137,464,738	9,262,051	2,548,568			149,275,358
MLTSS	49,279,481		62,392	20,147		49,362,020
Prescription Drugs		1,029,394	633,557			1,662,951
Case Mgmt & Other Medical	20,864,887	2,843,418	1,912,206	183,882		25,804,392
Total Medical Expenses	**309,311,254**	**26,351,426**	**5,156,722**	**204,029**	**-**	**341,023,431**
Medical Loss Ratio	*87.9%*	*98.1%*	*98.1%*	*85.1%*	*0.0%*	*88.8%*
GROSS MARGIN	**42,455,362**	**512,398**	**98,520**	**35,653**	**-**	**43,101,934**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	12,557,441	1,103,346	176,742	108,657	288,309	14,234,494
Non-Salary Operating Expenses	5,049,007	739,394	133,764	1,459	394,669	6,318,293
Depreciation & Amortization	1,032,477		1,540			1,034,018
Other Operating Expenses	4,973,843	89,962	14,244	10,083	1,423	5,089,555
Indirect Cost Allocation, Occupancy	(1,631,572)	2,265,414	27,514	16,867		678,223
Total Administrative Expenses	**21,981,197**	**4,198,115**	**353,804**	**137,066**	**684,401**	**27,354,583**
Administrative Loss Ratio	*6.2%*	*15.6%*	*6.7%*	*57.2%*	*0.0%*	*7.1%*
Operating Income/(Loss)	**20,474,165**	(3,685,717)	(255,284)	(101,413)	(684,401)	**15,747,351**
Investments and Other Non-Operating	(7,369,280)					(618,938)
CHANGE IN NET ASSETS	**$ 13,104,885**	$ (3,685,717)	$ (255,284)	$ (101,413)	$ (684,401)	**$ 15,128,413**
BUDGETED CHANGE IN NET ASSETS	(6,733,622)	(254,944)	433,666	(122,128)	(943,849)	573,768
Variance to Budget - Fav/(Unfav)	$ 19,838,507	$ (3,430,773)	$ (688,950)	$ 20,715	$ 259,448	$ 14,554,645

CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Twelve Months Ending June 30, 2026

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	10,079,451	221,283	6,559	6,883		10,307,293
REVENUES						
Capitation Revenue	$ 4,661,513,666	$ 432,026,075	$ 60,844,646	$ 2,966,222	$ -	$ 5,157,350,610
Total Operating Revenue	**4,661,513,666**	**432,026,075**	**60,844,646**	**2,966,222**	**-**	**5,157,350,610**
MEDICAL EXPENSES						
Provider Capitation	1,324,514,218	173,741,898				1,498,256,116
Facility and Professional Claims	1,657,850,764	94,768,440	26,991,280			1,779,610,484
MLTSS	558,369,309		762,793	352,917		559,485,019
Prescription Drugs		109,549,236	7,020,672			116,569,908
Case Mgmt & Other Medical	706,742,265	25,357,227	18,298,327	2,250,936		752,648,755
Total Medical Expenses	**4,247,476,556**	**403,416,801**	**53,073,072**	**2,603,853**	**-**	**4,706,570,282**
Medical Loss Ratio	*91.1%*	*93.4%*	*87.2%*	*87.8%*	*0.0%*	*91.3%*
GROSS MARGIN	**414,037,110**	**28,609,274**	**7,771,574**	**362,369**	**-**	**450,780,328**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	140,473,194	12,481,545	2,181,194	1,274,808	1,621,672	158,032,412
Non-Salary Operating Expenses	38,670,909	7,201,410	1,261,050	17,524	3,524,762	50,675,655
Depreciation & Amortization	11,580,228		12,079			11,592,307
Other Operating Expenses	38,741,971	1,371,668	133,743	97,015	1,854	40,346,252
Indirect Cost Allocation, Occupancy	(9,045,174)	14,124,440	207,794	96,976		5,384,036
Total Administrative Expenses	**220,421,129**	**35,179,062**	**3,795,860**	**1,486,323**	**5,148,288**	**266,030,662**
Administrative Loss Ratio	*4.7%*	*8.1%*	*6.2%*	*50.1%*	*0.0%*	*5.2%*
Operating Income/(Loss)	**193,615,982**	(6,569,788)	**3,975,714**	(1,123,954)	(5,148,288)	**184,749,666**
Investments and Other Non-Operating	16,236,427					131,507,345
CHANGE IN NET ASSETS	**$ 209,852,409**	$ (6,569,788)	**$ 3,975,714**	$ (1,123,954)	$ (5,148,288)	**$ 316,257,011**
BUDGETED CHANGE IN NET ASSETS	20,473,178	(12,022,940)	4,419,791	(1,443,411)	(10,764,679)	98,998,623
Variance to Budget - Fav/(Unfav)	$ 189,379,231	$ 5,453,152	$ (444,077)	$ 319,457	$ 5,616,391	$ 217,258,388

Preliminary

Back to Agenda

CalOptima Health

Highlights – Consolidated, for Twelve Months Ending June 30, 2026

MONTH TO DATE RESULTS:

- Change in Net Assets is $15.1 million, favorable to budget $14.6 million
- Operating surplus is $15.7 million, with a deficit in non-operating income of $0.6 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $316.3 million, favorable to budget $217.3 million
- Operating surplus is $184.7 million, with a surplus in non-operating income of $131.5 million

Change in Net Assets by Line of Business (LOB) ($ millions):

June 2026				July 2025 - June 2026		
Actual	Budget	Variance	Operating Income (Loss)	Actual	Budget	Variance
20.5	(2.6)	23.0	Medi-Cal	193.6	24.6	169.0
(3.7)	(0.3)	(3.4)	OneCare	(6.6)	(12.0)	5.5
(0.3)	0.4	(0.7)	PACE	4.0	4.4	(0.4)
(0.1)	(0.1)	0.0	MSSP	(1.1)	(1.4)	0.3
(0.7)	(0.9)	0.3	Covered CA	(5.1)	(10.8)	5.6
15.7	**(3.4)**	**19.2**	**Total Operating Income (Loss)**	**184.7**	**4.8**	**179.9**
			Non-Operating Income (Loss)			
7.2	8.3	(1.1)	Net Investment Income/Expense	140.1	100.0	40.1
(7.8)	(4.3)	(3.5)	Other Income/Expense	0.0	(8.6)	(5.8)
(0.6)	**4.0**	**(4.6)**	**Total Non-Operating Income/(Loss)**	**131.5**	**94.2**	**37.3**
15.1	**0.6**	**14.6**	**TOTAL**	**316.3**	**99.0**	**217.3**

CalOptima Health - Consolidated
Enrollment Summary
For the Twelve Months Ending June 30, 2026

June 2026					July 2025 - June 2026			
Actual	**Budget**	**$ Variance**	**%Variance**	**Enrollment (by Aid Category)**	**Actual**	**Budget**	**$ Variance**	**%Variance**
107,766	123,398	(15,632)	(12.7%)	Adult	1,429,726	1,517,237	(87,511)	(5.8%)
233,324	253,320	(19,996)	(7.9%)	Child	2,953,713	3,080,796	(127,083)	(4.1%)
286,561	310,127	(23,566)	(7.6%)	Expansion	3,741,556	3,875,084	(133,528)	(3.4%)
3,010	2,501	509	20.4%	LTC	36,232	30,107	6,125	20.3%
148,479	149,882	(1,403)	(0.9%)	SPD	1,812,963	1,782,248	30,715	1.7%
8,296	9,003	(707)	(7.9%)	Whole Child Model	105,261	108,732	(3,471)	(3.2%)
787,436	**848,231**	(60,795)	(7.2%)	**Medi-Cal Total**	**10,079,451**	**10,394,204**	(314,753)	(3.0%)
18,958	**18,193**	**765**	**4.2%**	**OneCare**	**221,283**	**215,313**	**5,970**	**2.8%**
577	**573**	**4**	**0.7%**	**PACE**	**6,559**	**6,612**	(53)	(0.8%)
571	**558**	**13**	**2.3%**	**MSSP**	**6,883**	**6,696**	**187**	**2.8%**
806,971	**866,997**	(60,026)	(6.9%)	**CalOptima Health Total**	**10,307,293**	**10,616,129**	(308,836)	(2.9%)
				Enrollment (by Network)				
298,368	329,395	(31,027)	(9.4%)	HMO	3,948,282	4,084,487	(136,205)	(3.3%)
149,342	155,653	(6,311)	(4.1%)	PHC	1,897,379	1,929,116	(31,737)	(1.6%)
71,393	77,542	(6,149)	(7.9%)	Shared Risk Group	853,573	870,991	(17,418)	(2.0%)
268,333	285,641	(17,308)	(6.1%)	Fee for Service	3,380,217	3,509,610	(129,393)	(3.7%)
787,436	**848,231**	(60,795)	(7.2%)	**Medi-Cal Total**	**10,079,451**	**10,394,204**	(314,753)	(3.0%)
18,958	**18,193**	**765**	**4.2%**	**OneCare**	**221,283**	**215,313**	**5,970**	**2.8%**
577	**573**	**4**	**0.7%**	**PACE**	**6,559**	**6,612**	(53)	(0.8%)
571	**558**	**13**	**2.3%**	**MSSP**	**6,883**	**6,696**	**187**	**2.8%**
806,971	**866,997**	(60,026)	(6.9%)	**CalOptima Health Total**	**10,307,293**	**10,616,129**	(308,836)	(2.9%)

Note:* Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2026

	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	YTD Actual	YTD Budget	Variance
HMOs															
Adult	67,587	67,579	68,311	68,508	68,160	66,645	65,123	63,288	62,002	60,344	58,934	57,225	773,706	793,380	(19,674)
Child	73,203	72,978	72,855	72,899	72,345	70,973	70,328	69,430	68,850	67,919	66,518	65,182	843,480	918,679	(75,199)
Expansion	182,912	181,318	182,080	181,632	179,847	175,204	173,049	169,517	166,654	162,993	159,346	155,652	2,070,204	2,115,391	(45,187)
LTC	3	12	(1)			1	1					2	18	12	6
SPD	20,739	20,738	20,896	20,798	20,700	21,213	20,857	20,168	19,960	19,703	19,304	19,078	244,154	239,899	4,255
Whole Child Model	1,508	1,526	1,499	1,371	1,449	1,399	1,403	1,393	1,326	1,278	1,339	1,229	16,720	17,126	(406)
Total	345,952	344,151	345,640	345,208	342,501	335,435	330,761	323,796	318,792	312,237	305,441	298,368	3,948,282	4,084,487	(136,205)
PHCs															
Adult	3,936	3,870	3,761	3,668	3,632	3,526	3,423	3,296	3,230	3,135	3,068	2,959	41,504	42,427	(923)
Child	129,804	128,525	127,408	126,859	126,480	124,703	124,033	122,561	121,702	120,678	119,504	118,004	1,490,261	1,503,197	(12,936)
Expansion	21,807	21,373	20,988	20,479	20,259	20,012	19,772	19,316	19,098	18,884	18,495	18,178	238,661	256,267	(17,606)
SPD	4,775	4,791	4,754	4,517	4,510	4,699	4,654	4,541	4,511	4,533	4,516	4,505	55,306	55,240	66
Whole Child Model	6,119	5,909	5,992	5,913	5,972	5,982	6,044	6,069	6,088	5,924	5,939	5,696	71,647	71,985	(338)
Total	166,441	164,468	162,903	161,436	160,853	158,922	157,926	155,783	154,629	153,154	151,522	149,342	1,897,379	1,929,116	(31,737)
Shared Risk Groups															
Adult	11,382	11,126	10,872	10,652	13,363	13,277	13,129	12,927	12,770	12,645	12,573	12,430	147,146	152,131	(4,985)
Child	18,444	18,179	17,845	17,764	21,036	20,822	20,848	20,685	20,631	20,587	20,379	20,234	237,454	232,644	4,810
Expansion	34,473	33,658	33,030	32,525	37,053	36,360	36,073	35,866	35,685	35,301	34,939	34,467	419,430	439,902	(20,472)
LTC		1				1							2	10	(8)
SPD	3,418	3,327	3,355	3,268	4,042	4,109	4,123	3,999	4,041	3,996	3,967	3,940	45,585	41,085	4,500
Whole Child Model	226	252	301	265	396	385	406	404	334	298	367	322	3,956	5,219	(1,263)
Total	67,943	66,543	65,403	64,474	75,890	74,954	74,579	73,881	73,461	72,827	72,225	71,393	853,573	870,991	(17,418)
Fee for Service (Dual)															
Adult	876	859	867	846	861	758	783	769	789	797	761	782	9,748	13,572	(3,824)
Child		1											1		1
Expansion	3,187	3,126	3,065	3,171	3,382	2,453	2,669	3,045	3,012	2,746	2,798	2,760	35,414	53,335	(17,921)
LTC	2,311	2,446	2,667	2,763	2,833	2,793	2,800	2,791	2,756	2,750	2,634	2,684	32,228	26,661	5,567
SPD	107,827	107,645	108,097	108,113	108,327	108,940	108,174	108,276	107,965	107,467	107,465	107,261	1,295,557	1,252,535	43,022
Whole Child Model	15	26	15	13	23	11	10	10	24	24	12	11	194	173	21
Total	114,216	114,103	114,711	114,906	115,426	114,955	114,436	114,891	114,546	113,784	113,670	113,498	1,373,142	1,346,276	26,866
Fee for Service (Non-Dual - Total)															
Adult	44,785	43,246	41,276	39,488	38,439	37,065	36,162	36,335	35,976	35,424	35,056	34,370	457,622	515,727	(58,105)
Child	35,975	34,671	34,330	33,798	30,558	30,303	30,169	31,158	30,811	30,311	30,529	29,904	382,517	426,276	(43,759)
Expansion	93,242	89,170	85,738	83,769	79,512	79,262	78,979	79,964	78,856	77,260	76,591	75,504	977,847	1,010,189	(32,342)
LTC	286	305	350	340	359	326	347	344	329	350	324	324	3,984	3,424	560
SPD	15,643	15,501	14,961	14,481	13,920	14,407	14,263	14,015	13,759	13,819	13,897	13,695	172,361	193,489	(21,128)
Whole Child Model	1,296	1,252	1,231	1,155	983	974	887	947	1,024	946	1,011	1,038	12,744	14,229	(1,485)
Total	191,227	184,145	177,886	173,031	163,771	162,337	160,807	162,763	160,755	158,110	157,408	154,835	2,007,075	2,163,334	(156,259)
Grand Totals															
Total MediCal MM	**885,779**	**873,410**	**866,543**	**859,055**	**858,441**	**846,603**	**838,509**	**831,114**	**822,183**	**810,112**	**800,266**	**787,436**	**10,079,451**	**10,394,204**	(314,753)
OneCare	**17,971**	**17,873**	**18,242**	**18,211**	**18,287**	**18,599**	**18,617**	**18,593**	**18,573**	**18,710**	**18,649**	**18,958**	**221,283**	**215,313**	**5,970**
PACE	**528**	**529**	**529**	**536**	**543**	**544**	**537**	**546**	**557**	**563**	**570**	**577**	**6,559**	**6,612**	(53)
MSSP	**553**	**551**	**556**	**571**	**582**	**582**	**573**	**583**	**591**	**584**	**586**	**571**	**6,883**	**6,696**	**187**
Grand Total	**904,278**	**891,812**	**885,314**	**877,802**	**877,271**	**865,746**	**857,663**	**850,253**	**841,313**	**829,385**	**819,485**	**806,971**	**10,307,293**	**10,616,129**	(308,836)

Note:* Total membership does not include MSSP

ENROLLMENT– JUNE MONTH:

Overall, June enrollment was 806,971

- Unfavorable to budget 60,026 or 6.9%
- Decreased 12,514 or 1.5% from Prior Month (PM) (May 2026)
- Decreased 97,054 or 10.7% from Prior Year (PY) (June 2025)

Medi-Cal enrollment was 787,436

- Unfavorable to budget 60,795 or 7.2% due to freeze of enrollment for members 19 years or older with Unsatisfactory Immigration Status (UIS) and asset test reinstatement
- Medi-Cal Expansion (MCE) enrollment unfavorable to budget 23,566
- Child (CHD) enrollment unfavorable to budget 19,996
- Adult (FAM) enrollment unfavorable to budget 15,632
- Seniors and Persons with Disabilities (SPD) enrollment unfavorable to budget 1,403
- Whole Child Model (WCM) enrollment unfavorable to budget 707
- Long-Term Care (LTC) enrollment favorable to budget 509
- Decreased 12,830 or 1.6% from PM

OneCare enrollment was 18,958

- Favorable to budget 765 or 4.2%
- Increased 309 or 1.7% from PM

PACE enrollment was 577

- Favorable to budget 4 or 0.7%
- Increased 7 or 1.2% from PM

MSSP enrollment was 571

- Favorable to budget 13 or 2.3%
- Decreased 15 or 2.6% from PM

CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2026

June 2026					July 2025 - June 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
787,436	**848,231**	(60,795)	(7.2%)	**Member Months**	**10,079,451**	**10,394,204**	(314,753)	(3.0%)
				Revenues				
351,766,616	338,368,868	13,397,748	4.0%	Capitation Revenue	4,661,513,666	4,161,142,347	500,371,319	12.0%
351,766,616	**338,368,868**	**13,397,748**	**4.0%**	**Total Operating Revenue**	**4,661,513,666**	**4,161,142,347**	**500,371,319**	**12.0%**
				Medical Expenses				
101,702,148	108,328,942	6,626,794	6.1%	Provider Capitation	1,324,514,218	1,336,063,783	11,549,565	0.9%
60,270,847	64,755,997	4,485,150	6.9%	Facilities Claims	794,569,017	789,560,988	(5,008,029)	(0.6%)
77,193,891	74,261,409	(2,932,482)	(3.9%)	Professional Claims	863,281,747	892,775,478	29,493,731	3.3%
49,279,481	49,800,991	521,510	1.0%	MLTSS	558,369,309	597,571,456	39,202,147	6.6%
(68,403)	9,429,555	9,497,958	100.7%	Incentive Payments	59,300,518	113,992,877	54,692,359	48.0%
12,041,080	11,169,195	(871,885)	(7.8%)	Medical Management	109,358,183	132,698,286	23,340,103	17.6%
8,892,209	1,765,381	(7,126,828)	(403.7%)	Other Medical Expenses	538,083,563	21,714,330	(516,369,233)	(2378.0%)
309,311,254	**319,511,470**	**10,200,216**	**3.2%**	**Total Medical Expenses**	**4,247,476,556**	**3,884,377,198**	(363,099,358)	(9.3%)
42,455,362	**18,857,398**	**23,597,964**	**125.1%**	**Gross Margin**	**414,037,110**	**276,765,149**	**137,271,961**	**49.6%**
				Administrative Expenses				
12,557,441	12,576,699	19,258	0.2%	Salaries, Wages & Employee Benefits	140,473,194	148,437,602	7,964,408	5.4%
3,341,172	2,116,913	(1,224,259)	(57.8%)	Professional Fees	15,939,764	18,680,257	2,740,493	14.7%
1,162,741	1,981,574	818,833	41.3%	Purchased Services	18,446,031	25,890,516	7,444,485	28.8%
545,093	438,849	(106,244)	(24.2%)	Printing & Postage	4,285,114	5,671,294	1,386,180	24.4%
1,032,477	947,711	(84,766)	(8.9%)	Depreciation & Amortization	11,580,228	11,372,543	(207,685)	(1.8%)
4,973,843	4,091,970	(881,873)	(21.6%)	Other Operating Expenses	38,741,971	50,928,091	12,186,120	23.9%
(1,631,572)	(735,465)	896,107	121.8%	Indirect Cost Allocation, Occupancy	(9,045,174)	(8,861,101)	184,073	2.1%
21,981,197	**21,418,251**	(562,946)	(2.6%)	**Total Administrative Expenses**	**220,421,129**	**252,119,202**	**31,698,073**	**12.6%**
20,474,165	(2,560,853)	**23,035,019**	**899.5%**	**Income (Loss) From Operations**	**193,615,982**	**24,645,947**	**168,970,035**	**685.6%**
				Non-Operating Income (Loss)				
(8,490,253)	-	(8,490,253)	0.0%	Community Reinvestment	21,156,773	-	21,156,773	100.0%
(2,979)	-	(2,979)	0.0%	Net QAF & IGT Income/Expense	(2,979)	-	(2,979)	(100.0%)
1,123,952	(4,172,769)	5,296,721	0.0%	Other Income /Expense	(4,917,368)	(4,172,769)	(744,599)	(17.8%)
(7,369,280)	(4,172,769)	(3,196,511)	(76.6%)	**Total Non-Operating Income/(Loss)**	**16,236,427**	(4,172,769)	**20,409,196**	**489.1%**
13,104,885	(6,733,622)	**19,838,507**	**294.6%**	**Change in Net Assets**	**209,852,409**	**20,473,178**	**189,379,231**	**925.0%**
87.9%	***94.4%***	(6.5%)		***Medical Loss Ratio***	***91.1%***	***93.3%***	(2.2%)	
6.2%	***6.3%***	***0.1%***		***Admin Loss Ratio***	***4.7%***	***6.1%***	***1.3%***	

MEDI-CAL INCOME STATEMENT– JUNE MONTH:

REVENUES are $351.8 million, favorable to budget $13.4 million:

- Unfavorable volume-related variance of $24.3 million
- Favorable price-related variance of $37.6 million
  - $31.7 million due to favorable Calendar Year (CY) 2026 capitation rates and member mix by the Department of Health Care Services (DHCS)
  - $13.0 million due to add-on rates received from DHCS for CY 2025 Proposition 35
  - $12.3 million favorable estimate for CY 2026 Medical Loss Ratio (MLR) due to DHCS
  - Offset by $19.4 million for Proposition 56, Enhanced Care Management (ECM) and UIS risk corridors

MEDICAL EXPENSES are $309.3 million, favorable to budget $10.2 million:

- Favorable volume-related variance of $22.9 million
- Unfavorable price-related variance of $12.7 million
  - Professional Claims expense unfavorable variance of $8.3 million due primarily to CY 2025 Proposition 35
  - Other Medical Expenses unfavorable variance of $7.3 million due primarily to reinsurance expenses
  - Managed Long-Term Services and Supports (MLTSS) expense unfavorable variance of $3.0 million
  - Medical Management expense unfavorable variance of $1.7 million
  - Provider Capitation expense unfavorable variance of $1.1 million
  - Facilities Claims expense unfavorable variance of $0.2 million
  - Offset by Incentive Payments expense favorable variance of $8.8 million due primarily to hospital shared risk pool

ADMINISTRATIVE EXPENSES are $22.0 million, unfavorable to budget $0.6 million:

- Non-Salary expense unfavorable to budget $0.6 million

NON-OPERATING INCOME/(LOSS) is ($7.4) million, unfavorable to budget $3.2 million due to the Health Resources and Services Administration (HRSA) grant that covered $2.0 million of the 500 Building's Street Medicine Traffic Control Office which opened in June

CHANGE IN NET ASSETS is $13.1 million, favorable to budget $19.8 million

CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2026

June 2026					July 2025 - June 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
18,958	**18,193**	**765**	**4.2%**	**Member Months**	**221,283**	**215,313**	**5,970**	**2.8%**
				Revenues				
24,828,162	29,122,489	(4,294,327)	(14.7%)	Medicare Part C	315,636,015	341,903,215	(26,267,200)	(7.7%)
2,035,662	11,424,824	(9,389,162)	(82.2%)	Medicare Part D	116,390,060	125,796,192	(9,406,132)	(7.5%)
26,863,824	**40,547,313**	(13,683,489)	(33.7%)	**Total Operating Revenue**	**432,026,075**	**467,699,407**	(35,673,332)	(7.6%)
				Medical Expenses				
13,216,562	17,001,329	3,784,767	22.3%	Provider Capitation	173,741,898	199,375,507	25,633,609	12.9%
6,218,055	5,260,920	(957,135)	(18.2%)	Facilities Claims	65,534,217	62,135,579	(3,398,638)	(5.5%)
3,043,996	2,043,203	(1,000,793)	(49.0%)	Professional Claims	29,234,223	24,197,855	(5,036,368)	(20.8%)
1,029,394	10,973,691	9,944,297	90.6%	Prescription Drugs	109,549,236	128,351,162	18,801,926	14.6%
685,467	645,142	(40,325)	(6.3%)	Incentive Payments	4,671,940	7,611,878	2,939,938	38.6%
1,649,295	1,525,168	(124,127)	(8.1%)	Medical Management	13,944,556	18,088,458	4,143,902	22.9%
508,656	114,921	(393,735)	(342.6%)	Other Medical Expenses	6,740,731	1,360,263	(5,380,468)	(395.5%)
26,351,426	**37,564,374**	**11,212,948**	**29.8%**	**Total Medical Expenses**	**403,416,801**	**441,120,702**	**37,703,901**	**8.5%**
512,398	**2,982,939**	(2,470,541)	(82.8%)	**Gross Margin**	**28,609,274**	**26,578,705**	**2,030,569**	**7.6%**
				Administrative Expenses				
1,103,346	1,231,145	127,799	10.4%	Salaries, Wages & Employee Benefits	12,481,545	14,546,479	2,064,934	14.2%
100,322	115,474	15,152	13.1%	Professional Fees	1,031,484	1,394,600	363,116	26.0%
568,177	505,573	(62,604)	(12.4%)	Purchased Services	4,855,118	5,432,230	577,112	10.6%
70,894	33,849	(37,045)	(109.4%)	Printing & Postage	1,314,808	1,355,286	40,478	3.0%
89,962	153,679	63,717	41.5%	Other Operating Expenses	1,371,668	1,495,050	123,382	8.3%
2,265,414	1,198,163	(1,067,251)	(89.1%)	Indirect Cost Allocation, Occupancy	14,124,440	14,378,000	253,560	1.8%
4,198,115	**3,237,883**	(960,232)	(29.7%)	**Total Administrative Expenses**	**35,179,062**	**38,601,645**	**3,422,583**	**8.9%**
(3,685,717)	(254,944)	(3,430,773)	(1345.7%)	**Change in Net Assets**	(6,569,788)	(12,022,940)	**5,453,152**	**45.4%**
98.1%	***92.6%***	***5.4%***		***Medical Loss Ratio***	***93.4%***	***94.3%***	(0.9%)	
15.6%	***8.0%***	(7.6%)		***Admin Loss Ratio***	***8.1%***	***8.3%***	***0.1%***	

ONECARE INCOME STATEMENT – JUNE MONTH:

REVENUES are $26.9 million, unfavorable to budget $13.7 million:

- Favorable volume-related variance of $1.7 million
- Unfavorable price-related variance of $15.4 million due to Part D Shared Risk estimate and CY 2026 Hierarchical Condition Category (HCC) estimate

MEDICAL EXPENSES are $26.4 million, favorable to budget $11.2 million:

- Unfavorable volume-related variance of $1.6 million
- Favorable price-related variance of $12.8 million
  - Prescription Drugs expense favorable variance of $10.4 million due to increase in rebate estimates
  - Provider Capitation expense favorable variance of $4.5 million
  - Offset by:
    - Professional Claims expense unfavorable variance of $0.9 million
    - Facilities Claims expense unfavorable variance of $0.7 million
    - Other Medical expense unfavorable variance of $0.4 million

ADMINISTRATIVE EXPENSES are $4.2 million, unfavorable to budget $1.0 million

- Non-Salary expense unfavorable to budget $1.1 million
- Salaries, Wages & Employee Benefits expense favorable to budget $0.1 million

CHANGE IN NET ASSETS is ($3.7) million, unfavorable to budget $3.4 million

CalOptima Health
PACE
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2026

June 2026					July 2025 - June 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
577	**573**	4	0.7%	**Member Months**	**6,559**	**6,612**	(53)	(0.8%)
				Revenues				
4,011,375	3,958,982	52,393	1.3%	Medi-Cal Capitation Revenue	45,217,714	45,433,996	(216,282)	(0.5%)
968,728	951,466	17,262	1.8%	Medicare Part C Revenue	11,365,400	10,647,027	718,373	6.7%
275,139	357,239	(82,100)	(23.0%)	Medicare Part D Revenue	4,261,532	4,073,202	188,330	4.6%
5,255,243	**5,267,687**	(12,444)	(0.2%)	**Total Operating Revenue**	**60,844,646**	**60,154,225**	**690,421**	**1.1%**
				Medical Expenses				
1,912,206	1,609,216	(302,990)	(18.8%)	Medical Management	18,298,327	19,056,585	758,258	4.0%
895,428	899,500	4,072	0.5%	Facilities Claims	12,929,384	10,232,132	(2,697,252)	(26.4%)
1,323,417	850,780	(472,637)	(55.6%)	Professional Claims	10,470,453	9,666,537	(803,916)	(8.3%)
633,557	780,249	146,692	18.8%	Prescription Drugs	7,020,672	8,875,230	1,854,558	20.9%
62,392	53,569	(8,823)	(16.5%)	MLTSS	762,793	527,852	(234,941)	(44.5%)
329,722	316,852	(12,870)	(4.1%)	Patient Transportation	3,591,443	3,519,679	(71,764)	(2.0%)
5,156,722	**4,510,166**	(646,556)	(14.3%)	**Total Medical Expenses**	**53,073,072**	**51,878,015**	(1,195,057)	(2.3%)
98,520	**757,521**	(659,001)	(87.0%)	**Gross Margin**	**7,771,574**	**8,276,210**	(504,636)	(6.1%)
				Administrative Expenses				
176,742	188,251	11,509	6.1%	Salaries, Wages & Employee Benefits	2,181,194	2,229,017	47,823	2.1%
17,581	13,949	(3,632)	(26.0%)	Professional Fees	168,960	167,092	(1,868)	(1.1%)
95,310	80,257	(15,053)	(18.8%)	Purchased Services	874,066	867,739	(6,327)	(0.7%)
20,873	11,183	(9,690)	(86.7%)	Printing & Postage	218,024	232,440	14,416	6.2%
1,540	1,623	83	5.1%	Depreciation & Amortization	12,079	19,465	7,387	37.9%
14,244	11,106	(3,138)	(28.3%)	Other Operating Expenses	133,743	130,746	(2,997)	(2.3%)
27,514	17,486	(10,028)	(57.3%)	Indirect Cost Allocation, Occupancy	207,794	209,920	2,126	1.0%
353,804	**323,855**	(29,949)	(9.2%)	**Total Administrative Expenses**	**3,795,860**	**3,856,419**	**60,559**	**1.6%**
(255,284)	**433,666**	(688,950)	(158.9%)	**Change in Net Assets**	**3,975,714**	**4,419,791**	(444,077)	(10.0%)
98.1%	***85.6%***	***12.5%***		***Medical Loss Ratio***	***87.2%***	***86.2%***	***1.0%***	
6.7%	***6.1%***	(0.6%)		***Admin Loss Ratio***	***6.2%***	***6.4%***	***0.2%***	

CalOptima Health
MSSP
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2026

June 2026					July 2025 - June 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
571	**558**	13	2.3%	**Member Months**	**6,883**	**6,696**	**187**	**2.8%**
				Revenues				
239,682	249,054	(9,372)	(3.8%)	Medi-Cal Capitation Revenue	2,966,222	2,988,648	(22,426)	(0.8%)
239,682	**249,054**	(9,372)	(3.8%)	**Total Operating Revenue**	**2,966,222**	**2,988,648**	(22,426)	(0.8%)
				Medical Expenses				
183,882	194,138	10,256	5.3%	Medical Management	2,250,936	2,329,601	78,665	3.4%
20,147	32,938	12,791	38.8%	Waiver Services	352,917	395,487	42,570	10.8%
204,029	**227,076**	**23,047**	**10.1%**	**Total Program Expenses**	**2,603,853**	**2,725,088**	**121,235**	**4.4%**
35,653	**21,978**	**13,675**	**62.2%**	**Gross Margin**	**362,369**	**263,560**	**98,809**	**37.5%**
				Administrative Expenses				
108,657	126,489	17,832	14.1%	Salaries, Wages & Employee Benefits	1,274,808	1,495,721	220,913	14.8%
1,457	1,500	43	2.9%	Professional Fees	17,484	18,000	516	2.9%
2	-	(2)	(100.0%)	Purchased Services	40	-	(40)	(100.0%)
10,083	8,530	(1,553)	(18.2%)	Other Operating Expenses	97,015	102,250	5,235	5.1%
16,867	7,587	(9,280)	(122.3%)	Indirect Cost Allocation, Occupancy	96,976	91,000	(5,976)	(6.6%)
137,066	**144,106**	**7,040**	**4.9%**	**Total Administrative Expenses**	**1,486,323**	**1,706,971**	**220,648**	**12.9%**
(101,413)	(122,128)	**20,715**	**17.0%**	**Change in Net Assets**	(1,123,954)	(1,443,411)	**319,457**	**22.1%**
85.1%	***91.2%***	(6.1%)		***Medical Loss Ratio***	***87.8%***	***91.2%***	(3.4%)	
57.2%	***57.9%***	***0.7%***		***Admin Loss Ratio***	***50.1%***	***57.1%***	***7.0%***	

CalOptima Health
Covered California
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2026

June 2026					July 2025 - June 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
-	-	-	**0.0%**	**Member Months**	-	-	-	**0.0%**
				Revenues				
-	-	-	0.0%	Capitation Revenue	-	-	-	0.0%
-	-	-	**0.0%**	**Total Operating Revenue**	-	-	-	**0.0%**
				Medical Expenses				
-	44,982	44,982	100.0%	Medical Management	-	539,806	539,806	100.0%
-	**44,982**	**44,982**	**100.0%**	**Total Medical Expenses**	**-**	**539,806**	**539,806**	**100.0%**
-	(44,982)	**44,982**	(100.0%)	**Gross Margin**	**-**	(539,806)	**539,806**	(100.0%)
				Administrative Expenses				
288,309	385,292	96,983	25.2%	Salaries, Wages & Employee Benefits	1,621,672	4,061,973	2,440,301	60.1%
393,169	418,337	25,168	6.0%	Professional Fees	3,498,262	5,020,000	1,521,738	30.3%
1,500	52,000	50,500	97.1%	Purchased Services	26,500	624,000	597,500	95.8%
-	19	19	100.0%	Printing & Postage	-	250	250	100.0%
1,423	43,219	41,796	96.7%	Other Operating Expenses	1,854	518,650	516,796	99.6%
684,401	**898,867**	**214,466**	**23.9%**	**Total Administrative Expenses**	**5,148,288**	**10,224,873**	**5,076,585**	**49.6%**
(684,401)	(943,849)	**259,448**	**27.5%**	**Income (Loss) From Operations**	(5,148,288)	(10,764,679)	**5,616,391**	**52.2%**
(684,401)	(943,849)	**259,448**	**27.5%**	**Change in Net Assets**	(5,148,288)	(10,764,679)	**5,616,391**	**52.2%**
0.0%	***0.0%***	***0.0%***		***Medical Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	
0.0%	***0.0%***	***0.0%***		***Admin Loss Ratio***	***0.0%***	***0.0%***	***0.0%***	

CalOptima Health
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2026

June 2026					July 2025 - June 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Building Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
93,130	29,711	(63,419)	(213.5%)	Purchased Services	947,195	356,499	(590,696)	(165.7%)
214,561	191,643	(22,918)	(12.0%)	Depreciation & Amortization	2,278,995	2,299,716	20,721	0.9%
21,938	25,120	3,182	12.7%	Insurance Expense	276,157	301,484	25,327	8.4%
469,909	219,803	(250,106)	(113.8%)	Repair & Maintenance	2,319,789	2,637,702	317,913	12.1%
41,183	59,087	17,904	30.3%	Other Operating Expenses	629,718	709,110	79,392	11.2%
(840,722)	(525,375)	315,347	60.0%	Indirect Cost Allocation, Occupancy	(6,451,854)	(6,304,511)	147,343	2.3%
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

CalOptima Health
Building 500 - City Parkway
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2026

June 2026					July 2025 - June 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
182,231	118,200	64,031	54.2%	Building Income	1,721,597	1,418,466	303,131	21.4%
182,231	**118,200**	**64,031**	**54.2%**	**Total Operating Revenue**	**1,721,597**	**1,418,466**	**303,131**	**21.4%**
				Administrative Expenses				
88,187	19,129	(69,058)	(361.0%)	Purchased Services	694,375	229,570	(464,805)	(202.5%)
59,495	75,661	16,166	21.4%	Depreciation & Amortization	708,570	907,954	199,384	22.0%
7,807	9,239	1,432	15.5%	Insurance Expense	100,817	110,934	10,117	9.1%
270,288	104,662	(165,626)	(158.2%)	Repair & Maintenance	912,303	1,255,889	343,586	27.4%
13,986	31,298	17,312	55.3%	Other Operating Expenses	233,277	375,576	142,299	37.9%
(46,571)	(25,412)	21,159	83.3%	Indirect Cost Allocation, Occupancy	(280,570)	(304,988)	(24,418)	(8.0%)
393,190	**214,577**	(178,613)	(83.2%)	**Total Administrative Expenses**	**2,368,773**	**2,574,935**	**206,162**	**8.0%**
(210,959)	(96,377)	(114,582)	(118.9%)	**Change in Net Assets**	(647,175)	(1,156,469)	**509,294**	**44.0%**

CalOptima Health
Building 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Twelve Months Ending June 30, 2026

June 2026					July 2025 - June 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Building Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
37,172	3,337	(33,835)	(1013.9%)	Purchased Services	412,233	40,000	(372,233)	(930.6%)
9,397	9,646	249	2.6%	Depreciation & Amortization	112,769	115,807	3,038	2.6%
4,984	-	(4,984)	(100.0%)	Insurance Expense	57,643	-	(57,643)	(100.0%)
16,698	28,537	11,839	41.5%	Repair & Maintenance	47,605	342,400	294,795	86.1%
(796)	720	1,516	210.6%	Other Operating Expenses	4,470	8,640	4,170	48.3%
67,455	**42,240**	(25,215)	(59.7%)	**Total Administrative Expenses**	**634,720**	**506,847**	(127,873)	(25.2%)
(67,455)	(42,240)	(25,215)	(59.7%)	**Change in Net Assets**	(634,720)	(506,847)	(127,873)	(25.2%)

OTHER PROGRAM INCOME STATEMENTS – JUNE MONTH:

PACE

- **CHANGE IN NET ASSETS** is ($0.3) million, unfavorable to budget $0.7 million

MSSP

- **CHANGE IN NET ASSETS** is ($101,413), favorable to budget $20,715

Covered CA

- **CHANGE IN NET ASSETS** is ($0.7) million, favorable to budget $0.3 million

NON-OPERATING INCOME STATEMENTS – JUNE MONTH:

BUILDING 500 City Parkway

- **CHANGE IN NET ASSETS** is ($0.2) million, unfavorable to budget $0.1 million

BUILDING 7900 Garden Grove Blvd

- **CHANGE IN NET ASSETS** is ($67,455), unfavorable to budget $25,215

INVESTMENT INCOME

- Net Investment Income of $7.2 million due to $13.3 million in net interest income, offset by $6.1 million in realized and unrealized loss on investments

COMMUNITY REINVESTMENT

- Unfavorable variance of $8.5 million due to Community Reinvestment obligation estimates

CalOptima Health
Balance Sheet
June 30, 2026

			June-26	May-26	$ Change	% Change
ASSETS						
	Current Assets					
		Operating Cash	365,036,442	274,730,860	90,305,582	32.9%
		Short-term Investments	1,860,077,841	1,835,320,651	24,757,191	1.3%
		Receivables - Other	18,701,816	15,809,461	2,892,354	18.3%
		Prepaid Expenses	15,017,558	17,404,444	(2,386,885)	(13.7%)
		Capitation Receivables	612,910,005	618,494,839	(5,584,834)	(0.9%)
		Total Current Assets	**2,871,743,663**	**2,761,760,255**	**109,983,408**	**4.0%**
		Total Capital Assets, Net	**110,411,802**	**108,981,068**	**1,430,734**	**1.3%**
	Other Assets					
		Net Pension Assets	4,069,081		4,069,081	100.0%
		Restricted Deposit & Other	300,000	300,000	-	0.0%
		Total Other Assets	**4,369,081**	**300,000**	**4,069,081**	**1,356.4%**
	Board Designated Assets					
		Board Designated Reserves	1,636,982,171	1,635,396,290	1,585,882	0.1%
		Statutory Designated Reserves	141,572,745	141,432,587	140,158	0.1%
		Total Designated Assets	**1,778,554,917**	**1,776,828,877**	**1,726,040**	**0.1%**
TOTAL ASSETS			**4,765,079,462**	**4,647,870,200**	**117,209,262**	**2.5%**
	Deferred Outflows	GASB 68 - PERS - Contributions	1,886,033	94,666	1,791,367	1,892.3%
		GASB 68 - PERS - Difference in Experience	24,960,547	20,669,960	4,290,587	20.8%
		GASB 68 - PERS - Changes in Assumptions	3,079,433	4,311,207	(1,231,774)	(28.6%)
		GASB 68 - PERS - Difference in Earnings	-	2,361,239	(2,361,239)	(100.0%)
		GASB 75 - OPEB - Contributions	721,000	637,000	84,000	13.2%
		GASB 75 - OPEB - Changes in Assumptions	276,000	552,000	(276,000)	(50.0%)
		GASB 53 - INVT - Changes in Fair Value	-	-	-	0.0%
		Advance Discretionary Payment			-	0.0%
TOTAL ASSETS & DEFERRED OUTFLOWS			**4,796,002,475**	**4,676,496,272**	**119,506,203**	**2.6%**
LIABILITIES						
	Current Liabilities	Accounts Payable	225,655,524	159,917,521	65,738,003	41.1%
		Accrued Payroll Liabilities	33,159,177	23,476,431	9,682,746	41.2%
		Deferred Revenue	5,921,439	7,971,083	(2,049,645)	(25.7%)
		Due to State of California and CMS	805,087,542	793,732,113	11,355,429	1.4%
		Medical Claims Liabilities	362,479,476	345,288,653	17,190,823	5.0%
		Capitation and Withholds	125,273,074	136,136,895	(10,863,821)	(8.0%)
		Total Current Liabilities	**1,557,576,231**	**1,466,522,696**	**91,053,535**	**6.2%**
		GASB 96 Subscription Liabilities	21,952,296	21,952,296	-	0.0%
		Capital Lease Payable	196,705	200,903	(4,198)	(2.1%)
		Community Reinvestment, Capital Lease Payable	66,941,338	58,451,085	8,490,253	14.5%
		Post Employment Health Benefits Liability	15,772,000	17,506,482	(1,734,482)	(9.9%)
		Net Pension Liabilities	-	5,840,992	(5,840,992)	(100.0%)
TOTAL LIABILITIES			**1,662,438,570**	**1,570,474,454**	**91,964,116**	**5.9%**
	Deferred Inflows					
		GASB 68 - PERS - Difference in Experience	889,598	1,321,519	(431,921)	(32.7%)
		GASB 68 - PERS - Difference in Experience	13,474,595	-	13,474,595	100.0%
		GASB 75 - OPEB - Changes in Assumptions	449,000	1,322,000	(873,000)	(66.0%)
		GASB 75 - OPEB - Difference in Experience	1,910,000	1,666,000	244,000	14.6%
		GASB 53 - INVT - Changes in Fair Value	-	-	-	0.0%
	Required TNE		134,332,567	134,824,287	(491,721)	(0.4%)
	Funds in excess of TNE		2,982,508,146	2,966,888,011	15,620,134	0.5%
	Net Assets		**3,116,840,712**	**3,101,712,299**	**15,128,413**	**0.5%**
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION			**4,796,002,475**	**4,676,496,272**	**119,506,203**	**2.6%**

BALANCE SHEET – JUNE MONTH:

ASSETS of $4.8 billion increased $119.5 million from May or 2.6%

- Operating Cash and Short-term Investments increased $115.1 million due primarily to the Managed Care Organization (MCO) tax revenue receipt
- Net Pension Assets increased $4.1 million due to the annual true-up under Governmental Accounting Standards Board Statement (GASB) No. 68

LIABILITIES of $1.7 billion increased $92.0 million from May or 5.9%

- Accounts Payable increased $65.7 million due to the CY 2026 MCO tax accrual
- Total Claims Liabilities increased $17.2 million due to variability in claims experience
- Due to the State of California and the Centers for Medicare & Medicaid Services (CMS) increased $11.4 million due primarily to risk corridor estimates
- Accrued Payroll Liabilities increased $9.7 million due to the timing of pay period cut-offs for payment
- Capitation and Withholds decreased $10.9 million due to accrual adjustments for CalOptima Health's shared risk pool and the OneCare CY 2025 annual HCC payout

NET ASSETS of $3.1 billion, increased $15.1 million from May or 0.5%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of June 30, 2026

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	817,907,910				
MetLife Tier One	819,074,261				
Board Designated Reserves	1,636,982,171	1,085,485,002	1,736,776,003	551,497,169	(99,793,832)
Current Reserve Level (X months of average monthly revenue) [1]	*3.77*	*2.50*	*4.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	70,856,586				
MetLife Tier Two	70,716,160				
Statutory Designated Reserves	141,572,745	134,332,567	147,765,823	7,240,179	(6,193,078)
Current Reserve Level (X min. TNE) [1]	*1.05*	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

CalOptima Health
Statement of Cash Flow
June 30, 2026

	June 2026	July - June 2026
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	15,128,413	316,257,011
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation & Amortization	1,317,471	14,692,641
Changes in assets and liabilities:		
Prepaid expenses and other	2,386,885	(3,834,496)
Capitation receivable	2,692,479	117,499,914
Medical claims liability	17,190,823	(685,257,863)
Deferred revenue	(2,049,645)	(16,133,124)
Payable to health networks	(10,863,821)	(28,720,292)
Accounts payable	65,738,003	(8,330,983)
Accrued payroll	2,107,271	(4,004,603)
Other accrued liabilities	19,841,484	788,997,017
Net cash provided by/(used in) operating activities	113,489,365	491,165,222
GASB53, GASB 68, GASB 75 and Advance Discretionary Payment Adjustments	10,116,733	10,116,732
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES:		
Change in Investments	(24,757,191)	(519,151,240)
Change in Property and Equipment	(2,748,205)	(26,481,738)
Change in Restricted Deposit & Other	(4,069,081)	(4,069,081)
Change in Board Designated Reserve	-	-
Change in Homeless Health Reserve	(1,726,040)	(61,747,409)
Net cash provided by/(used in) investing activities	(33,300,516)	(611,449,468)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	90,305,582	(110,167,514)
CASH AND CASH EQUIVALENTS, beginning of period	274,730,860	475,203,955
CASH AND CASH EQUIVALENTS, end of period	**365,036,442**	**365,036,442**

Preliminary

Back to Agenda

CalOptima Health
Spending Plan
For the Twelve Months Ending June 30, 2026

Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
Total Net Position @ 6/30/2026	**$3,116.8**			**100.0%**
Resources Assigned				
Board Designated Reserve[1]	**$1,637.0**			**52.5%**
Statutory Designated Reserve[1]	**$141.6**			**4.5%**
Capital Assets, net of Depreciation	**$110.4**			**3.5%**
Resources Allocated				
Homeless Health Initiative[2]	14.1	63.3	49.2	0.5%
Housing and Homelessness Incentive[2]	25.6	87.4	61.8	0.8%
Intergovernmental Transfers (IGT)	34.7	52.1	17.3	1.1%
Digital Transformation and Workplace Modernization[3]	20.6	100.0	79.4	0.7%
CalFresh and Redetermination Outreach Strategy	1.7	6.0	4.3	0.1%
Coalition of Orange County Community Health Centers Grant	10.7	50.0	39.3	0.3%
Mind OC Grant (Irvine)	-	15.0	15.0	0.0%
General Awareness Campaign	0.0	4.7	4.7	0.0%
Member Health Needs Assessment	0.3	1.3	1.0	0.0%
Five-Year Hospital Quality Program Beginning MY 2023	104.8	153.5	48.7	3.4%
Skilled Nursing Facility Access Program	10.0	10.0	-	0.3%
National Alliance for Mental Illness Orange County Peer Support Program Grant	2.0	5.0	3.0	0.1%
Stipend Program for Master of Social Work Students Grant	-	5.0	5.0	0.0%
Wellness & Prevention Program Grant	1.0	2.7	1.7	0.0%
CalOptima Health Provider Workforce Development Fund Grant	39.6	50.0	10.4	1.3%
Garden Grove Bldg. Improvement	16.0	17.5	1.5	0.5%
PACE Facility - Irvine	29.1	29.5	0.4	0.9%
Dyadic Services Program Academy	0.2	1.9	1.7	0.0%
Medi-Cal Provider Rate Increases (07/2024 - 12/2026)	105.2	526.2	421.0	3.4%
Medi-Cal Provider Rate Increases (07/2026 - 12/2028)	429.6	429.6	-	13.8%
Homeless Prevention and Stabilization Pilot Program	0.2	0.3	0.1	0.0%
OneCare Member Engagement and Education	0.0	0.3	0.2	0.0%
Medi-Cal Eligibility Outreach Strategy	20.7	21.8	1.1	0.7%
Supplemental food support for Medi-Cal members	3.8	8.0	4.2	0.1%
Orange County Community Health Assessment and Improvement Plan	0.5	1.0	0.5	0.0%
Subtotal	**870.4**	**1,642.0**	**771.6**	**27.9%**
Resources Available for New Initiatives				
Unallocated/Unassigned[1]	**$357.5**			**11.5%**

[1] Total Designated Reserves and unallocated reserve amount can support approximately 183 days of CalOptima Health's current operations.

[2] See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.

[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

CalOptima Health
Key Financial Indicators
As of June 30, 2026

	Item Name	June 2026					July 2025 -June 2026				
		Actual	Budget	Variance	%		Actual	Budget	Variance	%	
Income Statement	*Member Months*	806,971	866,997	(60,026)	(6.9%)		10,307,293	10,616,129	(308,836)	(2.9%)	
	Operating Revenue	384,125,364	384,432,922	(307,558)	(0.1%)		5,157,350,610	4,691,984,627	465,365,983	9.9%	
	Medical Expenses	341,023,431	361,858,068	20,834,637	5.8%		4,706,570,282	4,380,640,809	(325,929,473)	(7.4%)	
	General and Administrative Expense	27,354,583	26,022,962	(1,331,620)	(5.1%)		266,030,662	306,509,110	40,478,448	13.2%	
	Non-Operating Income/(Loss)	(618,938)	4,021,876	(4,640,814)	(115.4%)		131,507,345	94,163,915	37,343,430	39.7%	
	Summary of Income & Expenses	15,128,413	573,768	14,554,645	2,536.7%		316,257,011	98,998,623	217,258,388	219.5%	
Ratios	**Medical Loss Ratio (MLR)**	**Actual**	**Budget**	**Variance**			**Actual**	**Budget**	**Variance**		
	Consolidated	88.8%	94.1%	(5.3%)			91.3%	93.4%	(2.1%)		
	Administrative Loss Ratio (ALR)	**Actual**	**Budget**	**Variance**			**Actual**	**Budget**	**Variance**		
	Consolidated	7.1%	6.8%	(0.4%)			5.2%	6.5%	1.4%		

Key:

> 0%
> -20%, < 0%
< -20%

Investment	Investment Balance (excluding CCE)	Current Month	Prior Month	Change	%
	@6/30/2026	3,606,320,271	3,583,580,561	22,739,710	0.6%

Unallocated/Unassigned Reserve Balance	Current Month @June 2026	Fiscal Year Ending June 2025	Change	%
Consolidated	357,469,971	264,975,684	92,494,287	34.9%
*Days Cash On Hand**	183			

*Total Designated Reserves and unallocated reserve amount can support approximately 183 days of CalOptima Health's current operations.

CalOptima Health
Digital Transformation Strategy ($100 million total reserve)
Funding Balance Tracking Summary
For the Twelve Months Ending June 30, 2026

	June 2026				July 2025 - June 2026				All Time to Date			
	Actual Spend	Approved Budget	Variance $	Variance %	Actual Spend	Approved Budget	Variance $	Variance %	Actual Spend	Approved Budget	Variance $	Variance %
Capital Assets (Cost, Information Only):												
Total Capital Assets	**268,572**	**7,612,936**	**7,344,365**	**96.5%**	**2,274,584**	**12,161,000**	**9,886,416**	**81.3%**	**17,885,535**	**38,931,116**	**21,045,581**	**54.1%**
Operating Expenses:												
Salaries, Wages & Benefits	-	-	-	0.0%	-	-	-	0.0%	17,826,058	17,826,058	-	0.0%
Professional Fees	1,096,934	250,000	(846,934)	(338.8%)	3,603,262	3,000,000	(603,262)	(20.1%)	10,404,073	9,800,811	(603,262)	(6.2%)
Purchased Services	-	-	-	0.0%	(141,754)	-	141,754	0.0%	1,190,915	1,332,669	141,754	10.6%
GASB 96 Amortization Expenses	-	-	-	0.0%	-	-	-	0.0%	2,563,169	2,563,169	-	0.0%
Other Expenses	282,747	4,355,057	4,072,310	93.5%	4,746,916	6,360,269	1,613,353	25.4%	25,842,657	27,456,010	1,613,353	5.9%
Medical Management	-	-	-	0.0%	-	-	-	0.0%	5,502,156	5,502,156	-	0.0%
Total Operating Expenses	**1,379,681**	**4,605,057**	**3,225,376**	**70.0%**	**8,208,424**	**9,360,269**	**1,151,845**	**12.3%**	**63,329,030**	**64,480,875**	**1,151,845**	**1.8%**

Funding Balance Tracking: July 2025	**Approved Budget**	**Actual Spend**	**Variance**
Beginning Funding Balance	100,000,000	100,000,000	-
Less:			
Capital Assets[1]	38,931,116	17,885,535	21,045,581
FY2023 Operating Budget[2]	8,381,011	8,381,011	-
FY2024 Operating Budget	22,788,092	22,788,092	-
FY2025 Operating Budget	24,289,000	23,951,502	337,498
FY2026 Operating Budget	5,187,500	8,208,424	(3,020,924)
Ending Funding Balance	**423,281**	**18,785,436**	**18,362,155**
Add: Prior year unspent Operating Budget	**337,498**		
Total available Funding	**760,779**		

[1] Staff will continue to monitor the project status of DTS' Capital Assets
[2] Unspent budget from this period is added back to available DTS funding
[3] On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024

Note: Report includes applicable transactions for GASB 96, Subscriptions - Based Information Technology Arrangements.

CalOptima Health
Summary of Homeless Health Initiatives (HHI) and Allocated Funds
As of June 30, 2026

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
HHI - IGT'S	61,496,005	61,496,005	49,245,005	12,251,000	-
HHI - Existing Reserves	1,800,000	1,800,000	-	1,800,000	-
HHIP	40,100,000	40,100,000	-	40,100,000	-
Total	**103,396,005**	**103,396,005**	**49,245,005**	**54,151,000**	**-**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-	IGT's
Recuperative Care	6,194,190	6,194,190	-	IGT's
Medical Respite	250,000	250,000	-	IGT's
Day Habilitation (County for HomeKey)[4]	-	-	-	IGT's
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-	IGT's
CalOptima Homeless Response Team	1,681,734	1,681,734	-	IGT's
Homeless Coordination at Hospitals	10,000,000	10,000,000	-	IGT's
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support[5]	925,540	925,540	-	IGT's
FQHC (Community Health Center) Expansion	21,902	21,902	-	IGT's
HCAP and CalOptima Health Days	9,888,914	5,034,955	4,853,959	IGT's
Vaccination Intervention and Member Incentive Strategy[2]	54,649	54,649	-	IGT's
Street Medicine[3]	14,279,077	9,806,021	4,473,056	IGT's & Existing Reserves
Outreach and Engagement	7,000,000	2,276,015	4,723,985	IGT's
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000	IGT's & Existing Reserves
Subtotal of Approved Initiatives	**103,396,005**	**49,245,005**	**54,151,000**	
Transfer of funds to HHIP[4]	(40,100,000)	-	(40,100,000)	
Program Total	**63,296,005**	**49,245,005**	**14,051,000**	

[1]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1 million from HHI to HHIP.

[2]On June 5, 2025, CalOptima Health's Board of Directors approved the close out of the Vaccination Intervention and Member Incentive Strategy program and transfer of the remaining funds of $68,699 to unallocated reserves for new initiatives.

[3]On August 7, 2025, CalOptima Health's Board of Directors approved $9.3 million to expand the Street Medicine Program ($3.2 million remaining from Street Medicine Initiative (from the Homeless Health Initiatives Reserve), $1.8 million from Existing Reserves, and $4.3 million from Intergovernmental Transfer balance resulting from a June 5, 2025, Board action), to fund 2-year grant agreements to Healthcare in Action (Anaheim), Celebrating Life Community Health Center (Costa Mesa), and AltaMed (Santa Ana).

[4]On February 5, 2026, CalOptima Health's Board of Directors approved the closeout of the Day Habilitation (County for HomeKey) and designated the remaining balance of $2.5 million as available for allocation to deliver enhanced services for Medi-Cal members.

[5]On April 2, 2026, CalOptima Health's Board of Directors approved the closeout of the CalOptima Days, HCAP and FQHC Administrative Support and make $37,721 in IGT 8 funds available toward future IGT initiatives to deliver covered services for Medi-Cal members.

CalOptima Health
Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds
As of June 30, 2026

Summary by Funding Source:	Total Funds[1]	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	65,931,189	65,931,189	34,733,595	31,197,594	-
Existing Reserves & HHI Transfer	87,384,530	87,384,530	61,797,392	25,587,138	-
Street Medicine Support Center - GG Building[2]	7,000,000	7,000,000	-	7,000,000	-
Total	**160,315,719**	**160,315,719**	**96,530,987**	**63,784,733**	-

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	1,400,000	913,500	486,500	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,821,311	800,001	HHI & DHCS
Infrastructure Projects	5,832,314	5,832,310	4	HHI
Capital Projects	126,247,564	73,140,270	53,107,294	HHI, DHCS & Existing Reserves
System Change Projects	19,314,530	9,968,205	9,346,325	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	**$160,315,719[1]**	**$96,530,987**	**$63,784,733**	
Transfer of funds to Street Medicine Support Center-GG Building	**(7,000,000)**	**-**	**($7,000,000)**	Existing Reserves
Program Total	**$153,315,719**	**$96,530,987**	**$56,784,733**	

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments

[2]On October 7, 2025, CalOptima Health's Board of Directors approved up to $7.0 million for general contractor services & furniture, fixtures & equipment for the Street Medicine Support Center

CalOptima Health
Fiscal Year 2025-26 Budget Allocation Changes
Reporting Changes as of June 30, 2026

Transfer Month	Line of Business	From	To	Amount	Reason to Re-Allocate Funds
July	Medi-Cal	Human Resources - Training and Seminar - Participant Guides	Human Resources - Cert./Cont. Education - Educational Reimbursement	$90,000	For Educational Reimbursement
July	Medi-Cal	Human Resources - Professional Fees - Executive Recruiters, Direct Hire and Conversion Fees	Human Resources - Advertising - Combined: Recruitment and Job Postings Network	$90,000	For Job Posting Advertising
July	Medi-Cal	ITS - Infrastructure - Maintenance HW/SW - Software License	ITS - Infrastructure - Maintenance HW/SW - Server - Maintenance coverage for on-premises physical servers, storage and SAN switches	$28,150	For Server Maintenance Coverage
July	Medi-Cal	ITS - Application Development - Professional Fees - Development and QA Professional Services	ITS - Application Development - Purchased Services - General - Managed Services for Website Support	$120,250	For Website Maintenance Support
August	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Software License	ITS - Infrastructure - Other Operating Expenses - Server Connectivity Maintenance	$140,238	For Server Maintenance
August	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Maintenance for Firewalls and IPSEC VPNS	ITS - Infrastructure - Professional Fees - IT Advisory Subscription	$162,890	For Professional Services
August	Medi-Cal	ITS - Application Development - Automation Application for the Board and Committee Material Preparation	ITS - Application Development - Policies and Regulation Compliance Identification - Readily Compliance Project	$65,000	For Readily Compliance Project
September	Medi-Cal	ITS - Infrastructure - Maintenance HW/SW Network Connectivity Maintenance and Support	ITS - Infrastructure - Maintenance HW/SW Maintenance of Operations and Desktop Application Software and Hardware	$52,420	For Right Fax
September	Medi-Cal	Customer Service - Printing and Postage - Member Communication	Human Resources - Professional Fees - Employee Feedback	$70,000	For Leadership Development
October	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Annual Volume License Adjustment	ITS - Infrastructure - Other Operating Expenses - Enterprise Monitoring for On-premise and cloud instances	$34,415	For On-Premise and Cloud Database Monitoring Maintenance
October	Medi-Cal	ITS - Infrastructure - Other Operating Expense - Annual Volume Licenses Contract	ITS - Applications Management - Interest - GASB 96	$41,558	For License Agreement Renewal
October	Medi-Cal	ITS - Applications Management - Interest - GASB 96	ITS - Applications Management - Other Operating Expenses - Subscription-Based Information Technology Arrangements (SBITAs)	$41,558	For Increase Against Original Contract
October	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Annual Volume License Adjustment	ITS - Applications Management - Other Operating Expenses - TeamDynamix	$26,780	For TeamDynamix Solutions
November	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Annual Volume License Adjustment	ITS - Infrastructure - Other Operating Expenses - Data backup and protection	$249,999	For Infrastructure Maintenance
November	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Domain Names and IP Addresses	ITS - Infrastructure - Other Operating Expenses - Data backup and protection	$29,472	For Maintenance and Data Protection
December	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Network Firewall Upgrade and Enhancement	ITS - Infrastructure - Other Operating Expenses - Capital Software Expense	$15,000	For Capital Software
December	OneCare	Operations Management - Professional Fees - OneCare Consulting Services	ITS - Applications Management - Other Operating Expenses - Predictive Analytics Modeling	$18,000	For Application Development
December	OneCare	Communications - Purchased Services - Print Advertising	Communications - Printing and Postage - Direct Mail to Prospective Members	$75,000	For OneCare Direct Mail
December	Medi-Cal	ITS - Applications Management - Other Operating Expenses - Corporate Application SW	ITS - Applications Management - Other Operating Expenses - Writing assistance tool	$54,800	For Writing Assistance Tool
December	Medi-Cal	Accounting - Professional Fees - Investment Advisory Services	Accounting - Professional Fees - OPEB Valuation	$15,000	For Actuarial Services
January	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Additional Software License	ITS - Applications Management - Other Operating Expenses - CRM Licenses	$100,000	For Additional CRM Licenses
January	Medi-Cal	Human Resources - Other Operating Expenses - Employee Engagement Events and Logo Apparel	Human Resources - Professional Fees - Employee Feedback	$34,000	For Consulting Services
January	Medi-Cal	Human Resources - Purchased Services - Background Screening	Human Resources - Other Operating Expenses - Tuition Reimbursement	$20,000	For Educational Reimbursement
January	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Volume Licenses Contract	ITS - Infrastructure - Professional Fees - Consulting	$50,000	For Consulting Services
January	Medi-Cal	ITS - Application Development - Purchased Services to Med - Managed Service Support	ITS - Applications Management - Purchased Services to Med - Closed Loop Referral System and Support	$155,000	For Closed Loop Referral System and System
January	Medi-Cal	ITS - Applications Management - Maintenance HW/SW to Med - Software License	ITS - Applications Management - Purchased Services to Med - Closed Loop Referral System and Support	$22,000	For Closed Loop Referral System and System
January	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Additional Software License	Medi-Cal and CalAIM - Professional Fees - Grant Consulting	$50,000	For Grant Consulting Services
February	PACE	PACE Marketing - Printing and Postage - Member Communication - Direct Mail and Marketing Materials	PACE Marketing - Purchased Services - Advertising - Outdoor Ads	$23,000	For Advertising Campaigns
February	Medi-Cal	ITS - Application Development - Other Operating Expenses - Capital Software Expense	ITS - Application Development - Professional Fees - Development and QA Profession Services	$230,000	For Management Contractor for Operations
February	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Annual Volume License	ITS - Applications Management - Other Operating Expenses - GASB 96 Variable Expenses	$89,100	For Volume License Supplement
February	Medi-Cal	Facilities - Printing and Postage - General Postage for Outgoing Mail	Facilities - Other Operating Expenses - Purchases and Installation of Office Furniture	$50,000	For Supplies and Minor Equipment
February	Medi-Cal	Executive Office - Other Operating Expenses - Travel	Executive Office - Other Operating Expenses - Training and Seminar	$15,000	For Professional Development
February	Medi-Cal	ITS - Cyber Security - Professional Fees - AI Implementation Services for Security Controls	Accounting - Professional Fees - Accounting and Finance System Support	$100,000	For System Support

Fiscal Year 2025-26 Budget Allocation Changes
Reporting Changes as of June 30, 2026 (cont.)

Transfer Month	Line of Business	From	To	Amount	Reason to Re-Allocate Funds
March	Medi-Cal	Communications - Other Operating Expenses - Promotional Items	Communications - Purchased Services - Regulatory Compliance Remediation Services	$60,000	For Document Remediation Services
March	Covered California	IS - Enterprise Data and System - Regulatory Enrollment Transactions	ITS - Applications Management - Core System Configuration	$120,000	For Facets Implementation
March	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - User Licenses	ITS - Application Development - Other Operating Expenses - Office Software Suite License Costs	$50,000	For Office Software Suite License Costs
March	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - User Licenses	ITS - Applications Management - Other Operating Expenses - Finance Software Maintenance	$50,000	For Finance Software Maintenance
March	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Network Connectivity Expenses	ITS - Application Development - Other Operating Expenses - Application Software Maintenance	$75,000	For Testing Tool
March	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Network Connectivity Expenses	ITS - Infrastructure - Other Operating Expenses - Office Software Suite License Costs	$52,000	For Office Software Suite License Costs
March	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Network Connectivity Expenses	ITS - Applications Management - User Licenses for Customer Relationship Management Software	$52,000	For Customer Relationship Management Software
March	Medi-Cal	ITS - Infrastructure - Professional Fees - Process Enhancements	ITS - Application Development - Professional Fees - Development Enhancement	$200,000	For Development Enhancement
March	OneCare	Customer Service - Printing and Postage - Marketing Materials	Cultural and Linguistics Services - Purchased Services - Translations and Interpreter Services	$100,000	For Translations and Interpreter Services
March	Medi-Cal	IS - Enterprise Data and System - Other Operating Expenses - Application Software Maintenance	ITS - Infrastructure - Other Operating Expenses - User Licenses and Other Minor Computer Equipment	$15,855	For Computer Equipment
March	Medi-Cal	IS - Enterprise Data and System - Other Operating Expenses - Application Software Maintenance	IS - Enterprise Architecture - Professional Fees - External Consultant for Core Labor Work Support	$15,000	For External Consultant
April	Medi-Cal	ITS - Cyber Security - Other Operating Expenses - File Level Encryption	Human Resources - Professional Fees - Employee Feedback	$61,000	For Emergent Success
April	Medi-Cal	Procurement and Vendor Management - Purchased Services - Procurement Platform	Procurement and Vendor Management - Other Operating Expenses - Subscription Fees	$17,000	For Service Subscription
April	Medi-Cal	Claims Administration - Purchased Services - Change Healthcare EDI Clearinghouse	Claims Administration - Professional Fees - External Medical Review	$117,000	For Medical Reviews
April	Medi-Cal	IS - Enterprise Data and System - Other Operating Expenses - Software Maintenance	ITS - Application Development - Other Operating Expenses - Workflow Software Solution	$12,766	For Workflow Solution
April	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Maintenance for Replacements	ITS - Applications Management - Professional Fees - Facets Technical Support	$200,400	For Facets Technical Support Consulting
April	Medi-Cal	IS - Enterprise Data and System - Other Operating Expenses - Software Maintenance	ITS - Application Development - Other Operating Expenses - Subscription Service	$24,000	For IT Subscription Service
April	Medi-Cal	IS - Enterprise Data and System - Other Operating Expenses - Software Maintenance	ITS - Application Development - Other Operating Expenses - SurveyMonkey License	$31,432	For SurveyMonkey License
April	Medi-Cal	IS - Enterprise Data and System - Other Operating Expenses - Software Maintenance	ITS - Application Development - Other Operating Expenses - Management Training Software	$45,500	For Management Training Software
April	Medi-Cal	ITS - Cyber Security - Other Operating Expenses - Intrusion Prevention System	ITS - Application Development - Professional Fees - Cloud Platform Assistance	$100,000	For Cloud Platform Enhancement
April	Medi-Cal	Accounting - Other Operating Expenses - Training and Seminar	Accounting - Purchased Services - Tax Form Processing Fees	$20,000	For TIN Matching Add-On Services
May	Medi-Cal	ITS - Infrastructure - Purchased Services - Business Workflow Platform	ITS - Infrastructure - Professional Fees - External Consulting	$50,000	For Consulting Services
May	Medi-Cal	ITS - Applications Management - Other Operating Expenses - Licenses and Platform	ITS - Enterprise Architecture - Professional Fees - External Consulting	$45,000	For Consulting Services
May	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Network Connectivity Expenses	ITS - Infrastructure - Other Operating Expenses - Minor Computer Equipment	$40,000	For Hardware Equipment
May	Medi-Cal	Facilities - Other Operating Expenses - Office Supplies	Facilities - Other Operating Expenses - Purchases and Installation of Office Furniture	$60,000	For Minor Equipment
May	Medi-Cal	Facilities - Other Operating Expenses - Office Supplies	Facilities - Other Operating Expenses - Purchases and Installation of Office Furniture	$16,000	For Minor Equipment
May	Medi-Cal	ITS - Applications Management - Other Operating Expenses - Travel	ITS - Applications Management - Other Operating Expenses - Training and Seminar	$20,000	For Training and Seminar
June	Medi-Cal	Communications - Printing and Postage - Community Relations Communications	Communications - Other Operating Expenses - Promotional Items	$29,000	For Public Activities
June	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Software License	ITS - Infrastructure - Other Operating Expenses - Telecommunications Expenses	$98,010	For Telephone Bills
June	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Data Masking	ITS - Infrastructure - Purchased Services - Printing Support	$12,000	For Printer Lease
June	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Network Connectivity Maintenance	ITS - Infrastructure - Other Operating Expenses - Technology Equipment	$21,854	For Equipment
June	Medi-Cal	Accounting - Professional Fees - Investment Advisory Services - Accounting System Support	ITS - Application Development - Professional Fees - Software Development Support	$63,000	For Additional Enhancement
June	Medi-Cal	Accounting - Purchased Services - Checking Printing and Mailing Fees	Accounting - Professional Fees - Accounting and Finance System Support	$120,000	For Additional Enhancement
June	Medi-Cal	Community Relations - Other Operating Expenses - Travel Costs	Community Relations - Other Operating Expenses - Community Events Fees	$100,000	For Public Activities
June	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Numeracle Caller ID	ITS - Infrastructure - Other Operating Expenses - Telecommunications Expenses	$13,000	For Paging System

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $250,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Preliminary

Preliminary Unaudited Financial Summary June 30, 2026

Board of Directors Meeting

August 6, 2026

Nancy Huang, Chief Financial Officer

Our Mission

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

Our Vision

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

Financial Highlights Notes: June 2026

- $12.3 million reduction to the estimated remittance to the California Department of Health Care Services (DHCS) related to Calendar Year (CY) 2026 Medical Loss Ratio (MLR) requirements

- $9.9 million increase to the estimated CY 2026 Enhanced Care Management (ECM) Risk Corridor settlement based on the updated methodology from DHCS

- $8.5 million increase to the estimated CY 2026 Community Reinvestment obligation

CalOptima Health

Financial Highlights
June 2026

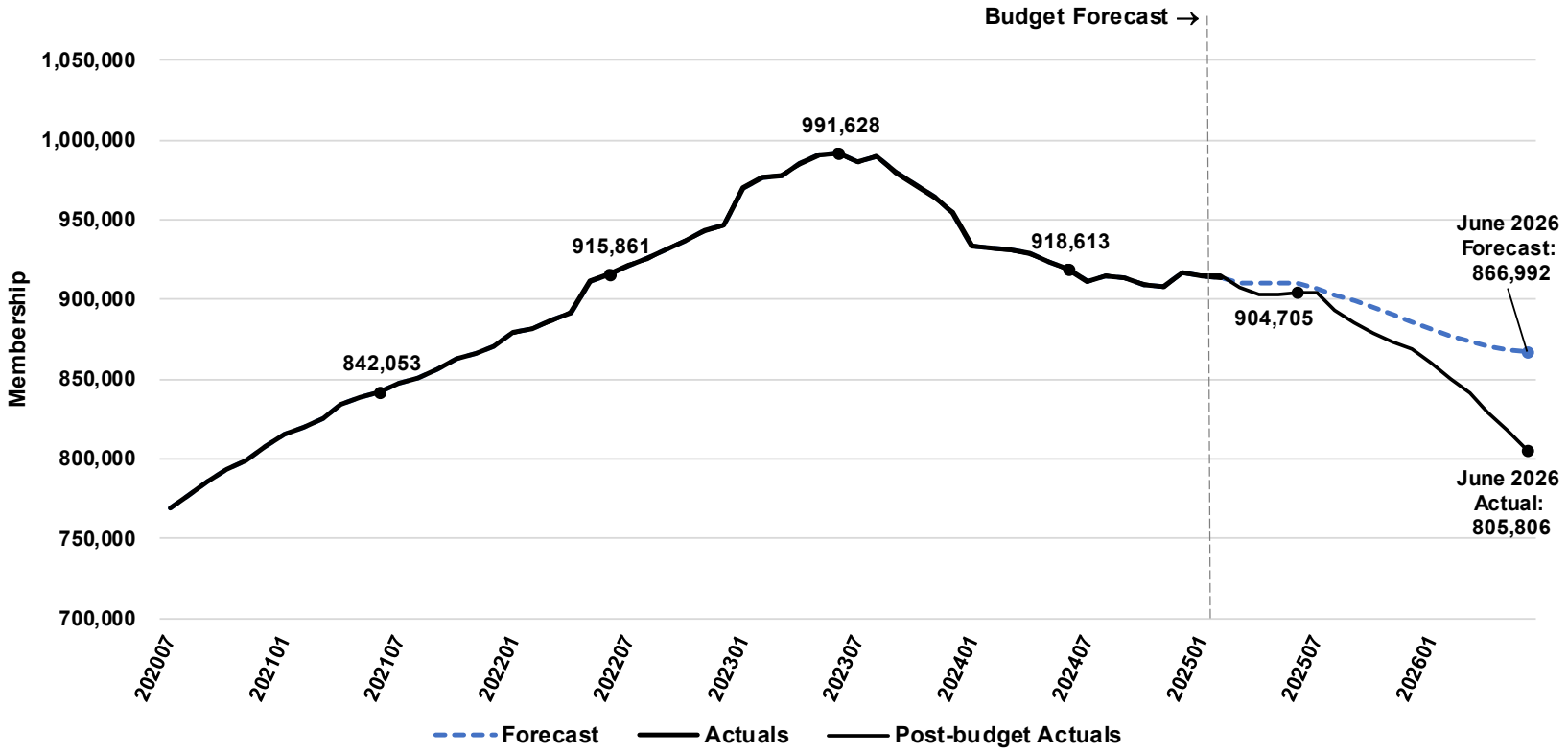
June 2026					July 2025 - June 2026			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
806,971	866,997	(60,026)	(6.9%)	Member Months	10,307,293	10,616,129	(308,836)	(2.9%)
384,125,364	384,432,922	(307,558)	(0.1%)	Revenues	5,157,350,610	4,691,984,627	465,365,983	9.9%
341,023,431	361,858,068	20,834,637	5.8%	Medical Expenses	4,706,570,282	4,380,640,809	(325,929,473)	(7.4%)
27,354,583	26,022,962	(1,331,620)	(5.1%)	Administrative Expenses	266,030,662	306,509,110	40,478,448	13.2%
15,747,351	(3,448,108)	**19,195,459**	**556.7%**	**Operating Margin**	**184,749,666**	**4,834,708**	**179,914,958**	**3,721.3%**
				Non-Operating Income (Loss)				
7,228,413	8,333,251	(1,104,839)	(13.3%)	Net Investment Income/Expense	140,121,594	100,000,000	40,121,594	40.1%
(199,656)	-	(199,656)	(100.0%)	Grant Expense	(23,568,780)	-	(23,568,780)	(100.0%)
(8,490,253)	-	(8,490,253)	(100.0%)	Community Reinvestment	21,156,773	-	21,156,773	100.0%
842,559	(4,311,375)	5,153,934	119.5%	Other Income/Expense	(6,202,242)	(5,836,085)	(366,157)	(6.3%)
(618,938)	**4,021,876**	(4,640,814)	(115.4%)	**Total Non-Operating Income (Loss)**	**131,507,345**	**94,163,915**	**37,343,430**	**39.7%**
15,128,413	**573,768**	**14,554,645**	**2,536.7%**	**Change in Net Assets**	**316,257,011**	**98,998,623**	**217,258,388**	**219.5%**
88.8%	*94.1%*	(5.3%)		*Medical Loss Ratio*	*91.3%*	*93.4%*	(2.1%)	
7.1%	*6.8%*	(0.4%)		*Administrative Loss Ratio*	*5.2%*	*6.5%*	*1.4%*	
4.1%	(0.9%)	*5.0%*		*Operating Margin Ratio*	*3.6%*	*0.1%*	*3.5%*	
100.0%	*100.0%*			*Total Operating*	*100.0%*	*100.0%*		

CalOptima Health

Actuals v. Budget – Total Membership

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Consolidated



Notes:

- Data included in this report are based on member eligibility months rather than booked enrollment (as used in the financials).
- Includes data as of July 10, 2026

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FY 2025-26: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - Month To Date (MTD) June 2026: $15.1 million, favorable to budget $14.6 million or 2,536.7% driven by:
    - Favorable CY 2026 capitation rates by DHCS, offset by unfavorable variance expense in Total Non-Operating Income/Expenses
    - Offset by unfavorable Community Reinvestment expense and Grant Expense
  - Year To Date (YTD) July 2025 – June 2026: $316.3 million, favorable to budget $217.3 million or 219.5% driven by Net Investment Income, favorable member mix, capitation rates and Community Reinvestment

CalOptima Health

FY 2025-26: Management Summary (cont.)

- Enrollment
  - MTD: 806,971 members, unfavorable to budget 60,026 or 6.9% due to freeze on enrollment of new members 19 years or older with Unsatisfactory Immigration Status (UIS) and asset test reinstatement
  - YTD: 10,307,293 member months, unfavorable to budget 308,836 or 2.9%

CalOptima Health

FY 2025-26: Management Summary (cont.)

- Revenue
  - MTD: $384.1 million, unfavorable to budget $0.3 million or 0.1% due to:
    - $13.7 million unfavorable to budget in OneCare (OC) Line of Business (LOB)
    - Offset by $13.4 million favorable to budget in Medi-Cal (MC) due to lower enrollment, member mix and capitation rates

CalOptima Health

FY 2025-26: Management Summary (cont.)

- Revenue
  - YTD: $5,157.4 million, favorable to budget $465.4 million or 9.9% due primarily to:
    - MC LOB CY 2023 and 2024 Hospital Directed Payments (DP), CY 2024 Quality Incentive Program (QIP), CY 2025 Skilled Nursing Facility Workforce and Quality Incentive (SNF WQIP), favorable member mix and capitation rates
    - Offset by OC LOB lower than anticipated Risk Adjustment Factor (RAF)

CalOptima Health

FY 2025-26: Management Summary (cont.)

- Medical Expenses
  - MTD: $341.0 million, favorable to budget $20.8 million or 5.8% due to:
    - $10.1 million in Prescription Drugs due to increase in OC prescription drugs rebate estimates
    - $9.5 million in Incentive Payments due to adjustments to MC Shared Risk Pool
    - $10.4 million in capitation expense due primarily to lower MC enrollment
    - Offset by $7.5 million in Other Medical Expenses primarily due to MC reinsurance expenses

CalOptima Health

FY 2025-26: Management Summary (cont.)

- Medical Expenses (cont.)
  - YTD: $4,706.6 million, unfavorable to budget $325.9 million or 7.4% due to:
    - $521.7 million in Other Medical expense primarily due to CY 2023 and 2024 Hospital DP, CY 2024 QIP and CY 2025 SNF WQIP
    - Offset by favorable variances to budget:
      - $57.6 million in Incentive Payments expense primarily due to release of accrual for MC Pay-for-Value (P4V) Incentive Payments
      - $72.2 million in claims expenses due to lower utilization
      - $37.2 million in Provider Capitation expense
      - $28.9 million in Medical Management expense

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FY 2025-26: Management Summary (cont.)

- Administrative Expenses
  - MTD: $27.4 million, unfavorable to budget $1.3 million or 5.1% due to the timing of administrative expense activities
  - YTD: $266.0 million, favorable to budget $40.5 million or 13.2% due to the timing of administrative expense activities

FY 2025-26: Management Summary (cont.)

- Non-Operating Income (Loss)
  - MTD: ($0.6) million, unfavorable to budget $4.6 million or 115.4% due to:
    - $8.5 million unfavorable variance in Community Reinvestment
    - $1.1 million unfavorable variance in Net Investment Income
    - Offset by $5.2 million favorable variance in Other Income/Expense primarily driven by the write off of capital projects
  - YTD: $131.5 million, favorable to budget $37.3 million or 39.7% due to:
    - $40.1 million favorable variance in Net Investment Income
    - $21.2 million favorable variance in Community Reinvestment
    - Offset by $23.6 million unfavorable variance in Grant Expense

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FY 2025-26: Key Financial Ratios

- Medical Loss Ratio (MLR)

	Actual	Budget	Variance (%)
MTD	88.8%	94.1%	(5.3%)
YTD	91.3%	93.4%	(2.1%)

- Administrative Loss Ratio (ALR)

	Actual	Budget	Variance (%)
MTD	7.1%	6.8%	(0.4%)
YTD	5.2%	6.5%	1.4%

CalOptima Health

FY 2025-26: Key Financials Ratios (cont.)

- Balance Sheet Ratios
  - Current ratio*: 1.8
  - Board Designated Reserve level: 3.76
  - Statutory Designated Reserve level: 1.05
  - Net-position: $3.1 billion, including required TNE of $134.3 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations.

CalOptima Health

Enrollment Summary: June 2026

June 2026					July 2025 - June 2026			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
107,766	123,398	(15,632)	(12.7%)	FAM	1,429,726	1,517,237	(87,511)	(5.8%)
233,324	253,320	(19,996)	(7.9%)	CHD	2,953,713	3,080,796	(127,083)	(4.1%)
286,561	310,127	(23,566)	(7.6%)	MCE	3,741,556	3,875,084	(133,528)	(3.4%)
3,010	2,501	509	20.4%	LTC	36,232	30,107	6,125	20.3%
148,479	149,882	(1,403)	(0.9%)	SPD	1,812,963	1,782,248	30,715	1.7%
8,296	9,003	(707)	(7.9%)	WCM	105,261	108,732	(3,471)	(3.2%)
787,436	**848,231**	(60,795)	(7.2%)	**Medi-Cal Total**	**10,079,451**	**10,394,204**	(314,753)	(3.0%)
18,958	**18,193**	**765**	**4.2%**	**OneCare**	**221,283**	**215,313**	**5,970**	**2.8%**
577	**573**	**4**	**0.7%**	**PACE**	**6,559**	**6,612**	(53)	(0.8%)
571	**558**	**13**	**2.3%**	**MSSP***	**6,883**	**6,696**	**187**	**2.8%**
806,971	**866,997**	(60,026)	(6.9%)	**CalOptima Health Total**	**10,307,293**	**10,616,129**	(308,836)	(2.9%)

*MSSP enrollment is included in Medi-Cal total

Consolidated Revenue & Expenses: June 2026 MTD

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	787,436	18,958	577	571		806,971
REVENUES						
Capitation Revenue	$ 351,766,616	$ 26,863,824	$ 5,255,243	$ 239,682	$ -	$ 384,125,364
Total Operating Revenue	**351,766,616**	**26,863,824**	**5,255,243**	**239,682**	**-**	**384,125,364**
MEDICAL EXPENSES						
Provider Capitation	101,702,148	13,216,562				114,918,710
Facility and Professional Claims	137,464,738	9,262,051	2,548,568			149,275,358
MLTSS	49,279,481		62,392	20,147		49,362,020
Prescription Drugs		1,029,394	633,557			1,662,951
Case Mgmt & Other Medical	20,864,887	2,843,418	1,912,206	183,882		25,804,392
Total Medical Expenses	**309,311,254**	**26,351,426**	**5,156,722**	**204,029**	**-**	**341,023,431**
Medical Loss Ratio	*87.9%*	*98.1%*	*98.1%*	*85.1%*	*0.0%*	*88.8%*
GROSS MARGIN	**42,455,362**	**512,398**	**98,520**	**35,653**	**-**	**43,101,934**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	12,557,441	1,103,346	176,742	108,657	288,309	14,234,494
Non-Salary Operating Expenses	5,049,007	739,394	133,764	1,459	394,669	6,318,293
Depreciation & Amortization	1,032,477		1,540			1,034,018
Other Operating Expenses	4,973,843	89,962	14,244	10,083	1,423	5,089,555
Indirect Cost Allocation, Occupancy	(1,631,572)	2,265,414	27,514	16,867		678,223
Total Administrative Expenses	**21,981,197**	**4,198,115**	**353,804**	**137,066**	**684,401**	**27,354,583**
Administrative Loss Ratio	*6.2%*	*15.6%*	*6.7%*	*57.2%*	*0.0%*	*7.1%*
Operating Income/(Loss)	**20,474,165**	(3,685,717)	(255,284)	(101,413)	(684,401)	**15,747,351**
Investments and Other Non-Operating	(7,369,280)					(618,938)
CHANGE IN NET ASSETS	**$ 13,104,885**	$ (3,685,717)	$ (255,284)	$ (101,413)	$ (684,401)	**$ 15,128,413**
BUDGETED CHANGE IN NET ASSETS	(6,733,622)	(254,944)	433,666	(122,128)	(943,849)	573,768
Variance to Budget - Fav/(Unfav)	$ 19,838,507	$ (3,430,773)	$ (688,950)	$ 20,715	$ 259,448	$ 14,554,645

CalOptima Health

Consolidated Revenue & Expenses: June 2026 YTD

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	10,079,451	221,283	6,559	6,883		10,307,293
REVENUES						
Capitation Revenue	$ 4,661,513,666	$ 432,026,075	$ 60,844,646	$ 2,966,222	$ -	$ 5,157,350,610
Total Operating Revenue	**4,661,513,666**	**432,026,075**	**60,844,646**	**2,966,222**	**-**	**5,157,350,610**
MEDICAL EXPENSES						
Provider Capitation	1,324,514,218	173,741,898				1,498,256,116
Facility and Professional Claims	1,657,850,764	94,768,440	26,991,280			1,779,610,484
MLTSS	558,369,309		762,793	352,917		559,485,019
Prescription Drugs		109,549,236	7,020,672			116,569,908
Case Mgmt & Other Medical	706,742,265	25,357,227	18,298,327	2,250,936		752,648,755
Total Medical Expenses	**4,247,476,556**	**403,416,801**	**53,073,072**	**2,603,853**	**-**	**4,706,570,282**
Medical Loss Ratio	*91.1%*	*93.4%*	*87.2%*	*87.8%*	*0.0%*	*91.3%*
GROSS MARGIN	**414,037,110**	**28,609,274**	**7,771,574**	**362,369**	**-**	**450,780,328**
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	140,473,194	12,481,545	2,181,194	1,274,808	1,621,672	158,032,412
Non-Salary Operating Expenses	38,670,909	7,201,410	1,261,050	17,524	3,524,762	50,675,655
Depreciation & Amortization	11,580,228		12,079			11,592,307
Other Operating Expenses	38,741,971	1,371,668	133,743	97,015	1,854	40,346,252
Indirect Cost Allocation, Occupancy	(9,045,174)	14,124,440	207,794	96,976		5,384,036
Total Administrative Expenses	**220,421,129**	**35,179,062**	**3,795,860**	**1,486,323**	**5,148,288**	**266,030,662**
Administrative Loss Ratio	*4.7%*	*8.1%*	*6.2%*	*50.1%*	*0.0%*	*5.2%*
Operating Income/(Loss)	**193,615,982**	(6,569,788)	**3,975,714**	(1,123,954)	(5,148,288)	**184,749,666**
Investments and Other Non-Operating	16,236,427					131,507,345
CHANGE IN NET ASSETS	**$ 209,852,409**	$ (6,569,788)	**$ 3,975,714**	$ (1,123,954)	$ (5,148,288)	**$ 316,257,011**
BUDGETED CHANGE IN NET ASSETS	20,473,178	(12,022,940)	4,419,791	(1,443,411)	(10,764,679)	98,998,623
Variance to Budget - Fav/(Unfav)	$ 189,379,231	$ 5,453,152	$ (444,077)	$ 319,457	$ 5,616,391	$ 217,258,388

CalOptima Health

Balance Sheet: As of June 2026

ASSETS	
Current Assets	
Operating Cash	$365,036,442
Short-term Investments	1,860,077,841
Capitation Receivable	612,910,005
Receivables - Other	18,701,816
Prepaid Expenses	15,017,558
Total Current Assets	**2,871,743,663**
Capital Assets	
Capital Assets	213,902,410
Less: Accumulated Depreciation	(103,490,609)
Capital Assets, Net of Depreciation	**110,411,802**
Other Assets	
Net Pension Assets	4,069,081
Restricted Deposit	300,000
Board Designated Reserves	1,636,982,171
Statutory Designated Reserves	141,572,745
Total Other Assets	**1,782,923,998**
TOTAL ASSETS	**4,765,079,462**
Deferred Outflows	**30,923,013**
TOTAL ASSETS & DEFERRED OUTFLOWS	**$4,796,002,475**

LIABILITIES & NET POSITION	
Current Liabilities	
Accounts Payable	$225,655,524
Medical Claims Liability	362,479,476
Accrued Payroll Liabilities	33,159,177
Deferred Revenue	5,921,439
Due to State of California and CMS	805,087,542
Capitation and Withholds	125,273,074
Total Current Liabilities	**1,557,576,231**
Other Liabilities	
GASB 96 Subscription Liabilities	21,952,296
Community Reinvestment	66,941,338
Capital Lease Payable	196,705
Post Employment Health Benefits Liability	15,772,000
Net Pension Liabilities	0
Total Other Liabilities	**104,862,339**
TOTAL LIABILITIES	**1,662,438,570**
Deferred Inflows	**16,723,193**
Net Position	
Required TNE	134,332,567
Funds in Excess of TNE	2,982,508,146
TOTAL NET POSITION	**3,116,840,712**
TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION	**$4,796,002,475**

CalOptima Health

Board Designated Reserve and TNE Analysis: As of June 2026

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	817,907,910				
MetLife Tier One	819,074,261				
Board Designated Reserves	1,636,982,171	1,085,485,002	1,736,776,003	551,497,169	(99,793,832)
Current Reserve Level (X months of average monthly revenue) [1]	*3.76*	*2.50*	*4.00*		

Statutory Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier Two	70,856,586				
MetLife Tier Two	70,716,160				
Statutory Designated Reserves	141,572,745	134,332,567	147,765,823	7,240,179	(6,193,078)
Current Reserve Level (X min. TNE) [1]	*1.05*	*1.00*	*1.10*		

[1] *See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.*

CalOptima Health

Spending Plan: As of June 2026

Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
Total Net Position @ 6/30/2026	**$3,116.8**			**100.0%**
Resources Assigned				
Board Designated Reserve[1]	**$1,637.0**			**52.5%**
Statutory Designated Reserve[1]	**$141.6**			**4.5%**
Capital Assets, net of Depreciation	**$110.4**			**3.5%**
Resources Allocated				
Homeless Health Initiative (HHI)[2]	14.1	63.3	49.2	0.5%
Housing and Homelessness Incentive (HHIP)[2]	25.6	87.4	61.8	0.8%
Intergovernmental Transfers (IGT)	34.7	52.1	17.3	1.1%
Digital Transformation and Workplace Modernization[3]	20.6	100.0	79.4	0.7%
CalFresh and Redetermination Outreach Strategy	1.7	6.0	4.3	0.1%
Coalition of Orange County Community Health Centers Grant	10.7	50.0	39.3	0.3%
Mind OC Grant (Irvine)	-	15.0	15.0	0.0%
General Awareness Campaign	0.0	4.7	4.7	0.0%
Member Health Needs Assessment	0.3	1.3	1.0	0.0%
Five-Year Hospital Quality Program Beginning MY 2023	104.8	153.5	48.7	3.4%
Skilled Nursing Facility Access Program	10.0	10.0	-	0.3%
National Alliance for Mental Illness Orange County Peer Support Program Grant	2.0	5.0	3.0	0.1%
Stipend Program for Master of Social Work Students Grant	-	5.0	5.0	0.0%
Wellness & Prevention Program Grant	1.0	2.7	1.7	0.0%
CalOptima Health Provider Workforce Development Fund Grant	39.6	50.0	10.4	1.3%
Garden Grove Bldg. Improvement	16.0	17.5	1.5	0.5%

Spending Plan: As of June 2026 (cont.)

Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
PACE Facility - Irvine	29.1	29.5	0.4	0.9%
Dyadic Services Program Academy	0.2	1.9	1.7	0.0%
Medi-Cal Provider Rate Increases (07/2024 - 12/2026)	105.2	526.2	421.0	3.4%
Medi-Cal Provider Rate Increases (07/2026 - 12/2028)	429.6	429.6	-	13.8%
Homeless Prevention and Stabilization Pilot Program	0.2	0.3	0.1	0.0%
OneCare Member Engagement and Education	0.0	0.3	0.2	0.0%
Medi-Cal Eligibility Outreach Strategy	20.7	21.8	1.1	0.7%
Supplemental food support for Medi-Cal members	3.8	8.0	4.2	0.1%
Orange County Community Health Assessment and Improvement Plan	0.5	1.0	0.5	0.0%
Subtotal	**870.4**	**1,642.0**	**771.6**	**27.9%**
Resources Available for New Initiatives				
Unallocated/Unassigned1	**357.5**			**11.5%**

Total Designated Reserves and unallocated reserve amount can support approximately 183 days of CalOptima Health's current operations.
See HHI and HHIP summaries and Allocated Funds for list of Board Approved Initiatives. Amount reported includes only portion funded by reserves.
On June 6, 2024, the Board of Directors approved an update to the Digital Transformation Strategy which will impact these figures beginning July 2024.

Homeless Health Initiative and Allocated Funds: As of June 2026

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
HHI - IGT'S	61,496,005	61,496,005	49,245,005	12,251,000	-
HHI - Existing Reserves	1,800,000	1,800,000	-	1,800,000	-
HHIP	40,100,000	40,100,000	-	40,100,000	-
Total	**103,396,005**	**103,396,005**	**49,245,005**	**54,151,000**	**-**

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funding Source(s)
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000	11,400,000	-	IGT's
Recuperative Care	6,194,190	6,194,190	-	IGT's
Medical Respite	250,000	250,000	-	IGT's
Day Habilitation (County for HomeKey)[4]	-	-	-	IGT's
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-	IGT's
CalOptima Homeless Response Team	1,681,734	1,681,734	-	IGT's
Homeless Coordination at Hospitals	10,000,000	10,000,000	-	IGT's
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support[5]	925,540	925,540	-	IGT's
FQHC (Community Health Center) Expansion	21,902	21,902	-	IGT's
HCAP and CalOptima Health Days	9,888,914	5,034,955	4,853,959	IGT's
Vaccination Intervention and Member Incentive Strategy[2]	54,649	54,649	-	IGT's
Street Medicine[3]	14,279,077	9,806,021	4,473,056	IGT's & Existing Reserves
Outreach and Engagement	7,000,000	2,276,015	4,723,985	IGT's
Housing and Homelessness Incentive Program (HHIP)[1]	40,100,000	-	40,100,000	IGT's & Existing Reserves
Subtotal of Approved Initiatives	**103,396,005**	**49,245,005**	**54,151,000**	
Transfer of funds to HHIP[4]	(40,100,000)	-	(40,100,000)	
Program Total	**63,296,005**	**49,245,005**	**14,051,000**	

[1]On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of $40.1 million from HHI to HHIP.

[2]On June 5, 2025, CalOptima Health's Board of Directors approved the close out of the Vaccination Intervention and Member Incentive Strategy program and transfer of the remaining funds of $68,699 to unallocated reserves for new initiatives.

[3]On August 7, 2025, CalOptima Health's Board of Directors approved $9.3 million to expand the Street Medicine Program ($3.2 million remaining from Street Medicine Initiative (from the Homeless Health Initiatives Reserve), $1.8 million from Existing Reserves, and $4.3 million from Intergovernmental Transfer balance resulting from a June 5, 2025, Board action), to fund 2-year grant agreements to Healthcare in Action (Anaheim), Celebrating Life Community Health Center (Costa Mesa), and AltaMed (Santa Ana).

[4]On February 5, 2026, CalOptima Health's Board of Directors approved the closeout of the Day Habilitation (County for HomeKey) and designated the remaining balance of $2.5 million as available for allocation to deliver enhanced services for Medi-Cal members.

[5]On April 2, 2026, CalOptima Health's Board of Directors approved the closeout of the CalOptima Days, HCAP and FQHC Administrative Support and make $37,721 in IGT 8 funds available toward future IGT initiatives to deliver covered services for Medi-Cal members.

CalOptima Health

Housing and Homelessness Incentive Program: As of June 2026

Summary by Funding Source:	Total Funds[1]	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	65,931,189	65,931,189	34,733,595	31,197,594	-
Existing Reserves & HHI Transfer	87,384,530	87,384,530	61,797,392	25,587,138	-
Street Medicine Support Center - GG Building[2]	7,000,000	7,000,000	-	7,000,000	-
Total	**160,315,719**	**160,315,719**	**96,530,987**	**63,784,733**	-

Funds Allocation, approved initiatives:	Allocated Amount	Utilized Amount	Remaining	Funding Source(s)
Office of Care Coordination	2,200,000	2,200,000	-	HHI
Pulse For Good	1,400,000	913,500	486,500	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,821,311	800,001	HHI & DHCS
Infrastructure Projects	5,832,314	5,832,310	4	HHI
Capital Projects	126,247,564	73,140,270	53,107,294	HHI, DHCS & Existing Reserves
System Change Projects	19,314,530	9,968,205	9,346,325	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	**160,315,719**	**$96,530,987**	**$63,784,733**	
Transfer of funds to Street Medicine Support Center-GG Building	**(7,000,000)**	**-**	**($7,000,000)**	Existing Reserves
Program Total	**153,315,719**	**96,530,987**	**56,784,733**	

[1]Total funding $160.3 million: $40.1 million Board-approved reallocation from HHI, $47.2 million from CalOptima Health existing reserves and $73.0 million from DHCS HHIP incentive payments.

[2]On October 7, 2025, CalOptima Health's Board of Directors approved up to $7.0 million for general contractor services & furniture, fixtures & equipment for the Street Medicine Support Center.

CalOptima Health

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Board of Directors Meeting
August 6, 2026

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima Health's Board of Directors including, but not limited to, updates on internal and health network monitoring and audits conducted by CalOptima Health's Delegation Oversight and Internal Audit departments, regulatory audits, privacy updates, fraud, waste, and abuse updates, and any notices of non-compliance or enforcement action issued by regulators.

A. UPDATES ON REGULATORY AUDITS

1. Medicare

a. Calendar Year (CY) 2019 Part C Risk Adjustment Data Validation (RADV) Audit (CON19 RADV) *(applicable to OneCare)*

Update

- No New Updates since the last report.

Previously Reported

- Medical records have been reviewed, validated and submitted to CMS. Awaiting review from CMS and next steps.
- June 12, 2025 – The Centers for Medicare & Medicaid Services (CMS) notified CalOptima Health that its OneCare contract (H5433) had been selected for a Payment Year (PY) 2019 Contract-Level Risk Adjustment Data Validation (CON19 RADV) audit.
- CMS will be conducting a medical record review to validate the accuracy of a subset of PY 2019 risk adjustment data and payments associated with encounters with dates of service from January 1, 2018, through December 31, 2018.
- Medical record submission window extended to November 10, 2025. Previous due date September 15, 2025.

Background

- The PY 2019 RADV audit will focus on risk-adjusted payments made to Medicare Advantage Organizations (MAOs) for the 2019 coverage year that CMS believes may be at higher risk for overpayments.

b. CY 2024 CMS Financial Audit *(applicable to PACE (Program of All-inclusive Care for the Elderly))*

Back to Agenda

Update

- Final audit report received.
- The previously noted observation remained in the final audit report. There are no findings. Nothing further is required from CMS.

Previously Reported

- Exit Conference conducted on 4/2/26.
- 4/3/26 - General representation Letter, Agree/Disagree Letter, and updated Ongoing Concerns submitted. No findings. CalOptima agrees with the one observation.

Background

- At least one-third of MAOs are selected for the annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CMS will audit and inspect any books and records of the MAO that pertain to 1) the ability of the organization to bear the risk of potential financial losses, or 2) services performed or determinations of amounts payable under the contract. The Pharmacy Benefit Management (PBM) company will also be required to provide CMS with all requested supporting documentation for this audit.

c. 2026 Medicare Part C and Part D Data Validation Audit (MDVA) *(applicable to OneCare)*

Update

- 6/12/26 – Final results received. All audited measures passed with a score of 100%.
- Closing conference to be conducted in July.

Previously Reported

- Audit kick-off call conducted on March 4, 2026.
- Virtual onsite sessions held: Part D on April 2, 2026; Part C on April 7, 2026.
- Source documentation requests and data file findings have been received for all measures.

Background

- CMS requires MAOs to contract with an independent consulting firm annually to conduct an independent review to validate the accuracy and completeness of data reported to CMS by CalOptima Health per the Medicare Part C and Part D Reporting Requirements.

d. Calendar Year (CY) 2014 Part C Risk Adjustment Data Validation (RADV) Audit (CON14 RADV) *(applicable to OneCare)*

Update

- No new updates since the last report.

Previously Reported

- 3/4/26 – The RADV Audit Report, Payment Error Calculation Methodology, and summary of findings were received. CMS identified an overpayment of $74,532.47.

Back to Agenda

- 5/1/26 – Appeal justification submitted to CMS

Background

- The Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) program is CMS' primary way to address overpayments to Medicare Advantage Organizations (MAOs). During a RADV audit, CMS confirms that any diagnoses submitted by an MAO for risk adjustment are supported in the enrollees' medical records. If diagnoses are unsupported by the medical records, CMS may collect overpayments. MA RADV audits occur after the final risk adjustment data submission deadline for the MA contract year.

e. Calendar Year (CY) 2015 Part C Risk Adjustment Data Validation (RADV) Audit (CON15 RADV) *(applicable to OneCare*

Update

- No new updates since the last report.

Previously Reported

- 3/4/26 – The RADV Audit Report, Payment Error Calculation Methodology, and summary of findings were received. CMS identified an overpayment of $105,873.93.
- CalOptima Health Financial Analysis department determined that an appeal will not be filed with CMS.

Background

- The Medicare Advantage (MA) Risk Adjustment Data Validation (RADV) program is CMS' primary way to address overpayments to Medicare Advantage Organizations (MAOs). During a RADV audit, CMS confirms that any diagnoses submitted by an MAO for risk adjustment are supported in the enrollees' medical records. If diagnoses are unsupported by the medical records, CMS may collect overpayments. MA RADV audits occur after the final risk adjustment data submission deadline for the MA contract year.

f. Calendar Year (CY) 2020 Part C Risk Adjustment Data Validation (RADV) Audit (CON20 RADV) *(applicable to OneCare)*

Update

- 4/3/26 – Enrollee Data list received; 35 enrollees selected.
- Medical records are being reviewed, validated and submitted to CMS, and this process will continue until the submission window closes.

Previously Reported

- 3/20/26 – Contract selected received.
- Below are the key dates for the audit:
  - Enrollee Data List Available: 4/3/26
  - Medical record submission window Opens: 4/13/26
  - Medical record submission deadline: 8/28/26
  - Hardship exception request deadline: 9/11/26

Back to Agenda

Background

- CMS will be conducting a medical record review to validate the accuracy of a subset of PY 2020 risk adjustment data and payments associated with encounters with dates of service from January 1, 2019, through December 31, 2019.

g. Calendar Year (CY) 2021 Park C Risk Adjustment Data Validation (RADV) Audit (CON21 RADV) (applicable to OneCare)

Update

- 5/29/26 – Contract selected received.
- 6/12/26 – Enrollee Data list received; 35 enrollee selected.
  - Medical record submission window opens: 6/22/26
  - Medical record submission deadline: 11/6/26
  - Hardship exception request deadline: 11/20/26
- Medical records are being reviewed, validated and submitted to CMS, and this process will continue until the submission window closes. .

Background

- CMS will be conducting a medical records review to validate the accuracy of a subset of PY 2021 risk adjustment data and payments associated with encounters with dates of services from January 1, 2020 through December 31, 2020.

h. *2026 Department of Health Care Services (DHCS) PACE Audit*

Update

- 5/14/26 – Exit conference held.
- Six preliminary findings and two areas of concern were noted. Internal corrective action plans were issued to address the preliminary findings while awaiting DHCS' audit report.

Previously Reported

- 2/19/26 – Audit engagement letter received.
- DHCS onsite conducted 4/20/26-4/21/26. Additional documents were requested during the onsite review.
- 4/23/26 – All requested documents were submitted.
- Exit conference scheduled for 6/14/26.

Background

- DHCS will conduct a routine review of CalOptima Health's PACE program. The following areas are included in the scope of the review: grievance documentation procedures; participant records for clinical appropriateness and care planning; transportation; personnel records; subspecialty subcontractor agreements; serious incident reports; onsite facility review; emergency preparedness; and meal preparation and kitchen procedures.
- DHCS conducts this audit every three years on the PACE program.

Back to Agenda

2. Medi-Cal

a. 2026 Department of Health Care Services (DHCS) Annual Routine Medical Audit

- On 6/19/26, DHCS hosted a virtual Exit Conference to review the DRAFT audit findings reports in response to the audit conducted in February 2026.
- The draft audit reports cover DHCS's review of both the Primary (aka "Main Contract") and Secondary contracts (aka "State Supported Services"). The draft findings are as follows:
  - **Primary/Main Contract**
    - Draft report identified **4 Findings** across 2 audit categories.

Category #	Audit Area	# of Findings
1	Utilization Management	0
2	Case Management and Coordination of Care	2
3	Network and Access to Care	0
4	Member's Rights	0
5	Quality Management	0
6	Administrative and Organizational Capacity	2

  - **Secondary Contract - State Supported Services (SSS)**
    - Draft Report Identified **No Findings**

- **Exit Conference & Rebuttal Period:** CalOptima Health will have 15 calendar days from the 6/19/26 Exit Conference to provide feedback on the content of the draft report, if necessary. Feedback is due to DHCS on 7/6/26.
- **Final Report & CAP Request:** DHCS will review CalOptima Health's feedback and finalize the draft report. The formal request for the Corrective Action Plan (CAP) will accompany the Final Report.
- **CAP Response:** Medi-Cal Regulatory Affairs & Compliance (RAC) anticipates that CalOptima Health will have thirty (30) calendar days from the date of receipt to respond to the formal CAP request.
  - RAC Medi-Cal has met with the impacted business areas and confirmed remedial efforts are complete or underway. RAC Medi-Cal anticipates a timely CAP submission.

B. REGULATORY NOTICES OF NON-COMPLIANCE

- CalOptima Health did not receive any notices of non-compliance from its regulators in May or June 2026.

Back to Agenda

C. UPDATES ON HEALTH NETWORK MONITORING AND AUDITS

- 2026 Delegation Oversight Annual Audit (DOAA):
  - Heritage Provider Network – Regal Medical Group – Lookback period April 1, 2025, to March 31, 2026 (Annual Audit webinar week June 15, 2026 – June 18, 2026).

D. INTERNAL AUDIT DEPARTMENT (IAD)

a. 2026 Approved Internal Annual Audit Work Plan Changes

- None to report

b. Internal Annual Audits in Process

- 2025 Utilization Management (Medi-Cal)
- 2025 Utilization Management (OneCare)
- 2025 Grievance and Appeals (Medi-Cal)
- 2026 Grievance and Appeals (Medi-Cal)
- 2026 Case Management (Medi-Cal) - New

c. Internal Annual Audits Completed

- 2025 Grievance and Appeals (OneCare) on 6/19/26
- 2026 Customer Service (OneCare) on 6/23/26
- 2025 Claims Administration (OneCare) on 6/23/26
- 2025 Claims Administration (Medi-Cal) on 6/24/26

d. Internal Ad Hoc Audits in Process

- 2025 CalAIM Community Supports Housing Transition Navigation Services
- 2026 Claims Payment Integrity and Systems Controls Audit

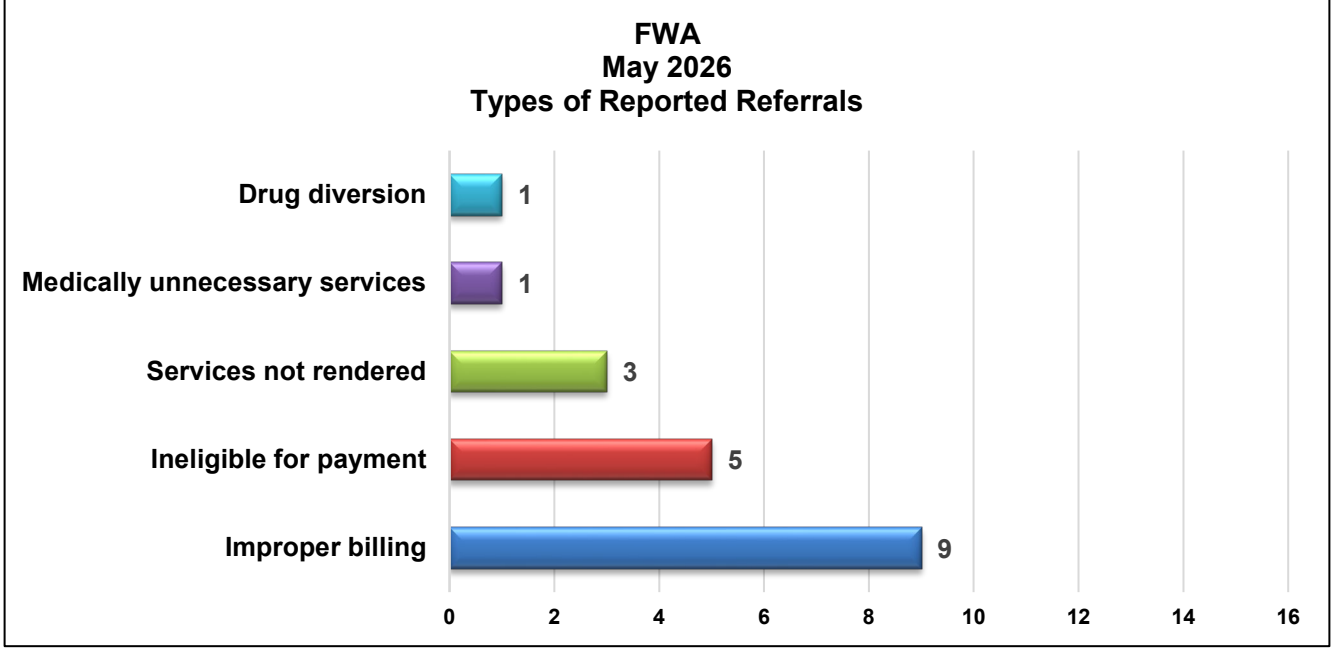
e. Grants Review

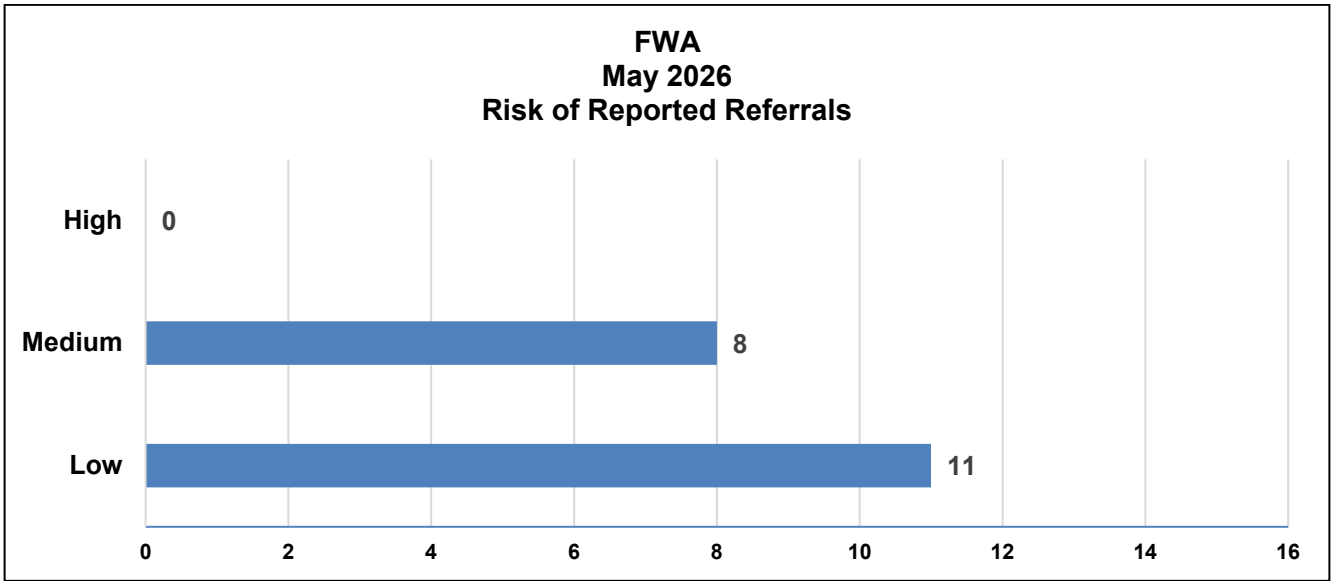
Grants currently under review include:

- Coalition of Orange County Community Health Centers, Population Health Value-Based Care (PHVBC) Grant
- 2022 CalAIM Enhanced Care Management (ECM) Incentive Payment Program (IPP) Grant Program (3 grants)
- 2023 Flagship Incentive Payment Program (IPP) Grant Program (1 grant)
- 2023 Enhanced Care Management (ECM) Academy Grant Program (4 grants)Housing and Homelessness Incentive Program (HHIP) Capital Grants (2 grants)

Back to Agenda

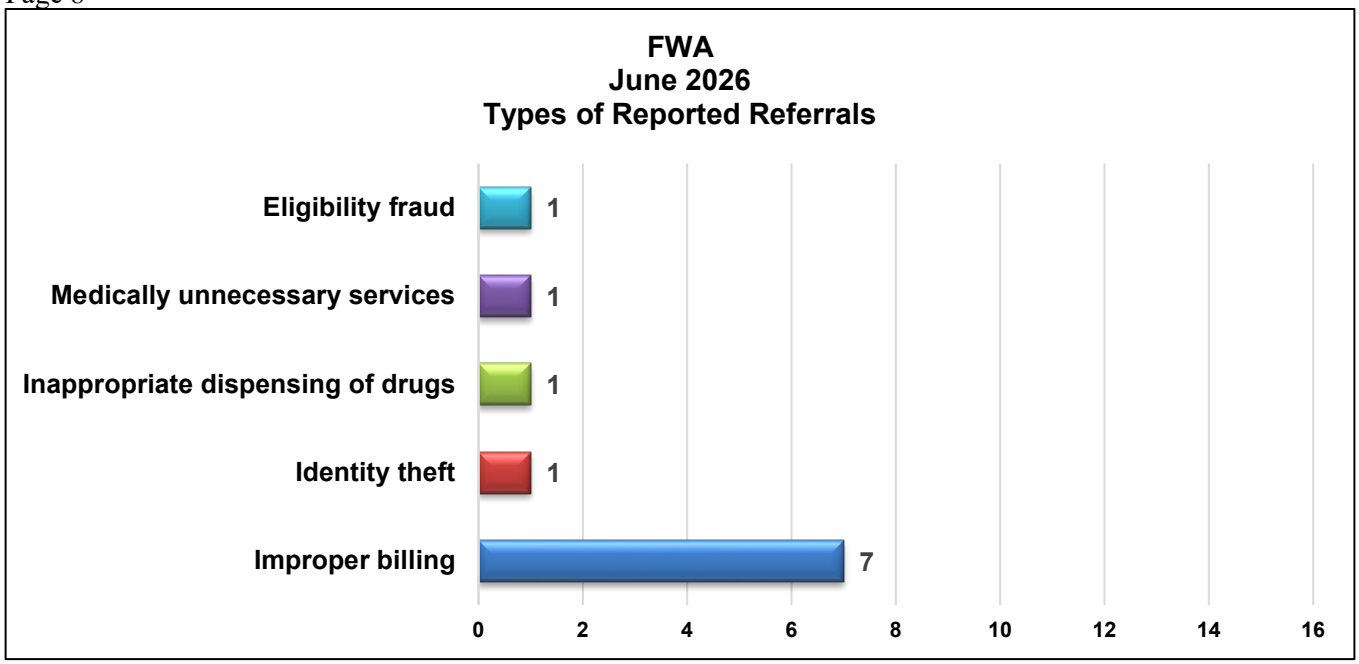
E. FRAUD, WASTE & ABUSE (FWA) INVESTIGATIONS

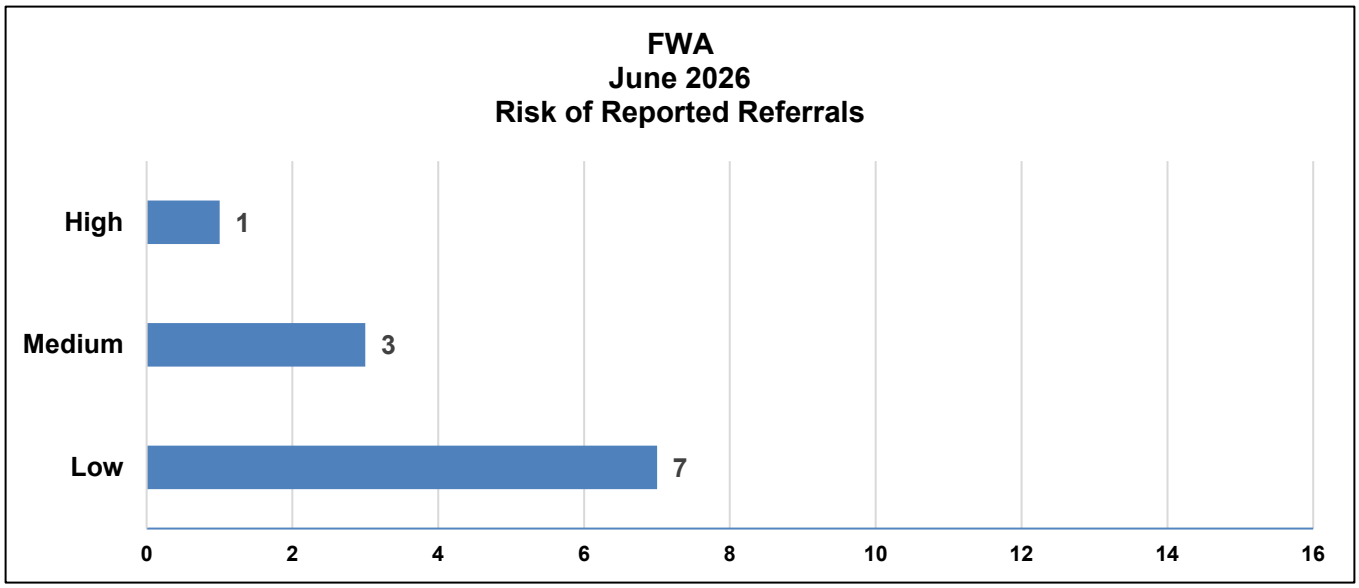




Number of New Cases Referred to DHCS and DOJ (State)	19
Number of New Cases Referred to CMS (Federal)	13
Total Number of Referrals Reported	**19**

Back to Agenda

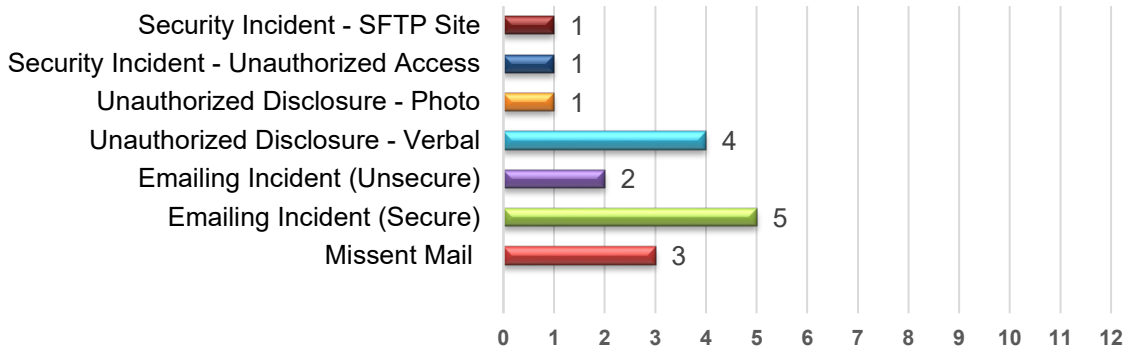


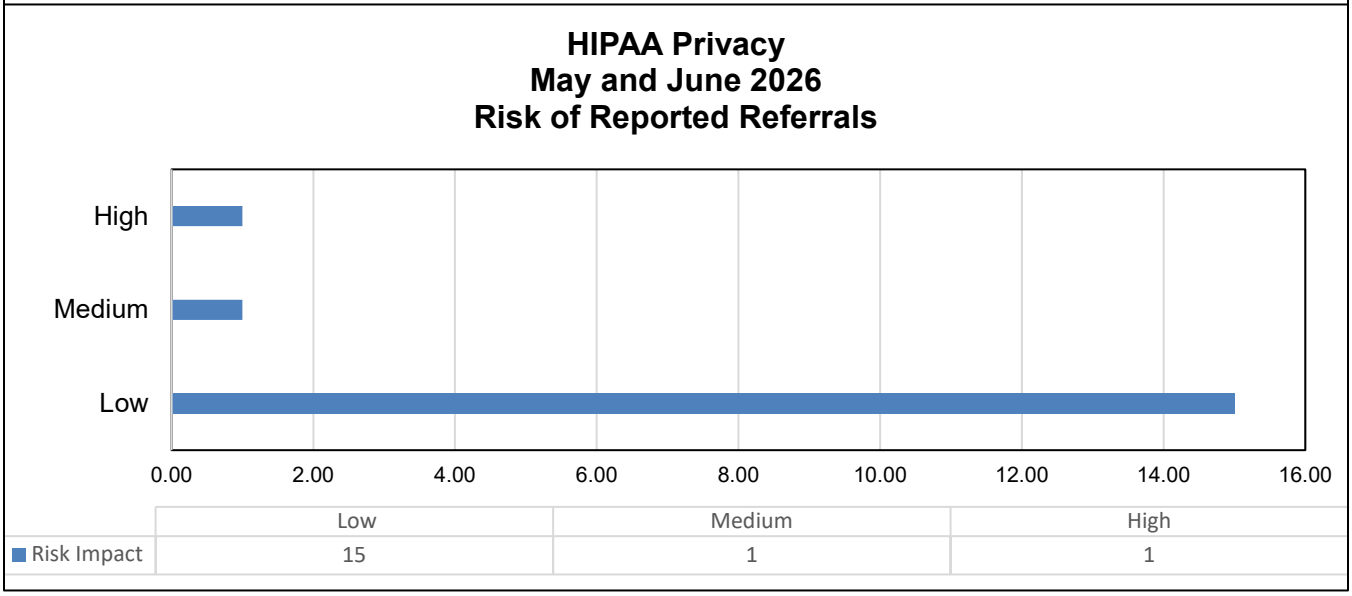


Total Number of New Cases Referred to DHCS (State)	11
Total Number of New Cases Referred to DHCS and CMS	5
Total Number of Referrals Reported	**11**

Back to Agenda

F. PRIVACY UPDATE





Total Number of Referrals Reported to DHCS (State)	17
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

Back to Agenda

VAN SCOYOC ASSOCIATES

Date: **July 24, 2026**

To: **Board of Directors**
CalOptima Health

From: **Shawn Friesen, Vice President**
Van Scoyoc Associates

Re: **CalOptima Health, Board of Directors – August Advocacy Report**

Outreach to Orange County Delegation and Beyond Continues on Capitol Hill

Van Scoyoc Associates (VSA) continued outreach to members of the Orange County delegation in Congress, the broader California congressional delegation, and outside California on behalf of CalOptima Health. VSA remained in regular communication with congressional offices regarding CalOptima Health's advocacy priorities, organizational initiatives, community events, and concerns related to federal Medicaid policy. VSA also informed delegation offices about the launch of CalOptima Health Covered as an option for Orange County residents who rely on the Covered California health insurance marketplace for their health insurance coverage. Delegation offices contacted included Senators Alex Padilla (D-CA) and Adam Schiff (D-CA), Representatives Linda Sanchez (D-CA-38), Young Kim (R-CA-40), Derek Tran (D-CA-45), Lou Correa (D-CA-46), Dave Min (D-CA-47), and Mike Levin (D-CA-49). VSA also continued engagement beyond Orange County and met and communicated with multiple offices regarding CalOptima Health priorities and initiatives, including the offices of Senator Deb Fischer (R-NE) and Representatives Vince Fong (R-CA-20), David Valadao (R-CA-22), Jay Obernolte (R-CA-23), Pete Aguilar (D-CA-33), Ken Calvert (R-CA-41), and Robert Garcia (D-CA-42).

CalOptima Health Meets with Representatives Sanchez and Min, Takes Message to Capitol Hill

On June 23 and 24, Veronica Carpenter, CalOptima Health's Chief Administrative Officer, and Jordan Abushawish, CalOptima Health's Senior Director of Federal and Local Government Affairs, traveled to Washington, D.C. to meet with key congressional offices on Capitol Hill regarding CalOptima Health's priorities and initiatives. VSA coordinated the schedule, which included visits with Representatives Linda Sanchez (D-CA-38) and Dave Min (D-CA-47) and meetings with the following delegation offices: Senators Alex Padilla (D-CA) and Adam Schiff (D-CA), Representatives Young Kim (R-CA-40), Derek Tran (D-CA-45), Lou Correa (D-CA-46), and Mike Levin (D-CA-49). Additional meetings included staff for the Senate Finance Committee Chairman Mike Crapo (R-ID) and Ranking Member Ron Wyden (D-OR); policy staff for the House Energy and Commerce Committee Chairman Brett Guthrie (R-KY-2); and the offices of Representatives David Valadao (R-CA-22), Jay Obernolte (R-CA-23), Pete Aguilar (D-CA-33), Ken Calvert (R-CA-41), and Robert Garcia (D-CA-42). The meetings provided an opportunity to discuss concerns regarding the implementation of the Medicaid work requirement, CalOptima Health's investments to prepare for upcoming changes to the Medicaid program, CalOptima Health's commitment to program integrity and combatting fraud, and the upcoming launch of CalOptima Health's Covered California product.

CMS Expands Medicaid Program Integrity Actions and Defers Additional California Funding

The U.S. Department of Health & Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS), and HHS Office of Inspector General (OIG) continued the Administration's attention to fraud and abuse and highlighted the Administration's heightened scrutiny of state Medicaid programs. On July 21, HHS announced the deferral of approximately $867.5 million in additional Medicaid payments to California pending documentation supporting claims involving certain in-home care programs and other high-risk areas. Combined with the approximately $1.3 billion deferred in May, CMS has deferred roughly $2.17 billion in California Medicaid funding this year. CMS has emphasized that the

actions are payment deferrals rather than permanent funding cuts and that funds will be released if the state substantiates the claims. Separately, HHS OIG issued a report in July recommending that CMS work with states to strengthen Medicaid managed care contracts and improve the timeliness and quality of MCO provider-fraud referrals. The Administration's broader emphasis on Medicaid program integrity is expected to continue and will remain important for California and its Medicaid managed care organizations (MCOs).

CMS Issues Medicaid Work Requirement Rule, States and Congress Push Back

On June 1, CMS issued the interim final rule (IFR) implementing the Medicaid community engagement requirement, which was enacted under H.R. 1 last year. More commonly referred to as the work requirement, the law requires, no later than January 1, 2027, that certain adults ages 19 through 64 must complete 80 hours per month of work, education, job training, or community service to qualify for or maintain Medicaid coverage. The IFR establishes standards for exemptions, verification, outreach, and state reporting, but stakeholders have raised concerns that the rule's definition of "medically frail" requires individuals not only to have a qualifying condition but also to demonstrate that the condition significantly impairs their ability to meet the requirement. Managed care plans may assist states with outreach, data sharing, and referrals, but may not determine compliance or issue formal notices. Twenty-five states and the District of Columbia filed suit challenging portions of the rule. Furthermore, the entire House Democratic Caucus sent a letter to CMS urging the agency to revise the medical frailty policy and to delay implementation. At the time of this writing, Senate Finance Committee Ranking Member Ron Wyden (D-OR) was circulating a similar letter to CMS among the Senate Democratic Caucus.

MACPAC Report Highlights Work Requirements, Managed Care Oversight, Prior Authorization, and PACE

On June 15, the Medicaid and CHIP Payment and Access Commission (MACPAC) released its June 2026 Report to Congress. The report recommends that CMS establish a transparent plan to monitor and evaluate implementation of Medicaid community engagement requirements, including coverage losses, state administrative burden, and information technology performance. MACPAC also recommends stronger federal and state oversight of automated prior authorization tools, including expert review of adverse determinations and disclosure of managed care plans' use of automation. Additional recommendations call for more accessible managed care performance data and tools for state oversight. Of particular relevance to CalOptima Health, MACPAC also recommended improved coordination between CMS and states on audits of the Program of All-Inclusive Care for the Elderly (PACE), public release of existing PACE performance information, and development of a standardized national quality measure set for PACE organizations.

CMS Proposes Major Changes to Medicaid Provider Tax Rules

On July 21, CMS issued a proposed rule implementing new statutory limits on health care-related taxes, including provider and managed care organization taxes. Among its provisions, the proposal would establish new indirect hold-harmless thresholds tied generally to tax structures in place on July 4, 2025, phase in lower thresholds for most provider classes in Medicaid expansion states beginning October 1, 2027, and impose new reporting requirements. CMS also proposes to formally recognize services of health insurers as a permissible tax class, bringing state taxes on health plans under the new framework. CMS estimates the proposal would reduce federal Medicaid spending by $246 billion over 10 years. The rule could have significant implications for California's financing structure and its MCO tax. Comments are due September 21.

California Republicans Question State MCO Tax Changes

In June, Representative Jay Obernolte (R-CA-23) led a letter signed by California's Republican House members and Representative Kevin Kiley (I-CA-3) to Governor Gavin Newsom and State Medicaid Director Tyler Sadwith regarding changes to California's managed care organization tax included in the Fiscal Year 2026-2027 state budget. The lawmakers expressed concern that the revised tax would increase costs for privately insured Californians, would direct revenue toward general budget stabilization rather than health care, and would conflict with the intent of Proposition 35. The letter

asks the state to provide estimates of the impact on commercial premiums, explain how MCO tax revenue will be allocated, identify the share dedicated to Medi-Cal provider reimbursement and services, and describe whether alternative approaches were considered.

Federal Court Blocks Portions of 2027 ACA Exchange Rule

On July 16, a federal district court granted a preliminary injunction blocking implementation of eight provisions of the 2027 Affordable Care Act (ACA) Exchange rule. The blocked policies include mandatory income verification for certain low-income enrollees, elimination of income self-attestation when federal tax data are unavailable, expanded verification for special enrollment periods, broader catastrophic-plan eligibility, increased out-of-pocket limits for bronze plans, relaxed network adequacy standards, and elimination of standardized plan requirements and limits on non-standardized plan options. Other provisions of the May 15 final rule remain in effect, including lower federal Exchange user fees, stronger agent and broker oversight, and additional state flexibility. The Administration is expected to appeal, and the litigation creates uncertainty for states and issuers preparing for the 2027 plan year.

Congress and HHS Increase Focus on Medicare Advantage Oversight and Transparency

Federal policymakers continued to focus on Medicare Advantage prior authorization and transparency. In June, the HHS OIG reported that Medicare Advantage (MA) organizations denied a substantial share of requests for long-term acute care hospital and inpatient rehabilitation facility services and frequently overturned denials on appeal, raising concerns that some beneficiaries were initially denied medically necessary care. The House Energy & Commerce Health Subcommittee subsequently advanced several bipartisan bills, including the Improving Seniors' Timely Access to Care Act of 2025 (H.R. 3514) and the Prior Authorization Accountability Act (H.R. 9396). On July 21, the full Energy and Commerce Committee incorporated several transparency and prior authorization provisions into the broader Lower Costs, More Transparency Act of 2026 (H.R. 9393), which was advanced unanimously by the full Committee in a vote of 45-0. While there is bipartisan support for price transparency legislation and MA prior authorization reforms, the timing for House and Senate action remains uncertain.

CALOPTIMA HEALTH - STATE LEGISLATIVE REPORT
July 28, 2026

General Update

Prior to adjourning for summer recess on July 2 — the deadline for second-house policy committees to hear and report bills — the Legislature concluded one of the busiest stretches of the 2026 Session, having passed the 2026-27 State Budget by its June 15 constitutional deadline and advanced more than 700 bills to fiscal committees.

Legislators return on August 3 for the final month of the legislative session, when attention will focus on second-house fiscal committee action and floor votes, with August 31 marking the deadline for each house to pass bills. As the second year of the two-year legislative session, August marks the Legislature's final opportunity to advance bills to the Governor before adjournment. Healthcare is expected to remain a dominant focus as lawmakers consider the remaining policy measures affecting Medi-Cal, provider financing, county organized health systems (COHS), and implementation of the enacted state budget.

For CalOptima Health, attention has largely shifted from the budget to implementation and several remaining policy measures affecting COHS. Of particular interest are continued discussions regarding governance, Medi-Cal financing, and preserving the flexibility of local managed care plans as California prepares for significant operational and fiscal changes over the next several years.

Budget Update

Healthcare remained one of the dominant issues throughout budget negotiations. Although the Administration successfully achieved significant General Fund savings, the Legislature modified several of the Governor's original healthcare proposals following extensive negotiations.

Federal actions continue to influence nearly every major healthcare discussion in Sacramento. Legislative leaders remain concerned about the potential impact of future federal Medicaid changes on the Medi-Cal program, resulting in continued scrutiny of financing mechanisms, provider reimbursement, eligibility policies, and the long-term sustainability of Medi-Cal.

The U.S. Centers for Medicare & Medicaid Services (CMS) deferred approximately $1.3 billion in Medicaid reimbursements to California in May — the largest such deferral in CMS history — followed by a further $867.5 million deferral in July, both pending review of claims the federal government identified as high-risk. Both actions were concentrated primarily in California's In-Home Supportive Services (IHSS) program. While California officials were not surprised by the Trump Administration's increased scrutiny of the state's Medi-Cal program, the magnitude of the federal actions nonetheless rattled Sacramento and reinforced concerns regarding future federal funding and oversight. California has disputed the allegations underlying both deferrals. These issues are expected to remain a significant focus throughout the remainder of the legislative session and into next year's budget cycle as additional federal guidance becomes available.

The 2026-27 Budget Act reflects a compromise between the Governor's May Revision and legislative priorities, preserving many core Medi-Cal programs while achieving significant General Fund savings. Although several of the Administration's original proposals were modified during negotiations, the enacted budget continues to emphasize long-term sustainability of the Medi-Cal program amid ongoing fiscal pressures and uncertainty surrounding future federal Medicaid funding.

The following chart highlights the key healthcare issues included in the final budget.

Key Issue	Budget Bills Adopted
Transition UIS Population from Medi-Cal Managed Care to FFS	SB 164 moves eligible Unsatisfactory Immigration Status (UIS) individuals into the Medi-Cal fee-for-service (FFS) delivery system, effective Jan. 1, 2027. SB 111 funds the transition: $31M for care coordination, $8M for culturally/linguistically appropriate navigation via clinics and community-based organizations, and $5.2M to expedite provider enrollment and reduce backlogs.
UIS Monthly Premiums	SB 164 requires the Governor's 2027–28 May Revision (no sooner than May 14, 2027) to set UIS premiums (ages 19–59) between $30–$50/month. Exempt: under 19, over 59, pregnant, or postpartum.
Asset Limit (Seniors/Disabled)	SB 164 sets a lower asset limit, effective July 1, 2027: $21,000 (household of 1), $31,000 (household of 2), +$1,550 per additional member (up to 10).
MCO Tax Proposal	SB 125 restructures the tax in two parts, effective Jan. 1, 2027 (pending CMS approval): a Prop 35–aligned tax lowering the Medi-Cal plan rate, and a separate, non-Prop 35 tax raising the commercial rate to match. Rate: $8.85 per enrollee per month into a new Medi-Cal Stability Fund — ~$2.3B annually for 2027–2029, substantially less than the prior tax generated.
Cap PACE Rates	Not included in SB 164; Governor's proposal rejected.
CalAIM Extension	SB 164 extends CalAIM from Dec. 31, 2026, to Dec. 31, 2031 (pending federal approval). DHCS to seek approval for Employment Supports and BridgeCare (HCBS/caregiver supports for near-dual Medicare enrollees).
Qualified Immigrant Coverage	Beginning October 1, 2026, H.R. 1 eliminates federal Medicaid matching funds for certain categories of qualified immigrants, including many humanitarian entrants such as refugees and asylees, limiting federal reimbursement primarily to emergency and pregnancy-related services. SB 164 prevents a loss of coverage by continuing full-scope Medi-Cal for these individuals using state-only funding. The budget does not establish a sunset for this backfill, making it an ongoing General Fund commitment unless federal law changes or the Legislature revisits the policy.

Key Legislation Updates

PACE Rate-Setting Transparency – AB 1672 (Solache-D) – CalPACE sponsored legislation to require greater transparency in DHCS' rate-setting process. Securing the Governor's approval may prove challenging given the bill's proposed expansion of administrative transparency and reporting requirements. This bill was placed on the Senate Appropriations Committee suspense file on June 15.

"Water's Edge" Tax Election Removal – AB 1790 (Connolly-D) – Under current law, a "water's edge" election generally permits multi-national companies to exclude much of their foreign income from California taxation. AB 1790 would ultimately repeal the water's edge election and increase the tax base. This anticipated $3 billion per year in added revenue to help fund healthcare and other state priorities. This bill is sponsored by SEIU. The bill failed to advance by the fiscal deadline and was not in any budget discussions or bills. It would require a two-thirds vote to move and is unlikely to be acted on this year.

Medi-Cal: Special Commissions – AB 2194 (Valencia-D) – Originally sponsored by the County of Orange, this bill makes targeted changes to the governance of CalOptima Health. As initially introduced, it would have staggered the terms of Board members to prevent the entire Board from turning over at one time and allowed the alternate County Supervisor representative access to confidential Board materials. The bill passed the Assembly with broad support. However, the author removed it from the Senate Health Committee agenda twice after CalOptima Health adopted a "Support if Amended" position seeking removal of the provision granting the alternate member access to confidential information.

On June 15, Assemblymember Valencia substantially amended his own bill, expressing frustration that the Orange County Board of Supervisors had not clarified whether it continued to support the legislation unanimously — a condition he said had been important to his decision to author the bill. The amendments represented a significant departure from the original measure, proposing to remove the two County Supervisors from the CalOptima Health Board and eliminate the Board of Supervisors' authority to appoint Board members. Following extensive lobbying of key decision-makers and discussions with the author, the bill was amended again and now more closely reflects its original intent. The current version staggers Board member terms and requires CalOptima Health to commission an independent audit of its governance structure. During committee hearings, the author stated he intends to continue pursuing future governance reforms aimed at reducing the concentration of supervisorial authority over the CalOptima Health Board.

Initiative & Proposition Update

2026 Billionaire Tax Act (Proposition 40) – Proponents led by SEIU-UHW have qualified this statewide ballot measure that would impose a one-time 5% wealth tax on individuals with a net worth exceeding $1 billion, with a significant portion of the revenue dedicated to Medi-Cal and other healthcare programs. The measure is expected to become one of the most expensive and closely watched campaigns on the November ballot. While supporters argue it would provide a dedicated funding source for California's healthcare safety net, opponents contend it could reduce investment, encourage taxpayers to leave the state, and produce volatile revenues that cannot be relied upon for ongoing program funding.

Opposition has intensified substantially. The technology-backed committee Building a Better California has raised more than $120 million to oppose the measure and has successfully advanced companion constitutional initiatives designed to invalidate or significantly limit the tax if approved by voters. The campaign is expected to become one of the most expensive ballot measure contests in California history. The measure continues to face strong opposition from Governor Gavin Newsom and leading gubernatorial candidate Xavier Becerra.

Community Clinic Accountability and Transparency Act (Proposition 44) – Voters will consider a measure requiring federally qualified health centers (FQHCs) to spend at least 90% of revenue on direct patient care and mission-related services, while imposing new financial reporting and transparency requirements. Supporters such as SEIU argue the initiative will improve accountability and ensure public funds are directed toward patient care. Opponents, including the California Primary Care Association (CPCA), California Medical Association, and numerous community clinics, contend the measure would undermine the financial stability of safety-net providers, reduce access to care, and conflict with federal FQHC requirements.

On April 30, CPCA and Open Door Community Health Centers filed a federal lawsuit seeking to block the initiative, arguing that it conflicts with federal FQHC funding and operational requirements. Some Capitol observers and stakeholders have also characterized the initiative as occurring within the broader context of ongoing labor and unionization disputes involving community clinics.

Health Care Union "Right to Vote" (withdrawn from ballot) – In June, the California Hospital Association (CHA) qualified this statewide ballot initiative that would have required healthcare labor organizations to obtain approval from their members before spending union dues on ballot measure campaigns above specified thresholds, while also imposing additional political spending disclosure requirements.

However, on June 25 — the deadline for finalizing the November ballot — CHA and the California Federation of Labor Unions, AFL-CIO (formerly known as the California Labor Federation) reached a settlement resolving several ongoing healthcare ballot disputes. As part of that agreement, both the union member right-to-vote initiative and SEIU-UHW's competing healthcare executive compensation initiative were withdrawn from the ballot, leaving only the Billionaire Tax (Proposition 40) and the Community Clinic Accountability and Transparency Act (Proposition 44) as the major healthcare-related statewide initiatives for voters to consider.

2025–26 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
SB 483 Stern	**Mental Health Diversion:** Would require that a court be satisfied that a recommended mental health treatment program is consistent with the underlying purpose of mental health diversion and meets the specialized treatment needs of the defendant. ***Potential CalOptima Health Impact*:** Increased oversight of behavioral health treatment for members.	**07/16/2025** Passed Assembly Public Safety Committee; referred to Assembly Appropriations Committee **06/04/2025** Passed Senate floor	CalOptima Health: Watch
SB 490 Umberg	**Alcohol and Drug Programs:** Would implement specific timelines for the California Department of Health Care Services (DHCS) to investigate unlicensed treatment facilities (i.e., sober living homes) that were unlawfully advertising or providing services. ***Potential CalOptima Health Impact*:** Increased oversight of treatment facilities that serve CalOptima Health members.	**06/30/2026** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **01/26/2026** Passed Senate floor	CalOptima Health: Watch
SB 626 Smallwood-Cuevas	**Maternal Mental Health Screenings and Treatment:** Would require a licensed health care practitioner who provides perinatal care for a patient to screen, diagnose and treat the patient for a maternal mental health condition. ***Potential CalOptima Health Impact:*** Increased access to behavioral health services for eligible members.	**08/28/2025** Passed Assembly floor; referred to Senate for concurrence in amendments **06/02/2025** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 812 Allen	**Qualified Youth Drop-In Center Health Care Coverage:** Would require a health plan to provide coverage for mental health and substance use disorders (SUDs) at a qualified youth drop-in center, defined as a center providing behavioral or primary health and wellness services to youth 12 to 25 years of age with the capacity to provide services before and after school hours and that has been designated by or embedded with a local educational agency or institution of higher education. ***Potential CalOptima Health Impact*:** Increased access to behavioral health services for CalOptima Health Medi-Cal youth members.	**07/16/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/28/2025** Passed Senate floor	CalOptima Health: Watch CAHP: Concerns
SB 874 Weber-Pierson	**Behavioral Health Treatment (BHT) Workgroup:** Would require any provider of BHT services under Medi-Cal to complete background checks. Additionally, would require DHCS to convene a stakeholder workgroup to review the implementation of BHT services in Medi-Cal and release clinical guidance and treatment plan requirements. ***Potential CalOptima Health Impact:*** Enhanced oversight and quality of BHT services provided to members under 21 years of age with autism spectrum disorder and/or related conditions.	**06/30/2026** Passed Assembly Public Safety Committee; referred to Assembly Appropriations Committee **05/19/2026** Passed Senate floor	CalOptima Health: Watch
AB 37 Elhawary	**Behavioral Health Workforce:** Would require the California Workforce Development Board to study how to expand the workforce of mental health service providers providing services to homeless persons. ***Potential CalOptima Health Impact*:** Increased access to behavioral health services for members experiencing homelessness.	**01/16/2026** Died in Assembly Business and Professions Committee **03/13/2025** Referred to Assembly Labor and Employment Committee	CalOptima Health: Watch
AB 348 Krell	**Full-Service Partnership:** Establishes presumptive eligibility for Full-Service Partnership programs contingent upon meeting criteria and receiving recommendation for enrollment by a licensed behavioral health clinician. ***Potential CalOptima Health Impact*:** Increased continuity of care for members with serious mental illness.	**10/13/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 384 Connolly	**Inpatient Prior Admission Authorization:** Would prohibit a health plan from requiring prior authorization for admission to medically necessary 24-hour care in inpatient settings, including general acute care hospitals and psychiatric hospitals, for mental health and SUDs as well as for any medically necessary services provided to a beneficiary while admitted for that care. ***Potential CalOptima Health Impact*:** Modified utilization management (UM) procedures for covered Medi-Cal benefits.	**01/23/2026** Died in Assembly Appropriations Committee **04/22/2025** Passed Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
AB 423 Davies	**Disclosures for Alcoholism, Drug Abuse Recovery or Treatment Programs and Facilities:** Would mandate a business-operated recovery residence to register its location with DHCS. ***Potential CalOptima Health Impact*:** Increased oversight for members who have received SUD treatment.	**01/16/2026** Died in Assembly Health Committee **02/18/2025** Referred to Assembly Health Committee	CalOptima Health: Watch
AB 618 Krell	**Behavioral Health Data Sharing:** Would require each Medi-Cal managed care plan (MCP), county specialty mental health plan (MHP) and Drug Medi-Cal program to electronically share data for its members to support coordination of behavioral health services. Would also require DHCS to determine minimum data elements and the frequency and format of data sharing through a stakeholder process and guidance, with final guidance to be published by January 1, 2027. ***Potential CalOptima Health Impact*:** Increased coordination between Medi-Cal delivery systems regarding behavioral health services.	**07/07/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/03/2025** Passed Assembly floor	**05/07/2025** CalOptima Health: SUPPORT LHPC: Sponsor
AB 877 Dixon	**Nonmedical SUD Treatment:** Would require DHCS and the California Department of Managed Health Care (DMHC) to send a letter to the chief financial officer of every health plan (including a Medi-Cal MCP) that provides SUD coverage in residential facilities. The letter must inform the plan that SUD treatment in licensed or unlicensed facilities is almost exclusively nonmedical, with rare exceptions, including for billing purposes. These provisions would be repealed on January 1, 2027. ***Potential CalOptima Health Impact*:** Enhanced transparency and clarity around nonmedical treatment provided for SUDs.	**01/16/2026** Died in Assembly Health Committee **03/03/2025** Referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 951 Ta	**Autism Diagnosis:** Prohibits a health plan from requiring an enrollee previously diagnosed with pervasive developmental disorder or autism to receive a diagnosis to maintain coverage for behavioral health treatment for their condition. ***Potential CalOptima Health Impact*:** Increased access to care for specific behavioral health treatments.	**07/30/2025** Signed into law	CalOptima Health: Watch
AB 1970 Harabedian	**Mental Health and SUD Utilization Management:** Would prohibit a health plan from imposing step therapy as a prerequisite to authorizing coverage of any prescription drug used for the treatment of a mental illness or SUD. ***Potential CalOptima Health Impact:*** Expanded covered benefits for members.	**06/24/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/18/2026** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Budget			
H.R. 1 Arrington (TX)	**One Big Beautiful Bill Act:** Makes substantial changes to Medicaid program funding and policies, including but not limited to the following: • Work, community service and/or education requirement of 80 hours per month for able-bodied adults without dependents (with exceptions for pregnant women, foster youth, medically frail, caregivers and others), effective December 31, 2026, or no later than December 31, 2028 • Increased frequency of eligibility redeterminations for Medicaid Expansion (MCE) enrollees from annually to every six months, effective December 31, 2026 • Emergency Medicaid services provided to all undocumented beneficiaries subject to the traditional Federal Medical Assistance Percentage (FMAP) — 50% in California — regardless of the FMAP for which those would otherwise be eligible, effective October 1, 2026 • Cost-sharing for MCE enrollees with incomes of 100–138% Federal Poverty Level (FPL), not to exceed $35 per service and 5% of total income, and not to be applied to primary, prenatal, pediatric, or emergency care, effective October 1, 2028 • Prohibition on any new or increased provider taxes, effective immediately • Significant restrictions on current Managed Care Organization (MCO) taxes, which could effectively repeal California's MCO tax that was recently made permanent by Proposition 35 (2024), with a potential winddown period of up to three fiscal years (FYs) ***Potential CalOptima Health Impact*:** Reduced funding to CalOptima Health and contracted providers; decreased number of members; increased administrative costs; implementation of co-pay systems; increased financial and administrative burdens for some existing members; decreased health care utilization by some existing members; reduced benefits for some existing members. A separate overview is also enclosed.	**07/04/2025** Signed into law	**05/20/2025** CalOptima Health: OPPOSE

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 7148 Cole (OK)	**Consolidated Appropriations Act, 2026:** Would provide FY 2026 appropriations for several federal departments and agencies, including the U.S. Department of Health and Human Services (HHS), as well as extend several expiring health care programs and increase health care oversight. Specifically, the bill would strengthen compliance among pharmacy benefit managers (PBMs), extend Medicare telehealth flexibilities through December 31, 2027, extend the hospital-at-home waiver for five years, and delay Medicaid disproportionate share hospital (DSH) cuts until FY 2028. ***Potential CalOptima Health Impact:*** Continued access to Medicare telehealth flexibilities for dual-eligible CalOptima Health members and delayed cuts to certain contracted hospitals.	**02/03/2026** Signed into law **01/30/2026** Passed Senate floor **01/22/2026** Passed House floor	CalOptima Health: Watch
SB 101 Wiener **AB 102** Gabriel	**Budget Act of 2025:** Makes appropriations for the government of the State of California for FY 2025–26. Total spending is $321 billion, of which $228.4 billion is from the General Fund. ***Potential CalOptima Health Impact:*** An overview of the FY 2025–26 Enacted State Budget is enclosed.	**06/30/2025** Signed into law	CalOptima Health: Watch
SB 106 Laird	**Budget Act of 2025 Junior:** Amends the Budget Act of 2025 by appropriating $90 million to Planned Parenthood in response to H.R. 1 cuts. ***Potential CalOptima Health Impact:*** Continued funding for certain family planning services.	**02/11/2026** Signed into law	CalOptima Health: Watch
SB 111 Laird **AB 109** Gabriel	**Budget Act of 2026:** Makes appropriations for the government of the State of California for FY 2026–27. Total spending is $351.7 billion, of which $251.1 billion is from the General Fund. ***Potential CalOptima Health Impact:*** An overview of the FY 2026–27 Enacted State Budget is enclosed.	**06/29/2026** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 125 Committee on Budget and Fiscal Review	**Medi-Cal MCO Provider Tax Trailer Bill (2026):** Authorizes DHCS to submit a new MCO tax model, effective January 1, 2027, through December 31, 2029, to the U.S. Centers for Medicare & Medicaid Services (CMS). If approved by CMS, a tax amount of $8.85 per member per month would be levied on Medi-Cal and commercial health plan lives (with the Medi-Cal portion to be ultimately reimbursed). ***Potential CalOptima Health Impact:*** An overview of the FY 2026–27 Enacted State Budget is enclosed.	**06/29/2026** Signed into law	CalOptima Health: Watch
SB 164 Committee on Budget and Fiscal Review	**Health Omnibus Trailer Bill (2026):** Consolidates and enacts certain budget trailer bill language containing policy changes needed to implement health-related expenditures in the FY 2026–27 state budget. ***Potential CalOptima Health Impact:*** An overview of the FY 2026–27 Enacted State Budget is enclosed.	**06/29/2026** Signed into law	CalOptima Health: Watch
AB 100 Gabriel	**Budget Acts of 2023 and 2024:** Increases Medi-Cal's current FY 2024–25 General Fund appropriation by $2.8 billion and federal funds appropriation by $8.25 billion in order to solve a deficiency in the Medi-Cal budget. ***Potential CalOptima Health Impact:*** Continued funding for current Medi-Cal rates and initiatives through June 30, 2025.	**04/14/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 116 Committee on Budget	**Health Omnibus Trailer Bill I (2025):** Consolidates and enacts certain budget trailer bill language containing policy changes needed to implement health-related expenditures in the FY 2025–26 state budget. Provisions related to the Medi-Cal program include but are not limited to the following: • Enrollment freeze for undocumented individuals 19 years or older, effective no sooner than January 1, 2026, with exceptions for pregnant individuals • Implementation of $30 monthly premiums for undocumented individuals ages 19-59, effective no sooner than July 1, 2027 • Reinstatement of the asset limit at $130,000 for individuals, adding $65,000 for each additional household member, capping at 10 members, effective January 1, 2026 • Enacts Program of All-Inclusive Care for the Elderly (PACE) provider sanctions, effective immediately ***Potential CalOptima Health Impact:*** An overview of the FY 2025–26 Enacted State Budget is enclosed.	**06/30/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 144 Committee on Budget	**Health Omnibus Trailer Bill II (2025):** Consolidates and enacts certain budget trailer bill language containing policy changes needed to implement health-related expenditures in the FY 2025–26 state budget. Specifically, this bill: • Establishes the list of immunizations by the Advisory Committee on Immunization Practices (ACIP) • Exempts foster youth and former foster youth with Unsatisfactory Immigration Status (UIS) from various service limitations in the Medi-Cal program (including enrollment freeze and monthly premiums) • Requires DHCS to convene a workgroup to discuss the implementation of the Children and Youth Behavioral Health Initiative (CYBHI) school fee schedule • Establishes the Abortion Access Fund to provide family planning services through grants and contracts • Requires Covered California to provide payments to qualified health plans to defray the costs of state-mandated gender-affirming care benefits ***Potential CalOptima Health Impact:*** An overview of the FY 2025–26 Enacted State Budget is enclosed.	**09/17/2025** Signed into law	CalOptima Health: Watch
California Advancing and Innovating Medi-Cal (CalAIM)			
SB 324 Menjivar	**Enhanced Care Management (ECM) and Community Supports Contracting:** Would require a Medi-Cal MCP to give preference to contracting with community providers that demonstrate capability of providing access and meeting quality requirements when covering the ECM benefit and/or Community Supports. In addition, would require DHCS to develop standardized templates to be used by MCPs. Would also require DHCS to develop guidance to allow community providers to subcontract with other community providers. ***Potential CalOptima Health Impact*:** Increased collaboration with community providers and standardized contracts.	**07/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/27/2025** Passed Senate floor	CalOptima Health: Watch CAHP: Watch LHPC: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 543 Gonzalez	**Street Medicine:** Authorizes a Medi-Cal MCP to elect to offer Medi-Cal covered services through a street medicine provider. MCPs that elect to do so would be required to allow a Medi-Cal beneficiary who is experiencing homelessness to receive those services directly from a contracted street medicine provider, regardless of the beneficiary's network assignment. Additionally, requires the MCP to allow a contracted street medicine provider enrolled in Medi-Cal to directly refer the beneficiary for covered services within the appropriate network and share that information with the relevant county for inclusion in CalSAWS. ***Potential CalOptima Health Impact*:** Continued access to street medicine services for members experiencing homelessness.	**10/06/2025** Signed into law	CalOptima Health: Watch CAHP: Watch
AB 2138 Krell	**ECM Peer Support Specialists:** Would require ECM providers to include at least one peer support specialist in their interdisciplinary teams; specialists would have lived experience with recovery from mental illness and/or substance use. Additionally, would outline conditions where peer support specialists cannot be disqualified based on criminal background, fingerprint-based background check or similar screening that is a condition of employment, contracting, certification, credentialing, enrollment or participation in providing peer support services. ***Potential CalOptima Health Impact*:** Expanded access to peer support specialists for certain high-need members.	**04/23/2026** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
AB 2348 Bonta	**Community Supports Extension:** Would extend Community Supports within the Medi-Cal managed care program — by proposing that the supports are deemed cost-effective and medically appropriate services — beyond the existing CalAIM initiative, beginning January 1, 2027. Additionally, would implement quarterly public reporting on Community Supports utilization with ongoing technical assistance. ***Potential CalOptima Health Impact*:** Safeguards access to Community Supports for Medi-Cal members.	**06/24/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/24/2026** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Covered Benefits			
SB 40 Wiener	**Insulin Coverage:** Prohibits a health plan, effective January 1, 2026 (or a policy offered in the individual or small group market, effective January 1, 2027), from imposing a copayment or other cost sharing of more than $35 for a 30-day supply of an insulin prescription drug or imposing a deductible, coinsurance, or any other cost sharing on an insulin prescription drug. Additionally, requires a health plan to cover all types of insulin without step therapy on and after January 1, 2026. ***Potential CalOptima Health Impact:*** Decreased out-of-pocket costs for future members enrolled in Covered California line of business; new UM procedures.	**10/13/2025** Signed into law	CalOptima Health: Watch CAHP: Oppose
SB 62 Menjivar **AB 224** Bonta	**Essential Health Benefits (EHBs):** Expresses the intent of the Legislature to review California's EHB benchmark plan and establish a new benchmark plan for the 2027 plan year. Additionally, upon approval from HHSs and by January 1, 2027, requires the new benchmark plan include certain additional benefits, including coverage for fertility services, hearing aids and exams, and durable medical equipment. ***Potential CalOptima Health Impact:*** New covered benefits for future members enrolled in Covered California line of business.	**10/13/2025** SB 62 signed into law **10/13/2025** AB 224 signed into law	CalOptima Health: Watch CAHP: Concerns
SB 535 Richardson **AB 575** Arambula	**Obesity Care Access Act:** Would require an individual or group health care plan that provides coverage for outpatient prescription drug benefits to cover at least one specified anti-obesity medication and bariatric surgery for the treatment of obesity. ***Potential CalOptima Health Impact:*** Expanded covered benefits for future members enrolled in Covered California line of business.	**07/15/2025** SB 535 passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/28/2025** SB 535 passed Senate floor **02/24/2025** AB 575 referred to Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 912 Cervantes	**Comprehensive Perinatal Services:** Would require DHCS to oversee a statewide community-based perinatal services program and enroll providers to deliver such services, but would maintain the role of the California Department of Public Health (CDPH) in regards to contracts, grants and agreements. ***Potential CalOptima Health Impact:*** Enhanced access to and delivery of perinatal services for pregnant and postpartum members.	**04/22/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch
SB 944 Wiener	**Acupuncture Coverage:** Would remove the limitation requiring federal matching funds for acupuncture to be a covered benefit, preserving it as a covered benefit under Medi-Cal. ***Potential CalOptima Health Impact:*** Maintained covered benefits for members.	**06/09/2026** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/19/2026** Passed Senate floor	CalOptima Health: Watch
AB 242 Boerner	**Genetic Disease Screening:** Would expand statewide newborn screenings to include Duchenne muscular dystrophy by January 1, 2027. ***Potential CalOptima Health Impact:*** Expanded covered benefits for members.	**01/23/2026** Died in Assembly Appropriations Committee **04/01/2025** Passed Assembly Health Committee	CalOptima Health: Watch
AB 298 Bonta	**Cost-Sharing Under Age 21:** Effective January 1, 2026, would prohibit a health plan from imposing a deductible, coinsurance, copayment, or other cost-sharing requirement for in-network health care services provided to an individual under 21 years of age, with certain exceptions for high deductible health plans that are combined with a health savings account. ***Potential CalOptima Health Impact:*** Increased costs for CalOptima Health; decreased costs for future members enrolled in Covered California line of business under 21 years of age.	**01/23/2026** Died in Assembly Appropriations Committee **01/13/2026** Passed Assembly Health Committee **02/10/2025** Referred to Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
AB 350 Bonta	**Fluoride Treatments:** Would require a health plan to provide coverage for fluoride varnish in the primary care setting for children under 21 years of age by January 1, 2026. ***Potential CalOptima Health Impact:*** New covered benefit for pediatric members.	**08/29/2025** Passed Senate Appropriations Committee; referred to Senate floor **07/02/2025** Passed Senate Health Committee **06/02/2025** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 432 Bauer-Kahan	**Menopause:** Would have required a health plan that covers outpatient prescription drugs to provide coverage for evaluation and treatment options for symptoms of perimenopause and menopause. Would also have required a health plan to annually provide clinical care recommendations for hormone therapy to all contracted primary care providers who treat individuals with perimenopause and menopause. ***Potential CalOptima Health Impact:*** New covered benefits for members; increased communications to providers.	**10/13/2025** Vetoed	CalOptima Health: Watch CAHP: Oppose
AB 636 Ortega	**Diapers:** Would add diapers as a covered Medi-Cal benefit for the following individuals, contingent upon appropriation by the Legislature: • Children greater than three years of age diagnosed with a condition that contributes to incontinence • Other individuals under 21 years of age to address a condition pursuant to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standards ***Potential CalOptima Health Impact:*** New covered benefit for pediatric members.	**01/23/2026** Died in Assembly Appropriations Committee **04/01/2025** Passed Assembly Health Committee	CalOptima Health: Watch
AB 1949 Lee	**Acupuncture Treatment Flexibility:** Would state the intent of the Legislature to enact legislation that allows more flexibility in Medi-Cal coverage for acupuncture treatments. ***Potential CalOptima Health Impact:*** Expanded covered benefit for members.	**06/10/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/26/2026** Passed Assembly floor	CalOptima Health: Watch
AB 2160 Celeste Rodriguez	**Lactation Services:** Would require DHCS to update Medi-Cal's coverage guidance on lactation services by July 1, 2027, to clarify coverage policies for various lactation services, including health education, support and consultation. ***Potential CalOptima Health Impact:*** Expanded access to lactation services for members.	**06/24/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/26/2026** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 2208 Stefani	**Federally Mandated Copayments:** In accordance with the minimum requirements of H.R.1, would set copayments at $0.01 for nonemergency services delivered to Medicaid Expansion adults with incomes between 100% and 138% of the federal poverty level, no later than October 1, 2028. Would exempt emergency and family planning services from copayments and prohibit service denial due to unpaid copayments. In addition, would allow self-attestation for Medi-Cal eligibility, including related to work or community engagement activities. ***Potential CalOptima Health Impact:*** Minimized financial burden on Medi-Cal members; decreased member burden to enroll in or maintain Medi-Cal coverage; minimized loss of members due to H.R. 1.	**07/01/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/26/2026** Passed Assembly floor	CalOptima Health: Watch
AB 2240 Stefani	**Private Duty Nursing for Specialty Care:** Would require DHCS to measure and assess whether private duty nursing services provided as part of the EPSDT benefit are in compliance with federal Medicaid requirements. The assessment would include a comparison of the hours of authorized EPSDT private duty nursing services to the hours actually provided to eligible children, as well as a determination of whether reimbursement rates are sufficient to ensure that all authorized hours are able to be provided. ***Potential CalOptima Health Impact:*** Expanded access to care for youth Medi-Cal members; increased reimbursement rates to private duty nurses.	**04/22/2026** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Eligibility and Enrollment			
SB 1202 Weber Pierson	**Eligibility Dashboard and Outreach:** Would mandate the development of a data dashboard to track Medi-Cal application and enrollment data, reflecting changes in federal Medicaid law. Would also require DHCS and Medi-Cal MCPs to conduct outreach and education to Medi-Cal beneficiaries about community engagement requirements and changes to eligibility while aligning cultural and linguistic standards. In addition, would remove the requirement for Medi-Cal MCPs to contact a beneficiary for permission to share contact information with the county for eligibility determination purposes. ***Potential CalOptima Health Impact:*** Improved visibility of member eligibility and enrollment data; increased outreach to and engagement with members; modified data sharing process with the Orange County Social Services Agency; increased retention of existing Medi-Cal members.	**06/09/2026** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/19/2026** Passed Senate floor	CalOptima Health: Watch
SB 1422 Durazo	**Medi-Cal Eligibility:** Would repeal the Medi-Cal enrollment freeze for UIS individuals who are 19 years of age or older, which was included in the FY 2025–26 Enacted State Budget and became effective on January 1, 2026. Additionally, would require the California Department of Finance to determine and report to the Legislature and the Governor the cost of re-implementing full-scope Medi-Cal benefits for UIS individuals and whether including those costs in the General Fund would create a deficit; following such determination, implementation would be staggered by age, beginning with those over 49 years of age. Certain limitations would be maintained, such as the elimination of dental benefits and the implementation of $30 monthly premium payments. ***Potential CalOptima Health Impact:*** Expanded Medi-Cal eligibility for UIS individuals; increased number of members.	**05/14/2026** Passed Senate Appropriations Committee; referred to Senate floor **04/09/2026** Passed Senate Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 315 Bonta	**Home and Community-Based Alternatives (HCBA) Waiver:** Would remove the cap on the number of HCBA Waiver slots and instead require DHCS to enroll all eligible individuals who apply for HCBA Waiver services. By March 1, 2026, would require DHCS to seek any necessary waiver amendments to ensure there is sufficient capacity to enroll all individuals currently on a waiting list. Would also require DHCS by March 1, 2026, to submit a rate study to the Legislature addressing the sustainability, quality and transparency of rates for the HCBA Waiver. ***Potential CalOptima Health Impact*:** Expanded member access to HCBA Waiver services.	**01/23/2026** Died in Assembly Appropriations Committee **03/25/2025** Passed Assembly Health Committee	CalOptima Health: Watch
AB 974 Patterson	**Managed Care Enrollment Exemption:** Would exempt any dual-eligible and non-dual-eligible beneficiaries who receive services from a regional center and who use the Medi-Cal fee-for-service (FFS) delivery system as a secondary form of health care coverage from mandatory enrollment in a Medi-Cal MCP. ***Potential CalOptima Health Impact:*** Decreased number of members.	**01/23/2026** Died in Assembly Appropriation Committee **04/22/2025** Passed Assembly Health Committee	CalOptima Health: Watch
AB 1012 Essayli	**Unsatisfactory Immigration Status:** Would make an individual who does not have satisfactory immigrant status ineligible for Medi-Cal benefits. In addition, would transfer funds previously appropriated for such eligibility to a newly created Serving our Seniors Fund to restore and maintain payments for Medicare Part B premiums for eligible individuals. ***Potential CalOptima Health Impact:*** Decreased number of members.	**01/31/2026** Died at Assembly desk **02/21/2025** Introduced	CalOptima Health: Watch
AB 1161 Harabedian	**State of Emergency Continuous Eligibility:** Would require DHCS and the California Department of Social Services to provide continuous eligibility for its applicable programs (including Medi-Cal and CalFresh) to all beneficiaries within a geographic region who have been affected by a state of emergency or a health emergency. ***Potential CalOptima Health Impact*:** Extended Medi-Cal eligibility for certain members.	**01/23/2026** Died in Assembly Appropriations Committee **04/29/2025** Passed Assembly Health Committee **04/08/2025** Passed Assembly Human Services Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1907 Addis	**Aligned Covered California Enrollment:** Would authorize Covered California to enroll an individual in the plan in which other members of the individual's household are enrolled, or the lowest cost plan available. ***Potential CalOptima Health Impact:*** Increased enrollment in future Covered California line of business; streamlined enrollment process for certain members.	**06/17/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/21/2026** Passed Assembly floor	CalOptima Health: Watch
AB 2161 Bonta	**Community Engagement Implementation:** Would integrate federal community engagement requirements into the Medi-Cal program. Would prevent California from extending H.R. 1's work requirements to state-funded Medi-Cal populations. Would also minimize administrative load by automating verification using available data sources and require that any federal work requirement implementation be applied in the least burdensome way possible. ***Potential CalOptima Health Impact*:** Modifications to eligibility for certain members; minimized impact of new community engagement requirements.	**07/01/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/26/2026** Passed Assembly floor	CalOptima Health: Watch
AB 2201 Boerner	**Eligibility Redetermination Changes:** Subject to an appropriation, would seek to align state provisions for Medi-Cal eligibility redeterminations with federal requirements, such as changing the current 12-month renewal cycle to a six-month cycle for adults covered under Medicaid Expansion. Additionally, would encourage counties to verify beneficiary income and assets through existing data sources to streamline the redetermination process. ***Potential CalOptima Health Impact*:** Modifications to eligibility redetermination for certain members.	**07/01/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/26/2026** Passed Assembly floor	CalOptima Health: Watch
AB 2363 Bains	**Coverage Penalty Exemption:** Would prohibit the imposition of a penalty for not maintaining minimum essential health coverage on individuals enrolled in Medi-Cal in 2024 or 2025. ***Potential CalOptima Health Impact:*** Reduced financial penalties for certain current and future members.	**02/202026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Operations and Administration			
SB 278 Cabaldon	**Health Data HIV Test Results:** Authorizes disclosures of HIV test results that identify or include identifying characteristics of a Medi-Cal beneficiary without written authorization of the member or their representative to the MCP for quality improvement efforts such as value-based payment and incentive programs. ***Potential CalOptima Health Impact:*** Increased quality oversight of HIV program development.	**10/13/2025** Signed into law	CalOptima Health: Watch
SB 497 Wiener	**Legally Protected Health Care Activity:** Prohibits a health care provider, health plan, or contractor from releasing medical information related to a person seeking or obtaining gender-affirming health care or mental health care in response to a criminal or civil action. Also prohibits these entities from cooperating with or providing medical information to an individual, agency, or department from another state or to a federal law enforcement agency or in response to a foreign subpoena. ***Potential CalOptima Health Impact:*** Increased protection of medical information related to gender-affirming care; increased staff training regarding disclosure processes.	**10/13/2025** Signed into law	CalOptima Health: Watch
SB 530 Richardson	**Medi-Cal Time and Distance Standards:** Extends current Medi-Cal time and distance standards until January 1, 2029. In addition, requires a Medi-Cal MCP to ensure that each subcontractor network complies with certain appointment time standards and incorporate into reporting to DHCS, unless already required to do so. Additionally, the use of telehealth providers to meet time or distance standards does not absolve the MCP of responsibility to provide a beneficiary with access, including transportation, to in-person services if the beneficiary prefers. ***Potential CalOptima Health Impact:*** Increased oversight of contracted providers; increased reporting to DHCS.	**10/06/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 660 Menjivar	**California Health and Human Services Data Exchange Framework (DxF):** Requires the Center for Data Insights and Innovation within California Health and Human Services Agency (CalHHS) to absorb all functions related to the DxF initiative, including the data sharing agreement and policies and procedures, by January 1, 2026. Additionally, expands DxF to include social services information. ***Potential CalOptima Health Impact:*** Increased care coordination with social service providers.	**10/03/2025** Signed into law	CalOptima Health: Watch
SB 987 Weber Pierson	**California Health Access Fund (CHAF):** Would require DHCS to administer the CHAF to ensure California residents who lose health care coverage due to the impacts of H.R. 1 (or other divestments from health care services) can continue to receive health care services and that providers are also reimbursed for these services. Furthermore, money in the fund would include deposits equal to the amount of any savings to the state that resulted from decreased enrollment in the Medi-Cal program caused by enrollment barriers from new federal policy changes. ***Potential CalOptima Health Impact:*** Extended health care benefits for certain future former members.	**03/26/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch
AB 45 Bauer-Kahan	**Reproductive Data Privacy:** Prohibits the collection, use, disclosure, sale, sharing, or retention of the information of a person who is physically located at, or within a precise geolocation of, a family planning center, except any collection or use necessary to perform services or provide goods that have been requested. Also authorizes an aggrieved person to institute and prosecute a civil action against any person or organization in violation of these provisions. ***Potential CalOptima Health Impact:*** Increased safeguards regarding reproductive health information.	**09/26/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 257 Flora	**Specialty Telehealth Network Demonstration:** Would require the establishment of a demonstration project or grant program for a telehealth and other virtual services specialty care network designed to serve patients of safety-net providers. ***Potential CalOptima Health Impact:*** Expanded member access to telehealth specialists.	**01/23/2026** Died in Assembly Appropriations Committee **03/25/2025** Passed Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose
AB 316 Krell	**Artificial Intelligence Defenses:** Prohibits a defendant that developed or used artificial intelligence from asserting a defense that artificial intelligence autonomously caused the alleged harm to the plaintiff. ***Potential CalOptima Health Impact:*** Increased liability related to UM procedures.	**10/13/2025** Signed into law	CalOptima Health: Watch
AB 403 Ortega	**Medi-Cal Community Health Service Workers:** Would require DHCS to annually review the Community Health Worker (CHW) benefit and present an analysis to the Legislature beginning July 1, 2027. The analyses would include an assessment of Medi-Cal MCP outreach and education efforts, CHW utilization and services, demographic disaggregation of the CHWs and beneficiaries receiving services, and fee-for-service reimbursement data. ***Potential CalOptima Health Impact:*** New reporting requirements to DHCS.	**01/23/2026** Died in Assembly Appropriations Committee **03/25/2025** Passed Assembly Health Committee	CalOptima Health: Watch
AB 577 Wilson	**Prescription Drug Antisteering:** Would prohibit a health plan or pharmacy benefit manager (PBM) from engaging in specified steering practices, including requiring an enrollee to use a retail pharmacy for dispensing prescription oral medications and imposing any requirements, conditions or exclusions that discriminate against a physician in connection with dispensing prescription oral medications. Additionally, would require a health care provider, physician's office, clinic or infusion center to obtain consent from an enrollee and disclose a good faith estimate of the applicable cost-sharing amount before supplying or administering an injected or infused medication. ***Potential CalOptima Health Impact:*** Increased oversight of contracted PBM and referral processes.	**01/23/2026** Died in Assembly Appropriations Committee **04/29/2025** Passed Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 688 Gonzalez	**Telehealth for All Act of 2025:** Beginning in 2028 and every two years thereafter, requires DHCS to use Medi-Cal data and other data sources to produce analyses in a publicly available Medi-Cal telehealth utilization report. ***Potential CalOptima Health Impact:*** New reporting requirements to DHCS.	**10/07/2025** Signed into law	CalOptima Health: Watch
AB 980 Arambula	**Health Plan Duty of Care:** As it pertains to the required "duty of ordinary care" by a health plan, would define "medically necessary health care service" to mean legally prescribed medical care that is reasonable and comports with the medical community standard. ***Potential CalOptima Health Impact:*** Modified UM procedures.	**01/16/2026** Died in Assembly Health Committee **04/22/2025** Re-referred to Assembly Health Committee	CalOptima Health: Watch
AB 2194 Valencia	**CalOptima Health Governance:** Would implement staggered terms on the CalOptima Health Board of Directors (Board), effective for the new terms expected to begin in August 2028. To accommodate a transition, the following three Board seats would serve initial two-year terms: 1. Community clinic representative 2. Practicing licensed medical provider who is not affiliated with a health network 3. Accounting or public finance professional or actively licensed attorney In addition, would require an independent external audit of CalOptima Health's governance procedures and practices, including but not limited to policies related to conflict-of-interest, vendor contracting and procurement, and governance structures and responsibilities, as well as the Orange County Health Care Agency's nomination process for Board members. ***Potential CalOptima Health Impact:*** Increased continuity of Board representation; increased staff workload to initiate and respond to independent external audit	**07/01/2026** Passed Senate Local Government Committee; referred to Senate Appropriations Committee **06/24/2026** Passed Senate Health Committee **04/16/2026** Passed Assembly floor	**06/18/2026** CalOptima Health: OPPOSE
AB 2565 Wallis	**Pharmacist Services:** Would require DHCS to update its model evidence of coverage (EOC) to explicitly include the obligation of MCPs to cover pharmacist services. ***Potential CalOptima Health Impact:*** Updated member-facing materials, such as EOCs and member handbooks.	**06/03/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/14/2026** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Older Adult Services			
SB 242 Blakespear	**Medicare Supplemental Coverage Open Enrollment Periods:** Would make Medicare supplemental benefit plans available to qualified applicants with end stage renal disease under the age of 64 years. Would also create an annual open enrollment period for Medicare supplemental benefit plans and prohibit such plans from denying an application or adjusting premium pricing due to a preexisting condition. Additionally, would authorize premium rates offered to applicants during the open enrollment period to vary based on the applicant's age at the time of issue, but would prohibit premiums from varying based on age after the contract is issued. ***Potential CalOptima Health Impact:*** Expanded Medicare coverage options for dual-eligible members.	**01/23/2026** Died in Senate Appropriations Committee **04/30/2025** Passed Senate Health Committee	CalOptima Health: Watch CAHP: Oppose
SB 412 Limón	**Home Care Aides:** Requires a home care organization to ensure that a home care aide completes training related to the special care needs of clients with dementia prior to providing care and annually thereafter. ***Potential CalOptima Health Impact:*** New training requirements for PACE staff.	**10/06/2025** Signed into law	CalOptima Health: Watch
Providers			
SB 32 Weber Pierson	**Timely Access to Care:** Would require DHCS, DMHC and the California Department of Insurance to consult stakeholders for the development and adoption of geographic accessibility standards of perinatal units to ensure timely access for enrollees by July 1, 2027. ***Potential CalOptima Health Impact:*** Additional timely access standards; increased contracting with perinatal units.	**07/01/2025** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **06/02/2025** Passed Senate floor	CalOptima Health: Watch LHPC: Oppose
SB 250 Ochoa Bogh	**Medi-Cal Provider Directory — SNFs:** Requires an annually updated provider directory issued by a Medi-Cal MCP to include SNFs as a searchable provider type. ***Potential CalOptima Health Impact:*** Modifications to CalOptima Health's online provider directory.	**10/03/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 306 Becker	**Prior Authorization Exemption:** No later than January 1, 2028, requires health plans — except Medi-Cal MCPs — to eliminate prior authorization for the most frequently approved health care services, except in cases of fraudulent provider activity or clinically inappropriate care. ***Potential CalOptima Health Impact:*** In future Covered California line of business, implementation of new UM procedures to assess prior authorization approval rates; decreased number of prior authorizations; decreased care coordination for members.	**10/06/2025** Signed into law	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
SB 504 Laird	**HIV Reporting:** Authorizes a health care provider for a patient with an HIV infection that has already been reported to a local health officer to communicate with a local health officer or CDPH to obtain public health recommendations on care and treatment or to refer the patient to services provided by CDPH. ***Potential CalOptima Health Impact:*** Increased coordination of care for HIV-positive members.	**10/13/2025** Signed into law	CalOptima Health: Watch
SB 1049 Pierson	**Claim Reimbursements:** Would grant a provider 90 days to submit a corrected claim after a health care plan denies a claim or sends a notice of overpayment for a claim based on a defect that could be rectified by submitting a corrected claim. Additionally, would prohibit denial of a corrected claim on the grounds that the provider did not submit the claim within the applicable filing deadline. ***Potential CalOptima Health Impact:*** Modified claims review process.	**06/23/2026** Passed Assembly Health Committee; referred to Assembly Appropriations Committee **05/19/2026** Passed Senate floor	CalOptima Health: Watch CAHP: Oppose Unless Amended
AB 29 Arambula	**Adverse Childhood Experiences (ACEs) Screening Providers:** Would require DHCS to include community-based organizations, local health jurisdictions and doulas as qualified providers for ACEs trauma screenings and require clinical or other appropriate referrals as a condition of Medi-Cal payment for conducting such screenings. ***Potential CalOptima Health Impact:*** Increased access to care for pediatric members with ACEs.	**01/23/2026** Died in Assembly Appropriations Committee **04/01/2025** Passed Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 50 Bonta	**Over-the-Counter Contraceptives:** Allows pharmacists to provide over-the-counter hormonal contraceptives without following certain procedures and protocols, such as requiring patients to complete a self-screening tool. As such, these requirements are limited to prescription-only hormonal contraceptives. ***Potential CalOptima Health Impact:*** Increased member access to hormonal contraceptives.	**09/26/2025** Signed into law	CalOptima Health: Watch
AB 55 Bonta	**Alternative Birth Centers Licensing:** Removes the requirement for alternative birth centers to provide comprehensive perinatal services as a condition of CDPH licensing and Medi-Cal reimbursement. ***Potential CalOptima Health Impact:*** Decreased member access to comprehensive perinatal services; reduced operating requirements for alternative birth centers.	**10/11/2025** Signed into law	CalOptima Health: Watch LHPC: Support
AB 220 Jackson	**Medi-Cal Subacute Care Authorization:** Would require a provider seeking prior authorization for pediatric subacute or adult subacute care services under the Medi-Cal program to submit a specified form. Additionally, would prohibit a Medi-Cal MCP from developing or using its own criteria for medical necessity and from requiring a subsequent treatment authorization request upon a patient's return from a bed hold for acute hospitalization. ***Potential CalOptima Health Impact:*** Modified UM procedures and forms.	**09/04/2025** Passed Senate floor; referred to Assembly for concurrence in amendments **05/29/2025** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 280 Aguiar-Curry	**Provider Directory Accuracy:** Would require health plans — except Medi-Cal MCPs — to maintain accurate provider directories, starting with minimum 60% accuracy by July 1, 2026, and increasing to 95% by July 1, 2029, or otherwise receive administrative penalties. If a patient relies on inaccurate directory information, would require the provider to be reimbursed at the out-of-network rate without the patient incurring charges beyond in-network cost-sharing amounts. Would also allow DMHC to update standardized formats to collect directory information as well as establish methodologies to ensure accuracy, such as use of a central utility, by January 1, 2026. Additionally, would require a health plan to provide information about in-network providers to enrollees upon request, including whether the provider is accepting new patients at the time, and would limit the cost-sharing amounts an enrollee is required to pay for services from those providers under specified circumstances. Would also require that, within 30 days of receiving a request from a health plan, a provider must confirm that its information is current and accurate or update the required information. ***Potential CalOptima Health Impact:*** In future Covered California line of business, increased oversight of provider directory; increased coordination with contracted providers; increased penalty payments to DMHC.	**07/09/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **06/02/2025** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose
AB 375 Nguyen	**Qualified Autism Service Paraprofessional:** Would expand the definition of "health care provider" to also include a qualified autism service paraprofessional. ***Potential CalOptima Health Impact:*** Increased access to autism services for eligible members; additional provider contracting and credentialing.	**06/08/2026** Passed Senate Business, Professions and Economic Development Committee; referred to Senate Appropriations Committee **01/29/2026** Passed Assembly floor	CalOptima Health: Watch
AB 416 Krell	**Involuntary Commitment:** Authorizes a person to be taken into custody by an emergency physician under the Lanterman-Petris-Short Act and exempts the emergency physician from criminal and civil liability. ***Potential CalOptima Health Impact:*** New legal standards for certain CalOptima Health providers.	**10/13/2025** Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 510 Addis	**Utilization Review Peer-to-Peer Review:** Would allow a provider to request review of a decision to delay, deny or modify health services by another physician or peer health care professional matching the specialty of the service within two business days. In urgent cases, responses must match the urgency of the patient's condition. If these deadlines are not met, the authorization request would be automatically approved. ***Potential CalOptima Health Impact***: Expedited and modified UM, grievance and appeals procedures for covered Medi-Cal benefits; increased hiring of specialists to review grievances and appeals.	**01/23/2026** Died in Assembly Appropriations Committee **04/22/2025** Passed Assembly Health Committee	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
AB 512 Harabedian	**Prior Authorization Timelines:** Would have shortened the timeline for prior or concurrent authorization requests to no more than 24 hours via electronic submission or 48 hours via non-electronic submission for *urgent* requests and three business days via electronic submission or five business days via non-electronic submission for *standard* requests, starting from plan receipt of the information reasonably necessary and requested by the plan to make the determination. ***Potential CalOptima Health Impact***: Expedited and modified UM procedures for covered Medi-Cal benefits.	**10/06/2025** Vetoed	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
AB 517 Krell	**Wheelchair Prior Authorization:** Would prohibit a Medi-Cal MCP from requiring prior authorization for the repair of a Complex Rehabilitation Technology (CRT)-powered wheelchair, if the cost of repair does not exceed $1,250. Would also no longer require a prescription or documentation of medical necessity, if the wheelchair has already been approved for use by the patient. Additionally, would require supplier documentation of the repair. ***Potential CalOptima Health Impact:*** Modified UM procedures for a covered Medi-Cal benefit.	**01/23/2026** Died in Assembly Appropriations Committee **04/08/2025** Passed Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 539 Schiavo	**One-Year Prior Authorization Approval:** Would require a prior authorization for a health care service to remain valid for a period of at least one year, or throughout the course of prescribed treatment if less than one year, from the date of approval. ***Potential CalOptima Health Impact:*** Modified UM procedures for covered Medi-Cal benefits; decreased number of prior authorizations; increased costs.	**07/01/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/12/2025** Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
AB 787 Papan	**Provider Directory Disclosures:** Would require a health plan to include in its provider directory a statement advising an enrollee to contact the plan for assistance in finding an in-network provider. Would also require the plan to respond within one business day if contacted for such assistance and to provide a list of in-network providers confirmed to be accepting new patients within two business days for urgent requests and five business days for nonurgent requests. Medi-Cal MCPs would not be required to distribute a printed provider directory. ***Potential CalOptima Health Impact:*** Expanded customer service support and staff training; technical changes to CalOptima Health's provider directory.	**06/18/2025** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/05/2025** Passed Assembly floor	CalOptima Health: Watch
AB 1041 Bennett	**Provider Credentialing:** Requires a health plan — except a Medi-Cal MCP — to credential a provider within 90 days of receipt of a completed application; otherwise, a credential is conditionally approved for 120 days, except as specified. A plan is required to notify the provider whether the application is complete within 10 days of receipt. Additionally, requires a health plan to subscribe to and use the Council for Affordable Quality Healthcare credentialing form on and after January 1, 2028. ***Potential CalOptima Health Impact:*** Expedited and modified credentialing procedures for future Covered California line of business.	**10/11/2025** Signed into law	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose Unless Amended
AB 1843 Elhawary	**Communicable Disease:** Would prohibit health plans from requiring authorization for direct-acting antiviral drugs needed for hepatitis C treatment. ***Potential CalOptima Health Impact:*** Modified UM procedures.	**06/24/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/21/2026** Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1887 Zbur	**Prescription Drug Coverage for Rare Diseases:** Would require a health care service plan – except a Medi-Cal MCP — to complete prior authorization or other utilization review within 30 days for a drug approved for the treatment of a rare disease, and prescribed by a specialist with expertise in such disease, unless a biosimilar, interchangeable biologic or generic version of the drug is available. ***Potential CalOptima Health Impact:*** New UM procedure for future Covered California line of business.	**07/01/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/27/2026** Passed Assembly floor	CalOptima Health: Watch
AB 2352 Valencia	**Nonprofit Public Benefit Corporations:** Would allow nonprofit public benefit corporations that offer nonspecialty mental health services to be enrolled as Medi-Cal providers. ***Potential CalOptima Health Impact:*** Increased number of contracted mental health providers; increased access to mental health services for Medi-Cal members.	**06/24/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee **05/27/2026** Passed Assembly floor	CalOptima Health: Watch
AB 2457 Connolly	**Medi-Cal Provider Credentialing:** Would extend the requirements of AB 1041 (2025) to Medi-Cal MCPs. ***Potential CalOptima Health Impact:*** Expedited and modified credentialing procedures for Medi-Cal line of business.	**03/25/2026** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
Rates & Financing			
SB 339 Cabaldon	**Medi-Cal Laboratory Rates:** Would require Medi-Cal reimbursement rates for clinical laboratory or laboratory services to *equal* the lowest of the following metrics: 1. the amount billed; 2. the charge to the general public; 3. 100% of the lowest maximum allowance established by Medicare; or 4. a reimbursement rate based on an average of the lowest amount that other payers and state Medicaid programs are paying. For any such services related to the diagnosis and treatment of sexually transmitted infections on or after July 1, 2027, the Medi-Cal reimbursement rates shall not consider the rates described in clause (4) listed above. ***Potential CalOptima Health Impact*:** Increased payments to contracted clinical laboratories.	**04/29/2025** Passed Senate Judiciary Committee; referred to Senate Appropriations Committee **04/23/2025** Passed Senate Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1672 Solache	**PACE Rates:** Would modify how PACE rates are negotiated by eliminating the requirement for consultation during rate setting and instead mandating direct negotiation of rates. Additionally, would require DHCS to provide written responses to comments and the rationale for rate assumptions before federal submission. ***Potential CalOptima Health Impact:*** Modified rate-setting process for PACE line of business.	**06/03/2026** Passed Senate Health Committee; referred to Senate Appropriations Committee **04/16/2026** Passed Assembly floor	CalOptima Health: Watch CalPACE: Sponsor
AB 2036 Patel	**Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) Reimbursement:** Would clarify how FQHC and RHC services are reimbursed on a per-visit basis, including how such Prospective Payment System (PPS) rates are set and adjusted based on necessary documentation. ***Potential CalOptima Health Impact:*** Improved access to care for members assigned to contracted FQHCs; improved financial stability of contracted FQHCs.	**02/17/2026** Introduced; referred to Assembly Health Committee	CalOptima Health: Watch
AB 2327 Lowenthal	**Subcontractor Rates:** Would require Medi-Cal MCPs operating as fully or partially delegated subcontractors to be compensated with actuarially sound rates starting January 1, 2027s. ***Potential CalOptima Health Impact:*** Modifications to rate setting for Medi-Cal subcontractors.	**04/21/2026** Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch

Information in this document is subject to change as bills proceed through the legislative process.

CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California

Last Updated: July 27, 2026

2026 Federal Legislative Dates

January 5	119th Congress, 1st Session convenes
July 24–August 30	Summer recess for House
August 8–September 13	Summer recess for Senate
December 18	2nd session adjourns

Source: Floor Calendars, United States Congress: https://www.congress.gov/calendars-and-schedules

2026 State Legislative Dates

January 5	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
January 16	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2025
January 23	Last day for any committees to hear and report to the Floor any bills introduced in that house in 2025
January 31	Last day for each house to pass bills introduced in that house in 2025
February 20	Last day for legislation to be introduced in 2026
March 27–April 5	Spring recess
April 24	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2026
May 1	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house in 2026
May 15	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house in 2026
May 26–29	Floor session only
May 29	Last day for each house to pass bills introduced in that house in 2026
June 15	Budget bill must be passed by midnight
July 2	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 3–August 2	Summer recess
August 14	Last day for fiscal committees to report bills in their second house to the Floor
August 17–31	Floor session only
August 21	Last day to amend bills on the Floor
August 31	Last day for each house to pass bills; final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature

Source: Legislative Deadlines, California State Senate: https://www.senate.ca.gov/legislative-deadlines-calendar

About CalOptima Health

CalOptima Health is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to serve member health with excellence and dignity, respecting the value and needs of each person. We provide coverage through three major programs: Medi-Cal, OneCare (HMO D-SNP) and the Program of All-Inclusive Care for the Elderly (PACE)

H.R. 1: One Big Beautiful Bill Act

Fiscal Year 2025 Federal Budget Reconciliation

As signed into law on July 4, 2025

Please note that H.R. 1 includes several distinct implementation dates over the coming years, but there are no major immediate impacts to Medicaid beneficiaries until 2026.

In addition, most Medicaid provisions of H.R. 1 still require federal rulemaking by the U.S. Centers for Medicare and Medicaid Services (CMS) and subsequent state implementation by the California State Legislature and/or the California Department of Health Care Services (DHCS).

MEDICAID HIGHLIGHTS
Eligibility
Work, community service and/or education requirement of **80 hours per month** for able-bodied adults ages 19–64 (with exceptions for short-term hardship, parents with dependents under age 14, pregnant women, medically frail, caregivers and others), effective **December 31, 2026** (or no later than **December 31, 2028**, at the discretion of the U.S. Secretary of Health and Human Services [HHS])
Increased frequency of eligibility redeterminations for Medicaid Expansion (MCE) enrollees from annually to **every six months**, effective **December 31, 2026**
Financing
Prohibition on any new or increased provider taxes, effective **immediately**
Existing provider taxes (except those related to nursing or intermediate care facilities) would be gradually reduced from the current maximum **6.0%** hold harmless threshold to a new **3.5%** hold harmless threshold by **0.5% annually** from **October 1, 2027, through October 1, 2031**
Significant restrictions on current Managed Care Organization (MCO) taxes, which could effectively **repeal** California's MCO tax that was recently made permanent by Proposition 35 (2024), with a potential winddown period of up to **three fiscal years** at the discretion of the HHS Secretary
Cap on new state-directed payments (SDPs) at **100%** of the Medicare payment rate, effective **immediately**; gradually reduces existing SDPs to that cap by **10% annually**, starting **January 1, 2028**
Emergency Medicaid services provided to all undocumented beneficiaries would be subject to the traditional Federal Medical Assistance Percentage (FMAP) — **50%** in California — regardless of the FMAP for which those would otherwise be eligible, effective **October 1, 2026**
Access
Cost-sharing for MCE enrollees with incomes of **100–138%** Federal Poverty Level (FPL), not to exceed **$35** per service and **5.0%** of total income, and not to be applied to primary, prenatal, pediatric, behavioral or emergency care, effective **October 1, 2028**
Temporary **one-year** prohibition on all Medicaid funding to Planned Parenthood, effective **immediately**

Back to Agenda

Fiscal Year 2025–26 Enacted State Budget

On May 14, 2025, Governor Gavin Newsom released a Fiscal Year (FY) 2025–26 Revised State Budget Proposal, known as the May Revision. On June 13, the State Senate and State Assembly both passed a counterproposal — Senate Bill (SB) 101 — as a placeholder budget to meet the June 15 constitutional deadline while negotiations with the governor on a final budget remained ongoing.

On June 24, Gov. Newsom and legislative leaders announced a final budget agreement. After both houses of the Legislature passed the agreed-upon revisions as Assembly Bill (AB) 102 on June 27, Gov. Newsom signed both SB 101 and AB 102 into law. Additionally, the Legislature passed and the governor signed the consolidated Health Trailer Bill (AB 116) containing policy changes needed to implement health-related budget expenditures. Together, these bills represent the FY 2025–26 Enacted State Budget.

MEDI-CAL HIGHLIGHTS
Unsatisfactory Immigration Status (UIS)-Member Impacts
Freeze on *new* enrollment of UIS individuals ages 19+ (except those who are pregnant or one-year postpartum), effective **January 1, 2026**, including a three-month grace/cure period for re-enrollment following payment of outstanding premium balances; *currently enrolled* individuals are not affected
Implementation of $30/month premiums for UIS individuals ages 19–59, effective **July 1, 2027**
Elimination of dental coverage for UIS individuals ages 19+, effective **July 1, 2026**
Elimination of Prospective Payment System rates to Federally Qualified Health Centers for state-only-funded services provided to UIS individuals, effective **July 1, 2026**
All-Member Impacts
Reinstatement of asset limit at $130,000 for individuals (plus $65,000 for each additional household member) in non-Modified Adjusted Gross Income eligibility categories, effective **January 1, 2026**
Elimination of pharmacy coverage for GLP-1 agonists for weight loss; coverage for diabetes and on a case-by-case basis will continue, effective **January 1, 2026**
Elimination of pharmacy coverage of some over-the-counter drugs, including COVID-19 antigen tests, vitamins and certain antihistamines, such as dry eye products, effective **January 1, 2026**
Implementation of prior authorization for hospice services, effective **July 1, 2026**
Limitation on capitation payments to Program of All-Inclusive Care for the Elderly (PACE) organizations at the midpoint of the actuarial rate ranges, effective **January 1, 2027**
Elimination of the Workforce and Quality Incentive Program (WQIP) for skilled nursing facilities, effective **December 31, 2025**, with all close-out activities to be completed by January 1, 2027

State agencies, including the California Department of Health Care Services, will begin implementing the policies included in the enacted budget. Staff will continue to monitor these policies and provide updates regarding issues that have a significant CalOptima Health impact. In addition, the Legislature continues to advance policy bills through the legislative process. Bills with funding allocated in the enacted budget are more likely to be passed and signed into law. The Legislature has until September 12, 2025, to pass legislation, and Gov. Newsom has until October 12, 2025, to either sign or veto that passed legislation.

Back to Agenda

Fiscal Year 2026–27 Enacted State Budget

Impact Analysis

July 15, 2026

Background

On January 9, 2026, Governor Gavin Newsom released the Fiscal Year (FY) 2026–27 Proposed State Budget, reflecting a minor $2.9 billion budget shortfall due to increased state program costs and the loss of significant federal funding, despite state tax revenue coming in higher than expected. While the proposed budget did not include any major new commitments or spending reductions, the Medi-Cal program would still be particularly affected as policy changes from federal H.R. 1 legislation, enacted on July 4, 2025, and the previous FY 2025–26 enacted state budget continue to be implemented.

On May 14, Governor Newsom released the FY 2026–27 Revised State Budget Proposal, known as the May Revision, which reflects updated economic forecasts and revenue projections. After accounting for budget solutions, the May Revision proposed $349.4 billion in total funding ($246.6 billion General Fund [GF]). Revenues are projected to be $16.5 billion higher than estimated in January's proposed budget across the three-year budget window, primarily driven by stronger-than-expected personal income tax collections and a spike in capital gains realizations associated with the artificial intelligence boom.

On June 15, the State Senate and State Assembly both passed a counterproposal — Assembly Bill (AB) 109 — as a placeholder budget to meet the June 15 constitutional deadline while negotiations with the governor on a final budget continued.

On June 26, Gov. Newsom and legislative leaders announced a final budget agreement. After both houses of the State Legislature passed the agreed-upon revisions as Senate Bill (SB) 111 on June 29, Gov. Newsom signed both AB 109 and SB 111 into law that same day. Additionally, the Legislature passed and the governor signed the consolidated Health Trailer Bill (SB 164), which contains policy changes needed to implement health-related budget expenditures. Together, these bills — along with additional trailer bills covering other policy areas — represent the FY 2026–27 Enacted State Budget.

Summary

The FY 2026–27 Enacted State Budget includes $351.7 billion in total spending ($251.1 billion GF) to support a balanced budget for FY 2026–27 and positive year-end balances and reserves over the next two FYs through a combination of revenue and spending solutions. New revenue streams include a sales tax on pre-written software projects, limits on business tax credits and a new Managed Care Organization (MCO) tax, as discussed later. However, the final budget agreement mitigates several spending reductions proposed in the May Revision by rejecting or delaying them until the following budget year. Still, significant cutbacks in the Medi-Cal program remain included, in part due to new federal Medicaid requirements under H.R. 1 and ongoing guidance from the U.S. Centers for Medicare & Medicaid Services (CMS). Both the State Senate and the State Assembly aim to revisit any included reductions and consider additional delays, restorations or modifications of those reductions as part of the FY 2027–28 budget process, consistent with the state's fiscal condition at that time.

The following are significant provisions in the FY 2026–27 Enacted State Budget that may impact CalOptima Health and its members, providers and stakeholders:

Back to Agenda

Medi-Cal Eligibility & Enrollment

- Transition the Unsatisfactory Immigration Status (UIS) population from Medi-Cal managed care plans to the Medi-Cal fee-for-service system, effective January 1, 2027.
    - The California Department of Health Care Services (DHCS) claims that this is required in response to a State Medicaid Director Letter issued by CMS in September 2025 that disallows coverage of federally eligible emergency Medicaid services within a risk-based managed care delivery system for the UIS population.
    - Program of All-Inclusive Care for the Elderly (PACE) participants are exempt from the transition and are therefore allowed to maintain enrollment in PACE.
    - $39 million has been appropriated to support the transition, including $31 million for care coordination, such as language access, integrated care planning, member outreach, and provider coordination, as well as $8 million for contracts with clinics and community-based organizations to provide navigation services.
    - In total, approximately 117,000 CalOptima Health members will be transitioned, including 295 vulnerable children enrolled in the Whole Child Model program.
- Delay the transition of the Qualified Non-Citizen (QNC) population to restricted-scope Medi-Cal from October 1, 2026, through July 1, 2027. In the meantime, the QNC population will be transitioned alongside the UIS population to Medi-Cal FFS on January 1, 2027.
- Require the next governor's FY 2027–28 May Revision to set a Medi-Cal premium between $30 and $50 per month for UIS adults ages 19–59, effective July 1, 2027. A $30-per-month premium was already set to take effect on the same date, pursuant to the FY 2025–26 enacted state budget.
- Further reduce the asset limit for seniors and disabled adults to $21,000 per individual or $31,000 per couple, effective July 1, 2027. An asset limit of $130,000 per individual was recently implemented on January 1, 2026.
- Augment funding by $197 million GF in FY 2026–27 to support increased county workload as a result of H.R. 1 changes to Medi-Cal eligibility and enrollment.
- Appropriate $1.5 million GF in FY 2026–27 to clear the Medi-Cal Home and Community Based Alternatives (HCBA) Waiver waitlist and serve all eligible individuals seeking enrollment in the HCBA Waiver program.

Medi-Cal Benefits

- Renew the California Advancing and Innovating Medi-Cal (CalAIM) initiative from January 1, 2027, through December 31, 2031, with the following new components subject to federal approval:
    - **Employment Supports**: A county opt-in benefit to provide employment support services, including job readiness assessments, individualized employment planning, job placement assistance, and post-employment retention services.
    - **BridgeCare Pilots**: A county opt-in benefit to provide home- and community-based services and caregiver supports to individuals enrolled in Medicare who meet the near-dual eligibility criteria.
- Delay the elimination of UIS adult dental benefits until July 1, 2027.
- Maintain the community-based mobile crisis services benefit until July 1, 2027, despite the expiration of enhanced federal funding.

Medi-Cal Efficiencies

- Strengthen utilization management controls for applied behavior analysis (ABA)/behavioral health treatment (BHT) and transportation services, including non-medical transportation

Back to Agenda

(NMT) and non-emergency medical transportation (NEMT). More details can be found in this DHCS fact sheet. CalOptima Health currently requires prior authorization for ABA/BHT and NEMT services (with exceptions), but not for NMT services.
- Eliminate the incentive component of the Quality Withhold and Incentive Program, which would effectively result in a rate cut to Medi-Cal managed care plans.
- Refine eligibility criteria, referral pathways, service definitions and utilization management criteria for Enhanced Care Management (ECM) and Community Supports, effective January 1, 2027. More details can be found in this DHCS fact sheet. CalOptima Health has already adopted or has recommended adopting several of these proposed reforms to improve the quality and sustainability of the CalAIM program.

Rates and Financing

- Delay the elimination of Proposition 56 dental supplemental payments until July 1, 2027.
- Delay elimination of Prospective Payment System (PPS) rates to community clinics for UIS beneficiaries until July 1, 2027.
- Submit a new MCO Tax model, effective January 1, 2027, due to the expiration of the existing MCO tax on that same date. The new model would consist of two components:
    - The first component would comply with Proposition 35 (2024) but is expected to be rejected by CMS due to noncompliance with the provider tax uniformity requirements under H.R. 1.
    - The second component would comply with H.R. 1 but would not be tied to Proposition 35. Under this component, an $8.85 per member per month (PMPM) tax would be imposed on both Medi-Cal and non-Medi-Cal plans to sustain the Medi-Cal targeted rate increases (TRI) for primary care, maternal health and non-specialty mental health services that were implemented on January 1, 2024. However, this would effectively sweep remaining MCO Tax revenues into the GF to support existing Medi-Cal costs, rather than additional provider rate increases as intended by Proposition 35.
- Appropriate $90 million GF to the California Department of Health Care Access and Information (HCAI) in FY 2026–27 to provide one-time grants to hospitals in immediate and significant financial distress, and authorize the California Department of Finance to augment up to an additional $50 million.
- Appropriate $250 million GF to DHCS in FY 2026–27 to support designated public hospitals.
- Appropriate $30 million GF in FY 2026–27 to support rate increases for private duty nursing.
- Appropriate $26 million to maintain access to gender affirming care through a provider network stabilization program.
- Appropriate $40 million to support uncompensated care and continued access for reproductive health services.

Miscellaneous

- Initiate process to develop and release a proposed “fair share” tax on large corporations whose employees are enrolled in Medi-Cal by April 1, 2027.
- Appropriate $800,000 annually ongoing to hire additional DHCS nursing staff to evaluate PACE enrollment applications and make level-of-care determinations more timely.
- Increase ongoing funding from $190,000 to $300,000 annually to expand the state premium subsidy program for Covered California enrollees up to 200% of the Federal Poverty Level, effective July 1, 2026, to partially offset the expiration of the federal enhanced Advance Premium Tax Credits (eAPTCs) on December 31, 2025.

Back to Agenda

- Augment funding by $223 million GF in FY 2026–27 to support increased county workload as a result of H.R. 1 changes to CalFresh eligibility and enrollment.
- Redirect the state's share of Medical Loss Ratio (MLR) remittances from the Medi-Cal Physician and Dentists Loan Repayment Program to the GF, which would reduce GF costs by $25 million annually ongoing. For context, Medi-Cal managed care plans that fall below the minimum 85% MLR requirement must remit the difference to DHCS.
- Appropriate additional one-time funding of $100 million to food banks in FY 2026–27 as part of the CalFood program.
- Appropriate one-time funding of $16.5 million for diaper banks.

Rejected Proposals

The following notable proposals in the May Revision were ***not*** included in the final budget:

- Eliminate the adult acupuncture benefit, effective January 1, 2027.
- Implement a rate cap for PACE organizations at the lower bound of the actuarial rate range, effective January 1, 2027. A rate cap at the midpoint of the rate range is already set to take effect on the same date. Since CalOptima Health's PACE rates are currently at the midpoint of the rate range, this new proposal would have resulted in an effective rate cut to CalOptima Health.
- Shift the costs of growth in In-Home Supportive Services (IHSS) to counties, eliminate the IHSS Backup Provider System and align IHSS termination with Medi-Cal termination.

Next Steps

State agencies, including DHCS, will begin implementing the policies included in the enacted budget. In addition, the Legislature may consider additional clean-up budget bills and will continue to advance policy bills through the legislative process. The Legislature has until August 31, 2026, to pass legislation, and Gov. Newsom has until September 30, 2026, to either sign or veto that passed legislation. Policy bills with funding allocated in the enacted budget are more likely to be passed and signed into law.

Government Affairs staff will continue to monitor policies included in the enacted budget, engage in any additional necessary advocacy efforts and provide updates on issues that have a significant impact on CalOptima Health. If you have any questions, please contact GA@caloptima.org.

Back to Agenda

CalOptima Health Community Outreach Summary —July and August 2026

Background

CalOptima Health is committed to serving the community by sharing information with current and potential members and by strengthening relationships with community partners. To this end, our team attends community coalitions, collaborative meetings and advisory groups and supports our community partners' public activities. Participation includes providing Medi-Cal educational materials and, if criteria are met, financial support and/or CalOptima Health-branded items.

CalOptima Health's participation in public activities promotes:

- Member interaction/enrollment in a CalOptima Health program
- Community awareness of CalOptima Health
- Partnerships that increase positive visibility and relationships with community organizations

Community Outreach Highlight

On Saturday, August 1, CalOptima Health hosted its 4th Annual Back-to-School Event in partnership with Orange Unified School District at El Modena High School. The event brought together CalOptima Health staff, community partners and volunteers to help children and families prepare for a healthy and successful start to the new school year.

Children received backpacks filled with school supplies, shoes and socks, bike helmets, hygiene kits, lunch bags, life vests, and access to vision screenings, dental screenings, sports physicals and haircuts. Families also benefited from Medi-Cal and CalFresh enrollment assistance, food and diaper distributions (while supplies lasted), and the opportunity to connect with CalOptima Health departments and community-based organizations offering valuable health, social and supportive services.

In addition to essential resources, attendees enjoyed meals, ice cream, cultural performances and family-friendly activities that fostered community engagement and promoted overall well-being.

The event reflects CalOptima Health's ongoing commitment to improving the health and well-being of Orange County families by reducing barriers to care, connecting members with essential resources, and ensuring children have the tools they need to thrive both in the classroom and at home.

Summary of Public Activities

As of July 10, CalOptima Health will participate in, organize or convene 77 public activities in July and August. In July, there were 36 public activities, including 12 community/collaborative meetings, 23 community events and one Health Network Forum.

In August, there will be 41 public activities, including 12 community/collaborative meetings, 25 community events, two community-based presentations, one Community Connections Meeting and one Health Network Forum. A summary of the agency's participation in community events throughout Orange County is attached.

Endorsements

CalOptima Health provided no endorsements since the last reporting period (i.e., letters of support, program/public activity events with support or use of name/logo). Endorsement requests must meet the requirements of CalOptima Health's Policy AA.1214: Guidelines for Endorsements by CalOptima Health, for letters of support and use of CalOptima Health's name and logo. For more information on policy requirements, please visit: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

For additional information or questions, contact CalOptima Health Executive Director Deanne Thompson at 714-954-2141 or deanne.thompson@caloptima.org.

Attachment to the August 6, 2026, CalOptima Health Outreach Summary

Community Events Hosted by CalOptima Health and Community Partners in July and August 2026:

July 2026

July 9, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 11, 10 a.m.–2 p.m., Wellness Retreat, hosted by CIELO

The Village, 1505 17th St., Santa Ana,

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 13, 9 a.m.–1 p.m., Health Care Fair, hosted by Project Fair Care Health

Delhi Center, 505 E. Central Ave., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 16, 3–5:30 p.m., Backpacks for Success, hosted by the City of Placentia

Whitten Community Center, 900 S. Melrose Ave., Placentia

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 16, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 18, 10 a.m.–2 p.m., Children's Expo, hosted by the Boys and Girls Club of Fountain Valley in collaboration with the office of Orange County Supervisor Janet Nguyen

Freedom Hall Mile Square Park, 16801 Euclid St., Fountain Valley

- Sponsorship fee: $5,750; included a resource table.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

July 19, 10 a.m.–2 p.m., Community Health Event, hosted by Project Fair Care Health

Sports Basement Orange County, 10800 Kalama River Ave., Fountain Valley

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 21, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 22, 5–7 p.m., Back to the 80s Colon Cancer Prevention Event, hosted by Latino Health Access

Latino Health Access, 450 W. 4th St., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 22, 4–6 p.m., Backpack & School Supplies Distribution and Family Resource Fair, hosted by Boys and Girls Club of Santa Ana

Boys and Girls Club of Santa Ana, 950 W. Highland St., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 23, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 23, 6–8 p.m., Summer Resource Fair, hosted by Latino Muslim Unity

Jerome Park, 2115 W McFadden Ave., Santa Ana

- Sponsorship fee: $3,000; included logo on flyer, and a resource booth.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 24, 3–5:30 p.m., National Night Out, hosted by Project Access Vintage Crossings

Project Access Vintage Crossings Resource Center, 708 E. South St., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 24, 4–6 p.m., Resource Fair, hosted by Project Access Horizon

Project Access Horizon Resource Center, 2414 N. Tustin Ave., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation
Exhibitor/Attendee

July 24, 5–7 p.m., Summer Extravaganza, hosted by Wings of Kindness

Mondragon Family Markets, 407 E. North St., Anaheim

- Sponsorship fee: $3,000; included social media promotions, event signage, website recognition, and sponsor acknowledgments before, during, and after the event. A resource booth and speaking opportunity.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 25, 9 a.m.–1 p.m., Social Recreation & Back to School Fair, hosted by the Regional Center of Orange County

Heritage Museum of Orange County, 3101 W. Harvard St., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 25, 9 a.m.–1 p.m., I-Ride Safe Academy, hosted by City of Irvine Councilmember Betty Martinez Franco

Irvine City Council, 1 Civic Center Plaza, Irvine

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 28, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 29, 4–7 p.m., Backpacks for Success Distribution Day, hosted by Community Action Partnership of Orange County

El Modena Family Resource Center, 18672 E. Center Ave., Orange

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 29, 3–5 p.m., Back to School Event, hosted by Hope Through Housing

Miraflores Apartments, 1445 S. Anaheim Blvd., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 30, 4–6 p.m., Back to School Supply Giveaway, hosted by United Across Borders

Santa Ana High School, 520 W. Walnut St., Santa Ana

- Sponsorship fee: $3,000; included a resource booth and speaking opportunity.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 30, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

July 31, 3–5 p.m., Back to School and Community Health Fair, hosted by Project Access Crossing at Cherry Orchard

Project Access Crossing at Cherry Orchard, 2748 W. Lincoln Ave., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 2026

August 1, 9 a.m.–1 p.m., Back-to-School Health and Wellness Fair, hosted by CalOptima Health and Orange Unified School District

El Modena High School, 3920 E. Spring St., Orange

- At least 60 staff members attended (in person)
- Health/Resource Fair, open to the public

August 1, 9 a.m.–Noon, Back to School Kickoff, hosted by Newport Mesa Unified School District

IKEA Parking Lot, 1475 S. Coast Dr., Costa Mesa

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 1, 10 a.m.–Noon, Back to School Career and Resource Fair, hosted by Big Brothers Big Sisters of Orange County

Big Brothers Big Sisters Office, 1801 E. Edinger Ave., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 2, 10 a.m.–2 p.m., 4th Annual Back to School Bash, hosted by Office of Anaheim Mayor Pro Tem Carlos Leon

Madison Elementary School, 1510 S. Nutwood St., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 4, 8:30 a.m.–1 p.m., Project HERO back to School, hosted by Magnolia School District

Maxwell Elementary School, 2613 Orange Ave., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted CalFresh Outreach (e.g., colleges, food banks) Community Presentation Exhibitor/Attendee

August 4, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 4, 5–8 p.m., National Night Out 2026, hosted by Garden Grove Police Department

Garden Grove Police Department, 11301 Acacia Pkwy., Garden Grove

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 5, 3–5 p.m., Back to School, hosted by Hope Through Housing

Oakcrest Terrace Apartments, 22744 Eastpark Dr., Yorba Linda

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 5, 3–6 p.m., Welcome Back to School Health Fair, hosted by Fullerton School District

Nicolas Community Center, 1100 W. Olive Ave., Fullerton

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

August 6, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 6, 5–6 p.m., CalOptima Health Medi-Cal Overview in English and Vietnamese

The Center at Founders Village Senior & Community Center, 17967 Bushard St., Fountain Valley

- At least one staff member to present
- Community-based organization presentation, open to members/community

August 7, 9–11 a.m., Older Adult Congressional Collaborative, hosted by the Office of Congressman Lou Correa

Downtown Anaheim Community Center, 250 E. Center St., Anaheim

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 8, 9 a.m.–Noon, Super Senior Saturday, hosted by City of Buena Park

Ehlers Senior Activity Center, 8150 Knott Ave., Buena Park

- Registration fee: $150; includes a resource booth.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

August 8, 9 a.m.–12:30 p.m., Back-to-School Resource Fair, hosted by TGR Learning Lab

TGR Learning Lab, 1 Tiger Woods Way, Anaheim

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 8, 10:30 a.m.–1 p.m., Back to School Resource Fair, hosted by Northgate Gonzalez Market

Northgate Gonzalez Market, 2030 E. Lincoln Ave., Anaheim

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 9, 9 a.m.–1 p.m., 3rd Annual Back to School Resource Fair, hosted by Asian American Senior Citizens Services Center, Inc. in collaboration with the office of Santa Ana Mayor Valerie Amezcua

Santa Ana Elks Lodge, 1751 S. Elk Lane, Santa Ana

- Sponsorship fee: $5,000; includes marketing on flyers, banners, social media, and promotional materials. Logo placement on event signage and materials. A resource booth, speaking opportunity or presentation during the program. Verbal recognition during the event and post-event acknowledgment in communications.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 11, 2–6 p.m., Back to School Event, hosted by Capistrano Unified School District

Del Obispo Elementary School, 25591 Camino Del Avion, San Juan Capistrano

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 11, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 13, 4:30–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Anaheim Neighborhood

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 15, 8 a.m.–Noon, 2026 Back-to-School Safety & Support Day for Survivors & Families, hosted by Crime Survivors Resource Center

Crime Survivors Resource Center, 1301 N. Tustin Avenue, Ste A., Santa Ana

- Sponsorship fee: $2,500; includes a resource booth. Verbal recognition announcements at the event. Logo placement on website, flyers, newsletters, email blasts, social media and banner.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 15, 4–9 p.m., Trans Pride OC, hosted by the LGBTQ Center of OC

Fullerton Museum Center, 301 N Pomona Ave., Fullerton

- Sponsorship fee: $1,000; includes a resource booth, thank you post on social media, recognition in post-event email, and individual social media spotlight.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 19, 4–6 p.m., Back to School Safety & Support Day, hosted by Project Access Triada

Family Resource Center at Triada Apartments, 616 N. Lacy St., Santa Ana

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 20, 2–4 p.m., Back to School Resource Fair, hosted by Westminster School District

Johnson Middle School, 13603 Edwards St., Westminster

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 21, 9 a.m.–1:30 p.m., Golden Future Senior Expo, hosted by Golden Future Senior Expos

Hyatt Regency, 1107 Jamboree Rd., Newport Beach

- Registration fee: $1,650; includes a resource booth.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 21, 3–7 p.m. Back to School Resource Fair, hosted by the City of Santa Ana

Garfield Community Center, 501 N. Lacy St., Santa Ana

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

August 25, 9–10:30 a.m., CalOptima Health Community Connections Meeting, hosted by CalOptima Health

County Community Service Center, 675 Placentia Ave., Ste. 100, Brea

- At least four staff members to attend (in person)
- Steering committee meeting, open to collaborative members

CalOptima Health-hosted | CalFresh Outreach (e.g., colleges, food banks) | Community Presentation | Exhibitor/Attendee

August 26, 5–6 p.m., CalOptima Health Medi-Cal Overview in Spanish

CIELO, Virtual

- At least one staff member to present
- Community-based organization presentation, open to members/community

August 29, 10 a.m.–2 p.m., 4th Annual Recovery Happens Picnic, hosted by Orange County Health Care Agency.

Downtown Anaheim Community Center, 250 E. Center St., Anaheim

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

These sponsorship request(s) and community event(s) met the requirements of CalOptima Health Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at:
https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx

Board-Approved Strategic Initiatives Executive Summary – Report Period: October 2025 – December 2025

CalOptima Health's Board of Directors has authorized $1,229.1 million in funding and investment in strategic initiatives designed to improve member and community health and wellness through Community Outreach and Investments, Quality Incentive Programs, and Infrastructure and Capacity Building. Comprehensive impact summary reports are attached for strategic initiatives.

Exhibit 1: Board Approved Initiatives

As of 12/31/25

Board-approved Initiatives	INITIATIVE LEADER	Program Status	Payment Status	Board Approved Amount	Spent Amount	Amounts Committed[1]	Unspent Balance	Resource Available[2]	Duration
Community Outreach and Investments									
CalFresh and Redetermination Outreach	Thompson	In progress	In Progress	$ 6.0	$ 4.2	$ 4.3	$ 1.8	$ 1.7	02/02/2023 - 12/31/2024
CalFresh Outreach Strategy	Thompson	Complete	Complete	$ 2.0	$ 2.0	$ 2.0	$ 0.0	$ 0.0	04/01/2022 - 12/31/2022
CalOptima Health Community Reinvestment Program	Rose	In progress	Not yet started	$ 19.0	$ -	$ -	$ 19.0	$ 19.0	11/01/2023 - 12/31/2026
Garden Grove Recovery Center Development and Maintenance	Bruno-Nelson	In progress	In Progress	$ 17.5	$ 0.9	$ 1.1	$ 16.7	$ 16.4	09/01/2023 - 04/30/2026
General Awareness and Brand Development	Thompson	In progress	In Progress	$ 4.7	$ 4.4	$ 4.4	$ 0.3	$ 0.3	04/01/2023 - 06/30/2026
In-Home Care Pilot Program with the UCI Family Health Center	Dabbah	Complete	Complete	$ 2.0	$ -	$ 0.3	$ 2.0	$ 1.8	09/01/2023 - 08/31/2025
Member and Population Health Needs Assessment	Laverdiere	In progress	In Progress	$ 1.3	$ 0.7	$ 1.2	$ 0.6	$ 0.1	03/14/2025 - 07/31/2026
Medi-Cal Eligibility Outreach Strategy	Thompson	In progress	In Progress	$ 19.8	$ -	$ -	$ 19.8	$ 19.8	09/05/2025 - 12/31/2028
OneCare Member Engagement and Education - Star Rating	Sanchez	In progress	In Progress	$ 0.3	$ 0.1	$ 0.3	$ 0.2	$ -	04/01/2025 - 03/31/2026
OneCare Outreach and Engagement Strategy	Thompson	Complete	Complete	$ 1.0	$ 1.0	$ 1.0	$ 0.0	$ 0.0	07/01/2024 - 06/30/2025
Provider Workforce Development	Laverdiere	In progress	In Progress	$ 50.0	$ 8.6	$ 29.7	$ 41.4	$ 20.3	12/01/2023 - 12/31/2030
Homeless Prevention and Stabilization Pilot Program	Hunn	In progress	In Progress	$ 0.3	$ 0.1	$ 0.3	$ 0.2	$ 0.0	01/01/2025 - 01/01/2028
Supplemental Food Support for Medi-Cal Members	Bruno-Nelson	In progress	In Progress	$ 8.0	$ 7.1	$ 8.0	$ 0.9	$ -	11/01/2025 - 02/28/2026
Subtotal				*$ 385.5*	*$ 222.1*	*$ 284.6*	*$ 163.4*	*$ 100.9*	
Quality Incentive Programs									
Comprehensive Community Cancer Screening*	Pitts	In progress	In Progress	$ 50.1	$ 12.5	$ 20.6	$ 37.6	$ 29.5	12/02/2022 - 12/31/2027
Five-Year Hospital Quality Program	Lee	In progress	In Progress	$ 153.5	$ 39.4	$ 153.5	$ 114.1	$ -	01/01/2023 - 12/31/2028
Subtotal				*$ 205.4*	*$ 52.8*	*$ 175.9*	*$ 152.7*	*$ 29.5*	
Infrastructure and Capacity Building									
Digital Transformation Strategy (DTS)[3]	Kim	In progress	In Progress	$ 100.0	$ 78.0	$ 99.6	$ 22.0	$ 0.4	07/01/2021 - 6/30/2026
Medi-Cal Provider Rate Increases	Kim	In progress	In progress	$ 526.2	$ 315.7	$ 526.2	$ 210.5	$ -	07/01/2024 - 12/31/2026
Skilled Nursing Facility Access Program	Dabbah	In progress	In progress	$ 10.0	$ -	$ -	$ 10.0	$ 10.0	01/01/2023 - 12/31/2026
Subtotal				*$ 638.2*	*$ 394.7*	*$ 627.8*	*$ 243.5*	*$ 10.4*	
Total				**$ 1,229.1**	**$ 669.6**	**$ 1,088.3**	**$ 559.6**	**$ 140.8**	

[1] Amounts Committed include payments and remaining balance of open Purchase Orders and/or an estimation of amounts committed

[2] Resource Available is the amount available for new initiatives after deduction of the Spent Amount and the Additional Amounts Committed from the Board Approved Amount

[3] Additional Amounts Committed for DTS are preliminary estimates

[4] Past Supplemental Funding

* Initiatives funded by IGT dollars

Note: Totals may not add due to rounding

Back to Agenda

CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	3/12/26	**Initiative Name:**	CalFresh and Redetermination Outreach	**Start Date:**	2/2/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	Ongoing
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$6.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health outreach strategy to support Medi-Cal redetermination and enroll potentially eligible CalOptima Health members in the CalFresh program.	- Unspent balance of $1.8 million will be utilized to fund a campaign featuring renewal messages and the importance of keeping Medi-Cal coverage. - Staff will continue to use remaining funds to promote redetermination activities beyond FY27; intending to use for the general brand/"Stay Covered" campaign.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Develop a comprehensive marketing and advertising campaign to promote Medi-Cal redetermination.	Campaign development Number of impressions/media buys	Discovery sessions, secondary research and campaign strategy completed Q1 FY26. Campaign concept completed Q2 FY26. Campaign selection and most asset executions to be completed Q3 FY26. The remaining assets (TV spots and out-of-home ads) to be completed Q4 (4/26).
Collaborate w/ key stakeholders by hosting community events focused on Medi-Cal redetermination and the CalFresh program throughout the county.	Number of community events Number of members served	6 community events focused on Medi-Cal redetermination and CalFresh programs were hosted. Served approximately 7,900 members.
Fund Community Enrollers to support members with Medi-Cal renewals and enrollment in CalFresh.	Number of Community Enrollers	12 enrollment partners were funded in round 1 and those grants are coming to a close at the end of 2025. Seven of those grantees were funded again in round 2. Grant performance metrics are reported separately.

Back to Agenda

CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	3/12/26	**Initiative Name:**	CalFresh Outreach Strategy	**Start Date:**	3/3/2022
Reporting Period:	Oct-Dec (Q2)			**End Date:**	4/30/2026
Program Status:	Complete	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$2.0 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalFresh Outreach Strategy is designed to enroll potentially eligible CalOptima Health members in the CalFresh program to promote food security.	- Community Relations and Communications have fully spent funds. - Program is complete. - Recommending re-allocation of the remaining $10,000 to the funding source through COBAR for April BOD. - This is the final report on this initiative.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Develop a comprehensive marketing and advertising campaign to promote enrollment in CalFresh.	Campaign development Number of impressions/media buys	Advertising ads concluded in January 2025.
Collaborate w/ key stakeholders by hosting community events focused on the CalFresh program throughout the county.	Number of community events Number of members served	In 2025, CalOptima Health hosted 4 large scale events that included CalFresh enrollment assistance with the support of Social Services Agency and funded Community Enrollers. At these events, approximately 4,900 members and community members were served.
Increase enrollment in CalFresh program.	Number of members supported by CalFresh	SSA reports a 34% growth in CalFresh enrollment from January 2021 thru May 2024, as compared to statewide enrollment growth of 30.8%.

Back to Agenda

CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	3/12/2026	**Initiative Name:**	CalOptima Health Community Reinvestment (CR) Program	**Start Date:**	11/1/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	2024
Program Status:	In Progress	**Initiative Owner:**	Dr. Michaell Rose	**Approved Amount:**	$19.0 Million
Payment Status:	Not Started				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
As part of the Comprehensive Quality Strategy and Population Health Management Policy Guide, DHCS is requiring all MCPs to reinvest a portion of their net income into community-driven solutions that address social drivers of health and reduce health disparities as follows: - 5% of the portion of annual net income that is less than or equal to 7.5% of revenue for the year; and - 7.5% of the portion of annual net income that is greater than 7.5% of revenue for the year.	- This Board action allocated funds for Community Reinvestment in CY 2024. No new investments are currently planned out of the remaining funds from this Board action as the program does not start until 2026. Separate Board actions will request any needed funding for the DHCS Community Reinvestment program. - On October 2, 2025, the Board approved reallocation of $19M from the existing $38M committed to the Community Reinvestment Program to fund the expanded Medi-Cal Eligibility Outreach Strategy. - The remaining funds will be returned to reserves for allocation to future community investments.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Establish Community Reinvestment Program internal and external stakeholder workgroups	Establish internal stakeholder workgroup by Q1 2025 and external stakeholder workgroup by Q3 2025.	Community Reinvestment Joint Internal and External Stakeholder Workgroup reconvened on January 12, 2026.
Develop Community Reinvestment Program activities and workplan	Community Reinvestment Program Workplan developed by Q2 2025.	Initial CR plan submission is due to DHCS in Q3 CY 2026.
Obtain stakeholder input on Community Reinvestment through engagement with Member/Provider Advisory Committees	Stakeholder committees convened for community input on investments	Presented and solicited feedback from MAC/PAC on 10/9/25, QIHEC on 10/14/25, Community Investment Oversight Committee on 10/24/25, Population Health Collaborative Committee on 2/4/26, and OC CHIP Steering Committee on 2/18/26.

Back to Agenda

CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	3/10/26	**Initiative Name:**	Garden Grove Recovery Center Development and Maintenance	**Start Date:**	9/1/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	7/1/27
Program Status:	In Progress	**Initiative Owner:**	Dr. Kelly Bruno-Nelson	**Approved Amount:**	$16.4 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Street Medicine Support Center is a service-enriched supportive housing facility focused on providing individuals enrolled in the Garden Grove Street Medicine Program with continued medical wraparound services, housing navigation, and Enhanced Care Management. These services will assist in retaining housing, improving health status, and maximizing the ability to live and (if applicable) work in the community. There will be 50 furnished, private rooms and an outdoor space for socialization and overall mental wellness.	Plans were submitted to the City of Garden Grove in July 2025. CalOptima Health is current awaiting results. Once approval from the City is obtained, next steps on the construction project will begin.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Secure architectural firm and complete design and plan approval process	Firm contracted and plans approved by City of Garden Grove	Plans were submitted to the City of Garden Grove in July 2025; currently awaiting reponses.
Complete construction	Certificate of Occupancy secured date	TBD
Secure a provider	Contract with provider successfully executed	TBD

Back to Agenda

CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	3/12/26	**Initiative Name:**	General Awareness and Brand Development	**Start Date:**	4/1/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	6/30/2026
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$4.7 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
To create and implement a General Awareness and Brand Development campaign that will support enhanced recognition of CalOptima Health's key role in the community, improve understanding of our values and vision, and better reach our members.	In March 2026, a refreshed Brand Awareness campaign was launched. The new ads strengthen and adapt brand messaging to reinforce CalOptima Health's role as Orange County's health care safety net, especially in response to evolving Medi-Cal policies. The ads underscore the importance of maintaining one's health coverage and leverage CalOptima Health's 30-year anniversary as a trusted community partner. A plan to spend the remaining $300,000 is targeted for June 2026.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Brand platform development and consulting	Research, strategy, brand messaging and design platforms, brand concept and guidelines	- Discovery sessions, secondary research and campaign strategy completed in Q1 (July-September 2025).
Campaign media buys	Media placements, monitoring and reporting	- Campaign will be featured in various digital and traditional media formats, including: programmatic display and video, connected TV, social media, radio and streaming audio, print (newspaper and other publications), and out-of-home (outdoor posters, transit shelters and OCTA buses).
Campaign creation and execution	Media plan, campaign development and campaign production	- Campaign concepting was completed Q2 (October-December 2025). - Campaign selection and most asset executions will be completed Q3 (January-March 2026). - The remaining assets (TV spots and out-of-home ads) will be completed in Q4

Back to Agenda

CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	3/11/2026	**Initiative Name:**	Homeless Prevention and Stabilization Pilot Program	**Start Date:**	1/1/2025
Reporting Period:	Oct-Dec (Q2)			**End Date:**	1/01/2028
Program Status:	In Progress	**Initiative Owner:**	Dr. Kelly Bruno-Nelson	**Approved Amount:**	$269,703
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
To evaluate the effectiveness of the Homeless Prevention and Stabilization program (HPSP) using a combination of administrative data and data from surveys that will be administered by faculty at the University of California, Irvine. Data will be collected for both the program participants (treatment group) and a sample of similar individuals not enrolled in the program (comparison group). HPSP aims to assist approximately 200 families and will be rolled out over a two-year period.	- The research group continues to survey Cohort 1 participants and comparison group, especially at the 12-month mark. - They are also recruiting participants into Cohort 2, which was just underway as report #2 was submitted. - During this reporting period for report #3, the research team has started on the data analysis activities of administrative court records and of administrative data from the Homeless Management Information System (HMIS). - Funds will continue to be distributed after reports have been received and reviewed.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Complete cohort baseline surveys; complete cohort 1 6-month surveys, and provide status update on data analysis and findings	Report #1	Submitted. As of June 1, 2025, the research team has received 148 completed baseline surveys for Cohort 1: 39 HPSP participants and 109 comparison group participants. As of June 1, 2025, there were 17 completed 6-month surveys; 10 for participants and 7 for control group. Analysis is underway.
Complete cohort 2 baseline surveys and provide status update on data analysis and findings	Report #2	Cohort 1: 85 families enrolled in HPSP, 45 baseline surveys and 136 for comparison group. For 6-month survey, 30 for HPSP and 70 for comparison. For 12-month surveys: 8 for HPSP and 2 for comparison. Cohort 2: 32 HPSP participants, 14 completed baseline survey and 121 for comparison group.
Complete cohort 1 18-month surveys, complete cohort 2 6-month surveys, and provide status update on the data analysis and findings	Report #3 and #4	Report 3 due June 30, 2026 Report 4 due November 30, 2026
Complete cohort 2 18-month survey ad provide a status report update on the data analysis and findings	Report #5	Report 5 due June 30, 2027
Provide a draft evaluation report and final evaluation report	Report #6 and #7	Report 6 due July 31, 2027 Report 7 due November 1, 2027

Back to Agenda

CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	3/6/2026	**Initiative Name:**	In-Home Care Pilot Program	**Start Date:**	9/1/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	8/31/2025
Program Status:	Complete	**Initiative Owner:**	Dr. Zeinab Dabbah	**Approved Amount:**	$2.0 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
CalOptima Health contracted with UCI to partner with home-based care Dispatch Health services to provide services to CalOptima Health members assigned to a UCI FQHC with acute medical needs. The program provided same-day high acuity care, focused medical intervention within 24 to 72 hours post discharge, and hospital-at-home alternative care in lieu of hospitalizations.	- The program supported 316 valid and reimbursable visits (out of 452). - CalOptima Health processed payment of $72,860 for validated member visits and services provided through 9/10/2025. UCI confirmed receipt in January 2026. - Due to low penetration rates, this program will be closed. - Remaining unspent funds as of 9/30/2025 - $1,927,140 will be returned to CalOptima Health funding source through COBAR in April. - Program and payment are complete. This report serves as the Final Report.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Improve access to in-home acute care	Number of members seen in in-home acute care	385 members seen in in-home acute care that were referred by UCI FQHCs
Reduce emergency department (ED) visits by 20%	Percentage of members seen through in-home acute care instead of ED	219 members seen in in-home care acute care
Achieve utilization of Dispatch Health by at least 10%	911 Diversion Rate	24.5% of members were diverted to Dispatch Health in place of 911 service
Reduce hospital observation stay by 10%	Observation Diversion Rate	5.8% of members seen by Dispatch Health were observed in ED
Reduce hospital admission by 10%	Hospital Diversion Rate	3.4% reduction of hospital admission for members seen by Dispatch Health

Back to Agenda

CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	3/12/26	**Initiative Name:**	Medi-Cal Eligibility Outreach Strategy	**Start Date:**	9/5/2025
Reporting Period:	Oct-Dec (Q2)			**End Date:**	12/31/2028
Program Status:	In Progress	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$19.8 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
This initiative builds upon a previous outreach initiative with the goal of informing the public and CalOptima Health members of Medi-Cal eligibility changes. The current initiative and outreach strategy is in response to upcoming federal and state legislative changes and will employ a multi-channel approach to identify and reach members in need of the information for continuity of Medi-Cal coverage.	- Funding has been allocated as follows: $5M for Community Enroller grants; $2M for funding SSA eligibility support; $0.8M for outreach; and $12M for future activities. - Staff have established a cross-functional workgroup to identify strategies and drive implementation to maximize coverage continuity for Medi-Cal members. - Updates on the Community Enrollers grant program will be provided separately.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Implement an integrated media campaign that includes print, radio, digital, and broadcast media outlets throughout Orange County	Research, strategy, and design media campaign	- Ad agency partner (Acento) was selected Q2 (October-December 2025). - Contract for ad agency was completed Q3 (March 2026). - Project kick-off meeting will occur March-April 2026.
Campaign media buys that include print, radio, digital, and broadcast media outlets	Media placements, monitoring, and reporting	Not started
Create and disseminate toolkit materials in multiple languages for use by providers, community health centers, community-based organizations, and other community stakeholders	Completion of toolkit	Not started
Implement appropriate interventions identified through HR1 Implementation Workgroup to decrease member disenrollment	Member retention rate	-Established HR1 Implementation Workgroup focusing on 5 key areas: policy and implementation, member communications and outreach, SSA collaboration and data sharing opportunities, data analytics, and call center preparedness.

Back to Agenda

CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	3/12/2026	**Initiative Name:**	Member and Population Health Needs Assessment	**Start Date:**	3/14/2025
Reporting Period:	Oct-Dec (Q2)			**End Date:**	7/31/2026
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$1.3 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Conduct a comprehensive Member and Population Health Needs Assessment (MPHNA) and Health Equity Asset Mapping (HEAM) to assess the whole-person health needs and preferences of CalOptima Health members, inform the development of programs and strategic initiatives and to meet the requirements of the Community Reinvestment program.	- Contract with NORC extended through 7/31/2026 to expand member reach and increase survey responses. - Member online survey closed on 1/23/2026 with sufficient responses to proceed. - A total of 11 focus groups and 22 interviews with key informants were completed 12/19/2025. - Development of the MPHNA report in progress. - A brief HEAM report analyzing gaps and barriers identified, with recommendations to be included in appendix of MPHNA report.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Support meeting the requirements of DHCS population health initiatives, e.g., Population Health Management Strategy, (PNA), and Medi-Cal Transformation initiatives.	Deployment of MPHNA	- Member online survey closed on 1/23/2026 with 1,858 completed member surveys. - A total of 11 focus groups and 22 interviews with key informants were completed on 12/19/2025.
Identify trends and opportunities in population health and social needs of CalOptima Health members.	MPHNA report findings produced	- Development of MPHNA draft report in progress; target delivery of final report in August 2026.
Identify assets and resources avaliable in the community and conduct gap analysis.	Detailed community asset mapping and list of community investment opportunities through an interactive dashboard produced	- Final version of HEAM completed on 1/30/2026. - HEAM report in progress. Final HEAM report will be included in appendix of MPHNA report.
Develop recommendations for interventions based on assessment findings.	Final report with actionable strategies and recommendations developed and presented	- MPHNA report in progress; target delivery of final report in August 2026.

Back to Agenda

CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	3/9/2026	**Initiative Name:**	OneCare Member Engagement and Education - Star Rating	**Start Date:**	06/26/2025
Reporting Period:	Oct-Dec (Q2)			**End Date:**	06/30/2026
Program Status:	In Progress	**Initiative Owner:**	Javier Sanchez	**Approved Amount:**	$300,000
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The goal of the OneCare Member Engagement and Education initiative is to develop a comprehensive outreach and engagement plan to maximize current OneCare members' engagement in order to improve OneCare star ratings. (Note: this is a pilot with a target of reaching 500 OneCare members.) CalOptima Health selected Wider Circle as the vendor partner to carry out this pilot project.	- Initiated community-based engagement, peer support, and ongoing member outreach to help members take preventive health actions. - Members are averaging 4-5 interactions with Wider Circle staff including initial outreach, follow up phone calls and/or event participation. - Focus remains on engaging members and assisting with SDOH referrals to resources along with gap closures for open quality measures. - Currently at maximum enrollment, based on contract. - Anticipating spending the entirety of the budgeted cost for Wider Circle during the remaining project months.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Improve from current Annual Wellness Visit completion rate of 36% to 66% or greater for the target population.	Annual Wellness Visit (AWV) completion rate	- AWV rate is at 43%. - Roughly 75% of enrolled members have indicated a positive health action, such as completion of AWV.
Improve from current voluntary disenrollment rate of 12% to 10-12% for the target population.	OneCare member attrition rate	The Member Attrition rate for this group will be provided in the next report.
Improve from current rate of 65% to 70% or greater for the target population.	Health Risk Assessment completion rate	- Initial and annual HRA completion rate is tracking about 70% on average. - Engaged members are taking action related to other health activities like controlling A1c and high blood pressure, as well as closing gaps in care like getting preventive screenings, based on claims supported validation.

Back to Agenda

CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	3/12/26	**Initiative Name:**	OneCare Outreach and Engagement Strategy	**Start Date:**	07/01/2024
Reporting Period:	Oct-Dec (Q2)			**End Date:**	6/30/2025
Program Status:	Complete	**Initiative Owner:**	Deanne Thompson	**Approved Amount:**	$1.0 Million
Payment Status:	Complete				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Expansion of the CalOptima Health OneCare outreach and engagement strategy to enroll and retain eligible CalOptima Health members who are also enrolled in Medicare.	- Funds are fully allocated and spent - outcomes are included below. - Program and payment are complete. This is the Final Report.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Increase outreach for CalOptima Health OneCare through continuous and heavy presence in the market with a full range of advertising tactics.	Number of media buys	- Launched in FY25 Q4: out-of-home, place-based ads at senior centers, pharmacies, clinics/point-of-care, grocery stores, Walmart stores, Western Union locations, restaurants, retail/recreation centers and digital bulletins. - Campaign was featured in 200 locations and over 800 digital screens.
Retain existing CalOptima Health OneCare members with targeted mailings.	Number of members retained	- In FY24, two retention mailers to members were sent out resulting in decreased disenrollment (i.e., increased retention) of 8.5% and 5.9%, respectively for April 2024 and June 2024.
Increase direct mail outreach to prospective OneCare members by customizing messages and segmenting the mailing.	Number of mailers sent to three segmented audiences (fee-for-service members, members of another Medicare Advantage plan, former OneCare members)	- This strategy was implemented in October 2024 with FY25 budget funds and in coordination with the new campaign roll out.

Back to Agenda

CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	3/12/2026	**Initiative Name:**	Provider Workforce Development	**Start Date:**	12/1/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	12/31/2030
Program Status:	In Progress	**Initiative Owner:**	Donna Laverdiere	**Approved Amount:**	$50.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Provider Workforce Development Initiative was approved to close gaps in Orange County's health care workforce and increase access to high-quality, equitable care for CalOptima Health members. The five initiatives include: educational investments to increase supply of health care professionals (non-physician), the Workforce Training & Development Innovation Fund, the Physician Recruitment Incentive Program, the Physician Loan Repayment Program, and the Orange County Health Care Workforce Development Collaborative.	- Grants Rounds 1 & 2: Educational investment and workforce training and development grants are on track. - Kicked off the Orange County Health Care Workforce Development Collaborative project on 2/11/2026 with the Orange County Department of Education (OCDE). - Stakeholders are currently being identified for invitation to participate in the collaborative; invitees will include educational institutions, providers organizations, organizations focusing on workforce development, and community partners. - The first of three collaborative Stakeholder meetings is scheduled for 4/21/2026.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Implement Physician Recruitment Incentive Program	Number of physicians recruited to close network gaps	- Reviewing data from internal stakeholders to inform program design, provider targeting, and evaluation criteria. Program planning currently in process. - Target implementation in Q3 of calendar year 2026.
Implement Physician Loan Repayment Program	Number of physicians receiving loan repayment awards	- On hold. Conducting further evaluation of this proposed program.
Develop Orange County Health Care Workforce Development Collaborative	Launch collaborative to increase the health care workforce in Orange County	- Kicked off the collaborative on 2/11/2026. - The collaborative will 1) deep-dive on workforce gap themes and barriers; 2) validate findings and strategic priority-setting; 3) identify actionable strategies to expand the workforce to improve access to care for Medi-Cal members.

Back to Agenda

CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	3/10/26	**Initiative Name:**	Supplemental Food Support for Medi-Cal Members	**Start Date:**	11/1/2025
Reporting Period:	Oct-Dec (Q2)			**End Date:**	2/28/2026
Program Status:	In Progress	**Initiative Owner:**	Dr. Kelly Bruno-Nelson	**Approved Amount:**	$8.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
In response to the Federal government shutdown in September 2025, CalOptima Health allocated up to $8 million to prevent CalOptima Health members from experiencing additional food insecurity: $1.5 million in grant agreements to two Orange County food banks; $6.5 million to provide members enrolled in SNAP a $25 nonmonetary grocery flex card.	- A total of 153,000 grocery gift cards were distributed in phases from 11/21/2025 to 12/5/2025. - 50.7% of eligible families successfully activated their cards, totaling 77,881 activations. - The project will end on 2/28/26 and unspent funds will be calculated at program end. - Reporting related to the grants will be provided separately.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Distribute grocery flex cards to CalOptima members enrolled in SNAP.	Number of cards activated	- 153,000 grocery gift cards were distributed - 50.7% of eligible families have activated their cards

Back to Agenda

CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	3/18/2026	**Initiative Name:**	Digital Transformation Strategy	**Start Date:**	2022
Reporting Period:	Oct-Dec (Q2)			**End Date:**	2027
Program Status:	In Progress	**Initiative Owner:**	Yunkyung Kim	**Approved Amount:**	$100.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Digital Transformation Strategy to enhance overall experience for members, providers, and employees by bridging technology and business areas, improving member and provider experience, operational effectiveness, and financial performance.	- Finance Dynamics went live on Nov. 3, a month ahead of schedule. - Customer Relations Management (CRM) went live on February 26th. - Data Masking was delayed to April to avoid impact to the CRM go-live.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Complete Digital Transformation projects on-time and within budget	95% of projects delivered on-time and within budget	- 42 of 50 (84%) DT projects have been completed to date. - 95% of these projects were delivered within planned schedule and budget. - Of the 8 remaining projects, 6 are in flight and 2 are being assessed to start in the next fiscal year.

Back to Agenda

CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	3/23/2026	**Initiative Name:**	Medi-Cal Provider Rate Increases	**Start Date:**	7/1/2024
Reporting Period:	Oct-Dec (Q2)			**End Date:**	12/31/2026
Program Status:	In Progress	**Initiative Owner:**	Yunkyung Kim	**Approved Amount:**	$526.2 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
Authorize the CEO to execute amendments to delegated Health Networks and specific CalOptima Health Medi-Cal FFS CCN/COD contracts that update contracted rates, effective 7/1/2024, and incorporate requirements to comply with DHCS mandated Targeted Rate Increases (TRI) and other regulatory and operational requirements, effective 1/1/2024. This initiative aims to improve quality outcomes through increased access, increased provider and member satisfaction (i.e. CAHPS measures), and decreased provider terminations due to non-market competitive rates.	-Continue to trend provider retention and termination to determine causes. -Continue to work with Health Networks and providers on initiatives to improve access to care and HEDIS measures. Results for MY2024 in comparison to MY2023 show improvement. -MY2025 rates to be reported no later than June 15, 2026. -Vendor survey results delivered March 2026. Survey result analysis in progress.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Maintain and increase members' access to care.	Maintain and enhance network adequacy.	Since the rate increase, expanded the network with the addition of: - More than 900 Specialty Physicians into the Medi-Cal network - More than 500 Behavioral Health providers - 4 new FQHCs
	Increase timely access to care for members.	Contracted with a vendor to provide education and resurvey providers for timely compliance. The vendor is in process of fielding the survey; various interventions are occurring with providers and HNs to improve member satisfaction and timely compliance.
Maintain and increase quality of care for members.	Increase quality scores through the 2024 HEDIS and Quality Scores.	- MY2023 to MY2024 reflected improvement by 3% in aggregate for 16 HEDIS measures, while the scoring for 7 CAHPS measures remained the same. - MY2025 rates to be reported no later than June 15, 2026.
Improve provider satisfaction.	Increase provider satisfaction scores.	Vendor survey results delivered March 2026. Survey result analysis in progress.

Back to Agenda

CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	3/12/26	**Initiative Name:**	Skilled Nursing Facility Access Program	**Start Date:**	1/1/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	12/31/2026
Program Status:	In Progress	**Initiative Owner:**	Dr. Zeinab Dabbah	**Approved Amount:**	$10.0 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Skilled Nursing Facility (SNF) Access Program aims to enhance quality through better access and further strengthen the safety net system across Orange County for medically complex individuals transitioning from the hospital to home, or from one care setting to another. It will establish a dedicated Skilled Nursing Facility team. The goal is to assist in recovery by providing the necessary nursing and rehabilitative care to help members regain independence and facilitate safe discharge.	- Identified and amended contract with the largest independent hospitalist and SNFist group Southern California Hospitalist Netwtork (SCHN); Launch date is March 16,2026. - Identified and partnered with 21 contracted SNF facilities to be included in program. - Developed workflow and clinical pathways for smooth operational transition for members from inpatient acute facilities to pilot SNFs, with buy-in and support from contracted hospitals to participate in program. - Developed a pay-for-performance SNF contract. - Weekly meetings with CalOptima Health clinical staff, SNFists and SNF personnel to ensure progress and engagement; monthly meetings with SCHN and CalOptima Health leadership to address any challenges.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Launch SNFist program to contracted Facilities	Contract with SNFist group	- Contract Amendment completed 2/18/26, effective March 1, 2026. - 21 facilities participating.
Reduce length of stay (LOS) at SNF to allow for increased bed capacity	Reduce SNF LOS to average LOS of 14 days or less (current 24) at participating SNFs	TBD - Quarterly review of LOS to be conducted
Reduce unnecessary hospital readmissions	Reduce Average Hospital Readmission Rate from SNF to less than 14% per quarter	TBD - Quarterly review of readmission rates to be conducted

Back to Agenda

CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	3/10/2026	**Initiative Name:**	Comprehensive Community Cancer Screening and Support Program	**Start Date:**	12/02/2022
Reporting Period:	Oct-Dec (Q2)			**End Date:**	12/31/2027
Program Status:	In Progress	**Initiative Owner:**	Dr. Richard Pitts	**Approved Amount:**	$50.1 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Comprehensive Community Cancer Screening and Support Program aims to create a culture of cancer prevention, early detection and collaboration with partners to work towards a shared goal of dramatically decreasing late-stage cancer incidence and ensuring that all Medi-Cal members have equitable access to high quality care.	- Accomplishments include: 1) Conducted in-person Member Success Story meeting in 11/2025. 2) Launched 2-way texting campaign for lung cancer screening campaign, which included measure of "DONE" responses. 3) Coordinated 4 mobile mammography events with Alinea and health clinics - 102 members screened. - This program includes the award of 15 grants to partner organizations totaling $16.4 million. Reporting for these grants will be provided separately. - Staff are actively exploring potential new interventions to help sustain ongoing efforts.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Increase community and member awareness and engagement	Develop and launch a multimedia, multilingual campaign within the first four years of the program (*Data provided by Maricich)	67 million campaign digital ad impressions; 0.30% Click-through rate (CTR); 24.3 million digital added value impressions; 10.7 million completed video views; 184K digital clicks to landing page
Increase access to cancer screening for eligible member	Develop and implement a community grant initiative by year two of the Cancer Screening and Support program	Round 1 grants launched in 9/2024 and has wrapped up by end of 12/2025. All 15 grantees have actively worked to increase access to cancer screening services in year 1. Round 2 grants successfully began in 1/2026 and all 15 grants will continue to increase access to screening services and improve screening rates.
	# of CalOptima members who received appropriate cancer screening	BCS (Breast Cancer Screening): 7,279 CCS (Cervical Cancer Screening): 13,546 COL (Colorectal Cancer Screening): 14,125 Lung (Lung Cancer Screening): 633
Improve quality and member experience during cancer screening and treatment procedures	Extend vendor contract(s) to support members through screening, diagnosis and cancer treatment starting in Year 2	Community grants are supporting this metric: mPulse is outreaching to members via text for general cancer awareness, screening information, and support during treatment.
	Establish contract to evaluate cancer incidence, experiences, and genomic technologies to reduce disparities in late-stage cancer diagnosis by Year 2	Actively working with UCI Chao Family Center to identify priority focus areas to enhance the community cancer screening program. Although it was initially planned to refine the SOW for the research and evaluation initiative, due to time constraint, this initiative may not be launched.

Back to Agenda

CalOptima Health

Board-Approved Initiative Status and Impact Summary

Report Date:	3/12/2026	**Initiative Name:**	Five-Year Hospital Quality Program	**Start Date:**	1/1/2023
Reporting Period:	Oct-Dec (Q2)			**End Date:**	12/31/2028
Program Status:	In Progress	**Initiative Owner:**	Linda Lee	**Approved Amount:**	$153.5 Million
Payment Status:	In Progress				

INITIATIVE OVERVIEW

Program Description *(Overview of initiative describing overall goal, purpose, and benefits)*	**Critical updates and next steps** *(e.g. key accomplishments, opportunity to scale or meet goals faster, issues identified and mitigation plan)*
The Hospital Quality Program for CalOptima Health-contracted hospitals aims to improve quality of care to members through increased quality and patient safety efforts. Program goals: 1) Support hospital quality standards for Orange County; 2) Provide industry benchmarks and data-driven feedback; 3) Recognize hospitals demonstrating quality performance; 4) Provide comparative information on network hospitals; and 5) Identify areas for improvement.	Measurement year 2024 performance score cards were developed and distributed to contracted hospitals in Q4 2025. Incentive payments were distributed in Q1 2026.

OUTCOMES

Objective *(Results to be achieved by the initiative)*	**Metric** *(Quantifiable measure to track and assess progress)*	**Results** *(Current state or progress)*
Reward contracted Medi-Cal hospitals for high performance on hospital quality of care, patient experience, and hospital safety using CMS hospital quality and Leapfrog patient safety measures.	The percentage of contracted hospitals earning hospital quality incentives. Metric equals number of hospitals earning any incentive amount divided by number of eligible contracted hospitals.	70% (20/28) of contracted hospitals earned incentives.
	The percentage of hospital quality dollars awarded. Metric equals total incentives awarded divided by total annual incentive pool.	56% ($16,737,814/$30,000,000) of hospital quality dollars were awarded.
Improve hospital quality	Star Rating	Two hospitals achieved 5 stars. Five hospitals received 4 stars. 4 hospitals received 3 stars. Five hospitals received 2 stars. One hospital received 1 star. 18 hospitals had reportable results.
Improve hospital patient experience	Star Rating	Zero hospitals achieved 5 stars. One hospital received 4 stars. Ten hospitals received 3 stars. Six hospitals received 2 stars. Two hospitals received 1 star. 19 hospitals had reportable results.
Improve hospital patient safety	Safety Grade	Eight hospitals achieved a safety grade of A. Four hospitals received a safety grade of B. Seven hospitals received a safety grade of C. One hospital received a safety grade of D. 20 hospitals had reportable results.

Back to Agenda

Hospital Performance Measurement Year 2024

Hospitals	2024				
	Hospital Quality Stars Rating	Hospital Patient Survey Rating	Leapfrog Hospital Safety Grade	Maximum Incentive Possible	Incentive Earned
Anaheim Global Medical Center	N/A	N/A	C	$297,814	$29,781
Anaheim Regional Medical Center	3	2	B	$1,166,360	$408,226
Chapman Global Medical Center	1	2	C	$147,516	$14,752
Children's Hospital of Orange County	5	3	A	$3,467,166	$2,773,733
Foothill Regional Medical Center	N/A	1	N/A	$841,665	$0
Hoag Memorial Hospital Presbyterian	5	3	A	$2,247,838	$1,798,271
Long Beach Memorial Medical Center	2	3	C	$153,211	$45,963
Memorial Care Orange Coast Medical Center	3	3	B	$875,167	$481,342
Memorial Care Saddleback Medical Center	4	4	A	$373,293	$298,635
Orange County Global Medical Center	2	1	C	$2,078,340	$207,834
Pomona Valley Hospital Medical Center	3	3	A	$45,685	$27,411
Providence Mission Hospital	4	3	A	$1,265,808	$886,065
Providence St. Joseph Hospital	4	3	C	$3,393,805	$2,036,283
Providence St. Jude Medical Center	4	3	A	$1,239,588	$867,712
South Coast Global Medical Center	N/A	N/A	C	$318,206	$31,821
UCI – Fountain Valley	2	2	C	$805,911	$80,591
UCI – Los Alamitos	3	2	D	$98,521	$19,704
UCI Medical Center	4	3	A	$9,237,655	$6,466,359
UCI – Placentia Linda	2	2	B	$69,388	$10,408
UCSD Medical Center – San Diego	5	3	B	$323,636	$242,727
Whittier Hospital Medical Center	2	2	A	$50,982	$10,196
TOTALS				**$28,497,555**	**$16,737,814**

Back to Agenda



FY 2025 - 2027 Strategic Plan and Performance Metrics Report

Strategic Development

Date Last Updated: **07/22/2026**

Back to Agenda

CalOptima Health

FY 2025 - 2027 Strategic Plan and Performance Metrics Report

Executive Status Report - June 2026

Goal	3-Year Performance Metric	Owner	Actual	3-Year Target
1.1	Glycemic Status Assessment for Patients With Diabetes (GSD) - Medi-Cal	Kelly Giardina	51.74%	27.98%
1.1	Glycemic Status Assessment for Patients With Diabetes (GSD) - OneCare	Kelly Giardina	57%	92%
1.2	Percentage of members successfully enrolled in Complex Case Management	Kelly Giardina	0.03%	0.04%
1.3	Initial Health Appointment (IHA) Completion Rate - Medi-Cal	Kelly Giardina	34%	40%
1.3	Annual Wellness Visit (AWV) Completion Rate - OneCare	Kelly Giardina	28%	70%
1.4	Number of Community-Based Organizations (CBOs) participating in prevention campaigns and quality care gap closures	Marie Jeannis	33	10
2.1	Medi-Cal Star Rating	Linda Lee	4.0	4.0
2.1	Medicare Star Rating	Linda Lee	3.0	3.5
2.2	Quarterly count of grievances related to Access and Availability	Michael Gomez	854	640
2.3	Overall provider satisfaction rate	Michael Gomez	TBD	70%
2.4	Percentage of Follow-Up After Emergency Department Visit for Mental Illness (FUM) within 30 days	Carmen Katsarov	33th	50th
3.1	Number of members served through Street Medicine	Dr. Kelly Bruno-Nelson	1,200	750
3.2	Number of individuals who attend or participate in community listening sessions, focus groups, or stakeholder engagement sessions	Marie Jeannis	1,517	250
3.3	Percentage of net income allocated to community investments in health equity, prevention, and access to care	Donna Laverdiere	9.7%	7.5%
3.4	Percentage of grant agreements on track and in compliance with program objectives and budget expenditures	Dr. Kelly Bruno-Nelson	94%	90%

Goal	3-Year Performance Metric	Owner	Actual	3-Year Target
4.1	Treatment authorization processing time (business days) for all providers (Routine)	Kelly Giardina	1.17	1.63
4.1	Treatment authorization processing time (business days) for all providers (Urgent)	Kelly Giardina	0.36	0.61
4.2	Claims auto-adjudication rate - Medi-Cal	Ladan Khamseh	83%	84%
4.2	Claims auto-adjudication rate - OneCare	Ladan Khamseh	72%	79%
4.3	Membership growth by Line of Business - OneCare	Javier Sanchez	19,034	30,000
4.3	Membership growth by Line of Business - PACE	Javier Sanchez	578	700
4.3	Membership growth by Line of Business - Covered CA	Donna Laverdiere	TBD	20,000
4.4	Voluntary Disenrollment rate	Javier Sanchez	5.74%	5.00%
4.5	Percentage of Digital Transformation projects completed on time and within budget	Kathleen Linder	82%	95%
4.6	CAHPS Rating of Health Plan	Ladan Khamseh	3.0	4.0
4.7	Quarterly Administrative Loss Ratio measure	Nancy Huang	5.2%	7.0%
4.8	Percentage of open positions filled by qualified internal candidates	Steve Eckberg	49%	50%

Back to Agenda

CalOptima Health

FY 2025 - 2027 Strategic Plan and Performance Metrics Report

Executive Status Report - June 2026

1.0 Equity and Population Health

CalOptima Health will infuse the pursuit of health equity throughout our work and will continue to innovate and develop tools and interventions that advance the physical, behavioral, and social health of our members.

Organization Goal	3-Year Performance Metric	Owner	Key Highlights To-Date	Actual	3-Year Target	Notes
1.1 Utilize technology and innovation to strengthen equity and population health management programs.	Glycemic Status Assessment for Patients With Diabetes (GSD) - Medi-Cal	Kelly Giardina	•Expanded internal and Health Network Disease Management program and launched member outreach list in April 2026. •TeleMed2U endocrinology telehealth pilot for diabetic members launched April 2026. •Multilingual text outreach to members to encourage diabetes testing. •Note: The GSD measure typically starts low early in the year and rises over time as more members complete A1c screenings within the target range.	51.74%	27.98%	• Target based on 66th percentile. This metric was revised in December 2025 to ensure alignment with appropriate diabetes measure. • Inverse Measure (Lower is Better)
1.1 Utilize technology and innovation to strengthen equity and population health management programs.	Glycemic Status Assessment for Patients With Diabetes (GSD) - OneCare	Kelly Giardina	•Projected rate at year-end is 90%, 4-Stars. •Expanded internal and Health Network Disease Management program and launched member outreach list in April 2026. •TeleMed2U endocrinology telehealth pilot for diabetic members launched 4/2026. •Multilingual text outreach to members to encourage diabetes testing. •Note: The GSD measure typically starts low early in the year and rises over time as more members complete A1c	57%	92%	• Target based on 5-Stars. This metric was revised in December 2025 to ensure alignment with appropriate diabetes measure.
1.2 Implement a consistent model of care for population health/care management, including delegated networks.	Percentage of members successfully enrolled in Complex Case Management	Kelly Giardina	•Review and oversight of current Complex Case Management (CCM) enrollment numbers in Health Network Joint Operation meetings. •Training meetings with CalOptima Health Community Network (CCN), Providence, and AltaMed. •Expectations and progress towards improvement including the Member Satisfaction Survey results discussed in clinical health network oversight quarterly meetings and bi-weekly forums. •Direct network on target (0.05%).	0.03%	0.04%	• .05% = approximately 400 members. Targets set at 0.03% in year 1, 0.04% in year 2, and 0.05% in year 3.
1.3 Annually assess members' health and social needs and utilize data to develop targeted interventions.	Initial Health Appointment (IHA) Completion Rate - Medi-Cal	Kelly Giardina	•Updating the auto-assignment process to reduce the timeframe for members to be assigned to Health Network and Primary Care Provider; effective July 1, 2026. •Expanding data input through Initial Health Appointment (IHA) measure in Cozeva; effective January 1, 2027. •Updated IHA Policy and Procedure to include OneCare members (DHCS APL 26-001). •Monthly text campaigns for IHA.	34%	40%	
1.3 Annually assess members' health and social needs and utilize data to develop targeted interventions.	Annual Wellness Visit (AWV) Completion Rate - OneCare	Kelly Giardina	•Updating the auto-assignment process to reduce the timeframe for members to be assigned to Health Network and Primary Care Provider; effective July 1, 2026. •Monthly text campaigns for Annual Wellness Visits.	28%	70%	
1.4 Increase access to preventive services for vulnerable populations in pursuit of health equity.	Number of Community-Based Organizations (CBOs) participating in prevention campaigns and quality care gap closures	Marie Jeannis	•Met with American Cancer Society (ACS), Boys & Girls Club (BGC) and Second Baptist Church (SBC) to co-develop HPV prevention outreach strategies. •HPV Campaign launched via social media in February 2026. •Attended two community events with BGC and SBC to field test the HPV flyer. •Developed member newsletter article and culturally responsive messaging for social media with the ACS and CA Dept. of Public Health.	33	10	

Back to Agenda

CalOptima Health

FY 2025 - 2027 Strategic Plan and Performance Metrics Report

Executive Status Report - June 2026

2.0 Quality and Value

CalOptima Health is committed to providing the highest quality physical, behavioral, and social health care to our members and to ensuring sound stewardship of public dollars by achieving greater value.

Organization Goal	3-Year Performance Metric	Owner	Key Highlights To-Date	Actual	3-Year Target	Notes
2.1 Achieve NCQA rating of 4-stars for Medi-Cal. Achieve CMS rating of 3.5-stars for Medicare.	Medi-Cal Star Rating	Linda Lee	•Continue to implement initiatives to improve clinical and member experience measures. •Deployed Cozeva data exchange and provider electronic health record (EHR) integration.	**4.0**	**4.0**	
2.1 Achieve NCQA rating of 4-stars for Medi-Cal. Achieve CMS rating of 3.5-stars for Medicare.	Medicare Star Rating	Linda Lee	•Continue to implement initiatives to improve high priority measures. •Expand at-home visit program. •Deployed Cozeva data exchange and provider electronic health record (EHR) integration.	**3.0**	**3.5**	
2.2 Improve access to care by strengthening the delivery system through provider support and workforce initiatives.	Quarterly count of grievances related to Access and Availability	Michael Gomez	•CalOptima Health has established a Network Adequacy workgroup comprised of leadership from various departments. •Grievances related to Network Adequacy will be presented at the Network Adequacy workgroup scheduled July 27, with next steps to be identified by the workgroup.	**854**	**640**	• Inverse Measure (Lower is Better)
2.3 Increase provider engagement through improved provider tools, data exchange, and collaboration.	Overall provider satisfaction rate	Michael Gomez	•Launched 100 day RX supply and the members with elevated A1C reports in the Provider Portal. •Added additional trainings and attestations through the Provider Portal. •Uploaded the Pay for Value (P4V) Manual to the Provider Portal. •Quality Improvement is supplying Provider Relations with Gaps in Care reports to review with providers at office visits. •Rolling out the Cozeva connectivity within the Provider Portal to improve data.	**TBD**	**70%**	• New Measure - no data available at this time
2.4 Expand the delivery of Behavioral Health services, invest in the workforce, and drive quality improvement through innovation.	Percentage of Follow-Up After Emergency Department Visit for Mental Illness (FUM) within 30 days	Carmen Katsarov	•TELEMED2U completed over 6,000 visits from April -June 2026. (Year 3 of contract). •Follow-Up after Emergency Department Visit for Mental Illness (FUM) 30 Day prospective rate had a 8.97% increase from 30.77% (March) to 39.74% (May). •Over $574,706 paid out to school districts for Mental Health services through DHCS school fee schedule, to provide increased access to services that are free for students.	**33th**	**50th**	• Percentile based HEDIS benchmarks

Back to Agenda

CalOptima Health

FY 2025 - 2027 Strategic Plan and Performance Metrics Report

Executive Status Report - June 2026

3.0 Community Partnerships and Investments

CalOptima Health will continue to demonstrate our partnership with Orange County members, providers, county agencies, and community organizations through Medi-Cal Transformation programs and robust community investments and partnerships to advance health equity.

Organization Goal	3-Year Performance Metric	Owner	Key Highlights To-Date	Actual	3-Year Target	Notes
3.1 Expand social support services through Medi-Cal Transformation and other social health initiatives.	Number of members served through Street Medicine	Dr. Kelly Bruno-Nelson	•As of June 2026, there were 460 members enrolled in CalOptima Health's Street Medicine Program. •58 individuals have been permanently housed since program inception (April 2023). •96% of enrolled members have an active relationship with their Primary Care Physician. •CalOptima Health released a Notice of Opportunity to expand the Street Medicine Program into a City Collaborative in June 2026.	**1,200**	**750**	
3.2 Expand community involvement in co-creation of solutions that best serve members.	Number of individuals who attend or participate in community listening sessions, focus groups, or stakeholder engagement sessions	Marie Jeannis	•Health Equity Community Stakeholder Workgroup (HECSW): Engaged 95 individuals to develop strategies to minimize Medi-Cal coverage loss. •Collaborated with HECSW partners, Center for Asian Americans in Action, Coalition of OC Community Health Centers, Kaiser Permanente, OC Health Care Agency, and Social Services Agency to co-design meeting facilitation approach and materials. •Developed a Drivers of Change diagram with strategies to increase navigator resources on access, retention, work requirements, and redetermination. •Completed and collected 415 community member surveys, five focus groups reaching 91 individuals, and 20 interviews with CBO staff for the Community Resource Center.	**1,517**	**250**	
3.3 Prioritize community investments that advance health equity, drive prevention, and improve access to care.	Percentage of net income allocated to community investments in health equity, prevention, and access to care	Donna Laverdiere	•Ongoing monitoring of board-approved initiatives; closed out a total of 7 initiatives with unspent balance during Apr-Jun period, totaling $23M returned to funding source for potential new initiatives or future reallocation. •Member and Population Helath Needs Assessment report in development, with release targeted in August 2026; findings and recommendations will inform community investments for fiscal year 2027. •Community Reinvestment Plan for CY2024 has been met through voluntary investments, with a total of $13M.	**9.7%**	**7.5%**	
3.4 Ensure that all community investment programs include clear accountability metrics and regular performance monitoring requirements.	Percentage of grant agreements on track and in compliance with program objectives and budget expenditures	Dr. Kelly Bruno-Nelson	•Awarding grants through the (1) MY2024 Quality Improvement Grant Program, (2) Community Enrollers Round 3 and (3) Equity and Practice Transformation Notice of Funding Opportunities. •Housing and Homeless Incentive Program Round 6 NOFO launched in May 2026. •COBAR was approved to launch the City Health Improvement Grant opportunity in June 2026.	**94%**	**90%**	

Back to Agenda

CalOptima Health

FY 2025 - 2027 Strategic Plan and Performance Metrics Report

Executive Status Report - June 2026

4.0 Operations, Finance and People

CalOptima Health's continued investment in our performance and people are vital to ensuring the highest level of care and service to our members across their lifespan.

Organization Goal	3-Year Performance Metric	Owner	Key Highlights To-Date	Actual	3-Year Target	Notes
4.1 Improve the turnaround time for treatment authorization for direct and delegated networks.	Treatment authorization processing time (business days) for all providers (Routine)	Kelly Giardina	•TeleMed2U effective April 1, 2026 . •Adjusted staff schedules to align with weekday v. weekend volumes. •Implemented a Continuity of Care (COC) indicator to ensure prioritization for timely processing.	**1.17**	**1.63**	• Inverse Measure (Lower is Better)
4.1 Improve the turnaround time for treatment authorization for direct and delegated networks.	Treatment authorization processing time (business days) for all providers (Urgent)	Kelly Giardina	•TeleMed2U effective April 1, 2026. •Adjusted staff schedules to align with weekday v. weekend volumes. •Implemented a Continuity of Care (COC) indicator to ensure prioritization for timely processing.	**0.36**	**0.61**	• Inverse Measure (Lower is Better)
4.2 Improve the turnaround time for claims payment for direct and delegated networks.	Claims auto-adjudication rate - Medi-Cal	Ladan Khamseh	•As of June 2026, rate remains steady at 83% as Claims and IT teams continue to automate manual processes using logic enhancements in Facets.	**83%**	**84%**	
4.2 Improve the turnaround time for claims payment for direct and delegated networks.	Claims auto-adjudication rate - OneCare	Ladan Khamseh	•As of June 2026, rate is 72% as Claims and IT teams continue to automate manual processes using logic enhancements in Facets.	**72%**	**79%**	
4.3 Launch and grow programs that take care of our members and their families across their lifespan.	Membership growth by Line of Business - OneCare	Javier Sanchez	•Increased broker engagement, leading to net positive growth. •Started the year with membership of 18,532.	**19,034**	**30,000**	
4.3 Launch and grow programs that take care of our members and their families across their lifespan.	Membership growth by Line of Business - PACE	Javier Sanchez	•PACE Garden Grove: Enrollment census reached 578 members as of June (max capacity: 625); 47 spots remain, with capacity expected to be reached in ~3-4 months at the current growth rate. •Expansion Planning: Staff have successfully identified a second PACE location in Irvine. The building purchase is currently in escrow.	**578**	**700**	
4.3 Launch and grow programs that take care of our members and their families across their lifespan.	Membership growth by Line of Business - Covered CA	Donna Laverdiere	•Met with Covered CA leadership to discuss Qualified Health Plan (QHP) submission and rate negotiation. •Continued to respond to DMHC comments to advance licensure process. •Drafted internal staff training to launch prior to go-live. •CalOptima's participation was announced on 7/21/26 by Covered California; QHP contract will be presented for approval at the August Board.	**TBD**	**20,000**	• New Measure - no data available at this time

Back to Agenda

CalOptima Health

FY 2025 - 2027 Strategic Plan and Performance Metrics Report

Executive Status Report - June 2026

4.0 Operations, Finance and People

CalOptima Health's continued investment in our performance and people are vital to ensuring the highest level of care and service to our members across their lifespan.

Organization Goal	3-Year Performance Metric	Owner	Key Highlights To-Date	Actual	3-Year Target	Notes
4.4 Optimize the Medicare line of business to improve the member retention rate and support growth.	Voluntary Disenrollment rate	Javier Sanchez	•Over the course of the year, Wider Circle has enrolled 693 OneCare members. •As of July 2026, members have completed 7,173 total interactions across 721 unique members. •Monitoring gap closures for annual wellness visit, managing blood pressure and monitoring blood sugar levels. Q1 results, using claims validation, show that the Wider Circle program is moving the needle on all three measures.	**5.74%**	**5.00%**	• Overall target is <5% for each calendar year end • Inverse Measure (Lower is Better)
4.5 Implement the comprehensive Digital Transformation strategic roadmap to improve member experience and efficiency.	Percentage of Digital Transformation projects completed on time and within budget	Kathleen Linder	•On track to finish Digital Transformation initiatives planned in FY2027. •Selected future state HR platform and completed contracting. •Launched data platform and provider credentialing system RFPs. •Continued data masking effort focusing on initial migration and ongoing operations planning.	**82%**	**95%**	• Rolling data based on project completion
4.6 Optimize member engagement functions to improve member retention, satisfaction, and outcomes.	CAHPS Rating of Health Plan	Ladan Khamseh	•Voluntary Disenrollment Survey: Outreach to members who are disenrolling from OneCare. The targeted member count was 502,93 surveys were completed, and 19% response rate. 12 members ultimately chose not to disenroll from OneCare. •Customer Service After-Call Survey: Q2 Overall Satisfaction achieved a rate of 94.7%, based on 2,084 distributed surveys. Of these, 712 were completed, representing a response rate of 32.2%.	**3.0**	**4.0**	
4.7 Ensure fiscal accountability and stewardship, including a balanced operating budget, quarterly budget reconciliation, and vendor and provider contracting.	Quarterly Administrative Loss Ratio measure	Nancy Huang	•Actual Administrative Loss Ratio (ALR) is 5.2% as of June 2026.	**5.2%**	**7.0%**	• Inverse Measure (Lower is Better)
4.8 Launch expanded employee development and retention efforts to drive employee engagement and advancement.	Percentage of open positions filled by qualified internal candidates	Steve Eckberg	•HR strategic plan for FY27 includes two focus areas to increase the pool of internal qualified candidates: development and retention. •Employee development programs equip current staff with skills needed for future roles or advancement. •Increasing awareness of the value of CalOptima Health employment to minimize voluntary turnover.	**49%**	**50%**	

Back to Agenda

Member Grievances and Appeals Report First Quarter 2026

Board of Directors Meeting

August 6, 2026

Heather Sedillo, Director, Grievance and Appeals Resolution Services (GARS)

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.

Definitions

- Grievance: An expression of dissatisfaction with any aspect of a CalOptima Health program, provider or representative.

- Appeal: A request by the member or on the member's behalf for the review of any decision to deny, modify, or discontinue a covered service.

Back to Agenda

Grievances

Back to Agenda

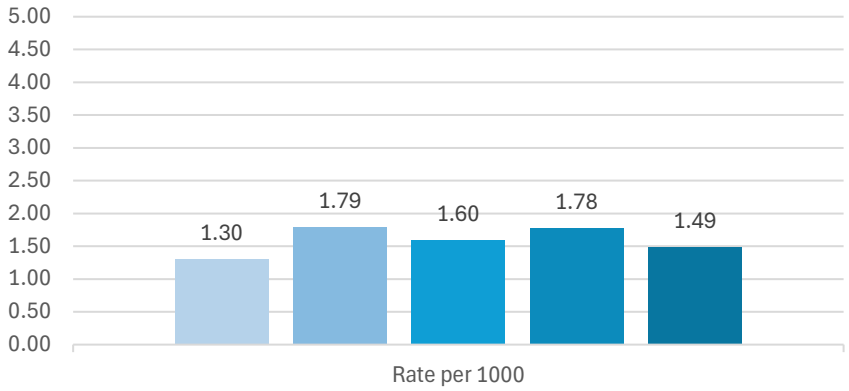
Grievances Q1 2026 Summary

- Total grievance volume (Customer Service + GARS) decreased from 5,200 in Q4 to 4,925 in Q1.
- CCN remained the highest-volume Health Network, with top grievance drivers being Provider / Staff Attitude, Authorizations, and Plan Customer Service.
- In Q1, from the members with multiple grievances presented in Q4, there was a decrease of 61% of grievances submitted in Q1 from that group of members.
- Grievance category drivers in Q1 were Provider Services, Plan Customer Services, and Delay in Referral by Provider which was consistent with what we presented in Q4.
- Discrimination grievances increased, from 40 in Q4 to 50 in Q1.

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Grievance Volume by Line of Business (LOB)

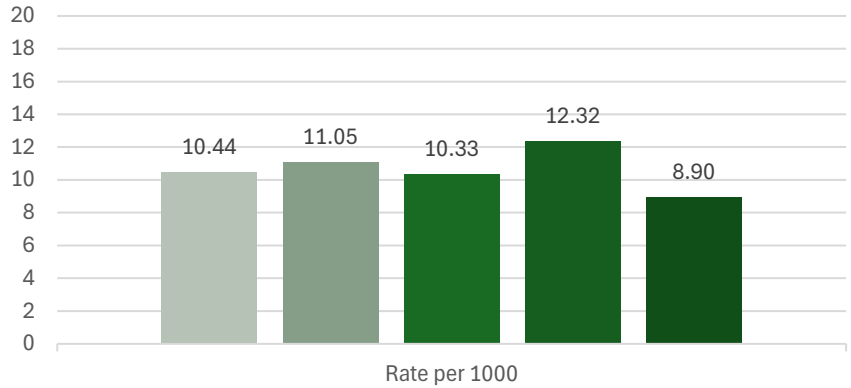
Medi-Cal
Rate per 1,000 Member Months



Total Grievances

Timeframe	Total Grievances
Q1 2026	4,023
Q4 2025	4,554
Q3 2025	4,781
Q2 2025	4,778
Q1 2025	3,958

OneCare
Rate per 1,000 Member Months



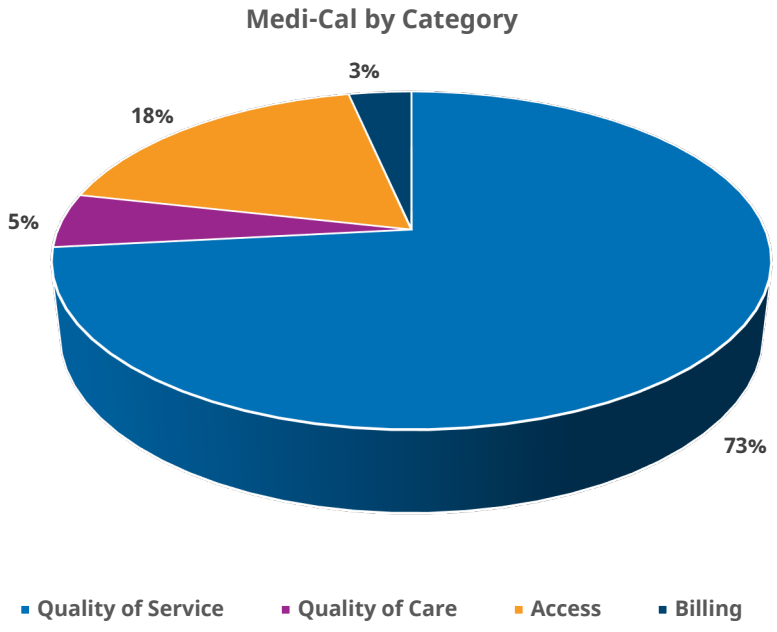
Total Grievances

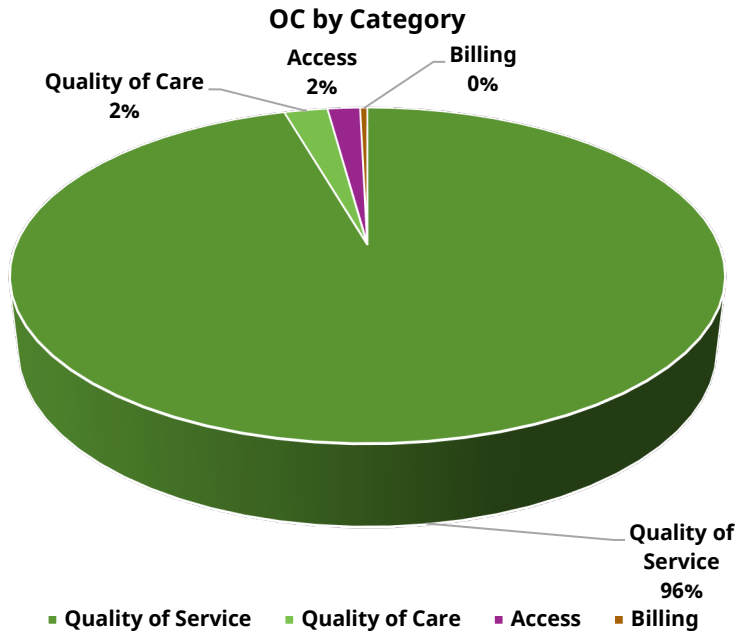
Timeframe	Total Grievances
Q1 2026	902
Q4 2025	713
Q3 2025	643
Q2 2025	574
Q1 2025	552

Note: Totals on this slide include Customer Service and GARS data.

Back to Agenda

Medi-Cal and OneCare Q1 2026 Grievance Type by Category





Keynote:
The Nurse Specialist triage process continues to improve the identification of true Quality-of-Care cases, resulting in more accurate categorization and a quarter-over-quarter decline in QOC classifications.

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Back to Agenda

Grievance Trends for Q1 2026

Medi-Cal- Quality of Service

Trend	Percentage of Total Volume
Provider Services	19% (498)
Plan Customer Services	14% (358)
Delay in Referral by Provider	10% (271)

Medi-Cal- Access

Trend	Percentage of Total Volume
Appointment Availability	25% (160)
Telephone Accessibility	16% (101)
Delay in Referral Provider	10% (63)

OneCare- Quality of Service

Trend	Percentage of Total Volume
Transportation NMT	16% (76)
Provider Services	11% (53)
Gift Card Related	9% (44)

OneCare- Access

Trend	Percentage of Total Volume
Telephone Accessibility	33% (3)
Appointment Availability	33% (3)

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Back to Agenda

Actions Taken in Response to Trends

- Trends identified
  - Medi-Cal grievances about provider services.
  - OneCare grievances about transportation providers.

- Actions Taken
  - Collaborated with the Provider Action Workgroup to review providers with 10+ grievances; service issues included Telephone Accessibility, Appointment Availability, and Provider Staff. Provider Relations receives these reports for awareness and follow-up.
  - Ongoing collaboration with the transportation vendor through recurring meetings to address on-time performance, root causes, and strengthen monitoring. Members identified with multiple transportation-related grievances were added to escalation monitoring for enhanced oversight and timely service improvement.

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Appeals

Back to Agenda

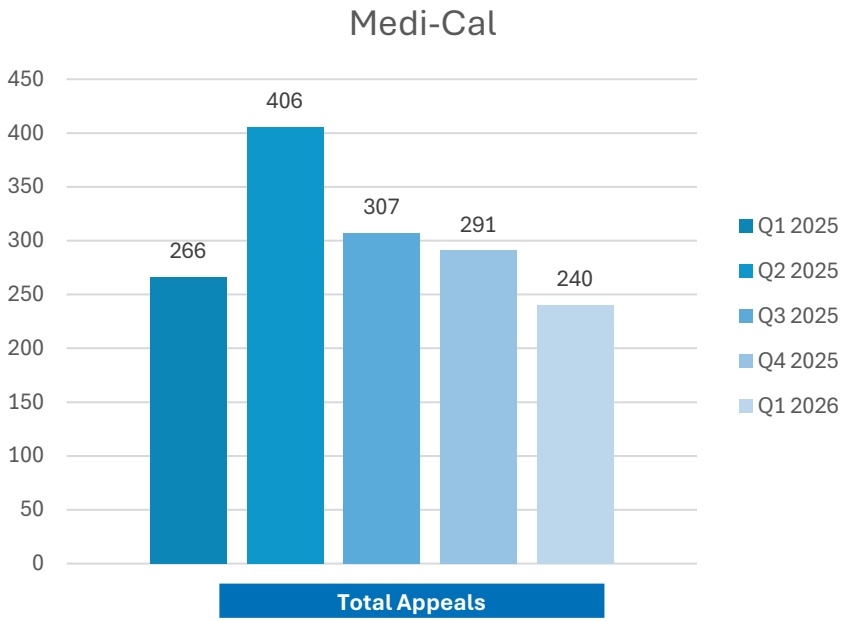
Appeals Q1 2026 Summary

- Medi-Cal and OneCare appeals volume decreased by 70 from Q4 to Q1, with 100% compliance and an average turnaround time (TAT) of 27 days for case closures.
- Top overturn reasons: Criteria met based on new information received during the appeal; Community-Based Provider/INN access standards were not met; and Plan-Directed Care guideline met.
- Medi-Cal and OneCare overturn rates increased from 25% to 36% and 24% to 43%, respectively.
- UM Provider appeals volume increased from 446 in Q4 to 452 in Q1. Genetic Lab appeals decreased from Q4, from 156 to 84. The overturn rate remained consistent with Q4 at 6%.
- External reviews (QIO, IRE, SFH) had low overturn rates, except for SNF continued-stay denial appeals (QIO). The leading reason for SNF overturns was that the member was deemed unsafe for discharge.

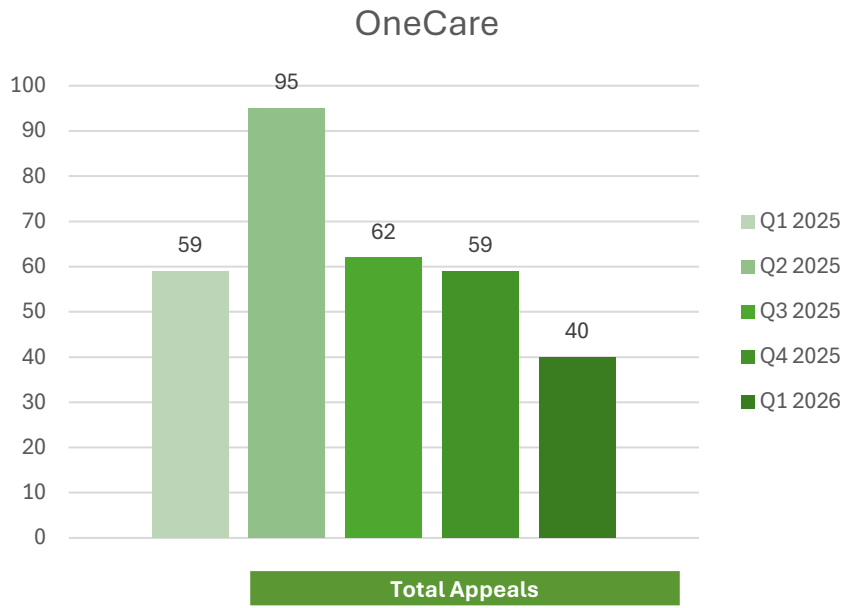
Reference Slides: 33-45

Back to Agenda

Appeals Volume by Line Of Business (LOB)



Q1 2026	240
Q4 2025	291
Q3 2025	307
Q2 2025	406
Q1 2025	266



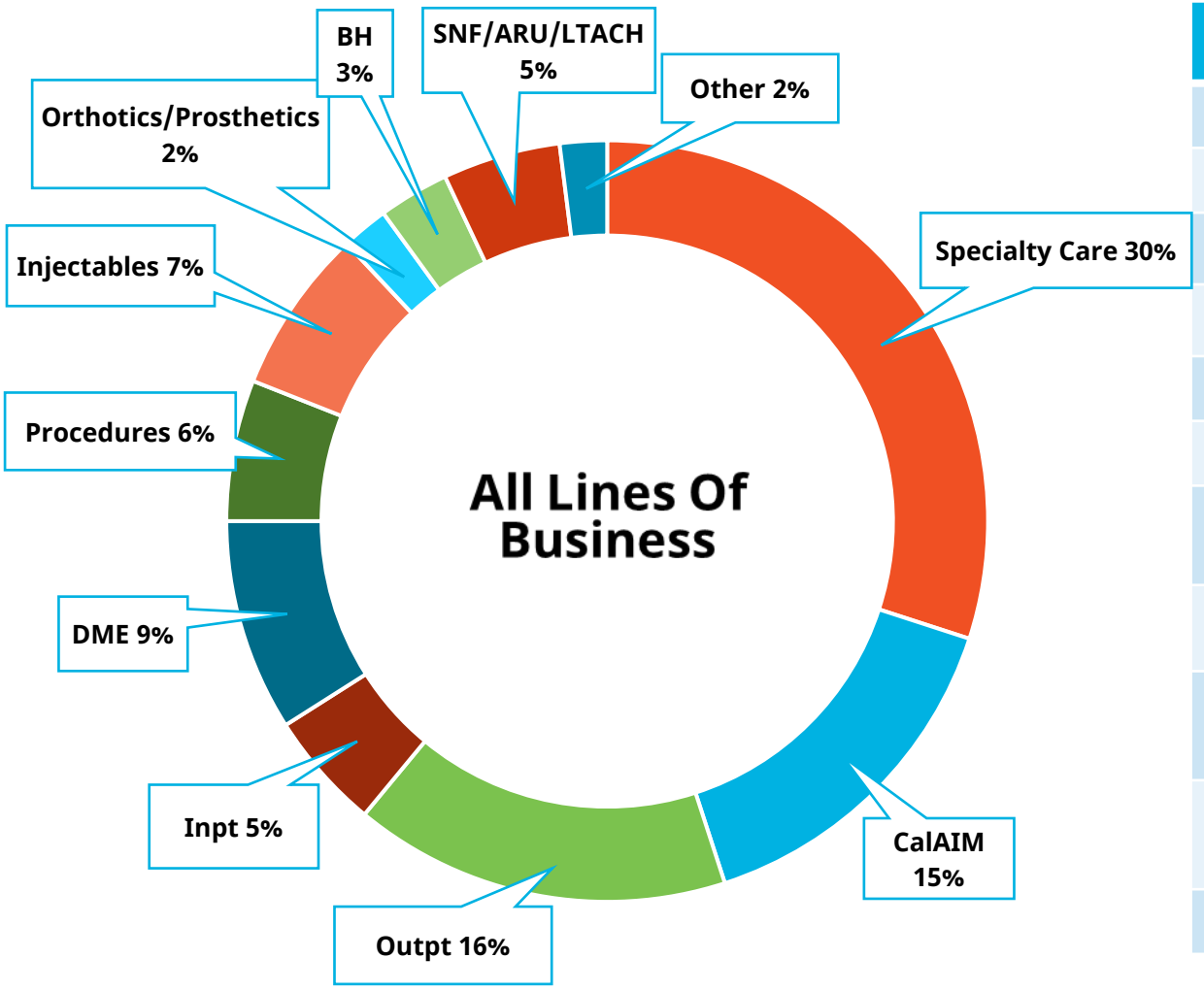
Q1 2026	40
Q4 2025	59
Q3 2025	62
Q2 2025	95
Q1 2025	59

CalOptima Health

Back to Agenda

Member Appeals

All Lines of Business
Appealed Services



Services	Qty	%
Specialty care	81	30%
Outpatient	46	16%
CalAIM	42	15%
DME	25	9%
Injectables	20	7%
Procedures	18	6%
SNF/ARU/ LTACH	15	5%
Inpatient	13	5%
Behavioral Health (BH)	9	3%
Orthotics/ Prosthetics	6	2%
Other	5	2%

Keynote: In Q1, CalAIM appeals continued to decline and became the third most frequently appealed service among members. Specialty care appeals slightly increased from 72 to 81, while Outpatient appeals increased by 64% compared to Q4.

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Back to Agenda

Q1 2026 Appeals Trends

Medi-Cal Appeals

Type	Overturn Count	Uphold Count	Total	Overturn Percentage (%)
Specialty Care	27	44	71	38%
CalAIM	7	35	42	17%
Outpatient	16	19	35	46%

OneCare Appeals

Type	Upheld Count	Overturned Count	Total	Overturn Percentage (%)
Outpatient Services	6	5	11	45%
Specialty Care	5	5	10	50%
Inpatient Services	8	2	10	20%

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Back to Agenda

Actions Taken in Response to Trends

- Trends identified
  - Requests for specialists or higher-level care are being redirected to in-network providers who cannot treat the condition or see the member in a timely manner based on their needs and access to care standards.
  - Post service inpatient hospitalization appeals from Non-Contracted Providers.

- Actions Taken
  - After an appeal is overturned, health networks receive the review criteria for educational purposes.
  - Network overturn trends are tracked and shared with the Delegation Oversight Medical Director during quarterly meetings with Health Network partners.
  - Education provided to Health Networks on the Post-Stabilization Authorization requirements.

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Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 6, 2026
Regular Meeting of the CalOptima Health Board of Directors

Report Item

15. Approve Actions Related to the Street Medicine Program City Collaborative Expansion

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Kelly Bruno-Nelson, Executive Director, Medi-Cal/CalAIM, (714) 954-2140

Recommended Actions

1. Approve the Notice of Interest Opportunity Evaluation Committee's recommendation of Coastal Communities Continuum as the new city collaborative for the expansion of CalOptima Health's Street Medicine Program.
2. Approve the updated Street Medicine Program's scope of work for the solicitation to identify a new street medicine provider to implement the Street Medicine Program in the newly selected city collaborative.
3. Appropriate up to $4.3 million from the California Advancing and Innovating Medi-Cal (CalAIM) Incentive Payment Program, Program Years 1 and 2, for the Delivery System Infrastructure priority area to support the two-year grant agreement with the street medicine provider selected through the solicitation process.
4. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background

On March 17, 2022, CalOptima Health's Board of Directors (Board) committed $8 million from the Homeless Health Initiatives Reserve for purposes of street medicine. On May 5, 2022, the Board approved the Street Medicine Program scope of work (SOW). On November 3, 2022, the Board authorized the Chief Executive Officer (CEO) to execute a contract with Healthcare in Action to provide street medicine canvasing-based services. The pilot launched in Garden Grove on April 1, 2023. Based on the success of the program in Garden Grove, on October 5, 2023, the Board unanimously voted to:

1. Authorize CalOptima Health staff to expand CalOptima Health's Street Medicine Program into two additional cities;
2. Approve the notice of interest opportunity process that CalOptima Health would release to cities, including commitments from CalOptima Health and evaluation criteria; and
3. Approve the SOW for the request for qualifications (RFQu) to identify providers capable of implementing the Street Medicine Program.

CalOptima Health launched the RFQu for street medicine providers on November 9, 2023. On December 7, 2023, the Board authorized CalOptima Health to expand its Street Medicine Program to the cities of Anaheim and Costa Mesa. On March 7, 2024, the Board approved (i) Celebrating Life Community Health Center to provide street medicine services in Costa Mesa and Healthcare in Action to provide street medicine services in Anaheim and (ii) an allotment of an additional $1.8 million in existing reserves to help fund the street medicine provider grant agreements. The programs launched on August 12, 2024, and September 3, 2024, respectively.

Back to Agenda

In accordance with CalOptima Health's strategic priority of overcoming health disparities and based on the success of the Street Medicine Program, on December 5, 2024, the Board unanimously voted to approve a notice of interest opportunity to identify one additional host-city for the expansion of CalOptima Health's Street Medicine Program. On December 6, 2024, the notice of interest opportunity launched, and it was closed on January 17, 2025. On March 6, 2025, the Board authorized CalOptima Health to expand its Street Medicine Program to the city of Santa Ana and approved the SOW for the request for proposals to identify providers capable of implementing the program. On June 5, 2025, the Board approved AltaMed to provide street medicine services in Santa Ana and the program launched on March 9, 2026.

In continued support of CalOptima Health's strategic priority of overcoming health disparities, and based on the success of the program, on February 5, 2026, the Board unanimously voted to approve a Notice of Interest Opportunity to identify a city collaborative for the expansion of CalOptima Health's Street Medicine Program.

Discussion

City Collaborative Expansion

To expand CalOptima Health's existing Street Medicine Program, CalOptima Health's Notice of Interest Opportunity Evaluation Committee (Committee) reviewed and scored the two applications received for the Street Medicine Program Notice of Interest Opportunity. Scores for both applications are as follows:

City Collaborative	Score
Coastal Communities Continuum	88.25
North Service Planning Area (N SPA) Homeless Collaborative	75

Using the evaluation criteria below, the Committee recommends awarding the Street Medicine Program expansion to the highest scoring city collaborative. With Board approval, CalOptima Health staff will begin collaborating with Coastal Communities Continuum to ensure seamless integration of its Street Medicine Program with consideration of the city collaborative's broader endeavors to address homelessness.

	Criterion	Maximum Points	Basis for Assigning Points
1.	Program sustainability	20	Collaborative's sustainability, including geographic coverage, Point-in-Time count density per square mile and the number of participating cities.
2.	Resource sharing	15	Collaborative's willingness to share resources across the collaborative (*e.g.*,: shelters).

Back to Agenda

3.	CalOptima Health core value alignment, including commitment to treat individuals with dignity and respect	10	Collaborative's demonstrated commitment to trauma-informed, inclusive, person-centered programs and those that align with harm-reduction principles.
4.	Collective, aligned, comprehensive, existing efforts and strategies to address homelessness	15	Collaborative must demonstrate commitment and shared value alignment to addressing the homelessness crisis.
5.	Existing partnerships and community involvement	15	Collaborative must describe existing partnerships that will positively contribute to the Street Medicine Program.
6.	Collaborative readiness and governance	15	Collaborative must demonstrate readiness and governance capacity, including documented experience working together to address homelessness, evidence of prior agreements or coordinated initiatives, and the ability to make joint decisions that prioritize the goals of the collaborative.
7.	Uploaded letters of interest	5	Application portal includes a letter of interest that the city manager or County CEO must sign/upload for each participating city.
8.	All attestations complete	5	Application portal includes attestations that the collaborate must make regarding the Street Medicine Program.
Total Earnable Points		**100**	

Provider Solicitation Process

Based on the city collaborative expansion to the Street Medicine Program (as opposed to operating in a single city) and the need for an additional street medicine provider, CalOptima Health staff updated the SOW by adding (i) language related to CalOptima Health's Care Traffic Control and (ii) the definition of a city collaborative. These additions will assist CalOptima Health staff in soliciting and identifying an additional street medicine provider. CalOptima Health staff requests that the Board approve the updated SOW included as Attachment 1. With the Board's approval, CalOptima Health staff will launch the solicitation on August 10, 2026. At closing on October 2, 2026, a committee of evaluators from CalOptima Health will review and score the submissions. Based on this scoring, CalOptima Health staff will request the Board's approval of the selected street medicine provider and approval to enter into a grant agreement with the selected provider at the Board's December 2026 meeting.

Back to Agenda

CalAIM Grant Agreement
Similar to existing Street Medicine Program, CalOptima Health staff will ensure financial sustainability of the Coastal Communities Continuum city collaborative expansion by implementing CalAIM services. CalOptima Health staff determined that it takes approximately two years of operations to achieve financial sustainability. Therefore, CalOptima Health staff will develop a two-year grant agreement. To fund the grant agreement, CalOptima Health staff requests an appropriation of up to $4.3 million from Incentive Payment Program (IPP) funds to cover the remaining grant cost. As of June 30, 2026, IPP funds available for new initiatives is $52.8 million.

Fiscal Impact
The recommended action will have a fiscal impact of up to $4.3 million for the two-year grant agreement with the selected street medicine provider for the city collaborative. These funds derive from the unallocated balance of CalAIM IPP Program Years 1 and 2 and has no additional net fiscal impact.

Rationale for Recommendation
In order to engage CalOptima Health members experiencing homelessness where they are and on their own terms and to reduce or eliminate barriers to medical and social care, CalOptima Health staff recommends that the Board expand the Street Medicine Program to include the Coastal Communities Continuum city collaborative in the third quarter of 2027.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. CalOptima Health Street Medicine Program Scope of Work

/s/ Michael Hunn *07/28/2026*
Authorized Signature **Date**

Back to Agenda

SECTION 1 - SCOPE OF WORK

1.1 Project Objective

The fundamental approach of Street Medicine is to engage people experiencing homelessness where they are and on their own terms to maximally reduce or eliminate barriers to care access and follow-through services. CalOptima's Street Medicine Program provides health and social services developed specifically to address the unique needs and circumstances of unsheltered individuals. Working in collaboration with various county, city, and community organizations, the goals of the Program are to bridge the gaps in receiving quality medical care and improve the health outcomes of unsheltered individuals by delivering compassionate and respectful medical and social care through direct street outreach and engagement.

CalOptima's Street Medicine Program is a critical piece of a larger, comprehensive approach to caring for individuals living on the street. CalOptima's overall approach relies on three integrated components: (1) outreach and engagement; (2) coordinated medical care that meets people where they are; and (3) comprehensive ECM and Community Supports. Together, these components address acute health concerns and deploy integral preventative care, moving beyond stop-gap medical services to build the types of relationships that support a person's move home.

Services are provided in the field with a canvassing-based approach by both Coordination Care Teams and Medical Care Teams. The Coordination Care Team members are responsible for providing ECM and Housing Navigation (and additional housing-related Community Supports, as applicable), routine face to face visits to address various needs of the members and scheduling appointments with the Medical Care Team. Given that CalAIM services are what makes the program financially sustainable, it is encouraged that the Coordination Care Team make authorization for CalAIM services a priority among new patients. The Medical Care Team will be responsible for primary medical care including, but not limited to, ongoing medical care, ordering, drawing and reading labs, prescribing medications, referrals to specialists as needed and urgent care, as needed. The Medical Care Team will offer all enrolled patients the opportunity to serve as their Primary Care Physician (PCP). Serving as PCP enables the provider to provide the most comprehensive, continuous care for the individual. If interested, the Coordination Care Team will work with CalOptima to make arrangements. Patient care will always be provided on the street and will never take place in the street medicine provider's office location.

CalOptima Health is expanding its Program to a city collaborative and is looking for providers who can implement CalOptima's Street Medicine Program in the cities of {enter collaborative cities}. A collaborative is defined as a minimum of two contiguous non-serviced cities covering no more than 100 square miles, with an average of at least 200 unsheltered individuals per 50 square miles, that are prepared to participate in and support a street medicine program as a single, unified system rather than as individual

Back to Agenda Back to Item

jurisdictions operating independently. While the collaborative approach is new, CalOptima Health's Street Medicine Program will continue to function under a single program model set by CalOptima Health's standards and operational guidance. The program will not vary by city. Further, it is understood that those experiencing homelessness can be transient in nature and services may sometimes be provided outside of collaborative limits. The service area will be broken up into several zones. Zones will be determined with the knowledge from the various city officials as well as other individuals and organizations who are familiar with and serve within the boundaries of the defined service collaborative area.

It is understood that while staffing up a new location, fewer staff will likely be used to cover most of the geographical area of the program. As the program grows, more staff will be hired, and zones will be established.

To ensure proper care and support of patients enrolled in the program, service provision standards have been established. For the Medical Care Team that serves a patient panel of 200, there is to be a minimum of one patient encounter every 60 days, varying on acuity of medical needs. For the Care Coordination Teams, each carrying 25 patients, there is to be a minimum of one face to face patient encounter every 14 days. Services may be provided more frequently based on each patient's specific needs. Street Medicine Team members will ensure efficient and safe care is delivered to each patient. Further, the Team will regularly meet with CalOptima staff and others to discuss the program.

CalOptima has a platform called Care Traffic Control (CTC) to measure program outputs and outcomes as well as track and monitor compliance with the Operations Manual. CalOptima Health requires that Street Medicine Providers provide weekly data files to CTC from their Electronic Health Record, with the expectation that any necessary IT support is in place to ensure these uploads occur without interruption. Further, teams are also responsible for reviewing their submissions to confirm that all data is complete, accurate, and up to date before each weekly upload.

CalOptima Health has a Street Medicine Operations Manual that defines how the Street Medicine Program is structured and must be followed in its entirety. In addition to following CalOptima's Street Medicine Operations Manual, providers must also follow CalOptima's ECM Policy Guide and Community Supports Policy Guide, staffing requirements, documentation requirements, meeting requirements and reporting requirements, including data entry into CTC. Entities deemed qualified will be expected to comply with all the foregoing.

1.2 Description of Services

1.2.1 Medical services provided by Street Medicine providers in the field may include:

A. Primary Care Services

B. Urgent Care: acute infection, cough, UTI, etc.

C. Wound care and ongoing wound management.

D. Vaccinations in alignment with public health guidance.

E. Phlebotomy and specimen collection.

F. Point of care testing (Urine dipstick [macroscopic urinalysis], urine hCG [pregnancy], whole blood creatinine, whole blood electrolytes, whole blood glucose, whole blood hemoglobin, COVID-19 antigen, sexually transmitted infections such as HIV/AIDS, syphilis, etc.)

G. Medication reconciliation and review

H. Prescription delivery (or able to prescribe for delivery)

I. Injectable anti-psychotics and other street psychiatry services

J. Age-appropriate health screenings

K. Chronic disease management

L. Referral to hospital on voluntary or 5150 basis

M. Specialist referral, as well as appointment scheduling, where applicable

N. Appropriate harm reduction methods, as needed, and in coordination with the Orange County Health Care Agency (e.g., Naloxone distribution and medically assisted treatment, etc.)

1.2.2 Street Medicine providers must ensure that services are provided in a manner consistent with CalOptima policies and procedures. It is expected that the provider is able to provide documentation attesting staff or partners have received trauma-informed and recovery-centered training.

1.2.3 Membership / Eligibility Management: Individuals enrolled must have CalOptima Medi-Cal and be experiencing unsheltered homelessness. This includes individuals who lack an adequate night-time residence and/or who have a primary residence that is a public or private place not designed for ordinary use or habitation.

1.3 Minimum Staffing Requirements

CalOptima will review the staffing model of each Street Medicine Program provider to ensure that it meets the needs of the population served. Staff for a street medicine team with a panel of 200 patients should include at a minimum:

1.3.1 A supervising Medical Doctor

1.3.2 One dedicated clinical provider such as a Nurse Practitioner (NP), or Physician Assistant (PA)

1.3.3 One clinical support individual such as a LVN

1.3.4 One Program Director

1.3.5 One Program Manager

1.3.6 One Coordination Care Team Supervisor

1.3.7 Eight Peer Navigators

1.3.8 One Mental Health Professional

1.4 Required Services

Providers will be responsible for the following:

1.4.1 Providing services to all unsheltered CalOptima Health members encountered within the identified geographic location.

1.4.2 Maintaining consistent recurring schedules during traditional hours and staff as established by CalOptima Health, and be prepared to spend no less than 4 hours in the field on a given day.

1.4.3 Serving as a medical home/primary care provider, as appropriate.

1.4.4 Providing CalAIM ECM and Community Support services to individuals enrolled in the program.

1.4.5 Possessing the necessary medical equipment and supplies to provide medical services on the street or in the mobile unit provided by CalOptima, including, but not limited to:

A. Stethoscope

B. Blood pressure cuff

C. Pulse oximeter

D. Wound care supplies

E. Phlebotomy and point of care testing supplies

F. Frequently used medication for immediate dispensation: vaccines, insulin, diabetes medication, etc.

G. Other medical supplies, as appropriate

1.4.6 Arranging transportation for specialist appointments at brick and mortar healthcare offices.

1.4.7 Making telehealth equipment available and providing services through this modality in a manner consistent with CalOptima Policies and Procedures, meeting all regulatory requirements.

1.4.8 Following CalOptima-identified clinical treatment protocols for specific conditions that can be treated in the street, to include post discharge planning and care transitions.

1.4.9 Referring patients to emergency room or recuperative care, as needed.

1.4.10 Providing connection to housing by way of Homeless Management Information System (HMIS) and Coordinated Entry System (CES) as well as other methods to secure permanent housing.

1.4.11 Developing materials (e.g., schedules, flyers, etc.), in collaboration with CalOptima, that can be shared publicly and with other service providers.

1.4.12 Submitting claims using program specific billing guidelines and/or encounter tracking reports as developed by CalOptima and specified in contract. Routinely reconciling claims reports.

1.4.13 Submitting, tracking and reporting outcome data as determined by CalOptima Health.

1.4.14 Participating in Care Traffic Control by providing accurate and complete data weekly to CalOptima.

1.4.15 Parking the van at CalOptima Health.

1.4.16 Working out of CalOptima Health's Care Traffic Control.

1.5 Deliverables

Prior to the program start date indicated in final contract, participating providers are expected to have the necessary infrastructure in place (e.g., functional mobile units, medical supplies, technology, staff, etc.). Street Medicine providers will be expected to provide the following:

1.5.1 Claims for CalOptima Health members in accordance with CalOptima Health's Billing Guidelines, within one month of service delivery.

1.5.2 Documentation as defined in the contract, provided within the applicable specified timeframe.

1.5.3 Weekly reports on:

A. Individuals served by the program

B. Housing status of individuals served

C. PCP status of individuals served

D. Patient Rosters

E. Referrals received by approved referral sources

F. Outcomes data as established by CalOptima

G. Visit information for all appointments

H. Daily unique and total contacts per day with notation of broad encounter outcomes using CalOptima programs and/or other tracking mechanisms.

I. Types of service provided and by whom, e.g. provider or other organization

J. Additional reports that CalOptima may require.

1.6 Proposal Requirements

Include the following information in your proposal.

1.6.1 An explanation of how you will provide services to all individuals enrolled and serve as their medical home/primary care provider, as appropriate.

1.6.2 Medi-Cal Provider number.

1.6.3 Description of completed trauma-informed care, recovery-focused, and person-centered training, and how these will continue to be provided regularly.

1.6.4 A list of dedicated staff and their roles in this engagement.

1.6.5 Experience, if any, providing services out of a mobile unit. If none, explain how the requirement will be met.

1.6.6 Experience, if any, serving the unhoused population.

1.6.7 Experience providing connection to housing by way of CalAIM Enhanced Care Management and Community Supports, as well as enrollment in the CES and HMIS. Indicate whether your organization is contracted as a CalAIM ECM and/or Housing Services provider, and whether your organization is trained in and uses CES and HMIS.

1.6.8 A description of your IT department and confirmation that it will be able to ensure reporting and data exchange requirements can be met within the first two months of contract signature. Indicate whether your agency has sole control over your Electronic Health Record platform.

1.6.9 All relationships your organization currently has with the organizations listed below:

A. Homeless shelters/navigation centers

B. Other Street medicine programs or mobile clinics

C. Other organizations who serve the unsheltered

D. Recuperative care sites

E. Post-hospitalization housing

F. Hospitals

G. Emergency Personnel

H. County of Orange Health Care Agency, including Outreach & Engagement

1.7 CalOptima Responsibilities

CalOptima will evaluate the capacity of each proposer to determine current state of infrastructure and information sharing capabilities, and will also be responsible for the following:

1.7.1 Serving as the lead of its Street Medicine Program. This includes being the primary point of contact with the city collaborative as well as all partners.

1.7.2 Educating the selected applicants on CalOptima Health's Street Medicine Program requirements.

1.7.3 Developing and maintaining all program contracts, future policies and procedures, and any other documents required by DHCS or other regulatory entities.

1.7.4 Developing an incentive structure that enables providers to meet the requirements of the program.

1.7.5 Providing timely compensation and/or payment of associated incentives.

1.7.6 Training providers on documentation requirements and program-specific billing guidelines, and provide tools for data collection.

1.7.7 Providing interpretation services for members.

1.7.8 Providing training for CalAIM Community Supports and Enhanced Care Management (ECM) to support continuity of care, including, training and access to software or other programs, such as SafetyNet Connect.

1.7.9 Convening Street Medicine teams on a basis to be determined to assess program needs and opportunities for improvement.

1.7.10 Funding the CalOptima-designed Street Medicine Program van.

1.7.11 Convening Steering Committee meetings with all necessary stakeholders, as needed.

1.7.12 Providing office space for the Street Medicine Team as well as van parking.

1.7.13 Serving as the branding lead for the Program, including providing co-branded Street Medicine items (van wrap, shirts, flyers, etc.) that the selected provider will use and wear.

1.7.14 Maintaining an updated CalOptima Health Street Medicine Operations Manual.

SECTION 2 - EVALUATION CRITERIA

Proposals will be evaluated by an Evaluation Committee according to the following criteria.

a) Organization and completeness of proposal

b) Ownership of Electronic Health Record System

c) Experience & Expertise – demonstrates direct experience in providing street-based healthcare and familiarity with best practices in serving unsheltered populations

d) Clear description of how the organization will meet the specific duties and requirements of the RFP, including staffing, service delivery, and logistical capacity to operate effectively in street-based settings.

e) Capacity & Qualifications – organization has the necessary staffing, training, licensing, and infrastructure to meet the needs of the population served.

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 6, 2026
Regular Meeting of the CalOptima Health Board of Directors

Report Item

16. Approve Actions Related to the Housing and Homelessness Incentive Program – Funding Allocations

Contacts

Kelly Bruno-Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions

1. Rescind the Board-approved grant award to City Net and return the unspent funds of $1.3 million to Housing and Homelessness Incentive Program (HHIP) Priority 3: Partnerships and capacity to support referrals (capital projects).
2. Receive the unspent balance of $143,500 from the grant award with Orange County Office of Care Coordination and return the unspent funds to HHIP Priority 3: Partnerships.
3. Ratify the grant amendment with Illumination Health + Home to update the project description, reporting schedule, and payment terms; and return $1.4 million from the initial grant award to HHIP Priority 3: Partnerships.
4. Approve distribution of up to $2.9 million in unspent funds in HHIP Priority 3: Partnerships related to the aforementioned recommended actions in the HHIP Notice of Funding Opportunity Round 7.

Background

CalOptima Health began participating in the California Department of Health Care Services' HHIP in April 2022 with the submission of a letter of intent to participate. Since that time, CalOptima Health has completed each program component and earned associated incentive dollars to spend against an investment plan with priority investment areas. These investment areas, and subsequent community investments through grant awards, are designed to improve the services and care for members experiencing (or at risk of experiencing) homelessness and to facilitate stronger partnerships and a more seamless continuum of services within Orange County (OC).

At the outset of the program, CalOptima Health was eligible for $83.78 million and, as of program close, earned a total of $72.9 million (or 87%). In addition, the CalOptima Health Board of Directors (Board) allocated additional reserve dollars to contribute toward related community investments in the amount of $40.1 million in September 2022, $22.3 million in June 2023, and $25 million in December 2023. The total HHIP incentive dollars plus Board allocated reserves dollars total $160.3 million.

CalOptima Health has stewarded these funds into significant community investment over the past two years, granting $127.9 million of those total funds across four priority areas. Some of these commitments have been allocated to projects that have evolved or are no longer relevant or moving forward. Therefore, staff would like to have these funds re-allocated back to their original HHIP funding priority to be re-awarded through the Notice of Funding Opportunity (NOFO) process.

Back to Agenda

Discussion
Based on nearly four years of substantial community investment and related community feedback and understanding of the evolution of grant-awarded projects, CalOptima Health staff requests that the Board rescind one unused grant. Please see below for additional details:

Kingdom Causes dba City Net: On October 5, 2023, the Board approved a $1.3 million capital grant award for City Net. The proposed capital project was to support the development of new permanent supportive housing. City Net later determined it would not be able to complete the project due to changes in partnership with the faith-based institution providing the land for the project and therefore returned the award to CalOptima Health.

CalOptima Health staff also requests that the Board return the remainder of two Board-approved grants to HHIP Priority 3: Partnerships. Please see below for additional details:

OC Office of Care Coordination: On December 1, 2022, the Board approved a $2.2 million grant award to OC Office of Care Coordination to support administration of two annual Point in Time (PIT) counts, stipends for lived experience committee participants, and other capacity building efforts. OC Office of Care Coordination met the terms of the grant agreement and completed the project at lower-than-anticipated costs. The grantee did so under budget and therefore returned the unused grant funds of $143,500 to CalOptima Health.

Illumination Health + Home: On May 2, 2024, the Board approved a $3.5 million capital grant award to Illumination Health + Home to develop the nation's first children's recuperative care center. Illumination Health + Home opened the children's recuperative care center with 18 beds but did not complete the expansion of the facility to 30 beds due to unforeseen environmental issues. Staff requests that the Board ratify the grant amendment executed on July 6, 2026. The amendment included updates to the project description, reporting schedule, and payment terms. Specifically, the amendment reduces the number of beds for the project by 60%. As such, the amendment updates the maximum allowable grant amount to $2.1 million. Staff recommends that the resulting $1.4 million variance be returned to HHIP Priority 3: Partnerships for redistribution.

Staff recommend that the rescinded and unspent funds totaling $2.9 million be distributed under Priority Area 3 in NOFO Round 7, planned for October 2026.

If the Board approves the recommended actions, the total allocations to NOFO 7 will be as shown below.

HHIP Funding Priority	Total Amount Allocated As of March 5, 2026	Amount Added Through Proposed Actions on August 6, 2026	Total to be Distributed in NOFO Round 7
Priority 2. Infrastructure to coordinate and meet member housing needs	$0.3	--	$0.3

Priority 3. Partnerships and capacity to support referrals (capital projects)	$25.0	$2.9	$27.9
Priority 4. Systems Change	$2.5	--	$2.5
Total Amount Requested for Approval	**$27.8**	**$2.9**	**$30.7**

*Table in millions

Fiscal Impact
The recommended actions will increase the amount available to fund grants in HHIP Priority Area 3: Partnerships and capacity to support referrals for services by $2.9 million.

Rationale for Recommendation
CalOptima Health staff is preparing to determine distribution of the remainder of the HHIP incentive funding by December 31, 2026, the same time the CalAIM program waiver is set to expire. Allocating these funds to the appropriate priorities will support this timeline and effort to ensure robust services are available to all CalOptima Health members.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
None.

Board Actions

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 1, 2022	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$36.5 million
March 2, 2023	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$19.25 million
June 2, 2023	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$52.3 million
December 7, 2023	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$25 million
April 4, 2024	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$16.18 million
May 2, 2024	Approve Actions Related to the Housing and Homelessness Incentive Program	-	$25 million

Back to Agenda

Board Meeting Dates	Action	Term	Not to Exceed Amount
December 5, 2024	Approve Actions Related to the Housing and Homelessness Incentive Program		$20.13 million
February 6, 2025	Approve Actions Related to the Housing and Homelessness Incentive Program		$.6 million
May 1, 2025	Approve Actions Related to the Housing and Homelessness Incentive Program		$2.7 million
October 2, 2025	Approve Actions Related to the Housing and Homelessness Incentive Program		$32.6 million
March 5, 2026	Approve Actions Related to the Housing and Homelessness Incentive Program		$10.0 million

/s/ Michael Hunn *07/28/2026*
Authorized Signature **Date**

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 6, 2026
Regular Meeting of the CalOptima Health Board of Directors

Report Item

17. Approve Actions Related to CalOptima Health's Qualified Health Plan Contract with Covered California

Contact

Donna Laverdiere, Executive Director, Strategic Development, (714) 986-6981

Recommended Action

Authorize the Chief Executive Officer, or designee, to execute the Qualified Health Plan Contract with Covered California for Plan Year 2027.

Background

Over the past two years, CalOptima Health has made significant progress in preparation for entrance into the Covered California program. The CalOptima Health Board of Directors (Board) has taken several actions related to Covered California. On August 1, 2024, the Board authorized the Chief Executive Officer (CEO) to convene the Covered California Stakeholder Steering Committee comprised of key external partners and providers to discuss considerations for potential participation in Covered California. CalOptima Health leadership and staff convened the Covered California Stakeholder Steering Committee, which has met on a regular basis over the past two years. On October 3, 2024, the Board directed the CEO to request the Orange County Board of Supervisors (BOS) to amend CalOptima Health's governing ordinance to remove the prohibition on participation in Covered California. On January 14, 2025, the BOS unanimously voted to amend the ordinance to allow CalOptima Health's participation in Covered California.

On June 15, 2025, the Board approved the submission of CalOptima Health's initial filing to the California Department of Managed Health Care (DMHC) to expand the scope of its current Knox-Keene Act license to enable CalOptima Health to offer a Covered California product. On December 4, 2025, the Board approved submission of a Letter of Intent to apply, which CalOptima Health submitted to Covered California on February 13, 2026. In addition, a key step in the preparations to enter the program for Plan Year (PY) 2027 was the submission of a Qualified Health Plan (QHP) Application to Covered California for certification as a QHP on April 27, 2026.

Discussion

The QHP Certification process is a multi-phased review carried out by Covered California every year to select health plans that will participate in the California Exchange for the upcoming coverage year. The process evaluates the submitted QHP Application and determines whether the health plan may participate in the Covered California program. CalOptima Health has successfully completed all milestones throughout the spring and summer of 2026.

Back to Agenda

QHP Application Timeline:

QHP Certification Step	Date/Timeframes	Status
Letter of Intent to Apply due to Covered California	February 13, 2026	Complete
QHP Application Opened	March 2026	Complete
QHP Application Due	April 30, 2026	Complete
Final QHP Contingent Certification Decisions	July 21, 2026	Complete
QHP Contract Execution	July 31, 2026 - August 2026	Pending
Final QHP Certification	October 2026	Pending

In June 2026, Covered California held review meetings with all applicant health plans. On June 15, 2026, CalOptima Health participated in this meeting in person and received positive feedback on its application and rate filing submissions.

On July 21, 2026, Covered California issued a press release announcing CalOptima Health as a new entrant to the Covered California program for PY 2027.

On July 31, 2026, CalOptima Health received the 2027 PY Amendment to the Covered California QHP Issuer Contract for 2026-2028 for the Individual Market with instructions to sign by August 28, 2026.

CalOptima Health's entry to the Exchange for PY 2027 is dependent on final approval from DMHC on its application to expand the scope of its Knox-Keene License as well as execution of the QHP contract. Staff anticipates a decision on the DMHC license expansion review process in the near future.

The execution of the QHP Contract with Covered California completes the final step in the QHP Certification process and will enable CalOptima Health to participate in Covered California for the upcoming PY 2027.

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact on the Fiscal Year 2026-27 Operating Budget.

Rationale for Recommendation
The recommended action will allow CalOptima Health to contract with Covered California as a QHP for PY 2027.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. PY 2027 QHP Model Contract

/s/ Michael Hunn *07/28/2026*
Authorized Signature **Date**

Back to Agenda



2027 PLAN YEAR AMENDMENT to the COVERED CALIFORNIA QUALIFIED HEALTH PLAN ISSUER CONTRACT FOR 2026 – 2028 FOR THE INDIVIDUAL MARKET

between

Covered California

and

xxx ("Contractor")

June 18, 2026

Back to Agenda Back to Item

RECITALS **1**

Article 1 – General Provisions **3**

1.1 Purpose 3

1.2 Applicable Laws and Regulations 3

1.3 Relationship of the Parties 4

1.4 General Duties of Covered California 6

1.4.1 Confidentiality of Contractor Documents 7

1.5 General Duties of Contractor 7

1.6 Coordination with Other Programs 9

1.7 Changes in Requirements 10

1.8 Evaluation of Contractor Performance 10

1.9 Required Notice of Contractor Changes 10

1.10 Nondiscrimination 11

1.11 Conflict of Interest; Integrity 12

1.12 Other Financial Information 13

1.13 Other Laws 13

1.14 Contractor's Representations and Warranties 14

1.15 Fraud, Waste and Abuse; Ethical Conduct 15

1.16 Current Enrollee Notification 16

Article 2 – Eligibility And Enrollment **17**

2.1 Eligibility and Enrollment Responsibilities 17

2.1.1 Covered California Responsibilities 17

2.1.2 Contractor Responsibilities 17

2.1.3 Collection Practices 19

2.2 Covered California for the Individual Market 19

2.2.1 Open Enrollment, Auto Enrollment, and Special Enrollment Periods 19

2.2.2 Covered California for the Individual Market Coverage Effective Dates 20

2.2.3 Premiums for Coverage in Covered California for the Individual Market 20

2.2.4 Terminations of Coverage 21

2.2.5 Notice to Provider Regarding Covered California Enrollee's Grace Period Status 22

Back to Agenda Back to Item

Article 3 – Promoting Enrollment 23
3.1 Transitions of Coverage 23
3.2 Marketing 25
3.2.1 Enrollment and Marketing Coordination and Cooperation 25
3.2.1.1 Covered California Activities to Promote Enrollment 25
3.2.1.2 Contractors Activities to Promote Enrollment 26
3.2.2 Enrollee Materials and Branding Documents 27
3.2.2.1 Co-branded Materials 27
3.2.2.2 Marketing Materials that Must Be Submitted to Covered California 28
3.2.2.3 Member Communications Materials 30
3.2.2.4 Mailing Addresses; Other Enrollment Information 30
3.2.2.5 Evidence of Coverage on Contractor's Website 30
3.2.2.6 Distribution of Enrollment Materials 31
3.2.3 Additional Marketing Efforts 31
3.3 Agents in Covered California for the Individual Market 31

Article 4 – QHP Issuer Program Requirements 36
4.1 Basic Requirements 36
4.1.1 Licensed in Good Standing 36
4.1.2 Certification 37
4.1.3 Plan Naming Conventions 38
4.1.4 Operational Requirements and Liquidated Damages 38
4.2 Benefit Standards 41
4.2.1 Essential Health Benefits 41
4.2.2 Patient-Centered Standard Benefit Designs 41
4.2.3 Offerings Outside of Covered California 42
4.2.4 Pediatric Dental Benefits 42
4.2.5 Segregation of Funds 43
4.2.6 Prescription Drugs 43
4.2.7 Hearing Aid Coverage for Children Program 44
4.3 Network Requirements 44
4.3.1 Service Areas 45
4.3.2 Network Adequacy 46
4.3.3 Network Stability 46
4.3.4 Essential Community Providers 47
4.3.5 Special Rules Governing American Indians and Alaskan Natives 52
4.3.6 Access Monitoring 53
4.4 Participating Providers 53

Back to Agenda Back to Item

4.4.1 Provider Contracts 53
4.4.2 Provider Credentialing 55
4.4.3 Enrollee Costs; Disclosure 55
4.4.4 Covered California Provider Directory 56
4.4.5 Use of Symphony Provider Directory 56
4.5 Premium Rate Setting 58
4.5.1 Rating Variations 58
4.5.2 Covered California for the Individual Market Rates 58
4.5.3 Rate Methodology 59
4.6 Customer Service Standards 59
4.6.1 Basic Customer Service Requirements 59
4.6.2 Covered California Enrollee Appeals and Grievances 60
4.6.3 Applications and Notices 60
4.6.4 Customer Service Call Center (Call Center) 61
4.6.5 Customer Service Transfers 62
4.6.6 Customer Care 63
4.6.7 Notices 63
4.6.8 Contractor-Specific Information 64
4.6.9 Covered California Enrollee Materials: Basic Requirements 64
4.6.10 New Covered California Enrollee Enrollment Packets 65
4.6.11 Summary of Benefits and Coverage 66
4.6.12 Electronic Listing of Participating Providers 66
4.6.13 Access to Medical Services Pending ID Card Receipt 67
4.6.14 Explanation of Benefits 67
4.6.15 Secure Plan Website for Enrollees and Providers 67
4.6.16 Required Reports 68
4.6.17 Contractor Staff Training about Covered California 68
4.6.18 Customer Service Training Process 68

Article 5 – Advancing Equity, Quality, and Value 70

5.1 Covered California Quality and Equity Initiatives 70
5.2 Quality Improvement and Disparities Reduction Programs 70
5.2.1 General Requirements 70
5.2.2 Payment Obligations for Quality and Health Equity Performance 71
5.2.3 Removal from Covered California 72
5.2.4 Quality Improvement Plans and Minimum Performance Level Action Plans 73
5.3 Utilization Management 76

Back to Agenda Back to Item

5.4 Transparency and Quality Reporting 76
5.5 Quality Rating System 76
5.6 Data Submission Requirements 77

Article 6 – Financial Provisions 78

6.1 Covered California for the Individual Market 78
6.1.1 Rates and Payments 78
6.1.2 Financial Consequences of Non-Payment of Premium 79
6.1.3 Covered California for the Individual Market Participation Fees 80

Article 7 – Performance Standards 83

7.1 Performance Standards 83
7.2 Penalties 83
7.3 No Waiver 83

Article 8 – Contract Term; Recertification and Decertification 84

8.1 Agreement Term 84
8.2 Agreement Termination 84
8.2.1 Covered California Termination 84
8.2.2 Contractor Termination 85
8.2.3 Notice of Termination 85
8.2.4 Remedies in Case of Contractor Default or Breach 86
8.2.5 Contractor Insolvency 87
8.3 Recertification 87
8.3.1 Recertification Process 87
8.3.2 Non-Recertification Election 88
8.4 Decertification 89
8.5 Effect of Termination 89
8.6 Coverage Following Termination and Decertification 92

Article 9 –Insurance and Indemnification 94

9.1 Contractor Insurance 94
9.1.1 Required Coverage 94
9.1.2 Workers' Compensation 95
9.1.3 Subcontractor Coverage 95
9.1.4 Premium Payments and Disclosure 95

Back to Agenda Back to Item

9.2 Indemnification 95

Article 10 – Privacy and Security 97

10.1 Privacy and Security Requirements for Personally Identifiable Data 97

10.2 Protection of Information Assets 105

Article 11 – Recordkeeping 108

11.1 Clinical Records 108

11.2 Financial Records 108

11.3 Storage 109

11.4 Back-Up 109

11.5 Examination and Audit Results 110

11.6 Notice 111

11.7 Confidentiality 111

11.8 Tax Reporting 112

11.9 Electronic Commerce 112

Article 12 – Intellectual Property 113

12.1 Warranties 113

12.2 Intellectual Property Indemnity 114

12.3 Federal Funding 115

12.4 Ownership and Cross-Licenses 115

12.5 Survival 117

Article 13 – Special Terms and Conditions 118

13.1 Dispute Resolution 118

13.2 Attorneys' Fees 119

13.3 Notices 119

13.4 Amendments 120

13.5 Time is of the Essence 120

13.6 Publicity 120

13.7 Force Majeure 121

13.8 Further Assurances 121
13.9 Binding Effect 121
13.10 Titles/Section Headings 122
13.11 Severability 122
13.12 Entire Agreement/Incorporated Documents/Order of Precedence 122
13.13 Waivers 123
13.14 Incorporation of Amendments to Applicable Laws 123
13.15 Choice of Law, Jurisdiction, and Venue 123
13.16 Counterparts 123
13.17 Ambiguities Not Held Against Drafter 123
13.18 Clerical Error 123
13.19 Administration of Agreement 124
13.20 Performance of Requirements 124

Article 14 – Definitions 125

COVERED CALIFORNIA
QUALIFIED HEALTH PLAN ISSUER CONTRACT
between
Covered California
and
_____ (“Contractor”)

THIS QUALIFIED HEALTH PLAN ISSUER CONTRACT (“Agreement”) is entered into by and between Covered California, an independent entity established within the government of the State of California doing business as Covered California and _____, a health insurance issuer as defined in Title 10 California Code of Regulations (“CCR”) § 6410 (“Contractor”). (Except as otherwise expressly defined, capitalized terms shall have the meaning set forth at Article 14 Definitions).

RECITALS

A. Covered California is authorized under the Federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (collectively, “Affordable Care Act”), and the California Patient Protection and Affordable Care Act, (Chapter 655, Statutes of 2010 and Chapter 659, Statutes of 2010) (“California Affordable Care Act”) to selectively contract with Health Insurance Issuers in order to make available to Covered California Enrollees health care coverage choices that seek to provide the optimal combination of choice, value, access, quality, and service to Qualified Individuals;

B. The Application process conducted by Covered California is based on the assessment of certain requirements, criteria and standards that: (i) Covered California determines are reasonable and necessary for bidding Health Insurance Issuers to market, offer, and sell Qualified Health Plans (QHPs) through Covered California, (ii) are set forth in the Application, and (iii) are required under applicable laws, rules and regulations or otherwise necessary to meet the needs of Covered California Enrollees, including, those set forth at Government Code § 100500 et seq. and 45 C.F.R. Part 155 et seq.;

C. In connection with the evaluation of the responses to the Application received from Health Insurance Issuers, Covered California is required: (i) to evaluate the proposed QHP Issuer's compliance with requirements imposed under the Application, and (ii) to give greater consideration to potential QHP Issuers that further the mission of Covered California by promoting, among other items, the following: (1) affordability for the consumer – both in premiums and at point of care, (2) "value" competition based upon quality, service, and price, (3) competition based upon meaningful QHP Issuer choice and ability to demonstrate product differentiation: Patient-Centered Benefit Designs, (4) competition throughout the State, (5) alignment with Providers and delivery systems that serve the low-income population, (6) delivery system improvement, effective prevention programs, and payment reform, (7) administrative capability and financial solvency, and (8) robust customer service;

D. Contractor is a Health Insurance Issuer authorized to provide Covered Services to Enrollees under applicable laws, rules and regulations pursuant to: (i) a certificate of authority issued by the California Department of Insurance ("CDI") under § 699 et seq. of the California Insurance Code, or (ii) a license issued by the Department of Managed Health Care ("DMHC") pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (§ 1340 et seq. of the California Health and Safety Code). (Except as otherwise stated, references to "Codes" set forth herein shall refer to the laws of the State of California.);

E. Based on Covered California's evaluation of the proposal submitted by Contractor in response to the Application ("Proposal") and its consideration of other factors required to be considered under applicable laws, rules and regulations and as otherwise necessary to meet the needs of Covered California Enrollees, Covered California intends to designate Contractor as a QHP Issuer (as defined at 10 CCR § 6410) pursuant to Covered California's determination that Contractor's proposed QHPs meet the requirements necessary to provide health insurance coverage as a QHP to Qualified Individuals who purchase health insurance coverage through Covered California;

F. Contractor desires to participate in Covered California as a QHP Issuer; and

G. Contractor and Covered California desire to enter into this Agreement to set forth the terms and conditions of Contractor's role as a QHP Issuer and operation of the QHPs through Covered California.

ARTICLE 1 – GENERAL PROVISIONS

1.1 Purpose

This Agreement sets forth the expectations of Covered California and Contractor with respect to: (i) the delivery of services and benefits to Covered California Enrollees; (ii) the respective roles of Covered California and Contractor related to enrollment, eligibility, and customer service for Covered California Enrollees; (iii) coordination and cooperation between Covered California and Contractor to promote quality, high value care for Covered California Enrollees and other health care consumers; (iv) Covered California's expectation of enhanced alignment between Contractor and its participating providers to deliver high quality, high value health care services; and (v) administrative, financial, and reporting relationships and agreements between Covered California and Contractor.

Covered California enters into this Agreement with Contractor to further its mission to increase the number of insured Californians, improve health care quality and access to care, promote health, lower costs, and reduce health disparities. Covered California seeks to accomplish this mission by creating an innovative and competitive marketplace that empowers consumers to choose the health plan and providers that offer the best value. Covered California's "Triple Aim" framework seeks to improve the patient care experience, including quality and satisfaction, improve the health of the population, and reduce the per capita costs of Covered Services. Through the execution of this Agreement, Covered California and Contractor jointly commit to be actively engaged in promoting change and working collaboratively to define and implement additional initiatives to continuously improve quality and value.

1.2 Applicable Laws and Regulations

a) This Agreement is in accord with and pursuant to the California Affordable Care Act, Section 100500 et seq., Title 22 of the California Government Code (Chapter 655, Statutes of 2010 and Chapter 659, Statutes of 2010) and the implementing regulations, Title 10, Chapter 12 of the California Code of Regulations, § 6400 et seq., as enacted or as modified during the course of this Agreement. This Agreement is also in accord with and pursuant to the Federal Patient Protection and Affordable Care Act and its implementing Federal regulations, as enacted or modified during the course of this Agreement, including standards for QHP certification set forth at

45 C.F.R. Part 156 et seq. (Subpart C: Qualified Health Plan Minimum Certification Standards).

b) Contractor is subject to the obligations imposed on Contractor under applicable laws, rules and regulations of the Federal Affordable Care Act, the California Affordable Care Act, and any other applicable Federal, State or local laws, rules and regulations. The parties to this Agreement recognize and acknowledge there may be material changes to the above-referenced rules and regulations and other applicable Federal, State, or local laws, rules and regulations. Should such an event arise, the parties agree that revisions to this Agreement may be necessary to align provisions contained herein with the changes made to these laws. Nothing in this Agreement limits such obligations imposed on Contractor, including any failure to reference a specific State or Federal regulatory requirement applicable to Covered California or Contractor. In those instances where Covered California imposes a requirement in accordance with the California Affordable Care Act or as otherwise authorized by California law that exceeds a requirement of the Federal Affordable Care Act or other Federal law, the State law and Covered California requirement shall control unless otherwise required by law, rules and regulations.

c) Compliance Programs. Contractor shall, and shall require Participating Providers and all Subcontractors to, comply with all applicable Federal, State, and local laws, regulations, executive orders, ordinances and guidance, including, the Affordable Care Act, the California Affordable Care Act, the Americans with Disabilities Act, the Anti-Kickback Statute, the Public Contracts Anti-Kickback Act, the Stark Law, the Knox-Keene Health Care Service Plan Act of 1975, and California Insurance Code, as applicable.

1.3 Relationship of the Parties

a) Independent contractors. The parties acknowledge that in performance of the duties under this Agreement Covered California and Contractor are acting and performing as independent contractors. Nothing in this Agreement shall be construed or deemed to create a relationship of employer or employee or partner or joint venture or principal and agent between Covered California and Contractor. In accordance with State and Federal law, Covered California is not operating on behalf of Contractor or any Subcontractor of Contractor. Neither Contractor nor its Participating Providers, authorized Subcontractors, or any agents, officers, or employees of Contractor shall be deemed as agents, officers, employers, partners, or associates of Covered California.

b) Subcontractors. Contractor shall require any Subcontractor or assignee to comply with applicable requirements in this Agreement. Nothing in this Agreement shall limit Contractor's ability to hold Subcontractor liable for performance under a contract between Contractor and its Subcontractor(s). Contractor's obligations pursuant to this Agreement and applicable laws, rules and regulations shall not be waived or released if Contractor subcontracts or otherwise delegates services of this contract. Contractor shall exercise due diligence in the selection of Subcontractors and monitor services provided by Subcontractors for compliance with the terms of this Agreement and applicable laws, rules or regulatory requirements or orders.

    i. Notwithstanding any relationship(s) that Contractor may have with delegated and Downstream Entities, Contractor maintains responsibility for its compliance and the compliance of any of its delegated or Downstream Entities with all applicable federal standards related to Exchanges. Contractor maintains responsibility for ensuring its delegated and Downstream Entities comply with the Federal standards related to Exchanges, including the standards in 45 C.F.R. Part 156, subpart C with respect to each of its QHPs on an ongoing basis, as well as the Exchange processes, procedures, and standards in accordance with 45 C.F.R. Part 155, subpart K, unless the standard is specifically applicable to a Federally-facilitated Exchange.

    ii. Contractor's delegation agreements shall comply with the specifications included in 45 C.F.R. § 156.340 and must include language stating that Covered California may demand and receive the delegated or Downstream Entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to Contractor's obligations in accordance with federal standards until ten (10) years from the final date of the agreement period.

c) Contractor shall notify Covered California in advance of assignment or delegation of duties under this Agreement. Notification to Covered California shall apply to new assignment and delegation as well as changes or amendments to existing assignment or delegation for the following:

    i. Enrollment and Eligibility
    ii. Customer Service Call Center
    iii. Managed Behavioral Health Organizations (MBHOs) or Behavioral Health Vendor

iv. Third Party Administrator for Dental Providers
v. Third Party Administrator for Provider Contracts
vi. Third Party Administrator for Claims Administration

1.4 General Duties of Covered California

Covered California is approved by the United States Department of Health and Human Services ("DHHS") pursuant to 45 C.F.R. § 155.105 and performs its duties in accordance with State and Federal laws and this Agreement. The duties of Covered California include:

a) Certification of QHP Issuers (45 C.F.R. Part 155, Subpart K);

b) Consultation with stakeholders (45 C.F.R. § 155.130);

c) Consumer assistance tools and programs, including operation of a toll-free call center (45 U.S.C. § 18031(d) and 45 C.F.R. § 155.205);

d) Eligibility and enrollment determinations in Covered California for the Individual Market (45 C.F.R. Part 155, Subparts D and E);

e) Financial support for continued operation of Covered California (45 C.F.R. § 155.160);

f) Navigator program standards, in accordance with Federal rules, designed to raise awareness of Covered California by providing consumer access to education and other resources regarding eligibility, enrollment, and program specifications (45 C.F.R. § 155.210);

g) Non-interference with Federal law and nondiscrimination standards (45 C.F.R. § 155.120);

h) Notices to Enrollees (45 C.F.R. § 155.230);

i) Oversight, financial, and quality activities (45 C.F.R. § 155.200);

j) Participation of brokers to enroll Qualified Individuals in QHPs (45 C.F.R. § 155.220);

k) Ensuring that individuals can pay premiums owed directly to QHP issuers and ensuring compliance with related Federal requirements (45 C.F.R. § 155.240);

l) Privacy and security of personally identifiable information (45 C.F.R. § 155.260);

m) Use of standards and protocols for electronic transactions (45 C.F.R. § 155.270);

n) Operation and management of CalHEERS. Covered California also has a duty, as part of its management of CalHEERS, to determine how CalHEERS presents information about cost, quality, and provider availability for consumers to inform their selection of issuer and benefit design in Covered California. Covered California shall solicit comment from Contractor on the design but retains final authority to make design and presentation decisions in its sole discretion; and

o) Covered California agrees to provide a dedicated team member responsible for working with Contractor to resolve any and all issues that arise from implementation of Covered California.

1.4.1 Confidentiality of Contractor Documents

Covered California shall treat as confidential and exempt from public disclosure all documents and information provided by Contractor to Covered California, or to the vendor for Covered California, provided the documents or information are deemed to be, or qualify for treatment as, confidential information under the Public Records Act, Government Code § 7920.000 et seq., or other applicable Federal and State laws, rules and regulations. Documents and information that Covered California will treat as confidential include provider rates and Contractor's business or marketing plans.

1.5 General Duties of Contractor

Contractor and Covered California acknowledge and agree that Contractor's QHPs are important to furthering Covered California's goal of delivering better care and higher value. Contractor agrees that Contractor's QHPs submitted and certified through the annual certification process for the current Plan Year, shall be offered through Covered California to provide access to Covered Services to Covered California Enrollees in accordance with the terms and conditions required by this Agreement and as required for designation of each health insurance plan as a QHP.

Contractor shall maintain the organizational and administrative capacity to support and ensure implementation and operation of this Agreement. This requirement includes the following:

a) Contractor maintains the legal capacity to contract with Covered California and complies with the requirements for participation in Covered California pursuant to this Agreement and applicable Federal and State laws, rules and regulations;

b) A dedicated liaison is available as the primary contact person to coordinate and cooperate with Covered California in the implementation of this Agreement and the contact person and/or other personnel are available to Covered California as needed to fulfill Contractor's duties under this Agreement.

    i. Key individual(s) who will have primary responsibility for servicing the Covered California account and flow of responsibilities include the following representatives: Chief Executive Officer, Chief Finance Officer, Chief Operations Officer, Chief Medical Officer, and Dedicated Liaison.

        1. Contractor shall timely notify Covered California within ten (10) Days in the event of a change of key individual(s) (as defined in 1.5b)i.)) occurs.

c) Contractor's QHPs are offered in accordance with the terms and conditions of this Agreement and comply with the Affordable Care Act and the California Affordable Care Act and implementing regulations, and with applicable Federal and State laws, rules and regulations, as may be amended from time to time as required under applicable laws, rules and regulations, or as otherwise authorized under this Agreement;

d) Notify Covered California of:

    i. All routine or non-routine surveys and audits conducted by State and Federal Regulators concerning Contractor's Covered California lines of business;

    ii. Any material concerns identified by Contractor or material concerns, including any enforcement actions resulting in monetary penalties equal to or exceeding $100,000, identified by State and Federal Regulators that may impact Contractor's performance under this Agreement within ten (10) Days following Contractor's knowledge of such concern;

    iii. In the event Contractor fails to meet Medical Loss Ratio (MLR) minimum standards in the individual market, Contractor shall notify

Covered California of such failure on or before the date on which Contractor reports MLR rebate information to the U.S. Department of Health and Human Services pursuant to 45 C.F.R. § 158.260. The notice to Covered California shall include: (i) Contractor's MLR, (ii) the number of subscribers for both on and off-exchange in the individual market to whom issuer will pay a MLR rebate directly, (iii) the amount of rebates provided as a premium credit, (iv) the amount of rebates provided in lump sum, and (v) the amount of rebates that were de minimis and the number of subscribers who did not receive a rebate because it was de minimis.

e) Provide Covered California with copies of any preliminary or final reports, findings, or orders related to Subsection (d) of this Section 1.5, within 48 hours of Contractor receiving them from State and Federal Regulators; and

f) Participate in Business Review meetings between Covered California and Contractor to report and review program performance results, including all Services and components of the program, i.e., clinical, financial, contractual reporting requirements, customer service, appeals, and any other program recommendations.

g) All notifications shall be made according to the "Contract Reporting Requirements" table posted on Contractor's extranet website provided by Covered California (Carrier Management (External) page, PMD Resources, Contract Reporting Compliance).

1.6 Coordination with Other Programs

Contractor and Covered California recognize that the performance of Services under this Agreement depends upon the joint effort of Covered California, Contractor, Participating Providers, and other authorized Subcontractors of Contractor. Contractor shall coordinate and cooperate with Participating Providers and such Subcontractors to the extent necessary, and as applicable, to promote compliance by Participating Providers and such Subcontractors with the terms set forth in this Agreement. Contractor shall also coordinate and comply with requirements of other State agencies that affect its Enrollees, including, the Department of Health Care Services ("DHCS") (and the Medi-Cal program) regarding the development and implementation of CalHEERS with respect to eligibility and enrollment considerations or as may be required under inter-governmental agency agreements or other laws, rules, regulations, or program instructions.

Contractor shall cooperate with Covered California and other relevant government agencies to implement coverage or subsidy programs. Such programs may provide State or Federal funding for all or a portion of Covered California Enrollee premiums or subsidies to reduce or eliminate cost-sharing charges.

1.7 Changes in Requirements

The parties agree that Covered California may make prospective changes to benefits and services during a contract year to incorporate changes in State or Federal laws, requirements imposed by State and Federal Regulators, or as mutually agreed by Covered California and Contractor. The projected cost of any such benefit or service change will be included in the cost of health care projections and changes to the Monthly Rates will be implemented after Contractor has demonstrated the cost impact of the benefit or service change in accordance with the requirements set forth in Article 6.

1.8 Evaluation of Contractor Performance

Covered California shall evaluate Contractor's performance during Business Review meetings with respect to fulfillment of its obligations under this Agreement on an ongoing basis, including as described in Section 1.5 f). In the event evaluations conducted by Covered California reveal a significant problem or pattern of non-compliance with terms of this Agreement as reasonably determined and documented by Covered California, Covered California shall have the right, without limitation, to conduct reasonable additional reviews of Contractor's compliance and operational performance. Such evaluations shall also be considered in connection with decisions relating to re-certification and de-certification in accordance with the terms set forth at Article 8.

1.9 Required Notice of Contractor Changes

Notices pursuant to this Section shall be provided by Contractor promptly within ten (10) Days following Contractor's knowledge of such occurrence; provided, however, such notice shall be provided immediately if such occurrence may reasonably be deemed to adversely affect the quality of care or safety of Covered California Enrollees.

All written notices from Contractor pursuant to this Section shall contain sufficient information to permit Covered California to evaluate the events under the same criteria that were used by Covered California in its award of this Agreement to Contractor. Contractor agrees to provide Covered California with such additional

information as Covered California may request. If Contractor requests confidential treatment for any information it provides, Covered California shall treat the information as confidential, consistent with Section 1.4.1..

Contractor shall notify Covered California in writing upon the occurrence of any of the following events:

a) Contractor is in breach of any of its obligations under this Agreement;

b) Change in the majority ownership, control, or business structure of Contractor;

c) Change in Contractor's business, partnership or corporate organization that may reasonably be expected to have a material impact on Contractor's performance of this Agreement or on Covered California's rights under this Agreement;

d) Breach by Contractor of any term set forth in this Agreement or Contractor otherwise ceases to meet the requirements for a QHP Issuer, including those set forth at 45 C.F.R. § 156.200 et seq. (Subpart C - Qualified Health Plan Minimum Certification Standards);

e) Immediate notice in the event that Contractor files any federal bankruptcy action or state receivership action, any federal bankruptcy or state receivership action is commenced against Contractor, Contractor is adjudicated bankrupt, or a receiver is appointed and qualifies; and

f) Changes in Contractor's Provider Network by notice consistent with Section 4.3.

    i. Contractor shall notify Covered California with respect to any material changes to its Essential Community Provider (ECP) contracting arrangements consistent with Section 4.3.4; and

    ii. Significant changes in operations of Contractor that may reasonably be expected to significantly impair Contractor's operation of QHPs or delivery of Covered Services to Covered California Enrollees.

1.10 Nondiscrimination

a) Services and Benefits. During the performance of this Agreement, Contractor shall not, and shall require Participating Providers and other Subcontractors, as well as their agents and employees to not, in accordance with the Affordable Care Act Section 1557 (42 U.S.C. § 18116), cause an individual to

be excluded on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 U.S.C. § 2000d et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. § 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. § 6101 et seq.), or Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), or subject to any other applicable State and Federal laws, from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity offered through Covered California.

b) Employment and Workplace. Contractor shall not, and shall require Participating Providers and other Subcontractors, as well as their agents and employees to not, unlawfully discriminate, harass or allow harassment, against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS)), mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), age (40 or over), marital status, genetic information, sexual orientation, gender identity, or use of family and medical care leave. Contractor shall, and shall require Participating Providers and other Subcontractors, as well as their agents and employees, to evaluate and treat employees and applicants for employment in a manner that is free from such discrimination and harassment. Contractor shall, and shall require Participating Providers and Subcontractors, as well as their agents and Employees, to comply with the provisions of the Fair Employment and Housing Act (Government Code § 12900 et seq.) and the applicable regulations promulgated thereunder (2 CCR § 10000 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code §12990, set forth in CCR Chapter 5 of Division 4.1 of Title 2, including, 2 CCR § 11102 et seq., are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Contractor shall, and shall require Participating Providers and other Subcontractors to give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Contractor shall include the nondiscrimination and compliance provisions of this clause in all subcontracts to perform work under this Agreement.

1.11 Conflict of Interest; Integrity

Contractor shall be, and shall require Participating Providers to be free from any conflicts of interest with respect to Services provided under this Agreement. Contractor represents that Contractor and its personnel do not currently have, and will not have throughout the term of the Agreement, any direct interest that may present a conflict in any manner with the performance of Services required under this Agreement. Contractor also represents that it is not aware of any conflicts of interest of any Participating Provider or any basis for potential violations of Contractor or Participating Provider with respect to laws, rules and regulations that govern referrals required for the provision of certain Covered Services, including Federal and State anti-kickback and anti-self-referral laws, rules and regulations. Contractor shall immediately (i) identify any conflict of interest that is identified during the term of the Agreement, and (ii) take any necessary action to assure that any activities are not improperly influenced by a conflict of interest.

Contractor shall comply with any and all other policies adopted by Covered California regarding conflicts of interest and ethical standards, copies of which shall be made available by Covered California for review and comment by Contractor prior to implementation.

1.12 Other Financial Information

In addition to financial information to be provided to Covered California under other provisions of this Agreement or pursuant to applicable laws, rules and regulations, at the request of Covered California, Contractor shall provide Covered California with financial information that is (i) provided by Contractor to State and Federal Regulators or other regulatory bodies, or (ii) reasonable and customary information prepared by Contractor, including supporting information relating to Contractor's Enrollees. Possible requests may include annual audited financial statements and annual profit and loss statements.

1.13 Other Laws

Contractor shall comply with applicable laws, rules and regulations, including the following:

a) Americans with Disabilities Act. Contractor shall comply with the Americans with Disabilities Act (ADA) of 1990, (42 U.S.C. § 12101 et seq.), which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA, unless specifically exempted.

b) Drug-Free Workplace. Contractor shall comply with the requirements of the Drug-Free Workplace Act of 1990 (Government Code § 8350 et seq.).

c) Child Support Compliance Act. Contractor shall fully comply with all applicable State and Federal laws relating to child and family support enforcement, including disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with § 5200) of Part 5 of Division 9 of the Family Code.

d) Domestic Partners. Contractor shall fully comply with Public Contract Code § 10295.3 with regard to benefits for domestic partners.

e) Environmental. Contractor shall comply with environmental laws, rules and regulations applicable to its operations, including, those relating to compliance with the requirements of the Electronic Waste Recycling Act of 2003, Chapter 8.5, Part 3 of Division 30, commencing with § 42460 of the Public Resources Code, relating to hazardous and solid waste.

f) Other Laws. Contractor shall comply with any and all other State and Federal laws, rules and regulations applicable to this Agreement, to the operation of Covered California, and to Contractor's provision of Services under this Agreement.

1.14 Contractor's Representations and Warranties

Contractor represents and warrants that neither the execution of this Agreement by Contractor, nor the acts contemplated hereby, nor compliance by Contractor with any provisions hereof will:

a) Violate any provision of the charter documents of Contractor;

b) Violate any laws, rules, regulations, or any judgment, decree, order, regulation or rule of any court or governmental authority applicable to Contractor; or

c) Violate, or be in conflict with, or constitute a default under, or permit the termination of, or require the consent of any person under, any agreement to which Contractor may be bound, the occurrence of which in the aggregate would have a material adverse effect on the properties, business, prospects, earnings, assets, liabilities, or condition (financial or otherwise) of Contractor.

Due Organization. Contractor represents and warrants that it is duly organized, validly existing, and in good standing under the laws of the state of its incorporation or organization.

Power and Authority. Contractor represents and warrants that: (i) it has the power and authority to enter into this Agreement and to carry out its obligations hereunder; (ii) the execution of this Agreement has been duly authorized and executed by Contractor and no other internal proceeding on the part of Contractor is necessary to authorize this Agreement; and (iii) to the best of its knowledge, Contractor has completed, obtained, and performed all registrations, filings, approvals, authorizations, consents, or examinations required by any State and Federal Regulators and other government or governmental authority for its acts contemplated by this Agreement.

1.15 Fraud, Waste and Abuse; Ethical Conduct

Contractor shall maintain and enforce policies, procedures, processes, systems, and internal controls (i) to reduce Fraud, Waste, and Abuse, and (ii) to enhance compliance with other applicable laws, rules, and regulations in connection with the performance of Contractor's obligations under this Agreement.

a) Contractor shall maintain an effective compliance program that includes a minimum of the following "7 Core Elements" as defined by CMS: Written Policies, Procedures and Standards of Conduct; Compliance Program Oversight; Training and Education Communication; Auditing and Monitoring; Consistent Discipline; and Corrective Actions and meets the requirements of applicable laws, rules, and regulations Contractor shall provide evidence of such compliance program as reasonably requested by Covered California.

b) Contractor shall communicate within ten (10) Days to Covered California any material concerns identified by Contractor or material concerns, including any enforcement actions resulting in monetary penalties equal to or exceeding $100,000, identified by State and Federal Regulators related to regulatory compliance that may impact performance under this Agreement following Contractor's knowledge of such occurrence; provided, however, such notification shall be provided immediately if such occurrence may reasonably be deemed to adversely affect the quality of care or safety of Covered California Enrollees. All notifications shall be made according to the "Contract Reporting Requirements" table posted on Contractor's extranet website

provided by Covered California (Carrier Management (External) page, PMD Resources, Contract Reporting Compliance).

c) If Contractor receives any preliminary or final reports, findings, or orders related to material concerns identified by State and Federal Regulators that may impact performance under this Agreement pursuant to this Section, it shall provide Covered California with copies of them within 48 hours of receiving them from State and Federal Regulators.

d) Contractor shall provide Covered California with a description of its fraud, waste, and abuse detection and prevention programs and report total monies recovered by Contractor in the most recent 12-month period for Contractor's total book of business as well as, total monies recovered for Covered California business only. This description shall be updated during each year that this Agreement is in effect and shall include an overview of fraud and abuse detection and prevention program activities conducted by Contractor, Participating Providers, other Subcontractors and their authorized Agents, including a summary of key findings, relevant data analytics and fraud risk assessments to circumvent fraud, waste, and abuse, and the development, implementation, and enforcement of any corrective action plans for changing, upgrading, or improving these programs.

e) Contractor shall maintain and enforce a code of ethical conduct and make it available to Covered California upon request.

f) Contractor shall refer potential fraud activities identified through fraud detection and response measures to Covered California. Contractor shall follow the established Carrier Referral Process posted on Contractor's extranet website provided by Covered California (Carrier Management (External) page, Contractor's folder, Data Integrity, Fraud Referral folder).

g) Contractor shall not terminate Covered California Enrollee coverage for fraud without prior review and approval from Covered California.

1.16 Current Enrollee Notification

Contractor shall notify Contractor's Enrollees of the availability of Covered California coverage and potential eligibility for subsidies in Covered California as required in State and Federal law. Contractor shall identify potential subsidy-eligible individuals, educate them about Covered California coverage, and assist them in enrolling in QHPs in Covered California.

ARTICLE 2 – ELIGIBILITY AND ENROLLMENT

2.1 Eligibility and Enrollment Responsibilities

2.1.1 Covered California Responsibilities

a) Covered California shall be solely responsible for the determination of eligibility and enrollment of individuals in Covered California in accordance with applicable Federal and State laws, rules and regulations.

b) Covered California shall determine eligibility and enroll eligible individuals in Covered California pursuant to its management and participation in CalHEERS, a project jointly sponsored by Covered California and DHCS with the assistance of the Office of Systems Integration. Covered California and CalHEERS shall develop, implement, and maintain processes to make the eligibility and enrollment decisions regarding Covered California and other California health care programs and submit that information to Contractor in a timely manner in accordance with Federal and State laws, rules and regulations, and the terms set forth in this Agreement.

c) Covered California shall notify Contractor regarding each eligible applicant who has completed an application for enrollment and selected Contractor as the QHP Issuer. Covered California shall transmit information required for Contractor to enroll the applicant within five (5) business days of receipt of verification of eligibility and selection of Contractor's QHP.

d) Covered California shall send enrollment information to Contractor on a daily basis and Contractor shall reconcile specified enrollment information received from Covered California with Contractor's enrollment data on a monthly basis through the Reconciliation Process.

e) Covered California shall utilize the Dispute Process pursuant to Section 2.1.2 d) to resolve issues related to the Reconciliation Process.

2.1.2 Contractor Responsibilities

a) Contractor shall comply with all Federal and State eligibility and enrollment laws and regulations, including the Affordable Care Act § 1411 et seq. (42 U.S.C. § 18081 et seq.), 45 C.F.R. § 155.400 et seq., Government Code §§ 100503 and 100503.4, and 10 CCR § 6400 et seq.

b) Contractor shall comply with all Covered California eligibility and enrollment determinations, including those made through CalHEERS and that result from an applicant's appeal of a Covered California determination. Within ten (10) Days of receiving a request from Covered California to implement the appeals decision, Contractor shall implement appeals decisions and provide communication to Covered California with evidence the appeal resolution has been implemented. Contractor shall immediately notify Covered California if it receives an appeal decision that does not have all necessary data elements required for Contractor to implement the appeal decision. In the event that a Covered California Enrollee requires immediate care, the QHP Issuer will work closely with Covered California to implement any eligibility or enrollment changes as soon as reasonably possible. Contractor shall accept all Enrollees assigned by Covered California except as otherwise authorized by policies and procedures of Covered California or upon the approval of Covered California.

c) Contractor shall participate in the Reconciliation Process to review and compare the Covered California enrollment reconciliation file, distributed monthly, against Contractor's membership enrollment and financial databases. Contractor shall prepare a comparison extract in accordance with the file validations and resolution timelines, as mutually agreed upon in the "Data Integrity Reconciliation Process Guide". Contractor shall provide Covered California with evidence through email confirmation that the enrollment and financial changes identified through the Reconciliation Process have been implemented within fifteen (15) business days. Further evidence of implementation is provided by individual records submitted in the next reconciliation cycle. Contractors are to follow the process as stated in the "Reconciliation Process Guide". In the event Contractor is unable to implement the changes within fifteen (15) business days, Contractor shall provide written notification to Covered California by the fifteenth (15th) business day. The written notification shall explain the reason why such changes cannot be implemented by the due date and shall identify another date in which the changes will be implemented.

   In the event Covered California identifies ongoing and persistent data issues (including L2 data errors) with Contractor through the Reconciliation Process which have persisted for two reconciliation cycles or more and have not been resolved, Contractor shall conduct root cause analysis, develop a corrective action plan to resolve the issues, and shall identify the implementation date of when the issues will be resolved. Contractor's written analysis shall be

provided to Covered California within sixty (60) Days from Covered California's request.

d) Contractor shall participate in the Dispute Process established by Covered California to resolve issues related to the Reconciliation Process. Contractor shall submit a supplemental file to dispute identified discrepancies found in the Covered California enrollment reconciliation file in accordance with the defined list of fields and technical requirements established by Covered California through the "Data Integrity Reconciliation Dispute Process Guide."

   Contractor shall utilize Covered California's Dispute Process, prior to submitting premium tax credit disputes to the Center for Medicaid and Medicare Services or the Center for Consumer Information and Health Insurance Oversight.

e) Contractor shall rely upon Covered California as the system of record for eligibility and enrollment during the term of this Agreement; provided, however, that Contractor shall: (i) reconcile premium payment information with enrollment and eligibility information received from Covered California on a monthly basis, and (ii) Contractor shall only accept changes to eligibility information submitted by Covered California Enrollees when Covered California notifies or confirms such change to Contractor.

2.1.3 Collection Practices

Contractor shall maintain fair and reasonable collection practices that comply with applicable laws, rules and regulations. Contractor shall monitor the collection activities and provide Covered California with reasonable documentation to facilitate Covered California's monitoring, tracking, or reporting with respect to Contractor's collection efforts including, policies, and procedures, and copy of any form of delinquency or termination warning, or notice sent to a Covered California Enrollee or Employer. Contractor shall not initiate collection activities if they have knowledge of a pending appeal, including notice from the consumer, Covered California, or Contractor's State Regulators.

2.2 Covered California for the Individual Market

2.2.1 Open Enrollment, Auto Enrollment, and Special Enrollment Periods

Contractor acknowledges and agrees that Covered California is required to: (i) allow Qualified Individuals to enroll in a QHP or change QHPs during annual Open Enrollment Periods, (ii) automatically enroll specified qualified individuals in

coverage pursuant to Government Code 100503.4, and (iii) allow certain Qualified Individuals to enroll in or change QHPs during Special Enrollment Periods as a result of specified triggering events per applicable Federal and State laws, rules and regulations. Contractor agrees to accept new Enrollees in Covered California who enroll during these periods and shall coordinate and participate with Covered California vendor's automated system for verification of Special Enrollment Period triggering events through a mutually agreed upon process.

2.2.2 Covered California for the Individual Market Coverage Effective Dates

Contractor shall ensure coverage effective dates for the Covered California Enrollee are consistent with applicable State law.

Covered California and Contractor shall require payment of premium in accordance with the premium payment due dates specified in 10 CCR § 6410 and the premium payment process specified in 10 CCR § 6500 and other applicable State law.

Contractor shall provide Covered California with information necessary to confirm Contractor's receipt of premium payment from a Covered California Enrollee that is required to commence coverage. Covered California shall establish the specific terms and conditions relating to commencement of coverage, including the administration of a state financial assistance program, advance payments of the premium tax credit and cost sharing reductions, and cancellation or postponement of the effective date of coverage in the event of nonpayment or partial payment of an initial premium, in accordance with applicable laws, rules and regulations.

The first premium binder payment shall be either paid directly to Contractor or processed through a third-party administrator and deposited into an account owned by the third-party administrator and settled by the third-party administrator to Contractor's own bank account.

2.2.3 Premiums for Coverage in Covered California for the Individual Market

Contractor shall not be entitled to collect from Covered California Enrollees or receive funds above the premium amounts except with respect to cost-sharing amounts or to the extent that such payment (i) is expressly authorized under the QHPs, such as out-of-network services that comply with the notice requirements set forth at Section 4.4.3, or (ii) relates to a charge for non-sufficient funds or transaction fees initiated by a Covered California Enrollee at rates that are

reasonable and customary for such transactions. Contractor shall not pursue collections of any said fees from Covered California. Contractor shall not pursue collection of any delinquent premiums from Covered California for an Enrollee enrolled in Covered California for the Individual Market who is responsible for directly paying their premium to Contractor.

In the case of partial month enrollments Contractor shall follow the methodology specified in 10 CCR § 6500(i):

The premium for coverage lasting less than one month shall equal the product of:

a) The premium for one month of coverage divided by the number of Days in the month; and
b) The number of Days for which coverage is being provided in the month.

The same methodology shall apply to the proration of APTC, State premium assistance payments, and CSR amounts for a coverage lasting less than one (1) month.

Premiums charged to individuals includes the assessment of the Participation Fee.

2.2.4 Terminations of Coverage

Contractor shall provide a Covered California Enrollee with notice and shall terminate coverage in a Contractor's QHP in accordance with the requirements established by Covered California pursuant to 10 CCR § 6506 and other applicable State and Federal laws, rules, and regulations.

Contractor shall terminate coverage for an individual Covered California Enrollee's non-payment of premium as follows: (i) effective as of the last Day of the first month of a three (3) month grace period in the event of nonpayment of premiums by individuals receiving advance payments of the premium tax credit or State premium assistance payments; or (ii) effective the last Day of coverage established by grace periods under applicable State law, including requirements relating to Health and Safety Code § 1365 and Insurance Code § 10273.6 for individuals not receiving advance payments of the premium tax credit or State premium assistance.

Contractor shall notify the Agent or Agency of Record of a late payment notification at the same time the Covered California Enrollee receives notification.

Covered California must send a termination transaction to Contractor within ten (10) business days of any individual Covered California Enrollee termination. Contractor must send a termination transaction to Covered California within ten (10) Days of grace period expiration.

Contractor shall request termination of a Covered California Enrollee for fraud or misrepresentation through the Carrier Referral Process posted on Contractor's extranet website provided by Covered California (Carrier Management (External) page, Contractor's folder, Data Integrity, Fraud Referral folder) and provide Covered California with supporting documentation for each request to terminate. Contractor may not terminate for fraud or misrepresentation without prior approval from Covered California.

2.2.5 Notice to Provider Regarding Covered California Enrollee's Grace Period Status

a) In the event of nonpayment of premium by an individual Covered California Enrollee receiving advance payments of the premium tax credit or state advance premium assistance subsidy, or both, Contractor shall provide notice to its network providers in accordance with the applicable state and federal law.

b) Notwithstanding (a) above, this notice obligation does not relieve the QHP Issuer from compliance with existing state laws governing claims payment.

ARTICLE 3 – PROMOTING ENROLLMENT

Covered California selectively contracts with Health Insurance Issuers that agree to actively support and work to achieve Covered California's mission of increasing the number of insured Californians—and maintaining their coverage across programs. Having insurance coverage is a vital first step toward assuring all Californians get the best care possible and to improving health equity and reducing health disparities. Given California's diversity, Covered California and Contractor agree to engage in diverse and varied efforts to promote enrollment and support consumers moving between forms of coverage. Covered California and Contractor agree to conduct independent, coordinated and complementary efforts to reduce gaps in coverage by supporting Enrollee transitions between coverage programs, conduct active marketing and outreach efforts and to support Agents to provide Enrollees the in-person and in-language education and enrollment support they need to make informed choices. Covered California and Contractor agree to support these efforts as enumerated in this Article.

Although the requirements and expectations in this Article are not included as performance standards in Attachment 2 — Performance Standards with Penalties and Attachment 3 — Performance Standards and Expectations, Covered California will actively monitor Contractor's performance with respect to its obligations under this Article and will factor in such performance in its decisions to recertify Contractor's QHPs in future years.

3.1 Transitions of Coverage

To further Covered California's mission of ensuring that as many individuals possible have the benefit of insurance coverage, Contractor agrees to establish policies and practices in coordination with Covered California that maximize smooth transitions and facilitate coverage for Enrollees to and from Covered California and other health coverage programs, including between Medi-Cal, Medicare, and other governmental health care programs, employer-sponsored insurance (ESI), and for individuals with off-exchange coverage who may now or in the future benefit from Advanced Premium Tax Credits. With regard to facilitating the enrollment of consumers leaving ESI, Contractor shall coordinate with Covered California to make best efforts to ensure all consumers leaving ESI, including those who may be eligible for coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and the California Continuation Benefits Replacement Act, Health and Safety Code § 1366.20 et seq. ("Cal-COBRA"), understand the options they may have for coverage through Covered California. Covered California expects Contractor to fully assist

enrollee transition to other eligible coverage either in Medi-Cal or Covered California, as applicable and permitted by such programs.

Covered California will assist enrollee transition from Covered California to coverage through Medi-Cal, Medicare, or ESI.

To the extent Contractor has enrollees in small and large group ESI or Medi-Cal, to further the parties' commitment to maximizing enrollment in health insurance coverage, Contractor will work with Covered California to develop and implement operational processes to ensure continuity of coverage for Enrollees transitioning from Contractor's non-exchange lines of businesses to Covered California. This includes conducting consumer outreach efforts and supporting Covered California in the implementation of auto-enrollment or facilitated enrollment activities.

Contractor shall conduct Consumer outreach to include an annual notification to Enrollees in Contractor's individual and group health care coverage regarding their potential eligibility for reduced or no-cost coverage through Covered California and Medi-Cal as required by Health and Safety Code § 1366.50 and California Insurance Code §10786, and as further required by those statutes, shall provide Enrollee contact data for Covered California's outreach to consumers who terminated from ESI coverage and are not known to have transitioned to other health coverage. Contractor shall make best efforts to assist Enrollees with transitioning to and from other programs, including prominently displaying information in termination of coverage material, on Contractor's website, and by educating Service Center representatives on eligibility and enrollment considerations.

Contractor shall work with Covered California and support implementation processes to assist Enrollees that may be eligible for auto-enrollment in Covered California coverage, including notification on coverage options or Enrollee's right to opt-out of coverage. Contractor shall work with Covered California on content development to ensure consumers receive consistent messaging and experience. Contractor shall ensure that effectuation only occurs either after binder payment is received or Enrollee opts-in to coverage.

3.2 Marketing

3.2.1 Enrollment and Marketing Coordination and Cooperation

Covered California and Contractor recognize that effective enrollment of eligible individuals depends on robust efforts taken by both parties and successful coordination on efforts to do marketing and outreach to promote enrollment. Covered California invests a substantial portion of its annual budget on multi-segment marketing efforts during both the Open and Special Enrollment Periods to market coverage via its QHPs and drive enrollment. Contractor is expected to engage in robust marketing, including direct response and co-branded marketing with Covered California, to drive enrollment and promote the value of health insurance coverage.

Contractor is expected to spend at least 0.4% of projected premium on direct response advertising, outreach and community-based efforts, and non-open enrollment "brand" marketing that includes co-branding with Covered California. Brand marketing that does not reference Covered California does not count towards this expectation.

3.2.1.1 Covered California Activities to Promote Enrollment

Covered California will take such action as it deems necessary and feasible to develop and implement programs and activities to support Contractor in its marketing and enrollment efforts, in accordance with applicable laws, rules and regulations. Such activities may include making available the following programs and resources for use by or for the benefit of Contractor:

a) The Shop and Compare Tool available by electronic means to facilitate a comparison of QHPs that is consistent with tools Covered California will use for its own eligibility screenings, to ensure that preliminary eligibility screenings use the same tool;

b) Education, marketing, and outreach programs that will seek to increase enrollment through Covered California and inform consumers, including Contractor's current Enrollees, that there is a range of QHPs available in Covered California in addition to Contractor's QHPs;

c) A standard interface through which Contractor shall electronically accept the initial binding payment (via credit card, debit card, Automated Clearing House or other mutually acceptable means of electronic funds transfer, mutually acceptable web-based payments, which may include accepting

online credit card payments, and all general-purpose pre-paid debit cards and credit card payment) to effectuate coverage in Covered California for the Individual Market;

d) Complete documentation and reasonable testing timelines for interfaces with Covered California's eligibility and enrollment system;

e) Eligibility and enrollment training for Contractor's staff and for licensed Agents and brokers;

f) Joint marketing programs to support renewal, retention, and enrollment in Covered California of existing members of Contractor's health insurance plans who are eligible for the Federal subsidies;

g) Joint marketing activities of Covered California, Contractor, and other Health Insurance Issuers designed to drive awareness and enrollment in Covered California;

h) Covered California's annual marketing plans, including Open Enrollment Period, Special Enrollment Period, and retention and renewal efforts; and

i) Customer service support that will include substantially extended customer service hours during Open Enrollment Periods.

Covered California will treat as confidential all Contractor marketing plans, materials, and spend reports consistent with Section 1.4.1. The obligation of Covered California to maintain confidentiality of this information shall survive termination or expiration of this Agreement.

3.2.1.2 Contractors Activities to Promote Enrollment

Contractor shall support marketing and enrollment efforts as follows:

a) Contractor shall prominently display a link to the Covered California website landing page, https://www.coveredca.com/, on its website in a location that is easily accessible to consumers;

b) Educate its Agents on Contractor's QHPs offered in Covered California, work with Covered California to efficiently educate its Agents and brokers about Covered California's individual marketplace, and inform Agents that a prospective Enrollee's health status is irrelevant to advice provided with respect to health plan selection other than informing individuals about their estimated out-of-pocket costs;

c) Provide education and awareness regarding eligibility for Federal tax credits, plan offerings and benefits available through Covered California in connection with any applicable outreach to Contractor's existing members, as mutually agreed;

d) Make any translated marketing and outreach materials available concurrently with English materials;

e) Cooperate with Covered California to develop and implement a Covered California Enrollee retention plan;

f) Submit to Covered California Open Enrollment Period, Special Enrollment Period, and Retention and Renewal marketing plans as defined in Section 3.2.2.2;

g) Submit to Covered California marketing material as defined in Section 3.2.2.2;

h) After the applicable annual periods close, submit to Covered California actualized marketing spend reports for Open Enrollment Period, Special Enrollment Period, and Retention and Renewal as defined in Section 3.2.2.2;

i) Have successfully tested interfaces with Covered California's eligibility and enrollment system or be prepared to complete successful interface tests by dates established by Covered California; and

j) Contractor shall accept the following payment types for binder and monthly premium payments: credit card, debit card, Automated Clearing House, or other mutually acceptable means of electronic funds transfer; mutually acceptable web-based payments, which may include accepting online credit card payments, and all general-purpose pre-paid debit cards and credit card payment; as well as paper checks, cashier's checks, money orders, and cash from Covered California Enrollees for the Individual Market.

3.2.2 Enrollee Materials and Branding Documents

3.2.2.1 Co-branded Materials

a) Contractor shall include the Covered California logo on premium invoices, Covered California Enrollee identification cards, and Covered California Enrollee termination notices. Contractor shall include the Covered California logo and other information in notices and other materials based upon the mutual agreement of Covered California and Contractor as to which materials

will include the Covered California logo. Contractor must submit these materials to Covered California as defined in Section 3.2.2.2.

b) Contractor shall comply with Covered California co-branding requirements related to the format and use of the Covered California logo as outlined in the Covered California Brand Style Guide. Covered California shall post the Brand Style Guide on Contractor's section of the extranet website provided by Covered California (Hub page, Marketing Resources library).

   i. Identification Cards. Contractor shall issue identification cards to Covered California Enrollees in a form that shall be agreed to by Covered California. Contractor shall submit proposed identification cards to Covered California annually, at least thirty (30) Days prior to Open Enrollment.

c) Except as otherwise provided in Section 3.2.2.2, Contractor may, at its discretion, co-brand other marketing materials such as TV, radio, out-of-home, print, digital, social, etc.

3.2.2.2 Marketing Materials that Must Be Submitted to Covered California

a) Co-branded Materials. Contractor must submit all co-branded marketing materials to Covered California at least ten (10) Days prior to releasing materials publicly unless specified otherwise within this Section. The materials provided to Covered California under this Section will not require prior approval by Covered California before Contractor distributes such materials; provided, however, that Contractor shall make a good faith effort to incorporate any changes proposed by Covered California with respect to such materials.

b) Acquisition Marketing Materials. Contractor shall provide Covered California with marketing materials and related collateral used by Contractor to promote enrollment of the individual market inside and outside Covered California, such as TV, radio, out-of-home, print, digital, social, or any other media channel used in the campaigns at least thirty (30) Days prior to Open Enrollment Period, and at least thirty (30) Days prior to Special Enrollment Period, and at such other intervals as may be reasonably requested by Covered California. Materials submitted should be a representative sample of the larger body of work. Covered California shall treat these materials as confidential consistent with Section 1.4.1.

c) Marketing Plans. Contractor and Covered California recognize that uninsured Californians, Covered California Enrollees and other health care consumers benefit from efforts relating to outreach activities designed to increase awareness of coverage options available through Covered California and encourage enrollment. The parties shall create and share marketing plans on an annual basis and at such other intervals as may be reasonably requested by Covered California. Contractor shall submit to Covered California an Open Enrollment Marketing Plan at least thirty (30) Days prior to the Open Enrollment Period, a Special Enrollment Marketing Plan at least thirty (30) Days prior to the Special Enrollment Period, and a Retention and Renewal Marketing Plan at least thirty (30) Days before the Calendar Year begins. The marketing plans of Covered California and Contractor shall include proposed and actual marketing approaches, proposed spending amounts, messaging and channels, and provide samples of any planned marketing materials and related collateral. Contractor shall include this information for both on and off-exchange individual market efforts. Covered California shall treat these materials as confidential consistent with Section 1.4.1.

d) Actualized Spend Reports. After the applicable enrollment periods close, submit to Covered California actualized spend reports for:

    i. Open Enrollment Period within thirty (30) Days after Open Enrollment Period closes;

    ii. Special Enrollment Period, and Retention and Renewal within sixty (60) Days after the Calendar Year ends for Contractor that participated in Covered California for that full Calendar Year.

e) Contact Guidelines. Covered California creates and posts a Covered California Enrollee Contact Guideline document for Contractors on the Marketing Resources page (Hub page, Marketing Resources library, QHP-QDP Enrollee Contact Guideline folder) of the Covered California extranet website by March 1 each Calendar Year. This document outlines the instances when Covered California Enrollees should contact Contractor and when they should contact Covered California. Contractor shall provide Covered California Enrollees with information on the instances when Covered California Enrollees should contact Contractor and when they should contact Covered California to resolve inquiries. Contractor may provide this information to Covered California Enrollees by: welcome letter or package, buck slip, insert, website or mail. Contractor shall submit to Covered California how the Covered California Enrollee Contact Guideline document

was shared with Covered California Enrollees at least (30) Days prior to Open Enrollment. The materials provided to Covered California under this Section will not require prior approval by Covered California before Contractor distributes such materials; provided, however, that Contractor shall make a good faith effort to incorporate any changes proposed by Covered California with respect to such materials.

f) Contractor Logo. In the event of a logo modification or rebrand, Contractor shall submit new logo to Covered California in a high-resolution design file format. Covered California will make a reasonable effort to update Contractor logo on all platforms in a timely manner. If Covered California advertising or collateral assets are already in production or live in market, Contractor acknowledges there may be some delay with incorporating the new version of the logo across all applicable assets.

3.2.2.3 Member Communications Materials

Upon request, Contractor shall provide Covered California with at least one (1) copy, unless otherwise specified, of any information Contractor intends to send or make available to all Covered California Enrollees, including, Evidence of Coverage (EOC), Enrollee newsletters, new Enrollee materials, health education materials, and special announcements. The materials provided to Covered California under this Section will not require prior approval by Covered California before Contractor distributes such materials; provided, however, that Contractor shall duly evaluate any changes proposed by Covered California with respect to such materials. Contractor shall maintain an electronic file that is open to Covered California, or email requested materials to Covered California. Such files shall be accessible by Covered California as required by applicable laws, rules and regulations, and as otherwise mutually agreed upon by the parties.

3.2.2.4 Mailing Addresses; Other Enrollment Information

Contractor shall update a Covered California Enrollee's address and other enrollment information on a continuous basis based on information Contractor receives from Covered California.

3.2.2.5 Evidence of Coverage on Contractor's Website

During each year of this Agreement which carries over into a subsequent Plan Year, Contractor shall make the Evidence of Coverage (EOC), including any documents referenced in the EOC, for the next benefit year available on Contractor's website no later than the first Day of the Open Enrollment Period

provided that Contractor has received any revisions in the material that is to be included in the EOC from Covered California and the State Regulators in sufficient time to allow for posting on the first Day of Open Enrollment. The EOC for the then-current benefit year shall remain on Contractor's website through December 31 of the then-current benefit year.

3.2.2.6 Distribution of Enrollment Materials

Contractor agrees to distribute to effectuated or pending Enrollees on and off-exchange the Open Enrollment publications developed and produced by Covered California for Enrollees prior to the Open Enrollment Period at a time and via a distribution method mutually agreed to by Contractor and Covered California. Contractor shall be responsible for the distribution cost associated with these publications.

3.2.3 Additional Marketing Efforts

a) Covered California may engage in additional marketing activities to ensure consumers are aware of new laws and new programs that could impact consumers, such as the State premium assistance program and State mandate. As part of those activities, Covered California may conduct marketing efforts co-branded with all QHP Issuers currently participating in Covered California or branded only with Covered California, including radio, television, or print advertisements, and make additional media buys using existing or new collateral and material, on behalf of Contractor.

b) Upon mutual agreement of the additional marketing activities, Contractor shall pay Covered California a mutually-agreed upon dollar amount to conduct those marketing activities, in accordance with Section 6.1.1 e).

3.3 Agents in Covered California for the Individual Market

Covered California recognizes that Agents provide an indispensable service to the Exchange and its QHPs, enrolling and renewing Covered California's Enrollees. Agents provide Enrollees the proactive in-language support, plan expertise, and encouragement crucial to capturing and maintaining a healthy risk mix for Covered California and increasing enrollment among historically underserved and uninsured populations. In addition, many Agents maintain and staff Covered California branded storefronts, providing walk-in enrollment locations for Enrollees hesitant to seek coverage online or by phone. Agents also provide help on demand to consumers, including outside of standard business hours.

The successful continuance of Covered California's robust enrollment and healthy risk mix depends on the efforts of its Agents. To this end, Covered California requires Contractor to contract with and adequately compensate Agents for enrollments in its QHPs.

a) Compensation. The provisions of this Section apply to Agents who sell Contractor's QHPs through Covered California for the Individual Market.

b) Compensation Methodology. Covered California recognizes that Agents provide critical services and education to consumers, including Contractor's current Enrollees, which assists consumers and Enrollees with determining the best QHP to suit their health insurance coverage needs. Contractor must pay a reasonable commission to Agents to ensure Contractor is fairly and affirmatively offering all of its products at each metal level during both Open and Special Enrollment Periods that allows the Agents to continue providing services. Contractor shall be solely responsible for compensating Agents who sell Contractor's QHP through the individual market of Covered California. Contractor shall use a standardized Agent compensation program with levels and terms that shall result in the same aggregate compensation amount to Agents whether products are sold within or outside of Covered California. Contractor shall provide Covered California on an annual basis, a document describing its standard Agent compensation program. This document shall include a description of its Agent commission, and bonus or incentive programs, standard Agent contract, and Agent policies. Agent commission descriptions must detail both new and renewal enrollment commission rates. Any reduction in Contractor's Agent commission rates after the annual Qualified Health Plan Certification negotiation meeting between Covered California and Contractor must be submitted to Covered California for approval at least sixty (60) Days before desired implementation. Covered California shall review submitted commission rate changes and approve or deny changes within thirty (30) Days of Contractor's submission of all necessary information.

c) Incentive Compensation Program. In order to enhance consistency in sales efforts for products offered inside and outside of Covered California, Contractor shall add the Agent's sale of Contractor's QHPs through Covered California to the Agent's sale of Contractor's individual plans and policies outside Covered California to determine Agent's aggregate sales that are used by Contractor to determine incentive or other compensation payable by Contractor to Agent, to the extent such aggregation is necessary to determine Agent compensation under Contractor's applicable Agent agreement or

compensation program. Contractor shall not change the Agent commission structure or rates during the Plan Year. Contractor must pay the same commission during the Open and Special Enrollment Periods for each Plan Year. Contractor shall not vary Agent commission levels by metal tier. Contractor shall approve and pay Agent commissions on all new Agent-of-record and change of Agent-of-record delegations as outlined in Sections 3.3 (f) and 3.3 (g) of this Agreement. Contractor shall provide information as may reasonably be required by Covered California from time to time to monitor Contractor's compliance with the requirements set forth in this Section. Contractor's standard Agent compensation and incentive compensation programs or provisions of its Agent agreements entered into or in effect prior to January 1, 2014 shall not be subject to the requirements of this Section.

d) Agent Appointments. Contractor shall maintain a reasonable appointment process for appointing Agents who contract with Contractor to sell Contractor's QHPs to individuals through Covered California. Such appointment process shall include: (i) providing or arranging for education programs to assure that Agents are trained to sell Contractor's QHPs through Covered California, (ii) providing or arranging for programs that enable agents to become certified by Covered California; provided, however, that certification by Covered California shall not be a required condition for an Agent to sell Contractor's QHPs outside of Covered California, and (iii) confirmation of Agent's compliance with State laws, rules and regulations applicable to Agents, including those relating to confidentiality and conflicts of interest, and such other qualifications as determined in Contractor's reasonable discretion. These appointment policies and procedures for both individual Agents and for Agencies must be submitted to Covered California on an annual basis and whenever revisions are made.

e) Agent Conduct. Contractor shall implement policies and procedures to ensure that only Agents who have been duly certified by Covered California and maintain that certification may receive compensation for enrolling individuals in Covered California.

f) Agent of Record. At initial enrollment, individuals may notify Covered California of an Agent delegation. Covered California shall send notice of the delegation to Contractor via the 834 enrollment file. The format of the reconciliation file shall be mutually agreed upon by both Covered California and Contractor. Upon receipt of the 834 enrollment file, Contractor shall approve the delegation (unless an Agent is not licensed, not appointed, the

agent or agency is not certified, or such delegation would conflict with Contractor's vesting provisions of its agent agreements) and has ten (10) Days to update its system. Covered California recognizes that Contractor may contract with insurance agencies who employ or contract with Agents. Covered California further understands that Contractor may delegate an employed or contracted Agent writing business for the benefit of an Agency, the Agency, or primary Agent at the Agency, instead of the specific Agent who enrolled a consumer. As such, an Agent delegation may consist of an Agent, Agency, or primary Agent with an Agency.

g) Change to Agent of Record. Individuals may notify Covered California of an Agent delegation change. Covered California shall send notice of the delegation change to Contractor via the 834 maintenance file. Upon receipt of the notification, Contractor shall approve the delegation change (unless an Agent is not licensed, not appointed, the agent or agency is not certified, or such delegation would conflict with Contractor's vesting provisions of its agent agreements) and has ten (10) Days to update their system to reflect this change upon receipt of all required information from Covered California. Contractor shall notify the existing agent of the delegation change within ten (10) business days. If there is Agent of Record information on the 834 enrollment file that Contractor disagrees with, Contractor shall send an Agent of Record Exception Notification according to the "Contract Reporting Requirements" table posted on Contractor's extranet website provided by Covered California (Carrier Management (External) page, PMD Resources, Contract Reporting Compliance) by 5PM on the last business day of the following month Contractor received the file. Notification shall include any data or explanation regarding the changes requested in the file that were not made.

h) Carrier Scorecard. Covered California will administer an annual Agent survey that rates the services Contractor provides to Agents, including those services required in this Section 3.3. Covered California will solicit comments from the QHP Issuers to develop the Agent Survey prior to finalization. Covered California will share the results of each QHP Issuer specific Agent survey with each QHP Issuer alone, and utilize it to identify areas of improvement and work with QHP Issuers to improve performance.

i) Agent Communication and Sales Strategy. Contractor shall provide Covered California with an agent communications and sales strategy for the individual market on an annual basis. Covered California may also request an update to the agent communications and sales strategy if market conditions in the

individual market change due to legislative action or economic fluctuations. The agent communications and sales strategy should detail the methods, frequency, and subject matter of communications that Contractor plans to send to agents over the course of the year. Furthermore, the communications and sales strategy shall detail Contractor's utilization of agents through an agent services support team as a resource to facilitate enrolling individuals in coverage both directly and through Covered California. Covered California shall treat these materials as confidential consistent with Section 1.4.1.

ARTICLE 4 – QHP ISSUER PROGRAM REQUIREMENTS

4.1 Basic Requirements

4.1.1 Licensed in Good Standing

Contractor shall be licensed and in good standing to offer health insurance coverage through its QHPs offered under this Agreement. For purposes of this Agreement, each QHP Issuer must be in "good standing," which is determined by Covered California pursuant to 45 C.F.R § 156.200(b)(4) and shall require: (i) Contractor to hold a certificate of authority from CDI or a health care service plan ("HCSP") license from DMHC, as applicable, and (ii) the absence of any material statutory or State Regulatory violations, including penalties, during the year prior to the date of the Agreement and throughout the term of Agreement, with respect to the State Regulators categories identified at Table 4.1.1 below ("Good Standing"). Covered California, in its sole discretion and in consultation with the appropriate State Regulators determines what constitutes a material violation for this purpose.

Table 4.1.1 Definition of Good Standing	Agency
Verification that issuer holds a state health care service plan license or insurance certificate of authority.	
• Approved for lines of business sought in Covered California (e.g. commercial, small group, individual)	DMHC and CDI
• Approved to operate in what geographic service areas	DMHC and CDI
• Most recent financial exam and medical survey report reviewed	DMHC
• Most recent market conduct exam reviewed	CDI
Affirmation of no material[1] statutory or regulatory violations, including penalties levied, during the year prior to the date of the Agreement or throughout the term of Agreement in relation to any of the following, where applicable:	
• Financial solvency and reserves reviewed	DMHC and CDI
• Administrative and organizational capacity acceptable	DMHC
• Benefit Design	
• State mandates (to cover and to offer)	DMHC and CDI
• Essential health benefits (State required)	DMHC and CDI
• Basic health care services	DMHC and CDI
• Copayments, deductibles, out-of-pocket maximums	DMHC and CDI
• Actuarial value confirmation (using the Federal Actuarial Value Calculator as applicable.)	DMHC and CDI
• Network adequacy and accessibility standards are met	DMHC and CDI
• Provider contracts	DMHC and CDI
• Language Access	DMHC and CDI
• Uniform disclosure (summary of benefits and coverage)	DMHC and CDI
• Claims payment policies and practices	DMHC and CDI
• Provider complaints	DMHC and CDI
• Utilization review policies and practices	DMHC and CDI
• Quality assurance/management policies and practices	DMHC and CDI
• Enrollee/Member grievances/complaints and appeals policies and practices	DMHC and CDI
• Independent medical review	DMHC and CDI
• Marketing and advertising	DMHC and CDI
• Guaranteed issue individual and small group	DMHC and CDI
• Rating Factors	DMHC and CDI
• Medical Loss Ratio	DMHC and CDI
• Premium rate review	DMHC and CDI
• Geographic rating regions	
• Rate development and justification is consistent with ACA requirements	DMHC and CDI

4.1.2 Certification

[1]Covered California, in its sole discretion and in consultation with the appropriate health insurance regulator, determines what constitutes a material violation for this purpose.

Contractor shall comply with requirements for QHPs set forth in this Agreement and under the California Affordable Care Act, the Affordable Care Act and other State and Federal laws, rules and regulations. Contractor shall maintain timely compliance with standards required for certification that are issued, adopted, or recognized by Covered California to demonstrate that each health plan it offers in Covered California qualifies as a QHP.

4.1.3 Plan Naming Conventions

Contractor must adhere to Covered California's Plan Naming Conventions on all State Regulators' plan filings, marketing materials, Enrollee materials, and SERFF submissions for on-exchange plans and off-exchange mirror products.

Covered California's Plan Naming Conventions are referenced each year during the Certification Application process in the "Covered California Plan Naming Conventions Memo."

4.1.4 Operational Requirements and Liquidated Damages

The timely and accurate submission of Contractor's QHP filings and documents to Covered California for upload into CalHEERS is critical to the successful launch of each Open Enrollment Period. When submissions are late, or inaccurate, Covered California suffers financial harm with each resubmission and such actions put the renewal and Open Enrollment process at risk. The parties agree that the liquidated damages below are proportional to the damages Covered California incurs from each respective error made by Contractor. Therefore, Contractor agrees to meet the following operational requirements:

a) SERFF Template Completion. Contractor must submit complete and accurate SERFF Templates to Covered California each year. Covered California will participate in two rounds of validation with Contractor. Contractor agrees to pay liquidated damages in the amount of $5,000 for each additional round of validation beyond the first two rounds. Changes to any or all of Contractor's SERFF Templates counts as one round of validation. If instructions provided by Covered California include inaccurate information which necessitates an additional round of validation, or an additional round of validation is necessary due to required changes by Covered California or Contractor's State Regulator, those rounds of validation will not be counted in the two rounds of validations.

b) CalHEERS Test and Load Deadlines. Contractor must participate in CalHEERS testing and provide certification of plan data and documents in the

CalHEERS pre-production environment. The pre-production environment is the test environment where the parties can validate templates and documents prior to Open Enrollment. Following Contractor's certification of the QHPs in the pre-production environment, any subsequent upload required to correct Contractor's errors in the production environment will result in liquidated damages in the amount of $25,000 for uploads each year. One upload, for purposes of this paragraph, includes all plan data and documents that must be resubmitted to correct Contractor's errors including Summary of Benefits and Coverage, Evidence of Coverage (EOC). Liquidated damages will not apply to additional uploads resulting from errors in the instructions provided by Covered California, or changes required by Covered California or Contractor's State Regulator.

If liquidated damages are applied by Covered California under this Section then no other remedies under Section 8.2.4 will apply to Contractor for that same or any related action.

c) Deadlines for Regulatory Approval. Covered California reserves the right to require that Contractor receive regulatory approval for licensure, rates, products, Summary of Benefits and Coverage, Evidence of Coverage (EOC), policy documents, network, and Service Area prior to participating in the CalHEERS pre-production environment.

d) Communication with Plan Manager and Covered California. Contractor shall notify Covered California in a timely manner of any system or operational changes which impact Covered California, Covered California Enrollees, or the CalHEERS system. This shall include the following:

    i. Contractor shall provide advance notification prior to any system change as soon as practicable but no later than the following:

        1. Contractor shall provide at least sixty (60) Days advance notification prior to any planned activity or modification to Contractor's system that impacts the ability to receive, accept, or send electronic transactions;

        2. Contractor shall provide at least sixty (60) Days advance notification prior to any planned activity or transitions or migrations of Contractor's system to a different platform;

        3. Contractor shall provide at least sixty (60) Days advance notification prior to any planned activity or transitions to new

vendors who will support Contractor's electronic integration and interface with the CalHEERS system.

4. Contractor shall avoid making any system changes that may impact CalHEERS thirty (30) Days prior to and during each Open Enrollment Period.

    a. Contractor shall provide at least thirty (30) Days advance notification, or immediately upon Contractor's knowledge if knowledge is acquired less than thirty (30) Days prior, for Covered California approval prior to any unplanned activity or system change needed to resolve any critical issue occurring in Contractor's production system during the Open Enrollment Period.

ii. Contractor shall provide at least thirty (30) Days advance notification, or immediately upon Contractor's knowledge if knowledge is acquired less than thirty (30) Days prior to any operational change being made. Examples of operational changes include: the closing of a call center, reducing call center hours, or relocating an existing call center to another location.

    1. Contractor shall avoid making any operational changes to its call center thirty (30) Days prior to and during the Open Enrollment Period.

        a. Contractor shall provide advance notification for Covered California approval prior to any unplanned activity or operational change needed to resolve any critical issue occurring in Contractor's call center during the Open Enrollment Period.

iii. Upon request, Contractor shall provide technical documentation to Covered California within fifteen (15) Days or as specified by Covered California. Technical documentation includes: Contractor's system lifecycle and release schedules, testing plan, system specification documents related to Contractor's integration and interface with the CalHEERS system, Reconciliation and Dispute Process documentation, or other technical documentation as requested by Covered California.

4.2 Benefit Standards

4.2.1 Essential Health Benefits

Each QHP offered by Contractor under the terms of this Agreement shall provide essential health benefits in accordance with the Benefit Plan Design requirements described in the Covered California Patient-Centered Benefit Plan Designs as approved by the Board for the applicable Plan Year, and as required under this Agreement, and applicable laws, rules and regulations, including California Health and Safety Code § 1367.005, California Insurance Code § 10112.27, California Government Code § 100503(e), and as applicable, 45 C.F.R. § 156.200(b).

4.2.2 Patient-Centered Standard Benefit Designs

a) During the term of this Agreement, Contractor shall ensure its QHPs provide the benefits and services at the cost-sharing and actuarial cost levels described in the Covered California Patient-Centered Benefit Plan Designs as approved by the Board for the applicable Plan Year. Contractor must notify and receive approval from Covered California for deviations from the Patient-Centered Benefit Plan Designs during the annual certification process. Covered California may approve, on a case-by-case basis, Contractor's request to deviate from the Board approved Patient-Centered Standard Benefit Plan Designs during the term of this Agreement.

b) During the term of this Agreement, for any Plan Year that the cost of the cost-sharing reduction program is built into the premium for Contractor's Silver-level QHPs, Contractor shall offer a non-mirrored Silver-level plan, that is not a QHP, outside of Covered California that complies with the benefits and services at the cost-sharing and actuarial cost level described in the plan design at Attachment 5 — Silver 70 Off-Exchange Plan, Non-Mirrored Silver Plan Design. This plan must not have any rate increase or cost attributable to the cost of the cost-sharing reduction program.

c) Contractor is encouraged to propose innovations in benefit design to Covered California, understanding truly beneficial innovations are likely to be incorporated into the standard benefit design, thus benefiting all Enrollees, not just Contractor's. New proposals must be submitted far enough in advance of the Board establishing each year's benefit designs to allow for adequate review by Covered California for consideration as a potential addition to the standard benefit design.

4.2.3 Offerings Outside of Covered California

a) Contractor acknowledges and agrees that as required under State and Federal law, QHPs and plans that are identical in benefits, service area, and cost sharing structure offered by Contractor outside Covered California must be offered at the same premium rate whether offered inside Covered California or outside Covered California directly from Contractor or through an Agent.

b) To the extent that Contractor intends to offer and sell new health products in the individual market outside of Covered California that are not the required offering of identical benefits described in Section 4.2.3 (a), Contractor shall notify Covered California of its intention to do so at least ninety (90) Days prior to filing such products with the applicable State Regulator. Such notice must include the proposed network of providers, benefit designs, service area, and any unique features of these products.

c) In the event that Contractor sells products outside Covered California, Contractor shall fairly and affirmatively offer, market, and sell all products made available to individuals in Covered California to individuals seeking coverage outside Covered California consistent with California law.

d) For purposes of this section, "product" does not include contracts entered into pursuant to Part 6.2 (commencing with § 12693) of Division 2 of the Insurance Code between the Department of Health Care Services (DHCS) and health care service plans for Healthy Families beneficiaries or to contracts entered into pursuant to Chapter 7 (commencing with § 14000) of, or Chapter 8 (commencing with §14200) of, Part 3 of Division 9 of the Welfare and Institutions Code between the DHCS and health care service plans for enrolled Medi-Cal beneficiaries.

4.2.4 Pediatric Dental Benefits

When Contractor elects to embed and offer Pediatric Dental Essential Health Benefit services either directly, or through a subcontract with a dental plan issuer authorized to provide specialized health care services, Contractor shall require its dental plan Subcontractor to comply with all applicable provisions of this Agreement, including standard benefit designs for the embedded pediatric dental benefit, as well as any network adequacy standards applicable to dental provider networks and any pediatric dental quality measures as determined by Covered California.

Coordination of Benefits. If a Contractor's QHP provides coverage for the pediatric dental essential health benefit, Contractor shall include a Coordination of Benefits (COB) provision in its Evidence of Coverage (EOC) or policy form that (i) is consistent with Health and Safety Code § 1374.19 or Insurance Code § 10120.2, and (ii) provides that the QHP is the primary dental benefit plan or policy under that COB provision. This provision shall apply to Contractor's QHPs offered both inside and outside of Covered California for the Individual Market, except where 28 CCR § 1300.67.13 or 10 CCR § 2232.56 provides for a different order of determination for COB in the small group market.

4.2.5 Segregation of Funds

Contractor shall comply with federal requirements relating to the required segregation of funds received for abortion services in accordance with the Affordable Care Act Section 1303 and 45 C.F.R. § 156.280.

4.2.6 Prescription Drugs

a) Formulary changes. Except in cases where patient safety is an issue, Contractor shall give affected Covered California Enrollees, and their prescribing provider(s), sixty (60) Days' written notice prior to the removal of a drug from formulary status, unless it is determined that a drug must be removed for safety purposes more quickly. If Contractor is not reasonably able to provide sixty (60) Days' written notice, Contractor must provide affected Covered California Enrollees with a sixty (60) Day period to access the drug as if was still on the formulary, that begins on the date the drug is removed from the formulary. This notice requirement shall apply only to single source brand drugs and the notice shall include information related to the appropriate substitute(s). The notice shall also comply with all requirements of the Health and Safety Code and Insurance Code, including provisions prohibiting Contractor from limiting or excluding coverage for a drug to a Covered California Enrollee in cases where the drug had been previously approved for coverage by Contractor for a medical condition of the Covered

California Enrollee, except under specified conditions. To the extent permitted in State and Federal law, an exception to the notice requirement will be allowed when Contractor continues to cover a drug prescribed for a Covered California Enrollee without interruption and under the same conditions, including copayment and limits that existed prior to the removal of the drug from formulary status.

b) Internet Link to Formularies. Contractor shall comply with applicable State and Federal laws relating to prescription drug formularies, including posting the formularies for each product offered on Contractor's website as required by Health and Safety Code § 1367.205 and Insurance Code § 10123.192. Contractor shall provide to Covered California and regularly update information necessary for Covered California to link to Contractor's drug formularies for each of the QHPs Contractor offers so that Covered California can ensure it complies with its obligation under Government Code § 100503.1.

c) Contractor shall have an opt-out retail option for mail order drugs to allow consumers to receive in-person assistance, and this option shall have no additional cost. However, as specified in the Covered California Patient-Centered Benefit Plan Designs, Contractor may offer mail order prescriptions at a reduced cost-share.

d) Contractor shall provide consumers with an estimate of the range of costs for specific drugs.

e) Contractor shall have a sufficient number of customer service representatives available during call center hours for consumers and advocates to obtain clarification on formularies and consumer cost-shares for drug benefits.

4.2.7 Hearing Aid Coverage for Children Program

a) Contractor shall provide information to Enrollees regarding the availability of the California Department of Health Care Service's (DHCS) Hearing Aid Coverage for Children Program (HACCP) within its Evidence of Coverage (EOC). Information shall include notice that some Enrollees under age 21 in need of hearing aids and related benefits not covered in the QHP may be eligible for such benefits through the HACCP and provide contact information for the HACCP for Enrollees to find more information and apply for benefits.

4.3 Network Requirements

4.3.1 Service Areas

a) Service Area Listing. During each year of this Agreement, Contractor agrees to offer QHPs in the Service Area listing set forth in the applicable Plan Year SERFF templates tested and validated by Contractor. Any such changes to Contractor's previous years' Service Areas shall be effective as of January 1 of the applicable Contract Year. In the event ZIP codes are added to the current Service Area by the United States Postal Service, the parties agree such added ZIP codes shall be automatically included in the Service Area and shall be reflected in the next scheduled update of the Service Area Listing.

   Contractor shall comply with Covered California's standards, developed in consultation with Health Insurance Issuers, regarding the development of Service Area listings based on ZIP code, including, those relating to: (i) the timing of such submissions prior to the Open Enrollment Period, (ii) the assignment of Covered California Enrollees residing in ZIP codes split across two rating regions, and (iii) required updates and notice of changes in ZIP codes within Contractor's region.

b) Withdrawal. Contractor shall not withdraw from any geographic region (as defined in Health and Safety Code § 1357.512 and California Insurance Code § 10753.14) for the individual market or modify any portion of its Service Area where Contractor provides Covered Services to Covered California Enrollees without providing prior written notice to, and obtaining prior written approval from Covered California, which shall not be unreasonably denied, and to the extent required, the State Regulators with jurisdiction over Contractor.

c) Service Area Eligibility. In order to facilitate Covered California's compliance with State and Federal law, Contractor shall monitor information it receives directly, or indirectly or through its Subcontractors to assure continued compliance with eligibility requirements related to participation of Qualified Individuals in Covered California for the Individual Market, including requirements related to residency in Contractor's service area.

   Contractor shall notify Covered California if it becomes aware that an individual Covered California Enrollee no longer meets the requirements for eligibility, based on place of residence. Covered California will evaluate, or cause CalHEERS to evaluate, such information to determine Covered California Enrollee's continuing enrollment in Contractor's Service Area under Covered California's policies which shall be established in accordance with applicable laws, rules and regulations.

4.3.2 Network Adequacy

a) Network Standards. Contractor's QHPs shall comply with the network adequacy standards established by Covered California and the applicable State Regulators responsible for oversight of Contractor, including, those set forth at Health and Safety Code § 1367.03 and 28 CCR § 1300.67.2 or Insurance Code § 10133.5 and 10 CCR § 2240 et seq., and, as applicable, other laws, rules, and regulations, including, those set forth at 45 C.F.R. § 156.230. Contractor shall cooperate with Covered California to implement network changes as necessary to address concerns identified by Covered California.

b) Participating Provider Stability. Contractor shall maintain policies and procedures that are designed to preserve and enhance Contractor's network development by facilitating the recruitment and retention of Participating Providers necessary to provide access to Covered Services. Such policies and procedures shall be consistent with applicable laws, rules and regulations, and will include an ongoing assessment of turnover rates of its Participating Providers to ensure that the turnover rates do not disrupt the delivery of quality care.

4.3.3 Network Stability

a) Contractor shall implement policies and practices designed (i) to reduce the potential for disruptions in Contractor's provider networks, and (ii) to minimize the amount of uncertainty, disruption, and inconvenience of Enrollees in the execution of the transition of care as required under State laws, rules and regulations in connection with any such disruption. Contractor agrees to maintain adequate records, reasonably satisfactory to Covered California, documenting its policies and its compliance with these requirements by Contractor and Participating Providers.

b) Block Transfers. If Contractor experiences a termination of a Provider Group(s) or hospital(s) that constitutes a block transfer as defined in Health and Safety Code § 1373.65 and Title 28, C.C.R. § 1300.67.1.3, Contractor shall provide Covered California with copies of the written notices Contractor proposes to send to affected Enrollees, in compliance with the notice requirements of Health and Safety Code § 1373.65, prior to mailing the notices to Enrollees.

c) Network Disruptions. If Contractor experiences any network hospital with a pending contract termination, including any hospitals that may experience a

break in maintaining a continuous contract, Contractor shall provide prior notice to Covered California as defined in 4.3.3 c) i. If Contractor experiences any other provider network disruptions or other similar circumstances that make it necessary for at least ten percent (10%) of Enrollees residing within any county of an affected region to change Participating Providers, as detailed in the QHP Network Disruption Reporting Template, Contractor agrees to provide prior notice to Covered California as defined in 4.3.3 c) i., in accordance with advance notice, meeting, and other requirements set forth in applicable laws, rules, and regulations, including Insurance Code § 10199.1 and Health and Safety Code §§ 1367.23 and 1366.1.

i. Contractor shall notify Covered California with respect to changes in its provider network as follows:

1. Contractor shall notify Covered California of any pending change in the composition of its provider network, as defined in 4.3.3 c), within any of the regions it covers, or its participating provider contracts, of and throughout the term of this Agreement at least sixty (60) Days prior to any change or immediately upon Contractor's knowledge of the change if knowledge is acquired less than sixty (60) Days prior to the change, and cooperate with Covered California in planning for the orderly transfer of plan members; and

2. Contractor shall ensure that Covered California Enrollees have access to care when there are changes in the provider network, including mid-year contract terminations between Contractor and Participating Providers.

d) Enrollee transfers. In the event of a change in Participating Providers or QHPs related to network disruption, block transfers, or other similar circumstances, Contractor shall, and shall require Participating Providers to, cooperate with Covered California in planning for the orderly transfer of Enrollees as necessary and as required under applicable laws, rules and regulations including, those relating to continuity of care.

4.3.4 Essential Community Providers

a) Contractor must provide reasonable and timely access to Covered Services for Low-income and Medically Underserved populations in each geographic rating region where Contractor's QHPs provide services to Covered California Enrollees, by providing access to Essential Community Providers (ECPs) as

specified in this Section. Contractor shall comply with other laws, rules and regulations relating to arrangements with ECPs, as applicable, including those rules set forth at 45 C.F.R. § 156.235. For the purposes of this Section the following definitions shall apply:

i. “Low-income” populations are individuals and families living at or below 200% of Federal Poverty Level.

ii. “Medically Underserved” populations are:

1. Individuals with HIV/AIDS,

2. American Indians and Alaska Natives,

3. Individuals living in Maternity Care Target Areas, as published by the Health Resources and Services Administration (HRSA),

4. Individuals living in designated Health Professional Shortage Areas, as published by HRSA,

5. Individuals living in designated Medically Underserved Areas, as published by HRSA, and

6. Individuals belonging to designated Medically Underserved Populations, as published by HRSA.

b) General ECP standard. Contractor shall maintain in its provider network a sufficient number and sufficient geographic distribution of ECPs, as specified below. A Contractor that provides a majority of Covered Services through providers employed by Contractor or through a single contracted medical group, as determined by Covered California, may instead comply with the Alternate ECP standard, specified in (c).

i. Provider sufficiency. Contractor’s provider network must, at a minimum:

1. Include a mix of ECPs (hospital and non-hospital) reasonably distributed to serve Low-income and Medically Underserved populations.

2. Include at least one ECP hospital in each county, or, in counties with more than one geographic rating region, one ECP hospital in each geographic rating region, where Contractor’s QHPs provide Covered Services to Covered California Enrollees.

3. Include at least fifteen percent (15%) of ECPs providing primary care services as defined in this Section d) x. in each applicable geographic rating region where Contractor's QHPs provide Covered Services to Covered California Enrollees.

4. Include at least fifteen percent (15%) of ECPs providing behavioral health services as defined in this Section d) xi. in each applicable geographic rating region where Contractor's QHPs provide Covered Services to Covered California Enrollees.

5. If Contractor is unable to achieve the sufficiency requirements in this Section b) i. 3. and b) i. 4., include at least fifteen percent (15%) of 340B non-hospital providers in each applicable geographic rating region where Contractor's QHPs provide Covered Services to Covered California Enrollees, and increase Contractor's provider network each Plan Year to achieve the sufficiency requirements in this Section b) i. 3. and b) i. 4. no later than Plan Year 2029. Contractor shall annually provide:

    a. Documentation of Contractor's good faith efforts to achieve the sufficiency requirements in this Section b) i. 3. and b) i. 4., and

    b. Documentation each subsequent Plan Year demonstrating increases in Contractor's percentage of contracts to meet the sufficiency requirements in Section b) i. 3. and b) i. 4.

ii. Sufficient geographic distribution. Covered California shall determine whether Contractor provides sufficient geographic distribution of care based on a consideration of factors, including:

1. The nature, type, and distribution of Contractor's ECP contracting arrangements in each geographic rating region where Contractor's QHPs provide Covered Services to Covered California Enrollees;

2. The balance of hospital and non-hospital ECPs in each geographic rating region where Contractor's QHPs provide Covered Services to Covered California Enrollees; and

3. The extent to which the providers in Contractor's network are accessible to and provide services that meet the needs of Low-income and Medically Underserved populations.

c) Alternate ECP standard. A Contractor that Covered California determines qualifies under the alternate ECP standard, due to its integrated delivery structure, must satisfy the requirement in (a) by providing services to the Low-income and Medically Underserved populations served by the entities listed in each of the ECP categories in (d). It must demonstrate that it does so in each geographic rating region where Contractor's QHPs provide services to Covered California Enrollees, either through its own system or by offering a contract to at least one ECP outside of its system in each such category.

d) ECP categories. ECPs shall include the following categories of entities:

i. Entities that participate in the program for limitation on prices of drugs purchased by covered entities under Section 340B of the Public Health Service Act (42 U.S.C. § 256B ("340B Entities").

ii. Entities that participate in the program described in Public Health Service Act § 1927(c)(1)(D)(i)(IV).

iii. Entities that participate in California's Disproportionate Share Hospital (DSH) Program, per the final DSH Eligibility List for the current fiscal year.

iv. Federally designated 638 Tribal Health Programs and Title V Urban Indian Health Programs.

v. Federally Qualified Health Centers.

vi. Community Clinics or health centers either licensed as a "community clinic" or "free clinic", by the State under Health and Safety Code section 1204, subdivision (a), or exempt from licensure under Health and Safety Code section 1206.

vii. State-owned family planning service sites or governmental family planning sites not receiving Federal funding under special programs, including Title X of the PHS Act, unless they have lost their status under that section, or sections 340(B) or 1927 of the PHS Act due to violations of Federal law.

viii. Pediatric oral services providers.

ix. Recipients of the Department of Health Care Access and Information's Community-Based Organization (CBO) Behavioral Health Workforce Grant Program.

x. Medi-Cal primary care providers located in quartiles 1 and 2 of the California Healthy Places Index.

xi. Medi-Cal behavioral health providers located in quartiles 1 and 2 of the California Healthy Places Index.

e) Covered California will post a non-exhaustive list of ECPs annually. If Contractor believes an entity it contracts with falls within one or more of the ECP categories, but the entity does not appear on Covered California's published list, Contractor may request approval from Covered California to include the entity as an ECP.

f) Covered California will annually publish a report on Contractor's efforts to achieve compliance with the requirements in Section 4.3.4. This report will include an assessment of Contractor's ability to meet the provider sufficiency requirements in this Section b) i., and if applicable, Contractor's documented approach to achieving the provider sufficiency requirements for ECPs providing primary care and behavioral health services, submitted in Section b) i. 5.

g) Reporting requirements for Contractors under the General ECP standard are contained within the required monthly provider data submission pursuant to Section 4.4.4. Contractor must provide a provider data file to Covered California upon request for the purpose of determining compliance with the ECP standard. This file is separate and distinct from the files provided to the Integrated Health Care Association's Symphony Provider Directory as described in Section 4.4.5.

h) Reporting requirements for Contractors under the Alternate ECP standard are contained within the annual Application for Certification. Contractor must provide access maps to demonstrate the extent to which it provides services to the Low-income and Medically Underserved populations served by the entities listed in each of the ECP categories.

i) Notice of changes to ECP network. Contractor shall notify Covered California with respect to any change as of and throughout the term of this Agreement to its ECP contracting arrangements, geographic distribution, percentage coverage, ECP classification type (e.g., 340B), and other information relating

to ECPs within thirty (30) business days of any change in ECP contracts. Contractor shall notify Covered California of any pending change in its ECP contracting arrangements at least sixty (60) Days prior to any change or immediately upon Contractor's knowledge of the change if knowledge is acquired less than sixty (60) Days prior to the change, and shall cooperate with Covered California in planning for the orderly transfer of plan members.

j) Indian Health Care Providers. For Contractor's provider contracts entered into on or after January 1, 2015, Contractor shall reference the Centers for Medicare & Medicaid Services "Model QHP Addendum for Indian Health Care Providers" ("Addendum").

Contractor is encouraged to adopt the Addendum whenever it contracts with those Indian health care providers specified in the Addendum. Adoption of the Addendum is not required; it is offered as a resource to assist Contractor in including specified Indian providers in its provider networks.

4.3.5 Special Rules Governing American Indians and Alaskan Natives

Contractor shall comply with applicable laws, rules and regulations relating to the provision of Covered Services to any individual enrolled in Contractor's QHP in Covered California for the Individual Market who is determined by Covered California to be an eligible American Indian or Alaskan Native as defined in Section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d). Such requirements include the following:

a) Contractor shall cover Covered Services furnished through a health care provider pursuant to a referral under contract for directly furnishing an item or service to an American Indian with no cost-sharing as described in the Affordable Care Act § 1402(d)(2).

b) Contractor shall not impose any cost-sharing on such individuals under three hundred (300) percent of federal poverty level ("FPL") in accordance with the Affordable Care Act § 1401(d)(1). Covered California will have a transparent process to identify Alaskan Natives and American Indians, including a specific identification of those under 300% of FPL so Contractor has information necessary to comply with Federal law.

c) Contractor shall provide monthly Special Enrollment Periods for American Indians or Alaskan Natives enrolled through Covered California.

d) Contractor shall comply with other applicable laws, rules and regulations relating to the provision of Covered Services to American Indians, including,

the Indian Health Care Improvement Act Sections 206 (25 U.S.C. § 1621e) and 408 (25 U.S.C. § 1647a).

4.3.6 Access Monitoring

a) Covered California, in alignment with other California public purchasers and State Regulators, shall implement an access-monitoring strategy for all QHP issuers. The strategy shall analyze data available from CMS QRS program, provider directory, and the HEI, and may include additional monitoring tools, such as secret shopper surveys, deployed by Covered California to assess Covered California Enrollee experience.

b) Contractor will be assessed across the following domains: Covered California Enrollee experience and outcomes, provider availability and accessibility, and service utilization and quality. Benchmarks will be established after two years of data collection and performance will be reported publicly. Underperforming QHP issuers will be required to submit and adhere to an improvement plan.

c) Contractor's data submission obligation for this Section can be met through regular data submissions detailed in Article 4, Section 4.4.4 (Covered California Provider Directory), Article 5, Section 5.5 (Quality Rating System) and Attachment 1, Article 5, Section 5.02.1 Data Submission (Healthcare Evidence Initiative).

4.4 Participating Providers

4.4.1 Provider Contracts

a) Contractor shall include in all of its contracts with Participating Providers the requirement for all Covered Services to be provided by duly licensed, certified or accredited Participating Providers consistent with the scope of their license, certification or accreditation and in accordance with applicable laws, rules, regulations, the standards of medical practice in the community, and the terms set forth in agreements entered into by and between Contractor and Participating Providers ("Provider Agreement").

b) Contractor shall include in each Provider Agreement a requirement that Participating Providers comply with all other applicable laws, rules and regulations.

c) Contractor shall use commercially reasonable efforts to require the provisions of Subsection (d) to be included in each: (i) Provider Agreement entered into

by and between Contractor and a Participating Provider, and (ii) any subcontracting arrangement entered into by a Participating Provider.

d) Provision of Covered Services. Contractor shall undertake commercially reasonable efforts to ensure that each Participating Provider Agreement and each subcontracting arrangement entered into by each Participating Provider complies with the applicable terms and conditions set forth in this Agreement, as mutually agreed upon by Covered California and Contractor, and which may include the following:

    i. Coordination with Covered California and other programs and stakeholders;

    ii. Relationship of the parties as independent contractors (Section 1.3 (a)) and Contractor's exclusive responsibility for obligations under the Agreement (Section 1.3 (b));

    iii. Participating Provider Directory requirements (Section 4.4.4);

    iv. Symphony Provider Directory requirements (Section 4.4.5);

    v. Implementation of processes to enhance stability and minimize disruption to provider network (Section 4.3;

    vi. Notices, network requirements, and other obligations relating to costs of out-of-network services and other benefits (Section 4.4.3);

    vii. Provider credentialing, including, maintenance of licensure and insurance (Section 4.4.2);

    viii. Customer service standards (Section 4.6);

    ix. Utilization management (Section 5.3);

    x. Maintenance of a corporate compliance program (Section 1.2);

    xi. Enrollment and eligibility determinations and collection practices (Article 2);

    xii. Appeals and grievances (Section 4.6.2);

    xiii. Enrollee and marketing materials (Section 3.2);

    xiv. Disclosure of information required by Covered California, including, financial and clinical (Section 1.12), Quality, Network Management and

Delivery System Standards (Article 5), and other data, books, and records (Article 11));

xv. Nondiscrimination (Section 1.10);

xvi. Conflict of interest and integrity (Section 1.11);

xvii. Other laws (Section 1.13);

xviii. Advancing Equity, Quality, and Value to the extent applicable to Participating Providers (Article 5), including, disclosure of contracting arrangements with Participating Providers as required pursuant to Attachment 1 — Advancing Equity, Quality, and Value;

xix. Performance Measures, to the extent applicable to Participating Providers (Article 7);

xx. Continuity of care, coordination and cooperation upon termination of Agreement and transition of Covered California Enrollees (Section 4.3.3 and Article 8);

xxi. Security and privacy requirements, including compliance with HIPAA (Article 10); and

xxii. Maintenance of books and records (Article 11).

4.4.2 Provider Credentialing

Contractor shall perform, or may delegate activities related to, credentialing and re-credentialing Participating Providers in accordance with a process reviewed and approved by State Regulators.

4.4.3 Enrollee Costs; Disclosure

Contractor shall, and shall require Participating Providers to, comply with applicable laws, rules and regulations governing liability of Enrollees for Covered Services provided to Enrollees, including, those relating to holding an Enrollee harmless from liability in the event Contractor fails to pay an amount owed by Contractor to a Participating Provider as required by Federal and State laws, rules and regulations.

To the extent that Contractor's QHPs either (i) provide coverage for out-of-network services, or (ii) impose additional fees for such services, Contractor shall disclose to the Covered California Enrollee, at the Covered

California Enrollee's request, the amount Contractor will pay for covered proposed non-emergency out-of-network services. Contractor shall require its Participating Providers to inform every Covered California Enrollee in a manner that allows the Covered California Enrollee the opportunity to act upon a Participating Provider's proposal or recommendation regarding (i) the use of a non-network provider or facility, or (ii) the referral of a Covered California Enrollee to a non-network provider or facility for proposed non-emergency Covered Services. Contractor shall require Participating Providers to disclose to a Covered California Enrollee considering accessing non-emergency services from a network provider if a non-network provider or facility will be used as part of the network provider's plan of care. Contractor's obligation for this provision can be met through routine updates to its provider manual. Participating Providers may rely on Contractor's provider directory in fulfilling their obligation under this provision.

4.4.4 Covered California Provider Directory

Contractor shall make its provider directory available to (i) Covered California electronically for publication online in accordance with guidance from Covered California, and (ii) in hard copy when potential Enrollees make such request. Unless otherwise agreed to by Covered California, Contractor shall continue to provide information describing all Participating Providers in its QHP networks in a format prescribed by Covered California on a monthly basis to support Covered California's centralized provider directory containing every QHP's network providers, this includes testing, implementation, and continued evaluation. Contractor acknowledges that Covered California may use Contractor's Participating Provider data for any non-commercial purposes. If Covered California's centralized provider directory is not operational, Contractor shall continue to provide Participating Provider information to Covered California on a monthly basis.

The network and directory information provided to Covered California shall take into consideration the ethnic and language diversity of providers available to serve Covered California Enrollees.

Once the Symphony Provider Directory is fully operational, Covered California will utilize it to populate Covered California's centralized provider directory as detailed in Article 4, Section 4.4.5.

4.4.5 Use of Symphony Provider Directory

a) In order to fulfill its obligation to assist Enrollees in making informed decisions when considering health care coverage choices and in choosing QHP Issuers and their associated network of Providers, Covered California is committed to implementing and participating in the Symphony Provider Directory, formerly known as the California Provider Directory Utility, being developed by the Integrated Health Care Association (IHA). Once fully operational, Covered California will utilize the Symphony Provider Directory to populate the Covered California Provider Directory.

   All QHP Issuers shall utilize the Symphony Provider Directory to populate, maintain, and continually update, provider network data including demographic, licensure, and other relevant information with respect to all their QHPs, as well as to provide information regarding the terms and restrictions governing such Providers' participation in the QHPs offered by Contractor through Covered California.

b) Contractor agrees to participate in the Symphony Provider Directory. In connection with such participation, Contractor shall:

   i. Execute such reasonable participation, subscription, or other agreements required by Covered California or IHA or their vendors to participate in the Symphony Provider Directory;

   ii. Populate, maintain, and continually update the Symphony Provider Directory with all relevant information with respect to its contracted Providers' participation in its QHPs, including all information regarding the terms and restrictions governing such Providers' participation in the QHPs offered through Covered California, identifiers for Covered California providers, and provider network data for Contractor's embedded dental plans;

   iii. Once fully operational with sufficient health plan and provider participation, use the Symphony Provider Directory as the exclusive platform to populate and maintain the information published in the Covered California Online Provider Directory concerning its QHPs; and

   iv. Work with Covered California, IHA and their respective vendors to ensure that the Symphony Provider Directory serves its primary purpose of effectively and efficiently assisting Enrollees in making informed decisions in selecting QHPs and Providers.

v. Agree to participate in testing and validation of Symphony Provider Directory functionality that may be required prior to the Directory becoming fully operational.

c) At a time and manner mutually agreed upon by Covered California and Contractor, Contractor agrees to report on its strategies to ensure that Contractor, and its contracted Providers, maintain compliance with the provisions of this Section 4.4.5.

4.5 Premium Rate Setting

4.5.1 Rating Variations

Contractor shall charge the premium rate in each geographic rating area for each of Contractor's QHPs as agreed upon with Covered California. Contractor may vary premiums by geographic area, family size, and age band (within 3:1 range requirement) as permitted by State law, including the requirements of State Regulators regarding rate setting and rate variation set forth at Health and Safety Code §§ 1357.512 and 1399.855, Insurance Code §§ 10753.14 and 10965.9, 10 CCR § 2222.12 and, as applicable, other laws, rules and regulations, including, 45 C.F.R. § 156.255(b).

Contractor shall comply with rate filing requirements imposed by its State Regulator, including, those set forth under Insurance Code § 10181 et seq. or Health and Safety Code § 1385.01 et seq. and as applicable, other laws, rules and regulations.

4.5.2 Covered California for the Individual Market Rates

For Covered California for the Individual Market, rates shall be established through an annual negotiation process between Contractor and Covered California for the following Calendar Year. The parties acknowledge that: (i) the Agreement does not contemplate any mid-year rate changes for Covered California for the Individual Market in the ordinary course of business, and (i) the annual negotiation process must be supported by Contractor through the submission of information in such form and at such date as shall be established by Covered California to provide Covered California with sufficient time for necessary analysis and actuarial certification.

In Covered California's review of the detailed rationale for each plan's rate development, it has generally taken the view that absent extraordinary circumstances, as determined by Covered California, profit margins over the

range that have historically been considered to be reasonable would be unacceptable. Therefore, for future Plan Years should Contractor receive profits or incur losses due to shifts in Federal policy or ACA-related judgements favorable to Contractor, Contractor should factor profits into a reduction of its premium rates, or increase its profit margin to recoup losses. These adjustments shall be consistent with applicable State and Federal laws, including the medical-loss ratio laws. Covered California will utilize the annual negotiation process in future years to consider how such profits or losses should be factored into future premium rates. In doing so, Covered California will consider Contractor's documented historic profit margin with Covered California and the need for Contractor to maintain sufficient regulatory reserves. The parties understand that California's State Regulators conduct their own independent review of rates subsequent to the parties' negotiation. In the event Contractor seeks to invoke this contract provision, Covered California would convey to the State Regulator its perspective on the reasonableness of profit margins and reserves given the exceptional circumstances.

4.5.3 Rate Methodology

Contractor shall provide, upon Covered California's request, in connection with any contract negotiation or recertification process as reasonably requested by Covered California, detailed documentation on Covered California-specific rate development methodology. Contractor shall provide justification, documentation, and support used to determine rate changes, including providing adequately supported cost projections. Cost projections include factors impacting rate changes, assumptions, transactions, and other information that affects the Covered California specific rate development process. Information pertaining to the key indicators driving the medical factors on trends in medical, pharmacy, or other healthcare Provider costs may also be requested to support the assumptions made in forecasting and may be supported by information from the Plan's actuarial systems pertaining to the Covered California-specific account.

4.6 Customer Service Standards

4.6.1 Basic Customer Service Requirements

Contractor acknowledges that superior customer service is a priority of Covered California. Contractor shall work closely with Covered California in an effort to ensure that the needs of Covered California Enrollees are met. Contractor shall provide and maintain all processes and systems required to ensure customer service, record protection and uninterrupted service to Covered California and

Contractor's Covered California Enrollees in accordance with the standards set forth in this Section 4.6, applicable laws, rules and regulations, including, those consumer assistance tools and programs required to be offered through Covered California as set forth at 45 C.F.R. § 155.205 and 45 C.F.R. § 155.210.

800 Numbers: Contractor shall make information available regarding Covered California pursuant to Contractor's toll-free hotline (i.e. 1-800 number) that shall be available to enrollees of Contractor. The hotline and information services shall be staffed and operated in accordance with the Customer Service Standards set forth in this Section 4.6 to provide support to Covered California Enrollees and in a manner designed to assure compliance with these Performance Standards. Contractor shall meet all State and Federal requirements for language assistance services applicable to its commercial lines of business. Covered California and Contractor will continue to evaluate on an ongoing basis the adequacy of language services provided for verbal and written communications and consider the adoption of additional standards as appropriate. Contractor shall provide this information to Covered California upon request.

4.6.2 Covered California Enrollee Appeals and Grievances

a) Internal Grievances and Appeals. Contractor shall maintain an internal review process to resolve a Covered California Enrollee's written or oral expression of dissatisfaction regarding Contractor and Participating Providers, including appeals of claim and benefit determinations, and complaints relating to the scope of Covered Services required to be covered under the QHP. Contractor's processes shall comply with State and Federal laws, rules and regulations relating to Enrollee rights and appeals processes, specifically including grievance requirements set forth at Health and Safety Code § 1368, regardless of the State Regulator for Contractor's QHPs.

b) External Review. Contractor shall comply with State and Federal laws, rules and regulations relating to the external review process, including independent medical review, available to Covered California Enrollees for Covered Services.

4.6.3 Applications and Notices

a) Contractor shall provide applications, forms, and notices to applicants and Enrollees in plain language and in a manner that is accessible and timely to individuals: (i) living with disabilities, including accessible websites and the provision of auxiliary aids and services at no cost to the individual in

accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act, or (ii) with limited English language proficiency.

b) Contractor shall provide applications, forms, and notices, including correspondence, in a manner that is accessible and timely to individuals who are limited English proficient as required by Health and Safety Code §§ 1367.04, 1367.041, 1367.042, and Insurance Code §§ 10133.8, and 10133.11. Contractor shall inform individuals of the availability of the services described in this section and otherwise comply with notice requirements imposed under applicable laws, rules and regulations, including, those set forth at 45 C.F.R. § 156.250 and Government Code § 100503(k).

4.6.4 Customer Service Call Center (Call Center)

a) Contractor and Covered California shall maintain a Call Center with the following hours of operation:

   i) Standard Operating hours for the Covered California and Contractor Call Center shall be Monday through Friday eight o'clock (8:00) a.m. to six o'clock (6:00) p.m. (Pacific Standard Time). Contractor may adjust hours as required by customer demand with prior agreement of Covered California.

   ii) Contractor shall also maintain Special Operating Hours for its Call Center as specified by Covered California in the supplemental documents for Service Center Hours of Operation provided on Contractor's Covered California extranet website (Carrier Management (External) page, PMD Resources, Service Center Hours of Operation). Contractor may adjust hours as required by customer demand; hours that are less than those stated in the supplemental documents for Service Center Hours of Operation provided on Contractor's Covered California extranet website (Carrier Management (External) page, PMD Resources, Service Center Hours of Operation) require prior agreement of Covered California.

b) Covered California Plan Management Division shall inform Contractor when updates have been made to the "Service Center Hours of Operation Matrix" including any changes to the Standard Operating hours, such as for Open Enrollment and specified holidays.

c) Outages and Temporary Closures. Contractor will inform Covered California of any unplanned changes to Call Center hours or functionality immediately upon Contractor's knowledge of such occurrence.

d) Contractor's Call Center shall be staffed at levels reasonably necessary to handle call volume and achieve compliance with Performance Standards set forth in Article 7 as specified in Attachment 3 — Performance Standards and Expectations. Contractor shall staff the Call Center with highly trained individuals to provide detailed benefit information, answer Enrollee questions about QHP benefits and coverage, and to resolve claim and benefit issues.

e) Contractor shall use a telephone system that includes welcome messages in English, Spanish, and other languages as required by State and Federal laws, rules, and regulations.

f) Contractor shall make oral interpreter services available at no cost for non-English speaking or hearing-impaired Enrollees during regular business hours as required by Federal and State law. Contractor shall monitor the quality and accessibility of call center services on an ongoing basis. Contractor shall report to Covered California monthly, in a format determined by Covered California, on the volume of calls received by the call center and Contractor's rate of compliance with related Performance Standards as outlined in Attachment 3 — Performance Standards and Expectations.

g) Contractor shall meet all State and Federal requirements for language assistance services for all of its commercial lines of business.

4.6.5 Customer Service Transfers

a) During Contractor's regularly scheduled customer service hours, Contractor shall have the capability to accept and handle calls transferred from Covered California and respond to callers requesting additional information from Contractor. Contractor shall maintain staff resources to comply with Performance Standards and sufficient to facilitate a live transfer (from Covered California to Contractor) of customers who call Covered California with escalated issues or complaints that need to be addressed by Contractor. Covered California shall maintain staff resources sufficient to facilitate a live transfer (from Contactor to Covered California) of customers who call Contractor with escalated issues, complaints, or address changes that need to be addressed by Covered California. Contractor and Covered California shall establish a designated customer service team available to handle the live transfer of escalated calls.

b) Examples of issues or complaints may include premium billing or claims issues; benefit coverage questions (before and after enrollment); complaints; network or provider details; and Contractor-specific questions or issues.

c) Contractor shall refer Enrollees and applicants with questions regarding premium tax credits and Covered California eligibility determinations to Covered California's website or Service Center, as appropriate.

d) Contractor shall work with Covered California to develop a mechanism to track handling and resolution of calls referred from Covered California to Contractor (such as through the use of call reference numbers).

4.6.6 Customer Care

a) Contractor shall comply with the applicable requirements of the Americans with Disabilities Act and provide culturally competent customer service to all Covered California Enrollees in accordance with the applicable provisions of 45 C.F.R. § 155.205 and § 155.210, which refer to consumer assistance tools and the provision of culturally and linguistically appropriate information and related products.

b) Contractor shall comply with HIPAA rules and other laws, rules and regulations respecting privacy and security.

4.6.7 Notices

a) For all forms of notices required under Federal and State law to be sent to Covered California Enrollees regarding rates, benefit design, network changes, or security/HIPAA references, Contractor shall submit an electronic copy to Covered California at least five (5) business days in advance of the message transaction. If Contractor is unable to notify Covered California in advance due to Federal or State notice requirements, Contractor shall send Covered California notification simultaneously.

b) Contractor shall provide a link to the Covered California website on its website.

c) When Contractor provides direct contacts for getting membership assistance, Contractor shall also include the Covered California website for Covered California-related issues.

d) Contractor shall use standardized member renewal language, developed by Covered California, and approved by DMHC and CDI for all Covered California Enrollee renewal notices.

e) All legally required notices sent by Contractor to Covered California Enrollees shall be translated into and available in languages other than English as required under applicable Federal and State laws, rules and regulations, including, Health and Safety Code §§ 1367.04, 1367.041, 1367.042, and Insurance Code §§ 10133.8, 10133.10, 10133.11.

f) Contractor shall release notices in accordance with Federal and State law. All such notices shall meet the accessibility and readability standards in applicable Federal regulations (45 C.F.R. Parts 155 and 156) and Covered California regulations located in 10 CCR §§ 6400 et seq.

g) Contractor must prominently inform consumers of their right to request a refund of any credits on their accounts in premium invoices, termination notices as required under 45 C.F.R § 156.270, and other notices where applicable.

4.6.8 Contractor-Specific Information

Upon request, Contractor shall provide training materials and participate in Covered California customer service staff training.

Contractor shall provide summary information about its administrative structure and the QHPs offered on Covered California. This summary information will be used by Covered California customer service staff when referencing Contractor or QHP information.

4.6.9 Covered California Enrollee Materials: Basic Requirements

a) Contractor shall provide or make available to Covered California Enrollees Plan materials required under the terms of the Agreement and applicable laws, rules and regulations. Such materials shall be available in languages as required by Federal and State law and receive any necessary regulatory approvals from the relevant State Regulators, be provided to Covered California as directed by Covered California, and shall include information brochures, a summary of the Plan that accurately reflects the coverage available under the Plan (a Summary of Benefits and Coverage), and related communication materials. Contractor shall, upon request by Covered California, provide copies of Covered California Enrollee communications and

give Covered California the opportunity to comment and suggest changes in such material.

b) Covered California Enrollee materials shall be available in English, Spanish and other languages as required by applicable laws, rules and regulations. Contractor shall comply with Federal and State laws, rules and regulations regarding language access. To the extent possible, Covered California Enrollee materials shall be written in plain language, as that term is defined in applicable laws, rules and regulations. Plan materials that require Covered California notification before usage are those that communicate specific eligibility and enrollment and other key information to Covered California Enrollees. Such materials may include:

   i. Welcome letters;

   ii. Covered California Enrollee ID card;

   iii. Billing notices and statements;

   iv. Notices of actions to be taken by QHP Issuer that may impact coverage or benefit letters;

   v. Termination Grievance process materials;

   vi. Drug formulary information;

   vii. Uniform Summary of Benefits and Coverage; and

   viii. Other materials required by Covered California.

4.6.10 New Covered California Enrollee Enrollment Packets

a) Contractor shall mail or provide online enrollment packets to all new Covered California Enrollees for the Individual Market in Covered California QHPs within ten (10) business days of receiving complete and accurate enrollment information from Covered California and the binder payment. Contractor may deliver Covered California Enrollee materials pursuant to other methods that are consistent with: (i) Contractor's submission of materials to Enrollees of its other plans; (ii) the needs of Covered California Enrollees; (iii) the consent of the Covered California Enrollee; and (iv) with applicable laws, rules and regulations. Contractor shall report to Covered California monthly, in a format mutually agreed upon by Covered California and Contractor, on the number and accuracy rate of identification cards that were sent to new Covered California Enrollees and Contractor's compliance with the Performance

Standards set forth in this Agreement. The enrollment packet shall include, at the minimum, the following:

i. Welcome letter;

ii. Covered California Enrollee ID card, in a form approved by Covered California;

iii. If Covered California Enrollee ID card is not included in the enrollment packet, Contractor must send a notice to the Covered California Enrollee that states the ID card will be sent separately, when the Covered California Enrollee should expect to receive it, and provide the information necessary for the Covered California Enrollee to receive services and for providers to file claims;

iv. Summary of Benefits and Coverage;

v. Pharmacy benefit information;

vi. Nurse advice line information; and

vii. Other materials required by Covered California.

b) Contractor shall maintain access to enrollment packet materials; Summary of Benefits and Coverage; claim forms and other Plan-related documents in both English and Spanish and any other languages required by State and Federal laws, rules and regulations to the extent required to timely meet all requirements of this Agreement for timely mailing and delivery of Plan materials to Covered California Enrollees. Contractor shall be responsible for printing, storing, and stocking, as applicable, all materials.

4.6.11 Summary of Benefits and Coverage

Contractor shall develop and maintain a Summary of Benefits and Coverage as required by Federal and State laws, rules, and regulations. The Summary of Benefits and Coverage must be available online and the hard copy sent to Covered California Enrollees on request shall be available to Covered California Enrollees in English, Spanish, and other languages as required by Federal and State laws, rules, and regulations. Contractor shall update the Summary of Benefits and Coverage annually and Contractor shall make the Summary of Benefits and Coverage available to Covered California Enrollees pursuant to Federal and State laws, rules, and regulations.

4.6.12 Electronic Listing of Participating Providers

Contractor shall create and maintain a continually updated electronic listing of all Participating Providers and make it available online for Covered California Enrollees, potential Enrollees, and Participating Providers, 24 hours a Day, 7 Days a week as required by Federal and State laws, rules, and regulations, including requirements to identify Providers who are not accepting new Enrollees.

4.6.13 Access to Medical Services Pending ID Card Receipt

Contractor shall promptly coordinate and ensure access to medical services for Covered California Enrollees who have not received ID cards but are eligible for services.

4.6.14 Explanation of Benefits

Contractor shall send each Covered California Enrollee an Explanation of Benefits to Covered California Enrollees in Plans that issue Explanation of Benefits or similar documents as required by Federal and State laws, rules, and regulations. The Explanation of Benefits and other documents shall be in a form that is consistent with industry standards.

4.6.15 Secure Plan Website for Enrollees and Providers

Contractor shall maintain a secure website, 24 hours, 7 Days a week. All content on the secure Enrollee website shall be available in English and Spanish and any other languages required under State and Federal law. If Contractor is new to offering coverage on Covered California, Contractor shall meet the requirements of this section within ninety (90) Days after the Effective Date of this Agreement. The secure website must include, at a minimum, the following information about the Plan:

a) Upon implementation by Contractor, benefit descriptions, information relating to Covered Services, cost sharing, and other information available;

b) Ability for Covered California Enrollees to view their claims status such as denied, paid, unpaid;

c) Ability to respond via e-mail to customer service issues posed by Covered California Enrollees and Participating Providers;

d) Ability to provide online eligibility and coverage information for Participating Providers;

e) Support for Covered California Enrollees to receive Plan information by e-mail; and

f) Covered California Enrollee education tools and literature to help Covered California Enrollees understand health costs and research condition information.

4.6.16 Required Reports

Contractor shall submit required reports as defined in this contract. For Contractor's convenience, all required reports are listed in the "Contract Reporting Requirements" table posted on Contractor's extranet website provided by Covered California (Carrier Management (External) page, PMD Resources, Contract Reporting Compliance folder).

Upon request, Contractor shall submit standard reports as described below in a manner and time as specified by Covered California:

a) Enrollee customer service reports including phone demand and responsiveness, initial call resolution, response to written correspondence, and number/accuracy/timeliness of ID card distribution;

b) Use of Plan website;

c) Enrollment reports; and

d) Premiums collected.

4.6.17 Contractor Staff Training about Covered California

Contractor shall arrange for and conduct staff training regarding the relevant laws, mission, administrative functions and operations of Covered California, including Covered California program information and products in accordance with Federal and State laws, rules and regulations, using training materials developed by Covered California.

Upon request by Covered California, Contractor shall provide Covered California with a list of upcoming staff trainings and make available training slots for Covered California staff to attend upon request.

4.6.18 Customer Service Training Process

Contractor shall demonstrate to Covered California that it has in place initial and ongoing customer service protocols, training, and processes to appropriately

interface with and participate in Covered California. As part of this demonstration, Contractor shall permit Covered California to inspect and review its training materials. Covered California will share its customer service training modules with Contractor.

ARTICLE 5 – ADVANCING EQUITY, QUALITY, AND VALUE

5.1 Covered California Quality and Equity Initiatives

The parties acknowledge and agree that furthering the shared goals of improved health, reduced health disparities, and high-quality healthcare require Contractor to work with the other QHP Issuers and its contracted providers to play an active role in building and supporting models of care to meet consumer and social needs for providing better care, promoting health and lowering per capita costs through improvement.

Contractor agrees to work with Covered California to develop or participate in initiatives to promote models of care that (i) promote a culture of continuous quality and value improvement, health promotion, and the reduction of health disparities to the benefit of all Enrollees and, to the extent feasible, other health care consumers, (ii) minimize unpredictable quality, (iii) reduce inefficiencies of the current system, and (iv) target excessive costs.

In order to further the mission of Covered California with respect to these objectives and to provide the Covered Services required by Enrollees, Covered California and Contractor shall coordinate and cooperate with respect to health equity and quality improvement activities conducted by Covered California in accordance with the terms set forth in this section and in Covered California's Attachment 1 — Advancing Equity, Quality, and Value.

5.2 Quality Improvement and Disparities Reduction Programs

5.2.1 General Requirements

a) Contractor shall maintain a quality improvement program to foster continuous quality improvement among its Participating Providers and other Subcontractors. Contractor's quality improvement program shall be subject to review by Covered California annually to evaluate Contractor's compliance with requirements set forth in Attachment 1 — Advancing Equity, Quality, and Value.

b) Contractor shall take steps to foster a culture of equity within its health plan operations and through its Participating Providers. Contractor shall maintain a disparities reduction program including collection of Enrollee demographic data, stratification of quality measures by demographic factors, and implementation and evaluation of interventions to reduce health disparities. Contractor's disparities reduction program shall be subject to review by

Covered California annually to evaluate Contractor's compliance with requirements set forth in Attachment 1 — Advancing Equity, Quality, and Value.

c) Contractor shall coordinate and cooperate with Covered California in implementing Attachment 1 — Advancing Equity, Quality, and Value, including (i) participating in meetings and other programs as reasonably requested from time to time by Covered California, (ii) providing mutually agreed upon data and other information required under Attachment 1 — Advancing Equity, Quality, and Value, and (iii) other activities as otherwise reasonably requested by Covered California. The parties acknowledge and agree that quality related activities contemplated under this Article 5 will be subject to and conducted in compliance with any and all applicable laws, rules, and regulations including those relating to the confidentiality of medical information and will preserve all privileges set forth at Health and Safety Code, § 1370.

d) Contractor shall conduct quality improvement and disparities reduction activities compliant with federally-required Quality Improvement Strategy (QIS) requirements.

e) Each of Contractor's products is required to meet or exceed the requirements, standards, and equity and quality benchmarks established in Attachment 1 — Advancing Equity, Quality, Value, Attachment 2 — Performance Standards with Penalties, and Attachment 4 — Quality Transformation Initiative. Contractor shall seek written approval from Covered California and its state regulator prior to offering consumer incentive programs to Covered California Enrollees. Consumer incentive programs shall be nondiscriminatory and comply with guidelines issued by Covered California as to program design, eligibility criteria, and reward amounts.

5.2.2 Payment Obligations for Quality and Health Equity Performance

a) Contractor is subject to potential payment obligations for quality and health equity performance requirements as specified in Attachment 2 — Performance Standards with Penalties and Attachment 4 — Quality Transformation Initiative. Contractor's performance will be measured during the Plan Year (Measurement Year) with payment obligations calculated based on premium in the same Plan Year. The maximum payment obligations collectively between these two begin at 3% of Contractor's total Gross Premium per product for Plan Year 2026 and increase by up to an additional 1% of Contractor's total Gross Premium per product in Plan Year 2027, up to

4% maximum over the contract period. Payment obligations for quality performance are as follows:

i. For Measurement Year 2026: 3% of Contractor's total Gross Premium per product for Plan Year 2026.

ii. For Measurement Year 2027: no more than 4% of Contractor's total Gross Premium per product for Plan Year 2027.

iii. For Measurement Year 2028: no more than 4% of Contractor's total Gross Premium per product for Plan Year 2028.

iv. Contractors newly participating with Covered California may be subject to reduced payment obligations during their first years, as specified in Attachment 2 – Performance Standards with Penalties and Attachment 4 – Quality Transformation Initiative.

5.2.3 Removal from Covered California

a) The clinical performance of Contractor's products offered by Covered California must meet or exceed the national 25th percentile benchmark for the Quality Rating System (QRS) Clinical Quality Management Summary Indicator or face removal from Covered California if not met.

b) Contractor's products with a minimum of two years of QRS reportable scores will be subject to this Section.

c) For each year that a product meets CMS eligibility criteria to report QRS measure scores and receive QRS star ratings, Covered California will calculate each product's composite score using the reportable measure scores on the QRS Clinical Quality Management Summary Indicator measures and compare it with the applicable 25th percentile composite benchmark.

d) Covered California sets the 25th percentile composite benchmark using a simple average of available QRS Clinical Quality Management Summary Indicator national measure scores. The benchmark year will be Measurement Year 2024 and will not change during the contract term. However, if new clinical measures with benchmarks after 2024 are introduced, Covered California may revise the 2024 benchmark to include these measures.

e) The 25th percentile composite benchmark and each product's clinical composite score are calculated by averaging measure scores. Reportable

measure scores are summed and divided by the count of reportable measure scores. The product's clinical composite score is compared to the matched QRS 25th percentile composite benchmark score to determine if the 25th percentile composite benchmark is achieved.

f) Consistent with CMS QRS scoring methodology, a minimum of 50% of the measures from the QRS 25th national percentile benchmark measures set must be reportable for a composite score to be calculated.

    i. If Contractor's products fall below the 25th percentile composite benchmark for the QRS Clinical Quality Management Summary Indicator measures for two (2) consecutive years (the Monitoring Period), Covered California will notify Contractor and specify the Remediation Period (the two years following the final year of the monitoring period) within which Contractor must raise the quality of those products above the 25th percentile composite benchmark. If the quality of those products does not improve within the Remediation Period, those products will not be certified for the Plan Year two years following the final year of the Remediation Period.

g) Once notified of the Remediation Period by Covered California, Contractor must submit a Minimum Performance Level Action Plan that meets the requirements specified in 5.2.4.

h) Covered California will not remove any products pursuant to this policy in a region where removal would result in fewer than three Issuers offering QHPs.

5.2.4 Quality Improvement Plans and Minimum Performance Level Action Plans

a) Upon notification of required improvement as specified in 5.2.3 and Attachment 4 – Quality Transformation Initiative, Contractor must submit a Minimum Performance Level Action Plan or Quality Improvement Plan to Covered California detailing the action(s) it plans to take to improve quality.

b) Minimum Performance Level Action Plan. A Minimum Performance Level Action Plan includes specific annual targets for improving Contractor's composite or individual measure score above the 25th percentile and details the quality improvement activities Contractor plans to achieve this improvement. Contractor shall submit a Minimum Performance Level Action Plan:

    i. If notified of the Remediation Period by Covered California, pursuant to 5.2.3.

ii. If requested by Covered California, for each CMS QRS measure for which Contractor scores below the 25th percentile national benchmark for two consecutive years.

c) Quality Improvement Plan. For each QTI Scored Measure, as defined in Attachment 4 – Quality Transformation Initiative, for which Contractor scored below the 25th percentile national benchmark for one year, a Quality Improvement Plan will be required. This Quality Improvement Plan must include annual targets for measure score improvement above the 25th percentile and describe the quality improvement activities intended to improve performance on that specific QTI Scored Measure.

d) Contractor's Quality Improvement Plan or Minimum Performance Level Action Plan must detail the actions that it is undertaking, or will undertake, to improve quality including:

i. QHP Issuer's root cause or gap analysis for each required clinical measure detailing the factors contributing to repeated poor quality performance;

ii. Which Quality Collaboratives from Attachment 1 Article 4.04 are or will be involved;

iii. A detailed outline and timeline of quality improvement interventions and health equity efforts and infrastructure across the organization to support measure improvement;

iv. Engagement and support for providers, including physicians and physician groups, in improvement activities. For example: development of registries and data analytics, facilitating data exchange, and innovative approaches to patient engagement to improve coordination, integration, and care delivery;

v. Contracting with higher performing providers;

vi. Developing or building on existing quality incentive programs for contracted providers that include or focus on measures in the QTI Scored Measures, specified in Attachment 4 – Quality Transformation Initiative, or other QRS Clinical Quality Management Summary Indicator measures;

vii. Using consumer incentive programs to target desired behavior change that could impact the QTI Scored Measures or other QRS Clinical Quality Management Summary Indicator measures;

viii. Improving data quality and completeness; and

ix. Eliminating providers from its networks based on their poor performance. To the extent this strategy is undertaken, Contractor must explicitly identify in the Minimum Performance Level Action Plan and Quality Improvement Plan any providers, including individual physicians and physician groups, identified as poor performing that Contractor is considering for removal from its QHP network if quality performance does not improve. If these providers are designated ECPs or serve predominantly low-income or vulnerable Enrollee populations, the Minimum Performance Level Action Plan and Quality Improvement Plan must outline how planned activities, strategies, and resources will be tailored to meet the unique needs of providers serving these communities. Any removal of contracted providers is subject to notice requirements as specified in 4.3.3 Network Stability of this Agreement.

e) Covered California reserves the right to approve or reject the Minimum Performance Level Action Plan and Quality Improvement Plan and request amendments. Upon receipt of the Minimum Performance Level Action Plan or Quality Improvement Plan, Covered California will approve or advise Contractor of any deficiencies. Contractor must resolve any identified deficiencies to Covered California's satisfaction within thirty (30) business days.

f) Contractor must regularly report to Covered California on its progress in implementing the Minimum Performance Level Action Plan and Quality Improvement Plan and achieving the annual targets for improvement, in writing and on a recurring basis as specified by Covered California.

g) Covered California will work with Contractor to ensure its Minimum Performance Level Action Plan and Quality Improvement Plan does not negatively impact Enrollees.

h) Covered California will closely monitor Contractor actions following approval of the Minimum Performance Level Action Plan and Quality Improvement Plan. Monitoring will include review of specified progress reports and

evaluation of Contractor compliance and performance in contractual and regulatory requirements, with oversight of Contractor's QHP network.

i) Contractor poor performance identified in Covered California's assessments and any documented pattern of actions negatively impacting Enrollees or contracted providers may result in early removal of Contractor's products from the Exchange, prior to the conclusion of the Remediation Period.

5.3 Utilization Management

Contractor shall maintain a utilization management program that complies with applicable laws, rules and regulations, including Health and Safety Code § 1367.01 and other requirements established by the applicable State Regulators responsible for oversight of Contractor.

5.4 Transparency and Quality Reporting

a) Pursuant to 45 C.F.R. § 156.220 and Centers for Medicare & Medicaid Services Transparency in Coverage requirements, Contractor shall provide Covered California and Enrollees with information reasonably necessary to provide transparency in Contractor's coverage, and report to Covered California and Enrollees the data as required by Covered California. This includes information relating to claims payment policies and practices, periodic financial disclosures, enrollment, disenrollment, claims denials, appeals, rating practices, cost sharing, payments with respect to any out -of -network coverage, and Enrollee rights. Contractor shall provide information required under this Section to Covered California and Enrollees in plain language.

b) Contractor shall timely respond to a Covered California Enrollee's request for cost sharing information and shall make cost sharing information available to individuals through the internet and pursuant to other means for individuals without internet access in a timely manner.

5.5 Quality Rating System

Contractor shall collect and annually report to Covered California, for each QHP Product Type, its Health Care Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Health Care Providers and Systems (CAHPS) data, and other performance data (numerators, denominators, and rates) as required for the federal Quality Rating System and as outlined in Attachment 1 —

Advancing Equity, Quality, and Value and Attachment 2 — Performance Standards with Penalties of this Agreement.

5.6 Data Submission Requirements

Contractor shall provide to Covered California information regarding Contractor's membership through Covered California in a manner consistent with applicable federal and California State law, as well as the terms and conditions of this Agreement as detailed in Attachment 1 — Advancing Equity, Quality, and Value, and Article 5, Section 5.02.1 Data Submission (Healthcare Evidence Initiative).

ARTICLE 6 – FINANCIAL PROVISIONS

6.1 Covered California for the Individual Market

6.1.1 Rates and Payments

a) Schedule of Rates. Covered California and Contractor have agreed upon monthly premium rates ("Monthly Rates") payable to Contractor as compensation for Services provided under this Agreement. The Monthly Rates for the Individual Exchange for Plan Year 2026 and the annual update for Plan Years 2027, and 2028 are those rates submitted by Contractor during the Certification Process and subsequently uploaded and validated by Contractor through the SERFF Templates for each Plan Year. The parties acknowledge and agree that the premium amounts set forth under the Monthly Rates are actuarially determined to ensure that premium revenues and cost sharing contributions will provide the total dollar amount necessary to support (i) the provision of Covered Services by Contractor through its QHPs, (ii) administrative expenses and reasonable reserves required by Contractor to meet the requirements outlined in this Agreement and in accordance with applicable laws, rules, and regulations, and (iii) the payment by Contractor of the Participation Fee, as further described in Section 6.1.3.

b) Updates. If the Term of this Agreement is longer than one year and Contractor's QHPs are certified for another year, the Monthly Rates for each subsequent year of the Agreement will be established no more frequently than annually during the Certification Process and in accordance with the procedures set forth at Section 4.5.

c) Collection and Remittance. Contractor understands that Contractor is responsible for collection and the Covered California Enrollee is responsible for remittance of the agreed-upon premium rates to Contractor in a timely manner. Contractor understands that individual Covered California Enrollees will remit their monthly premium payments directly to Contractor and Covered California will not aggregate premiums. The failure by a Covered California Enrollee to timely pay premiums may result in a termination of coverage pursuant to the terms set forth at Section 2.2.4. Contractor further understands that the premium payment collected by Contractor includes amounts allocated to the Participation Fee due to Covered California. The Participation Fees shall be billed by Covered California to Contractor and payable by Contractor to Covered California in accordance with the requirements set forth at Section 6.1.3.

d) State Funded Programs. If required by law, Covered California will administer State funded programs. Covered California shall remit advanceable or reconciled State funded payments to Contractor in accordance with program design documents adopted by Covered California for the applicable plan year. Payments will be calculated and delivered by Covered California separate from the Participation Fee invoices set forth in Section 6.1.3.

e) Payment for Additional Marketing Activities. Should Covered California engage in additional marketing activities in accordance with Section 3.2, Covered California will invoice Contractor for the mutually-agreed upon dollar amount. This invoice will be billed by Covered California to Contractor and payable by Contractor separate from the Participation Fee invoices set forth in Section 6.1.3. If, after Covered California completes the additional marketing activities, Covered California has not expended the full amount paid by Contractor pursuant to this Section 6.1.1e), Covered California shall pay any such unexpended funds back to Contractor.

6.1.2 Financial Consequences of Non-Payment of Premium

a) Premium payment rules. Contractor is responsible for enforcement of premium payment rules at its own expense, as outlined in the terms set forth in the Evidence of Coverage (EOC) regarding the failure by Enrollee to pay the premium in a timely manner as directed by the Enrollee policy agreement and in accordance with applicable laws, rules and regulations. Enforcement by Contractor shall include: chargebacks, delinquency and termination actions and notices, grace period requirements, and partial payment rules. Such enforcement shall be conducted in accordance with requirements in this Agreement consistent with applicable laws, rules and regulations.

b) Enrollee Terminations. In the event Contractor terminates a Covered California Enrollee's coverage in a QHP due to non-payment of premiums, loss of eligibility, fraud or misrepresentation, change in Covered California Enrollees selection of QHP, decertification of Contractor's QHP or as otherwise authorized under Section 2.2.4, Contractor must include the applicable State Regulator-approved appeals language, and any Covered California-required appeals language, in its notice of termination of coverage to the Covered California Enrollee.

c) Enrollee Disenrollment. In the event a Covered California Enrollee terminates coverage with a QHP for any reason, including termination due to non-payment of premium, Contractor may not charge the Covered California Enrollee any type of termination or disenrollment fee and the consumer must be allowed to re-enroll pursuant to federal and State open enrollment and special enrollment regulations.

d) Grace Period. Contractor acknowledges and agrees that applicable laws, rules, and regulations, including the Affordable Care Act and implementing regulations specify a grace period for individuals who receive advance payments of the premium tax credit through Covered California and that the Knox-Keene Act and Insurance Code set a grace period for other individuals with respect to delinquent payments. Contractor agrees to abide by the requirements set forth at Section 2.2.4 and required under applicable laws, rules, and regulations with respect to these grace periods.

e) Offsets. Pursuant to Section 1365 (a) of the Health and Safety Code, Contractor shall return the advanced State premium assistance paid to Contractor on behalf of a Covered California Enrollee who is terminated for nonpayment of premiums for the second and third months of the three-month grace period. Such repayments will be calculated by Covered California and offset from future payments of the advanced State premium assistance paid pursuant to Section 6.1.1(d). In the event that an issuer is no longer contracted with Covered California, Covered California will bill the issuer for any repayments due.

6.1.3 Covered California for the Individual Market Participation Fees

a) Contractor understands and agrees that: (i) under the Affordable Care Act and the California Affordable Care Act, Covered California may generate funds through Participation Fees on Contractor's QHPs, and (ii) Contractor is responsible for the timely payment of any Participation Fees to Covered California.

b) Contractor recognizes that the total cost of all Participation Fees for Covered California must be spread across Contractor's entire book of business in the single risk pool (both inside and outside Covered California) for the Individual Market.

c) The Participation Fee payable to Covered California during each month of this Agreement shall be equal to one (1.0) percent of the gross premium attributable to each Covered California Enrollee in Contractor's QHPs for such month. The Participation Fee will be assessed by Covered California and payable monthly by Contractor based on Covered California's gross premium records attributable to effectuated Covered California Enrollees in Contractor's QHPs sold through Covered California for the Individual Market for 2026 - 2028.

   The Participation Fee will be reviewed each year as part of Covered California's annual budget process. Should Covered California need to record any positive or negative adjustments to enrollment activity for prior years, the Participation Fee shall be calculated pursuant to Contractor's Agreement that was in place during the applicable Plan Year or years.

d) Participation Fee invoices will be issued by Covered California to Contractor on the 15th of the month. Contractor's Participation Fee obligation will be determined and billed by evaluating Contractor's then-current QHP effectuated enrollment and may be subject to adjustment to reflect changes in enrollment that may have occurred in prior months (including additions, terminations and cancellations of enrollment). Covered California may reduce Contractor's Participation Fee in specified months as a result of such changes in enrollment. In situations where Covered California has previously authorized and agreed to reimburse Contractor in writing for specified activities, such as additional marketing activities, Covered California may also reduce the Participation Fee to offset Contractor's expenses. Participation Fee payments will be due fifteen (15) Days from the date the invoice is emailed to Contractor. For invoices paid after fifteen (15) Days from the date the invoice is emailed, Contractor may be assessed a 1% per month late fee on the unpaid balance as of that date. Covered California, in its sole discretion, may assess the late fee for any month that Contractor fails to make the payment by the due date. Participation Fee payments will be applied to the oldest outstanding invoice or overall balance, including prior month late fees, whichever is greater.

e) In the event that Contractor disputes the amount of Participation Fees billed or deducted by Covered California, Contractor shall submit a written notice of such dispute to Covered California within thirty (30) Days following receipt of such bill or deduction by Covered California. Contractor's notice will document the nature of the discrepancies, including, reconciliation of any differences identified by Contractor in enrollment or premiums collected.

Covered California will respond to Contractor within forty-five (45) Days of receipt of the notice by either (i) paying the amount claimed by Contractor or (ii) providing a detailed explanation for the denial of the refund. If Contractor still disputes the findings of Covered California, Contractor may pursue additional remedies in accordance with Section 13.1.

f) Subject to the provisions of Section 11.5, Contractor agrees to a periodic audit or other examination by Covered California or its designee regarding the computation and payment of Participation Fees. In the case of material non-compliance with Participation Fee payments, Contractor shall implement any necessary corrective action. Covered California may perform follow up audits or examinations more frequently than annually to monitor Contractor's implementation of such corrective actions.

g) Contractor acknowledges that Covered California is required under Government Code § 100520(c) to maintain a prudent reserve as determined by Covered California.

ARTICLE 7 – PERFORMANCE STANDARDS

7.1 Performance Standards

Contractor shall comply with the Performance Standards set forth in Attachment 2 — Performance Standards with Penalties and Attachment 3 — Performance Standards and Expectations. Covered California will conduct or arrange for a review of Contractor's performance under the Performance Standards. Covered California shall be responsible for the actual and reasonable costs of the review, including the costs of any third-party designated by Covered California to perform such review. The review shall be in addition to any ongoing monitoring that may be performed by Covered California with respect to the Performance Standards.

7.2 Penalties

Covered California may impose penalties ("penalties") in the event that Contractor fails to comply or otherwise act in accordance with the Performance Standards. Penalties will be calculated in accordance with Attachment 2 — Performance Standards with Penalties.

7.3 No Waiver

Covered California and Contractor agree that the failure to comply with the Performance Standards may cause damages to Covered California and its Enrollees which may be uncertain and impractical or difficult to ascertain. The parties agree that Covered California shall assess, and Contractor promises to pay Covered California, in the event of such delayed, or failed performance that does not meet the Performance Standards, the amounts to be determined in accordance with the Performance Standards set forth at Attachment 2 — Performance Standards with Penalties.

The assessment of fees relating to the failure to meet Performance Standards shall be subject to the following: (i) be determined in accordance with the amounts and other terms set forth in the Performance Standards, (ii) be cumulative with other remedies available to Covered California under the Agreement, (iii) not be deemed an election of remedies, and (iv) not constitute a waiver or release of any other remedy Covered California may have under this Agreement for Contractor's breach of this Agreement, including Covered California's right to terminate this Agreement. Covered California shall be entitled, in its discretion, to recover actual damages caused by Contractor's failure to perform its obligations under this Agreement.

ARTICLE 8 – CONTRACT TERM; RECERTIFICATION AND DECERTIFICATION

8.1 Agreement Term

The term of this Agreement is specified on the STD 213, which is the signature page of this Agreement.

8.2 Agreement Termination

8.2.1 Covered California Termination

Covered California may, by ninety (90) Days' written notice to Contractor, and without prejudice to any other of the Covered California remedies, terminate this Agreement for cause based on one or more of the following occurrences:

a) Contractor fails to fulfill an obligation that is material to its status as a QHP Issuer or its performance under the Agreement;

b) Contractor no longer holds a license or certificate that is required for Contractor to perform its obligations under this Agreement or Contractor otherwise fails to maintain compliance with the "good standing" requirements pursuant to Section 4.1.1 and which impairs Contractor's ability to provide Services under the Agreement;

c) Contractor breaches any material term, covenant, warranty, or obligation under this Agreement that is not cured or substantially cured to the reasonable satisfaction of Covered California within forty-five (45) Days after receipt of notice of default from Covered California; provided, however, that such cure period may not be required and Covered California may terminate the Agreement immediately if Covered California determines pursuant to subparagraph (e) below that Contractor's breach threatens the health and safety of Covered California Enrollees;

d) Contractor knowingly has a director, officer, partner, or person with a beneficial ownership of more than five percent (5%) of Contractor's equity or has an employment, consulting, or other Subcontractor agreement for the provision of Services under this Agreement who is, or has been: (i) excluded, debarred, or suspended from participating in any federally funded health care program, (ii) suspended, or debarred from participation in any state contract or procurement process, or (iii) convicted of a felony or misdemeanor (or entered a plea of nolo contendere) related to a crime or violation involving the acquisition or dispersal of funds or delivery of Covered Services to beneficiaries of any State or Federal health care program;

e) Covered California reasonably determines that (i) the welfare of Covered California Enrollees is in jeopardy if this Agreement continues, as such determination shall be made in the reasonable discretion of Covered California based on consideration of professionally recognized standards and benchmarks, requirements imposed by accreditation agencies, and applicable laws, rules, and regulations; or (ii) Contractor fails to comply with a change in laws, rules or regulations occurring during the term of this Agreement and/or does not take any and all actions that may be required to amend the Agreement and otherwise establish and document compliance with any such changes; and (iii) Covered California reasonably determines, based on consultation with legal counsel and/or State and Federal Regulators and/or other State-based or Federal health benefit exchanges, that it may be at risk of being found noncompliant with Federal or State laws, rules, or regulations.

8.2.2 Contractor Termination

Contractor may, by ninety (90) Days' written notice to Covered California, and without prejudice to any other of the remedies, terminate this Agreement for cause based on one or more of the following occurrences:

a) Covered California breaches any material term, covenant, warranty, or obligation under this Agreement that is not cured or substantially cured to the reasonable satisfaction of Contractor within forty-five (45) Days after receipt by Covered California of notice from Contractor; or

b) Covered California fails to comply with a change in laws, rules or regulations occurring during the term of this Agreement or does not take any and all actions that may be required to amend the Agreement and otherwise establish and document compliance with any such changes, and Contractor reasonably determines, based on consultation with legal counsel and/or other State and Federal regulators and/or other State-based or Federal health benefit exchanges, that it may be at risk of being found noncompliant with Federal or State laws, rules, or regulations.

8.2.3 Notice of Termination

If Covered California determines, based on reliable information, that there is a substantial probability that Contractor will be unable to continue performance under this Agreement or Contractor will be in material breach of this Agreement in the next thirty (30) Days, then Covered California shall have the option to demand that Contractor provide Covered California with a reasonable assurance of performance. Upon Contractor's receipt of such a demand from Covered

California, Contractor shall provide to Covered California a reasonable assurance of performance responsive to Covered California's demand. If Contractor fails to provide assurance within ten (10) Days of Covered California's demand that demonstrates Contractor's reasonable ability to avoid such default or cure within a reasonable time period not to exceed thirty (30) Days, the failure shall constitute a breach by Contractor justifying termination of the Agreement by Covered California.

In case a party elects to terminate this Agreement in whole or in part under Section 8.2, the notifying party shall give the other party ninety (90) Days' written notice of termination for default, specifying the default or defaults justifying the termination. The termination shall become effective after the expiration of such notice period if the defaults specified by the notifying party in its notice remain uncured at that time; provided, however, that Covered California may require Contractor to discontinue the provision of certain Services if Covered California determines that the continuing provision of services may cause harm to Covered California Enrollees, Participating Providers, or other stakeholders.

Covered California shall be entitled to retain any disputed amounts that remain in the possession of Covered California until final resolution of all claims by the parties against each other arising out of any Contractor default alleged by Covered California.

8.2.4 Remedies in Case of Contractor Default or Breach

a) In addition to the termination provisions in Section 8.2.1, Covered California shall have full discretion to institute any of the following remedies, in accordance with Subsection (b) of this Section, in case of Contractor's breach, whether material or not, or default:

    i. Changing the order in which Contractor's QHPs are displayed in CalHEERS;

    ii. Removing Contractor's provider directory from the Covered California website;

    iii. Freezing Contractor's enrollment during Open or Special Enrollment Periods;

    iv. Recovery of damages to Covered California caused by the breach or default; and

v. Specific performance of particular covenants made by Contractor hereunder.

b) Prior to instituting any of the remedies in Subsection (a), Covered California shall provide written notice to Contractor that Contractor is in breach or default of this Agreement, identify the basis for such breach or default, and provide Contractor with a thirty (30) Day period to cure. During the cure period, the parties agree to meet and confer in an effort to informally resolve the breach or default. Contractor shall have thirty (30) Days from the date Contractor received notice of the breach or default to fully cure the breach or default unless the parties mutually agree to a longer cure period. If Contractor has not cured the breach or default within the thirty (30) Day period, or a longer cure period that has been mutually agreed upon, Covered California may institute any of the remedies identified in Subsection (a) of this section. All remedies of Covered California under this Agreement for Contractor default or breach are cumulative to the extent permitted by law.

c) This section shall not apply to any contractual requirements that are associated with a performance guarantee in Attachment 2 — Performance Standards with Penalties and Attachment 3 — Performance Standards and Expectations, or for failure to meet any quality targets in Attachment 1 — Advancing Equity, Quality, and Value.

8.2.5 Contractor Insolvency

Contractor shall notify Covered California immediately in writing in the event that Contractor files any federal bankruptcy action or state receivership action, any federal bankruptcy or state receivership action is commenced against Contractor, Contractor is adjudicated bankrupt, or a receiver is appointed and qualifies. In case any of the foregoing events occurs, Covered California may terminate this Agreement upon five (5) Days written notice. If Covered California does so, Covered California shall have the right to recover damages from Contractor as though the Agreement had been terminated for Contractor default.

8.3 Recertification

8.3.1 Recertification Process

During each year of this Agreement, Covered California will evaluate Contractor for recertification based on an assessment process conducted by Covered California in accordance with its procedures and on a basis consistent with applicable laws, rules and regulations. Covered California shall consider

Contractor for recertification unless (i) the Agreement is terminated sooner than the Expiration Date by Covered California in accordance with the requirements set forth at Section 8.2 or pursuant to other terms set forth in the Agreement, or (ii) Contractor makes a Non-Recertification Election pursuant to Section 8.3.2.

8.3.2 Non-Recertification Election

a) Contractor election. Contractor shall provide Covered California with notice on or before February 15th of each Plan Year whether Contractor will elect to not seek recertification of its QHPs for the following Plan Year ("Non-Recertification Election"). Contractor shall comply with conditions set forth in this Section 8.3.2 with respect to continuation of coverage and transition of Covered California Enrollees to new QHPs following Covered California's receipt of Contractor's Non-Recertification Election.

b) Continuation and Transition of Care. Except as otherwise set forth in this Section 8.3.2, Contractor shall continue to provide Covered Services to Covered California Enrollees in accordance with the terms set forth in the Agreement from and after Contractor's Non-Recertification Election up through the termination of coverage for Covered California Enrollees, as such termination of coverage shall be determined in accordance with the requirements of this section.

   Contractor shall take any further action reasonably required by Covered California to provide Covered Services to Covered California Enrollees and transition care following the Non-Recertification Election.

   Contractor shall coordinate and cooperate with respect to communications to Covered California Enrollees in Covered California for the Individual Market and other stakeholders regarding the transition of Covered California Enrollees to another QHP.

c) Covered California for the Individual Market. The following provisions shall apply to Covered California for the Individual Market:

   i. Following Covered California's receipt of the Non-Recertification Election, Contractor must continue to participate in the enrollment and eligibility assignment process, and may be assigned new Covered California Enrollees through the end of the Calendar Year;

   ii. Contractor will provide coverage for Covered California Enrollees assigned to Contractor until the earlier of (i) the end of the Calendar

Year, or (ii) the Covered California Enrollee's transition to another QHP during a Special Enrollment Period.

8.4 Decertification

Notwithstanding any other language set forth in this Section 8.4, the Agreement shall expire on the Expiration Date set forth in Section 8.1 in the event that Covered California elects to decertify Contractor's QHP based on Covered California's evaluation of Contractor's QHP during the recertification process that shall be conducted by Covered California pursuant to Section 8.2.

8.5 Effect of Termination

a) This Agreement shall terminate on the Expiration Date unless otherwise terminated earlier in accordance with the provisions set forth in this Agreement.

b) Contractor's QHPs shall be deemed decertified and shall cease to operate as QHPs as defined at 10 CCR § 6410 immediately upon termination or expiration of this Agreement in the event uninterrupted continuation of agreement between Covered California and Contractor is not achieved pursuant to either: (i) an extension of the term of the Agreement based upon the mutual agreement of the parties that is documented pursuant to a written amendment, or (ii) Contractor and Covered California enter into a new agreement that is effective immediately upon the expiration of this Agreement. There shall be no automatic renewal of this Agreement or recertification of Contractor's QHPs upon expiration of the term of this Agreement. Contractor may appeal the decertification of its QHP that will result in connection with the termination of this Agreement and such appeal shall be conducted pursuant to Covered California's process and in accordance with applicable laws, rules and regulations.

c) All duties and obligations of Covered California and Contractor shall cease upon termination of the Agreement and the decertification of Contractor's QHPs that shall occur upon the termination of this Agreement, except as set forth below or otherwise provided in the Agreement:

    i. Each party shall remain liable for any rights, obligations, or liabilities that have accrued or arise from activities carried on by it under this Agreement prior to the effective date of termination.

ii. Any information of the other party that is in the possession of the other party will be returned promptly, or upon the request of owner of such property, destroyed using reasonable measures to protect against unauthorized access to or use of the information in connection with its destruction, following the earlier of: (i) the termination of this Agreement, (ii) receipt of a written request to return or destroy the Information Assets, or (iii) the termination of the business relationship between the parties. If both parties agree that return or destruction of information is not feasible or necessary, the receiving party will continue to extend the protections outlined in this Agreement to all assets in its possession and will limit further use of that information to those purposes that make the return or destruction of the information or assets. Covered California reserves the right to inspect the storage, processes, and destruction of any Information Assets provided under this Agreement.

d) Contractor shall comply with the requirements set forth at Section 8.3.2 in the event that Contractor makes a Non-Recertification Election.

e) Contractor shall cooperate fully to effect an orderly transfer of Covered Services to another QHP during (i) any notice period set forth at Sections 8.2.3, 8.2.5, or 8.3.2, and (ii) if requested by Covered California to facilitate the transition of care or otherwise required under Section 8.6, following the termination of this Agreement. Such cooperation shall include the following:

i. Upon termination, Contractor, if offering an HMO, shall complete the processing of all claims for benefit payments under the QHP for Covered Services other than Capitated Services, and if offering a PPO, shall complete the processing of all medical claims for benefit payments under Contractor's QHP for Covered Services rendered on or before the termination date.

ii. Contractor will provide communications developed or otherwise approved by Covered California to communicate new QHP information to Covered California Enrollees in accordance with a timeline to be established by Covered California.

iii. In order to ensure the proper transition of Services provided prior to, and subsequent to, termination, Contractor will forward to any new QHP Issuer the electronic and direct paper claims that are received by Contractor, but which relate to Services provided by new contractor.

Any such information shall be subject to compliance with applicable laws, rules and regulations and shall be sent at such time periods and in the manner requested by Covered California for a period of up to three (3) months following the termination date.

iv. Contractor shall provide customer service to support the processing of claims for Covered Services rendered on or before the termination date for a period of two (2) months or such other longer period reasonably requested by Covered California at a cost to be mutually agreed upon per Covered California Enrollee.

v. If so instructed by Covered California in the termination notice, Contractor shall promptly discontinue the provision of Services requested by Covered California to be discontinued as of the date requested by Covered California.

vi. Contractor will perform reasonable and necessary acts requested by Covered California and as required under applicable laws, rules, regulations, consistent with industry standards to facilitate transfer of Covered Services herewith to a succeeding Contractor. Contractor shall comply with requirements reasonably imposed by Covered California relating to (i) the discontinuation of new enrollment or re-enrollment in Contractor's QHP, (ii) the transfer of Covered California Enrollee coverages to another QHP prior to the commencement date, (iii) the expiration of existing quotes, and (iv) such other protocols that may reasonably be established by Covered California.

vii. Contractor will reasonably cooperate with Covered California and any successor QHP Issuer in good faith with respect to taking such actions that are reasonably determined to be the best interest of the QHP Issuer, and Covered California Enrollees.

f) Contractor shall cooperate with Covered California's conduct of an accounting of amounts paid or payable and Covered California Enrollees enrolled during the month in which termination is effective in order to assure an appropriate determination of premiums earned by and payable to Contractor for Services rendered prior to the date of termination, which shall be accomplished as follows:

i. Mid-Month Termination: For a termination of this Agreement that occurs during the middle of any month, the premium for that month shall be apportioned on a pro rata basis. Contractor shall be entitled to

premiums from Covered California Enrollees for the period of time prior to the date of termination and Covered California Enrollees shall be entitled to a refund of the balance of the month. Contractor shall follow the methodology specified in 10 CCR § 6500 (i) for the refund of any excess premiums paid.

The same methodology shall apply to proration of APTC and CSR amounts for a coverage lasting less than one month.

ii. Responsibility to Complete Contractual Obligations: Contractor is responsible for completing submission and corrections to Encounter Data for Covered Services received by Covered California Enrollees during the period of the Agreement. Contractor is responsible for submitting any outstanding financial or other reports required for Covered Services rendered or Claims paid during the term of the Agreement.

g) Contractor shall (i) provide such other information to Covered California, Covered California Enrollees and/or the succeeding QHP Issuer, and/or (ii) take any such further action as is required to effect an orderly transition of Covered California Enrollees to another QHP in accordance with requirements set forth under this Agreement and/or necessary to the continuity and transition of care in accordance with applicable laws, rules, and regulations.

8.6 Coverage Following Termination and Decertification

a) Upon the termination of the Agreement or decertification of one or more of Contractor's QHPs, Contractor shall cooperate fully with Covered California in order to effect an orderly transition of Covered California Enrollees to another QHP as directed by Covered California. This cooperation shall include: (i) attending post-termination meetings, (ii) providing or arranging for the provision of Covered Services as may be deemed necessary by Participating Providers to assure the appropriate continuity of care, and (iii) communicating with affected Covered California Enrollees in cooperation with Covered California and the succeeding contractor as applicable, as reasonably requested by Covered California.

b) In the event the termination or expiration of the Agreement requires the transfer of some or all Covered California Enrollees into any other health plan, the terms of coverage under Contractor's QHP shall not be carried over to the replacement QHP, but rather the transferred Covered California Enrollees

shall be entitled only to the extent of coverage offered through the replacement QHP as of the effective date of transfer to the new QHP.

c) Notwithstanding the foregoing, the coverage of a Covered California Enrollee under Contractor's QHP may be extended to the extent that a Covered California Enrollee qualifies for an extension of benefits including, those to effect the continuity of care required due to hospitalization or disability. For purposes of this Agreement, "disability" means that the Covered California Enrollee has been certified as being totally disabled by the Covered California Enrollee's treating physician, and the certification is approved by Contractor. Such certification must be submitted for approval within thirty (30) Days from the date coverage is terminated. Recertification of Covered California Enrollee's disability status must be furnished by the treating Provider not less frequently than at sixty (60) Day intervals during the period that the extension of benefits is in effect. The extension of benefits shall be solely in connection with the condition causing total disability. This extension, which is contingent upon payment of the applicable premiums, shall be provided for the shortest of the following periods:

    i. Until total disability ceases;

    ii. For a maximum period of twelve (12) months after the date of termination, subject to plan maximums;

    iii. Until the Covered California Enrollee's enrollment in a replacement plan; or

    iv. Recertification.

ARTICLE 9 –INSURANCE AND INDEMNIFICATION

9.1 Contractor Insurance

9.1.1 Required Coverage

a) Without limiting Covered California's right to obtain indemnification or other forms of remedies or relief from Contractor or other third-parties, Contractor shall, at its sole cost and expense, obtain, and during the term of this Agreement, maintain in full force and effect, the insurance coverage described in this section and as otherwise required by law, including, coverage required to be provided and documented pursuant to § 1351 (o), (p), and (r) of the Health and Safety Code and relating to insurance coverage or self-insurance: (i) to respond to claims for damages arising out of the furnishing of Covered Services, (ii) to protect against losses of facilities where required by the director, and (iii) to protect against workers' compensation claims arising out of work-related injuries that might be brought by the employees and staff of Contractor. All insurance shall be adequate to provide coverage against losses and liabilities attributable to the acts or omissions of Contractor in performance of this Agreement and to otherwise protect and maintain the resources necessary to fulfill Contractor's obligations under this Agreement. Contractor shall arrange for continuous insurance coverage throughout the term of this Agreement. The minimum acceptable limits shall be as indicated below; Covered California may modify these limits based on Contractor's organization type and size:

   i. Commercial general liability or equivalent self-insurance covering the risks of bodily injury (including death), property damage, and personal injury, including coverage for contractual liability, with a limit of not less than $1 million per occurrence/$2 million general aggregate;

   ii. Employers liability insurance covering the risks of Contractor's employees and employees' bodily injury by accident or disease with limits of not less than $1 million per accident for bodily injury by accident, and $1 million per employee for bodily injury by disease, and $1 million disease policy limit;

   iii. Umbrella policy providing excess limits over the primary general liability, automobile liability, and employer's liability policies in an amount not less than $10 million per occurrence and in the aggregate;

iv. Cyber Liability insurance at such levels consistent with industry standards and reasonably determined by Contractor to cover network security, unauthorized access, unauthorized use, receipt or transmission of a malicious code, denial of service attack, unauthorized disclosure or misappropriation of private information and privacy liability Protected Health Information and Personally-Identifiable Information. The insurance must cover notification costs, credit card monitoring, and fines and penalties to the extent insurable incurred by Covered California due to Contractor's mistake or error.

9.1.2 Workers' Compensation

Contractor shall, in full compliance with State law, provide or purchase, at its sole cost and expense, statutory California's workers' compensation coverage which shall remain in full force and effect during the term of this Agreement.

9.1.3 Subcontractor Coverage

Contractor shall require all Subcontractors that may be authorized to provide Services on behalf of Contractor or otherwise under this Agreement to maintain insurance commensurate with the nature of such Subcontractors' work and all coverage for Subcontractors shall be subject to all the requirements set forth in this Agreement and applicable laws, rules and regulations. Failure of Subcontractor(s) to comply with insurance requirements does not limit Contractor's liability or responsibility.

9.1.4 Premium Payments and Disclosure

Premium on all insurance policies shall be paid by Contractor or its Subcontractors. Contractor shall provide thirty (30) Days' notice of cancellation to Covered California. Contractor shall furnish to Covered California copies of certificates of all required insurance prior to the Execution Date, and copies of renewal certificates of all required insurance within thirty (30) Days after the renewal date. Covered California reserves the right to review the insurance requirements contained herein to ensure that there is appropriate coverage that is in accordance with this Agreement. Covered California is to be notified by Contractor promptly if any aggregate insurance limit is exceeded. In such event, Contractor must purchase additional coverage to meet these requirements.

9.2 Indemnification

Contractor shall indemnify, defend, and hold harmless Covered California, the State, and all of the officers, trustees, Agents, and Employees of the foregoing, from and against any and all demands, claims, actions, losses, costs, liabilities, damages or deficiencies, including interest, penalties and attorneys' fees, related to any of the following:

a) Arise out of or are due to a breach by Contractor of any of its representations, warranties, covenants or other obligations contained in this Agreement; or

b) Are caused by or resulting from Contractor's acts or omissions constituting bad faith, willful misfeasance, negligence, or reckless disregard of its duties under this Agreement or applicable laws, rules, and regulations; or

c) Accrue or result to any of Contractor's Subcontractors, material men, laborers, or any other person, firm, or entity furnishing or supplying services, material, or supplies in connection with the performance of this Agreement.

The obligation to provide indemnification under this Agreement shall be contingent upon Covered California:

a) Providing Contractor with reasonable written notice of any claim for which indemnification is sought;

b) Allowing Contractor to control the defense and settlement of such claim; provided, however, that Contractor consults with Covered California regarding the defense of the claim and any possible settlements and agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes any restrictions or obligations on Covered California without Covered California's prior written consent, which will not be unreasonably withheld; and,

c) Cooperating fully with Contractor in connection with such defense and settlement. Indemnification under this section is limited as described herein.

ARTICLE 10 – PRIVACY AND SECURITY

10.1 Privacy and Security Requirements for Personally Identifiable Data

a) HIPAA Requirements. Contractor agrees to comply with applicable provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including the Administrative Simplification Provisions of HIPAA, as codified at 42 U.S.C. § 1320d et seq., the Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH"), and any current and future regulations promulgated under HITECH or HIPAA, all as amended from time to time and collectively referred to herein as the "HIPAA Requirements". Contractor agrees not to use or further disclose any Protected Health Information (PHI), other than as permitted or required by the HIPAA Requirements and the terms of this Agreement.

b) Covered California Requirements. With respect to Covered California General Functions, as outlined in 45 CFR § 155.200. Contractor agrees to comply with the following privacy and security requirements and standards applicable to Personally Identifiable Information (PII) which have been established and implemented by Covered California in accordance with the requirements of 45 CFR § 155.260 ("Covered California Requirements"):

    i. Uses and Disclosures. Pursuant to the terms of this Agreement, Contractor may receive from Covered California PHI and/or PII in connection with Covered California General Functions that is protected under applicable Federal and State laws and regulations. Contractor shall not use or disclose such PHI or PII obtained in connection with Covered California General Functions other than as is expressly permitted under Covered California Requirements and only to the extent necessary to perform the Covered California General Functions described within this Agreement.

    ii. Fair Information Practices. Contractor shall implement reasonable and appropriate fair information practices to ensure:

1. Individual Access. Contractor shall provide access to, and permit inspection and copying of PHI and PII in either an electronic or hard copy format as specified by the individual and as required by law, within thirty (30) Days of such request from the individual. If Contractor denies access, in whole or in part, Contractor must provide a written denial within the time limits for providing access, which includes the basis for the denial and a statement of the individual's review rights, if applicable. In the event any individual requests access to PHI or PII maintained by Covered California or another health plan directly from Contractor, Contractor shall within five (5) Days forward such request to Covered California and the relevant health plan as needed.

2. Amendment. Contractor shall provide an individual with the right to request an amendment of inaccurate PHI and PII. Contractor shall respond to such individual within sixty (60) Days of such a request either by making the correction and informing the individual of such correction or notifying the individual in writing that the request was denied, which notice shall provide an explanation for the denial and explain that the individual may submit a statement of disagreement with the denial.

3. Openness and Transparency. Contractor shall make available to individuals applicable policies, procedures, and technologies that directly affect such individuals and/or their PHI and PII.

4. Choice. Contractor shall provide individuals with a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their PHI and PII.

5. Limitations. Contractor represents and warrants that all PHI and PII shall be collected, used, and/or disclosed under this Agreement only to the extent necessary to accomplish a specified purpose under the terms of this Agreement or as permitted by Covered California Requirements and never to discriminate inappropriately.

6. Data Integrity. Contractor shall implement policies and procedures reasonably intended to ensure that PHI and PII in its possession is complete, accurate, and current, to the extent

necessary for Contractor's intended purposes, and has not been altered or destroyed in an unauthorized manner.

7. Safeguards. Contractor must have in place administrative, physical, and technical safeguards that meet or exceed the standards published in the National Institute of Standards and Technology (NIST), Special Publication 800-53 rev 5, or in the ISO/IEC 27001 to appropriately protect the confidentiality, integrity, and availability of the PHI and PII that it creates, receives, maintains, or transmits pursuant to the Agreement and to prevent the use or disclosure of PHI and/or PII other than as provided for in this Agreement, or as required by law. In furtherance of compliance with such requirements, Contractor shall:

    a. Encrypt all PHI and/or PII that is in motion and at rest, including data on portable media devices, consistent with the current Federal Information Processing Standards (FIPS) Publication 140 encryption standards;

    b. Implement a contingency plan for responding to emergencies and/or disruptions to business or systems used to deliver services pursuant to this Agreement without degradation of the PHI and/or PII security, and is tested at least annually;

    c. Maintain a Security Incident response plan; Mitigate to the extent practicable, any harmful effect that is known to Contractor of any Security Incident related to PHI and/or PII or of any use or disclosure of PHI and/or PII by Contractor or its Subcontractors or Agents in violation of the requirements of this Agreement or applicable privacy and security laws and regulations and agency guidance;

    d. Ensure that each individual user, including Contractor's employees, Sub-contractors, Agents or other such individuals, of any Covered California computer system through which PHI and/or PII is accessed be assigned and maintain their own unique user-id and password. Contractor shall immediately notify Covered California via the current provisioning process for access permissions provided by Covered California once any such

employees, Sub-contractors, Agents or other such individuals are no longer employed, retained, or acting in a role that does not require access to PHI and/or PII by Contractor. Contractor shall likewise cooperate in good faith to ensure the accounts of any such individuals are de-activated to prevent unauthorized access to PHI and/or PII through any such Covered California computer system; and

e. Destroy PHI and PII in a manner consistent with applicable State and Federal laws, regulations, and agency guidance on the destruction of PHI and PII, including NIST special publication 800-88 “Guidelines for Media Sanitization; and

f. Comply with all applicable Covered California policies within Section 10.2. Protection of Information Assets, including executing non-disclosure agreements and other documents required by such policies. Contractor shall also require any Subcontractors and Agents to comply with all such Covered California policies.

c) Compliance with California Requirements. With respect to all provisions of information under this Agreement, Contractor agrees to comply with all applicable California state health information privacy and security laws applicable to PII, including the Confidentiality of Medical Information Act, the California Insurance Information and Privacy Protection Act, and the Information Practices Act (IPA), all collectively referred to as “California Requirements.”

    i. With respect to the IPA, Contractor agrees to adhere to the standards and requirements of the IPA as if Contractor were Covered California itself. Contractor is therefore required to meet the same standards of privacy and information handling as Covered California and must comply with all applicable sections of the IPA related to the collection, use, storage, security, and disclosure of personal information as applicable and when handling any PII received from, or collected on behalf of, Covered California.

d) Interpretation. Notwithstanding any other provisions in this section, to the extent a conflict arises between the permissibility of a use or disclosure of PHI or PII under the HIPAA Requirements, Covered California Requirements, or

California Requirements with respect to Covered California General Functions, the applicable requirements imposing the more stringent privacy and security standards to such uses and disclosures shall apply. In addition, any ambiguity in this Agreement regarding the privacy and security of PHI and/or PII shall be resolved to permit Covered California and Contractor to comply with the most stringent of the applicable privacy and security laws or regulations.

e) Breach Notification.

i. Contractor shall report to Covered California any Breach or Security Incident reasonably calculated to result in the Breach of PII or PHI created or received in connection with Covered California General Functions in accordance with the provisions set forth herein. For purposes of this Paragraph (e), a "Breach" shall, in accordance with the HIPAA Breach Notification Rule, mean the impermissible use or disclosure of PII or PHI within Contractor's custody or control which is reasonably calculated to compromise the security or privacy of any such PII or PHI [45 C.F.R. § 164.400-414]. A "Security Incident" shall, in accordance with the HIPAA Security Rule, mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or the interference with system operations in an information system [45 C.F.R. § 164.304].

ii. Contractor shall, without unreasonable delay, but no later than within three (3) business days after Contractor's discovery of a Breach or Security Incident reasonably calculated to result in a Breach of PII or PHI subject to this Agreement, submit an initial report regarding any such Breach or Security Incident to Covered California. Reports shall be made on a form made available to Contractor by Covered California.

iii. Contractor shall cooperate with Covered California in investigating any such Breach or Security Incident and in meeting Covered California's obligations, if any, under applicable State and Federal security breach notification laws, regulatory obligations, or agency requirements. If the cause of the Breach or Security Incident is attributable to Contractor or its Agents or Subcontractors, Contractor shall be responsible for Breach notifications and reporting as required under applicable Federal and State laws, regulations, and agency guidance. Such notification(s)

and required reporting shall be done in cooperation with Covered California.

iv. To the extent possible, Contractor's initial report shall include: (i) the names of the individual(s) whose PHI and/or PII has been, or is reasonably believed by Contractor to have been accessed, acquired, used, or disclosed. In the event of a Security Incident, Contractor shall provide such information regarding the nature of the information system intrusion and any systems potentially compromised; (ii) a brief description of what happened including the date of the incident and the date of the discovery of the incident, if known; (iii) a description of the types of PHI and/or PII that were involved in the incident, as applicable; (iv) a brief description of what Contractor is doing or will be doing to investigate, to mitigate harm to the individual(s) and to its information systems, and to protect against recurrences; and (v) any other information that Covered California determines it needs to include in notifications to the individual(s) or relevant regulatory authorities under applicable privacy and security requirements.

v. Within three (3) Days of conducting its investigation, unless an extension is granted by Covered California, Contractor shall file a final report, which shall identify and describe the results and outcome of Contractor's above-referenced investigation and mitigation efforts. Contractor shall make all reasonable efforts to obtain the information listed above and shall provide an explanation if any information cannot be obtained. Contractor and Covered California will cooperate in developing content for any public statements.

f) Other Obligations. The following additional obligations apply to Contractor:

i. Subcontractors and Agents. Contractor shall enter into an agreement with any Agent or Subcontractor that will have access to PHI and/or PII that is received from, or created or received by, Contractor on behalf of Covered California or in connection with this Agreement, or any of its contracting Plans pursuant to which such Agent or Subcontractor agrees to be bound by the same or more stringent restrictions, terms and conditions as those that apply to Contractor pursuant to this Agreement with respect to such PHI and PII.

ii. Covered California Operations. Unless otherwise agreed to by Contractor and Covered California, Contractor shall provide patient medical and pharmaceutical information needed by Covered California

to fulfill its health oversight obligations under applicable law and effectively oversee and administer the Plans.

iii. Records and Audit. Contractor agrees to make its internal practices, books and records relating to the use and disclosure of PHI and/or PII received from Covered California, or created or received by Contractor on behalf of Covered California or in connection with this Agreement available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining Contractor's and/or Covered California's compliance with HIPAA Requirements. In addition, Contractor shall provide Covered California with information concerning its safeguards described throughout this section and/or other information security practices as they pertain to the protection of PHI and PII, as Covered California may from time to time request. Failure of Contractor to complete or to respond to Covered California's request for information within the reasonable timeframe specified by Covered California shall constitute a material breach of this Agreement. In the event of a Breach or Security Incident related to PHI and/or PII or any use or disclosure of PHI and/or PII by Contractor in violation of the requirements of this Agreement, Covered California will be permitted access to Contractor's facilities in order to review policies, procedures, and controls relating solely to compliance with the terms of this Agreement.

iv. Electronic Transactions Rule. In conducting any electronic transaction that is subject to the Electronic Transactions Rule on behalf of any Plan, Contractor agrees to comply with all applicable requirements of the Electronic Transactions Rule set forth in 45 C.F.R. Part 162. Contractor agrees to require that any Agent, including a Subcontractor, of Contractor that conducts standard transactions with PHI and/or PII of the Plan comply with all applicable requirements of the Electronic Transactions Rule.

v. Minimum Necessary. Contractor agrees to request and use only the minimum necessary type and amount of PHI required to perform its services and will comply with any regulations promulgated under the HIPAA Requirements and agency guidance concerning the minimum necessary standard pertaining to PHI. Contractor will collect, use, and disclose PII only to the extent necessary to accomplish a specified purpose under this Agreement.

vi. Indemnification. Contractor shall indemnify, hold harmless, and defend Covered California from and against any and all costs (including mailing, labor, administrative costs, vendor charges, and any other costs Covered California determines to be reasonable), losses, penalties, fines, and liabilities arising from or due to a Breach or other non-permitted use or disclosure of PHI and/or PII by Contractor or its Subcontractors or Agents, including, (i) damages resulting from any action under applicable (1) HIPAA Requirements, (2) Covered California Requirements or (3) California Requirements, and (ii) the costs of Covered California actions taken to: (1) notify the affected individual(s) and other entities of and to respond to the Breach; (2) mitigate harm to the affected individual(s); and (3) respond to questions or requests for information about the Breach or other impermissible use or disclosure of PHI and/or PII.

g) Privacy Policy. Covered California shall notify Contractor of any limitation(s) in its Privacy Policy, to the extent that such limitation may affect Contractor's use or disclosure of PHI and/or PII.

h) Reporting Violations of Law. Contractor may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(2), other provisions within the HIPAA Requirements, or any other applicable State or Federal laws or regulations.

i) Survival. Notwithstanding anything to the contrary in the Agreement, the provisions of this Section 10.1 on the protection of PII shall survive termination of the Agreement with respect to information that relates to Covered California General Functions until such time as all PII and PHI is destroyed by assuring that hard copy PII and PHI will be shredded and electronic media will be cleared, purged, or destroyed consistent with NIST Guidelines for Media Sanitization, or is returned to Covered California, in a manner that is reasonably acceptable to Covered California.

j) Contract Breach. Without limiting the rights of the parties pursuant to this Agreement, if Contractor breaches its obligations under this section, Covered California may, at its option: (i) exercise any of its rights of access and inspection under this Agreement; (ii) require Contractor to submit to a plan of monitoring and reporting, as Covered California may determine necessary to maintain compliance with this Agreement and such plan shall be made part of this Agreement; or (iii) notwithstanding any other provisions of this Agreement, after giving Contractor opportunity to cure the breach, terminate

this Agreement. If Contractor materially breaches its obligations under this section, Covered California may terminate this Agreement, with or without opportunity to cure the breach. Covered California's remedies under this section and any other part of this Agreement or provision of law shall be cumulative, and the exercise of any remedy shall not preclude the exercise of any other.

10.2 Protection of Information Assets

a) The following terms shall apply as defined below:

i. "Information Assets" means any information, including Confidential Information, necessary to the operation of either party that is created, stored, transmitted, processed, or managed on any hardware, software, network components, or any printed form, or is communicated orally. "Information Assets" does not include information that has been transferred from the Disclosing Party to the Receiving Party under applicable laws, regulations, and agency guidance, and that is being maintained and used by the Receiving Party solely for purposes that are not Covered California General Functions.

ii. "Confidential Information" includes, any information (whether oral, written, visual, or fixed in any tangible medium of expression), relating to either party's services, operations, systems, programs, inventions, techniques, suppliers, customers and prospective customers (excluding Covered California), cost and pricing data, trade secrets, know-how, processes, plans, reports, designs, and any other information of or relating to the business or either party, including Contractor's programs, but does not include information that (i) is described in the Evidence of Coverage (EOC); (ii) was known to the Receiving Party before it was disclosed to the Receiving Party by the Disclosing Party, (iii) was or becomes available to the Receiving Party from a source other than the Disclosing Party, provided such fact is evidenced in writing and the source is not bound by a confidentiality obligation regarding such information to Disclosing Party, or (iv) is developed by either party independently of the other party's Confidential Information, provided that such fact can be adequately documented.

iii. "Disclosing Party" means the party who sends Information Assets that it owns to the other party for the purposes outlined in this Agreement.

iv. “Receiving Party” means the party who receives Information Assets owned by the other party.

b) The Receiving Party shall hold all Information Assets of the Disclosing Party in confidence and will not use any of the Disclosing Party’s Information Assets for any purpose, except as set forth in this Agreement, or as otherwise required by law, regulation, or compulsory process.

c) The Receiving Party must take all reasonable and necessary steps to prevent the unauthorized disclosure, modification, or destruction of the Disclosing Party’s Information Assets. The Receiving Party must, at a minimum, use the same degree of care to protect the Disclosing Party’s Information Assets that it uses to protect its own Information Assets.

d) The Receiving Party agrees not to disclose the Disclosing Party’s Information Assets to anyone, except to employees or third parties who require access to the Information Assets pursuant to this Agreement, but only where such third parties have signed agreements regarding the Information Assets containing terms that are equivalent to, or stricter than, the terms of this section, or as otherwise required by law.

e) In the event the Receiving Party is requested to disclose the Disclosing Party’s Information Assets pursuant to a request under the California Public Records Act (PRA), a summons, subpoena, or in connection with any litigation, or to comply with any law, regulation, ruling, or government or public agency request, the Receiving Party shall, to the extent it may do so lawfully, give the Disclosing Party five (5) business days’ notice of such requested disclosure and afford the Disclosing Party the opportunity to review the request before Receiving Party discloses the Information Assets. The Disclosing Party shall, in accordance with applicable law, have the right to take such action as it reasonably believes may be necessary to protect the Information Assets, and such action shall not be restricted by the dispute resolution process of this Agreement. If such request is pursuant to the PRA, Covered California shall give Contractor five (5) business days’ notice to permit Contractor to consult with Covered California prior to disclosure of any Confidential Information. This subdivision shall not apply to restrict disclosure of any information to the State or in connection with a dispute between Covered California and Contractor or any audit or review conducted pursuant to this Agreement.

f) The Receiving Party shall notify the Disclosing Party in writing of any unauthorized disclosure, modification, or destruction of the Disclosing Party’s

Information Assets by the Receiving Party, its officers, directors, employees, contractors, Agents, or third parties. The Receiving Party shall make this notification promptly upon becoming aware of such disclosure, modification, or destruction, but in any event, not later than four (4) Days after becoming aware of the unauthorized disclosure, modification, or destruction. After such notification, the Receiving Party agrees to cooperate reasonably, at the Receiving Party's expense, with the Disclosing Party to remedy or limit the unauthorized disclosure, modification, or destruction, and/or its effects.

g) The Receiving Party understands and agrees the Disclosing Party may suffer immediate, irreparable harm in the event the Receiving Party fails to comply with any of its obligations under this section, that monetary damages will be inadequate to compensate the Disclosing Party for such breach and that the Disclosing Party shall have the right to enforce this section by injunctive or other equitable remedies. The provisions of this section shall survive the expiration, or termination, for any reason, of this Agreement.

h) To the extent that information subject to this section on Protection of Information Assets is also subject to HIPAA Requirements, Covered California Requirements or California Requirements in Section 10.1(b) and (c), such information shall be governed by the provisions of Section 10.1. In the event of a conflict or inconsistency between the requirements of the various applicable sections and attachments of this Agreement, including Section 10.1 and this Section 10.2, Contractor shall comply with the provisions that provide the greatest protection against access, use, or disclosure.

i) Survival. Notwithstanding anything to the contrary in the Agreement, the provisions of this Section 10.2 on Information Assets shall survive termination of the Agreement until such time as all Information Assets provided by Covered California to Contractor, or created, received, or maintained by Contractor on behalf of Covered California, is destroyed by assuring that hard copy Information Assets will be shredded and electronic media will be cleared, purged, or destroyed consistent with National Institute of Standards and Technology Guidelines for Media Sanitization or is returned to Covered California, in a manner that is reasonably acceptable to Covered California.

ARTICLE 11 – RECORDKEEPING

11.1 Clinical Records

Except with respect to any longer periods that may be required under applicable laws, rules and regulations, Contractor shall maintain, and require each Participating Provider and Subcontractor to maintain, a medical record documentation system adequate to fully disclose and document the medical condition of each Enrollee and the extent of Covered Services provided to Enrollees. Clinical records shall be retained for at least seven (7) years following the year of the final Claims payment. Except as otherwise required by State and Federal laws, rules, and regulations, if an audit, litigation, research, evaluation, claim, or other action involving the records has not been concluded before the end of the seven (7) year minimum retention period, the clinical records must be retained until all issues arising out of the action have been resolved. If responsibility for maintenance of medical records is delegated by Contractor to a Participating Provider or Subcontractor, Contractor shall require such Participating Provider or other Subcontractor to comply with the document retention requirements set forth in this Agreement and as otherwise required by applicable laws, rules and regulations.

11.2 Financial Records

a) Except as otherwise required to be maintained for a longer period by law or this Agreement, financial records, supporting documents, statistical records and all other records pertinent to amounts paid to or by Contractor in connection with this Agreement shall be retained by Contractor for at least ten (10) years from the date of the final claims payment. Contractor shall maintain accurate books, accounts, and records and prepare all financial statements in accordance with Generally Accepted Accounting Principles, applicable laws, rules and regulations, and requirements imposed by any governmental, or State or Federal Regulator having jurisdiction over Contractor.

b) Contractor shall maintain adequate data customarily maintained and reasonably necessary to properly document each of its transactions with Participating Providers, Covered California, and Enrollees during the period this Agreement remains in force and will keep records of claims, including medical review and high dollar special audit claims, for a period of ten (10) years or for such length of time as required by Federal or State law, whichever is longer. Subject to compliance with applicable laws, rules and regulations, including, those relating to confidentiality and privacy, at the end

of the ten (10) year retention period, at the option of Covered California, records shall either be transferred to Covered California at its request or destroyed.

c) Contractor shall maintain historical claims data and other records and data relating to the utilization of Covered Services by Enrollees online for two (2) years from date that the Agreement is terminated with respect to Covered Services provided to Enrollees during the term of this Agreement. These records shall include the data elements necessary to produce specific reports mutually agreed upon by Covered California and Contractor and in such form reasonably required by Covered California that is consistent with industry standards and requirements of State Regulators regarding statistical, financial, and/or data reporting requirements, including information relating to diagnosis, treatment, amounts billed (allowed and paid), dates of service, procedure numbers, deductible, out-of-pocket, and other cost sharing for each claim.

11.3 Storage

Such books and records shall be kept in a secure location at Contractor's office(s), and books and records related to this Agreement shall be available for inspection and copying by Covered California, Covered California representatives, and such consultants and specialists as designated by Covered California, at any time during normal business hours as provided in Section 11.5 hereof and upon reasonable notice. Contractor shall also ensure that related books and records of Participating Providers and Subcontractors shall be accurately maintained. If any inquiry, audit, investigation, litigation, claim, or other action involving the records is ongoing and has not been finally concluded before the end of the ten (10) year minimum retention period, the applicable financial records must be retained until all issues arising out of the action have been resolved.

11.4 Back-Up

Contractor shall maintain a separate back-up system for its electronic data processing functions and a duplicate data file which is updated regularly and stored off-site in a secured, controlled environment. Contractor's back-up system shall comply with applicable laws, rules and regulations, including, those relating to privacy and confidentiality, and shall be designed to meet or exceed industry standards regarding the preservation of access to data.

11.5 Examination and Audit Results

a) Contractor shall immediately submit to Covered California the results of final financial, market conduct, or special audits/reviews performed by State and Federal Regulators that have jurisdiction where Contractor serves Covered California Enrollees.

b) Contractor agrees to subject itself to Covered California for audits/reviews, either by Covered California or its designee, or the Department of General Services, California State Auditors, other state and federal regulatory agencies or their designee. Audits/reviews include the evaluation of the correctness of premium rate setting, Covered California's payments to Agents based on Contractor's report, questions pertaining to Covered California Enrollee premium payments and advance premium tax credit payments and State premium assistance payments, participation fee payments which Contractor made to Covered California, Contractor's compliance with the provision set forth in this contract, and review of Contractor's internal controls to perform the duties specified in this contract. Contractor also agrees to all audits subject to applicable State and Federal law regarding the confidentiality of and release of confidential Protected Health Information of Covered California Enrollees.

c) Contractor agrees that Covered California, the Department of General Services, the California State Auditors, other state and federal regulatory agencies, or their designated representative, shall, subject to applicable State and Federal law regarding the confidentiality and release of Protected Health Information of Enrollees, have the right to access, review and to copy any information and records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is stipulated. Contractor agrees to allow the auditor(s) access to such records, information and supporting documentation during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement.

d) Contractor agrees to implement corrective actions of an audit/review findings within ninety (90) Days. In the instance Contractor cannot implement the corrective action of a finding within ninety (90) Days, it shall submit a status report to Covered California stating why it cannot correct the finding within the specified time frame and shall propose another date for correction which shall also include a mitigation strategy. In all instances, Contractor and Covered California will do their best to resolve an audit/review finding within one hundred sixty (160) Days. Should Contractor disagree with Covered California's management decision on an audit/review finding, it may appeal such management decision to Covered California Executive Director whose decision is final and binding on the parties, in terms of administrative due process.

11.6 Notice

Contractor shall promptly notify Covered California in writing of any inquiry, audit, investigation, litigation, claim, examination, or other proceeding involving Contractor, or any Contractor personnel, Participating Provider or other authorized Subcontractor, that is threatened or commenced by any State and Federal Regulatory agency or other party that a reasonable person might believe could materially affect the ability of Contractor to perform in accordance with the terms set forth in this Agreement. Such notice shall be provided by Contractor to Covered California within ten (10) Days of Contractor's receipt of notice regarding such action; provided, however, that any such exchange of information shall be subject to compliance with applicable laws, rules and regulations, and shall not occur to the extent prohibited by order of the court, administrative agency, or other tribunal. or State or Federal regulatory authority having jurisdiction over the matter or by the laws and regulations governing the action. This section shall not be required with respect to disputes relating to claims and other matters noticed to Covered California in the ordinary course of business pursuant to other terms and conditions set forth in this Agreement or required by law.

11.7 Confidentiality

Covered California understands and agrees that Contractor shall only be obligated to provide access to such information to the extent that: (i) access to such information is permitted by applicable State and Federal law and regulation, including, State and Federal law or regulation relating to confidential or private information; and (ii) it would not cause Contractor to breach the terms of any contract to which Contractor is a party. Contractor shall use efforts reasonably

acceptable to obtain any necessary consents relating to Contractor's access to information.

11.8 Tax Reporting

Contractor shall provide such information to Covered California upon request and in such form as mutually agreed upon by the parties and reasonably required to document Contractor's compliance with, and/or to fulfill Covered California's obligations with respect to, income tax eligibility, computation and reporting requirements required under applicable laws, rules and regulations applicable to the operation of Covered California, including, those relating to premium tax credit, and other operations of Covered California set forth at 45 C.F.R. Part 155.

11.9 Electronic Commerce

Contractor shall use commercially reasonable efforts, which shall include Contractor's development, implementation and maintenance of processes and systems consistent with industry standards, to comply with the requirements of Covered California and applicable laws, rules and regulations relating to Contractor's participation in electronic commerce activities required under the terms of this Agreement. Contractor shall comply with service levels and system interface specifications documented by Covered California in appropriate CalHEERS documentation.

ARTICLE 12 – INTELLECTUAL PROPERTY

12.1 Warranties

a) Contractor represents, warrants and covenants to the best of its knowledge that:

i. It has secured and will secure all rights and licenses necessary for its performance of this Agreement, including consents, waivers, releases from all authors of or owners of any copyright interests in music or performances used, individuals, and talent (radio, television, and motion picture talent), owners of any interest in and to real estate site, locations, property, or props that may be used or shown.

ii. To the best of Contractor's knowledge, neither Contractor's performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary or contractual right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any state, the United States, or any foreign country. There is currently no actual or threatened claim by any such third party based on an alleged violation of any such right by Contractor.

iii. Neither Contractor's performance nor any part of its performance will violate the right of privacy of, or constitute false or misleading advertising or a libel or slander against any person or entity.

iv. It has not granted and shall not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to Covered California in this Agreement.

v. It has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this Agreement for the acquisition, operation, or maintenance of computer software in violation of copyright laws.

vi. It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor's performance of this agreement.

b) EXCEPT AS EXPRESSLY STATED ELSEWHERE IN THIS AGREEMENT, COVERED CALIFORNIA AND CONTRACTOR MAKE NO WARRANTY AND EXPRESSLY DISCLAIM ANY WARRANTY, EXPRESS OR IMPLIED, THAT THEIR INTELLECTUAL PROPERTY OR THE INTELLECTUAL PROPERTY RESULTING FROM THIS AGREEMENT IS MERCHANTABLE, FIT FOR A PARTICULAR PURPOSE, OR DOES NOT INFRINGE UPON ANY PATENT, TRADEMARK, COPYRIGHT OR THE LIKE, NOW EXISTING OR SUBSEQUENTLY ISSUED.

12.2 Intellectual Property Indemnity

a) Subject to Subsection (c) hereof, Contractor agrees to indemnify and hold Covered California harmless from any expense, loss, damage, or injury; to defend at its own expense any and all claims, suits, and actions; and to pay any judgments or settlements against Covered California to the extent they arise or are due to infringement of third-party intellectual property rights enforceable in the U.S., misuse of third-party confidential or trade secret information, failure to obtain necessary third-party consents, waivers or releases, violation of the right of privacy or publicity, false or misleading advertising, libel or slander, or misuse of social media, by Contractor or any Contractor Intellectual Property. Contractor's indemnification obligations under this section are subject to Contractor receiving prompt notice of the claim after Covered California becomes aware of such claim and being given the right to control the defense of such claim. Should any Intellectual Property licensed by Contractor to Covered California under this Agreement become the subject of an Intellectual Property infringement claim or other claim for which Contractor is obligated to indemnify Covered California, Contractor will promptly take steps reasonably and in good faith to preserve Covered California's right to use the licensed Intellectual Property in accordance with this Agreement at no expense or disruption to Covered California, except as otherwise stated in this Agreement. Covered California shall have the right to monitor and appear through its own counsel (at Covered California's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for Covered California to continue using the licensed Intellectual Property; or, replace or modify the licensed Intellectual Property so that the replaced or modified Intellectual Property becomes non-infringing provided that such replacement or modification is

functionally equivalent to the original licensed Intellectual Property, as its sole remedy.

b) Notwithstanding anything to the contrary in this Agreement, any such indemnification obligation of Contractor shall not extend to any infringement or alleged infringement to the extent that such infringement or alleged infringement resulted from (i) specific instructions to use certain Intellectual Property given to Contractor by Covered California; (ii) Covered California's unauthorized modification of Contractor Intellectual Property; (iii) Covered California's use of Contractor Intellectual Property in combination with any service or product not supplied, recommended or approved by Contractor, or used by Covered California in a manner for which it was not authorized; or (iv) Intellectual Property created or derived by Covered California.

c) Contractor agrees that damages alone would be inadequate to compensate Covered California for breach of any term of this Article by Contractor. Contractor acknowledges Covered California would suffer irreparable harm in the event of such breach and agrees Covered California shall be entitled to seek equitable relief, including an injunction, from a court of competent jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.

12.3 Federal Funding

If this Agreement is funded in whole or in part by the federal government, Covered California may acquire and maintain the Intellectual Property rights, title, and ownership, which results directly or indirectly from the Agreement; except as provided in 37 C.F.R. § 401.14 and except as stated herein. However, the federal government shall have a non-exclusive, nontransferable, irrevocable, paid-up license throughout the world to use, duplicate, or dispose of such Intellectual Property throughout the world in any manner for governmental purposes and to have and permit others to do so.

12.4 Ownership and Cross-Licenses

a) Intellectual Property Ownership. As between Contractor and Covered California, each Party shall remain at all times the sole and exclusive owner of all right, title and interest in and to the Intellectual Property that it owned or used prior to entry into this Agreement, or that it developed in the course of performance of this Agreement. Any Intellectual Property created by either Party in the performance of this Agreement shall not be considered a "work made for hire" of the other Party, as "work made for hire" is defined in the

United States Copyright Act, 17 U.S.C. § 101. Any rights not licensed to the other Party hereunder are expressly reserved exclusively by the originating Party.

b) License of Intellectual Property. Each Party (a "Licensor") grants the other Party (a "Licensee") the non-exclusive, royalty-free, paid-up, worldwide, irrevocable, right, during the term of this Agreement, to use the Licensor's Intellectual Property solely for the purposes of this Agreement and to carry out the Party's functions consistent with its responsibilities and authority as set forth in the enabling legislation and regulations. Such licenses shall not give the Licensee any ownership interest in or rights to the Intellectual Property of the Licensor. Each Licensee agrees to abide by all third-party license and confidentiality restrictions or obligations applicable to the Licensor's Intellectual Property of which the Licensor has notified the Licensee in writing.

c) Definition of Intellectual Property. For purposes of this Agreement, "Intellectual Property" means recognized protectable rights and interests such as: patents (whether or not issued), copyrights, trademarks, service marks, applications for any of the foregoing, inventions, Confidential Information, trade secrets, trade dress, domain names, logos, insignia, color combinations, slogans, moral rights, right of publicity, author's rights, contract and licensing rights, works, mask works, industrial design rights, rights of priority, know how, design flows, methodologies, devices business processes, developments, innovations, good will and all other legal rights protecting intangible proprietary information as may exist now and/or hereafter come into existence, and all registrations, renewals and extensions, regardless of whether those rights arise under the laws of the United States, or any other state, country or jurisdiction. For the avoidance of doubt, Protected Health Information and Personally Identifiable Information are not included in the definition of Intellectual Property, and are addressed under Article 10.

d) Definition of Works. For purposes of the definition of Intellectual Property, "works" means all literary works, writings and printed matter including the medium by which they are recorded or reproduced, photographs, art work, pictorial and graphic representations and works of a similar nature, film, motion pictures, digital images, animation cells, and other audiovisual works including positives and negatives thereof, sound recordings, tapes, educational materials, interactive videos and any other materials or products created, produced, conceptualized and fixed in a tangible medium of expression. It includes preliminary and final products and any materials and

information developed for the purposes of producing those final products. Works do not include articles submitted to peer review or reference journals or independent research projects.

12.5 Survival

The provisions set forth in this section shall survive any termination or expiration of this Agreement.

ARTICLE 13 – SPECIAL TERMS AND CONDITIONS

13.1 Dispute Resolution

a) If any dispute arising out of or in connection with this Agreement is not resolved within thirty (30) Days, or such other reasonable period of time determined by Contractor and Covered California staff normally responsible for the administration of this Agreement, the parties shall attempt to resolve the dispute through the submission of the matter for executive level involvement. The executive officer of each party or their designated representative shall meet and confer to attempt to resolve the dispute. If the parties agree, a neutral third party mediator may be engaged to assist in dispute resolution at either the line employee level or the executive level, or both. If after expending reasonable efforts at executive level resolution of the dispute, no resolution can be reached within thirty (30) Days, or such other reasonable period determined by Contractor and Covered California, then either party may seek its rights and remedies in a court of competent jurisdiction or otherwise available under this Agreement or applicable laws, rules and regulations.

b) Each party shall document in writing the nature of each dispute and the actions taken to resolve any disputes utilizing this dispute resolution procedure. Each party shall act in good faith to resolve such disputes. Neither party may seek its rights and remedies in court respecting any such notice of termination for default without first following the dispute resolution process stated in this Section.

c) Covered California and Contractor agree that the existence of a dispute notwithstanding, they will continue without delay to carry out all their responsibilities under this Agreement which are not affected by the dispute.

d) Either party may request an expedited resolution process if such party determines that irreparable harm will be caused by following the timelines set forth in Section 13.1(a). If the other party does not consent to such expedited process, the requesting party will hire, at its sole cost and expense, an independent mediator to determine whether such an expedited process is necessary to avoid or reduce irreparable harm. In the event that the mediator determines that irreparable harm may result from delays required under the thirty (30) Day period required under Section 13.1(a), the parties will engage in an expedited process that will require the parties to resolve the dispute

within five (5) business days or such other period as mutually agreed upon by the parties.

e) This Section shall survive the termination or expiration of this Agreement.

13.2 Attorneys' Fees

In the event of any litigation between the parties to enforce or interpret the provisions of this Agreement, the non-prevailing party shall, unless both parties agree, in writing, to the contrary, pay the reasonable attorneys' fees and costs of the prevailing party arising from such litigation, including outside attorneys' fees and allocated costs for services of in-house counsel, and court costs. These attorneys' fees and costs shall be in addition to any other relief to which the prevailing party may be entitled.

13.3 Notices

Any notice or other written communication that may or must be given hereunder shall be deemed given when delivered personally, or if it is mailed, three (3) Days after the date of mailing, unless delivery is by express mail, telecopy, electronic mail or telegraph, and then upon the date of the confirmed receipt, to either the representative executing the STD 213 or the following representatives:

For Covered California:

Covered California
Attention: James DeBenedetti
1601 Exposition Blvd.
Sacramento, CA 95815
Telephone No. (916) 228-8665
Email: James.DeBenedetti@covered.ca.gov

For Contractor:

Name:
Address:
City, State, Zip Code:
Telephone No. _____ FAX No.
Email: _____

Either party hereto may, from time to time by notice in writing served upon the other as aforesaid, designate a different mailing address or a different or additional person to which all such notices or other communications thereafter are to be addressed.

13.4 Amendments

a) By Covered California. In the event that any law or regulation is enacted or any decision, opinion, interpretive policy, or guidance of a court or governmental agency is issued (any of the foregoing, a "Change in Law") that Covered California determines, based on its consultation with legal counsel, regulators or other state-based or Federal health benefit exchanges: (i) affects or may affect the legality of this Agreement or any provision hereof or cause this Agreement or any provision hereof to prevent or hinder compliance with laws, rules or regulations, or (ii) adversely affects or may adversely affect the operations of Covered California or the ability of Covered California or Contractor to perform its respective obligations hereunder or receive the benefits intended hereunder, Covered California may, by written notice to Contractor, amend this Agreement to comply with or otherwise address the Change in Law in a manner reasonably determined by Covered California to carry out the original intent of the parties to the extent practical in light of such Change in Law. Such amendment shall become effective upon sixty (60) Days' notice, or such lesser period as required for compliance or consistency with the Change in Law or to avoid the adverse effect of the Change in Law. If Contractor objects to such amendment, it must notify Covered California in writing within twenty (20) Days of receipt of notice from Covered California. If the parties are unable to agree on an amendment within thirty (30) Days thereafter, Covered California may terminate this Agreement effective immediately.

b) Other Amendments. Except as provided in Section 13.4(a), this Agreement may be amended only by mutual consent of the parties. Except as provided herein, no alteration or variation of the terms of this Agreement shall be valid unless made in writing and signed by the parties hereto, and no oral understanding or agreement not incorporated herein shall be binding on any of the parties hereto.

13.5 Time is of the Essence

Time is of the essence in this Agreement.

13.6 Publicity

Contractor shall coordinate with Covered California with respect to communications to third parties regarding this Agreement; provided, however, that no external publicity release or announcement or other such communication

concerning this Agreement or the transactions contemplated herein shall be issued by Contractor without advance written approval by Covered California unless such communication complies with standards that may be issued by Covered California to Contractor based on consultation with Contractor from time to time.

13.7 Force Majeure

Except as prohibited by applicable laws, rules and regulations, neither party to this Agreement shall be in default of its obligations hereunder for delay or failure in performing that arises out of causes beyond the control and without the fault or negligence of either party and arising from a catastrophic occurrence or natural disaster, such as Acts of God or of the public enemy, acts of the State in its sovereign capacity, acts of the State Controller's Office or other State agency having an impact on Covered California's ability to pay its obligations, acts of the State legislature, fires, floods, power failure, disabling strikes, epidemics, quarantine restrictions, and freight embargoes. However, each party shall utilize its best good faith efforts to perform under this Agreement in the event of any such occurrence.

13.8 Further Assurances

Contractor and Covered California agree to execute such additional documents, and perform such further acts, as may be reasonable and necessary to carry out the provisions of this Agreement.

13.9 Binding Effect

This Agreement, any instrument or agreement executed pursuant to this Agreement, and the rights, covenants, conditions, and obligations of Contractor and Covered California contained therein, shall be binding upon the parties and their successors, assigns, and legal representatives.

13.10 Titles/Section Headings

Titles or headings are not part of this Agreement, are for convenience of reference only, and shall have no effect on the construction or legal effect of this Agreement.

13.11 Severability

Should one or more provisions of this Agreement be held by any court to be invalid, void, or unenforceable, such provision(s) will be deemed to be restated to affect the original intentions of the parties as nearly as possible in accordance with applicable law. The remaining provisions shall nevertheless remain and continue in full force and effect.

13.12 Entire Agreement/Incorporated Documents/Order of Precedence

This Agreement represents the entire understanding between the parties hereto with respect to the subject matter hereof. Any prior correspondence, memoranda, or agreements are replaced in total by this Agreement. This Agreement shall consist of:

a) The terms of this Agreement, including obligations set forth in other documents that are referenced herein;

b) All attached documents, which are expressly incorporated herein;

c) Terms and conditions set forth in the Application, to the extent that such terms are expressly incorporated by reference in specific sections of this Agreement and/or otherwise not inconsistent with the Agreement or Proposal; and,

d) The Proposal, which is expressly incorporated herein to the extent that such terms are not superseded by the terms set forth in this Agreement.

e) In the event there are any inconsistencies or ambiguities among the terms of this Agreement and incorporated documents, the following order of precedence shall be used:

   i. Applicable laws, rules and regulations;

   ii. The terms and conditions of this Agreement, including attachments; and

iii. Application.

13.13 Waivers

No delay on the part of either party in exercising any right, power, or privilege hereunder shall operate as a waiver thereof. No waiver on the part of either party of any right, power, or privilege hereunder, nor any single or partial exercise of any right, power, or privilege hereunder shall preclude any other or further exercise thereof or the exercise of any other right, power, or privilege hereunder.

13.14 Incorporation of Amendments to Applicable Laws

Any references to sections of Federal or State statutes or regulations shall be deemed to include a reference to any subsequent amendments thereof and any successor provisions thereto made from time to time from and after the date of this Agreement.

13.15 Choice of Law, Jurisdiction, and Venue

This Agreement shall be administered, construed, and enforced according to the laws of the State (without regard to any conflict of law provisions) to the extent such laws have not been preempted by applicable Federal law. Any suit brought hereunder shall be brought in the state or federal courts sitting in Sacramento, California, the parties hereby waiving any claim or defense that such forum is not convenient or proper. Each party agrees that any such court shall have in person jurisdiction over it and consents to service of process in any manner authorized by California law.

13.16 Counterparts

This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

13.17 Ambiguities Not Held Against Drafter

This Agreement having been freely and voluntarily negotiated by all parties, the rule that ambiguous contractual provisions are construed against the drafter of the provision shall be inapplicable to this Agreement.

13.18 Clerical Error

No clerical error shall operate to defeat or alter any terms of this Agreement or defeat or alter any of the rights, privileges, or benefits of any Covered California Enrollee.

13.19 Administration of Agreement

a) Covered California may adopt policies, procedures, rules and interpretations that are consistent with applicable laws, rules and regulations and deemed advisable by Covered California to promote orderly and efficient administration of this Agreement. The parties shall perform in accordance with such policies and procedures; provided, however, that any changes to policies and procedures that are not disclosed to Contractor prior to the Agreement Effective Date shall not result in additional obligations and risks to Contractor existing at the Agreement Effective Date except as otherwise mutually agreed upon by the parties.

b) Covered California shall provide ninety (90) Days' prior written notice by letter, newsletter, electronic mail, or other media of any material change (as defined below) in Covered California's policies, procedures or other operating guidance applicable to Contractor's performance of Services. The failure by Contractor to object in writing to any material change within thirty (30) Days following Contractor's receipt of such notice shall constitute Contractor's acceptance of such material change. For purposes of this section, "material change" shall refer to any change that could reasonably be expected to have a material impact on Contractor's compensation, Contractor's performance of Services under this Agreement, or the delivery of Covered Services to Covered California Enrollees.

13.20 Performance of Requirements

To the extent the Agreement requires performance under the Agreement by Contractor but does not specifically specify a date, the date of performance shall be based on the mutual agreement of Contractor and Covered California.

ARTICLE 14 – DEFINITIONS

Except as otherwise expressly defined, capitalized terms used in the Agreement and/or the Attachments shall have the meaning set forth below.

Affordable Care Act (Act) – The Federal Patient Protection and Affordable Care Act, (P.L. 111-148), as amended by the Federal Health Care and Education Reconciliation Act of 2010 (P.L. 111 -152), known collectively as the Affordable Care Act.

Agent(s) – Individuals who are licensed and in good standing as a life licensee under Insurance Code § 1626 by the California Department of Insurance to transact in accident and health insurance. The term used in this Agreement will only apply to Agents certified by Covered California to transact business in Covered California for the Individual and Covered California for Small Business Markets.

Agreement – This Agreement attached hereto, including attachments and documents incorporated by reference, entered into between Covered California and Contractor.

Agreement Effective Date – The effective date of this Agreement established pursuant to Section 8.1 of this Agreement.

Accreditation Association for Ambulatory Health Care (AAAHC) – A nonprofit accrediting agency for ambulatory health care settings.

Application – The Qualified Health Plan Certification Application for Plan Years 2026 - 2028.

Behavioral Health – A group of interdisciplinary services concerned with the prevention, diagnosis, treatment, and rehabilitation of mental health and substance abuse disorders.

Board – The executive board responsible for governing Covered California under Government Code § 100500.

Business Review – Meetings between Covered California and Contractor at a cadence, schedule, and location to be determined by Covered California to report and review program performance results including all Services and components of the program, i.e., clinical, financial, contractual reporting requirements, customer service, appeals and any other program recommendations.

California Affordable Care Act – The California Patient Protection and Affordable Care Act, AB 1602 and SB 900 (Chapter 655, Statutes of 2010 and Chapter 659, Statutes of 2010).

CAL COBRA – The California Continuation Benefits Replacement Act, or Health and Safety Code § 1366.20 et seq and Insurance Code § 10128.50 et seq.

Calendar Year – Calendar Year means the period of time beginning on January 1 and ending on December 31 of each year.

CalHEERS – The California Healthcare Eligibility, Enrollment and Retention System, a project jointly sponsored by Covered California and DHCS, with the assistance of the Office of Systems Integration to maintain processes to make the eligibility determinations regarding Covered California and other State health care programs and assist Enrollees in selection of health plan.

CCR – The California Code of Regulations.

CDI – The California Department of Insurance.

COBRA – Federal law (Consolidated Omnibus Budget Reconciliation Act of 1985) requiring continuing coverage of group health benefits to employees and their families upon the occurrence of certain qualifying events where such coverage would otherwise be terminated.

Confidentiality of Medical Information Act (CMIA) – The Confidentiality of Medical Information Act (California Civil Code § 56 et seq.) and the regulations issued pursuant thereto or as thereafter amended, to the extent applicable to operation of Contractor.

Contract Year – The full twelve (12) month period commencing on the effective date and ending on the Day immediately prior to the first anniversary thereof and each full consecutive twelve (12) month period thereafter during which the Agreement remains in effect.

Contractor – The Health Insurance Issuer contracting with Covered California under this Agreement to offer a QHP and perform in accordance with the terms set forth in this Agreement.

Covered California – The California Health Benefit Exchange, doing business as Covered California and an independent entity within the Government of the State.

Covered California Enrollee – Refers to every individual enrolled in Covered California for the purpose of receiving health benefits. Also referred to as “on-exchange”.

Covered California for the Individual Market – The Covered California program providing coverage to Covered California Enrollees, formerly referred to as the Individual Exchange.

Covered California for Small Business (CCSB) Covered California program providing coverage to eligible small businesses, formerly referred to as the Small Business Health Options Program (SHOP) and described in Government Code 100502(m).

Covered Services – The Covered Services that are covered benefits under the applicable Contractor and described in the Evidence of Coverage (EOC).

Days – Wherever in this Agreement a set number of days is stated or allowed for a particular event to occur, the days are understood to include all calendar days, including weekends and holidays, unless otherwise specified.

DHCS – The California Department of Health Care Services.

DHHS – The United States Department of Health and Human Services.

DMHC – The California Department of Managed Health Care.

Downstream Entity (Entities) – An individual or an entity that has an agreement with a Subcontractor or another Downstream Entity that relates directly or indirectly to the performance of Contractor's services under this Agreement. A provider is not a Downstream Entity solely because it enters into a provider agreement.

Effective Date – The date on which a Plan's coverage goes into effect.

Eligibility Information – The information that establishes an Enrollee's eligibility.

Eligibility File – The compilation of all Eligibility Data for an Enrollee or group of Enrollees into a single electronic format used to store or transmit the data.

Employee – A "qualified employee," as defined in 45 C.F.R. § 155.20.

Employer – A "qualified employer," as defined in § 1312(f)(2) of the Affordable Care Act.

Encounter – Any Health Care Service or bundle of related Covered Services provided to one Enrollee by one Health Care Professional within one time period. Any Covered Services provided must be recorded in the Enrollee's health record.

Encounter Data – Detailed data about individual services provided by a capitated managed care entity. The level of detail about each service reported is similar to that of a standard claim form.

Enrollee – Enrollee means each and every individual enrolled for the purpose of receiving health benefits in the health plan or market referenced. If no health plan or

market is referenced, this term is used to reference individuals enrolled in both on-exchange QHPs and off-exchange mirrored products in the individual market.

Evidence of Coverage (EOC) – The State-Regulator approved document which describes the benefits, exclusions, limitations, conditions, and the benefit levels of the applicable Plans issued to a Subscriber or Member.

Explanation of Benefits (EOB) – A statement sent from Contractor to an Enrollee listing services provided, amount billed, eligible expenses and payment made by the Plan.

Explanation of Payment (EOP) – A statement sent from Contractor to Providers detailing payments made for Covered Services.

Family Member – An individual who is within an Enrollee's family, as defined in 26 U.S.C. § 36B (d)(1).

Formulary – A list of outpatient prescription drugs, selected by the Plan(s) and revised periodically, which are available to Enrollees.

Fraud, Waste, and Abuse –
Fraud - Consists of an intentional misrepresentation, deceit, or concealment of a material fact known to the defendant with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury. (CA Civil Code §3294 (c)(3), CA Penal Code §§470-483.5). Prevention and early detection of fraudulent activities is crucial to ensuring affordable healthcare for all individuals. Examples of fraud include false applications to obtain payment, false information to obtain insurance, billing for services that were not rendered.

Waste - Intentional or unintentional, extravagant careless or needless expenditures, consumption, mismanagement, use, or squandering of resources, to the detriment or potential detriment of entities, but without an intent to deceive or misrepresent. Waste includes incurring unnecessary costs because of inefficient or ineffective practices, systems, decisions, or controls.

Abuse - Excessive, or improper use of something, or the use of something in a manner contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, maltreatment, or misuse of resources; or extravagant or excessive use to abuse one's position or authority. Often, the terms fraud and abuse are used simultaneously with the primary distinction is the intent. Inappropriate practices that begin as abuse can quickly evolve into fraud. Abuse can occur in financial or non-financial settings. Examples of abuse include excessive charges, improper billing

practices, payment for services that do not meet recognized standards of care and payment for medically unnecessary services.

Grace Period – A specified time following the premium due date during which coverage remains in force and a Covered California Enrollee or other authorized person or entity may pay the premium without penalty.

Good Standing - See Table 4.1.1

Health Care Professional – An individual with current and appropriate licensure, certification, or accreditation in a medical or behavioral health profession, including medical doctors (including psychiatrists), dentists, osteopathic physicians, psychologists, registered nurses, nurse practitioners, licensed practical nurses, certified medical assistants, licensed physician assistants, mental health professionals, chemical dependency counselors, clinical laboratory professionals, allied health care professionals, pharmacists, social workers, physical therapists, occupational therapists, and others to provide Covered Services.

Health Information Technology for Economic and Clinical Health Act (HITECH Act) – The Health Information Technology for Economic and Clinical Health Act, which was enacted as part of the American Recovery and Reinvestment Act of 2009, and the regulations issued pursuant thereto or as thereafter amended.

Health Insurance Issuer – Health Insurance Issuer has the same meaning as that term is defined in 42 U.S.C. § 300gg-91 and 45 C.F.R. § 144.103. Also referred to as "Carrier," "Health Issuer," or "Issuer."

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – The Health Insurance Portability and Accountability Act of 1996 and the regulations issued pursuant thereto or as thereafter amended.

Health Plan Employer Data and Information Set (HEDIS) – The data as reported and updated annually by the National Committee for Quality Assurance (NCQA).

Individual Exchange – Covered California through which Qualified Individuals may purchase QHPs.

Individually Identifiable Health Information (IIHI) – The "individually identifiable health information" as defined under HIPAA.

Information Practices Act (IPA) – The California Information Practices Act, Civil Code § 1798, et seq. and the regulations issued pursuant thereto or as thereafter amended.

Insurance Information and Privacy Protection Act (IIPPA) – The California Insurance Information and Privacy Protection Act, Insurance Code §§ 791-791.28, et seq., and the regulations issued pursuant thereto or as thereafter amended.

Integrated Delivery Systems – An integrated delivery system (IDS) is a network of physicians and healthcare facilities that provide a continuum of healthcare services managed under one organization or one parent company. Similar to an ACO, an IDS includes population-based care coordinated across the continuum including multi-discipline physician practices, hospitals, and ancillary Providers with combined risk sharing arrangements and incentives between health plans and Providers, and among Providers across specialties and institutional boundaries. The IDS is held accountable for nationally recognized evidence-based clinical, financial, and operational performance, as well as incentives for improvements in population outcomes.

Medicaid – The program of medical care coverage set forth in Title XIX of the Social Security Act and the regulations issued pursuant thereto or as thereafter amended.

Medicare – The program of medical care coverage set forth in Title XVIII of the Social Security Act and the regulations issued pursuant thereto or as thereafter amended.

Medicare Part D – The Medicare prescription drug program authorized under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), effective January 1, 2006, and the regulations issued pursuant thereto or as thereafter amended.

Monthly Rates – The rates of compensation payable in accordance with the terms set forth at Article 6 to Contractor for Services rendered under this Agreement.

NCQA – The National Committee for Quality Assurance, a nonprofit accreditation agency.

Nurse Advice Line – An advice line staffed by registered nurses (RNs) who assess symptoms (using triage guidelines approved by the Plan to determine if and when the caller needs to be seen by a Provider); provide health information regarding diseases, medical procedures, medication usage and side effects; and give care advice for managing an illness or problem at home.

Open Enrollment or Open Enrollment Period – The fixed time period as set forth in 45 C.F.R. § 155.410, Health and Safety Code § 1399.849 (c)(3), and Insurance Code § 10965.3 (c)(3) for individual applicants and Enrollees to initiate enrollment or to change enrollment from one health benefits plan to another. For benefit years beginning on or after January 1, 2019, references to Open Enrollment include the allowance for

Special Enrollment Periods for all individuals as described in Health and Safety Codes § 1399.849(c)(3), and Insurance Code § 10965.3(c)(3).

Participating Hospital – A hospital that, at the time of an Enrollee's admission, has a contract in effect with Contractor to provide Covered Services to Enrollees.

Participating Physician – A physician or a member of a Medical Group that has a contract in effect with Contractor to provide Covered Services to Enrollees.

Participating Provider – An individual Health Care Professional, hospital, clinic, facility, entity, or any other person or organization that provides Covered Services and that, at the time care is rendered to an Enrollee, has (or is a member of a Medical Group that has) a contract in effect with Contractor to provide Covered Services to Enrollees and accept copayments for Covered Services.

Participation Fee – The user fee on QHPs authorized under § 1311(d)(5) of the Affordable Care Act, 45 C.F.R. §§ 155.160(b)(1) and 156.50(b), and Government Code § 100503(n) to support Covered California operations.

Performance Standard – A financial assurance of service delivery at levels agreed upon between Covered California and Contractor.

Personally Identifiable Information – Any information that identifies or describes an individual, including their name, social security number, physical description, home address, home telephone number, education, financial matters, medical or employment history, and statements made by, or attributed to, the individual. It also includes any identifiable information collected from or about an individual for purposes of determining eligibility for enrollment in a Qualified Health Plan, determining eligibility for other insurance affordability programs, determining eligibility for exemptions from the individual responsibility provisions, or any other use of such individual's identifiable information in connection with Covered California.

Pharmacy Benefit Manager (PBM) – The vendor responsible for administering the Plan's outpatient prescription drug program. The PBM provides a retail pharmacy network, mail order pharmacy, specialty pharmacy services, and coverage management programs.

Plan(s) – The QHPs Covered California has entered into a contract with a Health Insurance Issuer to provide, hereinafter referred to as the Plan(s).

Plan Data – All the utilization, fiscal, and eligibility information gathered by Contractor about the Plans exclusive programs, policies, procedures, practices, systems and information developed by Contractor and used in the normal conduct of business.

Plan Year – Plan Year has the same definition as that term is defined in 45 C.F.R. § 155.20.

Premium – The dollar amount payable by the Covered California Enrollee after any advanced premium tax credits are applied, if any, to the QHP Issuer to effectuate and maintain coverage.

Premium Rate or Monthly Rate – The monthly premium due during a Plan Year, as agreed upon by the parties.

Primary Care – The provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health needs, developing a sustained partnership with patients, and practicing in the context of family and community. (Institute of Medicine, 1978) Contractors may allow Enrollees to select Nurse Practitioners and Physician Assistants to serve as their Primary Care clinician. Covered California does not require that Primary Care clinicians serve as a "gatekeeper" or the source of referral and access to specialty care. Covered California recognizes Internal Medicine, OBGYN, Pediatrics, General Practice, and Family Medicine as primary care specialties.

Proposal – The proposal submitted by Contractor in response to the Application.

Protected Health Information or Personal Health Information – Protected health information, including electronic protected health information (EPersonal Health Information) as defined in HIPAA that relates to an Enrollee. Protected Health Information also includes "medical information" as defined by the California Confidentiality of Medical Information Act (CMIA) at California Civil Code § 56, et seq.

Provider – A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health professional that delivers Covered Services.

Provider Claim(s) – Any bill, invoice, or statement from a specific Provider for Covered Services or supplies provided to Enrollees.

Provider Group – A group of physicians or other Health Care Professionals that is clinically integrated, financially integrated, or that contract together to provide care to patients in a coordinated manner.

Qualified Dental Plan or QDP – A dental care service plan contract or policy of insurance offered by a QDP Issuer and certified by Covered California. QDP means either a Children's Dental Plan or a Family Dental Plan.

Qualified Health Plan or QHP– A health care service plan contract or policy of insurance offered by a QHP Issuer and certified by Covered California.

Qualified Health Plan Issuer or QHP Issuer – A licensed health care service plan or insurer that has been selected and certified by Covered California to offer QHPs through Covered California, as specified in 10 CCR § 6410.

Qualified Individual – Qualified Individual has the same meaning as that term is defined in § 1312(f)(1) of the Affordable Care Act.

Quality Management and Improvement – The process for conducting outcome reviews, data analysis, policy evaluation, and technical assistance internally and externally to improve the quality of care to Enrollees.

Reconciliation Process – Covered California and CalHEERS engage in a cyclically occurring Reconciliation Process with each QHP and QDP Issuer participating in the individual market. The Reconciliation Process is leveraged to monitor and facilitate all eligibility and enrollment reconciliation efforts with the QHP and QDP Issuers as defined in the "Data Integrity Reconciliation Process Guide." As a component of the Reconciliation Process, the Dispute Process provides a platform for Issuer enrollment and eligibility disputes to be assessed. Assessment of each enrollment dispute includes focused analysis of operational cause, risk, and enterprise-wide impact.

Regulations – The regulations adopted by Covered California Board. (California Code of Regulations, Title 10, Chapter 12, §t 6400, et seq.)

Risk-Adjusted Premiums – Actuarially calculated premiums utilizing risk adjustment.

Risk-Based Capital or RBC – The approach to determine the minimum level of capital needed for protection from insolvency based on an organization's size, structure, and retained risk. Factors in the RBC formula are applied to assets, premium, and expense items. The factors vary depending on the level of risk related to each item. The higher the risk related to the item, the higher the factor, and vice versa.

Risk Adjustment – An actuarial tool used to calibrate premiums paid to Health Insurance Issuers based on geographical differences in the cost of health care and the relative differences in the health risk characteristics of Enrollees enrolled in each plan. Risk adjustment establishes premiums, in part, by assuming an equal distribution of health risk among Health Benefits Plans in order to avoid penalizing Enrollees for enrolling in a Health Benefits Plan with higher than average health risk characteristics.

Run-Out Claims – All claims presented and adjudicated after the end of a specified time period where the health care service was provided before the end of the specified time period.

Security Incident – The attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system.

Service Area – The designated geographical areas where Contractor provides Covered Services to Covered California Enrollees and comprised of the ZIP codes set forth in Contractor's current Plan Year SERFF templates tested and validated by Contractor.

Services – The provision of Services by Contractors and Subcontractors required under the terms of the Agreement, including, those relating the provision of Covered Services and the administrative functions required to carry out the Agreement.

Special Enrollment Period – The period during which a Qualified Individual or Enrollee who experiences certain qualifying events, as defined in applicable Federal and State laws, rules and regulations, may enroll in, or change enrollment in, a QHP through Covered California outside of the initial and annual Open Enrollment Periods.

State – The State of California

State Regulators – California Department of Insurance and Department of Managed Health Care, as applicable.

State and Federal Regulators – Department of Managed Health Care, California Department of Health Care Services, California Department of Insurance, US Department of Health and Human Services, and any other regulatory entity within the State of California that has jurisdiction over Contractor, as applicable.

Subcontractor(s) – An individual or entity that has an agreement with a Contractor that relates directly or indirectly to the performance of Contractor's services under this Agreement. A provider is not a Subcontractor solely because it enters into a provider agreement.

Utilization Management – Pre-service, concurrent or retrospective review which determines the Medical Necessity of hospital and skilled nursing facility admissions and selected Covered Services provided on an outpatient basis.

Utilization Review Accreditation Commission (URAC) – The independent and nonprofit organization that promotes health care quality through its accreditation and certification programs. It offers a wide range of quality benchmarking programs and

Services and validates health care industry organizations on their commitment to quality and accountability.

Virtual Interactive Physician/Patient Capabilities – Capabilities allowing Enrollees to have short encounters with a physician on a scheduled or urgent basis via telephone or video chat from the Enrollee's home or other appropriate location.

ATTACHMENT 1 TO COVERED CALIFORNIA 2026-2028 INDIVIDUAL MARKET QHP ISSUER CONTRACT: ADVANCING EQUITY, QUALITY, AND VALUE

The mission of Covered California is to increase the number of insured Californians, improve healthcare quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

Health Insurance Issuers contracting with Covered California to offer Qualified Health Plans (QHPs) are integral to Covered California's ability to achieve its mission of improving the quality, equity, and value of healthcare services available to Enrollees. QHP Issuers have the responsibility to work with Covered California to support models of care that promote the vision of the Affordable Care Act and meet Enrollee needs and expectations.

Given the unique role of Covered California and QHP Issuers in the State's healthcare ecosystem, Contractor is expected to contribute to broadscale efforts to improve the delivery system and health outcomes in California. For there to be a meaningful impact on overall healthcare cost, equity, and quality, solutions and successes need to be sustainable, scalable, and must expand beyond local markets or specific groups of individuals. This will require both Covered California and Contractor to coordinate with and promote alignment with other purchasers and payers, and strategically partner with organizations dedicated to delivering better quality, more equitable care, at higher value. In addition, QHP Issuers shall collaborate with and support their contracted providers in continuous quality and value improvement, which will benefit both Covered California Enrollees and the QHP Issuer's entire California membership.

Covered California is committed to balancing the need for QHP Issuer accountability with reducing the administrative burden of Attachment 1 by intentionally aligning requirements with other major purchasers, accreditation organizations, and regulatory agencies. In the same spirit, Covered California expects all QHP Issuers to streamline requirements and reduce administrative burden on providers as much as possible.

This Attachment 1 is focused on key areas that Covered California believes require systematic focus and investment in order to ensure its Enrollees and all Californians receive high-quality, equitable care. These include a commitment to advanced primary care, behavioral health, disparities reduction, cost, and data exchange and an emphasis on member-centered values and sustaining a robust health professional workforce.

By entering into this Agreement, Contractor affirms its commitment to be an active and engaged partner with Covered California and agrees to work collaboratively with

Back to Agenda Back to Item

Covered California to develop and implement policies and programs that will promote quality and health equity, and lower costs for Contractor's entire California membership.

Contractor shall comply with the requirements in this Attachment 1 by January 1, 2026, unless otherwise specified.

Contractor must complete and submit information, including reports, plans, and data, as described in this Attachment 1 annually at a time and in a manner determined by Covered California unless otherwise specified. Information will be used to assess compliance with requirements, evaluate performance, and for negotiation and evaluation purposes regarding any extension of this Agreement. When submitting its information to Covered California, Contractor shall clearly identify any information it deems confidential, a trade secret, or proprietary. Covered California will use Healthcare Evidence Initiative (HEI) data and measures to monitor Contractor performance and evaluate HEI measures' effectiveness in assessing Contractor performance. Contractor agrees to engage and work with Covered California to review its performance on all HEI generated measures, not only those measures specifically described in this Attachment 1. Contractor agrees to meet with Covered California at least twice a year to review its performance on HEI analysis. Based on these reviews, Covered California may revise the HEI measures during the contract period or in future contract years.

Contractor shall submit all required information as defined in Attachment 1 and listed in the annual "Contract Reporting Requirements" table found on Covered California's Extranet site (Hub page, PMD Resources library, Contract Reporting Compliance folder).

Covered California will use information on cost, quality, and health disparities provided by Contractor to evaluate and publicly report both QHP Issuer performance and its impact on the healthcare delivery system and health coverage in California.

ARTICLE 1 - EQUITY AND DISPARITIES REDUCTION

The Centers for Disease Control and Prevention adopted the definition of health equity as "the state in which everyone has a fair and just opportunity to attain their highest level of health" and health disparities as "preventable differences in the burden of disease, injury, violence or opportunities to achieve optimal health that are experienced by socially disadvantaged populations."[1]

To achieve health equity requires a comprehensive dismantling of the factors impeding health and wellness. The Federal Plan for Equitable Long-Term Recovery and Resilience outlines the seven vital conditions for Health and Well-Being, which include Basic Needs for Health and Safety, Human Housing, Reliable Transportation, Meaningful Work and Wealth, Thriving Natural World, Belonging and Civic Muscle, and Lifelong Learning.[2] Addressing health equity and disparities in healthcare is integral to the mission of Covered California. Covered California and Contractor will work in partnership with others to achieve these vital conditions for Covered California Enrollees.

1.01 Demographic Data Collection

Collection of accurate and complete member demographic data is critical to effective measurement and reduction of health disparities. Contractor will collect member self-reported race and ethnicity using the Centers for Disease Control and Prevention (CDC) Race and Ethnicity Codes Set that maps to the Office of Management and Budget (OMB) defined race and ethnicity categories. The collection and analysis of this disaggregated data will allow for the development of more focused and appropriate interventions to support health equity.

1.01.1 Expanded Demographic Data Collection

Contractor shall work with Covered California to expand the disparity identification and improvement requirements in this article. Covered California will continue to stratify measures by income, race and ethnicity, preferred language, and region for disparities identification and monitoring purposes. Other areas for consideration include:

1) Disability status

2) Sex characteristics

[1] *What is Health Equity* (June 11, 2024) Ctrs. for Disease Control & Prevention, https://www.cdc.gov/health-equity/what-is/index.html.
[2] *Fed. Plan for Equitable Long-Term Recovery & Resilience* (Jan. 20, 2022) https://health.gov/sites/default/files/2022-04/ELTRR-Report_220127a_ColorCorrected_2.pdf.

3) Veteran Status or Military Service

1.01.2 Race, Ethnicity, Language, Sexual Orientation and Gender Identity Data Collection

1) Race and Ethnicity Data Collection

a) Contractor must collect self-reported race and ethnicity data for at least eighty percent (80%) of its Covered California Enrollees during the Plan Year. Contractor must demonstrate compliance by including a valid, acceptable, and reasonable Covered California Enrollee self-identified race and ethnicity attribute for at least 80% of its Covered California Enrollees in its Healthcare Evidence Initiative (HEI) data submissions. Covered California provides lists of valid and acceptable standard values and reasonableness criteria in a methodology document.

b) New entrants. Contractor is required to collect self-identified race and ethnicity data during its first year contracting with Covered California. Contractor must demonstrate compliance by including a valid Covered California Enrollee self-identified race and ethnicity attribute for its Covered California Enrollees in its first year HEI data submissions. Contractor must meet the standard in (a) its second year contracted with Covered California.

2) Preferred Spoken and Written Language Data Collection

a) Contractor must collect data on Covered California Enrollees' preferred spoken and written languages and submit valid, acceptable, and reasonable data on spoken or written languages in its HEI submissions to ensure effective communication with providers and timely access to healthcare services.

b) New entrants. Contractor must collect data on Covered California Enrollees' preferred spoken and written languages and submit valid data on spoken or written languages in its HEI submissions to ensure effective communication with providers and timely access to healthcare services. Contractor must meet the standard in (a) in its second year contracted with Covered California.

3) Sexual Orientation and Gender Identity Data Collection

a) Contractor must collect data on Covered California Enrollees' sexual orientation and gender identity. Contractor must demonstrate compliance

by including valid Covered California Enrollee self-identified sexual orientation and gender identity attributes for its Covered California Enrollees in its HEI data submissions.

1.02 Identifying Disparities in Care

Covered California recognizes that the underlying causes of health disparities are multifactorial and include social and economic factors that impact health. While the healthcare system cannot single-handedly eliminate health disparities, there is evidence to show that when disparities are identified and addressed in the context of healthcare, they can be reduced over time through activities tailored to specific populations and targeting select measures. Therefore, Covered California is requiring Contractor to regularly collect data and report on its Covered California Enrollees as specified in this article to identify disparities, measure disparities over time, and develop disparity reduction efforts and targets to be determined by Covered California and Contractor. Covered California will continue to use and stratify HEI data to assess improvements in healthcare quality and equity.

1.02.1 Monitoring Disparities: Patient Level Data File

As directed by Covered California, Contractor must submit Healthcare Effectiveness Data and Information Set (HEDIS) measure patient level data files for its Covered California Enrollees. Covered California may require submission of all or some of the following HEDIS measures:

1) Blood Pressure Control for Patients with Hypertension (BPC-E);
2) Controlling High Blood Pressure (CBE ID #0018);
3) Glycemic Status Assessment for Patients with Diabetes: Glycemic Status (>9.0%) (CBE ID #0575);
4) Colorectal Cancer Screening (COL-E) (CBE ID #0034);
5) Colorectal Cancer Screening (CBE ID #0034);
6) Childhood Immunization Status (Combo 10) (CIS-E) (CBE ID #0038);
7) Childhood Immunization Status (Combo 10) (CBE ID #0038);
8) Depression Screening & Follow-Up for Adolescents & Adults (DSF-E) (CBE ID #0418);
9) Pharmacotherapy for Opioid Use Disorder (POD) (CBE ID #3400);

10) Prenatal Depression Screening and Follow-up (PND-E);

11) Postpartum Depression Screening and Follow-up (PDS-E);

12) Social Need Screening and Intervention (SNS-E).

Contractor must submit a patient level data file that includes a unique person identifier as specified by Covered California and valid race and ethnicity attributes for each person in the denominator. Contractor must also submit numerator and denominator totals and rates at the summary level.

Covered California will modify the measures set over time, with stakeholder input, to track disparities in care and health outcomes in additional areas, including behavioral health. Covered California will work with public purchaser partners to assess and monitor disparities across enrolled populations.

1.02.2 Monitoring Disparities: Healthcare Evidence Initiative

Contractor must meet with Covered California to review its performance on disparities measures using HEI data submitted in accordance with Article 5.02.1, including all or some of the measures listed in this section. Contractor must participate in engagement activities to address findings identified by Covered California and reported to Contractor in such performance meetings. Engagement activities may include learning activities, additional meetings, quarterly performance reviews, and other forms of collaboration arranged and scheduled by Covered California. Covered California may address all or some of the following measures in performance meetings:

1) Adult Preventive Visits per 1,000 Members;

2) Emergency Room Visits per 1,000 Members;

3) Breast Cancer Screening (BCS-E) (CBE ID #0031);

4) Child and Adolescent Well-Care Visits (WCV);

5) Follow-Up After Hospitalization for Mental Illness (FUH) (7 day & 30-day follow-up) (CBE ID #0576);

6) Initiation and Engagement of Substance Use Disorder (IET) (Submission Tool and Repository Measure Database I Partnership for Quality Measurement);

7) Proportion of Days Covered: Three Rates by Therapeutic Category (CBE ID

#0541)

a) Diabetes All Class (PDC-DR) (CBE ID #0541)

b) RAS Antagonists (PDC-RASA) (CBE ID #0541)

c) Statins (PDC-STA) (CBE ID #0541);

8) Behavioral Health Visits / 1000;

9) Behavioral Health Telehealth Visits / 1000;

10) Concurrent Use of Opioids and Benzodiazepines (COB);

11) Non-utilizer rates;

12) Primary Care Telehealth Visits / 1000;

13) Pharmacotherapy for Opioid Use Disorder (POD);

14) Primary Care Visits / 1000;

15) Use of High Dose Opioids (HDO).

1.03 Disparities Reduction

Achieving disparities reduction in care is critical for delivery of individualized, equitable care and promotion of health equity.

A multi-faceted approach in alignment with the Department of Managed Health Care (DMHC), the Department of Health Care Services/Medi-Cal (DHCS) and the California Public Employees Retirement System (CalPERS), will allow for sustained progress in reducing disparities for all Californians. Contractor must engage in the activities specified below for its Covered California Enrollees, in alignment with activities required by other California public purchasers and regulators. The requirements to monitor and intervene to address disparities are in addition to the health equity accountability requirements detailed in Attachment 4, Quality Transformation Initiative (QTI).

1) Contractor must participate in collaboration across QHP Issuers and with community through a minimum of one (1) equity focused learning session, working group, or community engagement activity. To meet this requirement, Contractor must host or attend an activity that was expressly pre-approved or suggested by Covered California and provide documentation of attendance. Contractor may submit additional relevant activities for consideration to Covered California to meet this requirement. Documentation of completed pre-

approved activities must be received by Covered California no later than 30 days after each pre-approved activity

2) Contractor must monitor and reduce identified health disparities, with a focus on addressing utilization disparities in Behavioral Health services as detailed in Article 2,

3) Contractor will monitor and reduce identified Maternal Health disparities in populations disproportionately affected, as outlined in Article 4.02.6.

4) Contractor must provide annual staff training focusing on cultural humility, effective collaboration with interpreters, and include the use of National Standards for Culturally and Linguistically Appropriate Services (CLAS).

1.04 Health Equity Capacity Building

Attaining health equity requires organizational investment in building a culture of health equity. Covered California remains committed to advancing health equity and ensuring that all Californians have access to high-quality, equitable care.

1.04.1 Health Equity Accreditation

Though no longer active, NCQA Health Equity Accreditation remains a recognized benchmark for advancing health equity practices. Covered California will consider requiring Contractor to achieve comparable health equity accreditation for future contract years and may consider additional health equity capacity building requirements in a future contract amendment.

1.04.2 Workforce

Developing and sustaining a diverse workforce representative of the population served is critical to achieving equitable health outcomes. Contractor must report on processes and initiatives to achieve and retain this workforce to best serve enrollee needs. To meet this requirement, Contractor may either: submit documentation demonstrating compliance with NCQA Health Equity Accreditation Standards from the 2024 standards year, as outlined in subsection 1, or provide requested documentation demonstrating efforts to achieve and maintain a diverse workforce representative of the population served, as outlined in subsection 2.

1. Contractor may submit the following NCQA Health Equity Accreditation Standards reports:

   a. Health Equity Standard 1: Organizational Readiness

If Contractor submitted evidence of NCQA Health Equity Accreditation during Plan Year

2026, it is not required to submit another report during this contract period to meet this requirement.

2. Contractor may complete and submit a report to Covered California that addresses each of the following components:

    a. How Contractor assesses alignment between workforce representation and the population served and implements measures to address any identified misalignment;

    b. How Contractor assesses if its recruitment or hiring practices create barriers to qualified applicants from certain groups, especially historically disadvantaged groups and implements measures to adjust identified recruitment or hiring practices accordingly;

    c. How Contractor assesses workforce cultural humility and implements measures to address any identified gaps in cultural humility;

    d. Inventory of staff and provider trainings provided related to cultural humility, racial humility, implicit bias, or other related topics. Inventory must specify which trainings are required and optional.

1.05 Culturally and Linguistically Appropriate Care

1.05.1 Evidence of Culturally and Linguistically Appropriate Services

Contractor must demonstrate provision of culturally and linguistically appropriate services to Enrollees. To meet this requirement, Contractor may either: submit documentation demonstrating compliance with NCQA Health Equity Accreditation Standards from the 2024 standards, as outlined in subsection 1, or provide requested documentation demonstrating culturally and linguistically appropriate services, as outlined in subsection 2. NCQA Health Outcomes Accreditation, including its associated 2026 standards reporting, will not be accepted to fulfill this requirement.

1) Contractor may submit the following NCQA Health Equity Accreditation Standards reports:

    a) Health Equity Standard 3: Access and Availability of Language Services

    b) Health Equity Standard 4: Practitioner Network Cultural Responsiveness

    c) Health Equity Standard 5: Culturally and Linguistically Appropriate Services Programs

If Contractor submitted the required components of the NCQA Health Equity Accreditation report during Plan Year 2026, it is not required to submit another report during this contract period to meet this requirement.

2) Contractor may complete and submit a report to Covered California that addresses each of the following components:

    a) Access and Availability of Language Services

        i) Vital information provided to Enrollees in threshold languages, including assessment of the use of competent translators based on proficiency in the source and target language, and whether translation is provided in a timely manner. For guidance on translation competency and timely access, see NCQA Health Equity Accreditation Standard 3.

        ii) Use of competent interpreter, as defined by NCQA Health Equity Accreditation Standard 3, or bilingual services to communicate with individuals who need to communicate in a language other than English. Support for providers in providing competent language services.

        iii) Annual distribution of a written notice communicating in English and threshold languages spoken by Limited-English-proficient (LEP) Individuals in California, the availability of free language assistance and how individuals can obtain language assistance in English and in threshold languages. For the purposes of this reporting, threshold languages are languages spoken by 1% of individuals served by the organization or by 200 individuals, whichever is less.

3) Provider Network Cultural Responsiveness

    a) How Contractor maintains a provider network that can serve its diverse membership and is responsive to member language needs and preferences.

    b) If and how Contractor:

        i) Collects languages in which a provider is fluent when communicating about medical care.

        ii) Collects language services available through the practice.

        iii) Collects provider race/ethnicity data.

iv) Publishes provider languages in the provider directory.

v) Publishes language services available through practices in the provider directory.

vi) Provides provider race/ethnicity on request.

vii) At least every three years, analyzes the capacity of its network to meet the language needs of members.

viii) At least every three years, analyzes the capacity of its network to meet the needs of members for culturally appropriate care.

ix) Develops a plan to address gaps identified as a result of analysis, if applicable.

x) Acts to address gaps based on its plan, if applicable.

4) Culturally and Linguistically Appropriate Services and Programs

a) Program description for improving culturally and linguistically appropriate services (CLAS) that includes the following elements:

i) A written statement describing Contractor's overall objective for serving a culturally and linguistically diverse population.

ii) A process to involve members of the culturally diverse community in identifying and prioritizing opportunities for improvement.

iii) A list of measurable goals for the improvement of CLAS and reduction of health care disparities.

iv) An annual work plan.

v) A plan for monitoring against the goals.

vi) Annual approval by the governing body.

b) If and how Contractor conducts an annual written evaluation of the CLAS program.

ARTICLE 2 - BEHAVIORAL HEALTH

Behavioral health services include identification, engagement, and treatment of those with mental health conditions and substance use disorders. Consistent with evidence and best practices, Covered California expects Contractor to ensure Enrollees receive timely and effective behavioral health services that is integrated with medical care, and in particular primary care. Covered California and Contractor recognize the critical importance of behavioral health services, as part of the broader set of healthcare services provided to Enrollees, in improving health outcomes and reducing costs.

2.01 Access to Behavioral Health Services

Monitoring and improving access to behavioral health services is necessary to ensure Enrollees are receiving appropriate and timely behavioral health services. Covered California will evaluate Contractor's efforts to ensure access to medically necessary behavioral health services, as specified in this Section.

2.01.1 Behavioral Health Provider Network

1) Contractor must submit the following National Committee for Quality Assurance (NCQA) Health Plan Accreditation Network Management reports:

    a) Network Standard 1, Element A: Cultural Needs and Preferences (including behavioral health providers);

    b) Network Standard 1, Element D: Practitioners Providing Behavioral Healthcare;

    c) Network Standard 2, Element B: Access to Behavioral Healthcare; and

    d) Network Standard 3, Element C: Opportunities to Improve Access to Behavioral Healthcare Services.

2) Contractor must submit the Network Management reports once every three years in accordance with the three-year NCQA accreditation cycle. Covered California will not require annual submission of the Network Management reports unless changes are made to the Network Management reports during the three-year cycle at which point Contractor must resubmit the revised reports to Covered California.

3) If Contractor's data upon which its Network Management report is based is older than four years at the time of health plan accreditation, Contractor shall provide to Covered California an updated data submission that addresses the NCQA Network Management standards for behavioral health listed above.

4) If Contractor is not yet NCQA accredited or is unable to provide components of its NCQA Network Management reports, Contractor must submit a separate report once every three years for its Covered California population that addresses each of the NCQA Network Management standards for behavioral health listed in 1) above. These reports can be from Contractor's accrediting body, Utilization Review Accreditation (URAC), the Accreditation Association for Ambulatory Health Care (AAAHC), or supplemental reports that include a description of (1) Contractor's behavioral health provider network, (2) how cultural, ethnic, racial and linguistic needs of Enrollees are met, (3) access standards, (4) the methodology for monitoring access to behavioral health appointments, and (5) at least one intervention to improve access to behavioral health services and the effectiveness of this intervention.

2.01.2 Offering Virtual Care for Behavioral Health

Virtual care, including telehealth, has the potential to address some of the access barriers to behavioral health services such as cost, transportation, and the shortage of providers, particularly for linguistically and culturally diverse Enrollees and for rural areas. As used in this Section, "virtual care" refers to all means to digitally interact with patients, including interactions conducted via telehealth and digital technologies such as remote patient monitoring or application-based interventions. Virtual care includes synchronous and asynchronous patient-provider communication, remote patient monitoring, e-consults, hospital at home, and other virtual health services.

Virtual care is not a replacement for Contractor developing a network of in-person behavioral health providers. However, given persistent and extensive workforce challenges, to strengthen access to behavioral health services, Covered California encourages Contractor to use network providers to provide virtual care for behavioral health services whenever possible.

1) Contractor must offer telehealth, as defined in Business and Professions Code, section 2290.5, for behavioral health services when clinically appropriate based on a Covered California Enrollee's needs and at a cost share equal to or less than the cost share for in-person behavioral health services.

2) Contractor must continue to comply with applicable network adequacy standards for in-person services for behavioral health.

2.01.3 Promoting Access to Behavioral Health Services

To ensure Covered California Enrollees are aware of the availability of behavioral health services, including services available through virtual care, Contractor must:

1) Clearly and prominently display the types of behavioral health services that are covered on key Covered California Enrollee webpages, such as the home page in its member portal and the provider directory page, accessible in different languages. Contractor shall submit evidence of compliance to Covered California annually such as through a website link, a screenshot of its homepage or other relevant resources.

2) Explain to consumers the scope and availability of behavioral health services, including virtual care, at minimum, in plan documents, such as Evidence of Coverage, and educate Covered California Enrollees how to access behavioral health services, including through virtual care;

   1) Inform primary care clinicians of the referral process for Covered California Enrollees for behavioral health services and available behavioral health resources for Covered California Enrollees;

   2) Ensure that Contractor's provider directory displays which providers offer behavioral health services, including through virtual care (e.g., Jane Doe, Ph.D. Psychologist, virtual care video/phone), or other member portal navigation features;

   3) Promote integration and coordination of care between third party virtual care vendor services and primary care and other network providers; and

   4) Implement at least one intervention during contract cycle focused on enhancing access for an identified sub-population that is not accessing necessary services at a rate similar to other subpopulations. Contractor will determine such underutilizing sub-populations using its own historic utilization data and analyses of HEI data conducted and provided by Covered California. Representative interventions include developing culturally appropriate materials, enhancing language options on a digital platform, engaging a member or community advisory board, or establishing a collaborative partnership with a community-based organization to facilitate equitable power sharing and the co-creation of solutions. Contractor must submit proposed intervention plan including proposed outcome measures to Covered California for approval prior to implementation. Covered California will work with Contractor in its first year contracting with Covered California to identify a qualifying activity to meet this requirement in the absence of historic utilization data.

   5) Submit to Covered California Enrollee educational materials required by this Section regarding scope, availability, and access to behavioral health services, inclusive of virtual care.

2.01.4 Monitoring Behavioral Health Service Utilization

Contractor agrees to engage and work with Covered California to review its behavioral health service utilization, which will be calculated by Covered California using HEI data submitted in accordance with Article 5.02.1, to further understand Enrollees' access to behavioral health services within Contractor's network.

2.01.5 Payment to Support Behavioral Health

Covered California and Contractor acknowledge the significance of embracing and broadening behavioral health payment frameworks that ensure sufficient funding to support accessible, data-driven, team-based care. This approach comes with a responsibility for delivering high-quality, equitable care and overseeing the overall cost of care.

To support behavioral health, Contractor must:

1) Report annually on its total behavioral health expenditure by product, in alignment with the Office of Health Care Affordability (OHCA) guidelines. Contractor shall follow the methodology provided by Covered California. Covered California will review and monitor progress toward OHCA designated benchmarks.

2) Share progress in meeting benchmarks by engaging in collaborative efforts among QHP Issuers and with the community. This includes participation in learning sessions, working groups, and community engagement initiatives, as facilitated by Covered California. Additionally, Contractor submit relevant activities for consideration by Covered California to fulfill this obligation.

2.02 Quality of Behavioral Health Services

Measuring and monitoring quality is necessary to ensure Enrollees receive appropriate, evidence-based treatment and to inform quality improvement efforts.

2.02.1 Screening for Depression

Contractor must work with its contracted providers, including primary care clinicians, to collect Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) measure results, stratified by race and ethnicity, for its Covered California Enrollees and submit patient level data files in accordance with Article 1.02.1.

Covered California strongly encourages Contractor to use the Patient Health Questionnaire-2 and 9 (PHQ-2, PHQ-9) in a culturally and linguistically appropriate

manner as standardized depression screening and measurement tools when implementing this measure. If a different tool is used, Contractor must specify the tool when it reports the measure results.

2.02.2 Monitoring Quality Rating System Behavioral Health Measures

To monitor the quality of Contractor's behavioral health services, Contractor agrees to engage and work with Covered California to review its performance on the behavioral health measures reported by Contractor to CMS for the Quality Rating System (QRS) submitted in accordance with Article 5.01.1.

2.03 Substance Use Disorders

Contractor shall work to address Covered California Enrollee substance use disorders which have a significant impact on individual health, leading to chronic health conditions, a decreased quality of life, and higher mortality rates. Untreated substance use contributes to increased health care costs through emergency department visits, hospital admissions, and the need for more intensive care. Effective integration of prevention, treatment, and recovery services is key to addressing substance use across the lifespan of Enrollees. Proactively addressing substance use can lead to cost savings for QHP Issuers and Enrollees, and promotes safer communities. This holistic approach ensures Enrollees receive the support necessary at each stage in their steps toward recovery, leading to healthier Enrollees and a reduced strain on healthcare systems. In addition, Contractor's efforts to reduce substance use support broader public health goals.

2.03.1 Guidelines for Appropriate Use of Opioids

Appropriate use of opioids and evidence-based treatment of opioid use disorder, including Medication Assisted Treatment (MAT), can improve outcomes, reduce inappropriate healthcare utilization, and lower opioid overdose deaths.

Contractor shall implement policies and programs that align with the guidelines from Smart Care California to promote the appropriate use of opioids by its contracted providers. Contractor's policies and programs shall use a harm reduction framework and an individualized approach to treatment planning and should consider Smart Care California guidelines when making formulary decisions (https://www.iha.org/wp-content/uploads/2021/02/Curbing-Opioid-Epidemic-Checklist-Health-Plans-Purchasers.pdf). Contractor's policies and programs must include the following priority areas:

1) Prevent: use opioids sparingly, with lower doses and shorter durations when medically appropriate; support non-pharmacological approaches to pain management such as removing prior authorizations for physical therapy;

2) Manage: identify patients on risky drug regimens such as high-dose opioids or opioids and sedatives; ensure providers co-prescribe naloxone with chronic opioid prescriptions; ensure providers develop individualized treatment plans; ensure providers are using appropriate medical standards of care to determine the need for and proper dosage of opioids for pain management while avoiding mandatory tapers;

3) Treat: streamline access to evidence-based treatment for opioid use disorder, including Medication Assisted Treatment (MAT) medications such as buprenorphine, methadone, and naltrexone, and behavioral therapy, by addressing cost and logistical barriers at all points in the healthcare system; and

4) Stop deaths: promote data-driven harm reduction strategies, such as naloxone access and syringe exchange.

2.03.2 Monitoring Opioid Use Disorder Treatment

To monitor access to opioid use disorder treatment, Contractor agrees to engage and work with Covered California to review its Medication Assisted Treatment (MAT) prescriptions, and to review its concurrent prescribing of opioids and naloxone rate using HEI data submitted in accordance with Article 5.02.1.

Contractor must collect Pharmacotherapy for Opioid Use Disorder (POD) measure results for its Covered California Enrollees and report those results, stratified by race and ethnicity, in accordance with Article 1.02.1.

2.03.3 Tobacco Treatment

Tobacco use is preventable and contributes to high morbidity and mortality. Reducing tobacco use will have a greater impact on health outcomes in marginalized communities which have disproportionately higher rates of use.

Contractor must ensure that Covered California Enrollees have access to medically necessary, comprehensive tobacco treatment services, including FDA-approved medications and pharmacotherapy, without undue barriers. These services shall be provided in accordance with evidence-based guidelines and best practices for tobacco treatment. Contractor must actively work to reduce financial, administrative, and other barriers that may hinder Covered California Enrollees' access to these medications and pharmacotherapy, thereby promoting successful tobacco treatment outcomes among Covered California Enrollee populations. To analyze Contractor’s tobacco treatment programs, Contractor must report:

1) Analysis of outcomes and results for Covered California Enrollees who use tobacco and enroll in tobacco treatment programs trended over time, inclusive

of evidenced-based counseling and appropriate pharmacotherapy, in accordance with current QRS measures. The analysis shall utilize administrative, claims, encounter, and other applicable relevant data and include evaluation of the following methods:

a) Advise Smokers and Tobacco Users to Quit;

b) Discuss Treatment Medications; and

c) Discuss Treatment Strategies.

2.03.4 Other Substances

1) To monitor the quality of Contractor's substance use services, Contractor must meet with Covered California to review its performance on substance use measures reported by Contractor to CMS for the Quality Rating System (QRS) submitted in accordance with Article 5.01.1. Contractor must participate in engagement activities to address findings identified by Covered California and reported to Contractor in such performance meetings.

2) Contractor must additionally collaborate across QHP Issuers and with community through a minimum of one (1) learning session, working group, or community engagement activity related to the quality of substance use services during the Plan Year. To meet this requirement, Contractor must host or attend an activity that was expressly pre-approved or suggested by Covered California, and provide documentation of attendance. Contractor may submit additional relevant activities for consideration to Covered California to meet this requirement. Documentation of completed pre-approved activities must be received by Covered California no later than 30 days after each pre-approved activity.

2.04 Integration of Behavioral Health Services with Medical Services

Integrated behavioral health services with medical services, particularly primary care services, increases access to behavioral health services and improves treatment outcomes. Evidence suggests the Collaborative Care Model, as defined by the Advancing Integrated Mental Health Solutions (AIMS) Center at the University of Washington, is a best practice among integrated behavioral health models (https://aims.uw.edu/collaborative- care).

Contractor shall aim to pay its contracted providers through population-based payment and other alternative payment models, in accordance with Article 4.01.3, to support behavioral health integration with primary care.

2.04.1 Promotion of Integrated Behavioral Health

To monitor the adoption of integrated behavioral health, Contractor must report:

1) How it is promoting the integration of behavioral health services with primary care, including data exchange between Contractor, its contracted primary care clinicians, and its behavioral health providers.

2.05 Behavioral Health Subcontractor, Downstream Entity, and Behavioral Health Network Provider Oversight

To ensure high-quality, equitable care is provided to Enrollees, Contractor shall be accountable for its delegated functions related to compliance with applicable provisions in Article 2 of Attachment 1. Contractor must hold its delegated entities accountable for meeting the health equity, quality, access, and delivery system reform requirements within Article 2 of Attachment 1. For the purposes of this Section, "delegated entities" are Contractor's behavioral health Subcontractors, Downstream Entities, and behavioral health network providers.

Contractor must demonstrate compliance with the requirements specified in Article 2.05 by December 31, 2027, or by the end of Contractor's second Plan Year contracted with Covered California.

2.05.1 Contractor Accountability, Duties, and Obligations

Contractor shall demonstrate robust compliance, monitoring, and oversight programs for all behavioral health delegated entities to ensure Covered California Enrollees receive quality behavioral health care and have access to behavioral health services. Contractor must disclose delegation arrangements and include justification for the use of delegated entities.

1) Contractor remains fully responsible for the performance of all duties, obligations, and services undertaken by its delegated entities.

2) Contractor must evaluate each prospective delegated entity's ability to perform the contracted services or functions.

3) Contractor must maintain policies and procedures to ensure that delegated entities fully comply with the terms and conditions of Article 2 of Attachment 1.

4) To ensure each delegated entity's compliance, Contractor must:

    a) Include all duties and obligations in Article 2 of Attachment 1, relating to the delegated duties, in all behavioral health Subcontractor agreements;

b) Ensure the behavioral health Subcontractor includes all obligations under Article 2 of Attachment 1, relating to the delegated duties, in all behavioral health Downstream Entity agreements;

c) Review behavioral health Subcontractors' policies and procedures applicable to the delegated functions;

d) Monitor and oversee all delegated functions, including those that may flow down to behavioral health Downstream Entities;

e) Ensure behavioral health network providers comply with all applicable requirements under Article 2 of Attachment 1 and all requirements set forth in their provider network agreements; and

f) Disclose all delegated relationships and submit a delegation report as specified in Article 2.05.3.

2.05.2 Quality and Health Equity Oversight

Contractor shall monitor and evaluate the quality of behavioral health care delivered by all its delegated entities and implement necessary improvements in any setting. Contractor must also monitor health disparities in behavioral health care using at minimum the measures described in Article 1.02.1. Contractor is responsible for the quality and health equity of all behavioral health services regardless of whether those services have been delegated.

1) Contractor must deliver quality behavioral health care that enables Covered California Enrollees to maintain, improve, or manage their behavioral health. This includes ensuring quality behavioral health care in each of the following areas:

    a) Clinical quality of behavioral health care;

    b) Access to behavioral health care providers and services;

    c) Continuity and care coordination across physical health care and behavioral health care settings, including in-person and virtual health, as well as coordination between levels of care and transitions in care to establish stable provider-patient relationships; and

    d) Overall Covered California Enrollee experience with behavioral health services.

2) Contractor shall be accountable for all access, quality improvement, and health equity functions for behavioral health services, including responsibilities that are

delegated. Contractor shall specify the following requirements in its delegated entity agreements, as applicable:

a) Access, quality improvement, and health equity responsibilities for behavioral health services and specific subcontracted functions and activities of delegated entities;

b) Schedule for Contractor's ongoing oversight, monitoring, and evaluation of delegated entities; and

c) Actions and remedies if a delegated entity's obligations are not satisfactorily performed.

3) Contractor shall maintain oversight procedures for behavioral health services to ensure its delegated entities comply with all access, quality improvement, and health equity delegated activities that:

a) Evaluate a delegated entity's ability to provide behavioral health services, including an initial determination that a behavioral health Subcontractor and Downstream Entity has the administrative capacity, experience, and budgetary resources to fulfill their contractual obligations;

b) Ensure delegated entities meet access, quality improvement, and health equity standards; and

c) Include continuous monitoring, evaluation, and approval of its delegated functions to the delegated entity.

2.05.3 Delegation Reporting

1) Contractor must provide a delegation report that describes:

a) All contractual relationships with delegated entities including:

i) Name of delegated entity;

ii) Type of delegated entity;

iii) Description of all delegated and sub-delegated functions; and

iv) Purpose and justification for delegation.

b) Contractor's oversight responsibilities for all delegated obligations.

c) How Contractor oversees or intends to oversee access, parity, quality improvement, and health equity functions that are delegated to delegated

entities.

d) How Contractor oversees or intends to oversee all delegated activities, including details regarding key personnel who will be overseeing such delegated functions.

2) Contractor must submit a delegation report by December 31, 2027, or by the end of Contractor's second Plan Year contracted with Covered California.

   To reduce administrative burden, Contractor may provide Covered California with delegation reports that are submitted by Contractor to the California Department of Health Care Services (DHCS) or the California Public Employees' Retirement System (CalPERS) if Contractor uses the same delegation arrangements for the products offered under these programs.

ARTICLE 3 - POPULATION HEALTH

Covered California and Contractor recognize the importance of population health, including ensuring the use of health promotion and prevention services, increasing utilization of high value services, risk stratifying Enrollees, and developing targeted interventions based on risk. To improve the health of Covered California Enrollees, Contractor shall identify opportunities, conduct outreach, and engage all Covered California Enrollees, not just Covered California Enrollees who obtain services from providers, in population health activities.

3.01 Population Health Management

Covered California and Contractor recognize that Population Health Management ensures accountability for delivering quality care. Population Health Management provides focus and a framework for improving health outcomes through registries, care coordination, and targeted patient engagement.

3.01.1 Population Health Management Plan

Submission of a Population Health Management plan is a requirement for health plan accreditation by the National Committee for Quality Assurance (NCQA). The Population Health Management plan provides a vehicle for establishing a formal strategy to optimize population health outcomes, including a defined approach for population identification and stratification, with attention to care management for Enrollees with complex needs. The Population Health Management plan is a critical part of achieving improvement in Enrollee health outcomes and is interrelated with all other quality care domains.

1) Contractor must submit the following components of its NCQA Population Health Management plan:

    a) Population Health Management Standard 1: Population Health Management Strategy;

    b) Population Health Management Standard 2: Population Identification; and

    c) Population Health Management Standard 6: Population Health Management Impact.

2) Contractor must submit the Population Health Management plan once every three years in accordance with the three-year NCQA accreditation cycle. Covered California will not require annual submission of the Population Health Management plan unless changes are made to the Population Health Management plan during the three-year cycle at which point Contractor must resubmit the revised plan to Covered California.

3) If Contractor is not yet NCQA accredited or is unable to provide components of its NCQA Population Health Management plan as specified in 1), Contractor must submit a separate Population Health Management plan for its Covered California population that addresses each of the following components:

    a) A Population Health Management Strategy for meeting the care needs of its Enrollees that includes the following:

        i) Goals, focus populations, opportunities, programs, and services available for keeping Enrollees healthy, managing Enrollees with emerging risk, patient safety or outcomes across settings, and managing multiple chronic illnesses.

        ii) Mechanism for informing Enrollees eligible for interactive programs with details of how to become eligible for participation, how to use program services, and how to opt in or out of a program.

        iii) Activities performed by Contractor targeted at populations or communities as a part of the Population Health Management strategy that are not direct Enrollee interventions.

        iv) Coordination of Enrollee programs across settings, providers, external management programs, and levels of care to minimize confusion and maximize reach and impact.

    b) Evidence of systematic collection, integration, and assessment of Enrollee data to assess the needs of the population and determine actionable categories for appropriate intervention, including the following:

        i) How Contractor integrates multiple sources of data for use in Population Health Management functions that includes: medical and behavioral claims or encounters, pharmacy claims, laboratory results, health appraisal results, a copy of individual risk assessment questions, electronic health records, health programs delivered by Contractor, and other advanced data sources.

ii) Contractor's process for at least annually assessing the following:

(1) Characteristics and needs, including health related social needs of its Enrollees;

(2) Needs of specific Enrollee subpopulations; and

(3) Needs of children and adolescents, Enrollees with disabilities, and members with serious and persistent mental illness.

iii) How Contractor uses the population assessment at least annually to review and update its Population Health Management activities and resources to address Enrollee needs. Also, how Contractor reviews community resources for integration into program offerings to address Enrollee needs.

iv) Its process, including data sources and population health categories, to stratify its Covered California population into subsets for targeted intervention at least annually.

c) A systemic process of measuring the effectiveness of its Population Health Management strategy to determine if Population Health Management goals are met and to gain insights into areas needing improvement, including the following:

i) How Contractor conducts its annual comprehensive analysis of the impact of its Population Health Management strategy that includes the following:

(1) Quantitative results of relevant clinical, cost and utilization, and experience measures;

(2) Comparison of results with a benchmark or goal; and

(3) Interpretation of results.

ii) Its process to identify and address opportunities for improvement, using the results from the Population Health Management impact analysis at least annually.

3.02 Health Promotion and Prevention

Health promotion and prevention are key components of high value healthcare. Research shows that treating those who are sick is often far more costly and less effective than preventing disease from occurring and keeping populations healthy. Covered California's health promotion and prevention requirements are centered on identifying Enrollees who are eligible for certain high value preventive and wellness benefits, notifying Enrollees about the availability of these services, making sure those eligible receive appropriate services and care coordination, and monitoring the health status of these Enrollees.

3.02.1 Diabetes Prevention Programs

Diabetes contributes to high rates of morbidity and mortality. Access to diabetes prevention programs is critical in the prevention of diabetes related complications. Contractor must:

1) Provide a Centers for Disease Control and Prevention (CDC)-recognized Diabetes Prevention Lifestyle Change Program, also known as a Diabetes Prevention Program (DPP) to its eligible Covered California Enrollees. The DPP must be available both in-person and online to ensure Covered California Enrollees have equitable access to these services in the event of service area challenges such as rural locations or limited program availability and to allow Covered California Enrollees a choice of modality (in-person, online, distance learning, or a combination of modes). The DPP must be accessible to eligible Covered California Enrollees with limited English proficiency (LEP) and eligible Covered California Enrollees with disabilities. The DPP is covered as a diabetes education benefit with zero cost sharing pursuant to the Patient-Centered Benefit Plan Designs. Contractor's DPP must have preliminary or full recognition by the CDC as a DPP, published on The National Registry of Recognized Diabetes Prevention Programs.

2) Report how Contractor informs eligible Covered California Enrollees about the availability of the DPP and how to enroll in the program.

3.03 Supporting At-Risk Enrollees Requiring Transition

Covered California is concerned about the impact that transitions of care from one QHP Issuer to another has on Covered California Enrollees, especially At-Risk Enrollees and High-Risk Enrollees. An Enrollee transition plan allows for a clear process to transfer critical health information for Covered California Enrollees, including At-Risk Enrollees and High-Risk Enrollees during transitions between healthcare coverage.

As used in this section, the following definitions shall apply:

1) An “At-Risk Enrollee” is a Covered California Enrollee who is:

    a) in the middle of acute treatment or those who would otherwise qualify for Continuity of Care under California law,

    b) in case management programs,

    c) in disease management programs, or

    d) on maintenance prescription drugs for a chronic condition.

2) A “High-Risk Enrollee” is an At-Risk Enrollee who is:

    a) Pregnant,

    b) Undergoing active cancer treatment,

    c) Scheduled for a planned procedure or surgery, or

    d) Undergoing medication assisted treatment for substance use disorders.

3.03.1 Enrollee Transition Plan

In the event of a service area reduction such that Contractor withdraws its existing, approved network from any geographic region or modifies any portion of its service area, Contractor must comply with an Enrollee Transition Plan to facilitate transitions of care with minimal disruption for At-Risk and High-Risk Covered California Enrollees who are transitioning from one QHP Issuer to another QHP Issuer. In such events, Covered California may automatically transition Contractor’s Covered California Enrollees in a different QHP Issuer to avoid gaps in coverage. If Contractor receives Covered California Enrollees from another QHP Issuer pursuant to a service area reduction, Contractor must implement policies and programs to facilitate transitions of care.

1) Data transfers

    a) Covered California shall facilitate the seamless transition of health information data for Covered California Enrollees between departing and receiving QHP Issuers. This transmission includes the secure transfer of personal health information submitted by departing QHP Issuer pursuant to this Section, enrollment records, and any other relevant data necessary to ensure no disruption in coverage and services for Covered California Enrollees. Special attention will be given to At-Risk and High-Risk Enrollees, ensuring their transition is managed with the highest

priority and sensitivity to prevent any lapse in necessary medical care or services. These efforts are aimed at ensuring appropriate continuity of care for Covered California Enrollees, thereby minimizing any potential impact on their ongoing treatment and health outcomes.

b) Covered California will coordinate with both departing and receiving QHP Issuers to establish a timeline and protocol for data transfer, ensuring compliance with all applicable laws and regulations governing the privacy, security, and confidentiality of such information.

2) If Contractor is terminating Covered California Enrollees, Contractor must:

a) Conduct outreach to alert all Covered California Enrollees impacted by the service area reduction that their QHP will be ending. Outreach must include instructions, timing, and options for enrolling with a new QHP Issuer. Outreach must notify Enrollees that they may contact their new QHP Issuer to request continuity of care.

b) Pursuant to the Enrollee Transition Plan, send Covered California and the Enrollee's new QHP Issuer health information relevant to creating transitions of care for transitioning Covered California Enrollees as follows:

i) For all terminating Covered California Enrollees impacted by the service area reduction, send primary care clinician information on record.

ii) For At-Risk Enrollees, send relevant personal health information.

c) Conduct outreach to providers in impacted service areas to facilitate Covered California Enrollee transitions with minimal disruption.

3) If Contractor receives terminating Covered California Enrollees from another QHP Issuer pursuant to a service area reduction, Contractor must:

a) Identify At-Risk Enrollees, either through existing Contractor practices, or through receipt of both health information from the prior QHP Issuer and the data file with transitioning enrollment information from Covered California (which would occur after these Covered California Enrollees have effectuated coverage).

b) Engage and conduct outreach to Covered California Enrollees including At-Risk Enrollees within 60 days of receiving health information from the departing Contractor or Covered California to ensure continuity of care and minimal to no disruption to health services.

c) Ensure At-Risk Enrollees' care transitions account for their medical situation, including participation in case or disease management programs, locating in-network providers with appropriate clinical expertise, and any alternative therapies, including specific drugs.

d) Establish internal processes to ensure all parties involved in the transition of care for At-Risk Enrollees are aware of their responsibilities. This includes anyone within or outside of Contractor's organization who are needed to ensure the transition of prescriptions or provision of care.

e) Provide information on continuity of care programs, including alternatives for transitioning to an in-network provider.

f) Consider receipt of High-Risk Enrollee health information as the Enrollee's request for continuity of care pursuant to Health and Safety Code, § 1373.96, or Insurance Code, § 10133.56.

g) Ensure the new At-Risk Enrollees have access to Contractor's formulary information prior to enrollment.

3.04 Social Health

Given the strong evidence of the role of social factors on health outcomes, addressing health-related social needs is an important step in advancing Covered California's goal to ensure everyone receives the best possible care.

Covered California acknowledges the importance of understanding patient health-related social needs – an individual's socioeconomic barriers to health – to move closer to equitable care and seeks to encourage the use of social needs informed and targeted care. As social needs are disproportionately borne by disadvantaged populations, identifying and addressing these barriers at the individual patient level is a critical first step in improving health outcomes, reducing health disparities, and reducing healthcare costs.

Identification and information sharing of available community resources is critical to meeting identified member social needs.

3.04.1 Screening for and Addressing Social Needs

1) Contractor must screen all Covered California Enrollees at least annually for unmet food, housing, and transportation needs, using one or more screening instruments specified in the Social Need Screening and Intervention (SNS-E) measure specifications. Screening for additional health-related social needs and screening in coordination with contracted providers is highly

encouraged.

2) Contractor must address Covered California Enrollees' identified health-related social needs and support linkages to appropriate social services throughout all regions covered. This requirement may be met through contracting with a vendor that maintains a resource directory or community resource platform applicable to Contractor's geographic licensed service area.

3) To demonstrate Contractor is screening for and addressing health-related social needs, Contractor must report, as annually requested by Covered California:

   a) Its process for screening Covered California Enrollees for social needs and collecting data for the Social Need Screening and Intervention (SNS-E) measure, including which Covered California Enrollee touch points include social need screening, whether the screening is performed by Contractor's staff, vendor, or network providers, and which screening instrument(s) are used to screen for health-related social needs.

   b) The social needs screening efforts by its provider network and the actions Contractor takes to coordinate screening and linkage to services with its provider network, including what support Contractor provides to contracted providers to connect Covered California Enrollees.

   c) Its process for linking Covered California Enrollees with food insecurity or other health-related social needs to resources and how Contractor tracks if or when the social need has been addressed.

   d) Measurement Year 2026, 2027, and 2028 performance on the Social Need Screening and Intervention (SNS-E) measure, stratified by race and ethnicity, and submitted via patient level data file in accordance with Article 1.02.1.

   e) The Enrollee screen positive rate for each of the three subcomponents of the Social Need Screening and Intervention (SNS-E) measure.

3.05 Use of Generative Artificial Intelligence in QHP Issuer Operations

This section acknowledges the transformative potential of Patient Care Decision Support Tools, including Generative Artificial Intelligence (GenAI), to enhance health plan operations and member experiences while promoting health equity. It sets forth a framework for the responsible use of Patient Care Decision Support

Tools by QHP Issuers, emphasizing compliance, bias mitigation, transparency, continuous improvement, and collaboration with shared learning.

Definitions:

1) Patient Care Decision Support Tools: Patient Care Decision Support Tools has the same meaning as defined in 45 C.F.R. § 92.4. Patient Care Decision Support Tools includes Artificial Intelligence and Generative Artificial Intelligence.

2) Artificial Intelligence: Artificial Intelligence has the same meaning as defined in Health and Safety Code, § 1367.01, subdivision (k) and Insurance Code, § 10123.135, subdivision (j). Artificial Intelligence includes Generative Artificial Intelligence.

3) Generative Artificial Intelligence (GenAI): Generative Artificial Intelligence is a subset of Artificial Intelligence that includes systems capable of creating content, predictions, or decisions from data inputs. This encompasses machine learning, natural language processing, and neural network technologies.

4) Human-in-the-Loop (HITL): A model where human judgment is incorporated into GenAI outputs to guide, review, or alter GenAI-made decisions or predictions.

5) Governance Structure: A written framework of systems and processes adopted by an organization to appropriately and ethically manage decision-making regarding use of Patient Care Decision Support Tools in the organization's operations.

3.05.1 Mitigating Bias in Use of Patient Care Decision Support Tools:

To minimize bias in the usage of Patient Care Decision Support Tools Usage, Contractor must:

1) Refrain from discrimination on the basis of race, color, national origin, sex, age, or disability in its health programs or activities through the use of Patient Care Decision Support Tools. In accordance with 45 C.F.R. § 92.210, Contractor has an ongoing duty to make reasonable efforts to identify uses of Patient Care Decision Support Tools in its health programs or activities that employ input variables or factors that measure race, color, national origin, sex, age, or disability, and must make reasonable efforts to mitigate the risk of discrimination resulting from the Tool's use in its health programs or activities.

3.05.2 Use of Best Practice in Patient Care Decision Support Tools

Contractor must adhere to the following requirements:

1) Stay abreast of and integrate best practices for Patient Care Decision Support Tools, reflecting both state and national developments as technologies, guidance, laws, and regulations evolve.

2) Establish and maintain protocols, including a Governance Structure, to identify and address bias within Patient Care Decision Support Tools.

3) Collaborate across QHP Issuers and Covered California through a minimum of one (1) learning session, working group or community engagement activity during the Plan Year to share insights, challenges, and strategies for bias mitigation, emerging use cases, and sharing of best practices. To meet this requirement, Contractor must host or attend an activity that was expressly pre-approved or suggested by Covered California, and provide documentation of attendance. Contractor must submit additional relevant activities for consideration to Covered California to meet this requirement. Documentation of completed pre-approved activities must be received no later than 30 days after each pre-approved activity.

3.05.3 Use of Artificial Intelligence in Utilization Management

Contractor shall comply with requirements in Health and Safety Code, § 1367.01, subdivision (k) or Insurance Code, § 10123.135, subdivision (j), as applicable, if Contractor uses an artificial intelligence including GenAI, algorithm, or other software tool for the purpose of utilization review or utilization management functions.

3.05.4 Enrollee Transparency

To ensure openness and effective communication, Contractor must:

1) Provide written notice to a Covered California Enrollee when Contractor knowingly uses artificial intelligence including GenAI, algorithm, or other software for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity under the benefits provided by the QHP, at the time Contractor communicates the decision to the Enrollee in writing, including electronically. Notice may include information regarding Contractor's use of bias mitigation strategies. This requirement shall not apply to Contractor's medical groups or other delegated entities.

2) Notify a Covered California Enrollee when Contractor uses GenAI in written interactive communications with the Enrollee about their benefits, such as chatbots.

3.05.5 Reporting Requirements for use of Artificial Intelligence

Contractor must provide to Covered California, as directed:

1) Comprehensive reports on the measures taken to identify and mitigate bias when Contractor uses an artificial intelligence including GenAI, algorithm, or other software for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity, under the benefits provided by the QHP for Covered California Enrollees.

2) A description of the Governance Structure established to oversee use of GenAI when Contractor uses an artificial intelligence including GenAI, algorithm, or other software GenAI for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity, under the benefits provided by the QHP for Covered California Enrollees, including frameworks for ethical use, transparency, and accountability in GenAI deployments and representative use cases.

ARTICLE 4 - DELIVERY SYSTEM AND PAYMENT STRATEGIES TO DRIVE QUALITY

Contractor is expected to contribute to broadscale efforts to improve the healthcare delivery system in California. Covered California and Contractor shall work collaboratively to achieve the goals of the Institute of Medicine's Quintuple Aim: improving population health, enhancing the care experience, reducing costs, addressing health care professional wellbeing, and advancing health equity. Contractor shall work with Covered California to promote advanced primary care, increase integration and coordination within the healthcare system, and manage and design networks based on value. Covered California and Contractor will align and collaborate with the Department of Health Care Services (DHCS) and the California Public Employees' Retirement System (CalPERS) as well as the Office of Health Care Affordability (OHCA) to enhance primary care investment, lower the total cost of care, and improve member affordability. Such coordinated efforts are crucial in realizing a transformed healthcare landscape in California.

4.01 Advanced Primary Care

Covered California and Contractor recognize that providing high-quality, equitable, and affordable care requires a foundation of advanced primary care. Advanced primary care is patient-centered, accessible, team-based, data driven, supports the integration of behavioral health services, and provides care management for patients with complex conditions. Advanced primary care is supported by alternative payment models such as population-based payments and shared savings arrangements. Contractor shall actively promote the development and use of advanced primary care models that promote access, care coordination, continuity of care, and quality while managing the total cost of care.

Contractor shall work with Covered California to provide comparison reporting for the requirements specified below for all lines of business to compare performance and inform future Covered California requirements.

4.01.1 Encouraging Use of Advanced Primary Care

Ensuring Enrollees have a primary care clinician is foundational for promoting access to and encouraging the use of advanced primary care. To encourage the use of primary care, Contractor must:

1) Ensure that upon enrollment, Covered California Enrollees are informed about the role and benefits of primary care and are given the opportunity to select a primary care clinician. Within sixty (60) Days of effectuation into the plan, if a Covered California Enrollee does not select a primary care clinician,

Contractor must provisionally assign the Covered California Enrollee to a primary care clinician, inform the Covered California Enrollee of the assignment, and provide the Covered California Enrollee with an opportunity to select a different primary care clinician. When assigning a primary care clinician, Contractor shall use commercially reasonable efforts consistent with the Covered California Enrollee's stated gender, language, ethnic and cultural preferences, geographic area, existing family member assignment, and any prior primary care clinician.

2) Engage and collaborate with Covered California to review the number and percent of Covered California Enrollees who select a clinician and who are assigned to a primary care clinician using HEI data submitted in accordance with Article 5.02.1.

3) Contractor agrees to provide Covered California with data and other information necessary to perform the evaluation in 2) above.

4.01.2 Measuring Advanced Primary Care

Advanced primary care is patient-centered, accessible, team-based, data driven, supports the integration of behavioral health services, and provides care management for patients with complex conditions. To support advanced primary care, primary care clinicians should have access to data related to the care their patients receive throughout the delivery system to promote integrated, continuous, and coordinated care.

1) Primary Care Clinician Selection

    a) Covered California will determine if Contractor's Covered California Enrollees utilized their assigned primary care clinician, another plan-identified primary care clinician, sought healthcare services elsewhere, or had no healthcare activity by comparing claims data with the primary care clinician National Provider Identifier (NPI).

    b) Contractor shall work with Covered California to review and improve primary care clinician selection and healthcare utilization using HEI submitted data in accordance with Article 5.02.1.

2) Member Value and Engagement in Care

    a) Contractor must ensure active engagement of Enrollees in care to improve health outcomes and member satisfaction. Through proactive engagement and outreach, Contractor enables Enrollees to access preventive services, manage chronic conditions, and

avoid unnecessary emergency room care and hospitalizations.

b) Contractor must monitor and increase the portion of Covered California Enrollees with continuous enrollment in Contractor's QHP throughout the prior Plan Year who have at least one medical or prescription drug claim during the Plan Year. This requirement aims to reduce the number of Enrollees without any healthcare activity and improve utilization of medically necessary care. By tracking claims data and engaging Enrollees through targeted outreach and coordinated care, Contractor can address gaps in care and ensure Enrollees utilize necessary health services, enhancing outcomes and maximizing the value of coverage.

3) Continuity of Care

a) Covered California will measure continuity of care for Contractor's Covered California Enrollees using the continuity of care index. The continuity of care index assesses the percentage of visits with the same provider, yielding an index ranging from 0 to 1, where 0 indicates all visits with different providers and 1 indicates all visits with the same provider. Using HEI submitted data in accordance with Article 5.02.1, Covered California will measure continuity of care for Covered California Enrollees with continuous enrollment in Contractor's QHP throughout the prior Plan Year and two or more primary care visits with any primary care clinician during the prior Plan Year.

b) Contractor shall collaborate with Covered California to establish benchmarks and improvement targets around continuity of care, and work with Covered California to review and improve Enrollee continuity of care.

4.01.3 Payment to Support Advanced Primary Care

Covered California and Contractor recognize the importance of adopting and expanding primary care payment models that provide the necessary revenue to fund accessible, data-driven, team-based care with accountability for providing high-quality, equitable care, and managing the total cost of care. To support advanced primary care, Contractor must:

1) Report annually on Contractor's total primary care spend by Contractor product in alignment with the Office of Health Care Affordability (OHCA). Contractor shall follow methodology provided by Covered California. Covered California will review and monitor progress toward OHCA designated

benchmarks.

2) Work with Covered California and other stakeholders to analyze the relationship between the percent of spend for primary care services with the total cost of health care expenditures (TCHE) and network performance of the overall delivery system, including assessing quality and equity.

3) To share progress on achieving benchmarks, Contractor must participate in collaboration across QHP Issuers **and** with community through learning sessions, working groups, and community engagement activities, as hosted by Covered California. Contractor may submit additional relevant activities for consideration to Covered California to meet this requirement.

4.02 Networks Based on Value

Contractor shall curate and manage its networks to address variation in quality and cost performance across network hospitals and providers, with a focus on improving underperforming hospitals and providers and reducing low value care and variation. As used in this Section, low-value care refers to services or treatments that offer minimal clinical benefit, deviate from evidence-based guidelines, or have safer, more cost-effective alternatives. Efforts to reduce low-value care are integral to enhancing quality, affordability, and equity within the healthcare system. Affordability is core to Covered California's mission to expand the availability of insurance coverage and prevent barriers to accessing care. Variation in unit price and total costs of care irrespective of quality is a key contributor to the high cost of coverage and medical services. Contractor shall hold its contracted hospitals and providers accountable for improving quality, managing and reducing cost and shall collaborate and provide support to its contracted hospitals and providers to monitor and improve performance.

4.02.1 Designing and Managing Networks Based on Value

Contractor shall design and manage its networks based on cost, quality, safety, patient experience, and equity to ensure that Enrollees receive high-quality, affordable, and equitable care. Contractor must:

1) Include cost, quality, safety, patient experience, and equity in evaluation and selection criteria for all providers, including physicians and physician groups, and all facilities, including hospitals, when designing and managing networks for its QHPs.

2) Report on Contractor's selection criteria and review of providers and facilities in networks for QHPs and if applicable, the rationale for excluding a provider or facility. Reports must include a detailed description of how cost, quality,

patient safety, patient experience, or other factors are considered in network design and provider and facility selection and review. Information submitted may be made publicly available by Covered California.

4.02.2 Payments to Support Networks Based on Value

To continue to build and strengthen networks based on value, Contractor must support its providers through value-based payment models that promote high-quality, affordable, and equitable access and care, and report on these efforts as specified in this Section:

1) Contractor must monitor and report on the total cost of health care expenditures by Contractor product annually, in alignment with OHCA. Contractor shall follow methodology provided by Covered California using HEI data submitted in accordance with Article 5.02.1. Covered California will review and monitor progress toward OHCA designated benchmarks.

2) Contractor must report on its network payment models using the Health Care Payment Learning and Action Network Alternative Payment Model (HCP LAN APM) categories and associated subcategories of fee for service with no link to quality and value (Category 1), fee for service with a link to quality and value (Category 2), alternative payment models built on a fee for service structure such as shared savings (Category 3), and population-based payment (Category 4). Contractor must report the percent of spend within each HCP LAN APM category and associated subcategory compared to its overall budget and the percent of members attributed to each HCP LAN APM Category by Contractor product annually in alignment with OHCA. Contractor shall follow methodology provided by Covered California. Covered California will review and monitor progress towards OHCA designated benchmarks.

3) To share progress on achieving benchmarks, Contractor must collaborate across QHP Issuers and with community through a minimum of one (1) learning session, working group, or community engagement activity. Contractor must host or attend an activity that was expressly pre-approved or suggested by Covered California and provide documentation of attendance. Contractor may submit additional relevant activities for consideration to Covered California to meet this requirement. Documentation of completed pre-approved activities must be received by Covered California no later than 30 days after each pre-approved activity.

4.02.3 Provider Value

Contractor shall contract with providers, including physicians and physician groups, that demonstrate they provide quality care and promote the safety of Enrollees at a

reasonable price. Contractor shall improve quality and cost performance across its contracted providers.

1) Covered California will work with the Integrated Healthcare Association (IHA), California providers, and QHP Issuers to profile and analyze variation in performance on provider quality measures. This profile and analysis will be based on national and state benchmarks, variation in provider performance, best existing science of quality improvement, and informed by effective engagement of stakeholders. To meet this expectation, Contractor must:

    a) Submit all necessary data to IHA and participate in the IHA Align. Measure. Perform (AMP) program for provider organizations and report AMP performance results for each contracted provider organization and each primary care practice that participates in its QHPs to Covered California or allow IHA to submit results to Covered California on Contractor's behalf. Contractor shall use AMP performance results to profile and analyze variation in performance on quality measures and total cost of care.

    b) To achieve maximum quality and safety performance in provider networks Contractor must participate in collaboration across QHP Issuers and with community through learning sessions, working groups, and community engagement activities, as hosted by Covered California. Contractor may submit additional relevant activities for consideration to Covered California to meet this requirement.

    c) To demonstrate Contractor is managing provider costs, Covered California may request copies of Contractor's medical management policy. In addition, Contractor must report:

        i) The factors Contractor considers in assessing relative unit prices and total cost of care;

        ii) Contractor's analysis of variation in unit prices including capitation and reimbursement rates;

        iii) The extent to which Contractor adjusts for or analyzes the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary care), or other factors;

        iv) How unit prices, capitation rates, and total cost of care are used in the selection of providers in networks for QHPs;

v) Details regarding identified barriers to providing affordable care and meeting OHCA targets, including challenges with provider contracting and rate setting; and

vi) The distribution of providers by region and by cost decile or describe other ways providers and facilities are grouped by costs, such as comparison of costs as a percentage of Medicare costs and the percentage of costs for Contractor that are expended in each cost decile.

4.02.4 Hospital Quality, Value, and Safety

Covered California has focused on aligned and collaborative efforts to promote hospital safety care coordination and patient experience. Covered California recognizes that improving hospital performance requires a comprehensive and cross-payer collaborative multi-stakeholder approach. Monitoring and improving hospital safety measures will improve clinical outcomes and reduce low value healthcare spending.

Contractor shall work with Covered California to support and enhance general acute care hospitals' efforts to achieve quality goals and contract with hospitals that demonstrate they provide high-quality, affordable, and equitable care and promote the safety of Enrollees. Contractor shall improve quality and cost performance across its contracted hospitals and track and report progress and strategies.

Covered California will work with Cal Healthcare Compare, California hospitals, and QHP Issuers to profile and analyze variation in performance on hospital quality measures. Analysis will be based on best available national and state benchmarks, variation in hospital performance considering hospital case mix and services provided, best existing science of quality improvement including the challenges of composite measures and informed by effective engagement of stakeholders. Assessment of hospital quality and safety shall not be based on a single measure alone.

1) Contractor must report the quality improvement support and technical assistance provided by Contractor or partner organization to strengthen performance of hospitals. Contractor must also report the extent and nature of its participation in improvement collaboratives such as Cal Healthcare Compare or equally qualified public reporting entities for patient safety quality and performance ratings in California.

2) Contractor must additionally participate in collaboration across QHP Issuers and with community through a minimum of one (1) learning session, working group, or community engagement activity during the Plan Year related to

quality improvement support and technical assistance to strengthen hospital quality and safety performance. To meet this requirement, Contractor must host or attend an activity that was expressly pre-approved or suggested by Covered California and provide documentation of attendance. Contractor may submit additional relevant activities for consideration to Covered California to meet this requirement. Documentation of completed pre-approved activities must be received by Covered California no later than 30 days after each pre-approved activity.

3) To demonstrate Contractor is managing hospital and facility cost and quality, Covered California may request information including:

    a. The factors Contractor considers in assessing relative unit prices and total cost of care;

    b. The extent to which Contractor adjusts for or analyzes the reasons for cost factors based on elements such as area of service, population served, market dominance, services provided by the facility (e.g., trauma or tertiary care), or other factors;

    c. How unit prices, total cost of care, and data obtained from the CMS Hospital Price Transparency Rule are used in the selection of facilities in networks for QHPs; and

    d. The distribution of facilities by region and by cost decile or describe other ways facilities are grouped by costs such as comparison of costs as a percentage of Medicare costs and the percentage of costs for Contractor that are expended in each cost decile.

    e. The shared efforts, findings, and progress made from joint initiatives, collaborative workshops or research projects to mitigate barriers to high value care.

4) Covered California supports price transparency as a resource for Enrollees to make better informed decisions about their healthcare services. Contractor shall require all contracted hospitals to adhere to the hospital price transparency requirements in Section 2718(e) of the Public Health Service Act and implementing regulations. This compliance includes establishing, updating, and publicly posting a comprehensive list of standard charges for items and services in a machine-readable format (MRF), using a CMS-provided template for uniformity. Contractor must verify that hospitals comply with the required display of standard charges, including the gross charge, discounted cash price, payer-specific negotiated charge, and the de-identified minimum and maximum negotiated charges. In alignment with the CMS

Hospital Price Transparency rule, Contractor shall report:

a. A list of network hospitals by region that do not provide a MRF that includes payer-specific negotiated amounts for all the services that could be provided by the hospital on an inpatient or outpatient basis; and

b. The number and percent of network hospitals by region that provide a consumer friendly, searchable display of current standard charges and information on the 300 CMS-specified shoppable services or as many services as the hospital provides as a comprehensive MRF with all items and services and in a display of shoppable services in a consumer-friendly format.

5) Contractor shall work with Covered California to provide comparison reporting for the requirements in Article 4.02.4 for all lines of business to compare performance and inform future Covered California requirements in this area.

4.02.5 Hospital Patient Safety

Covered California has focused on aligned and collaborative efforts to promote hospital safety based on the recognition that improving hospital performance in this area requires a comprehensive and cross-payer approach. Monitoring and improving hospital safety measures will improve clinical outcomes and reduce wasteful healthcare spending.

1) Contractor shall work with Covered California to support and enhance acute general hospitals' efforts to promote safety for their patients.

2) Covered California is committed to addressing the opioid epidemic and continues to pursue improvement in the appropriate use of opioids and access to treatment for substance use disorder in both the outpatient and hospital settings. Article 2.03.1 addresses opioid use in the outpatient setting. To support the appropriate use of opioids in the hospital setting, Contractor must:

a) Report its strategies to improve the appropriate use of opioids and access to treatment for substance use disorder in its network hospitals.

b) Encourage all network hospitals to utilize Healthcare Organizations Leading Substance Use Disorder (SUD) Care, which outlines key milestones to achieving opioid safety, and to participate in the Substance Use Disorder Care Honor Roll program from Cal Healthcare Compare. The self-assessment can be accessed from: https://calhospitalcompare.org/programs/opioid-care-honor-roll/

4.02.6 Comprehensive Pregnancy and Postpartum Care

According to the World Health Organization, maternal health refers to a woman's health during pregnancy, childbirth, and the postpartum period. Covered California recognizes that not all people who become pregnant or give birth identify as women. While Covered California primarily uses the term "pregnancy and postpartum" the term 'maternal' may also be used when appropriate.

Covered California is committed to ensuring access to high-quality, equitable pregnancy and postpartum care that addresses the full spectrum of needs related to pregnancy, childbirth, and the postpartum period and provides a comprehensive approach to improving maternal health outcomes. Contractor will:

1) Work collaboratively with Covered California to promote and encourage all network hospitals that provide pregnancy and postpartum services to use the resources provided by California Maternity Quality Care Collaborative (CMQCC) and enroll in the CMQCC Maternal Data Center (MDC).

2) Report annually on efforts made to engage with providers and Enrollees undergoing pregnancy, childbirth, and postpartum care to promote:

    a) The patients' right to choose a pregnancy and postpartum care provider, who aligns with their needs and may reflect their demographic characteristics, including race, ethnicity, language, socioeconomic status, sexual orientation, and gender identity.

    b) Pregnant and postpartum care options for the delivery of high-value care—right provider, right setting, right price—with accessible care options including same-day services for urgent needs and special considerations for patients with high-risk pregnancies, ensuring comprehensive safe and supportive pregnancy and postpartum care that promotes health, resilience, and disease prevention for the pregnant and postpartum patient and their family.

    c) Education and support throughout all phases of pregnancy and postpartum care to empower informed decision-making and promote positive health outcomes. This includes sharing safety ratings, promoting the appropriate use of C-sections, and offering educational resources to individuals and families to ensure they receive patient-centered, appropriate care while avoiding unnecessary interventions.

    d) Whole person care as defined by Cal Healthcare Compare's Maternity Honor Roll Program.

e) Information and awareness regarding accessibility of enterprise and local social support services available, such as food, housing, and transportation programs and resources.

3) Track and report the number in-network doulas, certified nurse midwives, and licensed midwives and include in development and submission of a network expansion strategy for the recruitment of a diverse network of care navigators, for racial and ethnic congruency between provider and members and increased access to Maternal health services that encompass the full spectrum of pregnancy, childbirth, and postpartum care. The network expansion strategy must prioritize access to doula and midwifery care when delivering services that are included as essential health benefits, including birth centers and home birth, to reduce administrative barriers and incentivize coordinated team-based care.

4) Health disparities exist across the full spectrum of maternal health, from preconception, to pregnancy, and the postpartum period. Disparities in pregnant and postpartum health disproportionately affect Black and Latino populations at higher rates than other racial groups. Reducing and eliminating gaps in prenatal and postpartum health requires a multifaceted approach. To accomplish this, Contractor must:

   a) Monitor and reduce maternal mental health disparities by providing medically necessary therapy, crisis intervention for perinatal mood disorders, and evidence-based SUD programs, including Medication-Assisted Treatment (MAT) and harm reduction strategies, with coordinated care across behavioral health, obstetric, and pediatric providers.

   b) Collect measure results, stratified by race and ethnicity, for its Covered California Enrollees and submit patient level data files for the following HEDIS measures in accordance with Article 1.02.1 for:

      i) Prenatal Depression Screening and Follow-up (PND-E), and

      ii) Postpartum Depression Screening and Follow-up (PDS-E)

   c) Review its performance, stratified by race and ethnicity, on the Prenatal and Postpartum Care (PPC) (CBE ID #1517) measure results generated by Covered California using Contractor's HEI data.

   d) Use available measure results to determine a maternal health disparity among subpopulations of Enrollees undergoing pregnancy, childbirth, and postpartum care. Contractor must implement at least one pre-approved intervention each Plan Year, or at least one multi-year

intervention with activities spanning each Plan Year during the contract cycle, focused on improving outcomes for a specific subpopulation identified. Representative interventions include: engaging with hospitals and providers, to address maternal health disparities; ensuring that its network perinatal providers, staff, and facilities are complying with the California Dignity in Pregnancy and Childbirth Act, which mandates implicit bias training in order to reduce the effects of implicit bias in pregnancy, childbirth, and postnatal care; or supporting its maternity care Enrollees, in accessing culturally and linguistically appropriate care, referrals to group prenatal care or community-centered care models for patients, in home lactation and nutrition consultants, doula support for prenatal, labor, delivery, and postnatal and postpartum care, and related services. Contractor must submit proposed intervention plan including proposed outcome measures to Covered California for approval prior to implementation. Covered California will work with Contractor in its first year contracting with Covered California to identify a qualifying activity to meet this requirement in the absence of available measure results.

4.03 Use of Virtual Care

Virtual care has the potential to improve access to and cost of care when used for the right conditions under the right payment models. Potential benefits include addressing barriers to care such as transportation, childcare, limited English proficiency (LEP), and time off work which may exist for Enrollees. As used in this Section, “virtual care” refers to all means to digitally interact with patients, including interactions conducted via telehealth and digital technologies such as remote patient monitoring or application-based interventions. Virtual care includes synchronous and asynchronous patient-provider communication, remote patient monitoring, e-consults, hospital at home, and other virtual health services.

4.03.1 Virtual Care Offerings

Contractor shall report the extent to which Contractor is supporting the use of virtual care when clinically appropriate to assist in providing high quality, accessible, patient-centered care. Covered California encourages Contractor to use network providers to provide virtual care whenever possible. Contractor must continue to comply with applicable network adequacy standards for in-person services.

To monitor Contractor’s virtual care services, Contractor must report:

1) The types and modalities of virtual care health services that Contractor offers to Covered California Enrollees, as well as the goal or desired outcome from the

service (e.g., decreased emergency department visits, better access to specialty care, improved diabetes management, etc.), including:

a) Interactive dialogue over the phone (voice only encounter),

b) Interactive face to face (video and audio encounter),

c) Asynchronous via email, text, instant messaging or other,

d) Remote patient monitoring (e.g., blood pressure, glucose control, etc.),

e) e-Consult,

f) Hospital at Home,

g) Other modalities.

2) An inventory of the third-party virtual care vendors serving Covered California enrollees, including each vendor's:

a) Taxpayer Identification Number (TIN) and National Provider Identifier (NPI),

b) Specialty designation (e.g., Urgent Care, Primary Care, Behavioral Health, etc.),

c) Modality offerings (including those modalities specified in 1) above),

d) Start and end dates for the vendor serving Covered California Enrollees, and

e) NCQA Virtual Care Accreditation status, URAC Digital/Telehealth Accreditation status, or both statuses if applicable

3) How Contractor is communicating with and educating Covered California Enrollees about virtual care services including:

a) Explaining service availability on key Covered California Enrollee website pages, such as the home page and provider directory page;

b) Explaining service cost-share on key Covered California Enrollee website pages like the summary of benefits and coverage page and medical cost estimator page; and

c) Explaining the availability of interpreter services for virtual care on key Covered California Enrollee website pages, such as the home page and

provider directory page.

4) How Contractor facilitates the integration and coordination of care between third party virtual care vendor services and primary care and other network providers, particularly if the virtual care service is for urgent care, chronic disease management, or behavioral health.

5) How Contractor screens for Covered California Enrollee access barriers to virtual care services such as broadband affordability, digital literacy, smartphone ownership, and the geographic availability of high-speed internet services.

6) A description of Contractor's virtual care reimbursement policies for network providers and for third party virtual care vendors, including payment parity between:

    a) Virtual care modalities, including voice only when appropriate, and comparable in-person services.

    b) Virtual care vendor and contracted provider rendered virtual care services.

7) The impact virtual care has on cost and quality of care provided to Covered California Enrollees, including the extent to which virtual care replaces or adds to utilization of specialty care, emergency department, or urgent care services.

8) Contractor agrees to establish use of quality monitoring measures for virtual care and to submit monitoring measures results to Covered California as annually requested.

4.03.2 Monitoring Virtual Care Utilization

Contractor agrees to engage and work with Covered California to review its utilization of virtual care services using HEI data submitted in accordance with Article 5.02.1. Contractor must submit an improvement plan to address outliers identified during the review process. Contractor must report strategies utilized to reduce fragmented and duplicate services.

4.04 Participation in Quality Collaboratives

Improving healthcare quality and reducing overuse and costs can only be done over the long-term through collaboration, data sharing, and effective engagement of hospitals, clinicians, and other providers of care. Covered California encourages Contractor participation in established statewide and national collaborative initiatives for quality improvement, addressing health disparities, and improving

data sharing.

Contractor must report its participation in quality collaboratives or initiatives, including the amount of financial support (if any) Contractor provides.

ARTICLE 5 - MEASUREMENT AND DATA SHARING

Measurement is foundational to assessing the quality, equity, and value of care provided by Contractor to Enrollees. As a result, Covered California uses a variety of measures in its assessment of QHP performance and has developed a robust Healthcare Evidence Initiative (HEI) to assess further dimensions of quality, equity, and value. Contractor agrees to work with Covered California to exchange and prioritize feedback on measure development and measure sets. This includes measurement refinements related to the National Committee for Quality Assurance (NCQA) Electronic Clinical Data System, the Quality Rating System, HEI measures, and others.

With the healthcare industry increasingly using electronic health records, data sharing between patients, providers, hospitals, and payers is a critical driver of quality of care. Covered California is committed to making patient data available and accessible to support population health management, clinical care, and coordination. Efficient data sharing decreases healthcare costs, reduces paperwork, improves outcomes, and gives patients more control over their healthcare.

5.01 Measurement and Analytics

5.01.1 Covered California Quality Rating System Reporting

Contractor and Covered California recognize that the Quality Rating System is an important mechanism to monitor QHP Issuers for quality performance, a standardized source of consumer information for Enrollees and the public, and it informs measure alignment with other purchasers and measure sets.

1) Contractor shall collect and report to Covered California, for each QHP product type, its numerators, denominators, and rates for the measures included in the CMS Quality Rating System measure set. This includes data for select HEDIS measures and may also include data for other types of measures included in the Quality Rating System. Contractor must provide all collected data to Covered California each year regardless of CMS submission and reporting requirements.

2) Covered California reserves the right to use Contractor-reported data to construct Contractor quality ratings that Covered California may use for purposes such as supporting consumer choice, quality improvement efforts, financial accountability, establishing performance standards, and other activities related to Covered California's role as a Health Oversight Agency. Covered California will publicly report the Quality Rating System scores and ratings each year.

5.01.1 National Committee for Quality Assurance (NCQA) Quality Compass Reporting

Contractor and Covered California recognize that performance measure comparison for the Covered California population to national benchmarks for commercial and Medicaid lines of business promotes health equity, informs efforts to address health disparities, and ensures consistent quality of care across all populations. To enable performance measure comparisons to national benchmarks, Contractor shall:

1) Collect and report HEDIS scores to the National Committee for Quality Assurance (NCQA) Quality Compass for its commercial (which includes Covered California Enrollees) and Medi-Cal lines of business. This submission to NCQA Quality Compass shall include the numerator, denominator, and rate for the NCQA Quality Compass required measures.

2) Submit to Covered California HEDIS scores including the measure numerator, denominator, and rate for the required measures that are reported to the NCQA Quality Compass and DHCS, for each product type for which it collects data in California, if requested. For Contractors that have commercial lines of business that do not permit public reporting of their results to NCQA Quality Compass, HEDIS scores for the NCQA Quality Compass measures set must still be submitted to Covered California if requested.

3) Report such information to Covered California in a form that is mutually agreed upon by Contractor and Covered California and participate in quality assurance activities to validate measure numerator, denominator, and rate data.

5.02 Data Sharing and Exchange

5.02.1 Data Submission (Healthcare Evidence Initiative)

Contractor must comply with the following data submission requirements:

1) General Data Submission Requirements

   a) California law requires Contractor to provide Covered California with information on cost, quality, and disparities to evaluate the impact of Covered California on the healthcare delivery system and health coverage in California.

   b) California law requires Contractor to provide Covered California with data needed to conduct audits, investigations, inspections, evaluations, analyses, and other activities needed to oversee the operation of

Covered California, which may include financial and other data pertaining to Covered California's oversight obligations. California law further specifies that any such data shall be provided in a form, manner, and frequency specified by Covered California.

c) Contractor is required to provide HEI Data that may include data and other information pertaining to quality measures affecting Enrollee health and improvements in healthcare quality and patient safety. This data may likewise include Enrollee claims and encounter data needed to monitor compliance with applicable provisions of this Agreement pertaining to improvements in health equity and disparity reductions, performance improvement strategies, alternative payment methods, as well as Enrollee specific financial data needed to evaluate Enrollee costs and utilization experiences. Covered California shall only use HEI Data for those purposes authorized by law.

d) The Parties mutually agree and acknowledge that financial and other data needed to evaluate Enrollee costs and utilization experiences includes information pertaining to contracted provider reimbursement rates and historical data as required by applicable California law.

e) Covered California may, in its sole discretion, require that certain HEI Data submissions be transmitted to Covered California through a vendor (herein, "HEI Vendor") which will have any and all legal authority to receive and collect such data on Covered California's behalf.

2) Healthcare Evidence Initiative Vendor

a) Contractor shall work with any HEI vendor which Covered California contracts with to assist with its statutory obligations.

b) The parties acknowledge that any such HEI Vendor shall be retained by Covered California and that Covered California shall be responsible for HEI Vendor's protection, use and disclosure of any such HEI Data.

c) Notwithstanding the foregoing, Covered California acknowledges and agrees that disclosures of HEI Data to HEI Vendor or to Covered California shall at all times be subject to conditions or requirements imposed under applicable federal or California State law.

3) HEI Vendor Designation

a) Should Covered California terminate its contract with its then-current HEI Vendor, Covered California shall provide Contractor with at least thirty

(30) Days' written notice in advance of the effective date of such termination.

b) Upon receipt of the aforementioned written notice from Covered California, Contractor shall terminate any applicable data-sharing agreement it may have with Covered California's then-current HEI Vendor and shall discontinue the provision of HEI Data to Covered California's then-current HEI Vendor.

4) Covered California shall notify Contractor of the selection of an alternative HEI Vendor as soon as reasonably feasibly possible, and the parties shall at all times cooperate in good faith to ensure the timely transition to the new HEI Vendor.

5) HIPAA Privacy Rule

a) PHI Disclosures Required by California law:

i) California law requires Contractor to provide HEI Data in a form, manner, and frequency determined by Covered California. Covered California has retained and designated an HEI Vendor to collect and receive certain HEI Data on its behalf.

ii) Accordingly, the parties mutually agree and acknowledge that the disclosure of any HEI Data to Covered California or to HEI Vendor which represents PHI is permissible and consistent with applicable provisions of the HIPAA Privacy Rule which permit Contractor to disclose PHI when such disclosures are required by law (45 CFR §164.512(a)(1)).

b) PHI Disclosures for Health Oversight Activities:

i) The parties mutually agree and acknowledge that applicable California law (CA Gov Code §100503.8) requires Contractor to provide Covered California with HEI Data for the purpose of engaging in health oversight activities and declares Covered California to be a health oversight agency for purposes of the HIPAA Privacy Rule (CA Gov Code §100503.8).

ii) The HIPAA Privacy Rule defines a "health oversight agency" to consist of a person or entity acting under a legal grant of authority from a health oversight agency (45 CFR §164.501) and HEI Vendor has been granted legal authority to collect and receive HEI Data from Contractor on Covered California's behalf.

iii) Accordingly, the parties mutually acknowledge and agree that the provision of any HEI Data by Contractor to Covered California or HEI Vendor which represents PHI is permissible under applicable provisions of the HIPAA Privacy Rule which permit the disclosure of PHI for health oversight purposes (45 CFR §164.512(d).

c) Publication of Data and Public Records Act Disclosures

i) Contractor acknowledges that Covered California intends to publish certain HEI Data provided by Contractor pertaining to its cost reduction efforts, quality improvements, and disparity reductions.

ii) Notwithstanding the foregoing, the parties mutually acknowledge and agree that data shall at all times be disclosed in a manner which protects the Personal Information (as that term is defined by the California Information Privacy Act) of Contractor's Enrollees or prospective Enrollees.

iii) The parties further acknowledge and agree that records which reveal contracted rates paid by Contractor to healthcare providers, as well as any Enrollee cost share, claims or encounter data, cost detail, or information pertaining to Enrollee payment methods, which can be used to determine contracted rates paid by Contractor to healthcare providers shall not at any time be subject to public disclosure and shall at all times be deemed to be exempt from compulsory disclosure under the Public Records Act. Accordingly, Covered California shall take all reasonable steps necessary to ensure such records are not publicly disclosed.

6) Merative is the current HEI Vendor. Merative is the measure developer for select measures used by Covered California. The measure definitions are derived from the Merative Health Insights® solution for these select measures.

5.02.2 Interoperability and Patient Access

Covered California and Contractor recognize that interoperability is critical to improved data exchange which in turn is foundational to providing less fragmented, more coordinated care. Data interoperability, as well as Enrollee and provider access to health records, will also give Enrollees greater control of their health information to support self-management. To support data interoperability, Contractor must:

1) Implement and maintain a secure, standards-based Patient Access API consistent with the existing Centers for Medicare & Medicaid (CMS) Interoperability & Patient Access final rule (CMS-9115-F) and any technical updates in the same time and manner imposed on QHP issuers operating in the Federally Facilitated Marketplaces pursuant to 45 C.F.R. §§ 156.221, 156.222, 156.223. Contractor must report:

    a) The number and percent of patients accessing their Patient Access Application Programming Interface (API).

2) Enhance QHP Issuer information services for Covered California Enrollees consistent with the existing CMS Interoperability and Patient Access final rule (CMS-9115-F) and any technical updates in the same time and manner imposed on QHP issuers operating in the Federally Facilitated Marketplaces pursuant to 45 C.F.R. §§ 156.221, 156.222, 156.223 that requires QHP Issuer participation in payer-to-payer data exchange and consumer education. Contractor must:

    a) Participate in payer-to-payer data exchange at enrollment; and

    b) Educate Covered California Enrollees about opting in to authorize data transfers from their prior health plan to their new health plan.

5.02.3 Data Exchange

Covered California and Contractor recognize that data sharing between patients, providers, hospitals, and payers is a critical quality of care driver. Efficient data sharing decreases healthcare costs, reduces paperwork, improves outcomes, and gives patients more control over their healthcare. Covered California and Contractor agree these goals are achievable only if providers, hospitals, and payers make patient data available and accessible in accordance with the California Health and Human Services Data Exchange Framework (DxF), Data Sharing Agreement (DSA), and shared Policies and Procedures (P&Ps). Covered California and Contractor recognize that Qualified Health Information Organizations (QHIOs) are DxF designated intermediaries that can assist DxF Participants to meet the requirements of the DSA. Contractor must:

1) Execute the DSA as required by Health and Safety Code section 130290.

2) Participate in at least one QHIO, that will share data to support quality measurement and operations purposes and report on its use of that QHIO's services and functions to support the following activities:

a) Contractor's DSA obligations set forth in the DxF P&Ps, including sharing data that Contractor is required to provide access to or exchange under the Data Elements to Be Exchanged P&P.

b) Request, receive, and use information from providers, hospitals, and other DxF Participants as needed by Contractor to support population health management, clinical care, and coordination initiatives for its Covered California Enrollees. These include the Quality Transformation Initiative, Healthcare Evidence Initiative, and Quality Rating System.

c) Enhance demographic and social risk factor data capture to improve health equity and access.

d) Monitor network hospitals' compliance with the requirement under the Technical Requirements for Exchange P&P.

3) Send Notification of Admit, Discharge, and Transfer (ADT) Events when requested by a DxF Participant for Covered California Enrollees. As requested by Covered California, Contractor must report:

    a) A list of network hospitals by region, including psychiatric hospitals and critical access hospitals, that have not sent requested Notification of ADT Events to at least one QHIO.

    b) For the above list, a description of whether and how these hospitals are sending Notification of ADT Events using methods that are acceptable to all requesting DxF Participants, as required by the Technical Requirements for Exchange P&P.

4) Unless prohibited by law, share information on Covered California Enrollees with primary care practices using standard file formats for assigned and selected members monthly. This benefits the primary care practices by supporting improvement on their quality measure performance, identifying and managing key populations to improve specific outcomes, and supporting partnership between practices and QHP Issuers on high risk and high cost populations.

    a) Data types to share include: Member enrollment/eligibility file, medical claims, behavioral health claims, pharmacy claims (no cost included in claims file), ADT feeds when available, and member assessment and care management data collected by the plan.

5.02.4 Data Aggregation

Covered California and Contractor recognize that aggregating data across purchasers, payers, and providers to more accurately understand the performance of providers that have contracts with multiple QHP Issuers can improve performance, contracting, and public reporting. To support data aggregation, Contractor must:

1) Submit all necessary data, including supplemental clinical data, to IHA and participate in the IHA Align. Measure. Perform (AMP) program and the IHA California Regional Healthcare Cost & Quality Atlas. Contractor must report AMP and Atlas performance results, sourced from IHA to Covered California or allow IHA to submit Contractor's performance results to Covered California on Contractor's behalf.

ARTICLE 6 - CERTIFICATION, ACCREDITATION, AND REGULATION

Covered California seeks to align with the standard measures and annual benchmarks for equity and quality in healthcare delivery established by the Department of Managed Health Care as required by Health and Safety Code section 1399.871. This furthers Covered California's goal to establish a common standard of core health plan functions across all QHP Issuers. Using a common standard will allow Covered California to phase in higher standards aimed at improving Enrollee outcomes that are aligned with a single health plan accreditation process and enhance coordinated improvement actions.

6.01 QHP Accreditation

6.01.1 NCQA Health Plan Accreditation

Contractor must obtain and maintain current NCQA health plan accreditation for its Covered California membership throughout the term of the Agreement. Contractor shall authorize NCQA to provide information and data to Covered California relating to Contractor's accreditation, including the NCQA submissions and audit results, and other data and information maintained by its accrediting agency as required by 45 C.F.R. § 156.275.

Contractor shall submit evidence of NCQA health plan accreditation to Covered California, annually at the end of Open Enrollment, if requested.

6.01.2 Accreditation Review

Contractor shall notify Covered California of the date of any accreditation review scheduled during the term of this Agreement and the results of such review.

Upon completion of any health plan accreditation review conducted during the term of this Agreement, Contractor shall submit to Covered California a copy of the assessment report within thirty (30) Days of receiving the report.

6.01.3 Changes in Accreditation Status

If Contractor receives any status other than Accredited in any category, including, Under Corrective Action, Scheduled, Accredited-Interim, Accredited-Provisional, Expired, In-Process, and Denied, loses an accreditation, or fails to maintain a current and up to date accreditation, Contractor shall:

1) Notify Covered California within ten (10) business days of such status change. Contractor must implement strategies to address Contractor's status to achieve a level of Accredited or to reinstate accreditation.

2) Submit to Covered California any Corrective Action Plan (CAP) issued by NCQA that it is subject to, regardless of whether Contractor's accreditation status has changed, within thirty (30) days of receiving the CAP. Contractor shall submit to Covered California any relevant updates to the CAP and progress, such as documentation and final rulings associated with the CAP.

3) Following the initial submission of the CAP, submit a written report to Covered California, when requested, but no less than quarterly, regarding the status and, if applicable, progress of the accreditation reinstatement. Contractor shall request a follow-up review by the accreditation entity no later than twelve (12) months after loss of accreditation and submit a copy of the follow-up assessment report to Covered California within thirty (30) Days of receipt, if applicable.

4) Proceed with any pre-NCQA Accreditation application submission steps to become newly accredited or re-accredited by NCQA.

5) Coordinate improvement efforts and the CAP, as applicable, with any improvement efforts and corrective action plan(s) imposed by the Department of Managed Health Care pursuant to Health and Safety Code, § 1399.872.

6.01.4 Disciplinary and Enforcement Actions

1) In the event Contractor's overall accreditation is suspended, revoked, or otherwise terminated, or in the event Contractor has undergone review prior to the expiration of its current accreditation and reaccreditation is suspended, revoked, or not granted at the time of expiration, Covered California reserves the right to terminate this Agreement, decertify Contractor's QHPs, or suspend enrollment in Contractor's QHPs, to ensure Covered California is in compliance with the federal requirement that all participating issuers maintain a current approved accreditation pursuant to 45 C.F.R. § 156.275(a).

2) Upon request by Covered California, Contractor will identify all health plan certification or accreditation programs undertaken, including any failed accreditation or certifications, and will also provide the full written report of such certification or accreditation undertakings to Covered California.

In this 2026-2028 QHP Issuer Contract, Covered California will continue to leverage the Quality Transformation Initiative as the primary financial incentive for quality and health equity performance and improvement. This Attachment 2 – Performance Standards with Penalties specifies performance standards in the areas of health disparities, collaboration across QHP Issuers and with community, data quality and completeness, oral health, and primary care utilization that are critical to Covered California meeting its mission.

The total amount at risk for Contractor's failure to meet the Performance Standards is equal to 0.2% of the total Gross Premium for each applicable Plan Year (At-Risk Amount). The amount at risk for each Performance Standard is a percent of the total At-Risk Amount for each Plan Year. Penalties will be determined on an annual basis at the end of each Calendar Year, based on Contractor's final year-end data for each Performance Standard. Where applicable, performance is assessed for each product (HMO, PPO, EPO) Contractor offers. Penalties are assessed by product for Contractors with multiple products. Covered California shall specify when the At-Risk Amount or the performance requirements differ by product.

This table represents a summary of the Performance Standards with Penalties which are detailed further in this Attachment:

Performance Standards with Penalties		**Percent of At-Risk Amount 2026-2028**
Health Disparities	1. Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification	10%
	2. Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken and Written Language	10%
Collaboration	3. Collaboration Across QHP Issuers and with Community	10%
Data	4. Healthcare Evidence Initiative (HEI) Data	40%
Oral Health	5. Pediatric Oral Evaluation, Dental Services (OEV-CH-A) (NQF #2517)	5%
	6. Pediatric Topical Fluoride for Children, Dental Services (TFL-CH-A) (NQF #3700)	5%
Utilization and Primary Care	7. Utilization and Primary Care: Overall Engagement with Members	10%
	8. Utilization and Primary Care: Monitoring Continuity of Care	10%

During the term of this Agreement, Contractor shall meet or exceed the Performance Standards identified in this Attachment. If Contractor recently contracted with Covered California for the first time, Contractor shall meet the Alternate Standard, if specified, for each performance standard during its first two Plan Years contracted with Covered California. Contractor shall be responsible for payment of penalties for Contractor's failure to meet the Performance Standards in accordance with the terms set forth in Article 7 of the Agreement and this Attachment. Contractor shall submit the data required by the Performance Standards by the date specified by Covered California. Some of the data required applies to a window of time. Some of the data represents a point in time. This measurement timing is described in more detail in the sections within this Attachment and further specified in methodology documents distributed for the applicable Measurement Year.

Contractor shall monitor and track its performance each month against the Performance Standards and, as requested, provide Covered California with a detailed Monthly Performance Report in a mutually-agreeable format. Contractor must report on Covered California business only and report Contractor's Enrollees in Covered California for the Individual Exchange separate from Contractor's Enrollees in Covered California for Small Business. The reporting period for each Performance Standard is specified below in the Performance Standards Table. All references to Days shall be calendar days and references to time of day shall be to Pacific Standard Time.

If Contractor fails to meet a Performance Standard reported in any calendar month (whether or not the failure is excused), Covered California may request and Contractor shall (a) investigate and report on the root cause of the problem; (b) develop a corrective action plan (where applicable); (c) to the extent within Contractor's control, remedy the cause of the performance failure and resume meeting the affected Performance Standards; (d) implement and notify Covered California of measures taken by Contractor to prevent recurrences, if the performance failure is otherwise likely to recur; and (e) make written recommendations to Covered California for improvements in Contractor's procedures.

When the results of the Performance Standards are calculated, Covered California will provide Contractor with a Final Contractor Performance Standard Evaluation Report, along with an invoice. Contractor shall remit payment either to Covered California within thirty (30) Days of receiving the Final Contractor Performance Standard Evaluation Report and invoice, or, if directed by Covered California, to an alternative entity that Covered California determines is able to support improvement on Performance Standards and Contractor's quality performance identified on the invoice.

If Contractor does not agree with the Final Contractor Performance Standard Evaluation Report, Contractor may dispute the Report in writing within thirty (30) Days of receipt of that Report. The written notification of dispute shall provide a detailed explanation of the basis for the dispute. Covered California shall review and provide a written response to

Contractor's dispute within thirty (30) Days of receipt of Contractor's notification of dispute. If Contractor still disputes the findings of Covered California, Contractor may pursue additional remedies in accordance with Section 13.1 of the Agreement.

Contractor shall not be responsible for any failure to meet a Performance Standard if and to the extent that the failure is excused pursuant to Section 13.7 of the Agreement (Force Majeure), or the parties agree that the lack of compliance is due to Covered California's failure to properly or timely perform (or cause to be properly or timely performed) any responsibility, duty, or other obligation under this Agreement, provided that Contractor timely notifies Covered California of the problem and uses commercially reasonable efforts to perform and meet the Performance Standards notwithstanding Covered California's failure to perform or delay in performing.

If Contractor wishes to avail itself of one of these exceptions, Contractor must notify Covered California in its response to the performance report identifying the failure to meet such Performance Standard. This response must include: (a) the identity of the Performance Standard that is subject to the exception, and (b) the circumstances that gave rise to the exception in sufficient detail to permit Covered California to evaluate whether Contractor's claim of exception is valid.

The parties may adjust, suspend, or add Performance Standards from time to time, upon written agreement of the parties, without an amendment to this contract.

Covered California and Contractor shall work together to periodically review and adjust the specific measures consistent with any applicable Federal regulations.

Performance Standards with Penalties

Definitions for Performance Standards: 1 – 8

Measurement Year: The Calendar Year that the activity being assessed is performed.
Reporting Year: The Calendar Year that performance data is reported to Covered California.
Assessment Year: The Calendar Year that performance data is evaluated, and Measurement Year performance level is determined.

When used to assess HEI Data submissions, the following definitions shall apply:
Full and Regular: All files, records, and portions of expected files for the intended period are present; formats match those in specifications or otherwise agreed to by Covered California, its HEI Vendor, and the data supplier; and data volumes, counts, and sums approximate the data supplier's historical patterns, or their deviation can be explained and justified by business circumstances identified by the data supplier.
Incomplete: A file or part of a file is missing, or critical data elements are not provided as per assessment methodology.
Irregular: Unexpected file or data element formatting, or record volumes or data element counts or sums deviate significantly from historical submission patterns for the data supplier.
Late: Contractor does not submit monthly HEI submission pursuant to the deadlines in the 2026-2028 HEI Data Submission Schedule.
Non-Usable: HEI Vendor cannot successfully include submitted HEI data in its database build or HEI Vendor's or Covered California's analysts determine that critical components of the submitted data cannot be used or relied upon in subsequent analytic work.
Establish a Baseline: Requested data is submitted to Covered California at a time and in a format specified, allowing Covered California to calculate a performance benchmark of a value greater than zero for comparison in future Assessment Years.
Baseline Rate: The performance benchmark established by Covered California using Contractor's data submissions for the applicable Performance Standard.

Performance Standards with Penalties
Performance Standard 1
1. Reducing Health Disparities: Demographic Data Collection – Enrollee Race and Ethnicity Self-Identification – Attachment 1, Article 1.01
a) Contractor must collect Enrollee self-reported race and ethnicity data for at least eighty percent (80%) of its Covered California Enrollees during the Plan Year. Contractor must demonstrate compliance by including valid, acceptable, and reasonable race and ethnicity attributes for at least 80% of Enrollees in its Healthcare Evidence Initiative (HEI) data submissions. Contractor must meet or exceed the required threshold at least once when assessed at two points in time in the Assessment Year. See separate methodology document for lists of valid and acceptable standard values and reasonableness criteria.
Measurement Years 2026, 2027, 2028 Contractor does not meet or exceed the 80% target for self-reported racial and ethnic data for Enrollees: **10% penalty** Contractor meets or exceeds the 80% target for self-reported racial and ethnic data for Enrollees: **no penalty**
b) Alternate Standard: Contractor must collect self-reported race and ethnicity data during the first Measurement Year it is contracted with Covered California and include valid race and ethnicity attributes for its Enrollees in HEI data submissions. Contractor must collect Enrollee self-reported race and ethnicity data for at least eighty percent (80%) of its Covered California Enrollees during the second Measurement Year it is contracted with Covered California. Contractor must demonstrate compliance by including valid, acceptable, and reasonable race and ethnicity attributes for at least 80% of Enrollees in its HEI data submissions.

Contractor must meet or exceed the required threshold at least once when assessed at two points in time in the Assessment Year. See separate methodology document for lists of valid standard values and reasonableness criteria.

Performance Standards with Penalties
Performance Standard 2
2. Reducing Health Disparities: Demographic Data Collection – Enrollee Spoken or Written Language – Attachment 1, Article 1.01
a) Contractor must include valid, acceptable, and reasonable spoken or written language attributes for Enrollees in its HEI submissions. Contractor's data submissions must demonstrate compliance at least once when assessed at two points in time in the Assessment Year. See separate methodology document for lists of valid and acceptable standard values and reasonableness criteria.
Measurement Years 2026, 2027, 2028 Contractor does not include valid, acceptable, and reasonable spoken or written language attributes for Enrollees in its HEI submissions: **10% penalty** Contractor includes valid, acceptable, and reasonable spoken or written language attributes for Enrollees in its HEI submissions: **no penalty**
b) Alternate Standard: Contractor must collect spoken and written language data during the first Measurement Year it is contracted with Covered California, and include valid spoken or written language attributes for its Enrollees in HEI data submissions. Contractor must collect spoken and written language data during the second Measurement Year it is contracted with Covered California, and include valid, acceptable, and reasonable spoken or written data attributes for its Enrollees. Contractor's data submissions must demonstrate compliance at least once when assessed at two points in time in the Assessment Year.

See separate methodology document for lists of valid standard values and reasonableness criteria.

Performance Standards with Penalties
Performance Standard 3
3. Collaboration Across QHP Issuers and With Community – Attachment 1, Articles 1.03, 2.01.3, 2.03.4, 3.05.2, 4.02.2, 4.02.4, 4.02.6
a) Contractor must host or attend QHP Issuer collaboration and community engagement activities approved by Covered California in at least six of the following seven required focus areas during the Plan Year: 1. Disparities Reduction 2. Access to Behavioral Health Services 3. Substance Use Disorders 4. Use of Generative Artificial Intelligence 5. Payments to Support Networks Based on Value 6. Hospital Quality, Value, and Safety 7. Comprehensive Pregnancy and Postpartum Care Contractor hosted collaborative QHP Issuer and community engagement activities must meet criteria specified by Covered California and must be submitted to and approved by Covered California in advance to count toward this requirement. Additionally, unless otherwise specified in Attachment 1, an event that addresses one or more of the focus areas that Covered California's Health Equity and Quality Transformation Division determines meets specified criteria, including, hosted learning sessions, working groups, and forums and roundtables, may count toward this requirement. Contractor must meet threshold for required activities which will be assessed once in the Assessment Year. See separate methodology document for activity submission and evaluation process.
Measurement Years 2026, 2027, 2028: Contractor hosts or attends QHP Issuer collaboration and community engagement activities approved by Covered California in fewer than six of the seven focus areas: **10% penalty**

Contractor hosts or attends QHP Issuer collaboration and community engagement activities approved by Covered California in at least six of the seven focus areas: **no penalty**
b) Alternate Standard: Contractor must host or attend Covered California specified events and collaborative QHP Issuer, community engagements, and qualifying implementation activities to meet Attachment 1 requirements approved by Covered California in at least six out of the following seven required focus areas during the Plan Year: 1. Disparities Reduction 2. Access to Behavioral Health Services 3. Substance Use Disorders 4. Use of Generative Artificial Intelligence 5. Payments to Support Networks Based on Value 6. Hospital Quality, Value, and Safety 7. Comprehensive Pregnancy and Postpartum Care Contractor hosted collaborative QHP Issuer and community engagement activities must meet criteria specified by Covered California and must be submitted to and approved by Covered California in advance to count toward this requirement. Additionally, unless otherwise specified in Attachment 1, an event that addresses one or more of the focus areas that Covered California's Health Equity and Quality Transformation Division determines meets specified criteria, including, hosted learning sessions, working groups, and forums and roundtables, may count toward this requirement. Contractor must meet threshold for required activities which will be assessed once in the Assessment Year. See separate methodology document for activity submission and evaluation process. Contractor does not host or attend activities in six out of seven of the focus areas: **10% penalty** Contractor hosts or attends activities in six out of seven of the focus areas: **no penalty**

Performance Standards with Penalties
Performance Standard 4
4. Data Submission specific to HEI in Attachment 1, Article 5.02.1
a) Contractor must complete Full and Regular submissions of data according to the standards outlined in Attachment 1, Article 5.02.1 and Attachment 1, Article 1.02.1. Contractor must meet threshold for data submissions for each calendar month during the Measurement Year.
Measurement Years 2026, 2027, 2028 Incomplete, Late, or Non-useable submission of HEI data: **40% penalty** Full and Regular submission of HEI data: **no penalty**
b) Alternate Standard: Contractor must submit data according to the standards outlined in Attachment 1, Article 5.02.1 and Attachment 1, Article 1.02.1, and participate in data quality meetings with Covered California staff and Merative representatives during the first Measurement Year it is contracted with Covered California. Contractor must complete Full and Regular submissions of data according to the standards outlined in Attachment 1, Article 5.02.1 and Attachment 1, Article 1.02.1 during the second Measurement Year it is contracted with Covered California. Contractor does not submit Full and Regular data in the second Measurement Year it is contracted with Covered California. **40% penalty** Contractor submits Full and Regular data in the second Measurement Year it is contracted with Covered California. **no penalty**

Performance Standards with Penalties		
Performance Standard 5		
5. Pediatric Oral Evaluation, Dental Services (OEV-CH-A) (NQF #2517)		
a) Contractor shall Establish a Baseline and meet or exceed the specified performance standard for the Pediatric Oral Evaluation, Dental Services (OEV-CH-A) (NQF #2517) measure. As specified, Contractor's data submissions must Establish a Baseline in the Assessment Year or meet or exceed the required increase over the Baseline Rate or performance threshold in the Assessment Year. If Contractor meets a 70% performance threshold for this metric, Contractor's performance will not be subject to financial penalties for failing to show annual improvement. Performance at or above the 70% threshold will require reporting and monitoring but will not be subject to penalties for failing to meet the annual improvement target.		
Measurement Year 2026 Contractor does not Establish a Baseline: **5% penalty** Contractor Establishes a Baseline: **no penalty**	Measurement Year 2027 Contractor demonstrates an increase of less than 10% over the Baseline Rate: **5% penalty** Contractor demonstrates a rate of 70% or greater or an increase of 10% or more over the Baseline Rate: **no penalty**	Measurement Year 2028 Contractor demonstrates an increase of less than 15% over the Baseline Rate: **5% penalty** Contractor demonstrates a rate of 70% or greater or an increase of 15% or more over the Baseline Rate: **no penalty**
b) Alternate Standard: Contractor must submit pediatric dental data during the first Measurement Year it is contracted with Covered California. Contractor must Establish a Baseline in the second Measurement Year it is contracted with Covered California.		

Contractor must demonstrate compliance with data submissions in the first Assessment Year it is contracted with Covered California.

As required, Contractor's data submissions must Establish a Baseline in the Assessment Year.

Contractor does not Establish a Baseline during the second Measurement Year it is contracted with Covered California: **5% penalty**.

Contractor Establishes a Baseline during the second Measurement Year it is contracted with Covered California: **no penalty.**

Performance Standards with Penalties		
Performance Standard 6		
6. Pediatric Topical Fluoride for Children, Dental Services (TFL-CH-A) (NQF #3700)		
a) Contractor shall Establish a Baseline and meet or exceed the specified performance standard for the Pediatric Topical Fluoride for Children, Dental Services (TFL-CH-A) (NQF #3700) measure. As specified, Contractor's data submissions must Establish a Baseline in the Assessment Year or meet or exceed the required increase over the Baseline Rate or performance threshold in the Assessment Year. If Contractor meets a 70% performance threshold for this metric, Contractor's performance will not be subject to financial penalties for failing to show annual improvement. Performance at or above the 70% threshold will require reporting and monitoring but will not be subject to penalties for failing to meet the annual improvement target.		
Measurement Year 2026 Contractor does not Establish a Baseline: **5% penalty** Contractor Establishes a Baseline: **no penalty**	Measurement Year 2027 Contractor demonstrates an increase of less than 10% over the Baseline Rate: **5% penalty** Contractor demonstrates a rate of 70% or greater or an increase of 10% or more over the Baseline Rate: **no penalty**	Measurement Year 2028 Contractor demonstrates an increase of less than 15% over the Baseline Rate: **5% penalty** Contractor demonstrates a rate of 70% or greater or an increase of 15% or more over the Baseline Rate: **no penalty**
b) Alternate Standard: Contractor must submit pediatric dental data during the first Measurement Year it is contracted with Covered California.		

Contractor must Establish a Baseline in the second Measurement Year it is contracted with Covered California.

As required, Contractor's data submissions must Establish a Baseline in the Assessment Year.

Contractor does not Establish a Baseline during the second Measurement Year it is contracted with Covered California: **5% penalty.**

Contractor Establishes a Baseline during the second Measurement Year it is contracted with Covered California: **no penalty.**

Performance Standards with Penalties		
Performance Standard 7		
7. Utilization and Primary Care: Overall Engagement with Members - Attachment 1, Article 4.01.2		
a) Contractor must Establish a Baseline and increase the portion of Covered California Enrollees with continuous enrollment in Contractor's QHP throughout the prior Plan Year with at least one medical or prescription drug claim each Plan Year. As specified, Contractor's data submissions must Establish a Baseline in the Assessment Year, or meet or exceed the required increase over the Baseline Rate or threshold in the Assessment Year.		
Measurement Year 2026	Measurement Year 2027	Measurement Year 2028
Contractor does not Establish a Baseline: **10% penalty** Contractor Establishes a Baseline: **no penalty**	Contractor demonstrates an increase in utilization of less than 5% over the Baseline Rate: **10% penalty** Contractor demonstrates (a) an increase of 5% or more over the Baseline Rate or (b) a Baseline Rate of over 80%: **no penalty**	Contractor demonstrates an increase in utilization of less than 10% over the Baseline Rate: **10% penalty** Contractor demonstrates (a) an increase of 10% or more over the Baseline Rate or (b) a Baseline Rate of over 80%: **no penalty**
b) Alternate Standard: Contractor must monitor the portion of its Covered California Enrollees with at least one medical or prescription drug claim during the first year it is contracted with Covered California. In the second Measurement Year it is contracted with Covered California, Contractor must Establish a Baseline for Covered California Enrollees with continuous enrollment in Contractor's QHP throughout the prior Plan Year with at least one medical or prescription drug claim in the Plan Year. As required, Contractor's data submissions must Establish a Baseline in the Assessment Year.		

Contractor does not Establish a Baseline during the second Measurement Year it is contracted with Covered California: **10% penalty.**

Contractor Establishes a Baseline during the second Measurement Year it is contracted with Covered California: **no penalty.**

Performance Standards with Penalties		
Performance Standard 8		
8. Utilization and Primary Care: Monitoring Continuity of Care - Attachment 1, Article 4.01.2		
a) Contractor must monitor the continuity of care index for Covered California Enrollees and Establish a Baseline. Contractor must plan and implement efforts to improve its continuity of care index if it does not achieve a continuity of care index of at least 0.7 for at least 60% of Enrollees. The continuity of care index measures Covered California Enrollees with continuous enrollment in Contractor's QHP throughout the prior Plan Year with two or more primary care visits with any primary care clinician during that Plan Year. As specified, Contractor's data submissions must Establish a Baseline and demonstrate compliance in the Assessment Year, or meet or exceed the required increase over the Baseline Rate or threshold in the Assessment Year.		
Measurement Year 2026	Measurement Year 2027	Measurement Year 2028
Contractor Establishes a Baseline of less than 0.7 for at least 60% of Enrollees and does not report to Covered California on planned improvement activities: **10% penalty** Contractor Establishes a Baseline and (a) reports to Covered California on planned improvement activities or (b) achieves a continuity of care index of at least 0.7 for at least 60% of Enrollees: **no penalty**	Contractor has a Baseline Rate of less than 0.7 for at least 60% of Enrollees and does not implement and report to Covered California on continuity of care improvement activities: **10% penalty.** Contractor (a) implements and reports to Covered California on continuity of care improvement activities or (b) achieved a continuity of care index of at least 0.7 for at least 60% of Enrollees: **no penalty.**	Contractor has a Baseline Rate of less than 0.7 for at least 60% of Enrollees and demonstrates an increase in continuity of care of less than 10% over the Baseline Rate: **10% penalty** Contractor demonstrates (a) an increase of 10% or more over the Baseline Rate or (b) a Baseline Rate of at least 0.7 for at least 60% of Enrollees: **no penalty**

b) Alternate Standard: Contractor must monitor continuity of care for its Covered California Enrollees during the first Measurement Year it is contracted with Covered California.

As required, Contractor's data submissions must Establish a Baseline and demonstrate compliance in the Assessment Year.

Contractor Establishes a Baseline of less than 0.7 for at least 60% of Enrollees and does not report to Covered California on planned improvement activities during the second Measurement Year it is contracted with Covered California: **10% penalty**

Contractor Establishes a Baseline and (a) reports to Covered California on planned improvement activities or (b) achieves a continuity of care index of at least 0.7 for at least 60% of Enrollees during the second Measurement Year it is contracted with Covered California. **no penalty**

During the term of this Agreement, Contractor shall meet or exceed the Performance Standards identified in this Attachment. Contractor shall submit the data required by the Performance Standards by the date specified by Covered California. Some of the data required applies to a window of time. Some of the data represents a point in time. This measurement timing is described in more detail in the sections within this Attachment.

Contractor shall monitor and track its performance each month against the Performance Standards and provide Covered California with a detailed Monthly Performance Report in a mutually-agreeable format. Contractor must report on Covered California business only and report Contractor's Enrollees in Covered California for the Individual Exchange separate from Contractor's Enrollees in Covered California for Small Business. Except as otherwise specified below in the Performance Standards Table, the reporting period for each Performance Standard shall be one calendar month. All references to Days shall be calendar days and references to time of day shall be to Pacific Standard Time.

If Contractor fails to meet any Performance Standard in any calendar month (whether or not the failure is excused), Covered California may request and Contractor shall (a) investigate and report on the root cause of the problem; (b) develop a corrective action plan (where applicable); (c) to the extent within Contractor's control, remedy the cause of the performance failure and resume meeting the affected Performance Standards; (d) implement and notify Covered California of measures taken by Contractor to prevent recurrences, if the performance failure is otherwise likely to recur; and (e) make written recommendations to Covered California for improvements in Contractor's procedures.

Performance scores will be determined on an annual basis at the end of each Calendar Year, based on Contractor's final year-end data for each Performance Standard. Where applicable, performance is assessed for each product (HMO, PPO, EPO) the Contractor offers.

Covered California will provide the Contractor an Initial Contractor Performance Standard Evaluation Report, covering preliminary year end data available, which Covered California will send to Contractor for review no later than February 28th of the following Calendar Year.

When the results of the Performance Standards are calculated, Covered California will provide Contractor with a Final Contractor Performance Standard Evaluation Report.

If Contractor does not agree with either the Initial or Final Performance Standard Evaluation Report, Contractor may dispute the Report in writing within thirty (30) Days of receipt of that Report. The written notification of dispute shall provide a detailed explanation of the basis for the dispute. Covered California shall review and provide a written response to Contractor's dispute within thirty (30) Days of receipt of Contractor's notification of dispute. If the Contractor still

disputes the findings of Covered California, Contractor may pursue additional remedies in accordance with Section 13.1 of the Agreement. The Final Contractor Performance Standard Evaluation Report will be posted publicly on Covered California's website.

Contractor shall not be responsible for any failure to meet a Performance Standard if and to the extent that the failure is excused pursuant to Section 13.7 of the Agreement (Force Majeure), or the parties agree that the lack of compliance is due to Covered California's failure to properly or timely perform (or cause to be properly or timely performed) any responsibility, duty, or other obligation under this Agreement, provided that Contractor timely notifies Covered California of the problem and uses commercially reasonable efforts to perform and meet the Performance Standards notwithstanding Covered California's failure to perform or delay in performing.

If Contractor wishes to avail itself of one of these exceptions, Contractor must notify Covered California in its response to the performance report identifying the failure to meet such Performance Standard. This response must include: (a) the identity of the Performance Standard that is subject to the exception, and (b) the circumstances that gave rise to the exception in sufficient detail to permit Covered California to evaluate whether Contractor's claim of exception is valid. Notwithstanding anything to the contrary herein, in no event shall any failure to meet a Customer Satisfaction Performance Standard fall within an exception.

The Parties may adjust, suspend, or add Performance Standards from time to time, upon written agreement of the parties, without an amendment to this Agreement.

Performance Standards and Expectations				
Covered California will create an Annual Report of Performance Standards and Expectations, displaying Contractor's final Plan Year 2027 performance in Performance Standards and Expectations, Standards 1.1 - 1.11, to be posted publicly on Covered California's website. Covered California will continue public reporting of its service level performance metrics.				
Performance Standard		**Performance Requirements**	**Contractor Must Submit Data by the 10th of the following month**	**Measurement Period**
1.1	**Abandonment Rate**	Expectation: No more than 3% of incoming calls abandoned in a calendar month. Divide number of abandoned calls by the number of calls offered to a phone representative.	X	January 1, 2027-December 31, 2027
1.2	**Service Level**	Expectation: 80% of calls answered in 30 seconds or less.	X	January 1, 2027-December 31, 2027
1.3	**Grievance Resolution**	Expectation: 99% of Covered California Enrollee grievances resolved within thirty (30) Days of initial receipt. Monthly reporting must include the number and percentage of grievances resolved within thirty (30) Days of receipt. Quarterly reporting must include the following details: The number of grievances reported by the following categories – Quality of Care, Quality of Service, Access and Availability, Benefit Coverage, Medical Necessity, and Other.	X	January 1, 2027-December 31, 2027

Performance Standards and Expectations				
Covered California will create an Annual Report of Performance Standards and Expectations, displaying Contractor's final Plan Year 2027 performance in Performance Standards and Expectations, Standards 1.1 - 1.11, to be posted publicly on Covered California's website. Covered California will continue public reporting of its service level performance metrics.				
Performance Standard		**Performance Requirements**	**Contractor Must Submit Data by the 10th of the following month**	**Measurement Period**
1.4	**Covered California member Email or Written Inquiries Answered and Completed**	Expectation: 90% of Covered California member email or written inquiries not relating to Urgent Access to Care issues answered and completed within fifteen (15) business days of the inquiry.	X	January 1, 2027-December 31, 2027
1.5	**ID Card Processing Time**	Expectation: 99% of ID cards issued within ten (10) business days of receiving complete and accurate enrollment information and binder payment for a specific consumer(s).	X	January 1, 2027-December 31, 2027
1.6	**Implementation of Appeals Decisions**	Expectation: 90% of Administrative Law Judge decisions will be implemented within ten (10) Days of Contractor's receipt of all necessary data elements from Covered California required to implement the appeals decision.		January 1, 2027-December 31, 2027

Performance Standards and Expectations				
Covered California will create an Annual Report of Performance Standards and Expectations, displaying Contractor's final Plan Year 2027 performance in Performance Standards and Expectations, Standards 1.1 - 1.11, to be posted publicly on Covered California's website. Covered California will continue public reporting of its service level performance metrics.				
Performance Standard		**Performance Requirements**	**Contractor Must Submit Data by the 10th of the following month**	**Measurement Period**
1.7	**834 Processing**	Expectation: Covered California will receive a TA1 and 999 file within three (3) business days of receipt of the 834 transaction 95% of the time.		Plan Year 2027 834 transactions will begin with renewals. October 1, 2026 – September 30, 2028
1.8	**834 Generation – Effectuation and Cancellation Transactions**	Expectation: Covered California will successfully receive and process effectuation, and cancellation 834 transactions within sixty (60) Days from either the coverage effective date or transaction timestamp, whichever is later 95% of the time.		Plan Year 2027 834 transactions will begin with renewals. October 1, 2026 – September 30, 2028
1.9	**834 Generation – Termination Transactions**	Expectation: Covered California will receive termination 834 transactions within ten (10) Days of the grace period expiration 95% of the time.		Plan Year 2027 834 transactions will begin with renewals. October 1, 2026 – September 30, 2028

Performance Standards and Expectations				
Covered California will create an Annual Report of Performance Standards and Expectations, displaying Contractor's final Plan Year 2027 performance in Performance Standards and Expectations, Standards 1.1 - 1.11, to be posted publicly on Covered California's website. Covered California will continue public reporting of its service level performance metrics.				
Performance Standard		**Performance Requirements**	**Contractor Must Submit Data by the 10th of the following month**	**Measurement Period**
1.10	**Reconciliation Process**	Expectation: Covered California shall receive a comparison reconciliation extract in accordance with the file validations and resolution timelines, as mutually agreed upon in the Reconciliation Process Guide (Extranet, Data Home, Contractor's folder) 90% of the time for accuracy and timeliness.		January 1, 2027-December 31, 2027
1.11	**Provider Directory Data Submission**	Expectation: Full and regular submission of provider data according to the standards outlined in the Performance Standard contract specific to contract Section 4.4.4. Submissions occur every month pursuant to the submission schedule (Extranet, Plan Home, Resources, Provider Directory Resources, Covered California Provider Data Submission Schedule_Current Year).		January 1, 2027-December 31, 2027

Performance Standards and Expectations				
Covered California will create an Annual Report of Performance Standards and Expectations, displaying Contractor's final Plan Year 2027 performance in Performance Standards and Expectations, Standards 1.1 - 1.11, to be posted publicly on Covered California's website. Covered California will continue public reporting of its service level performance metrics.				
Performance Standard		**Performance Requirements**	**Contractor Must Submit Data by the 10th of the following month**	**Measurement Period**
1.12	**Essential Community Providers – Section 4.3.4**	Expectation: 1. Contractor to demonstrate provider contracts that reflect a mix of essential community providers (hospital and non-hospital) reasonably distributed to serve Low-income and Medically Underserved populations. 2. Contractor to demonstrate provider contracts with at least one essential community provider (ECP) hospital in each county, or, in counties with more than one geographic rating region, one ECP hospital in each geographic rating region. 3. Contractor to demonstrate provider contracts with at least fifteen percent (15%) of ECPs providing primary care services in each applicable geographic rating region. 4. Contractor to demonstrate provider contracts with at least fifteen percent (15%) of ECPs providing behavioral health services in each applicable geographic rating region. 5. Or, if Contractor is unable to achieve 3 and 4,		January 1, 2027-December 31, 2027

Performance Standards and Expectations				
Covered California will create an Annual Report of Performance Standards and Expectations, displaying Contractor's final Plan Year 2027 performance in Performance Standards and Expectations, Standards 1.1 - 1.11, to be posted publicly on Covered California's website. Covered California will continue public reporting of its service level performance metrics.				
Performance Standard		**Performance Requirements**	**Contractor Must Submit Data by the 10th of the following month**	**Measurement Period**
		Contractor to demonstrate provider contracts with at least fifteen percent (15%) of 340B non-hospital providers in each applicable geographic rating region and demonstrate increases in Contractor's provider network each Plan Year to achieve these sufficiency requirements. Or meet Alternate Standard Contractor requirements. Refer to Section 4.3.4.		

ATTACHMENT 4 TO COVERED CALIFORNIA 2026-2028 INDIVIDUAL MARKET QHP ISSUER CONTRACT: QUALITY TRANSFORMATION INITIATIVE

Health Insurance Issuers contracting with Covered California to offer Qualified Health Plans (QHPs) are integral to Covered California's ability to achieve its mission of improving the quality, equity, and value of healthcare services available to Covered California Enrollees and all Californians. Covered California and Contractor recognize the value of improving the quality of care provided to Covered California Enrollees and reducing health disparities, as well as the substantial opportunities for improvement in the current quality and equity of care provided. Covered California and Contractor jointly agree to improve quality and reduce health disparities to promote the vision of the Affordable Care Act and meet Covered California Enrollee needs and expectations.

This Quality Transformation Initiative (QTI) is intended to set direct and substantial financial incentives for QHP Issuers to improve the quality of healthcare and to reduce health disparities for Covered California Enrollees and all Californians. Specifically, the QTI focuses on improving care for a small number of clinically important conditions for which there are major opportunities for improvement and good measures in current use. QHP Issuers that fail to meet specified benchmarks will be required to make payments that may be as high as 3.8% of premium. Importantly, Covered California remains committed to aligning the measures tied to substantial financial incentives with other major purchasers, including the California Department of Health Care Services (DHCS), the California Public Employees' Retirement System (CalPERS), and the Centers for Medicare & Medicaid Services' (CMS) Medicare payment programs.

For the QTI Scored Measures tied to financial incentives, performance will be assessed using measure scores on CMS Quality Rating System (QRS) and National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures for each of Contractor's products. Product has the same meaning as that term is used for purposes of calculating the CMS QRS scores. Pursuant to Attachment 1, Contractor must submit the data to determine measure scores by the date and in the manner specified by Covered California.

Contractor's QHPs with a minimum of two years of QRS reportable scores will be subject to the QTI performance requirements, and payments (QTI Payments) may be required depending on QHP performance. Covered California shall direct Contractor to spend QTI Payments on Population Health Investments (PopHIs) as selected by Covered California.

Covered California will determine QTI Payments on an annual basis when measure scores are available. QTI Payments are assessed for each product Contractor offers. Contractor shall not be responsible for any failure to meet the quality levels if and to the

Back to Agenda Back to Item

extent that the failure is excused pursuant to Section 13.7 of the Agreement (Force Majeure). Covered California and Contractor agree that the goal is continuous improvement in both quality and equity, regardless of where the product currently performs compared to national or California performance.

Covered California will use Contractor's measure scores to evaluate and publicly report QHP Issuer performance and the impact on healthcare quality and health disparities reduction in California.

1.01 QTI Scored and Reporting-only Measure Sets

1.01.1 2026 – 2028 QTI Scored Measure Set

For Measurement Years 2026-2028, Covered California has identified five areas of focus for improvement and related scored measures ("QTI Scored Measures," specified below) that will be subject to QTI Payments as detailed in Section 1.03. These measures are nationally endorsed, represent priority quality and equity domains, align with other purchaser measures, and span pediatric and adult Enrollees.

1) For each of its products for Measurement Years 2026-2028, Contractor will be assessed on the following QTI Scored Measures using QRS measure scores. Contractor will be assessed on the measures listed below using benchmarks established pursuant to Section 1.03:

    a) Blood Pressure Control for Patients with Hypertension (BPC-E);

    b) Glycemic Status Assessment for Patients with Diabetes: Glycemic Status (>9.0%) (CBE ID #0575)

    c) Colorectal Cancer Screening (COL-E) (CBE ID #0034)

    d) Childhood Immunization Status (Combo 10) (CIS-E) (CBE ID #0038)

    e) Depression Screening and Follow-Up for Adolescents and Adults (DSF-E) (CBE ID #0418).

2) If data is not available to assess performance on or establish a benchmark for any of the QTI Scored Measures specified in 1) above, Covered California, in its sole discretion, may choose not to assess Contractor's performance on the QTI Scored Measure, or may use the prior measure and benchmark specifications that align with the QTI Scored Measures, using data submitted directly to Covered California pursuant to Section 5.01.1 of Attachment 1 of this Agreement for performance assessment. Prior measures include:

    a) Controlling High Blood Pressure (CBE ID #0018).

    b) Colorectal Cancer Screening (CBE ID #0034).

    c) Childhood Immunization Status (Combo 10) (CBE ID #0038).

3) Covered California will evaluate the QTI Scored Measure Set periodically in collaboration with Contractor, other QHP Issuers, and stakeholders, and may

modify the measures through a contract amendment or for the next contract period.

1.01.2 2026 - 2028 Reporting-only QTI Measures

1) In addition to the QTI Scored Measures, Contractor will report on the following National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measure for Measurement Years 2026-2028 for each of its products:

    a) Pharmacotherapy for Opioid Use Disorder (POD) (CBE ID #3400).

    Covered California intends to include this measure as a QTI Scored Measure in future contract years.

2) Covered California will consider adding additional Reporting-only Measures, including behavioral health measures, through amendments to this Agreement for Plan Year 2027 and 2028.

1.02 Race and Ethnicity Stratification and Methodology

1) Contractor shall stratify QTI Scored Measure results by Race and Ethnicity using member self-reported Race and Ethnicity information, as specified in this Section. Covered California will assess performance based on Contractor's stratified results. For the purposes of this Attachment, the following definitions apply:

    "Stratified Measure" means QTI Scored Measures that Covered California determines meet reliability testing standards by confirming underlying performance variability, specified in 2) below.

    "Eligible Subpopulation" means the following stratified subpopulations, as defined by the federal Office of Management and Budget (OMB) or Centers for Disease Control (CDC) Race and Ethnicity Code Set, with at least 100 members in the denominator: American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Middle Eastern/North African, Native Hawaiian or Other Pacific Islander, and White. Eligible Subpopulation shall also include Multirace, used when an individual reports two or more CDC codes that cross higher OMB concepts.

    "All Other Members Subpopulation" means pooled results from members of the following subpopulations, as defined by OMB or CDC: Other Race, or Unknown, used when an individual has not reported race or ethnicity or where data is missing or inaccurate. The All Other Members Subpopulation shall also

include pooled results from members of subpopulations that would be Eligible Subpopulations but have fewer than 100 identified enrollees in the denominator.

2) For Measurement Years 2026-2028, the following QTI Scored Measures shall be Stratified Measures:

    a) Blood Pressure Control for Patients with Hypertension (BPC-E) or, if assessed, Controlling High Blood Pressure (CBE ID #0018);

    b) Colorectal Cancer Screening (COL-E) (CBE ID #0034), or, if assessed, Colorectal Cancer Screening (CBE ID #0034).

3) Contractor shall be assessed based on QTI Scored Measure performance for all Eligible Subpopulations and the All Other Members Subpopulation, using the benchmarks specified in Section 1.03. If one or more of Contractor's Stratified Measures does not include a sufficient number of Eligible Subpopulations, as determined by Covered California, Covered California may assess performance based on all of Contractor's reported Enrollee population for the measure.

4) As directed by Covered California, Contractor shall use OMB aggregated Race and Ethnicity Concepts for Stratified Measures; or, additional categories that rely on the CDC Race and Ethnicity Code Set to account for updates to these specifications or when more granular race and ethnicity information is necessary in order to accurately place a member's self-identified race and ethnicity within the aggregated OMB concepts.

5) For members that report both Race and Ethnicity and/or multiple Races, Contractor shall include member data in subpopulations as directed by Covered California. An individual member's data will not be duplicated in multiple Eligible Subpopulations or an Eligible Subpopulation and the All-Other Members Subpopulation.

6) Covered California will publicly report Contractor's scores on all Stratified Measures pursuant to Attachment 1, Article 1.02.1.

1.03 Benchmarks and QTI Payments

During the term of this Agreement, Contractor agrees to conduct quality improvement activities to meet or exceed the 66th national percentile for each QTI Scored Measure, including every Eligible Subpopulation and the All Other Members Subpopulation for Stratified Measures. If Contractor does not meet or exceed the 66th national percentile for one or more QTI Scored Measures, Contractor agrees to contribute QTI Payments as described below. Making QTI

Payments does not absolve Contractor of its responsibility to engage in quality improvement activities to meet or exceed required QTI benchmarks and engage in other innovative quality improvement strategies.

1) Covered California will establish benchmarks using the 25th and 66th QRS national percentile benchmarks for each QTI Scored Measure as follows:

    a) Using the QRS national percentiles for the QTI Scored Measure for Measurement Year 2025, if calculated and published by CMS.

    b) Using the QRS measure score Proof Sheets for Measurement Year 2025 to calculate the national percentiles for the QTI Scored Measures, if the national percentiles are not calculated and published by CMS for Measurement Year 2025.

    c) Using the prior version of the QRS measure, which has available national percentile benchmarks, if the national percentiles for the QTI Scored Measures are not calculated and published by CMS and the CMS Measurement Year 2025 Proof Sheet data is not available to establish a benchmark for the QTI Scored Measure.

    d) Covered California may update the established benchmark using the methods specified in i) and ii) below

        i) If Covered California establishes a benchmark pursuant to (b), it may replace the benchmark established using Proof Sheet data with the benchmark established by measure score results published by CMS the first Measurement Year the results are published.

        ii) If Covered California establishes a benchmark pursuant to (c), it may replace the prior measure benchmark with the QTI Scored Measure benchmark the first Measurement Year it is calculated and published by CMS, or the first Measurement Year data is available to calculate the benchmark using Proof Sheet data.

2) For each year of the Agreement, Covered California will compare Contractor's QTI Scored Measure, including scores for each Eligible Subpopulation and the All Other Members Subpopulation for Stratified Measures, for each product, against the benchmark to determine Contractor's QTI Payments, if any. Covered California may direct Contractor to submit QTI Scored Measures using alternative measure specifications, either to Covered California or to another entity, and score them using verified data sources or may use data submitted

pursuant to Section 5.01.1 of Attachment 1 of this Agreement to appropriately adjust Contractor's reportable QTI Scored Measure results.

3) Contractor agrees to make QTI Payments based on its QTI Scored Measure scores, including Stratified Measures, for each product as follows:

    a) Contractor must contribute the full apportioned measure payment amount if the QTI Scored Measure or, any Eligible Subpopulation or the All Other Members Subpopulation for Stratified Measures, is below the 25th national percentile benchmark.

    b) Contractor must contribute an apportioned measure payment amount at a declining constant rate, as determined by Covered California, for each QTI Scored Measure or, any Eligible Subpopulation or the All Other Members Subpopulation for Stratified Measures, is scored at or above the 25th and up to the 66th national percentile benchmark.

    c) Contractor will not be required to make any payments for QTI Scored Measures, and Stratified Measures where all Eligible Subpopulations and the All Other Members Subpopulation, meet or exceed the 66th national percentile benchmark.

4) Total QTI Payments at risk are divided by each assessed QTI Scored Measure. The QTI Payment at risk for each Stratified Measure is further divided and apportioned based on QHP-specific subpopulation denominator weights. Newly contracted QHP issuers will start with a reduced risk percentage in Year 1 of QTI eligibility, then increase the risk percentage in Year 2 to gradually align with the amounts listed in this Section. Total QTI Payments at risk shall not exceed those specified as follows:

    a) For Measurement Year 2026, the full payment amount is up to 2.8 percent of Contractor's total Gross Premium per product.

    b) For Measurement Year 2027, the full payment amount is up to 3.8 percent of Contractor's total Gross Premium per product.

    c) For Measurement Year 2028, the full payment amount is up to 3.8 percent of Contractor's total Gross Premium per product.

5) Covered California in consultation with stakeholders may, in its sole discretion, waive or reduce QTI Payments for Contractors that do not meet or exceed required benchmarks but otherwise, as determined by Covered California, demonstrate superior QHP quality or show significant improvement in one or more measure scores.

1.04 Preventing Increases in Health Disparities and Requiring Maintained Efforts

Contractor shall act in good faith to improve or maintain the health outcomes of all Covered California Enrollees to meet or exceed the established benchmarks. Covered California will monitor QHP performance across all QTI Scored Measures, considering performance in Eligible Subpopulations for Stratified Measures, for performance below established benchmarks that declines or demonstrates a lack of improvement in health outcomes that may indicate disinvestment in health interventions focused on a specific subpopulation or subpopulations. Lack of improvement describes static performance or negligible improvement for a subpopulation. If Contractor displays such declines or lack of improvement in performance, Covered California may require Contractor to enter into a Quality Improvement Plan, pursuant to Section 5.2.4 of the Agreement. If Contractor displays declines or lack of improvement amongst Eligible Subpopulations, Covered California may also re-weight Contractor's payment allocations for future Plan Years to increase amounts at risk tied to declining or lack of improving Eligible Subpopulations.

1.05 QTI Performance Report

Covered California will calculate Contractor's QTI Payments and issue a QTI Performance Report to Contractor on an annual basis within ninety (90) Days of receipt of the measure scores published through the CMS Marketplace Quality Module within CMS' Health Insurance and Oversight System for the Measurement Year.

If Contractor does not agree with the QTI Performance Report, Contractor may dispute the Report in writing within sixty (60) Days of receipt of that Report. The written notification of dispute must provide a detailed explanation of the basis for the dispute. Covered California must review and provide a written response to Contractor's dispute within sixty (60) Days of receipt of Contractor's notification of dispute. If Contractor still disputes the findings of Covered California, Contractor may pursue additional remedies in accordance with Section 13.1 of the Agreement.

Contractor's QTI Payment obligation as specified in the QTI Performance Report is final sixty (60) Days after receipt of the QTI Performance Report. If Contractor disputes the Report, Contractor's QTI Payment obligation is final upon receipt of Covered California's written response to the dispute or, if Contractor still disputes the findings and pursues additional remedies in accordance with Section 13.1 of the Agreement, at the end of the dispute resolution process under that section.

1.06 Administration of QTI Payments

Covered California shall direct Contractor's use of QTI Payments. Covered California shall issue PopHI Directives with payment instructions to Contractor, no later than thirty (30) Days before a payment is due.

Covered California will direct Contractor to transmit QTI Payments to PopHIs in the PopHI Directive using one of the following methods:

1) Funds will be transmitted to and retained by an entity as directed by Covered California; or

2) Funds will be retained by Contractor to be used only as expressly directed by Covered California.

1.07 Population Health Investments

1.07.1 Selection of Population Health Investments

Covered California shall issue PopHI Directives specifying how Contractor shall use QTI Payments. A PopHI is a targeted program established by Covered California, guided by the following principles:

1) Equity first: funds should preferentially focus on geographic regions or communities with the largest identified gaps in health and quality among California subpopulations,
2) Direct: use of funds should lead to measurable improvements in quality and outcomes for enrollees that are related to QTI Scored Measure performance,
3) Evidence-based: use of funds should be grounded in approaches that have established evidence of success in driving improvements in quality or outcomes, and
4) Additive: funds should be used to advance quality in a currently underfunded arena.

Covered California shall engage with stakeholders, including QHP Issuers, consumer advocates, providers, and others in developing recommendations for PopHIs and program designs. Based on engagement with stakeholders, Covered California, in its sole discretion, shall establish PopHIs and direct Contractor to implement them.

Covered California, in its sole discretion, may additionally direct or permit Contractor to design and operate its own PopHI that meets the guiding principles in this section. If directed or if permitted, Contractor PopHIs are subject to the implementation plan and reporting requirements specified sections 1.07.2 and

1.07.4 below.

1.07.2 Population Health Investment Implementation Plan

If directed in the PopHI Directive, Contractor must submit a written implementation plan that details actions Contractor will take to implement the PopHIs it funds and operates. Contractor's implementation plan shall include any information requested in the PopHI Directive.

Covered California will review Contractor's submissions and, if appropriate, issue written approval for Contractor's implementation plan. Covered California reserves the right to request additional information and documentation from Contractor regarding its actions in furtherance of an approved implementation plan.

1.07.3 Population Health Investment Expenses

Contractor shall track and document QTI Payments made pursuant to PopHI Directives.

Contractor shall be responsible for any expenses beyond those specified in a PopHI Directive related to implementing any PopHIs that exceed QTI Payments.

1.07.4 Evaluation and Data Submissions

Contractor agrees to provide data to Covered California to evaluate the success of Contractor's PopHI, upon request. Covered California will establish reasonable data reporting requirements upon approval of Contractor's PopHI implementation plan.

If Covered California in its sole discretion determines that Contractor's PopHI has not achieved improvements in quality and outcomes, or otherwise does not best serve Contractor's enrollees, Covered California may request changes in Contractor's PopHI program design or may cease Contractor's PopHI Directive.

1.08 Unspent Funds

Unspent QTI Payments shall be used as directed by Covered California. If Contractor has unspent QTI Payments at the end of the Calendar Year, Contractor shall use the payments during the next Calendar Year as directed by Covered California. Contractor shall not recover unspent QTI Payments or use unspent payments for purposes outside of Covered California's direction. Covered California reserves the right to request an audit of QTI Payments at any time.

1.09 Ongoing Assessment of the Quality Transformation Initiative

Payments

Covered California shall continuously assess the success of QTI Payments at achieving measurable quality improvements. Based on outcomes from PopHIs, feedback from stakeholders, and availability of funds, Covered California may consider revising or establishing additional programs, opportunities, and uses for QTI Payments.

1.10 Quality Improvement Plans

If Contractor scores below the 25th national percentile benchmark for a QTI Scored Measure, or for any Eligible Subpopulation or the All Other Members Subpopulation for Stratified Measures, Contractor must provide Covered California with a Quality Improvement Plan in accordance with Section 5.2.4 of the Agreement. The Quality Improvement Plan must address each QTI Scored Measure for which Contractor scores below the 25th national percentile benchmark.

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 6, 2026
Regular Meeting of the CalOptima Health Board of Directors

Report Item
18. Approve Actions Related to CalOptima Health's Community Reinvestment Plan

Contacts
Kelly Bruno-Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741
Yunkyung Kim, Chief Operating Officer, (714) 923-8834

Recommended Actions
1. Authorize the Chief Executive Officer, or designee, to submit the Community Reinvestment Plan to the Department of Health Care Services.

Background
The Department of Health Care Services (DHCS) released All Plan Letter (APL) 25-004 in February 2025, establishing that Medi-Cal Managed Care Plans (MCPs) must reinvest a portion of their annual net income into local communities to address unmet health-related social needs and support community wellbeing. The requirement includes both a Base Community Reinvestment (CR) and a Quality Achievement CR component. DHCS calculates net income as a statewide aggregate based on annual submissions, due no later than 12 months after each calendar year (CY) closes, and county-level allocation is generally proportional to the MCP's Medi-Cal membership by county. MCP CR spending must fall into one of five mandatory use categories. MCPs must align CR spending with community needs identified through each Local Health Jurisdiction's Community Health Assessment (CHA)/Community Health Improvement Plan (CHIP) process, Behavioral Health Integration Plan, and other stakeholder input. MCPs must also engage (i) their Community Advisory Committees, which includes CalOptima Health's Member Advisory Committee (MAC) and Provider Advisory Committee (PAC), and (ii) their Chief Health Equity Officer to inform and validate CR spending. Initial CR Plan (CRP) submission elements include (i) a description of community needs and CR activities, (ii) the MCP's approach to engaging its Community Advisory Committees and interested stakeholders, (iii) the expected dollar amount allocated to each CR activity, and (iv) a signed attestation from local Public Health and County Behavioral Health Directors or an authorized equivalent.

For the first year of the CR obligation – calculated based on CY 2024 net income – DHCS allows MCPs to apply voluntary investments toward satisfying their initial obligation, provided that several conditions are met. Voluntary investments are defined as documented investment commitments made prior to March 7, 2025, and formalized through a Memorandum of Understanding, grant agreement, or other binding written agreement. To qualify, the investments (i) must fall within one or more of the APL's mandatory use categories for CR activities, must not duplicate activities covered under the Medi-Cal contract, (ii) must be expended after DHCS's approval of the CRP, and fully exhausted before the end of initial CRP period in 2029, and (iii) may not be applied toward CR obligations calculated on CY 2025 or CY 2026 net income. This one-time flexibility allows MCPs to honor CR commitments already underway when DHCS first issued APL 25-004.

CalOptima Health must submit the initial CRP to DHCS by September 1, 2026. Once approved by DHCS, MCPs must post their initial three-year CRPs, and all subsequent updates, on their websites.

Back to Agenda

MCPs must submit annual CRP updates to DHCS confirming how the MCPs will expend their CY 2025 and CY 2026 net income obligations toward their planned CR activities.

Discussion

CalOptima Health's CRP reflects CalOptima Health's commitment to reinvesting in the health and well-being of its Medi-Cal members. CalOptima Health staff has developed the initial CRP through a rigorous, community-centered planning process, including drawing on the 2023 Orange County CHA, the OC Behavioral Health Services Act 2026–2029 Integrated Plan, the 2024–2026 Orange County CHIP, and direct input from CalOptima Health's MAC, PAC, Chief Health Equity Officer, and Quality Improvement and Health Equity Committee. CalOptima Health's initial three-year CRP period from 2026-2029 identifies three investment activity areas :

1. Behavioral Health Infrastructure, which funds community wellness spaces, school-based mental health capacity, non-Medi-Cal peer and mental health services, and organizational infrastructure development for dyadic care integration;
2. Healthcare Workforce Development, which builds a local healthcare workforce pipeline through scholarships, career pathway programs, mentorship, and educational partnerships targeting underrepresented communities; and
3. Housing and Homelessness Services and Infrastructure, which invests in capital funding for interim and permanent supportive housing and capacity building for community-based organizations addressing the root social determinants of homelessness.

All three activities are grounded in the APL's guiding principles – engaging the community, aligning investments with community-identified health priorities, and ensuring funding targets non-contract activities outside the scope of the Medi-Cal benefit – and staff has designed the initial CRP to advance health equity by directing resources to the populations and communities facing the greatest disparities in Orange County.

DHCS has confirmed that CalOptima Health's initial CR obligation based on CY 2024 net income is approximately $11.7 million. CalOptima Health has identified voluntary investments that meet the requirements of the APL that total the full reinvestment obligation for the first year. CalOptima Health will initiate these voluntary investments in late 2026, upon DHCS approval of this initial three-year CRP.

Prior to submitting the subsequent annual CRP updates for CY 2027 and CY 2028, CalOptima Health staff will return to the CalOptima Health Board of Directors (Board) for additional approvals to submit the annual CRP updates to DHCS. CalOptima Health will deliver a final CRP report in 2030. The Board can view the complete initial CRP in Attachment 1.

Fiscal Impact

The recommended action has no additional fiscal impact. Expenditures related to the CY 2024 CR obligation were accounted for in the Fiscal Year 2026 financial statements.

Back to Agenda

Rationale for Recommendation

CalOptima Health staff has undertaken a thorough community engagement process to align CR activities with regulatory requirements. The initial CRP summarizes those efforts, along with planned community spending that will fulfill CalOptima Health's CR obligation based on CY 2024 net income.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Attachment 1. CalOptima Health's Initial Community Reinvestment Plan
2. Attachment 2. Community Reinvestment Determination Letter -CAL
3. Attachment 3. CalOptima_Community Reinvestment Plan_ Presentation

/s/ Michael Hunn *07/28/2026*
Authorized Signature **Date**

Back to Agenda

APPENDIX B, EXHIBIT 5: PROPOSED ALLOCATION OF FUNDS

MCP Name: CalOptima Health

County Name: Orange County

Proposed Allocation of Funds by the MCP

Brief Description of Activity	Allocation of Base or Quality Achievement Funds?	Funding Allocation for Investment Period		
		Y1	Y2	Y3
Ex) Investment in community garden	*Base Community Reinvestment*	*$400,000*	*$200,000*	*$-*
Healthcare Workforce Development	Base Community Reinvestment	$4,689,025		
Healthcare Workforce Development	Quality Achievement	$1,247,274		
Behavioral Health Infrastructure	Quality Achievement	$2,214,046		
Housing and Homelessness Services and Infrastructure	Quality Achievement	$3,572,218		
Total	-	$11,722,563		

Proposed Allocation of Funds by Qualifying Subcontractor(s) – Not Applicable

COMMUNITY REINVESTMENT PLAN

MCP/Subcontractor Name: CalOptima Health

Activity 1: Behavioral Health Infrastructure

Description of Proposed Community Reinvestment Activities – Activity 1: Behavioral Health Infrastructure	
Question	**Response**
1) Provide a detailed description of the Community Reinvestment and the related use category or categories for the activity.	**Activity Description:** CalOptima Health will invest in behavioral health infrastructure activities across four complementary avenues. First, CalOptima Health will consider capital investments toward community wellness spaces—including community wellness centers and community resource centers—that provide accessible environments where Orange County residents can access peer support, mental health services, substance use, and behavioral health resources. Second, CalOptima Health will consider community-based strategies that strengthen schools' capacity to enhance student mental health and wellness, including school-adjacent or school-partnered programs that provide behavioral health and substance use supports beyond those funded through the educational or Medi-Cal system. Third, CalOptima Health will consider expanded peer support and community-based mental health services that are not covered by Medi-Cal, including peer-led wellness programming, and non-clinical mental health and substance use outreach. Fourth, CalOptima Health will consider investing in organizational infrastructure development for community-based organizations

	seeking to integrate dyadic care, a behavioral health approach to health care services, into their practice models—supporting the internal systems change work required to restructure service delivery workflows, build data infrastructure, and redesign staffing models in preparation to deliver integrated dyadic care—support not available through the Medi-Cal contract or considered covered services. All avenues will additionally focus on racial, ethnic, and linguistic disparities that limit access to behavioral health services. **Related Use Categories:** **Cultivating Improved Health** – This proposed activity cultivates improved health by expanding community access to behavioral health and peer support sites and services, investing in school-based mental health capacity, and building organizational infrastructure for dyadic care — all of which target the structural conditions that allow mental illness and SUD to become severe and disabling. This activity targets upstream root causes of poor health that drive emergency department utilization, chronic disease, housing instability, and premature mortality. **Cultivating Well-Being for Priority Populations** – This proposed activity cultivates well-being for priority populations by providing tailored supports and services identified through the OC CHIP and BHSA Integrated Plan, including children and youth, and individuals with serious mental illness, SUD, or co-occurring disorders.

	Cultivating Neighborhoods and Built Environment – This proposed activity cultivates neighborhoods and environments by increasing the number of trusted community spaces where mental and behavioral health services can be accessed and bolstering neighborhoods and environments to better promote health, well-being and safety. **Cultivating Local Communities** – This proposed activity cultivates local communities by increasing peer support programming, community wellness spaces, and school-partnered mental health strategies, bolstering community cohesion, reducing stigma, and promoting well-being at the neighborhood level and outside of conventional service delivery locations, particularly in communities with the greatest health disparities.
2) Please indicate all counties of operation where investments for this activity will occur.	Orange County, California.
3) Please specify the intended timeline for funding this activity (e.g., the CY 2026 – CY 2029 investment period based on CY 2024 – CY 2026 net income).	CY 2026 – CY 2029, based on CY 2024 – CY 2026 net income.

4) Provide a description of how the activity is informed by the LHJ's CHA. Please include a link or hard copy of the most recent CHA.	This proposed activity is informed by the 2023 Orange County Community Health Assessment (OC CHA), a comprehensive review of the health status and most pressing health needs of Orange County communities. Developed through collaborative efforts led by the OC Health Care Agency (OCHCA), the OC CHA gathered input from 174 participants representing individual community members, community-based organizations, public health agencies, health care systems, and hospitals, and used a data-driven scoring process to identify priority health issues. Two of the top priority health issues identified for Orange County were (1) mental health and (2) substance use. Key data points from the OC CHA that directly inform the proposed activities include: (1) 14.6% of OC adults report experiencing serious psychological distress in the past year, (2) drug and alcohol mortality rates have increased in both northern and southern OC over the past five years; and (3) behavioral health conditions were among the highest-ranked unmet needs as reported by 400 community partners. The OC CHA also documents persistent racial, ethnic, and linguistic disparities in access to behavioral health services, with Hispanic/Latino and Asian/Pacific Islander residents and non-English-speaking community members facing the greatest access barriers. Finally, the OC CHA's further findings on the social determinants of behavioral health — including economic disparities, housing instability, and limited access to community-based wellness resources —

	directly inform this activity's focus on community wellness spaces, school-based mental health capacity, peer support services, and organizational infrastructure development for dyadic care as upstream investments in behavioral health. OC CHA (2023) Available at: https://ochealthinfo.com/sites/healthcare/files/2023-10/Orange_County_Community_Health_Assessment-Final.pdf
5) If applicable, provide a description of how the activity is informed by the BHT community planning process.	This proposed activity is informed by the Orange County Behavioral Health Services Act (BHSA) 2026–2029 Integrated Plan, which represents Orange County's transition from the Mental Health Services Act framework to the new BHSA structure under Proposition 1 (2024). The BHSA Integrated Plan identifies several priorities directly aligned with this activity: (1) Orange County's adult Specialty Mental Health Services (SMHS) penetration rate is below the statewide benchmark, with disparities by race/ethnicity and written language; (2) DMC-ODS (Drug Medi-Cal Organized Delivery System) penetration rates for adults are below the statewide average; and (3) the BHSA mandates integration of mental health and SUD services, with full county implementation required by July 1, 2026. These priorities identified by the BHSA Integrated plan directly inform this activity's focus on community wellness spaces, school-based mental health capacity, peer support services, and organizational infrastructure development

	for dyadic care as upstream investments in behavioral health. CalOptima Health has been actively engaged in the Behavioral Health Transition community planning process, including participation in the OC CHIP Behavioral Health Workgroup and coordination with OC BHS on care transitions and data sharing. Available at: https://www.ochealthinfo.com/sites/healthcare/files/2026-04/BHSA_IntegratedAnnualPlan2026-29.pdf
6) If applicable, identify the LHJ CHIP activity that the Community Reinvestment activity matches. Please include a link or hard copy of the most recent CHIP.	This proposed activity is directly informed by the 2024–2026 Orange County Community Health Improvement Plan (OC CHIP), developed by the OC Health Care Agency in collaboration with more than 400 community health partners. The OC CHIP identified Mental Health as Priority Area 1, with a community goal to increase access to the full continuum of quality mental health services for all OC residents. It identifies substance use as Priority Area 2, with goals to decrease opioid deaths and reduce rates of substance use and misuse countywide. These priorities identified by the OC CHIP directly inform this activity's focus on community wellness spaces, school-based mental health capacity, peer support services, and organizational infrastructure development for dyadic care as upstream investments in behavioral health.

	Available at: https://www.ochealthinfo.com/page/oc-community-health-improvement-plan-2024-2026
7) Provide a description of the anticipated benefits of the Community Reinvestment activity, populations expected to benefit, and alignment with guiding principles identified in the APL. Note: If this activity is intended to meet the MCP's Quality Achievement Community Reinvestment requirement, the MCP must indicate how the activity aligns with the "Cultivating Improved Health" category.	**Anticipated Benefits:** This activity is expected to expand access to behavioral health and support services for CalOptima Health's member population. By investing in community wellness spaces, school-based mental health infrastructure, and organizational infrastructure for dyadic care integration, CalOptima Health will help build a community behavioral health ecosystem that reaches individuals before they reach crisis and expands community capacity to provide wellness support to the Medi-Cal population beyond what is already considered a covered service. **Populations Expected to Benefit:** (1) Adults and youth with serious mental illness (SMI), SUD, or co-occurring mental health and SUD conditions (2) Individuals with neurodevelopmental disabilities and co-occurring behavioral health needs (3) Hispanic/Latino and Asian/Pacific Islander members, who are disproportionately below-average in SMHS and NSMHS penetration rates (4) Non-English-speaking and limited-English-proficient members (more than 46% of OC residents speak a language other than English at home) (5) Justice-involved individuals with behavioral health needs (6) Individuals experiencing homelessness or housing instability with co-occurring

	behavioral health conditions **Alignment with Guiding Principles:** (1) Engage with the Community – Each activity ties back to the Community Advisory Committee (CAC) survey process, names what members and providers specifically said that informed the activity's design, and notes that the CHEO and CR Workgroup reviewed and incorporated that feedback. The community engagement rationale is activity-specific: behavioral health and peer support priorities for Activity 1; workforce shortages and cultural access barriers for Activity 2; housing capital and CBO partnership calls for Activity 3. (2) Align Community-Identified Priorities with Investments in Health Outcomes and Equity – Each response references the specific 2023 OC CHA and OC CHIP priorities that correspond to the activity, names the populations facing the greatest disparities that the investment targets and explains how the investment advances health equity at a structural level — not just service delivery. Activity 1 references mental health and SUD as the top two CHA priorities; Activity 2 references care navigation and economic disparities; Activity 3 references housing/homelessness and economic disparities with a focus on upstream social determinants. (3) Ensure Funding Targets Non-Contract Activities – Each response directly addresses the APL prohibition and explains specifically why the activity's investments fall outside covered services. Activity 1

	notes that wellness spaces, school programs, non-clinical peer services, and dyadic care infrastructure are all outside the Medi-Cal benefit structure. Activity 2 clarifies that pipeline development for new entrants is distinct from prohibited T&TA for existing Medi-Cal providers. Activity 3 restates the specific Community Supports exclusions from APL 25-004 and explains that capital housing investments and CBO systems change work are not MCP contract services. All three close with a grantee confirmation requirement. **Alignment with Cultivating Improved Health:** This activity aligns with the "Cultivating Improved Health" category by expanding community access to behavioral health and peer support sites and services, investing in school-based mental health capacity, and building organizational infrastructure for dyadic care — all of which target the structural conditions that allow mental illness and SUD to become severe and disabling. This activity targets upstream root causes of poor health — untreated mental illness and substance use disorders — that drive emergency department utilization, chronic disease, housing instability, and premature mortality.
8) Provide a description of the approach taken to engage the CAC in the Community Reinvestment planning process, including a summary of input and recommendations provided.	CalOptima Health engaged the Community Advisory Committee (CAC) as a key partner in the CR planning process. CalOptima Health met with the CAC on April 10, 2025, and October 9, 2025, to review CR program requirements, collect structured stakeholder input, and validate planning assumptions. Input from these meetings informed CR program planning activities, outreach strategy development,

	and implementation methodology based on partner organization and community-identified needs. During CAC engagement, the Chief Health Equity Officer (CHEO) delivered a formal presentation that included a program overview, the draft CR planning framework, and proposed program requirements and investment priority categories. Following the presentation and discussion, CalOptima Health distributed a standardized survey to CAC members to collect structured feedback on community needs, service gaps, operational barriers, and recommended program focus areas. Across respondents, the most frequently cited investment priorities were: (1) behavioral health and substance use disorder services, including expanded mental health coverage and access to SUD treatment; (2) housing stability and homelessness supports, including low-income housing, project-based vouchers, and civil legal aid as a housing stability strategy; (3) healthcare workforce development, particularly addressing reimbursement barriers and specialty provider shortages; (4) services for seniors facing financial and housing insecurity; and (5) specialized behavioral health programming for individuals with neurodevelopmental disabilities. This feedback was incorporated into updates to outreach strategies, funding priority criteria, and CR program design.

9) If applicable, provide a description of the approach taken to engage other community stakeholders in the Community Reinvestment planning process, including a summary of stakeholders involved and any input or recommendations provided.	CalOptima Health engaged a broad group of internal and external stakeholders to ensure the CR planning process was inclusive and grounded in community and partner perspectives. Surveys, focus groups, and listening sessions were used to gather structured input. The Community Reinvestment Joint Internal and External Stakeholder Workgroup was established, which includes representation from clinical, quality, Orange County community health departments, and equity leadership, to provide ongoing opportunities to review planning components and incorporate feedback from key partners. The CR Workgroup held its kickoff meeting on June 3, 2025, and reconvened on September 30, 2025, and January 12, 2026, reviewed draft materials, validated planning assumptions, and refined program elements based on stakeholder input. In addition, the CHEO presented and solicited feedback at several key committees, including Quality Improvement Health Equity Committee on October 10, 2025, the Community Investment Oversight Committee on October 24, 2025, the OC Population Health Collaborative Committee on February 2, 2026, and the OC CHIP Steering Committee on February 2, 2026. Internal contributors included cross-departmental leaders and executives, as well as ad hoc workgroups such as Accounting, Finance, and operational teams involved in implementation planning. External partners included the County Health Care Agency, County

	Behavioral Health, Kaiser Permanente, and community-based organizations engaged through the CHA/CHIP and Behavioral Health Transformation processes, as well as insights aligned with our 2025/2026 Member Population Health Needs Assessment (MPHNA). The MPHNA is a comprehensive assessment that evaluates CalOptima Health members' whole-person health needs and preferences. It integrates clinical data, social determinants of health, community feedback, and population-level trends to identify disparities, understand member characteristics, and inform program development, strategic initiatives, and Community Reinvestment activities. Stakeholders emphasized aligning CR priorities with identified community needs supporting the integration of behavioral health and social needs and strengthening coordination across countywide initiatives. Their input helped ensure that planning, outreach design, and implementation strategies were responsive to partner recommendations and reflective of the communities served.
10) Provide a description of any investments recommended by the CAC not included in the Community Reinvestment Plan.	CAC respondents made a few recommendations that are not included as standalone Community Reinvestment activities in the current plan. These include: food insecurity programs, better reimbursement rates for specialty services, provider training, and broader PACE program infrastructure expansion. These recommendations were not included as primary CRP activities for one or both of the following reasons: (1) they fall outside the allowable investment

	activity categories defined in Attachment A of DHCS APL 25-004; or (2) CalOptima Health has recently made investments in those areas through existing programs, contracts, or community benefit activities outside the scope of the CRP. CalOptima Health will continue to evaluate opportunities to support CAC-identified needs through other channels. Certain CAC recommendations — such as addressing the needs of seniors experiencing financial and housing insecurity, and strengthening cross-system navigation — are reflected within the scope of the Housing and Homelessness Services and Infrastructure activity.
11) Provide a summary of input provided by the Chief Health Equity Officer on the Community Reinvestment Plan and/or planning efforts.	CalOptima Health's Chief Health Equity Officer (CHEO), Dr. Michaell Silva Rose, provided strategic guidance and oversight during the development of the CR Plan. The CHEO led and facilitated CR planning efforts aligned with CalOptima Health's mission, health equity principles, and the requirements outlined in DHCS All Plan Letter (APL) 25-004. The Community Reinvestment Joint Internal and External Stakeholder Workgroup meets quarterly to guide CR planning and implementation. This workgroup is comprised of internal representatives of the following departments: Equity and Community Health, Grant Management, Quality, Strategic Development, Behavioral Health Integration, and CalAIM. Together they discuss CR updates and efforts, and develop strategies and tactics for the identified focus areas. External partners are also represented, such as the County Health Care Agency and County Behavioral

	Health, to ensure alignment with county priorities. Ad hoc workgroups, including Accounting and Finance, convene as needed to support fiscal oversight and operational requirements. Across the CR Joint Internal and External Stakeholder Workgroup's meetings, the CHEO outlined the overall vision, priorities, and expectations for the CR program. This included outlining the purpose and intent of community reinvestment, reviewing permitted investment categories, and reinforcing the importance of aligning activities with upstream drivers of health, such as housing instability, food insecurity, and access barriers. During CR Workgroup meetings, the CHEO led discussions on alignment with county public health and behavioral health partners, integration of findings from the MPHNA, CHA/CHIP, BH Integration Plan and other community resources. Overall, the CHEO's input shaped the structure, compliance alignment, and equity focus of the CR Plan, ensuring that CalOptima Health's investments meaningfully address community-identified needs, advance equitable outcomes, and fully meet DHCS requirements for CR.
12) If applicable, provide a summary of input provided by the QIHEC on the Community Reinvestment Plan and/or planning efforts.	The Quality Improvement Health Equity Committee (QIHEC) was included as part of CalOptima Health's broader advisory-committee engagement to support development of the CR Plan. As reflected in organizational materials and program updates, QIHEC received an overview of the Community Reinvestment

	Program and its requirements during the committee's October 14, 2025 session. During this meeting, the CHEO presented the CR framework, including DHCS' guiding principles, eligible investment categories, and the program's focus on addressing upstream drivers of health through community-level activities. QIHEC was invited to provide feedback on the alignment of proposed CR priorities with CalOptima Health's quality improvement and health equity goals. Documentation from this engagement indicates that QIHEC's discussion supported validation of program direction and helped confirm alignment between organizational quality priorities and CR planning efforts. The QIHEC received an additional briefing on the draft Community Reinvestment Plan prior to Board of Directors approval, providing an opportunity for formal feedback and recommendations before the plan was finalized.
13) Provide a description of how the Community Reinvestment activity will be measured and evaluated.	Per CalOptima Health's Grant Management Policy, all grant awards are required to have measurable outcomes outlined in their grant agreements. Therefore, in alignment with that policy, community investments under this activity will each include SMART objectives that directly track the progress of each unique grant project. These objectives will incorporate several of the following measures and others yet to be identified, given the fact that will be reflective of the unique programs selected for funding: **Process / Output Measures:** • Number of grants awarded and total

	dollars invested • Number of community wellness centers or wellness spaces funded, created, or enhanced • Number of school-based or school-partnered mental health and wellness programs and/or sites funded • Number of community-based organizations that complete dyadic care integration infrastructure projects (e.g., workflow redesign, data system buildout, staffing model restructuring) • Number of peer support programs or community mental health outreach programs established or expanded • Number of community-based organizations with capacity increases made possible by these investments **Outcome Measures:** • Number of CalOptima Health members served through funded programs • Number of students or youth reached through funded school-based or school-partnered mental health and wellness programs and/or sites • Number of peer-supported community wellness engagements conducted • Number of children and families served through dyadic care services at organizations that completed funded infrastructure development • Number of community-based organizations that successfully implement dyadic care service delivery following funded systems change work • Reduction in behavioral health-related emergency department visits or inpatient admissions attributable to funded community wellness and peer support programs

	• Improvements in quality metrics related to physician follow-ups after emergency department visits or in-patient hospitals stays **Health Equity Measures:** • Proportion of members served from priority populations, including Hispanic/Latino, Asian/Pacific Islander, individuals with limited English proficiency, justice-involved individuals, and individuals experiencing homelessness. • Access and utilization measures disaggregated by race/ethnicity, primary language, gender, age, disability status, and geographic location (e.g., ZIP Code) to identify disparities and monitor equitable access to services. • Implementation and utilization of interventions designed to reduce health disparities among Medi-Cal priority populations, including monitoring participation and reach. • Improvement in selected preventive care measures for priority populations. • Number and proportion of interventions that directly align with CalOptima Health's Health Equity Guiding Principles and demonstrate measurable progress toward reducing identified health disparities. Per CalOptima Health's Grant Management Policy, all grantees are required to submit progress reports and a final report. CalOptima Health's Grants Management Department will review performance data and conduct grantee check-ins to monitor progress and support course corrections as needed to maximize impact.

14) If applicable, please provide the name of any Qualifying Subcontractors that intend to invest in this activity.	Not applicable. CalOptima Health does not have any Qualifying Subcontractors.

Activity 2: Healthcare Workforce Development

Description of Proposed Community Reinvestment Activities – Activity 2: Healthcare Workforce Development	
Question	**Response**
1) Provide a detailed description of the Community Reinvestment and the related use category or categories for the activity.	**Activity Description:** CalOptima Health will invest in strategies that strengthen and diversify the local healthcare workforce in Orange County, with emphasis on high-demand roles including nurses, behavioral health clinicians, and community health workers (CHWs). Workforce development activities may include funding for scholarships, training programs, mentorship opportunities, and pipeline recruitment initiatives that draw new individuals into healthcare careers—with a focus on building a workforce that reflects and serves underserved communities in Orange County. CalOptima Health will also pursue partnerships with educational institutions and healthcare employers to create sustainable pipelines for a workforce that is culturally and linguistically reflective of the members it serves. **Related Use Categories:** **Cultivating a Health Care Workforce** – This proposed activity cultivates a health care workforce by building the next generation of healthcare workers, addressing workforce shortages in high-demand roles (nurses, behavioral health professionals, CHWs), and establishing healthcare career pipelines for youth and young adults in underserved communities. **Cultivating Improved Health** – A robust,

	culturally responsive healthcare workforce is an upstream determinant of health equity. This proposed activity cultivates improved health by investing in workforce capacity directly thereby improving community access to quality, linguistically appropriate care and addressing root causes of health disparities driven by provider shortages and lack of cultural/racial concordance. **Cultivating Local Communities** – This proposed activity cultivates local communities by investing in workforce development thereby creating career pathways, employment opportunities, and educational partnerships for OC residents and bolstering economic well-being and community advancement, particularly for residents from low-income and underrepresented backgrounds. **Cultivating Well-Being for Priority Populations** – This activity cultivates well-being for priority populations by training providers to serve specific priority populations (e.g., individuals with neurodevelopmental disabilities, seniors, non-English-speaking members) thereby ensuring the workforce is equipped to meet the tailored needs of CalOptima Health's most vulnerable members.
2) Please indicate all counties of operation where investments for this activity will occur.	Orange County, California.

3) Please specify the intended timeline for funding this activity (e.g., the CY 2026 – CY 2029 investment period based on CY 2024 – CY 2026 net income).	CY 2026 – CY 2029, based on CY 2024 – CY 2026 net income.
4) Provide a description of how the activity is informed by the LHJ's CHA. Please include a link or hard copy of the most recent CHA.	This proposed activity is informed by the 2023 Orange County Community Health Assessment (OC CHA), a comprehensive review of the health status and most pressing health needs of Orange County communities. Developed through collaborative efforts led by the OC Health Care Agency (OCHCA), the OC CHA gathered input from 174 participants representing individual community members, community-based organizations, public health agencies, health care systems, and hospitals, and used a data-driven scoring process to identify priority health issues. The OC CHA identifies care navigation and workforce capacity as foundational determinants of health equity in Orange County. Key findings that inform this activity include: (1) more than 46% of Orange County residents speak a language other than English at home, creating persistent barriers to culturally and linguistically appropriate healthcare access; (2) the CHA priority area of economic disparities — which includes limited access to career pathways and employment opportunities for low-income residents, many of whom are CalOptima Health members; and (3) healthcare workforce shortages, particularly in behavioral health, are identified as a structural barrier to achieving community health goals across

	multiple priority areas. The OC CHA also identifies the need for a more diverse and representative healthcare workforce as a long-term strategy for reducing health disparities. These findings directly inform this activity's focus on building a local healthcare workforce pipeline that reflects the diversity of Orange County's population, with emphasis on behavioral health professionals, bilingual and multilingual care navigators, community health workers, and peer support workers from underserved communities. OC CHA (2023) Available at: https://ochealthinfo.com/sites/healthcare/files/2023-10/Orange_County_Community_Health_Assessment-Final.pdf
5) If applicable, provide a description of how the activity is informed by the BHT community planning process.	This proposed activity is informed by the Orange County BHSA 2026–2029 Integrated Plan, which includes a dedicated Workforce Strategy section comprising two pillars: (1) maintaining an adequate network of qualified and culturally responsive providers; and (2) building workforce capacity to address statewide behavioral health goals. The BHSA Integrated Plan explicitly identifies statewide behavioral health workforce shortages as a significant implementation barrier, noting that building provider capacity, staffing, and training infrastructure — particularly for high-acuity and specialized services — can take considerable time. The Plan's PIVOT Innovation project specifically identifies support for community-based

	organizations (CBOs) in becoming credentialed Medi-Cal specialty behavioral health providers as a priority strategy for network expansion. BHSA allocates 3% of statewide funds to workforce infrastructure at the state level, and local managed care plans can complement this investment through community reinvestment and aligned partnerships. Available at: https://www.ochealthinfo.com/sites/healthcare/files/2026-04/BHSA_IntegratedAnnualPlan2026-29.pdf
6) If applicable, identify the LHJ CHIP activity that the Community Reinvestment activity matches. Please include a link or hard copy of the most recent CHIP.	This proposed activity is informed by the 2024–2026 Orange County Community Health Improvement Plan (OC CHIP). This activity aligns with the following OC CHIP priority areas and goals: The OC CHIP identifies Care Navigation as Priority Area 5, specifically goal 1, which emphasizes the need for a healthcare workforce that is culturally and linguistically appropriate across Orange County's highly diverse population — more than 46% of residents speak a language other than English at home, with Spanish, Vietnamese, Chinese, Korean, and Tagalog as the most common non-English languages. The OC CHIP also identifies Economic Disparities as Priority Area 6, recognizing the need to invest in career pathways and economic opportunity for residents most impacted by poverty and employment

	barriers, many of whom are CalOptima Health members. Workforce shortages — particularly in behavioral health — are identified as a key barrier to achieving access goals across multiple priority areas. These findings directly inform the proposed activity's focus on building a local healthcare workforce pipeline that reflects the diversity of Orange County's population, with emphasis on behavioral health professionals, bilingual and multilingual care navigators, community health workers, and peer support workers from underserved communities. Available at: https://www.ochealthinfo.com/page/oc-community-health-improvement-plan-2024-2026
7) Provide a description of the anticipated benefits of the Community Reinvestment activity, populations expected to benefit, and alignment with guiding principles identified in the APL. Note: If this activity is intended to meet the MCP's Quality Achievement Community Reinvestment requirement, the MCP must indicate how the activity aligns with the "Cultivating Improved Health" category.	**Anticipated Benefits:** This proposed activity is expected to expand and diversify the pool of qualified healthcare professionals serving CalOptima Health members and the broader Orange County community. By investing in training, scholarships, mentorship, and career pipelines, CalOptima Health will help address documented shortages in behavioral health, nursing, community health roles, and other careers/positions — improving member access to culturally and linguistically appropriate care. **Populations Expected to Benefit:** (1) CalOptima Health members will benefit from a larger, more diverse, and more culturally competent provider network (2) Emerging healthcare workers from low-income, underrepresented, and non-

	English-speaking communities who gain access to career pathways (3) Individuals with neurodevelopmental disabilities and co-occurring conditions who benefit from a provider workforce specifically trained to serve their needs (4) Seniors and older adults who benefit from expanded provider capacity in geriatric and complex care settings (5) Existing providers who gain cross-training in behavioral health and SUD treatment **Alignment with Guiding Principles:** (1) Engage with the Community – Each activity ties back to the CAC survey process, names what members and providers specifically said that informed the activity's design, and notes that the CHEO and CR Workgroup reviewed and incorporated that feedback. The community engagement rationale is activity-specific: behavioral health and peer support priorities for Activity 1; workforce shortages and cultural access barriers for Activity 2; housing capital and CBO partnership calls for Activity 3. (2) Align Community-Identified Priorities with Investments in Health Outcomes and Equity – Each response references the specific 2023 OC CHA and OC CHIP priorities that correspond to the activity, names the populations facing the greatest disparities that the investment targets, and explains how the investment advances health equity at a structural level — not just service delivery. Activity 1 references mental health and SUD as the top two CHA priorities; Activity 2 references care navigation and economic disparities;

	Activity 3 references housing/homelessness and economic disparities with a focus on upstream social determinants. (3) Ensure Funding Targets Non-Contract Activities – Each response directly addresses the APL prohibition and explains specifically why the activity's investments fall outside covered services. Activity 1 notes that wellness spaces, school programs, non-clinical peer services, and dyadic care infrastructure are all outside the Medi-Cal benefit structure. Activity 2 clarifies that pipeline development for new entrants is distinct from prohibited T&TA for existing Medi-Cal providers. Activity 3 restates the specific Community Supports exclusions from APL 25-004 and explains that capital housing investments and CBO systems change work are not MCP contract services. All three close with a grantee confirmation requirement. **Alignment with Cultivating Improved Health:** This activity aligns with "Cultivating Improved Health" by addressing the upstream structural barrier of provider shortages — a root cause of inequitable access to care. A robust culturally responsive healthcare workforce is an upstream determinant of health equity. Investing in workforce capacity directly improves community access to quality, linguistically appropriate care and addresses root causes of health disparities driven by provider shortages.

8) Provide a description of the approach taken to engage the CAC in the Community Reinvestment planning process, including a summary of input and recommendations provided.	CalOptima Health engaged the Community Advisory Committee (CAC) as a key partner in the CR planning process. CalOptima Health met with the CAC on April 10, 2025, and October 9, 2025, to review CR program requirements, collect structured stakeholder input, and validate planning assumptions. Input from these meetings informed CR program planning activities, outreach strategy development, and implementation methodology based on partner organization and community-identified needs. During CAC engagement, the Chief Health Equity Officer (CHEO) delivered a formal presentation that included a program overview, the draft CR planning framework, and proposed program requirements and investment priority categories. Following the presentation and discussion, CalOptima Health distributed a standardized survey to CAC members to collect structured feedback on community needs, service gaps, operational barriers, and recommended program focus areas. Across respondents, the most frequently cited investment priorities were: (1) behavioral health and substance use disorder services, including expanded mental health coverage and access to SUD treatment; (2) housing stability and homelessness supports, including low-income housing, project-based vouchers, and civil legal aid as a housing stability strategy; (3) healthcare workforce development, particularly addressing reimbursement barriers and specialty

	provider shortages; (4) services for seniors facing financial and housing insecurity; and (5) specialized behavioral health programming for individuals with neurodevelopmental disabilities. This feedback was incorporated into updates to outreach strategies, funding priority criteria, and CR program design.
9) If applicable, provide a description of the approach taken to engage other community stakeholders in the Community Reinvestment planning process, including a summary of stakeholders involved and any input or recommendations provided.	CalOptima Health engaged a broad group of internal and external stakeholders to ensure the CR planning process was inclusive and grounded in community and partner perspectives. Surveys, focus groups, and listening sessions were used to gather structured input. The CR Workgroup was established, which includes representation from clinical, quality, community health, and equity leadership, to provide ongoing opportunities to review planning components and incorporate feedback from key partners. The CR Workgroup held its kickoff meeting on June 3, 2025, and reconvened on September 30, 2025, and January 12, 2026, reviewed draft materials, validated planning assumptions, and refined program elements based on stakeholder input. In addition, the CHEO presented and solicited feedback at several key committees, including Quality Improvement Health Equity Committee on October 10, 2025, the Community Investment Oversight Committee on October 24, 2025, the OC Population Health Collaborative Committee on February 2, 2026, and the OC CHIP Steering Committee on February 2, 2026.

	Internal contributors included cross-departmental leaders and executives, as well as ad hoc workgroups such as Accounting, Finance, and operational teams involved in implementation planning. External partners included the County Health Care Agency, County Behavioral Health, Kaiser Permanente, and community-based organizations engaged through the CHA/CHIP and Behavioral Health Transformation processes, as well as insights aligned with our 2025/2026 Member Population Health Needs Assessment (MPHNA). The MPHNA is a comprehensive assessment that evaluates CalOptima Health members' whole-person health needs and preferences. It integrates clinical data, social determinants of health, community feedback, and population-level trends to identify disparities, understand member characteristics, and inform program development, strategic initiatives, and Community Reinvestment activities. Stakeholders emphasized aligning CR priorities with identified community needs supporting the integration of behavioral health and social needs and strengthening coordination across countywide initiatives. Their input helped ensure that planning, outreach design, and implementation strategies were responsive to partner recommendations and reflective of the communities served.

10) Provide a description of any investments recommended by the CAC not included in the Community Reinvestment Plan.	CAC respondents made a few recommendations that are not included as standalone Community Reinvestment activities in the current plan. These include: food insecurity programs, better reimbursement rates for specialty services, provider training, and broader PACE program infrastructure expansion. These recommendations were not included as primary CRP activities for one or both of the following reasons: (1) they fall outside the allowable investment activity categories defined in Attachment A of DHCS APL 25-004; or (2) CalOptima Health has recently made investments in those areas through existing programs, contracts, or community benefit activities outside the scope of the CRP. CalOptima Health will continue to evaluate opportunities to support CAC-identified needs through other channels.
11) Provide a summary of input provided by the Chief Health Equity Officer on the Community Reinvestment Plan and/or planning efforts.	CalOptima Health's Chief Health Equity Officer (CHEO), Dr. Michaell Silva Rose, provided strategic guidance and oversight during the development of the CR Plan. The CHEO led and facilitated CR planning efforts aligned with CalOptima Health's mission, health equity principles, and the requirements outlined in DHCS All Plan Letter (APL) 25-004. The Community Reinvestment Joint Internal and External Stakeholder Workgroup meets quarterly to guide CR planning and implementation. This workgroup is comprised of internal representatives of the following departments: Equity and Community Health, Grant Management, Quality, Strategic Development, Behavioral Health

	Integration, and CalAIM. Together they discuss CR updates and efforts, and develop strategies and tactics for the identified focus areas. External partners are also represented, such as the County Health Care Agency and County Behavioral Health, to ensure alignment with county priorities. Ad hoc workgroups, including Accounting and Finance, convene as needed to support fiscal oversight and operational requirements. Across the CR Joint Internal and External Stakeholder Workgroup's meetings, the CHEO outlined the overall vision, priorities, and expectations for the CR program. This included outlining the purpose and intent of community reinvestment, reviewing permitted investment categories, and reinforcing the importance of aligning activities with upstream drivers of health, such as housing instability, food insecurity, and access barriers. During CR Workgroup meetings, the CHEO led discussions on alignment with county public health and behavioral health partners, integration of findings from the MPHNA, CHA/CHIP, BH Integration Plan and other community resources. Overall, the CHEO's input shaped the structure, compliance alignment, and equity focus of the CR Plan, ensuring that CalOptima Health's investments meaningfully address community-identified needs, advance equitable outcomes, and fully meet DHCS requirements for CR.

12) If applicable, provide a summary of input provided by the QIHEC on the Community Reinvestment Plan and/or planning efforts.	The Quality Improvement Health Equity Committee (QIHEC) was included as part of CalOptima Health's broader advisory-committee engagement to support development of the CR Plan. As reflected in organizational materials and program updates, QIHEC received an overview of the Community Reinvestment Program and its requirements during the committee's October 14, 2025 session. During this meeting, the CHEO presented the CR framework, including DHCS' guiding principles, eligible investment categories, and the program's focus on addressing upstream drivers of health through community-level activities. QIHEC was invited to provide feedback on the alignment of proposed CR priorities with CalOptima Health's quality improvement and health equity goals. Documentation from this engagement indicates that QIHEC's discussion supported validation of program direction and helped confirm alignment between organizational quality priorities and CR planning efforts. The QIHEC received an additional briefing on the draft Community Reinvestment Plan prior to Board of Directors approval, providing an opportunity for formal feedback and recommendations before the plan was finalized.
13) Provide a description of how the Community Reinvestment activity will be measured and evaluated.	Per CalOptima Health's Grant Management Policy, all grant awards are required to have measurable outcomes outlined in their grant agreements. Therefore, in alignment with that policy, community investments under this activity will each include SMART objectives that directly track the progress of each unique

	grant project. These objectives will incorporate several of the following measures and others yet to be identified, given the fact that will be reflective of the unique programs selected for funding: **Process / Output Measures:** • Number of grants awarded and total dollars invested • Number of scholarships, stipends, or loan repayment awards disbursed • Number of training programs, residencies, or internship programs funded • Number of individuals enrolled in funded training or educational programs • Number of educational or employer partnerships established **Outcome Measures:** • Number of program participants who complete training and enter or advance in a healthcare career • Number of new providers credentialed or employed in underserved areas of Orange County • Number of funded organizations that expand their behavioral health or SUD service offerings in underserved communities • Increase in the number of bilingual or multilingual healthcare workers trained and placed in community-based healthcare roles in Orange County • Provider retention rates (tracked over the investment period) • Reduction in provider vacancy rates or time-to-fill for high-demand roles at funded organizations **Health Equity Measures:** • Proportion of program participants from

	underrepresented racial/ethnic communities • Proportion of participants from low-income backgrounds or ZIP codes with documented workforce shortages • Participant demographics disaggregated by race/ethnicity, primary language, gender, age, disability status, geographic location/zip code. •Percentage employed in Medi-Cal serving organizations or other safety-net providers. • Number of interventions that directly align with CalOptima Health's Health Equity Guiding Principles. Per CalOptima Health's Grant Management Policy, all grantees are required to submit progress reports and a final report. CalOptima Health's Grants Management Department will review performance data and conduct grantee check-ins to monitor progress and support course corrections as needed to maximize impact.
14) If applicable, please provide the name of any Qualifying Subcontractors that intend to invest in this activity.	Not applicable. CalOptima Health does not have any Qualifying Subcontractors.

Activity 3: Housing and Homelessness Services and Infrastructure

Description of Proposed Community Reinvestment Activities – Activity 3: Housing and Homelessness Services and Infrastructure	
Question	**Response**
1) Provide a detailed description of the Community Reinvestment and the related use category or categories for the activity.	**Activity Description:** CalOptima Health will invest in increasing the stock of stable, affordable and permanent supportive housing and interim housing sites, and in bolstering supportive services for individuals experiencing homelessness or housing insecurity in Orange County. Investments will include: (1) capital funding for interim housing sites, (2) capital funding for affordable and/or permanent supportive housing (PSH) units; and (3) capacity building and/or systems change funding for local housing agencies and community-based organizations that provide services addressing root social determinants of homelessness — such as educational attainment, career development, legal system navigation, and services that address other health-related social needs. CalOptima Health recognizes housing stability as a foundational health outcome and a prerequisite for sustained recovery, behavioral health treatment engagement, and reduced healthcare utilization. **Related Use Categories:** **Cultivating Neighborhoods and Built Environment –** This proposed activity cultivates neighborhoods and the build environment by funding investments in affordable and supportive housing infrastructure, including transitional or interim housing sites, PSH units, and community-based services that promote

	safe, stable living environments for members and community residents. This proposed activity increases the stock of units available and accessible to CalOptima Health members. **Cultivating Improved Health** – This proposed activity cultivates improved health by reducing housing instability, an upstream root cause of poor health outcomes and high healthcare utilization. Investments in housing stability address the social and structural determinants of health that directly contribute to chronic disease, substance use disorders, behavioral health crises, injury, and preventable hospitalizations. Ultimately, increasing housing availability for CalOptima Health members improves their health and their ability to remain healthy. **Cultivating Well-Being for Priority Populations** – This proposed activity cultivates well-being for priority populations by targeting investments in housing development for priority populations facing housing insecurity including individuals with mental illness and/or SUD, seniors, domestic violence survivors, justice-involved individuals, transition-age youth, and at-risk families. **Cultivating Local Communities** – This proposed activity cultivates local communities by ensuring diverse, secure, and supported neighborhoods in which CalOptima Health members participate and reside. By increasing the stock of affordable housing across the county, this proposed activity promotes advancement out of poverty and reduces housing

	insecurity. Furthermore, by supporting collaborative efforts designed to support residents in these newly constructed communities, these investments will build cross-sector partnerships that strengthen the local social service infrastructure. Ultimately these investments bolster the lives of all community members in new housing developments and in the surrounding areas, contributing to the wellbeing of the overall community.
2) Please indicate all counties of operation where investments for this activity will occur.	Orange County, California.
3) Please specify the intended timeline for funding this activity (e.g., the CY 2026 – CY 2029 investment period based on CY 2024 – CY 2026 net income).	CY 2026 – CY 2029, based on CY 2024 – CY 2026 net income.
4) Provide a description of how the activity is informed by the LHJ's CHA. Please include a link or hard copy of the most recent CHA.	This proposed activity is informed by the 2023 Orange County Community Health Assessment (OC CHA), a comprehensive review of the health status and most pressing health needs of Orange County communities. Developed through collaborative efforts led by the OC Health Care Agency (OCHCA), the OC CHA gathered input from 174 participants representing individual community members, community-based organizations, public health agencies, health care systems, and hospitals, and used a data-driven scoring process to identify priority health issues.

	The OC CHA identifies housing and homelessness as a top-ranked community health priority in Orange County. Key data from the OC CHA that directly inform this activity include: (1) housing instability and homelessness are documented as both a health outcome and a root cause of poor health across multiple priority areas; (2) OC's high cost of living — driven primarily by housing costs — is a documented driver of financial insecurity and housing loss for low-income residents, including seniors with depleted personal resources; (3) the CHA priority of economic disparities — is identified as a structural cause of housing insecurity requiring upstream investment; and (4) community prioritization processes consistently identified homelessness and housing instability as among the most pressing and under-addressed needs in Orange County. The OC CHA's documentation of the intersection between housing instability, behavioral health, economic disparities, and access to social services directly informs this activity's emphasis on an integrated approach to housing development, which pairs housing infrastructure investment with wraparound supports including care management, job development, peer-based housing stability services, and financial assistance to address root causes of homelessness. OC CHA (2023) Available at: https://ochealthinfo.com/sites/healthcare/files/2023-10/Orange_County_Community_Health_Assessment-Final.pdf

5) If applicable, provide a description of how the activity is informed by the BHT community planning process.	This proposed activity is informed by the Orange County BHSA 2026–2029 Integrated Plan. The BHSA Integrated Plan identifies housing as a mandated investment category, requiring 30% of total county BHSA funds to be directed toward housing services and supports. OC Behavioral Health Services' data reported in the Integrated Plan shows: 6,034 adults served by the behavioral health system were chronically homeless, experiencing homelessness, or at risk of homelessness in FY 2023–2024; 5,315 of these experienced unsheltered homelessness; 1,519 children and youth in the behavioral health system were homeless or at risk; and 1,260 individuals transitioned from unsheltered homelessness into permanent housing through behavioral health-linked interventions. The Integrated Plan prioritizes bridge (interim) housing, permanent supportive housing, and outreach and engagement services for people experiencing homelessness as core program categories. OC BHS is actively developing RFPs for housing services under BHSA, creating opportunities for CalOptima Health's CR investments to complement public funding and fill gaps. Available at: https://www.ochealthinfo.com/sites/healthcare/files/2026-04/BHSA_IntegratedAnnualPlan2026-29.pdf

6) If applicable, identify the LHJ CHIP activity that the Community Reinvestment activity matches. Please include a link or hard copy of the most recent CHIP.	This proposed activity is informed by the 2024–2026 Orange County Community Health Improvement Plan (OC CHIP). The OC CHIP identifies Housing and Homelessness as Priority Area 4, Goal 1 to broaden the housing and homelessness workgroup by incorporating members from various organizations involved in housing and homelessness initiatives throughout Orange County to work toward meaningful and sustainable solutions. Ultimately, capacity building and systems change work through this activity connects to the goal to broaden cross-sector collaboration and develop meaningful, sustainable solutions to homelessness in Orange County. The OC CHIP also identifies Economic Disparities as Priority Area 6, recognizing structural economic inequities — including housing costs and financial insecurity — as root causes of homelessness requiring upstream investment. Investing in affordable housing units advances progress toward this priority area. Finally, the OC CHIP specifically identifies within Priority Areas (1) Mental Health and (2) Substance Use that housing stability is recognized as a prerequisite for engagement in behavioral health treatment and recovery. By investing in housing units accessible to individuals with mental health and substance use disorders, this activity directly supports efforts advocated by the OC CHIP. These priorities identified by the OC CHIP directly informs this activity's emphasis on

	developing housing for priority populations and an integrated approach to housing development, which pairs housing infrastructure investment with wraparound supports including care management, job development, peer-based housing stability services, and financial assistance to address root causes of homelessness. Available at: https://www.ochealthinfo.com/page/oc-community-health-improvement-plan-2024-2026
7) Provide a description of the anticipated benefits of the Community Reinvestment activity, populations expected to benefit, and alignment with guiding principles identified in the APL. Note: If this activity is intended to meet the MCP's Quality Achievement Community Reinvestment requirement, the MCP must indicate how the activity aligns with the "Cultivating Improved Health" category.	**Anticipated Benefits:** This proposed activity is expected to increase housing stability for CalOptima Health members and Orange County residents who are homeless or at risk of homelessness — particularly those with co-occurring behavioral health conditions. Stable housing reduces emergency department utilization, improves engagement in behavioral health and primary care treatment, supports recovery from mental illness and SUD, and reduces cycling through crisis, incarceration, and institutionalization. **Populations Expected to Benefit:** (1) Adults and youth with serious mental illness (SMI) or SUD who are experiencing or at risk of homelessness (2) Seniors and older adults experiencing housing insecurity due to fixed incomes and depleted personal financial resources (3) Domestic violence survivors requiring safe housing and legal supports (4) Justice-involved individuals transitioning from incarceration who lack stable housing (5) Low-income families, including

	immigrants and limited-English-proficient households, facing housing insecurity (5) Transition-aged youth, and (6) CalOptima Health members with high healthcare utilization driven by housing instability **Alignment with Guiding Principles:** (1) Engage with the Community – Each activity ties back to the CAC survey process, names what members and providers specifically said that informed the activity's design, and notes that the CHEO and CR Workgroup reviewed and incorporated that feedback. The community engagement rationale is activity-specific: behavioral health and peer support priorities for Activity 1; workforce shortages and cultural access barriers for Activity 2; housing capital and CBO partnership calls for Activity 3. (2) Align Community-Identified Priorities with Investments in Health Outcomes and Equity – Each response references the specific 2023 OC CHA and OC CHIP priorities that correspond to the activity, names the populations facing the greatest disparities that the investment targets, and explains how the investment advances health equity at a structural level — not just service delivery. Activity 1 references mental health and SUD as the top two CHA priorities; Activity 2 references care navigation and economic disparities; Activity 3 references housing/homelessness and economic disparities with a focus on upstream social determinants. (3) Ensure Funding Targets Non-Contract

	Activities – Each response directly addresses the APL prohibition and explains specifically why the activity's investments fall outside covered services. Activity 1 notes that wellness spaces, school programs, non-clinical peer services, and dyadic care infrastructure are all outside the Medi-Cal benefit structure. Activity 2 clarifies that pipeline development for new entrants is distinct from prohibited T&TA for existing Medi-Cal providers. Activity 3 restates the specific Community Supports exclusions from APL 25-004 and explains that capital housing investments and CBO systems change work are not MCP contract services. All three close with a grantee confirmation requirement. **Alignment with Cultivating Improved Health:** This activity aligns with "Cultivating Improved Health" by addressing housing instability as an upstream root cause of poor health and high utilization. Investments in housing stability address the social and structural determinants of health that contribute to homelessness, behavioral health crises, and preventable hospitalizations.
8) Provide a description of the approach taken to engage the CAC in the Community Reinvestment planning process, including a summary of input and recommendations provided.	CalOptima Health engaged the Community Advisory Committee (CAC) as a key partner in the CR planning process. CalOptima Health met with the CAC on April 10, 2025, and October 9, 2025, to review CR program requirements, collect structured stakeholder input, and validate planning assumptions. Input from these meetings informed CR program planning activities, outreach strategy development, and implementation methodology based on partner organization and community-identified needs.

	During CAC engagement, the Chief Health Equity Officer (CHEO) delivered a formal presentation that included a program overview, the draft CR planning framework, and proposed program requirements and investment priority categories. Following the presentation and discussion, CalOptima Health distributed a standardized survey to CAC members to collect structured feedback on community needs, service gaps, operational barriers, and recommended program focus areas. Across respondents, the most frequently cited investment priorities were: (1) behavioral health and substance use disorder services, including expanded mental health coverage and access to SUD treatment; (2) housing stability and homelessness supports, including low-income housing, project-based vouchers, and civil legal aid as a housing stability strategy; (3) healthcare workforce development, particularly addressing reimbursement barriers and specialty provider shortages; (4) services for seniors facing financial and housing insecurity; and (5) specialized behavioral health programming for individuals with neurodevelopmental disabilities. This feedback was incorporated into updates to outreach strategies, funding priority criteria, and CR program design.

9) If applicable, provide a description of the approach taken to engage other community stakeholders in the Community Reinvestment planning process, including a summary of stakeholders involved and any input or recommendations provided.	CalOptima Health engaged a broad group of internal and external stakeholders to ensure the CR planning process was inclusive and grounded in community and partner perspectives. Surveys, focus groups, and listening sessions were used to gather structured input. The CR Workgroup was established, which includes representation from clinical, quality, community health, and equity leadership, to provide ongoing opportunities to review planning components and incorporate feedback from key partners. The CR Workgroup held its kickoff meeting on June 3, 2025, and reconvened on September 30, 2025, and January 12, 2026, reviewed draft materials, validated planning assumptions, and refined program elements based on stakeholder input. In addition, the CHEO presented and solicited feedback at several key committees, including Quality Improvement Health Equity Committee on October 10, 2025, the Community Investment Oversight Committee on October 24, 2025, the OC Population Health Collaborative Committee on February 2, 2026, and the OC CHIP Steering Committee on February 2, 2026. Internal contributors included cross-departmental leaders and executives, as well as ad hoc workgroups such as Accounting, Finance, and operational teams involved in implementation planning. External partners included the County Health Care Agency, County Behavioral Health, Kaiser Permanente, and community based organizations engaged

	through the CHA/CHIP and Behavioral Health Transformation processes, as well as insights aligned with our 2025/2026 Member Population Health Needs Assessment (MPHNA). The MPHNA is a comprehensive assessment that evaluates CalOptima Health members' whole-person health needs and preferences. It integrates clinical data, social determinants of health, community feedback, and population-level trends to identify disparities, understand member characteristics, and inform program development, strategic initiatives, and Community Reinvestment activities. Stakeholders emphasized aligning CR priorities with identified community needs supporting the integration of behavioral health and social needs and strengthening coordination across countywide initiatives. Their input helped ensure that planning, outreach design, and implementation strategies were responsive to partner recommendations and reflective of the communities served.
10) Provide a description of any investments recommended by the CAC not included in the Community Reinvestment Plan.	CAC respondents made a few recommendations that are not included as standalone Community Reinvestment activities in the current plan. These include: food insecurity programs, better reimbursement rates for specialty services, provider training, and broader PACE program infrastructure expansion. These recommendations were not included as primary CRP activities for one or both of the following reasons: (1) they fall outside the allowable investment activity categories defined in Attachment A of DHCS APL 25-004; or (2) CalOptima

	Health has recently made investments in those areas through existing programs, contracts, or community benefit activities outside the scope of the CRP. CalOptima Health will continue to evaluate opportunities to support CAC-identified needs through other channels.
11) Provide a summary of input provided by the Chief Health Equity Officer on the Community Reinvestment Plan and/or planning efforts.	CalOptima Health's Chief Health Equity Officer (CHEO), Dr. Michaell Silva Rose, provided strategic guidance and oversight during the development of the CR Plan. The CHEO led and facilitated CR planning efforts aligned with CalOptima Health's mission, health equity principles, and the requirements outlined in DHCS All Plan Letter (APL) 25-004. The Community Reinvestment Joint Internal and External Stakeholder Workgroup meets quarterly to guide CR planning and implementation. This workgroup is comprised of internal representatives of the following departments: Equity and Community Health, Grant Management, Quality, Strategic Development, Behavioral Health Integration, and CalAIM. Together they discuss CR updates and efforts, and develop strategies and tactics for the identified focus areas. External partners are also represented, such as the County Health Care Agency and County Behavioral Health, to ensure alignment with county priorities. Ad hoc workgroups, including Accounting and Finance, convene as needed to support fiscal oversight and operational requirements. Across the CR Joint Internal and External Stakeholder Workgroup's meetings, the

	CHEO outlined the overall vision, priorities, and expectations for the CR program. This included outlining the purpose and intent of community reinvestment, reviewing permitted investment categories, and reinforcing the importance of aligning activities with upstream drivers of health, such as housing instability, food insecurity, and access barriers. During CR Workgroup meetings, the CHEO led discussions on alignment with county public health and behavioral health partners, integration of findings from the MPHNA, CHA/CHIP, BH Integration Plan and other community resources. Overall, the CHEO's input shaped the structure, compliance alignment, and equity focus of the CR Plan, ensuring that CalOptima Health's investments meaningfully address community-identified needs, advance equitable outcomes, and fully meet DHCS requirements for CR.
12) If applicable, provide a summary of input provided by the QIHEC on the Community Reinvestment Plan and/or planning efforts.	The Quality Improvement Health Equity Committee (QIHEC) was included as part of CalOptima Health's broader advisory-committee engagement to support development of the CR Plan. As reflected in organizational materials and program updates, QIHEC received an overview of the Community Reinvestment Program and its requirements during the committee's October 14, 2025 session. During this meeting, the CHEO presented the CR framework, including DHCS' guiding principles, eligible investment categories, and the program's focus on addressing upstream drivers of health

	through community-level activities. QIHEC was invited to provide feedback on the alignment of proposed CR priorities with CalOptima Health's quality improvement and health equity goals. Documentation from this engagement indicates that QIHEC's discussion supported validation of program direction and helped confirm alignment between organizational quality priorities and CR planning efforts. The QIHEC received an additional briefing on the draft Community Reinvestment Plan prior to Board of Directors approval, providing an opportunity for formal feedback and recommendations before the plan was finalized.
13) Provide a description of how the Community Reinvestment activity will be measured and evaluated.	Per CalOptima Health's Grant Management Policy, all grant awards are required to have measurable outcomes outlined in their grant agreements. Therefore, in alignment with that policy, community investments under this activity will each include SMART objectives that directly track the progress of each unique grant project. These objectives will incorporate several of the following measures and others yet to be identified, given the fact that will be reflective of the unique programs selected for funding: **Process / Output Measures:** • Number of grants awarded and total dollars invested • Number of transitional/bridge/interim, affordable or permanent supportive housing units funded, created, or enhanced • Number of individuals placed in housing through funded programs • Number of service encounters provided

	(for programs that target upstream, social drivers of homelessness) • Number of community or cross-sector partnerships established or strengthened **Outcome Measures:** • Number of CalOptima Health members served through funded housing programs • Number of individuals who transition from transitional housing to permanent housing • Housing retention rate at 6 months and 12 months among members who are transition from homeless status to housed based on internal algorithm • Number of individuals who have resolved a social-need that could have otherwise contributed to homelessness **Equity Measures:** • Proportion of individuals served who are from priority populations (seniors, domestic violence survivors, justice-involved, limited-English-proficient) • Geographic distribution of funded services across northern and southern Orange County • Participant demographics disaggregated by race/ethnicity, primary language, gender, age, disability status, geographic location/zip code • Percentage successfully connected to supportive services (e.g., behavioral health, mental health, primary care, food assistance, transportation, employment or benefits navigation) • Number of interventions that directly align with CalOptima Health's Health Equity Guiding Principles.

	Per CalOptima Health's Grant Management Policy, all grantees are required to submit progress reports and a final report. CalOptima Health's Grants Management Department will review performance data and conduct grantee check-ins to monitor progress and support course corrections as needed to maximize impact.
14) If applicable, please provide the name of any Qualifying Subcontractors that intend to invest in this activity.	Not applicable. CalOptima Health does not have any Qualifying Subcontractors.

APPENDIX B, EXHIBIT 1: COMMUNITY REINVESTMENT ATTESTATION FORM FROM PUBLIC HEALTH DIRECTOR

Overview: On an annual basis, by September 1 or the first working day of September, MCPs with positive net income for the applicable calendar year are required to submit a Community Reinvestment Plan to DHCS. All new investment activities must align with community needs identified in the Community Health Assessment (CHA) and be generally agreeable to the Local Health Jurisdiction, and MCPs must obtain an attestation from Public Health Directors in support of this plan. In 2026 only, MCPs have the ability to claim voluntary investments toward their initial, 2026-2029 Community Reinvestment Obligation to honor existing investment commitments that may not be aligned with the CHA, but otherwise meet all requirements of APL 25-004. If an MCP is claiming Voluntary Investments for all or part of their Community Reinvestment obligation, MCPs must inform LHJs of these activities but are not required to obtain an attestation of agreement with the planned activities.

Please complete the attestation statement(s) that applies to your MCP:

Community Reinvestment Plan Attestation of Support: ***Applicable to all unless the MCP is fulfilling their entire obligation with voluntary investments in 2026.***

I, the undersigned, as an officer of [county / city name] Orange County, hereby attest that [MCP Name] CalOptima Health Community Reinvestment Plan for new investments anticipated in calendar year(s) [calendar year(s)] _____:

- Aligns with community needs identified in the most current Community Health Assessment (CHA):
  - ☐ Yes
  - ☐ No (If no, explain):

  ☐ Not applicable: This MCP is fulfilling their entire Community Reinvestment Obligation in this LHJ through voluntary investments.

- Includes an investment strategy that is agreeable to the Local Health Jurisdiction (LHJ):
  - ☐ Yes
  - ☐ No (if no, explain):

  ☐ Not applicable: This MCP is meeting their entire Community Reinvestment Obligation in this LHJ through voluntary investments.

And,

Voluntary Investment Attestation of Acknowledgement: ***Applicable only in 2026.***

I, the undersigned, as an officer of [county/city name] Orange County, hereby attest that [MCP name] CalOptima Health has informed the Local Health Jurisdiction (LHJ) of its proposed voluntary investment activities included in its Community Reinvestment Plan, to be expended in calendar year(s) [calendar year(s)] 2026-2029:

☑ Yes

☐ No (if no, explain):

☐ Not Applicable: This MCP is not claiming any voluntary investments in this LHJ.

By:

Veronica Kelley

(Please type full name here)

Director, Orange County Health Care Agency

(Please type title here)

(Signature) 6/11/2026 (Date)

This attestation must be signed by the designated lead public health official of the associated jurisdiction, which may include the Public Health Director or another officially authorized equivalent and submitted to their MCP.

APPENDIX B, EXHIBIT 2: COMMUNITY REINVESTMENT ATTESTATION FORM FROM COUNTY BEHAVIORAL HEALTH DIRECTOR

Overview: On an annual basis, by September 1 or the first working day of September, MCPs with positive net income for the applicable calendar year are required to submit a Community Reinvestment Plan to DHCS. All new investment activities must align with community needs identified in the Community Health Assessment (CHA) and be generally agreeable to the Local Health Jurisdiction and County Behavioral Health Department, and MCPs must obtain an attestation from County Behavioral Health Directors in support of this plan. In 2026 only, MCPs have the ability to claim voluntary investments toward their initial, 2026-2029 Community Reinvestment Obligation to honor existing investment commitments that may not be aligned with the CHA, but otherwise meet all requirements of APL 25-004. If an MCP is claiming Voluntary Investments for all or part of their Community Reinvestment obligation, MCPs must inform LHJs and County Behavioral Health Departments of these activities but are not required to obtain an attestation of agreement with the planned activities.

Please complete the attestation statement(s) that applies to your MCP:

Community Reinvestment Plan Attestation of Support: *Applicable to all unless the MCP is fulfilling their entire obligation with voluntary investments.*

I, the undersigned, as an officer of [county name] Orange County, hereby attest that [MCP Name] CalOptima Health Community Reinvestment Plan for new investments anticipated in calendar year(s) [calendar year(s)]_____:

- Is informed by needs identified in the Behavioral Health Transformation planning process:
  - ☐ Yes
  - ☐ No (if no, explain):
  - ☐ Not applicable: This MCP is fulfilling their entire Community Reinvestment Obligation in this LHJ through voluntary investments.
- To the extent CHA includes behavioral health needs as identified by the community, the County Behavioral Health Department agrees that the investment strategy is aligned with the CHA:
  - ☐ Yes
  - ☐ No (if no, explain):
  - ☐ Not applicable: This MCP is meeting their entire Community Reinvestment Obligation in this LHJ through voluntary investments.

» Includes an investment strategy that is agreeable to the County Behavioral Health Department:

☐ Yes

☐ No (if no, explain):

☐ Not applicable: This MCP is meeting their entire Community Reinvestment Obligation in this LHJ through voluntary investments.

Voluntary Investment Attestation of Acknowledgement: ***Applicable only in 2026.***

I, the undersigned, as an officer of [county name] Orange County, hereby attest that [MCP name] CalOptima Health has informed the County Behavioral Health Department of its proposed voluntary investment activities included in its Community Reinvestment Plan, to be expended in calendar year(s) [calendar year(s)] 2026-2029:

☑ Yes

☐ No (if no, explain):

☐ Not Applicable: This MCP is not claiming any voluntary investments in this LHJ.

By:

Veronica Kelley

(Please type full name here)

Director, Orange County Health Care Agency

(Please type title here)

_____ 6/11/26

(Signature) (Date)

This attestation must be signed by the designated lead behavioral health official of the associated jurisdiction, which may include the County Behavioral Health Director or another officially authorized equivalent and submitted to their MCP.

State of California—Health and Human Services Agency
Department of Health Care Services

DHCS

Michelle Baass
DIRECTOR

Gavin Newsom
GOVERNOR

July 15, 2026

Ms. Nancy Huang
CalOptima Health
505 City Parkway West
Orange, CA, 92868

Subject: CY 2024 Community Reinvestment Determination Letter

Dear Ms. Huang:

The Department of Health Care Services (DHCS) has completed its review of CalOptima Health's contractually required Medical Loss Ratio (MLR) calculation for the Managed Care population for the incurred period of January 1, 2024 to December 31, 2024. The findings from this review, based on point in time data, were used to determine the Managed Care Plan's Annual Net Income for purposes of calculating the Community Reinvestment Obligation Amounts as specified in APL 25-004.

Per APL 25-004, Managed Care Plans (MCPs) and their Qualifying Subcontractors are required to demonstrate their commitment to the local communities in which they operate by contributing a minimum percentage of positive annual net income to those communities. DHCS requires MCPs to make additional investments when MCPs do not meet specific quality outcome metrics. Qualifying Subcontractors are not subject to the additional quality achievement contribution.

Back to Agenda Back to Item

SUMMARY OF REQUIREMENTS

The Base Community Reinvestment requirement refers to the minimum level of net income that an MCP with positive net income is required to invest into initiatives that serve the communities in which the MCP operates, starting with net income based on CY 2024 Contract Revenues for community reinvestment activities initiated after DHCS approval of the Community Reinvestment Plan submitted in 2026. The MCP Contract requires MCPs to allocate Base Community Reinvestment funds equal to:

- 5% of the MCP's annual net income that is less than or equal to 7.5% of Medi-Cal Contract Revenues for the year; and
- 7.5% of the MCP's annual net income that is greater than 7.5% of Medi-Cal Contract Revenues for the year.

The Base Community Reinvestment requirement also applies to any Knox-Keene licensed health care service plan in a Subcontractor Agreement with an MCP that is required to submit a Medical Loss Ratio (MLR) report pursuant to APL 24-018 and assumes risk for at least 100,000 Members or at least 50% of the MCP's Members within a given county or rating region (Qualifying Subcontractor). Qualifying Subcontractors must allocate Base Community Reinvestment funds equal to:

- 5% of the Qualifying Subcontractor's annual net income that is less than or equal to 7.5% of revenues under its Subcontractor Agreement with the MCP for the year; and
- 7.5% of the Qualifying Subcontractor's annual net income that is greater than 7.5% of revenues under its Subcontractor Agreement with the MCP for the year.

If an MCP or its Qualifying Subcontractor operates in multiple counties, DHCS will calculate the Base Community Reinvestment funding obligations with the following allocation methodology:

- 100% of Base Community Reinvestment funds will be distributed among all counties where the MCP operates. Each county's share will be based on the square root of its Medi-Cal membership, divided by the sum of the square roots of all Medi-Cal membership across all counties served by the MCP.

The Quality Achievement Community Reinvestment requirement refers to the additional net income that MCPs are required to invest into counties where the MCP operates, in which the MCP does not meet minimum quality measure performance thresholds for the applicable CY. MCPs with counties assigned to Enforcement Tier 2 and Tier 3 are subject to this additional Quality Achievement Community Reinvestment. Subcontractors are not subject to the Quality Achievement Community Reinvestment component. The MCP contract requires that MCPs allocate Quality Achievement Community Reinvestment funds equal to:

- 7.5% of the MCPs annual net income

If an MCP operates in multiple counties and is subject to the Quality Achievement Community Reinvestment requirement, DHCS will calculate the MCP's Quality Achievement Community Reinvestment funding allocations in proportion to its Medi-Cal membership for counties in which it has received an Enforcement Tier 2 or Tier 3 assignment.

SUMMARY OF RESULTS

The following table summarizes DHCS's determination of the Managed Care Plan's Community Reinvestment Obligation Amount for CY 2024:

Managed Care Plan	County/Region	Reporting Period	Base Obligations Amount	Quality Obligations Amount	(Total Base+ Quality)
CalOptima Health	Orange	CY 2024	$ 4,689,025	$ 7,033,538	$ 11,722,563
Total to be Reinvested					$ 11,722,563

The following table summarizes DHCS's determination of the Managed Care Plan's Subcontractors Community Reinvestment Obligation Amount for the CY 2024:

Subcontractor	County/Region	Reporting Period	Base Obligations Amount	Quality Obligations Amount	(Total Base+ Quality)
N/A	N/A	N/A	N/A	N/A	N/A
Total to be Reinvested					N/A

Right of Appeal

If the plan disagrees with the Community Reinvestment calculation documented in this determination letter, the plan may appeal in writing to DHCS within 15 calendar days of the date of this letter. If no written appeal is received by that date, the Community Reinvestment calculation documented herein will be considered final and complete.

To appeal, the plan must respond on plan letterhead within 15 calendar days of the date of the determination letter to Rafael Davtian, Deputy Director of Health Care Financing, at Rafael.Davtian@dhcs.ca.gov, and copy CRDDManagement@dhcs.ca.gov. The appeal should utilize Subject line: “Community Reinvestment Appeal – Plan Name”.

The appeal must state the basis for the appeal and must include evidence supporting the findings, adjustments, and/or calculation being appealed. The Deputy Director of Health Care Financing will accept or deny the appeal within 30 days and notify the plan of this decision.

If applicable, and only if DHCS accepts an appeal, DHCS will reinitiate review of Community Reinvestment calculation to account for the additional evidence provided during the accepted appeal. Once the review is completed and if deemed appropriate, DHCS will issue a revised final Community Reinvestment calculation of the plans base and if applicable quality obligation amount. If an appeal is denied, the Community Reinvestment calculation documented in this letter will be considered final and complete.

If you have any questions regarding this determination letter, please contact Erica Johnson at Erica.Johnson@dhcs.ca.gov of the Capitated Rates Development Division.

Sincerely,

Derick Daniels

Derick Daniels
Assistant Division Chief, Capitated Rates Development Division
California Department of Health Care Services

cc: Rafael Davtian; Sean Barber; Derick Daniels; Erica Johnson;

Community Reinvestment Plan (CY2024-2026)

Board of Directors Meeting

August 6, 2026

Kelly Bruno-Nelson, Executive Director, Medi-Cal and CalAIM

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.

What Is the Community Reinvestment Requirement?

About the Community Reinvestment Requirement

- **What is it?**
  - DHCS All Plan Letter 25-004 requires Medi-Cal managed care plans to reinvest a portion of net income back into the communities they serve.
- **What must the plan include?**
  - Selected investment activities grounded in community health data, stakeholder input, and health equity principles — targeting upstream root causes of poor health.
- **Where do investments go?**
  - Non-contract activities that benefit the community — things Medi-Cal does not already cover.

KEY DATES

CY 2024-2026
Determines required amount to invest based on Net Income during this time period

CY 2027–2029
Time period the investments must be made

2030
Final Report due to DHCS for Community Reinvestment Plan

CalOptima Health

DHCS's Three Guiding Principles:
Developing Community Reinvestment Plans

1

Engage with the Community

CalOptima Health's Plan is directly informed by member and provider voices through the MAC and PAC, and informed by our Chief Health Equity Officer and internal workgroups and committees.

2

Align with Community Priorities

Activities are grounded in the 2023 OC Community Health Assessment, the Health Improvement Plan and the BHSA Integrated Plan, targeting the health priorities that OC residents and stakeholders have identified themselves.

3

Target Non-Contract Activities

All investments fund activities outside the Medi-Cal contract — expanding what is possible for our members and communities, not duplicating what already exists.

CalOptima Health

How CalOptima Health Built our Community Reinvestment Plan

CalOptima Health's Community Reinvestment Approach



- Data from:
  - OC CHA & CHIP
  - OC BHSA Integrated Plan
  - CalOptima Health Member and Population Needs Assessment
  - Community Asset Mapping

- Key Stakeholders:
  - Community listening sessions
  - CalOptima Health governance and advisory committees
  - County engagement
  - CHIP workgroups
  - BHT Planning Process

- Design to address key community issues identified in:
  - CHA/CHIP
  - MPHNA
  - Asset mapping findings
  - Stakeholder input
  - Community Benefit Hospitals' CHNA

- Communicate the plan
  - Validated by stakeholders
  - County attests to CHIP alignment
  - Board approval
  - Submit plan to DHCS Q3 2026

- Fund the Plan
  - Voluntary investments
  - Future funding opportunities

CalOptima Health

Connecting the Dots: Five Key Sources of Input

CHA

- Community Health Needs Assessment 2023
- Data indicators, support metrics and key evidence referenced for the CHIP design.

CHIP

- Community Health Improvement Plan 2024-2026
- Priority areas: mental health; substance use, diabetes and obesity, housing and homelessness, care navigation and economic disparities.

BHSA

- Behavioral Health Integration Plan 2026
- Priority areas: mental health and substance use disorder services, housing for people experiencing homelessness, healthcare workforce development

MAC & PAC

- Member and Provider Advisory Committees
- Priority areas: behavioral health and substance use disorder services, housing stability and homelessness, and healthcare workforce development. Focus on seniors, older adults and individuals with neurodevelopmental disabilities, the role of civil legal aid, and the importance of benefits and system navigation.

CHEO & QIHEC

- Health Equity Leadership
- Quality Improvement Leadership
- Other Internal Governance Structures

CalOptima Health

Aligning the Priorities: APL Community Reinvestment Activities

1. Promotes health, wellbeing and safety through the environment our neighbors live in.

   Cultivating Neighborhoods & Built Environment

2. Building the next generation of health care workers by supporting individuals across the career span.

   Cultivating Health Care Workforce

3. Addresses community-specific needs through tailored support and services.

   Cultivating Well-Being for Priority Populations

4. Bolsters the lives of individuals and contribute to advancement and well-being of the community.

   Cultivating Local Communities

5. Initiatives targeted toward upstream root causes of poor health using a variety of strategies and settings.

   Cultivating Improved Health

CalOptima Health

CalOptima Health's Plan: Three Key Investment Activities

Activity 1: Behavioral Health Infrastructure

BH

Connections to Reinvestment Categories:

1: Cultivating Neighborhoods and Built Environment
3: Cultivating Well-Being for Priority Populations
4: Cultivating Local Communities
5: Cultivating Improved Health

- Community wellness spaces — funding creation or enhancement of wellness centers where residents access peer support and mental health resources outside the Medi-Cal system
- School-based mental health — community-based programs that strengthen schools' capacity to support student behavioral health beyond what is covered by Medi-Cal
- Non-Medi-Cal peer and mental health services — peer-led wellness programs and community outreach not covered by Medi-Cal
- Dyadic care infrastructure — organizational systems change support for CBOs integrating dyadic care into their practice models

CalOptima Health

Activity 2: Healthcare Workforce Development

WF

Connections to Reinvestment Categories:

2: Cultivating a Health Care Workforce
3: Cultivating Well-Being for Priority Populations
4: Cultivating Local Communities
5: Cultivating Improved Health

- Scholarships and loan forgiveness — for students in nursing, behavioral health, social work, and community health worker programs
- Career pipeline programs — recruiting and training high school and college-age residents from underserved communities into healthcare careers
- Mentorship and professional development — pairing emerging healthcare workers with experienced clinicians
- Educational partnerships — with OC community colleges and universities to build sustainable, culturally reflective workforce pipelines

CalOptima Health

Activity 3: Housing and Homelessness Services & Infrastructure

HH

Connections to Reinvestment Categories:

1: Cultivating Neighborhoods and Built Environment
3: Cultivating Well-Being for Priority Populations
4: Cultivating Local Communities
5: Cultivating Improved Health

- Capital funding for interim housing — supporting development of interim housing sites for individuals experiencing homelessness
- Capital funding for permanent supportive housing (PSH) — investing in affordable and PSH units, especially for priority populations
- Ensuring supportive, wrap-around services are provided in housing developments
- Capacity building for CBOs — systems change funding for organizations addressing root social determinants of homelessness including legal system navigation, career development, and educational attainment

CalOptima Health

CalOptima Health's 2027 Community Reinvestment Plan: Met Through 2024

Voluntary Investments

Proposed Voluntary Investments to Meet CY2024 Requirement

Community Reinvestment Plan Activity		Dollar Amount
Healthcare Workforce Development	Base	$4,689,025
Healthcare Workforce Development	Quality	$1,247,274
Behavioral Health Infrastructure	Quality	$2,214,046
Housing and Homelessness Services and Infrastructure	Quality	$3,572,218
	Subtotal of Base	$4,689,025
	Subtotal of Quality	$7,033,538
	TOTAL VOLUNTARY INVESTMENT	$11,722,563

CY2024 Community Reinvestment Requirement	
Base Community Reinvestment	$4,689,025
Quality Achievement	$7,033,538
Total	$11,722,563

Next Steps

What Happens Next

Q3 2026
Plan approved by Board of Directors and submitted to DHCS

Q4 2026
Voluntary investments initiated across three activities and future opportunities launched

2027–2029
Annual plan updates submitted to DHCS; continued investment and grantee monitoring

2030
Final report submitted to DHCS summarizing four years of community impact

- Cycle repeats beginning in 2029.

CalOptima Health

CalOptima Health

Stay Connected With Us

www.caloptima.org

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 6, 2026
Regular Meeting of the CalOptima Health Board of Directors

Report Item

19. Approve Actions Related to New Provider Services Contract Template and Associated Exhibits

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Actions

1. Approve the new Provider Services Contract Template and associated exhibits for all lines of business for use between CalOptima Health and professional and ancillary providers, on or after August 6, 2026.
2. Authorize the Chief Executive Officer, or designee, to negotiate and/or execute new Provider Services Contracts with professional and ancillary providers within the fiscal amounts or rate arrangements approved by the CalOptima Health Board of Directors, on or after August 6, 2026.
3. Authorize the Chief Executive Officer, or designee, with the assistance of legal counsel, to make future changes to the new contract template and associated exhibits to comply with statutes, regulations, sub-regulatory guidance, and CalOptima Health policies and procedures.

Background and Discussion

CalOptima Health must maintain a network of providers sufficient to meet its legal and contractual obligations and to ensure access to covered services, timely access to care, and continuity of care. CalOptima Health uses its Board of Directors (Board)-approved templates to contract with providers as outlined in Policy EE.1141: CalOptima Health Provider Contracts.

Historically, CalOptima Health's provider contract templates have undergone a number of piecemeal changes. CalOptima Health staff and legal counsel desired to develop a new Provider Services Contract (PSC) Template to incorporate previously approved operational and regulatory contract language in a consistent manner and to achieve uniformity in language, structure, and format, where possible. To achieve this result, the review process overhauled the existing templates by drafting them into more consistent and concise documents and incorporating best practices for all lines of business. To that end, CalOptima Health and legal counsel drafted the PSC Template to:

- Reflect current operations and best practices;
- Minimize risk and protect CalOptima Health by ensuring all provisions required by law or CalOptima Health's government contracts are located in a single regulatory addendum that CalOptima Health can unilaterally amend;
- Eliminate redundancies by combining a number of templates into a single document to make the contracting and amending process easier; and
- Make the PSC Template consistent in form and content across all provider types.

Staff requests that the Board approve the new PSC Template and associated exhibits, and authorize the Chief Executive Officer (CEO), or designee, to execute new contracts with existing and future providers.

Back to Agenda

On March 6, 2025, the Board approved new provider contract templates and associated exhibits for the Covered California line of business. At this time, staff request approval to utilize the same PSC Template for all CalOptima Health lines of business, beginning on or after August 6, 2026. Staff has made updates since the March 6, 2025, approval, to further refine the documents including:

- Revisions to the PSC Template based on feedback from the California Department of Managed Health Care (DMHC) to comply with Covered California requirements;
- Revisions to Attachment A (Covered Services) for all provider-specific exhibits to include more detail in the "Days to Appointment" provision;
- Revisions to Attachment B (Compensation) for all provider-specific exhibits to rearrange provisions within the exhibit, add language to ensure reimbursement is the lesser of billed charges or the contracted rate, and include the June 4, 2026, Board-approved changes from Report Item #14 (Authorize Amendments to the CalOptima Health Fee-for-Service Professional Services Contracts for Contracted Specialist Physicians for the Medi-Cal, OneCare, and Program of All-Inclusive Care for the Elderly Programs (PACE));
- Revisions to Attachment C (Procedures for Requesting Interpretation Services) to ensure applicability to PACE and Covered California members;
- Revisions to Attachment D (Regulatory Requirements) to fix typos, spell out an abbreviated term, and add recent Department of Health Care Services (DHCS)-required provisions in accordance with All Plan Letter 26-007, Medi-Cal Managed Care Plan Guidance on Network Provider Agreements;
- Created new footers to aid in contract tracking; and
- Other non-substantial changes and renumbering of sections.

The new PSC Template and associated exhibits are outlined below.

Template Type	**Provider Type(s)**
Provider Services Contract (PSC), including Attachment C (Procedures for Requesting Interpretation Services) and Attachment D (Regulatory Requirements)	Primary care, specialist, behavioral health, ancillary, and non-hospital facilities (such as skilled nursing facilities)
Attachment A (Covered Services) and Attachment B (Compensation) Exhibits	Primary care, specialist, behavioral health, ancillary, and non-hospital facilities (such as skilled nursing facilities)

Staff requests that the Board authorize the CEO, or designee, with the assistance of legal counsel, to maintain the PSC Template and associated exhibits on a go-forward basis to comply with statutes, regulations, or sub-regulatory guidance and to align with CalOptima Health policies and procedures without separate Board approval. As CalOptima Health undertakes increasingly diverse activities and the landscape of health care provider types continues to evolve, CalOptima Health staff must regularly revise contract templates and their associated exhibits to incorporate changes with state and federal laws; new regulatory requirements, including in accordance with CalOptima Health's contracts with regulators; new or revised sub-regulatory guidance from Centers for Medicare & Medicaid Services, DHCS, and DMHC; and changes to CalOptima Health's policies and procedures. CalOptima Health staff recognizes the need to continually amend the PSC Template and associated exhibits to meet these requirements.

Back to Agenda

Staff will ensure that all current operational procedures related to timely notification, education, and solicitation of feedback from CalOptima Health's contracted providers pertaining to changes in statutes, regulations, and state guidance will continue without disruption. Templates and associated exhibits revised under this authority will be used in accordance with CalOptima Health Policy EE.1141: CalOptima Health Provider Contracts.

Staff will return to the Board to request approval of hospital services contract templates, any new provider types, and/or authorization of funding for provider rate adjustments.

Fiscal Impact

There is no additional fiscal impact to the Fiscal Year 2026-27 Operating Budget. To the extent there is any additional fiscal impact related to changes in the PSC Template and associated exhibits, such impact will be addressed in separate Board actions or in future operating budgets.

Rationale for Recommendation

The recommended actions will support contracting efforts to maintain CalOptima Health's robust provider network and ensure compliance with current and future statutory and regulatory requirements, best practices, and internal policies, to support CalOptima Health operations.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Provider Services Contract Template
2. Medical Provider Exhibits to PSC Template (Attachment A and B)
3. Non-Medical Provider Exhibits to PSC Template (Attachment A and B)
4. PCP Exhibits to PSC Template (Attachment A and B)

/s/ Michael Hunn — *07/28/2026*
Authorized Signature — **Date**

Back to Agenda

PROVIDER SERVICES CONTRACT

between

ORANGE COUNTY HEALTH AUTHORITY DBA CAL OPTIMA HEALTH

and

_____

TABLE OF CONTENTS

ARTICLE 1 DEFINITIONS 1

ARTICLE 2 PROVIDER OBLIGATIONS 6

ARTICLE 3 CALOPTIMA OBLIGATIONS 16

ARTICLE 4 PAYMENT PROCEDURES 16

ARTICLE 5 INSURANCE AND INDEMNIFICATION 18

ARTICLE 6 RECORDS, AUDITS AND REPORTS 19

ARTICLE 7 TERM AND TERMINATION 22

ARTICLE 8 GRIEVANCES AND APPEALS 24

ARTICLE 9 GENERAL PROVISIONS 24

ARTICLE 10 APPROVAL AND EXECUTION 28

ATTACHMENT A COVERED SERVICES

ATTACHMENT B COMPENSATION

ATTACHMENT C PROCEDURES FOR REQUESTING INTERPRETATION SERVICES

ATTACHMENT D REGULATORY REQUIREMENTS

ATTACHMENT E LOBBYING CERTIFICATION FORMS

PROVIDER SERVICES CONTRACT

This Provider Services Contract (the "**Contract**") is effective [insert effective date] ("**Effective Date**") by and between Orange County Health Authority, a public agency dba CalOptima Health, ("**CalOptima**") and **@@Provider Name@@** ("**Provider**"). CalOptima and Provider may each be referred to herein as a "**Party**" and collectively as the "**Parties**".

RECITALS

A. CalOptima is a County Organized Health System formed pursuant to Welfare and Institutions Code § 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008.

B. CalOptima contracts with the State of California, acting through the Department of Health Care Services ("**DHCS**"), the U.S. Department of Health and Human Services ("**HHS**"), acting through the Centers for Medicare & Medicaid Services ("**CMS**"), and California Department of Aging ("**CDA**"), and Covered California to arrange and pay for health care services rendered to beneficiaries who are enrolled in CalOptima's OneCare (a dual eligible special needs Medicare Advantage plan), Medi-Cal, MSSP, Covered California, and PACE programs ("**Programs**").

C. Provider provides the items and services described in this Contract and has all certifications, licenses, and permits necessary to furnish such items and services.

D. CalOptima desires to engage Provider to furnish, and Provider desires to furnish, certain items and services to Members as described herein. CalOptima and Provider desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the Parties agree as follows:

ARTICLE 1
DEFINITIONS

Capitalized words or phrases not otherwise defined in this Contract shall have the meanings set forth below:

1.1. "**Accreditation Organization**" means any organization engaged in accrediting, certifying and/or approving CalOptima, Provider, and/or their respective programs, centers, or services, including the National Committee for Quality Assurance ("**NCQA**") and the Joint Commission.

1.2. "**Advance Directive**" means a written directive or instruction, such as a power of attorney for health care or a living will, recognized under State law (whether statutory or as recognized by the courts of the State) for the provision of that individual's health care if the individual is unable to make their health care wishes known.

1.3. "**Agent**" means a person who has the authority to obligate or act on behalf of Provider, CalOptima, or a Regulator.

1.4. "**Authorization**" or "**Authorized**" means the written or telephonic approval of CalOptima or its delegate for the provision or referral of Covered Services, other than Emergency Services, in accordance with CalOptima Policies, Laws, and this Contract.

1.5. "**Business Day**" means Monday through Friday, except for legal holidays under State law, which are identified on the California Department of Human Resources' State Holidays website.

1.6. "**California Children's Services ('CCS')**" means those services authorized by the CCS Services Program for the diagnosis and treatment of the CCS Services Eligible Conditions of a specific Member.

1.7. "**CalOptima Policies**" means the policies and procedures relevant to this Contract, including those set forth in CalOptima's Provider Manual, provider newsletters, or other written communications to providers, and as amended from time to time at the sole discretion of CalOptima. CalOptima Policies include network management, quality management and improvement, utilization review, credentialing, peer review, Claims billing and reimbursement, member rights and responsibilities, and grievances and appeals, and Provider's failure to comply with CalOptima Policies constitutes a breach of this Contract.

1.8. "**CCR**" means the California Code of Regulations.

1.9. "**CCS Eligible Condition(s)**" means a physically handicapping condition, as defined in 22 CCR §§ 41515.2-41518.9.

1.10. "**CCS-Paneled Providers(s)**" means any of the following providers when used to treat Members for CCS Eligible Conditions:

1.10.1. A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with § 123800 of Chapter 3 of Part 2 of Division 106).

1.10.2. A licensed acute care hospital approved by the CCS Program.

1.10.3. A special care center approved by the CCS Program.

1.11. "**CCS Program**" means the State public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS Eligible Conditions.

1.12. "**CFR**" means the Code of Federal Regulations.

1.13. "**Claim**" means a request for payment submitted by Provider to CalOptima for services provided to a Member.

1.14. "**Clean Claim**" means a "Complete Claim" under Laws, including (as applicable) 28 CCR § 1300.71(a)(2), that also complies with the terms of this Contract and CalOptima Policies.

1.15. "**COB**" refers to the coordination of benefits determinations of the order of financial responsibility that applies when two or more health benefit plans provide coverage of items and services for an individual.

1.16. "**COD**" means a direct program CalOptima administers for Members not enrolled in a Health Network. COD consists of two components:

1.16.1. COD Members who are assigned to a Community Network in accordance with CalOptima Policies.

1.16.2. "**COD-Administrative**" provides services to Members who reside outside of CalOptima's service area, are transitioning into a Heath Network, have a Medi-Cal SOC, or are eligible for both Medicare and Medi-Cal.

1.17. "**Community Network**" means CalOptima's direct health network that serves Members who are enrolled in it pursuant to CalOptima Policies. Community Network Members are assigned to primary care providers ("**PCPs**") as their medical home, and their care is coordinated through the PCP.

1.18. "**Compliance Program**" means the program (including the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor, and ensure that CalOptima's operations and practices and the practices of CalOptima's Board of Directors, employees, contractors, and providers comply with Laws and ethical standards. The Compliance Program includes CalOptima's fraud, waste, and abuse ("**FWA**") plan.

1.19. "**Contracted Provider**" means a provider that is contracted with Provider to provide Covered Services to Members. All Contracted Providers are considered Subcontractors.

1.20. "**County**" means the County of Orange, State of California.

1.21. "**Covered Services**" means those Medically Necessary health care items, drugs, and services that a Member is entitled to receive under the Member's Program and are identified in Attachment A. Covered Services must generally be Authorized in accordance with CalOptima's Policies, including its utilization management program, except for Emergency Services.

1.22. "**DHCS Contract**" means the contract between CalOptima and DHCS under which CalOptima arranges for the provision of Covered Services to Medi-Cal beneficiaries in the County.

1.23. "**Emergency Services**" has the same meaning, unless otherwise provided in an attachment to this Contract with regard to a specific Program, as defined in 42 CFR §§ 422.113(b) and 438.114(a).

1.24. "**Encounter Data**" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS. Encounter Data records shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by Regulators.

1.25. **"False Claims Act" (FCA)** generally applies to fraud involving federal and/or state funds and imposes liability on any person who knowingly presents or causes another to present a false or fraudulent claim to the Government.

1.26. "**Government Contract(s)**" means the contract(s) between CalOptima and the federal and/or State government, including the DHCS Contract, pursuant to which CalOptima administers and pays for Covered Services under a Program.

1.27. "**Health Network**" means a physician group under a shared risk contract, physician-hospital consortium, or health care service plan licensed under the Knox-Keene Act that contracts with CalOptima on a capitated basis to provide Covered Services to non-COD Members.

1.28. "**Laws**" means any local, State, or federal statute, regulation, rule, or executive or agency order applicable to this Contract, including Regulators' operational guidance and other instructions

Back to Agenda Back to Item

related to the coverage, payment, and/or administration of Programs. Any state or federal statute, regulation, rule, or executive or agency order that only applies to a certain Program(s) shall only be considered part of Laws with respect to the Program(s) to which the state or federal statute, regulation, rule, or executive or agency order applies. Laws do not include any State statute, regulation, rule, or executive or agency order preempted by federal law.

1.29. "**Licenses**" means all licenses, certifications, accreditations, approvals, and permits that Provider must have in order to participate in the Programs and furnish the items and/or services under this Contract.

1.30. "**Medi-Cal**" is the Medicaid program for the State (*i.e.,* the program authorized by Title XIX of the federal Social Security Act ("**SSA**") and the regulations promulgated thereunder).

1.31. "**Medically Necessary**" or "**Medical Necessity**" means reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity, per Welfare & Institutions ("**W&I**") Code § 14059.5(a) and 22 CCR § 51303(a). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of twenty-one (21), Medical Necessity includes the standards in 42 USC § 1396d(r) as required by W&I Code §§ 14059.5(b) and 14132(v).

1.32. "**Medical Record**" means any record kept or required to be kept by any provider that documents all of the medical services received by the Member, including inpatient, outpatient, emergency care, and referral requests and Authorizations, as required by Laws and CalOptima Policies.

1.33. "**Medicare**" means the federal health insurance program defined in Title XVIII of the SSA and the regulations promulgated thereunder.

1.34. "**Member**" means any person who is eligible to receive Covered Services and is enrolled in a Program.

1.35. "**Minimum Standards**" means the minimum participation criteria established by CalOptima that providers that must satisfy to receive reimbursement from CalOptima for items and/or services furnished to Members, as further described in CalOptima Policies.

1.36. "**MOU**" means (i) an agreement between CalOptima and another government agency that delineates responsibilities for coordinating care to Members; and (ii) a contract between CalOptima and the County that incorporates such agreements, including the Coordination and Provision of Public Health Care Services Contract.

1.37. "**Overpayment**" means a payment Provider receives that, after applicable reconciliation, Provider is not entitled to receive or retain pursuant to Laws, Government Contracts, and/or this Contract.

1.38. "**Participating Provider**" means an institutional, professional, or other provider of health care services who has entered into a written agreement with CalOptima to provide Covered Services to Members.

1.39. "**Participation Status**" means whether a person or entity is or has been suspended, precluded, or excluded from participation in any federal and/or state health care programs and/or has a felony conviction, as specified in the Compliance Program and CalOptima Policies.

1.40. "**Privacy Requirements**" means the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), the Health Information Technology for Economic and Clinical Health ("**HITECH**") Act, the California Confidentiality of Medical Information Act ("**CMIA**"), California W&I Code § 14100.2, as amended, and the implementing regulations of those laws, including CCR § 51009 and 42 CFR § 431.300 *et seq.*

1.41. "**Program(s)**" means any of the following programs administered by CalOptima: the Medi-Cal, OneCare, the Multipurpose Senior Services Program ("**MSSP**"), the Program of All-Inclusive Care for the Elderly ("**PACE**"), or Covered California. Provider participates in the specific Program(s) identified in Attachment A.

1.42. "**Regulators**" mean those government agencies that regulate and oversee CalOptima, including the HHS Inspector General, CMS, DHCS, the Department of Justice ("**DOJ**"), the DOJ Bureau of Medi-Cal Fraud, the California Department of Managed Health Care ("**DMHC**"), the Comptroller General, Covered California, and any other government agencies that have authority to set standards and oversee the performance of the Parties.

1.43. "**SOC**" means the share of cost the Member owes as part of receiving Covered Services, including co-payments, and deductibles.

1.44. "**State**" means the State of California.

1.45. "**Subcontract**" means a contract between Provider (or another Subcontractor) and a Subcontractor that agrees to provide services related to fulfilling Provider's obligations under this Contract.

1.46. "**Subcontractor**" means a person or entity that entered into a Subcontract with Provider (or another Subcontractor) related to fulfilling any of Provider's obligations under this Contract, including Contracted Providers.

1.47. "**TRI**" means the set of provider targeted rate increases authorized by Assembly Bill 118 (Chapter 42, Statutes of 2023) and implemented by DHCS. The TRI applies to eligible network providers, as defined by DHCS. For services on the Medi-Cal TRI fee schedule from eligible network providers, CalOptima and its delegates must pay the greater of the DHCS published TRI fee schedule or the then current contractual rates inclusive of any Proposition 56 supplemental payment previously due to provider. The TRI applies to both fee-for-service and other provider payment arrangements such as capitation payments. In the case of capitation and other prospective payment arrangements, the expected fee-for-service equivalency of those rates must be the same or greater than the TRI fee schedule rate.

1.48. "**UM**" means the utilization management or utilization review of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

1.49. "**WCM Program**" means CalOptima's Whole Child Model program whereby CCS is a Medi-Cal managed care plan benefit with the goal to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

ARTICLE 2
PROVIDER OBLIGATIONS

2.1. **Covered Services**.

2.1.1 Provider shall furnish the Covered Services in all areas of the County that are Authorized by CalOptima (except for Emergency Services, which do not require Authorization) and listed in Attachment A to eligible Members. Provider shall furnish such items and services (i) in a manner satisfactory to CalOptima and its Regulators in accordance with Laws, Program requirements, Government Contracts, and CalOptima Policies, and (ii) in the same manner and in accordance with the same standards that Provider furnishes services to all other Provider patients, including the same availability and access.

2.1.2 Provider shall make Covered Services available and accessible to Members promptly and in a manner which ensures continuity of care and may not impose any limitations on the acceptance of Members for care or treatment that are not imposed on other patients.

2.1.3 Throughout the Term, Provider shall maintain the quantity and quality of its services and personnel in accordance with the requirements of this Contract, Laws, Government Contracts, Program requirements, and CalOptima Policies.

2.1.4 Neither Provider nor its Subcontractors will perform any work related to the Contract outside the United States of America without the prior written consent of CalOptima, which it may withhold in its sole discretion.

2.2. **Licensure and Qualifications**.

2.2.1 Provider represents and warrants that it has, and shall maintain during the Term, all valid and active Licenses necessary to render Covered Services, including (i) certification under and enrollment in Medicaid and Medicare; (ii) all provider and/or supplier numbers necessary to perform its obligations under this Contract, including National Provider Identifiers ("**NPIs**"); and (iii) being in good standing with State licensing boards applicable to its business, DHCS, CMS, and the HHS Officer of Inspector General ("**OIG**"), as applicable.

2.2.2 Provider shall ensure that every provider providing Covered Services and employed or engaged by Provider or Subcontractors shall at all times during the Term retain all valid licenses, certifications, and qualifications, without restriction, and meet Minimum Standards as necessary to provide or arrange for the provision of Covered Services to Members and bill for those Covered Services.

2.2.3 Provider or its delegate shall additionally verify the qualifications of all employees and Subcontractors providing services under this Contract consistent with the services to be provided. For employees and Subcontractors who have face-to-face contact with Members, Provider or its delegate shall also conduct background investigations, including county, state, and federal criminal history and abuse registry screening. Provider and its delegates shall comply with all Laws in conducting background investigations and shall exclude unqualified employees and Subcontractors from providing services under this Contract.

2.2.4 Provider's facilities, equipment, technology (hardware and software), and administrative services shall be at a level and quality necessary to meet industry standards and perform Provider's duties under this Contract and shall comply with Laws.

2.2.5 Provider shall notify CalOptima in writing and provide all correspondence with and notices from any government agencies or Accreditation Organizations regarding (i) investigations into Provider or its Subcontractors; (ii) citations and/or disapprovals of Provider for a failure to meet any material Law or Accreditation Organization standard; or (iii) the issuance of criminal, civil, and/or administrative sanctions (threatened or imposed) related to Provider's or a Subcontractor's licensure (including a malpractice lawsuit), FWA, (including execution of grand jury subpoena, search and seizure warrants, etc.), and/or Participation Status (including any indictment, arrest, or conviction for a felony or for any criminal charge related to Provider's services).

2.3. **Credentialing and Recredentialing**. Prior to providing any Covered Services and throughout the Term, Provider and all Subcontractors shall be credentialed and periodically recredentialed by CalOptima and fully cooperate with CalOptima credentialing and recredentialing procedures as required by CalOptima Policies, Government Contracts, and Laws. Only providers who CalOptima has determined meet applicable CalOptima credentialing criteria may be considered Contracted Providers.

2.3.1 Provider warrants and represents that as of the Effective Date and continuing through the end of Term its employees and Contracted Providers who will render Covered Services shall meet the credentialing standards set forth in this Section 2.3.

2.3.2 Provider's physician employees and Contracted Providers who will render Covered Services shall maintain clinical privileges in good standing and without restriction at a CalOptima Participating Provider hospital.

2.3.4 During the Term, Provider's employees and Contracted Providers who will render Covered Services shall maintain their professional competence and skills commensurate with the standards of the community and attend and participate in approved continuing education courses, as required by Laws.

2.3.5 CalOptima reserves the right to verify any and all credentialing and recredentialing requirements and any other credentialing standards that CalOptima, in its sole judgment, deems necessary and appropriate for Provider's employees and Contracted Providers. Rendering Covered Services is subject to CalOptima's approval of a provider's credentialing application. CalOptima may terminate this Contract upon written notice to Provider at any time if a significant portion of Provider's employees and Contracted Providers who render Covered Services fail to meet CalOptima's credentialing, recredentialing, and/or professional competence standards.

2.4. **Professional Standards**. Provider shall exercise independent professional judgment in providing Covered Services. All Covered Services under this Contract shall be provided or arranged by duly licensed, certified, or otherwise authorized professional personnel in a manner that (i) meets the cultural and linguistic requirements of this Contract, Government Contracts, and CalOptima Policies; (ii) within professionally recognized standards of practice at the time of treatment; and (iii) in accordance with Laws and CalOptima's UM and quality management ("**QM**") programs.

Back to Agenda Back to Item

2.5. **Eligibility**. Provider shall verify a Member's eligibility for the applicable Program benefits upon receiving request for Covered Services and at the beginning of each calendar month thereafter during the continued provision of such Covered Services. For Members SOC obligations, Provider shall collect SOC in accordance with CalOptima Policies and Laws.

2.6. **Compliance with Laws and Policies**. Provider shall comply with all Laws in effect during the Term that in any manner affect Provider's performance under this Contract. This Contract shall be governed by and construed in accordance with Laws and Government Contracts. Provider shall also comply with all applicable CalOptima Policies.

2.7. **Transfer of Care**. Upon request by a Member, Provider shall assist in the orderly transfer of the Member's care to another provider. In doing so, Provider shall make available to the new provider copies of the Medical Records, patient files, and other pertinent information, including information maintained by any Subcontractor, necessary for the efficient case management of the Member. In no circumstance shall CalOptima or a Member be billed for this service. Provider will not unilaterally assign or transfer Members to another Participating Provider or non-Participating Provider without the prior written approval of CalOptima.

2.8. **UM Program**. Provider shall comply with CalOptima's UM program requirements, including:

2.8.1 Provider shall comply with all concurrent and retrospective review, referral, and Authorization requirements set forth in CalOptima Policies. If Provider fails to obtain Authorization prior to providing Covered Services to or referrals for a Member, as required by this Contract and CalOptima's UM program, or if Provider provides services outside of the scope of the Authorization obtained, then CalOptima shall have no obligation to compensate Provider for such services; Provider will be deemed to have waived payment for such services and shall not seek payment from CalOptima, its delegate(s), or the Member. Authorization is not required for Emergency Services.

2.8.2 Provider shall allow CalOptima staff to initiate discussions with Provider to evaluate the appropriateness of items and services, and Provider shall comply with the evaluations and processes necessary for CalOptima to determine the Medical Necessity of items and services.

2.8.3 Provider shall permit CalOptima's UM Department staff and other qualified representatives of CalOptima to conduct concurrent reviews of the Medical Records of Members, including on site. CalOptima staff shall notify Provider prior to conducting any on-site reviews, shall wear appropriate identification, and shall schedule times reasonable for Provider.

2.9. **QM Program**. Provider shall comply with CalOptima's QM programs and shall participate and cooperate in QM program activities as required by CalOptima. Such activities may include (i) providing requested data; (ii) participating in assessment and performance audits and projects (including those required by Regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members; and (iii) participating in QM program development and implementation for the purpose of collecting and studying data reflecting clinical status and quality of life outcomes for Members. Provider shall cooperate with CalOptima and Regulators regarding any complaint, appeal or other review of Covered Services,

including Medical Necessity, and shall accept as final all decisions regarding disputes over Covered Services by CalOptima or Regulators, as applicable and as required under the applicable Program.

2.10. **QM Program Performance Data**. Provider shall also allow CalOptima to use CalOptima and Provider performance data for quality and reporting purposes, including quality improvement activities, public reporting to consumers, and performance data reporting to Regulators, as required by Laws, Government Contracts, Programs, and CalOptima Policies.

2.11. **Changes in Capacity**. Provider shall provide at least ninety (90) days' prior written notice to CalOptima of any significant changes in the capacity of Provider to furnish Covered Services to Members. Provider shall use reasonable efforts to eliminate or remedy any condition that results in a significant adverse change in capacity, including closure of any facility used by Provider.

2.12. **Marketing Requirements**. Provider shall comply with CalOptima's marketing guidelines relevant to the applicable Program(s) and marketing Laws.

2.13. **Provider Information**.

2.13.1 Provider shall provide demographic and other information about its Participating Providers, employed individual providers, and facilities, as applicable and requested by CalOptima, including (i) specialties (ii) certifications; (iii) panel availability, (iv) addition of new providers; (v) addresses; (vi) contact information; (vii) office hours; and (viii) information as outlined in CalOptima's Policy EE.1101. Provider shall promptly notify CalOptima of changes to such information during the Term.

2.13.2 CalOptima may list the name, address, and telephone number of Provider and a description of Provider's facilities and services in CalOptima's roster of Participating Providers, which is given to Members and/or prospective Members. However, CalOptima is not obligated to list the name of any particular provider in the roster. Provider and CalOptima agree that the use of the other Party's trademarks or logos in any form is prohibited without prior written approval of that Party.

2.13.3 Provider shall notify CalOptima within five (5) Business Days when (i) Provider is not accepting new Members, or (ii) if Provider previously not accepted new Members, Provider is currently accepting new Members.

2.14. **Health Networks.** Provider acknowledges and agrees that CalOptima has delegated financial responsibility to Health Networks for certain Covered Services rendered to Members enrolled in Health Networks. Provider agrees to extend to Health Networks the same terms contained in this Contract, including rates, for Covered Services provided to Members enrolled in Health Networks and to contract with a Health Network under the same terms as this Contract, at the request of a Health Network. Regardless of whether Provider is contracted with a Health Network, Provider also agrees to look solely to the applicable Health Network for payment for Covered Services rendered by Provider that are the financial responsibility of the Health Network pursuant to the Health Network's contract with CalOptima, and CalOptima and Member shall not be liable to Provider for those services.

2.15. **Linguistic and Cultural Sensitivity Services**. Provider shall comply with CalOptima Policies and Laws related to linguistic and cultural sensitivity. CalOptima will provide cultural competency, sensitivity, and diversity training. Provider shall address the special health needs of Members who are members of specific ethnic and cultural populations, including Vietnamese and Hispanic

persons. Provider shall in its policies, administration, and services: (i) honor Members' beliefs, traditions, and customs; (ii) recognize individual differences within a culture; (iii) create an open, supportive, and responsive organization in which differences are valued, respected, and managed; and (iv) through cultural diversity training, foster in Provider staff attitudes and interpersonal communication styles that respect Members' cultural backgrounds. Provider shall fully cooperate with CalOptima in the provision of cultural and linguistic services provided by CalOptima for Members receiving services from Provider. Provider shall provide translation of written materials in the threshold and concentration languages identified by CalOptima, as required by Laws, at no higher than the sixth (6^{th}) grade reading level.

2.16. **Provision of Interpreters**. Provider shall ensure that Members are provided with translation and interpreter services for Members as necessary to ensure effective communication regarding treatment, diagnosis, and medical history or health education pursuant to the requirements in this Contract, including Attachment C, CalOptima Policies, and Laws.

Interpreters shall be used where needed and when technical, medical, or treatment information is to be discussed. Provider shall not require a Member to use friends or family as interpreters. However, a friend or family member may be used when the use of the friend or family member: (i) is requested by a Member; (ii) will not compromise the effectiveness of service; (iii) will not violate a Member's confidentiality; and (iv) Member is advised that an interpreter is available at no cost to the Member.

2.17. **CalOptima's Compliance Program and Other Guidance**. Provider and its employees, board members, owners, Contracted Providers, and Subcontractors furnishing services under this Contract ("**Provider Agents**") shall comply with the requirements of the Compliance Program, including CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Program and Code of Conduct available to Provider, and Provider shall make them available to Provider Agents. Provider agrees to comply with, and be bound by, any and all MOUs.

2.18. **Equal Opportunity**. Provider and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Provider and its Subcontractors will take affirmative action to ensure that qualified applicants are employed and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age, or status as a disabled veteran or veteran of the Vietnam era. Such action shall include the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. As applicable, Provider and its Subcontractors will comply with all provisions of and furnish and post all information and reports required by Section 503 of the Rehabilitation Act of 1973 (as amended), the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. § 4212), and of the Federal Executive Order No. 11246 (as amended), including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity', and as supplemented by regulation at 41 CFR Part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

Provider and its Subcontractors will permit access to their books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

If Provider or its Subcontractors do not comply with the provisions herein or with any applicable federal rules, regulations, or orders referenced herein, CalOptima may cancel, terminate, or suspend this Contract in whole or in part, and Provider and its Subcontractors may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 (as amended), and such other sanctions and remedies provided under Laws.

Provider and its Subcontractors will include the provisions of this section in every Subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor or other Laws. Provider and its Subcontractors will take such action with respect to any subcontract or purchase order as directed by the Director of the Office of Federal Contract Compliance Programs or DHCS as a means of enforcing such provisions, including sanctions for noncompliance; provided, however, that if Provider and its Subcontractors become involved in or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Provider and its Subcontractors may request in writing to DHCS, which, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2.19. **Reporting Obligations**. In addition to any other reporting obligations under this Contract, Provider shall submit such reports and data relating to services covered under this Contract as required by CalOptima, including to comply with requests from Regulators.

2.20. **Subcontract Requirements**. If permitted by the terms of this Contract, Provider may subcontract for certain functions covered by this Contract, subject to the requirements of this Contract. Subcontracts shall not terminate the legal liability of Provider under this Contract. Provider must ensure that all Subcontracts are in writing, bind Subcontractors to all applicable provisions under this Contract, and incorporate all required provisions under this Contract or applicable Government Contracts. Provider shall process claims from and pay such Subcontractor for any Covered Services in compliance with the timeliness requirements set forth in Laws. Any Provider obligation under this Contract shall be deemed to include applicable Subcontractors. Provider shall make all Subcontracts available to CalOptima or its Regulators upon request. Provider is required to inform CalOptima of the name and business addresses of all Subcontractors. Additionally, Provider shall require that all Subcontracts relating to the provision of Covered Services include provisions requiring the Subcontractor to do the following:

2.20.1 Make all books and records related to this Contract available at all reasonable times for inspection, examination, or copying by CalOptima or Regulators in accordance with Government Contract requirements and Laws.

2.20.2 Maintain such books and records (i) in accordance with the general standards applicable to such books and records and any record requirements in this Contract, Laws, Government Contracts, or CalOptima Policies; and (ii) at the Subcontractor's place of business or at such other mutually agreeable location in the State.

2.20.3 Comply with all Laws with respect to providing Emergency Services.

2.20.4 Notify Provider of any investigations into Subcontractors' professional conduct or any suspension of or comment on a Subcontractor's Licenses, whether temporary or permanent.

2.20.5 Comply with the Compliance Program.

2.20.6 Comply with Member financial and hold harmless protections in this Contract and Laws.

2.21. **Fraud and Abuse Reporting**. Provider shall report to CalOptima all cases of suspected FWA, as defined in 42 CFR § 455.2, relating to the rendering of Covered Services, whether the cases relate to Provider, Provider's employees, Subcontractors, Contracted Providers, and/or Members, within five (5) Business Days of the date when Provider first becomes aware of or is on notice of such activity.

2.22. **Participation Status**. Provider shall have policies and procedures in place to verify the Participation Status of Provider Agents. In addition, Provider represents and warrants that:

2.22.1 Provider and Provider Agents shall meet CalOptima's Participation Status requirements at all times during the Term.

2.22.2 Provider shall immediately disclose to CalOptima any pending investigation involving, or any determination of, suspension, exclusion or debarment from a State or federal program of Provider or Provider Agents occurring and/or discovered during the Term.

2.22.3 Provider shall take immediate action (i) to prevent any Provider's Agent that does not meet Participation Status requirements from furnishing items or services related to this Contract to Members; and (ii) take any other actions required by Regulators, Government Contracts, and/or Laws.

2.22.4 Provider shall include the obligations of this Section 2.21 in its Subcontracts.

2.22.5 CalOptima shall not make payment for an item or service furnished by an individual or entity that does not meet Participation Status requirements. Provider shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with Laws.

2.23. **Physical Access for Members**. Provider's and its Subcontractor's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990 ("**ADA**"), and Provider and its Subcontractors shall ensure access for the disabled, which includes compliance with the ramps, elevators, restrooms, designated parking spaces, and drinking water requirements under the ADA and applicable State and local requirements.

2.24. **CLIA Laboratories**. Provider shall only use laboratories with a Clinical Laboratory Improvement Amendments ("**CLIA**") certificate of waiver or a certificate of registration along with a CLIA identification number. Provider shall ensure those laboratories with certificates of waiver provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

2.25. **Member Rights**. Provider shall ensure that each Member's rights, as set forth in Laws, Government Contracts, and CalOptima Policies, are fully respected and observed. Provider will not retaliate or take any adverse action against a Member for exercising the Member's rights.

2.26. **Member Communication**.

2.26.1 Provider, acting within the scope of practice and Laws, shall freely communicate with Members, regardless of benefit coverage limitations, about (i) their health status, medical care, or treatment options, including alternative treatments; (ii) the risks, benefits, and consequences of treatment or non-treatment; and (iii) a Member's right to participate in decisions regarding their health care, including the right to refuse treatment and to express

preferences about future treatment decisions. Provider will not solicit or encourage Members to select another health plan.

2.26.2 Provider shall use best efforts to ensure that no employee, agent, Subcontractor, officer, director, or representative of Provider makes any derogatory remarks regarding CalOptima to any Member. Nothing in this section shall be interpreted to discourage or prohibit Provider from discussing treatment options with Members or providing other professional advice or treatment to Members deemed appropriate by Provider within Provider's scope of practice.

2.26.3 Provider shall not make any false statements or misrepresentations when communicating with Members.

2.27. **Electronic Transactions**. Provider shall participate in secured electronic communications with CalOptima, including electronic claims submission, verification of eligibility, and enrollment through electronic means, and submission of electronic Authorization transactions in accordance with CalOptima Policies.

2.28. **Advance Directives**. If applicable, Provider shall maintain written policies and procedures related to Advance Directives and document patient records with respect to the existence of an Advance Directive in compliance with Laws. Provider shall not discriminate against any Member based on that Member's Advance Directive status. Nothing in this Contract shall be interpreted to require a Member to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

2.29. **WCM Program Compliance**. If Provider is a CCS-authorized provider, then in the provision of CCS Services to Members, Provider shall follow CCS Program guidelines, including CCS Program regulations, and where CCS clinical guidelines do not exist, Provider will use evidence-based guidelines or treatment protocols that are medically appropriate to the Member's CCS Eligible Condition.

2.30. **CCS Provider Compliance**.

2.30.1 Only CCS-Paneled Providers may treat a Member's CCS Eligible Condition.

2.30.2 If Provider is a CCS-Paneled Provider, Provider agrees to provide services for the WCM Program in accordance with this Contract and CalOptima Policies.

2.30.2.1 Provider shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

2.30.2.2 To ensure consistency in the provision of CCS Covered Services, Provider shall use all current and applicable CCS Program guidelines, including CCS Program regulations. When applicable CCS clinical guidelines do not exist, Provider shall use evidence-based guidelines or treatment protocols that are medically appropriate given Members' CCS Eligible Condition.

2.31. **Subcontract Terminations**. If a Subcontract terminates, Provider shall ensure that there is no disruption in services provided to Members.

2.32. **Government Claims Act**. Subject to Section 9.14, Provider shall ensure that Provider and Provider Agents comply with the applicable provisions of the Government Claims Act (California Government Code § 900 *et seq*.), including Government Code §§ 910 and 915, and CalOptima Policy AA.1217.

2.33. **Certification of Document and Data Submissions**. All data, information, and documentation provided by Provider to CalOptima pursuant to this Contract shall be accompanied by a certification statement on the Provider's letterhead, signed by Provider's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such officer) attesting that based on the best information, knowledge, and belief, the data, documentation, and information are accurate, complete, and truthful.

2.34. **CalOptima Oversight**. CalOptima is responsible for the monitoring and oversight of all obligations of Provider under this Contract, and CalOptima has the authority and responsibility to: (i) implement, maintain, and enforce CalOptima Policies governing Provider's duties under this Contract and/or governing CalOptima's oversight role; (ii) conduct audits, inspections, and/or investigations in order to oversee Provider's performance of duties described in this Contract; (iii) require Provider to take corrective action if CalOptima or a Regulator determines that corrective action is needed with regard to any Provider duty under this Contract; and/or (iv) revoke the delegation of any duty, if Provider fails to meet CalOptima standards in the performance of that duty. Provider shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima or its Regulators determine is necessary to comply with Laws, Government Contracts, Programs, Accreditation Organization standards, and/or CalOptima Policies.

2.35. **Conflicts of Interest**. Provider shall comply with all CalOptima requirements and Laws pertaining to conflicts of interest, including CalOptima's Conflict of Interest Code, the California Political Reform Act (California Government Code § 81000 *et seq*.), and California Government Code § 1090 *et seq*. (collectively, the "**Conflict of Interest Laws**").

2.35.1 Provider covenants that, to the best of its knowledge during the Term, no director, officer, or employee of CalOptima during their tenure has any interest, direct or indirect, in this Contract or the proceeds thereof, in accordance with 22 CCR § 53600(d). Provider further covenants that, for the Term, and consistent with the provisions of 22 CCR § 53600(f), no State officer or State employee shall be employed in a management or contractor position by Provider within one (1) year after the State office or State employee has terminated State employment.

2.35.2 Provider understands that if this Contract is made in violation of California Government Code § 1090 *et seq*., the entire Contract is voidable, Provider will not be entitled to any compensation for services performed pursuant to this Contract, and Provider will be required to reimburse CalOptima any sums paid to Provider. Provider further understands that Provider may be subject to criminal prosecution for a violation of California Government Code § 1090.

2.35.3 If Provider becomes aware of any facts that might reasonably be expected to either create a conflict of interest under the Conflict of Interest Laws or violate the provisions of this Section 2.35, Provider shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include identification of all persons, entities, and businesses implicated and a complete description of all relevant circumstances.

2.36. **Hospital Referrals**. Provider shall refer Members to providers that have hospital privileges at CalOptima contracted facilities, whenever possible.

2.37. **Information and Cyber Security**. Provider must have policies, procedures, and practices that address its information and cyber security measures, safeguards, and standards, including at least the following:

2.37.1 Access Controls. Access controls, including Multi-Factor Authentication, to limit access to Provider's information systems and any CalOptima information that Provider maintains or can access.

2.37.2 Encryption. Use of encryption to protect any CalOptima information, in transit and at rest, that Provider maintains or can access.

2.37.3 Security. Safeguards for the security of the information systems and CalOptima information that Provider maintains or can access, including hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, physical security controls, and personnel training programs that include phishing recognition and proper data management hygiene.

2.37.4 Software Maintenance. Software maintenance, support, updates, upgrades, third-party software components and bug fixes such that the software is, and remains, secure from vulnerabilities in accordance with the applicable industry standards.

2.37.5 Network Security. Network security that conforms to generally recognized industry standards and best practices.

2.37.6 Notice. Provider shall notify CalOptima by email (or by telephone if Provider is unable to email CalOptima) within twenty four (24) hours of any use, disclosure, or access of Members' (i) protected health information (as that term is defined under 45 CFR § 160.103), (ii) personal information (as that term is defined under Civil Code § 1798.3(a), or (iii) medical information (as that term is defined under Civil Code § 56.05(j)) (collectively "**Protected Information**") that violates applicable laws and/or this Contract ("**Breach**").

2.37.7 Investigation. Provider shall immediately investigate the Breach and report the following to CalOptima as soon as reasonably practicable:

2.37.7.1 The Breach details, including the date of the Breach and when it was discovered;

2.37.7.2 The identification of each Member whose Protected Information was accessed, used, or disclosed during the Breach;

2.37.7.3 The nature of the data elements involved and the extent of the data involved in the Breach;

2.37.7.4 A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed Protected Information;

2.37.7.5 A description of where the Protected Information is believed to have been

improperly transmitted or utilized;

2.37.7.6 A description of the probable causes of the Breach;

2.37.7.7 Whether a law enforcement official has requested a delay in notification of individuals of the Breach because such notification would impede a criminal investigation or damage national security; and

2.37.7.8 Whether any federal or State laws requiring notifying individuals of breaches were triggered.

For the purpose of this Section 2.36, "**Multi-Factor Authentication**" means authentication through verification of at least two (2) of the following types of authentication factors: (i) knowledge factors, such as a password; (ii) possession factors, such as a token or text message on a mobile phone; (iii) inherence factors, such as a biometric characteristic; or (iv) any other industry standard and commercially accepted authentication factors.

ARTICLE 3
CALOPTIMA OBLIGATIONS

3.1 **Service Authorization**. CalOptima shall provide a written Authorization process for Covered Services pursuant to CalOptima Policies.

3.2 **CalOptima Guidance**. CalOptima shall make available to Provider, on its website and upon request, all MOUs and CalOptima Policies applicable to Covered Services under this Contract.

3.3 **Member Eligibility**. CalOptima will maintain data on Member eligibility and enrollment and verify Member eligibility at the reasonable request of a Provider. CalOptima shall ensure Members are provided identification cards identifying Members as enrolled in the applicable Program.

3.4 **Care Management**. CalOptima shall provide care management services for Members.

3.5 **Member Materials**. CalOptima shall furnish Provider any written materials that CalOptima wants Provider to provide to Members, including translations into threshold languages at the appropriate grade level.

ARTICLE 4
PAYMENT PROCEDURES

4.1 **Payment**. CalOptima shall pay Provider for Covered Services provided to Members as provided in CalOptima Policies and Attachment B. Provider agrees to accept the compensation set forth in Attachment B as payment in full from CalOptima for such Covered Services. Notwithstanding the foregoing, Provider may also collect other amounts (*e.g.*, SOCs and/or third-party liability payments) where expressly authorized under the Program(s) and Laws.

4.2 **Billing and Claims Submission**. Provider shall submit Claims for Covered Services in accordance with CalOptima Policies applicable to the Claims submission process.

4.3 **Prompt Payment**. CalOptima shall pay Provider in the time and manner set forth in Attachment B, CalOptima Policies, and Laws.

4.4 **Limitations of CalOptima's Payment Obligations**. Notwithstanding anything to the contrary in this Contract, CalOptima's obligation to pay Provider any amounts shall be subject to CalOptima's receipt of the funding from the federal and/or State governments.

4.5 **Claim Completion and Accuracy**. Provider shall be responsible for the completion and accuracy of all Claims submitted (whether on paper forms or electronically), including Claims submitted for Provider by other parties. Use of a billing Agent does not abrogate Provider's responsibility for the truth and accuracy of the submitted information. A Claim may not be submitted before the delivery of service. Provider acknowledges that Provider remains responsible for all Claims and that anyone who misrepresents, falsifies, or causes to be misrepresented or falsified, any records or other information relating to that Claim may be subject to legal action.

4.6 **Claims Deficiencies**. CalOptima shall deny any Claim that fails to meet CalOptima requirements for claims processing and notify Provider of the denial pursuant to CalOptima Policies and Laws.

4.7 **Coordination of Benefits**. Provider shall practice COB with other programs or entitlements, recognizing where CalOptima is not the primary coverage, in accordance with Program requirements and Laws. Provider acknowledges that Medi-Cal is the payer of last resort.

4.8 **Member Financial Protections**. Provider and its Subcontractors shall comply with Member financial protections as follows:

4.8.1 Provider agrees to indemnify and hold Members harmless from all efforts to seek compensation from Members for Covered Services under this Contract. In no event shall a Member be liable to Provider for any amounts which are owed by, or are the obligation of, CalOptima.

4.8.2 In no event, including non-payment by CalOptima, CalOptima's or Provider's insolvency, or breach of this Contract by CalOptima, shall Provider or any of its Subcontractors bill, charge, seek compensation, collect reimbursement, or have any recourse against the State or any Member or person acting on behalf of a Member for Covered Services pursuant to this Contract. Notwithstanding the foregoing, Provider may collect SOC if and to the extent required under the applicable Program and/or Laws.

4.8.3 This provision does not prohibit Provider or its Subcontractors from billing and collecting payment for non-Covered Services if Provider provides written notice to the Member prior to providing the services of what services are non-Covered Services and the cost of those non-Covered Services and the Member agrees to the payment in writing prior to the actual delivery of non-Covered Services. Provider must give a copy of such agreement to the Member and place in the Member's Medical Records prior to rendering such services.

4.8.4 Upon receiving notice of Provider invoicing or balance billing a Member for the difference between the Provider's billed charges and the reimbursement paid by CalOptima for any Covered Services, CalOptima may sanction the Provider or take other action as provided in this Contract or allowed under Laws, including reimbursing the Member for such a balance bill and deducting the reimbursement amount from any payments otherwise owed to Provider.

4.8.5 This Section 4.8 shall be construed to be for the benefit of Members. This section shall supersede any oral or written contrary agreement now existing or hereafter entered into

between the Provider and its Subcontractors. Provider shall ensure the substance of this Section 4.8 is included in all Subcontracts.

4.9 **Overpayments**. Provider must immediately report any Overpayment identified by Provider and repay such Overpayment to CalOptima within sixty (60) days of such identification by Provider or receipt of notice of an Overpayment identified by CalOptima or any other entity.

4.10 **Offset**. If CalOptima determines that an Overpayment has occurred, CalOptima shall have the right to recover such amounts from Provider by offset from current or future amounts due from CalOptima to Provider under this Contract or any other arrangement between the Parties, after giving Provider notice and an opportunity to return/pay such amounts in accordance with Section 4.9 and the procedures, including the interest rates for untimely reimbursements, set forth in Health & Safety Code § 1371.1(a). This right to offset shall include:

4.10.1 Payments made under this Contract that are subsequently determined to have been paid at a rate that exceeds the payment required under this Contract.

4.10.2 Payments made for services provided to a Member who is subsequently determined to have not been eligible on the date of service.

4.10.3 Unpaid Conlan reimbursements owed by Provider to a Member.

4.10.4 Payments made for services provided by a provider that entered into a private contract with a Medicare beneficiary for Covered Services.

4.11. **Rate Adjustments**. CalOptima may adjust the payment rates under Attachment B during the Term to account for implementation of federal or State laws or regulations; changes in the State budget, Government Contract(s) or Regulators' policies; and/or changes in in the scope of Covered Services. CalOptima shall provide notice thereof to Provider as soon as practicable of any such changes, and such adjustments shall comply with Laws.

4.12. **Taxes and Contributions**. As applicable and required by Laws, Provider shall be responsible for withholding and paying all federal, State, and local taxes and contributions regarding (i) Provider's earnings under this Contract, (ii) the salaries or other benefits paid or made available to any persons retained or employed by Provider to furnish services under the Contract, or (iii) otherwise related to Provider's services under this Contract.

ARTICLE 5
INSURANCE AND INDEMNIFICATION

5.1 **Indemnification**. Each Party agrees to defend, indemnify, and hold each other and the State harmless with respect to any claims, costs, damages and expenses, including reasonable attorneys' fees, that are related to or arise out of the negligent or willful performance or non-performance by the indemnifying Party of any functions, duties, or obligations of the Party under this Contract.

5.2 **Insurance**. Provider, prior to providing any services under this Contract, shall maintain, and ensure its Subcontractors maintain, insurance coverage and amounts as set forth in this Article 5 and Attachment A, in accordance with Laws and industry standards.

5.3 **Insurer Ratings**. Such insurance will be secured and maintained at Provider's own expense. All above insurance shall be provided by an insurer:

5.3.1 With an A.M. Best rating of A-VII or better; and

5.3.2 "Admitted" to conduct business in the State, an insurer approved to do business in the State by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers, or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code § 12180.7.

5.4 **Captive Risk Retention Group/Self Insured**. Where any of the insurances mentioned in this Article 5 are provided by a captive risk retention group or are self-insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the captive risk retention group's or self-insured's audited financial statements and approves the waiver.

5.5 **Cancellation or Material Change**. Provider shall not of its own initiative cause such insurances as addressed in this Article 5 to be canceled or materially changed during the Term.

5.6 **Certificates of Insurance**. Prior to execution of this Contract, upon any change or renewal of insurance policies under this Article 5, or at CalOptima's request, Provider shall provide Certificates of Insurance to CalOptima showing the insurance coverage required under this Article 5 and further providing that (i) CalOptima is named as an additional insured on the Commercial General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and (ii) coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

5.7 **Failure to Maintain Insurance**. If Provider fails or refuses to maintain or produce proof of the insurance required by this Article 5, CalOptima shall have the right, at its election, to terminate this Contract immediately upon written notice to Provider. Such termination shall not affect Provider's right to be paid for its time and materials expended prior to notification of termination.

ARTICLE 6
RECORDS, AUDITS, REPORTS, AND OTHER INFORMATION

6.1 **Access to and Audit of Contract Records**. Provider and its Subcontractors shall allow CalOptima, Regulators, and/or their duly authorized Agents and representatives access to books and records related to services provided under the Contract, including Medical Records, contracts, documents, practitioner rosters, and electronic systems. Provider shall be given advance notice of such visit in accordance with CalOptima Policies. Such access shall include the right to directly observe all aspects of Provider's operations and to inspect, audit, and reproduce all records and materials and to verify Claims and reports submitted under this Contract. Provider shall maintain records in chronological sequence and in an immediately retrievable form in accordance with the Laws applicable to such record keeping. If a Regulator determines there is a reasonable possibility of fraud or similar risk, the Regulator may inspect, evaluate, and audit Provider at any time. Upon resolution of a full investigation of fraud, the Regulator reserves the right to suspend or terminate Provider and its Subcontractors from participation in the applicable Program; seek recovery of payments made to Provider; and impose other sanctions, and CalOptima may terminate this Contract immediately due to fraud.

6.2 **Medical Records**. As applicable to Covered Services, Provider and its Subcontractors shall establish and maintain, for each Member who has obtained Covered Services, Medical Records organized in a manner to contain such demographic and clinical information as necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services

provided to the Member. Such Medical Records shall be consistent with Laws, Program requirements, Government Contracts, and CalOptima Policies and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, Provider. Such Medical Records shall be in such a form as to allow trained health professionals, other than the Provider, to readily determine the nature and extent of the Member's medical problem and the services provided and to permit peer review of the care furnished to the Member. In accordance with Laws, Provider shall provide copies of Medical Records to other treating or consulting providers (i) to facilitate a Member's continuity of care, including Member transfers; (ii) when a Member seeks a second opinion on a diagnosis or treatment of a medical condition; or (iii) when such disclosure is necessary for a Member to access Medi-Cal or Medicare-covered services.

6.3 **Records Retention**. Provider shall maintain books and records in accordance with the time and manner requirements set forth in Laws and Programs, including as identified in Attachment D. When Provider furnishes Covered Services to a Member in more than one Program with different record retention periods, then the greater record retention requirement shall apply.

6.4 **Audit, Review, and/or Duplication**. Audit, review and/or duplication of data or records shall occur within regular business hours and shall be subject to Laws concerning confidentiality and ownership of records. Provider shall pay all duplication and mailing costs associated with such audits.

6.5 **Site Evaluations**. Provider shall permit CalOptima and Regulators to conduct periodic site evaluations, inspections, and onsite audits of Provider's facilities. CalOptima shall provide Provider five (5) Business Days' advance notice (or fewer if mutually agreed upon by the Parties) of any proposed site evaluation or inspection by CalOptima. If CalOptima or Regulators find any deficiencies in such facilities, Provider shall have thirty (30) days to correct such identified deficiencies, unless the Regulator requires that such deficiency be corrected within a shorter timeframe.

6.6 **Accreditation Surveys**. Provider shall cooperate with any surveys or evaluations relating to accreditation of CalOptima by any Accreditation Organization. Further, Provider agrees to implement any changes reasonably required as a result of all such Accreditation Organization surveys or evaluations.

6.7 **Confidentiality of Member Information**. Provider agrees to comply with Laws governing the confidentiality of Member medical and other information. Provider further agrees:

6.7.1 Privacy and Security Requirements. Provider shall comply with all Privacy Requirements. Provider shall also take actions and develop capabilities as required to support CalOptima compliance with Privacy Requirements, including acceptance and generation of applicable electronic files in HIPAA-compliant standards formats.

6.7.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with Laws. Provider shall protect from unauthorized disclosure all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.8 **Confidentiality of CalOptima Information**.

6.8.1 During the Term, Provider may access confidential material or information ("**Confidential Information**") belonging to CalOptima. Confidential Information includes CalOptima's computer programs and codes, business plans, customer/member lists and information, financial records, partnership arrangements, projections, methodologies, data, reports, agreements, intellectual property, trade secrets, licensing plans, and other proprietary information, or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. CalOptima's Confidential Information also includes all user and patient information and clinical data that comes into CalOptima's possession or control. Provider may only use Confidential Information to fulfill its obligations under this Contract and related internal administrative purposes. Provider shall protect CalOptima's Confidential Information at all times in the same manner as Provider protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

6.8.2 For the purposes of Section 6.8, Confidential Information does not include information that: (i) is already known to Provider at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of Provider; (iii) is independently developed without use or benefit of CalOptima's Confidential Information or proprietary information; (iv) is lawfully received from a third party that is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure, pursuant to California Public Records Act (Government Code Section 7920.000 *et seq*.), applicable provisions of California Welfare and Institutions Code, or other state or federal laws.

6.8.3 Disclosure of the Confidential Information is restricted to Provider's Agents, who are bound by confidentiality obligations no less stringent than those in this Section 6.8, on a "need to know" basis in connection with the services performed under this Contract. Provider may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; provided that a required disclosure of Confidential Information or proprietary information to an agency or court does not relieve Provider of its confidentiality obligations under this Section 6.8.

6.8.4 Provider shall establish and maintain environmental, safety, and facility procedures, data security procedures and other safeguards against the unauthorized access, destruction, loss, or alteration of CalOptima's Confidential Information in the possession, custody, or control of Provider. Those security procedures and other safeguards shall meet industry standards.

6.8.5 Upon written request of CalOptima, Provider shall promptly return to CalOptima or destroy all documents, notes, and other tangible materials containing CalOptima's Confidential Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of Provider's information systems procedures, provided that Provider shall make no further use of such copies.

6.8.6 If Provider breaches its obligations under this Section 6.8, CalOptima shall entitled to such injunctive relief, without any requirement to prove actual monetary damage or post a bond or other security, and any and all other remedies available at law or in equity. This Section 6.8 in no way limits the liability or damages that may be assessed against Provider if Provider breaches this Section 6.8.

6.9 **Data Submission**. Provider shall securely submit to CalOptima complete, accurate, reasonable, and timely provider data, Encounter Data, and other data and reports needed by CalOptima to meet its reporting requirements to Regulators, including DHCS and CMS, and as set forth in CalOptima Policies.

ARTICLE 7
TERM AND TERMINATION

7.1 **Term**. The term of this Contract shall begin on the Effective Date and continue in effect for [insert years] (X) years ("**Initial Term**"). The Contract then shall automatically renew for [insert number] (X) one (1)-year terms (each a "**Renewal Term**"), unless otherwise terminated under this Article 7 or directed by CalOptima's Board of Directors. The Initial Term and any Renewal Terms together constitute the "**Term**" of this Contract.

7.2 **Termination for Breach**. CalOptima may, in its sole discretion, terminate this Contract if CalOptima determines that Provider or any Subcontractor (i) has failed to perform its contracted duties and responsibilities in a timely and proper manner, including the service procedures and standards identified in this Contract; (ii) has committed acts that discriminate against Members on the basis of their health status or requirements for health care services; (iii) has not provided Covered Services in the scope or manner required under this Contract; (iv) has engaged in prohibited marketing activities; (v) has failed to comply with the Compliance Program; or (vi) has materially breached any other covenant, condition, or term of this Contract (each a "**Termination for Breach**"). In the event of a Termination for Breach, CalOptima shall give Provider prior written notice of its intent to terminate with a thirty (30)-day cure period, if the Termination for Breach is curable, in the sole discretion of CalOptima. If Provider does not cure the Termination for Breach within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this Section 7.2 are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. Provider shall not be relieved of its liability to CalOptima for damages sustained by virtue of the Contract breach by Provider or any Subcontractor.

7.3 **Termination for Non-Payment**. Provider may terminate the Contract if CalOptima fails to pay Provider for Covered Services, as required under the Contract ("**Non-Payment**"). In the event of Non-Payment, Provider shall give CalOptima prior written notice of its intent with a thirty (30)-day cure period. If CalOptima does not cure the Non-Payment within the thirty (30)-day cure period, Provider may terminate the Contract immediately following such thirty (30)-day period.

7.4 **Immediate Termination**. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice:

7.4.1 The suspension or revocation of any License required for Provider and/or Provider Agents to provide services under this Contract;

7.4.2 CalOptima's determination that the health, safety, or welfare of Members is jeopardized by continuation of this Contract;

7.4.3 The imposition of sanctions or disciplinary action against Provider or against Provider Agents in their capacities with Provider by any federal or state licensing agency;

7.4.4 Provider's failure to comply with Participation Status requirements;

7.4.5 Provider has committed FWA or permitted FWA in connection with Provider's obligations under the Contract;

7.4.6 CalOptima reasonably determines that Provider's facility, equipment, or personnel are insufficient to provide Covered Services;

7.4.7 Provider violates any Laws or is indicted;

7.4.8 Provider or its Contracted Providers fail to meet Minimum Standards and/or maintain the Licenses required to provide Covered Services;

7.4.9 Provider fails to satisfy the terms of a corrective action plan issued by CalOptima under this Contract;

7.4.10 Termination or non-renewal of any Government Contract;

7.4.11 Termination is required by a Regulator; or

7.4.12 The withdrawal of HHS's approval of the waiver granted to CalOptima under Section 1915(b) of the SSA. If CalOptima receives notice of termination from any Regulators or termination of the Section 1915(b) waiver, CalOptima shall immediately notify Provider.

7.5 **Termination for Insolvency**. If Provider, Provider's parent or holding company, or a Subcontractor becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, Provider shall immediately notify CalOptima, and CalOptima may immediately terminate the Contract at its sole option upon written notice to Provider. In the event of the filing of a petition for bankruptcy by or against Provider, Provider's parent or holding company, or a principal Subcontractor, Provider shall ensure that all tasks related to the Contract or the Subcontract are performed in accordance with the terms of the Contract. If CalOptima becomes insolvent, Provider will have the right to terminate the Contract immediately upon written notice to CalOptima.

7.6 **Termination Without Cause**. [After the Initial Term] Either Party may terminate this Contract without cause upon [insert number of days] (XX) days' prior written notice to the other Party.

7.7 **Termination of Individual Provider**. If Provider is a group of licensed providers and grounds for termination of any individual provider arise pursuant to Sections 7.2 or 7.4, then CalOptima may, in its sole discretion, terminate only the participation of such individual provider under this Contract rather than the entire Contract.

7.8 **Obligations Upon Termination**. Upon termination of this Contract, Provider shall continue to provide Authorized Covered Services to Members who retain eligibility and who are under the care of Provider at the time of such termination until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Payment for services under this Section 7.8 shall be at the contracted rates in effect under the Contract immediately prior to termination. Prior to the termination or expiration of this Contract and upon request by CalOptima or one of its Regulators to assist in the orderly transfer of Members' medical care, Provider shall make available to CalOptima and/or such Regulators, copies of any pertinent information, including information maintained by any Subcontractor, necessary for the efficient case management of Members. For purposes of this section only, "under the care of Provider" shall mean that a Member has an

Authorization from CalOptima to receive services from the Provider issued prior to the termination, all of the services Authorized have not yet been completed, and the time period covered by the Authorization has not yet expired. Termination shall not affect any rights or obligations hereunder that previously accrued or shall hereafter arise with respect to any occurrence prior to termination, and such rights and obligations shall continue to be governed by the terms of this Contract. The provision of or payment for services after the termination of the Contract shall not be construed as a renewal of this Contract for any further term or a rescission of any Contract termination.

7.9 **Survival**. The following provisions of this Contract shall survive termination or expiration of this Contract: Sections 2.20 (Fraud and Abuse Reporting), 2.24 (Member Rights), 4.8 (Member Financial Protections), 4.9 (Overpayments), 4.10 (Offset), 5.1 (Indemnification), 6.1 (Access to and Audit of Contract Records), 6.3 (Records Retention), 6.4 (Audit, Review, and/or Duplication) 6.7 (Confidentiality of Member Information), 6.8 (Confidentiality of CalOptima Information), 6.8 (Data Submission), 7.8 (Obligations Upon Termination), 7.9 (Survival), Article 8 (Grievances and Appeals), 9.5 (Governing Law and Venue), 9.7 (No Liability of the County of Orange), 9.14 (Dispute Resolution), 9.15 (Interpretation), and any other Contract provisions that by their nature are intended to survive termination or expiration of this Contract.

ARTICLE 8
GRIEVANCES AND APPEALS

8.1 **Provider Complaints and Disputes**. CalOptima has established a fast and cost-effective system for provider complaints, grievances, and appeals in accordance with Laws, Government Contracts, and Program requirements (Complaint and Disputes System). Provider shall have access to this Complaint and Disputes System for any issues arising under this Contract, as provided in CalOptima Policies related to the applicable Program. Provider shall attempt to resolve any complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract through the Complaint and Disputes System and exhaust all remedies under the Complaint and Dispute System prior to proceeding to arbitration under Section 9.14.

8.2 **Member Grievances and Appeals**. Provider agrees to cooperate in the investigation of any Member grievances, complaints, and appeals and be bound by CalOptima's decisions and, if applicable, State and/or federal hearing decisions or any subsequent appeals. Provider shall also continue providing services to a Member, if requested by CalOptima and the Member, until any grievance or appeal from a Member regarding Provider is resolved.

ARTICLE 9
GENERAL PROVISIONS

9.1 **Assignment, Assumption, and Change of Control**. Provider may not assign this Contract, either in whole or in part, without the prior written consent of CalOptima, which may be withheld in CalOptima's sole and absolute discretion. For purposes of this Section 9.1, assignment includes: (i) the change of more than fifty percent (50%) of the directors or trustees of Provider; (ii) the merger, reorganization, or consolidation of Provider with another entity when Provider is not the surviving entity; or (iii) a change in the management of Provider from management by persons appointed, elected or otherwise selected by the governing body of Provider (*e.g.,* the Board of Directors) to a third-party management person or entity. In addition, Provider must obtain CalOptima's prior written consent for any change of control. For purposes of this Section 9.1, a change of control includes the change of more than fifty percent (50%) of the ownership or equity interest in Provider (whether in a single transaction or in a series of transactions).

9.2 **Entire Agreement**. This Contract, including its attachments, addenda, exhibits, and amendments and all CalOptima Policies applicable to Covered Services (and any amendments thereto), constitutes the entire agreement between the Parties and supersedes and terminates any previous agreements between the Parties. All prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract not expressly set forth herein shall be of no further force, effect, or legal consequence after the Effective Date.

9.3 **Amendments**. CalOptima reserves the right to amend or terminate the Contract at any time when such modifications or terminations are (i) mandated by changes in Laws; (ii) required by Government Contracts; or (iii) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its federally-approved Section 1915(b) waiver ("**Regulatory Change**"). CalOptima shall promptly notify Provider in writing of such Regulatory Changes and in accordance with applicable federal and/or State requirements, and Provider shall comply with the new Regulatory Change requirements within thirty (30) days of the effective date of the Regulatory Change, unless otherwise instructed by a Regulator, including DHCS. Notwithstanding a Regulatory Change, any other amendment of a term to this Contract must be in writing and executed by the Parties unless otherwise permitted or required by Laws.

9.4 **Force Majeure**. Both Parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster, including an act of war, and excluding labor disputes. A Party invoking this clause shall provide the other Party with prompt written notice of any delay or failure to perform that occurs by reason of force majeure. If the force majeure event continues for a period of ten (10) days, the Party unaffected by the force majeure event may terminate this Contract upon notice to the other Party.

9.5 **Governing Law and Venue**. This Contract shall be governed by and construed in accordance with all laws of the State, federal laws, and regulations applicable to the Programs, and all contractual obligations of CalOptima. Subject to the restrictions in Section 9.14, Provider shall bring any and all legal proceedings against CalOptima under this Contract in California State courts in Orange County, California, unless mandated by law to be brought in federal court, in which case such legal proceeding shall be brought in the Central District Court of California.

9.6 **Independent Contractor Relationship**. Provider and any Agents or employees of Provider in performance of this Contract shall act in an independent capacity and not as officers, employees, or Agents of CalOptima. Provider's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Provider's personnel performing services under this Contract shall be at all times under Provider's exclusive direction and control and shall be employees and/or Agents of Provider. Provider shall pay all wages, salaries, and other amounts due its employees in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7 **Names and Marks**. Provider shall not use the name, logo or other proprietary mark of CalOptima in any press release, advertising, promotional, marketing or similar publicly disseminated material without obtaining CalOptima's express written approval of the material and consent to such use.

9.8 **No Liability of the County of Orange**. As required under County Ordinance No. 3896, as amended, the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County shall have no obligation or liability therefore.

9.9 **No Waiver**. Any failure of a Party to insist upon strict compliance with any provision of this Contract shall not be deemed a waiver of such provision or any other provision of this Contract. To be effective, a waiver must be in writing and signed and dated by the Parties.

9.10 **Notices**. Any notices required or permitted under this Contract shall be in writing and delivered to the addresses set forth below in this Section 9.10. Any notice not related to termination of this Contract may be sent electronically to the other Party's e-mail address listed in this section or such other address as may be provided by a Party to the other Party from time to time. If notice relates to termination of this Contract, such notice shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service that delivers to the noticed destination and provides proof of delivery to the sender. All notices sent to the addresses set forth in this section shall be effective (i) when first received by the Party, or (ii) upon refusal of delivery by the Party to which it was sent. Any Party whose address changes during the Term shall promptly notify the other Party in writing. If CalOptima cannot complete notice under this Section 9.10 because Provider's addresses are incorrect and/or Provider failed to notify CalOptima of the change, CalOptima shall provide notice under this Section 9.10, including for Contract termination, by making commercially reasonable efforts to deliver notice in any manner reasonably calculated to give Provider actual notice, and notice shall be deemed delivered upon the completion of those efforts.

If to CalOptima:

CalOptima
Attn: Director of Contracting
505 City Parkway West
Orange, CA 92868
[insert email]

If to Provider:

{{*Name on Notice_es_:signer1: }}
Name

{{*Title on Notice_es_:signer1: }}
Title

{{*Address on Notice_es_:signer1 }}
Address

9.11 **Prohibited Interests**. Provider covenants that, for the Term, no director, Member, officer, or employee of CalOptima during his/her tenure has any personal interest, direct or indirect, in this Contract or the proceeds thereof.

9.12 **Authority to Execute**. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract, the Parties are formally bound. If Provider is comprised of a group of licensed providers, then the signatory warrants that they have the authority to bind each of the providers included in the Providers' roster, and Provider agrees that the provisions of this Contract bind all officers, members or employees of Provider who are similarly licensed and that such providers shall accept, as payment in full for the provision of Covered Services to Members, the reimbursement rates set forth in this Contract.

9.13 **Severability**. If any provision of this Contract is rendered invalid or unenforceable by Laws or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect as though the invalid or unenforceable parts had not been included herein.

9.14 **Dispute Resolution**.

9.14.1 Meet and Confer. For any dispute not subject to or resolved by the provider appeals process, the Parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The Parties shall meet and confer within thirty (30) days of a written request submitted by either Party in an effort to settle any dispute. At each meet-and-confer meeting, each Party shall be represented by persons with final authority to settle the dispute. If either Party fails to meet within the thirty (30)-day period, that Party shall be deemed to have waived the meet-and-confer requirement, and at the other Party's option, the dispute may proceed immediately to arbitration under Section 9.14.2.

9.14.2 Arbitration. If the Parties are unable to resolve any dispute arising out of or relating to this Contract under Section 9.14.1, either Party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The Parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the Parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("**JAMS**") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The Parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the Parties cannot agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the Parties, two from each side; provided, however, that nothing stated in this section shall prevent a Party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the Parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either Party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction or authority to make errors of law and/or legal reasoning, to give a remedy or award damages that would not be available to such prevailing Party in a court of law, or to award punitive, exemplary, or treble damages. The Parties shall share the costs of arbitration equally, and each Party shall bear its own attorneys' fees and costs.

9.14.3 Exclusive Remedy. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 9.14.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes. Notwithstanding the foregoing, either Party may institute proceedings in a federal or state court of competent jurisdiction to seek temporary or preliminary injunctive relief to enforce the status quo in any dispute relating to this Contract pending the resolution of that dispute through arbitration.

9.14.4 Limitations Period. Provider acknowledges that Government Code § 911.2 requires a claim against a government entity to be brought no later than one (1) year after the accrual of the cause of action. As such, the Parties agree that arbitration under Section 9.14.2 must be initiated within one (1) year of the earlier of the date the dispute arose, was discovered, or should have been discovered with reasonable diligence; otherwise, the dispute will be deemed waived, and the complaining Party shall be barred from initiating arbitration or other proceedings related to the dispute, including any civil action in state or federal court. For disputes related to Claims, the one (1)-year limitations period under this Section 9.14.4 shall begin to run as of the final Claim denial date under CalOptima's provider appeals system. If Provider fails to participate in any portion of CalOptima's provider appeals system for a disputed Claim, as described in Section 8.1, Provider waives its right to arbitrate that claim. The deadline to file arbitration shall not be subject to waiver, tolling, alteration, or modification of any kind or for any reason other than fraud.

9.14.5 Waiver. By agreeing to binding arbitration as set forth in Section 9.14.2, the Parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

9.15 **Injunctive Relief**. If Provider breaches any provision of this Contract, CalOptima shall be entitled to any and all applicable remedies at law and/or equity to prevent further breach of this Contract, including injunctive relief without the necessity of posting bond.

9.16 **Interpretation**. Each Party has had the opportunity to have counsel of its choice examine the provisions of this Contract, and no implication shall be drawn against any Party by virtue of the drafting of this Contract.

9.17 **No Third-Party Beneficiaries**. Except as stated in Attachment D regarding DHCS, this Contract is intended solely for the benefit of the Parties and their respective successors and permitted assigns, and nothing in this Contract, express or implied, is intended to or shall confer upon any other person or entity any legal or equitable right, benefit, or remedy of any nature whatsoever under or by reason of this Contract.

9.18 **Without Limitation**. The words "include", "includes", and "including" are not words of limitation and shall be deemed to be followed by the phrase "without limitation".

9.19 **Recitals and Exhibits**. The recitals, attachments, exhibits, and/or addenda set forth in this Contract are made a part of the Contract by this reference.

ARTICLE 10
EXECUTION

10.1 **Execution**. This Contract may be executed in multiple counterparts, each of which shall be deemed an original and all of which together shall be deemed one and the same instrument. Subject to the State and United States providing funding during the Term and for the purposes with respect to which it is entered into, execution of the Government Contracts, and the approval of the Contract by Regulators, this Contract shall become effective as of the Effective Date.

IN WITNESS WHEREOF, the Parties have executed this Contract as follows:

Provider **CalOptima**

Back to Agenda Back to Item

{{_es_:signer1:signature}}	{{_es_:signer2:signature}}
Signature	Signature
{{*Name_es_:signer1 }}	{{N_es_:signer2:fullname }}
Print Name	Print Name
{{*_es_:signer1:title }}	{{*_es_:signer2:title }}
Title	Title
{{*_es_:signer1:date }}	{{*_es_:signer2:date }}
Date	Date

ATTACHMENT A
COVERED SERVICES

[*insert provider-specific exhibit*]

Back to Agenda Back to Item

ATTACHMENT B
COMPENSATION

[*insert provider-specific exhibit*]

Back to Agenda Back to Item

ATTACHMENT C
PROCEDURES FOR REQUESTING INTERPRETATION SERVICES

ARTICLE 1
CALOPTIMA DIRECT, PACE, AND COVERED CALIFORNIA MEMBERS

1.1 **CalOptima Responsibilities**. Excluding Members assigned to Health Networks for delegated responsibilities, CalOptima shall provide COD, PACE, and Covered California Members with face-to-face language and sign language interpretation services to ensure effective communication with providers, as set forth in this Article 1. Upon notification from Provider pursuant to the provisions of this Contract that interpreter services are required, CalOptima shall arrange for and make payment for interpreter services for Members in accordance with the procedures set forth in this Attachment C.

1.2 **Request for Interpretation Services**. To request interpretation services for a Member, Provider shall, at least one (1) week before the scheduled appointment with the Member, contact CalOptima Customer Service Department at (714) 246-8500. CalOptima Customer Service Department shall route the request to the Cultural and Linguistic ("**C&L**") Coordinator. CalOptima requires the following information at the time of the request:

1.2.1 Member name and ID, date of birth, and telephone number;

1.2.2 Name and phone number of the caretaker, if applicable;

1.2.3 Language or sign language needed;

1.2.4 Date and time of the appointment;

1.2.5 Address and telephone number of the facility where the appointment is to take place;

1.2.6 Estimated amount of time the interpretation service will be needed; and

1.2.7 Type of appointment: assessment, fitting/delivery, or other.

1.3 **C&L Coordinator**. CalOptima C&L Coordinator will make best efforts to secure an interpreter within seventy-two (72) hours of a request and will confirm the results of this effort to Provider and Member.

1.4 **Appointment Changes**. If there is any change with the appointment, Provider shall contact CalOptima Customer Service Department at least seventy-two (72) hours before the scheduled appointment.

1.5 **Provider Obligation for Cost**. If Provider fails to communicate with CalOptima Customer Service Department an interpretation request or change to an interpretation request more than seventy-two (72) hours before the appointment, Provider will incur the cost of an urgent interpretation service request.

ARTICLE 2
HEALTH NETWORK MEMBERS

2.1 Health Network Contact. For Health Network Members, Provider shall contact Member's Health Network customer service department to request the needed interpretation services and shall follow the Health Network policy and procedures for those services.

ATTACHMENT D
Regulatory Requirements

The following additional terms and conditions contained in the following regulatory addenda apply to items and services furnished to Members under the Programs listed in Attachment A. If these terms conflict with those elsewhere in the Contract, the terms from the applicable addendum in this Attachment D shall control with respect to the Program at issue.

[*include the regulatory addendums for the Programs listed in Attachment A*]

Medi-Cal Program Addendum

This Medi-Cal Addendum shall apply to the Medi-Cal Program. For avoidance of doubt, this addendum does not apply to CalOptima's PACE, MSSP, or Covered California Programs; provided, however, OneCare members are eligible for Medicare and Medi-Cal benefits, and this addendum shall apply to dual eligible Members' Medi-Cal benefits.

1. Definitions.

   1.1 "**Downstream Subcontractor**" means an individual or an entity that has an agreement with a Subcontractor or a Downstream Subcontractor that includes a delegation of Provider's and Subcontractor's duties and obligations under the Contract.

   1.2 "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one or more of the following: (i) placing the Member's health in serious jeopardy; (ii) serious impairment of bodily functions; (iii) serious dysfunctions to any bodily organ or part; or (iv) death.

   1.3 "**Health Equity**" means the reduction or elimination of health disparities, health inequities, or other disparities in health that adversely affect vulnerable populations.

   1.4 "**Laws**" means, without limitation, federal, state, tribal, or local statutes, codes, orders, ordinances, and regulations applicable to this Attachment G.

   1.5 "**Quality Improvement and Health Equity Transformation Program**" or "**QIHETP**" means the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in Laws, Government Program Requirements.

2. Compliance with Laws. This Contract shall be governed by and construed in accordance with all Laws and applicable regulations governing the DHCS Contract, including 42 Code of Federal Regulations ("**CFR**") § 438.230; the Knox Keene Act, Health and Safety ("**H&S**") Code §§ 1340 *et seq*., unless otherwise excluded under the DHCS Contract; 28 CCR §§ 1300.43 *et seq*; Welfare & Institutions ("**W&I**") Code §§ 14000 and 14200 *et seq*.; and 22 CCR §§ 53800 *et seq.*, 53900 *et seq*., 53250(c)(2) and 53864. Provider will comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, including all applicable requirements specified in the DHCS Contract, Laws, sub-regulatory guidance, and DHCS All Plan Letters ("**APLs**") and policy letters, and CalOptima Policies. Provider shall comply with all monitoring requirements of the Contract, the DHCS Contract, and any other monitoring requests by DHCS and CalOptima. [DHCS Contract,

Exhibit A, Attachment III, § 3.1.5(A.4), (A.5), (A.11), (B.7), (B.8), and (B.11); APL 26-007]

3. Provider Data. As applicable, Provider and its Subcontractors will submit to CalOptima complete, accurate, reasonable, and timely provider data, Program Data, Template Data, and any other reports or data as requested by CalOptima to meet its reporting requirements to DHCS. Provider shall submit all provider data to CalOptima in the form, format, and timeframe requested by CalOptima. Provider will make corrections to provider data as requested by CalOptima. Provider data shall include all data required under the Contract – including reports and Provider rosters. For purposes of this section, (1) "Program Data" means data that includes but is not limited to: Grievance data, Appeals data, medical exemption request denial reports and other continuity of care data, out-of-network request data, and PCP assignment data as of the last calendar day of the reporting month; and (2) "Template Data" means data reports submitted to DHCS by CalOptima, which includes, but is not limited to: data of Member populations, health care benefit categories, or program initiatives. [DHCS Contract, Exhibit A, Attachment III, §§ 1.2.5, 2.1.4, 2.1.5, 2.1.6, 3.1.5(A.6) and (B.10); APLs 14-009, 14-019, 16-019, 20-017, 26-007]

4. Encounter Data. As applicable, Provider will submit to CalOptima complete, accurate, reasonable, and timely Encounter Data requested by CalOptima in order to meet its reporting requirements to DHCS in compliance with applicable DHCS APLs, including APL 14-020 and any superseding or amendment APLs. All Encounter Data shall be submitted to CalOptima no later than ninety (90) days from the Date of Service in the form and format as designated by CalOptima. Provider will cooperate as requested by CalOptima if corrections to Encounter Data are required for CalOptima to comply with reporting requirements to DHCS. [DHCS Contract, Exhibit A, Attachment III, §§ 2.1.2, 3.1.5(A.6) and (B.10); APLs 14-009, 14-019, 16-019, 20-017, 26-007]

5. Reports. Provider, and its Participating Providers, agree to submit all reports required and requested by CalOptima to comply with applicable laws in a form acceptable to CalOptima. [DHCS APL 19-001, Attachment A, Requirement 6]

6. Data Privacy. Provider shall secure, handle, and exchange all data in accordance with any and all State and federal privacy laws and regulations, including data exchange policies and procedures, as defined by California Health and Human Services ("CalHHS") Data Exchange Framework in accordance with HSC § 130290, the CMS Interoperability and Patient Access Final Rule (CMS-9115-F), the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), and APL or other guidance, specifically pursuant to 45 CFR parts 160 and 164 subparts A and E, to the extent applicable. [DHCS Contract, Exhibit A, Attachment III, §§ 4.3.3, 4.3.8(A.17); APL 26-007]

   6.1 Data Sharing Agreement ("**DSA**") Agreement. Provider shall (i) execute the CalHHS DSA; (ii) comply with the DSA requirements, including the CalHHS policies and procedures incorporated into the DSA; and (iii) participate in the real-time exchange of, or provision of access to, health information between and among other DSA participants, including CalOptima and any other Participating Providers providing services to Members. [H&S Code § 130290; DHCS Contract, Exhibit A, Attachment III § 3.1.5(A.21) and (B.31); APL 26-007]

7. Additional Subcontracting Requirements. If Provider is allowed to subcontract services under this Contract and does so subcontract, then Provider shall, upon request, provide copies of such Subcontracts to CalOptima and/or DHCS.

   7.1 Subcontracts for Provision of Covered Services. Provider shall maintain copies of all contracts it enters into related to ordering, referring, or rendering Covered Services under

the Contract. Provider will ensure that such contacts are in writing. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.7); APL 26-007]

7.2 Subcontracts. Provider shall require all Subcontracts and downstream Subcontracts that relate to the provision of Covered Services be in writing and include all applicable provisions of the Contract and this Medi-Cal Program Addendum including:

7.2.1 The services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

7.2.2 As applicable, Section 2, *Compliance with Laws*; Section 3, *Provider Data*; Section 4, *Encounter Data*; Section 7, *Additional Subcontractor Requirements*; Section 8, *Records Retention*; Section 9, *Access to Books and Records*; Section 10, *Records Related to Recovery for Litigation*; Section 11, *Transfer*; Section 12, *Unsatisfactory Performance*; Section 13, *Hold Harmless*; Section 14, *Prohibition on Member Claims and Member Billing*; Section 15, *Prospective Requirements*; Section 16, *Network Provider Training*; Section 17, *Language Assistance and Interpreter Services*; Section 18, *Fraud, Waste, and Abuse Reporting*; Section 19, *Provider Identified Overpayments*; Section 20, *Health Care Provider's Bill of Rights*; Section 21, *Provider Grievances*; Section 22, *Effective Dates*; Section 23, *Assignment and Sub-delegation*; Section 24, *Quality Improvement & Utilization Management*; Section 25, *Emergency Services and Post-Stabilization Delegation*; Section 28, *Amendment and Termination*; Section 29, *Delegated Activities*; Section 30, *Utilization Data*; Section 59, *DHCS Beneficiary*; and any other section of this Attachment G that is applicable to the obligations Subcontractor has undertaken.

7.2.3 An agreement that Subcontractors shall notify Provider of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

7.2.4 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 14.12 of the base Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

[DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.12)]

8. Records Retention. Provider and Subcontractors shall maintain and retain all books and records of all items and services provided to Members, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term of at least ten (10) years from the final date of the DHCS Contract, or from the date of completion of any audit, whichever is later, in accordance with 42 CFR § 438.230(c). Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Provider's books and records shall be maintained within, or be otherwise accessible within, the State and pursuant to H&S Code § 1381(b). Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima and/or representatives of any regulatory or law enforcement agency immediate and direct access and inspection of all such records at the time of any onsite audit or review. This provision shall survive

the expiration or termination of this Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.9) and (B.14); APL 26-007; H&S Code § 1381; 28 CCR 1300.81]

9. Access to Books and Records. Provider agrees, and shall ensure its Subcontractors agree in Subcontracts, to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the Covered Services ordered, referred, or rendered under the terms of the Contract available for the purpose of an audit, inspection, evaluation, examination or copying, including information related to access requirements, claims submissions, and delivery of Covered Services in accordance with UM protocols, as set for in State Contract, Exhibit E, Section 1.1.22 (Inspection and Audit of Records and Facilities), at any time as follows: (i) in accordance with inspections and audits as directed by CalOptima, Regulators, the Department of Justice ("**DOJ**"), Office of Attorney General Division of Medi-Cal Fraud and Elder Abuse ("**DMFEA**"), DHCS's External Quality Review Organization contractor, and any other State or federal entity and their duly authorized designees statutorily entitled to have oversight responsibilities over CalOptima and/or Provider and its Subcontractors; (ii) at all reasonable times at Provider's and Subcontractor's respective places of business or at such other mutually agreeable location in the State; and (iii) in a form maintained in accordance with the general standards applicable to such book or record keeping. Provider and Subcontractors shall provide access to all security areas and facilities and cooperate and assist State representatives in the performance of their duties. If DHCS, CMS, DMFEA, or DOJ or any other authorized State or federal agency, determines there is a credible allegation of fraud against Provider, CalOptima reserves the right to suspend or terminate the Provider from participation in the Medi-Cal program; immediately suspend payments to Provider; seek recovery of payments made to Provider or any Subcontractor; impose other sanctions provided under the DHCS Contract, and conduct additional monitoring. Provider and Subcontractors shall cooperate in the audit process by signing any consent forms or documents required by but not limited to: DHCS, DMHC, the DOJ, Attorney General, Federal Bureau of Investigation, Bureau of Medi-Cal Fraud, and/or CalOptima to release any records or documentation Provider may possess in order to verify Provider's records. This provision shall survive the expiration or termination of this Contract and Subcontractors. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.8) and (B.13); Exhibit E, § 1.1.22(B); 42 CFR § 438.3(h); APL 26-007]

10. Records Related to Recovery for Litigation. Upon request by CalOptima, Provider shall timely gather, preserve and provide to CalOptima, DHCS, CMS, DMFEA, and any authorized State or federal agency in the form and manner specified by such entity, any information, subject to any lawful privileges, in Provider's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If v asserts that any requested documents are covered by a privilege, Provider shall: (i) identify such privileged documents with sufficient particularity to reasonably identify the documents while retaining the privilege; and (ii) state the privilege being claimed that supports withholding production of the document. Provider agrees to promptly provide CalOptima with copies of any documents provided to any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time is of the essence in responding to such requests. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records received by Provider or its Subcontractors related to this Contract or Subcontracts. Provider further agrees to timely gather, preserve, and provide to DHCS any records in Provider's or its Subcontractor's possession. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.10) and (B.15); Exhibit E, § 1.1.27; APL 26-007]

11. Transfer. Provider agrees, and will require its Subcontractors to assist, CalOptima in the transfer of Member care if in the event of: (i) termination of the DHCS Contract for any reason in accordance with the terms of the DHCS Contract; (ii) termination of this Contract for any reason; or (iii) a

Subcontract terminates for any reason. Such assistance will include making available to CalOptima and DHCS copies of each Member's medical records and files, and any other pertinent information necessary to provide affected Members with case management and continuity of care. Such records will be made available at no cost to CalOptima, DHCS, or Members. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.11) and (B.16); Exhibit E, § 1.1.17(B); APL 26-007]

12. Unsatisfactory Performance. Provider and its Subcontractors agree that the Contract or Provider's participation in the Medi-Cal program will be terminated, and/or subject to other fines, penalties, or other remedies, if DHCS or CalOptima determine that Provider has not performed satisfactorily. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.12) and (B.18); 42 CFR § 438.230(c)(iii); 22 CCR §§ 53250, 53867; APL 26-007]

13. Hold Harmless. Provider and its Subcontractors shall accept CalOptima's payment as described in this Contract as payment in full for all Covered Services and Administrative Services. Provider and its Subcontractors agree to hold harmless both the State and Members in the event that CalOptima cannot or will not pay for obligations undertaken by Provider pursuant to this Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.13) and (B.19); 22 CCR §§ 53250(e)(6), 53867; APL 26-007]

14. Prohibition on Member Claims and Member Billing. Provider and its Subcontractors will not bill or otherwise collect reimbursement from a Member for any services provided under this Contract. Provider and Subcontractors will ensure that Members are not balance billed for any service provided out of network. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.14), 3.3.6, 5.2.7; APL 26-007]

15. Prospective Requirements. CalOptima will inform Provider of prospective requirements added by State or federal law, or DHCS to the DHCS Contract that would impact Provider's obligations and functions before the requirement becomes effective. Provider agrees to comply with the new requirements within thirty (30) calendar days of the effective date, unless otherwise instructed by CalOptima or DHCS. Provider will ensure Subcontractors are (i) informed of prospective requirements that would impact their obligations before the requirements become effective and (ii) agree to comply with new requirements within thirty (30) calendar days of the effective date, unless otherwise instructed by CalOptima or DHCS. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.15), (B.23), and (B.24); APL 26-007]

16. Network Provider Training. Provider shall participate in training required by CalOptima in order for CalOptima to comply with the DHCS Contract. Such provider training may include, utilization management training, quality of care for children (early periodic screening, diagnosis and testing) training, Member's rights, and advanced directives. Training will also include training on cultural competency and linguistic programs as outlined in this section. Provider shall ensure that all Subcontractors receive all applicable training. [DHCS Contract, Exhibit A, Attachment III, §§ 2.3(F), 3.2.5, 5.1.1, 6.1.3(C)]

    16.1 Diversity, Health Equity, Cultural Competency, and Sensitivity Training. Provider shall ensure that annual diversity, Health Equity, cultural competency/humility, and sensitivity training is provided for employees and staff at all key points of contact, pursuant to the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.16) and (B.25), 5.2.11(C); APL 26-007]

    16.2 Cultural/Linguistic Training Programs. Provider shall participate in and comply with any applicable performance standards, policies, procedures, and programs established from

time to time by CalOptima and federal and State agencies and provided or made available to Provider with respect to cultural and linguistic services, including attending training programs and collecting and furnishing cultural and linguistic data to CalOptima and federal and State agencies. [DHCS Contract, Exhibit A, Attachment III, § 5.2.11]

16.3 Discharge Planning and Transitional Care Training. Provider will educate its discharge planning staff on the services, supplies, medications, and durable medical equipment requiring prior authorization, and CalOptima's policies regarding discharge planning and transitional care services, as applicable. [DHCS Contract, Exhibit A, Attachment III, § 4.3.10(A.6) and (A.7)]

17. Language Assistance and Interpreter Services. Provider and its Subcontractors will comply with language assistance standards developed pursuant to H&S Code § 1367.04 and the DHCS Contract. Provider agrees to provide or arrange for the provision of interpreter services for Members. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.17) and (B.26), 5.1.3(F); APL 26-007]

18. Fraud, Waste, and Abuse Reporting. Provider shall report suspected fraud, waste, or abuse to CalOptima within ten (10) business days and in accordance with the Contract. PROVIDER agrees to provide CalOptima with all information reasonably requested by CalOptima, DHCS, or other State and federal agencies with jurisdiction in order for CalOptima to comply with fraud, waste, or abuse investigations and reporting requirements. In the course of a fraud, waste, or abuse investigation, CalOptima may share with Provider information that DHCS has disclosed to CalOptima ("**FWA Confidential Data**"). Provider acknowledges and agrees to maintain FWA Confidential Data confidentially. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.2(D), 3.1.5(A.18) and (B.27); APL 26-007]

19. Provider Identified Overpayments. In addition to Overpayment requirements under the Contract, Provider shall report in writing to CalOptima when it has received an Overpayment, identify the reason for the Overpayment, and promptly return the Overpayment to CalOptima as outlined within sixty (60) calendar days of the date Provider identified the Overpayment. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.6, 3.1.5(A.19), (B.28); 42 CFR § 438.608(d)(2); APL 26-007]

20. Health Care Providers' Bill of Rights. Notwithstanding anything in this Contract to the contrary, Provider shall be entitled to the protections of the Health Care Providers' Bill of Rights, as set forth in H&S Code § 1375.7, in the administration of this Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.20); APL 26-007]

21. Provider Grievances. Provider and its Subcontractors have the right to submit a dispute or grievance through CalOptima's formal process to resolve provider disputes and grievances pursuant to H&S Code § 1367(h)(1). CalOptima's process to resolve Provider disputes or grievances are set forth in this Contract and the CalOptima Policies. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.20), (A.24), (B.35), 3.2.2(B); APL 26-007]

22. Effective Dates. This Contract and its amendments will become effective only as set forth in the DHCS Contract, which requires filing and approval by DHCS of template contracts and amendments, and Subcontractor and Downstream Subcontractor agreements and amendments. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.2, 3.1.5(B.4)]

23. Assignment and Sub-delegation. Provider agrees that any assignment or delegation of an obligation or responsibility under this Contract by Provider to a Subcontractor shall be void unless prior written approval is obtained from CalOptima and DHCS. Provider further agrees that assignment

or delegation by a Subcontractor is void unless prior written approval is obtained from DHCS. CalOptima or DHCS may withhold consent at their sole and absolute discretion. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.5) and (B.6); APL 19-001, Attachment A, Requirement 14]

24. Quality Improvement & Utilization Management. Provider and its Subcontractors agree to cooperate and participate in CalOptima's QMI program including participating in QI Program, UM Program, QIHETP, and population needs assessments. [DHCS Contract, Exhibit A, Attachment III, §§ 2.2.4, 3.1.5(B.20)]

25. Emergency Services and Post-Stabilization Delegation. Responsibility for coverage and payment of Emergency Services and post-stabilization care services have not been delegated to Provider under the Contract. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(B.9)]

26. Telehealth. When providing any Covered Services through telehealth and/or subsequently billing for telehealth Covered Services, Provider shall ensure that it complies with all applicable statutory and regulatory requirements, including H&S Code § 1374.13; W&I Code §§ 14132.72, 14132.100, and 14132.725; Business & Professions Code § 2290.5, and DHCS APL 23-007 (and any successor guidance) (collectively "Telehealth Requirements"). These Telehealth Requirements include (i) obtaining and documenting Member consent to use telehealth; (ii) ensuring the services can be appropriately delivered via telehealth; (iii) offering telehealth services via in-person, face-to-face interactions, as well, or arranging for referrals and facilitating in-person care so that a Member does not have to independently contact a different Provider; (iv) establishing all new patients through telehealth using an approved methodology; (v) complying with all privacy and confidentiality laws in rendering services; and (vi) satisfying the required documentation and coding requirements, as further outlined in CalOptima Policies. Claims for Covered Services provided through telehealth may not be reimbursable if they do not comply with these Telehealth Requirements.

27. Electronic Prescriptions. Provider shall ensure that any Participating Providers who may issue prescriptions under Business & Professions Code § 4040(a) have the capacity to prescribe electronically and shall issue electronic prescriptions in accordance with Business & Professions Code § 688.

28. Amendment and Termination. Provider and Subcontractors agree to notify CalOptima and/or Provider, as applicable, if this Contract or an agreement with a Subcontractor is amended or terminated. For purposes of this section, notice is considered given when the notice is properly addressed and deposited in the United States Postal Service as first-class registered mail, postage prepaid. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.17); APL 19-001, Attachment A, Requirement 13]

29. Delegated Activities. If Provider is specifically delegated by CalOptima, delegated activities and reporting requirements will be further set forth in a separate attachment or addendum to this Contract. Such delegation may include, claims processing, utilization management, quality improvement, Health Equity activities, credentialing activities, and any other obligation that CalOptima is permitted to delegated to Provider, to the extent agreed upon between CalOptima and Provider. Provider agrees to perform and will require its Subcontractors to perform the obligations and functions of CalOptima undertaken pursuant to the Contract, including but not limited to reporting responsibilities, in compliance with CalOptima's obligations under the DHCS Contract in accordance with 42 CFR § 438.230(c)(1)(ii). Provider agrees to the revocation of the delegated activities and/or obligations, and/or any other specific remedies in instances where DHCS or CalOptima determine that Provider has not performed satisfactorily. If CalOptima delegates quality improvement activities, the Parties agree that the Contract will include provisions that address, at

a minimum: (i) quality improvement responsibilities, and specific delegated functions and activities of CalOptima and Provider; (ii) CalOptima's oversight, monitoring, and evaluation processes and Provider's agreement to such processes; (iii) CalOptima's reporting requirements and approval processes, including, Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly; and (iv) CalOptima's actions/remedies if Provider's obligations are not met. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.1, 3.1.5(B.1), (B.8), (B.20), (B.29)]

30. Utilization Data. If and to the extent that the Provider is responsible for the coordination of care for Members, CalOptima shall share with Provider, in accordance with the appropriate Declaration of Confidentiality signed by Provider and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Provider shall receive the utilization data provided by CalOptima and use solely for the purpose of Member care coordination. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.22); APL 19-001, Attachment A, Requirement 23]

31. Medical Decisions. Provider will ensure that medical decisions or any course of treatment in the provision of Covered Services by Provider, Subcontractors, or Downstream Subcontractors are not unduly influenced by fiscal and administrative management. [DHCS Contract, Exhibit A, Attachment III, § 1.1.5]

32. Capacity, Licensure, and Enrollment. Provider and its Subcontractors shall furnish to Medi-Cal Members those Medically Necessary Covered Services that Provider and Subcontractor is required to provide under this Contract, consistent with the scope of Provider's and/or Subcontractor's license, certification, and/or accreditation, and in accordance with professionally recognized standards. Provider and its Subcontractors agree to comply with required provider screening, enrollment, and credentialing and recredentialing requirements. Provider warrants that it has and shall maintain through the Term adequate staff to comply with its obligations under the Contract. If Provider has a state-level enrollment pathway, Provider shall enroll in the Medi-Cal program through PAVE or another state department with a recognized enrollment pathway, or through CalOptima's screening and enrollment process that complies with APL 22-013. [DHCS Contract, Exhibit A, Attachment III, § 1.3.3; APLs 22-013, 26-007]

33. Medi-Cal Enrollment. If Provider is a provider type that is not able to enroll in Medi-Cal through the DHCS, Provider shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of 22 CCR § 51000.35.

34. Prohibition Against Payment to Excluded Providers. Provider agrees that CalOptima is prohibited from contracting with individuals excluded from participation in State or federal programs and agrees that CalOptima shall not pay Provider if Provider is excluded from State or federal programs, other than Emergency Services, as outlined in Sections 3.31 and 5.12 of the Contract. Provider further agrees to not contract with or make payments to Subcontractors excluded from State or federal programs. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.4, 3.1.5(A.28), 3.3.18; APLs 21-003, 26-007]

35. Ownership Disclosure Statement. Prior to commencing services under this Contract, Provider shall provide CalOptima with the disclosures required by 42 CFR §§ 438.608(c)(2), 438.602(c), and 455.105, including the names of the officers and owners of Provider holding more than five percent (5%) of the stock issued by Provider, and major creditors holding more than five percent (5%) of the debt of Provider by completing the form in Attachment B, and Provider shall notify CalOptima whenever changes occur to the information provided therein. Provider shall promptly notify

CalOptima of any change in the required disclosures. [DHCS Contract, Exhibit A, Attachment III, § 1.3.5; Exhibit E, § 1.1.11(A.5)]

35.1 If Participating Provider is not eligible to enroll in Medi-Cal, Provider shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of 22 CCR § 51000.35 for its Participating Providers.

36. Performance Improvement Projects. Provider and Subcontractors shall comply with all applicable performance standards and participate in performance improvement projects ("**PIP**s"), including any collaborative PIP workgroups, as may be directed by CMS, DHCS, or CalOptima. [DHCS Contract, Exhibit A, Attachment III, § 2.2.9(A)-(B)]

37. No Punitive Action. CalOptima will not take punitive action against Provider if Provider requests an expedited resolution of or supports a provider or Member appeal. CalOptima will not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member (i) for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, including any information the Member needs in order to decide among all relevant treatment options; (ii) for the risks, benefits, and consequences of treatment or non-treatment; (iii) for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment; and (iv) to express preferences about future treatment decisions. [DHCS Contract, Exhibit A, Attachment III, §§ 3.2.7, 4.6.5(A)]

38. Claims Processing. CalOptima will process claims in accordance with the DHCS Contract, H&S Code §§ 1371 through 1371.39 and their implementing regulations, including 42 CFR §§ 447.45 through 447.46 and 28 CCR § 1300.71, APL 23-020, and as outlined in the CalOptima Policies. If Provider or its Subcontractors are responsible for claims payments, Provider and its Subcontractors will pay claims consistent with this provision. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.23), (B.34), 3.3.5; APLs 23-020, 26-007]

39. Cost Avoidance/Other Health Coverage. Provider acknowledges that Medi-Cal is a payor of last resort except for services in which Medi-Cal is required to be the primary payer. Accordingly, CalOptima shall not pay claims for services provided to a Member who has third-party coverage without proof that Provider has first exhausted all other payment sources. Provider shall not refuse to provide Covered Services to Members when OHC is indicated in the Member's Medi-Cal eligibility record. Provider shall review the Member's eligibility record for third party coverage, and if the Member has third-party coverage, Provider must notify the Member to seek the service from the third-party coverage. [DHCS Contract, Exhibit E, § 1.1.25(G)]

40. Public Record. Notwithstanding any other term of the Contract, this Contract and all information received in accordance with the DHCS Contract will be public record on file with DHCS, except as specifically provided by Laws. DHCS ensures the confidentiality of information and contractual provisions filed with DHCS to the extent the information and provisions are specifically exempted by Laws. [DHCS Contract, Exhibit A, Attachment III, § 3.1.11]

41. Provider Preventable Condition. CalOptima will not pay for a provider preventable condition as described in 42 CFR § 438.3(g). Provider will ensure it does not pay for provider preventable conditions. [DHCS Contract, Exhibit A, Attachment III, § 3.3.17]

42. Member Rights. Provider and Subcontractors will not retaliate or take any adverse action against a

Member for exercising the Member's rights under the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, § 5.1.1(A.1.r)]

43. Medical Records. All medical records shall be maintained in accordance with CalOptima Policies. Provider shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Subcontractor site. [DHCS Contract, Exhibit A, Attachment III, § 5.2.14]

44. Timely Access/Standards of Accessibility. Provider and its Subcontractors will comply with applicable standards of accessibility and timely access requirements as outlined in the Contract and in CalOptima Policies. Provider and Subcontractors will comply with CalOptima's procedures for monitoring Provider's and Subcontractor's compliance with this section. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.22), (B.33), 5.2.5; H&S Code § 1367.03; APL 26-007]

45. Minor Consent Services. Provider and its Subcontractors are prohibited from disclosing, and agree not to disclose, any information related to minor consent services without the express consent of the minor Member. Provider and its Subcontractors will comply with CalOptima's requirements for services to minor Members as outlined in the CalOptima Policies. [DHCS Contract, Exhibit A, Attachment III, § 5.2.8(D)]

46. Emergency Preparedness Requirements. Provider and its Subcontractors agree to cooperate with and comply with CalOptima's Emergency requirements, CalOptima Policies, and training to ensure continuity of care for Members during an Emergency. For purposes of this section, "**Emergency**" means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by a public health crisis, natural and man-made hazards, or disasters. Provider and its Subcontractors will (i) annually submit to CalOptima evidence of adherence to CMS Emergency Preparedness Final Rule 81 Fed. Reg. 63859 and 84 Fed. Reg. 51732; (ii) advise CalOptima of Provider's Emergency plan; and (iii) notify CalOptima within twenty-four (24) hours of an Emergency if Provider closes down, is unable to meet the demands of a medical surge or is otherwise affected by an Emergency. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.25), (B.36), 6.1.3(C); APL 26-007]

47. State's Right to Monitor. Provider and Subcontractors shall comply with all monitoring provisions of this Contract, the DHCS Contract, and any monitoring requests by CalOptima and Regulators. Without limiting the foregoing, CalOptima and authorized State and federal agencies will have the right to monitor, inspect, or otherwise evaluate all aspects of the Provider's operation for compliance with the provisions of this Contract and Laws. Such monitoring, inspection, or evaluation activities will include inspection and auditing of Provider, Subcontractor, and Provider's and Subcontractors' facilities, management systems and procedures, and books and records, at any time, pursuant to 42 CFR § 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Provider. Access will be undertaken in such a manner as to not unduly delay the work of the Provider and/or the Subcontractor(s). [DHCS Contract, Exhibit D(f) § 8; Exhibit E, § 1.1.22(B)]

48. Laboratory Testing. Provider agrees that if any performance under this Contract includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC § 263a and the regulations thereto. [DHCS Contract, Exhibit D(f), § 18]

49. Third Party Tort Liability. Provider and Subcontractors shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, worker's compensation, class action claims or casualty liability insurance awards and uninsured motorist coverage. Provider shall identify and notify CalOptima, within five (5) calendar days of discovery, which shall in turn notify DHCS, of any action by the CalOptima Member that may result in casualty insurance payments, tort liability, Workers' Compensation awards, class action claims, or estate recovery that could result in recovery by the CalOptima Member of funds to which DHCS has lien rights under W&I Code Article 3.5 (commencing with Section 14124.70), Part 3, Division 9. [DHCS Contract, Exhibit E, §§ 1.1.25 and 1.1.26]

50. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Provider's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least seventy-five (75) days prior to the proposed effective date. [Exhibit A, Attachment III, § 5.2.9]

51. Confidentiality of Medi-Cal Members.

51.1 Provider and its Subcontractors shall have policies and procedures in place to guard against unlawful disclosure of protected health information, personally identifying information, and any other Member confidential information in accordance with 45 CFR Parts 160 and 164, Civil Code §§ 1798 *et seq.* Provider and its Subcontractors shall obtain prior written authorization from the Member in order to disclose such information unless exempted by 22 CCR § 51009. [DHCS Contract, Exhibit A, Attachment III, § 5.1.1(B)]

51.2 In accordance with 42 CFR § 431.300 *et seq*., as well as W&I Code § 14100.2 and regulations adopted thereunder, Provider and its employees, agents, and Subcontractors shall protect from unauthorized disclosure the names and other identifying information, records, data, and data elements concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Provider, its employees, and/or agents as a result of services performed under this Contract, except for statistical information not identifying any such persons. Provider and its employees, agents, and Subcontractors shall not use or disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima.

51.2.1 Provider and its employees, agents, and Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Provider may release medical records in accordance with Laws pertaining to the release of this type of information. Provider is not required to report requests for medical records made in accordance with Laws.

51.2.2 With respect to any identifiable information concerning a Member under this Contract that is obtained by Provider or its Subcontractors, Provider will, at the termination or expiration of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the Provider by CalOptima for this purpose.

51.2.3 For purposes of this Section 51.2, identity shall include the name, identifying

number, symbol, other identifying particular assigned to the individual, such as finger or voice print or a photograph.

[DHCS Contract, Exhibit D(f) § 14; Exhibit E, § 1.1.23]

52. Debarment Certification. By signing this Contract, Provider agrees to comply with applicable federal suspension and debarment regulations, including 2 CFR 180 and 2 CFR 376.

52.1 By signing this Contract, Provider certifies to the best of its knowledge and belief, that it and its principals:

52.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

52.1.2 Have not within a three (3)-year period preceding this Contract been convicted of or had a civil judgment rendered against them for: (i) commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; (ii) a violation of federal or State antitrust statutes; or (iii) commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, obstruction of justice, or the commission of any other offense indicating a lack of business integrity or business honesty that seriously affects its business honesty;

52.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of the offenses enumerated in Section 52.1.2, above;

52.1.4 Have not within a three (3)-year period preceding the Effective Date had one or more public transactions (federal, state, or local) terminated for cause or default;

52.1.5 Have not, within a three (3)-year period preceding this Contract, engaged in any of the violations listed under 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376;

52.1.6 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (*i.e.*, 48 CFR Part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

52.1.7 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

52.2 If the Provider is unable to certify to any of the statements in this Section 52, Provider shall submit an explanation to CalOptima prior to the Effective Date and then immediately upon any change in the certifications above during the Term.

52.3 The terms and definitions in this Section 52 not otherwise defined in the Contract have the meanings set out in 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376.

52.4 If the Provider knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause.

[DHCS Contract, Exhibit (D)(f) § 20]

53. DHCS Directives. If required by DHCS, Provider and its Subcontractors shall cease specified services for Members, which may include referrals, assignment of beneficiaries, and reporting, until further notice from DHCS. [DHCS Contract, Exhibit (D)(f) § 34)]

54. Lobbying Restrictions and Disclosure Certification.

54.1 This Section 54 is applicable to federally funded contracts in excess of one hundred thousand dollars ($100,000) per 31 USC § 1352. If this Section 54 is applicable to the Contract, Provider shall comply with the requirements in this Section 54, as well as complete the disclosure forms in Attachment B prior to the Effective Date.

54.2 Certification and Disclosure Requirements.

54.2.1 If this Contract is subject to 31 USC § 1352 and exceeds one hundred thousand dollars ($100,000) at any tier, Provider shall file the certification and disclosure forms in Attachment E prior to the Effective Date.

54.2.2 Provider shall file a disclosure (in the form set forth in Attachment E, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if Provider has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant that would be prohibited under Section 54.3 if paid for with appropriated funds.

54.2.3 Provider shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by Provider under Section 54.2.2. An event that materially affects the accuracy of the information reported includes:

54.2.3.1 A cumulative increase of twenty-five thousand dollars ($25,000) or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

54.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

54.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

54.2.4 Each Subcontractor who requests or receives from Provider or Subcontractor a contract, subcontract, grant, or subgrant exceeding one hundred thousand dollars ($100,000) at any tier under this Contract shall file a certification, and a disclosure form, if required, to the next tier above that Subcontractor.

54.2.5 All disclosure forms (but not certifications) completed under this Section 54.2 and Attachment E shall be forwarded from tier to tier until received by CalOptima. CalOptima shall forward all disclosure forms to DHCS program contract manager.

54.3 Prohibition. 31 USC § 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

[DHCS Contract, Exhibit (D)(f) § 37.b]

55. Air or Water Pollution Requirements. Any federally funded agreement and/or Subcontract in excess of one hundred thousand dollars ($100,000) must comply with the following provisions unless said agreement is exempt by Laws. If applicable, Provider agrees to comply with all standards, orders, or requirements issued under the Clean Air Act (42 USC §§ 7401 *et seq*.), as amended, and the Clean Water Act (33 USC §§ 1251 *et seq*.), as amended. [DHCS Contract, Exhibit (D)(f) § 12]

56. Smoke-Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994, requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of eighteen (18), if the services are funded by federal programs either directly or through State or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to one thousand dollars ($1,000) for each violation and/or the imposition of an administrative compliance order on the responsible party. Provider shall comply with the applicable requirements of the Pro-Children Act. Provider further agrees that it will insert this certification into any Subcontracts, if required by the Pro-Children Act. [DHCS Contract, Exhibit (D)(f) § 21]

57. Domestic Partners. Pursuant to H&S Code § 1261, if Provider is licensed pursuant to H&S Code § 1250, Provider agrees to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child. [H&S Code § 1261]

58. Conflict of Interest. Provider agrees to avoid conflicts of interest or the appearance of a conflict of interest and shall (i) comply with conflict of interest avoidance requirements of the DHCS Contract; (ii) comply with any conflict avoidance plan issued by CalOptima; and (iii) notify CalOptima within ten (10) calendar days of becoming aware of any potential, suspected, or actual conflict of interest. [DHCS Contract, Exhibit H]

59. DHCS Beneficiary. Provider expressly agrees and acknowledges that (i) DHCS is a direct beneficiary of the Contract and any Subcontractor or Downstream Subcontractor agreement with respect to the obligations and functions undertaken under the Contract; and (ii) DHCS may directly

enforce any and all provisions of the Subcontractor agreement or Downstream Subcontractor agreement. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.30)]

60. Employment Non-Discrimination. During the performance of this Contract, neither Provider nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, medical condition, mental disability, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, military and veteran status. Provider and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and shall comply with the provisions of the Fair Employment and Housing Act (Government Code §§ 12900 *et seq*.) and the applicable regulations promulgated thereunder (2 CCR §§ 11000 *et seq*.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code § 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Provider and Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Provider shall include the non-discrimination and compliance provisions of this Section 60 in all Subcontracts. [DHCS Contract, Exhibit E. § 1.1.28]

60.1 Provider and all Subcontractors shall comply with federal nondiscrimination requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973, as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations promulgated under the above-listed statutes. Provider and all Subcontractors shall comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, GC sections 7405 and 11135, W&I Code section 14029.91, and State implementing regulations. [DHCS Contract, Exhibit E. § 1.1.29]

61. Member Non-Discrimination. Neither Provider nor Subcontractors shall discriminate against Members or Potential Members on the basis of any characteristic protected under federal or State nondiscrimination law, including sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code § 422.56, including the statutes identified in Section 60 above. For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service that is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting or harassing a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; (v) assigning times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code § 422.56, to the Members to be served; (vi) treating a Member or potential Member differently from others in determining whether they satisfy any admission, Enrollment, quota, eligibility, membership; or adding other requirements or conditions which Members must meet in order to be provided any Covered Service; (vii) utilizing criteria or methods of

administration which have the effect of subjecting individuals to discrimination; (viii) failing to make auxiliary aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability; and (ix) failing to ensure meaningful access to programs and activities for limited English proficiency Members and potential Members.

61.1 Provider shall take affirmative action to ensure all Members are provided Covered Services without unlawful discrimination, except where needed to provide equal access to limited English proficiency Members or Members with disabilities, or where medically indicated. For the purposes of this Section 61, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

61.2 Provider shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Member Complaint Policy and shall forward copies of all such grievances to CalOptima, attention Grievance & Appeals Resolution Services, within five (5) days of receipt of same.

61.3 Provider shall require all Participating Providers to cooperate with CalOptima's Member Complaint Policy and time requirements to Appeal within designated time frames.

[DHCS Contract, Exhibit E § 1.1.30]

62. Program Integrity and Compliance Program. Provider will establish a robust integrity and compliance program with administrative and management policies and procedures designed to prevent and detect fraud, waste, and abuse in compliance with the requirements of 42 CFR § 438.608. [DHCS Contract, Exhibit A, Attachment III, § 1.3]

63. Federally Qualified Health Centers ("FQHC"), Rural Health Centers ("RHC"), or Indian Health Services ("IHS") Facility.

63.1 If Provider is an FQHC or an RHC, Provider will cooperate with and provide to CalOptima any information necessary for CalOptima to meet its obligations to DHCS pertaining to FQHCs and RHCs, including: (i) submitting documentation of services provided, reimbursement level, and payment amounts; (ii) certifying that this Contract is offered to Provider on the same terms and conditions as those offered to other network providers providing similar services and that reimbursement is not less than the level and amount of payment which the entity would make for the service if they were furnished by a provider that is not an FQHC; and (iii) allowing DHCS review and audit of CalOptima's records pertaining FQHC and RHC reimbursement.

63.2 If Provider is an FQHC or an RHC, Provider acknowledges and agrees that CalOptima is not required to pay Provider the Medi-Cal per-visit rate for the clinic. The Parties agree that any financial incentive arrangements that Provider and CalOptima enter into will comply with DHCS guidance including DHCS Contract, Attachment III, § 3.3.7(B.7) and applicable APLs.

63.3 To the extent Provider is an Indian Health Services facility that qualifies as an FQHC and RHC; Provider agrees and acknowledges that the terms of this section applicable to FQHCs and RHCs also apply to Provider.

63.4 If Provider is an Indian Health Services provider, CalOptima shall comply with all applicable provisions of DHCS APL 24-002, including any successor guidance, ("**APL 24-002**") and the Laws referenced therein, and if any other provision of this Contract conflicts with APL 24-002, the provisions of DHCS APL 24-002 shall control and supersede the conflicting provisions of this Contract.

[DHCS Contract, Exhibit A, Attachment III, § 3.3.7(B)]

64. Lead Screening. As applicable, Provider shall ensure the provision of a blood lead screening test to Members at ages and intervals specified in 17 CCR §§ 37000-37100 and applicable APLs. Provider will follow the Childhood Lead Poising in Prevention Branch guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including making referrals to the local public health department. Provider shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide the test in the Member's medical record. If the blood lead screen test is refused, proof of voluntary refusal of the test in the form of a signed statement by the Member's parent or guardian shall be documented in the Member's medical record. If the responsible party refuses to sign this statement, the refusal shall be documented in the Member's medical record. Documented attempts that demonstrate Provider's unsuccessful efforts to provide the blood lead screen test shall be considered towards meeting this requirement. [DHCS Contract, Exhibit A, Attachment III, § 5.3.4(D)]

65. Local Health Departments. If Provider or its Subcontractors are a Local Health Department, the Parties acknowledge that this Contract specifies the scope and responsibilities of both Parties in the provision of Covered Services to Members, billing and reimbursement, reporting responsibilities, and how services are to be coordinated between the Provider, its Subcontractors, and CalOptima. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.27), (B.38), 3.1.9(B); APL 26-007] [**Drafting Note**: This only applies if the Provider is a Local Health Department, CalOptima can leave this in for all providers or leave it for Local Health Departments only.]

66. Long-Term Care Providers. If Provider or its Subcontractors are a long-term care provider, Provider and its Subcontractors shall notify CalOptima if Provider or its Subcontractors are undergoing a change of ownership so that the Provider can provide CalOptima with verification of the process. [State Contract, Exhibit A, Attachment III, §§ 3.1.5(A.26), (B.37), 5.2.3(J); APL 26-007] [**Drafting Note**: This only applies if the Provider is an LTC provider. CalOptima can leave this in for all providers or leave it for LTCs only.]

67. Skilled Nursing Facilities. If Provider is a Skilled Nursing Facility, CalOptima will implement payment of all updated Medi-Cal Fee-For-Service per diem rates for Skilled Nursing Facilities and any necessary retroactive adjustments as needed, in compliance with APLs 24-009 and 26-010, as applicable. [APL 24-009; APL 26-007] [**Drafting Note**: This only applies if the Provider is an LTC provider. CalOptima can leave this in for all providers or leave it for LTCs only.]

OneCare Program Addendum

This OneCare Addendum shall only apply to the OneCare Program. For avoidance of doubt, this addendum does not apply to CalOptima's Medi-Cal, PACE, MSSP, or Covered California Programs; provided, however, OneCare members are eligible for Medicare and Medi-Cal benefits, and this addendum shall apply to dual eligible Members' Medicare benefits.

1. **Hold Harmless**. Provider agrees to hold harmless Members in case CalOptima cannot or will not pay for services under the Contract. This provision shall not prohibit collection of any applicable SOC billed in accordance with the terms of Members' evidence of coverage. Provider further agrees that this hold harmless provision shall survive the termination of the Contract regardless of the cause giving rise to the termination, shall be construed to be for the benefit of Members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between CalOptima or Provider and Members or persons acting on their behalf that relates to liability for payment for Covered Services.

2. **Accountability**. Any services or other activity under the Contract performed by Provider and any of its Subcontractors will be performed in accordance with CalOptima's contractual obligations to CMS and DHCS, including the requirements at 42 CFR § 438.414 in relation to the grievance system.

3. **Coordination of Benefits Requirements**. Provider shall coordinate with CalOptima for proper determination of COB and bill and collect from other payers and third-party liens such charges for which the other payer is responsible. Provider agrees to establish procedures to effectively identify, at the time of service and as part of their Claims payment procedures, individuals and services for which there may be a financially responsible party other than Medicare and the OneCare Program. Provider will bill and collect from other payers and third-party liens such amounts for Covered Services for which the other payer is responsible.

4. **Submission and Prompt Payment of Claims**. Provider agrees to submit Claims to CalOptima in such format as CalOptima may require (but at minimum the CMS forms 1500, UB 04 or other form as appropriate) within ninety (90) days after the services are rendered. CalOptima reserves the right to deny Claims that are not submitted within ninety (90) days of the date of service. CalOptima shall provide payment to Provider within forty-five (45) Business Days of CalOptima's receipt of a Clean Claim from Provider, or CalOptima will contest or deny Provider's Claim within forty-five (45) Business Days following CalOptima's receipt thereof.

5. **Claims Payment**. CalOptima will not pay Provider for a provider preventable condition. As a condition of payment, Provider will comply with the applicable reporting requirements on provider preventable conditions as described at 42 CFR § 447.26(d) and as may be specified by CalOptima or DHCS. Provider shall comply with such reporting requirements to the extent that Provider directly furnishes services.

6. **Cost-Sharing**. Provider agrees that Members will not be held liable for Medicare Part A and B cost-sharing. Medicare Parts A and B services must be provided at zero cost-sharing to Members. Provider and any of its contracted providers must not impose cost-sharing requirements on Members that would exceed the amounts permitted under the Medi-Cal Program, 42 USC § 1395w-22(a)(7), and 42 CFR § 422.504(g)(1)(iii). Provider shall (i) accept reimbursement from CalOptima under the Contract as payment in full for services rendered to Members; or (ii) bill Member's Medi-Cal managed care health plan, as applicable and in accordance with Laws, for any additional Medicare payments that may be reimbursed by Medi-Cal. Provider will also comply with requirements outlined in W&I Code § 14019.4 related to Medi-Cal services.

7. **Federal Funds**. Provider acknowledges that payments Provider receives from CalOptima are, in whole or part, from federal funds. Therefore, Provider and any of its Subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 80; the Age Discrimination Act of 1975, as implemented by 45 CFR Part 91; the ADA; Section 504 of the

Rehabilitation Act of 1973, as implemented by 45 CFR Part 84, and any other regulations applicable to recipients of federal funds.

8. **Compliance with Medicare Laws**. Provider will comply with all applicable federal and State laws (including Medicare laws), regulations, and CMS instructions, including laws and regulations designed to prevent or ameliorate FWA, including applicable provisions of federal criminal law, the False Claims Act (31 USC § 3729 *et seq*.), and the anti-kickback statute (Section 1128(B)(b) of the SSA), and HIPAA administrative simplification rules at 45 CFR Parts 160, 162 and 164. Further, Provider agrees that any services provided by Provider will be consistent with and will comply with CalOptima's contract with CMS ("**CMS Contract**").

9. **Language Assistance**. Provider will provide services in a culturally competent manner and agrees to arrange for the provision of interpreter services for Members at all Provider sites.

10. **Reporting**. Provider agrees to provide relevant reports, data, and information necessary for CalOptima to meet its obligations under the OneCare Program and Laws, including 42 CFR §§ 422.516 and 422.310. In addition, Provider shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 CFR § 455.2, relating to the rendering of Covered Services by Provider, whether by Provider, Provider's employees, Subcontractors, and/or Members within five (5) Business Days of the date when Provider first becomes aware of or is on notice of such activity.

11. **Offshore Activities**. Unless CalOptima has provided prior written authorization, all services provided by Provider pursuant to the Contract must be performed within the United States, the District of Columbia, or the United States territories.

12. **Excluded Individuals/Program Integrity**. Provider acknowledges and agrees that it is not excluded and shall not employ or contract for the provision of services pursuant to the Contract with any individual or entity (hereafter, "**Person**") whom Provider knows is excluded from participation in the Medicare or Medicaid programs under Section 1128 or 1128A of the SSA. Provider hereby certifies that no such excluded Person currently is employed by or under contract with Provider. Provider shall ensure that the Persons it employs or contracts for the provision of services pursuant to the Contract are in good standing and not on the CMS preclusion list, as defined in 42 CFR § 422.2. Provider shall promptly after discovery disclose to CalOptima any exclusion, or other event that makes a Provider employee or downstream entity ineligible to perform work related to federal health care programs, in accordance with 42 CFR § 422.752(a)(8). Provider agrees to be bound by the provisions set forth at 2 CFR Part 376.

13. **Emergency Medical Treatment and Labor Act**. Provider must comply with the federal Emergency Medical Treatment and Labor Act ("**EMTALA**"), as applicable, and ensure that there are no conflicts with hospital actions required to comply with EMTALA.

14. **Punitive Action**. CalOptima will not take punitive action against Provider if Provider requests an expedited resolution or supports a Member's appeal. CalOptima will not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is their patient for a Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, for any information a Member needs in order to decide among all relevant treatment options, for the risks, benefits, and consequences of treatment or non-treatment, for a Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

15. **Indemnity**. Provider is not required to indemnify CalOptima for any expenses and liabilities, including judgments, settlements, attorney's fees, court costs, and any associated charges, incurred in connection with any claim or action brought against CalOptima based on CalOptima's management decisions, utilization review provisions, other policies, guidelines, or actions.

MSSP Program Addendum

This MSSP Addendum shall only apply to the MSSP Program. For avoidance of doubt, this addendum does not apply to CalOptima's Medi-Cal, Medicare, PACE, or Covered California Programs.

1. **MSSP Site Manual**. Provider shall abide by the MSSP Site Manual, training manuals, and other guidance issued by the CDA Medi-Cal Services Branch, including any subsequent changes to applicable laws. The MSSP Site Manual, dated July 1, 1992, is produced by the CDA and includes all subsequent amendments.

2. **Provider Confidentiality Statement**. Provider shall sign and return a Contractor/Vendor Confidentiality Statement (CDA 1024 Form) with the Contract to ensure that Provider is aware of, and agrees to comply with, its obligations to protect CDA information and assets from unauthorized access and disclosure.

3. **Travel Reimbursement Limits**. If the Contract provides for the reimbursement of authorized travel, any reimbursement for such authorized travel shall be at a rate not to exceed those amounts paid by the State in accordance with the Department of Personnel Administration's rules and regulations, which may be found at http://www.dpa.ca.gov/textdocs/freepmls/PML2008019.pdf (generally), http://www.dpa.ca.gov/personnel-policies/travel/meals-and-incidentals.htm (per diem), and http://www.dpa.ca.gov/personnel-policies/travel/short-term-travel.htm (lodging). This is not to be construed as limiting Provider from paying any differences in costs, from funds not derived from MSSP, between the Department of Personnel Administration rates and any rates Provider is obligated to pay under other contractual agreements. No travel outside of the State shall be reimbursed, unless prior written authorization from the State is obtained (2 CCR § 599.615 *et seq*.).

4. **Records**. Provider shall maintain complete records, including accounting records, contracts, agreements, and insurance documentation, pertaining to its activities and expenditures hereunder in a form satisfactory to CDA and in accordance with this Contract, and Provider shall make all records pertaining to the Contract available for inspection and audit by CalOptima and the State, or either's duly authorized agents, at any time during normal business hours. All such records must be maintained and made available by the Provider; (i) until an audit has occurred and an audit resolution has been issued, or unless otherwise authorized in writing by CDA or DHCS's Audit Branch; (ii) for such longer period, if any, as is required by applicable statue, by any other clause of the Contract; or (iii) for such longer period as CDA deems necessary.

PACE Program Addendum

This PACE Program Addendum shall only apply to the PACE Program. For avoidance of doubt, this addendum does not apply to CalOptima's Medi-Cal, OneCare, MSSP, or Covered California Programs.

1. **Definitions**. PACE is a program that features a comprehensive medical and social services delivery system using an interdisciplinary team ("**IDT**") approach in an adult day health center that is supplemented by in-home and referral services, in accordance with Members' needs. The IDT is the group of individuals to which a PACE participant is assigned who are knowledgeable clinical and non-clinical PACE center staff responsible for the holistic needs of Members and who work in

an interactive and collaborative manner to manage the delivery, quality, and continuity of participants' care. All PACE program requirements and services will be managed directly through CalOptima. PACE services shall include the following:

1.1 All Medicare-covered items and services;

1.2 All Medi-Cal-covered items and services; and

1.3 Other services determined necessary by the IDT to improve and maintain the Members' overall health statuses.

2. **State Termination**.

2.1 CalOptima may terminate the Contract as it applies to providing services to Members if CalOptima's PACE Agreement or DHCS Contract with DHCS terminates for any reason. CalOptima shall notify Provider of any such termination immediately upon its provision of notice of termination of the PACE Agreement or DHCS Contract, or upon receipt of a notice of termination of the PACE Agreement from DHCS or CMS, or the DHCS Contract from DHCS.

3. **Provider Responsibilities**.

3.1 Service Area. Provider shall make PACE services available at a location accessible to Members within Orange County, California.

3.2 Services Authorized. Provider shall furnish only those services Authorized by the CalOptima PACE IDT. A primary care provider referral is deemed an IDT Authorization.

3.3 Interdisciplinary Team Meeting Participation. If necessary for the benefit of Member care delivery or planning, Provider shall participate in CalOptima PACE IDT meetings. Such participation may be by telephone, unless in-person attendance at such meetings is reasonably warranted under the circumstances.

3.4 Payment in Full. Provider shall accept CalOptima's payment as payment in full for services provided to Members and shall not seek any reimbursement for services directly from Members, Medi-Cal, Medicare, or another insurance carrier or provider. Provider shall not seek any type of cost-share amount from Members for PACE Covered Services. Members shall not be liable to Provider for any sum owed by CalOptima, and Provider agrees not to maintain any action at law or in equity against Members to collect sums that are owed by CalOptima. Surcharges to Members by Provider are prohibited. Whenever CalOptima receives notice of any such surcharge, CalOptima shall take appropriate action, and Provider shall reimburse Members as appropriate.

3.5 Hold Harmless. Provider will not bill the State, CMS, or Members if CalOptima does not pay for services performed by Provider pursuant to the Contract.

3.6 Reporting. Provider shall provide such information and written reports to CalOptima, DHCS, and HHS as may be necessary for compliance by CalOptima with its statutory obligations and to allow CalOptima to fulfill its contractual obligations to DHCS and CMS.

3.7 Coverage of Non-Network Providers. Provider agrees that should arrangements be made by Provider with another physician/provider who is not under contract with CalOptima to

provide Covered Services required under the Contract, such physician/provider shall (a) accept payment from Provider as full payment for services delivered to Members, (b) comply with the applicable provisions of the Contract, (c) only bill services to Provider, unless Provider has made other billing arrangements with CalOptima, (d) not bill Members under any circumstances, and (e) cooperate with and participate in CalOptima's quality assurance and improvement program.

3.8 Compliance with the Law. Provider shall comply with the applicable provisions of 42 CFR Part 460, including 42 CFR § 460.70.

4. **Provider Personnel**.

4.1. Provider shall ensure its employees and Contracted Providers providing direct patient care to PACE Members comply with all State and federal requirements for direct patient care staff in their respective setting, including:

4.1.1 Having not been convicted of criminal offenses related to their involvements with Medicare, Medicaid, Medi-Cal, or other health insurance or health care programs, or social service programs under Title XX of the SSA;

4.1.2 Not a pose any potential risk to Members because of conviction or physical, sexual, drug or alcohol abuse;

4.1.3 Be free of communicable diseases; and

4.1.4 Agree to abide by the requirements, philosophy, practices and protocols of CalOptima's PACE Program and 22 CCR § 78413.

4.2. Provider shall provide documentation within one (1) Business Day to CalOptima, upon request, a list of all Contracted Providers and Provider personnel employed during the requested period, including first and last name, job title, date of hire, date of termination (if terminated within the requested period), type of employment (full-time, part-time, volunteer, or other), and whether the position required a license.

4.3. Provider shall ensure its records contain the following for each employee:

4.3.1 An employment application, a full name, social security number, date of employment, date of birth, home address, educational background, and previous employment experience, including dates employed.

4.3.2 Proof that each employee received in-service training in first aid and in cardiopulmonary resuscitation within the first six (6) months of employment.

4.3.3 A background check completed prior to the employee's date of hire.

4.3.4 An OIG exclusion check completed prior to their date of hire.

4.3.5 Documentation that each employee has current and active licensure if licensure is required for their position.

4.3.6 A chest x-ray or test for tuberculosis infection for each employee, as recommended by the federal Centers for Disease Control and Prevention and licensed by the

federal Food and Drug Administration, performed not more than twelve (12) months prior to employment or within seven (7) days of employment.

4.3.7 A health examination signed by the examining physician or person lawfully authorized to perform such examination which indicates the employee is physically qualified to perform duties, is free from any condition that would create a hazard to self or others, and medically cleared of communicable diseases before engaging in direct Member contact.

4.3.8 Documentation that each employee completed the following CalOptima trainings:

4.3.8.1 Orientation to the PACE Program, including the Member Bill of Rights, service determination requests, and the grievance and appeals processes.

4.3.8.2 Skills competencies completed both ***before*** providing any independent care to Members, as well as annually.

4.4. Provider shall have written policies implementing the requirements of this Section 4 and retain employee records pertaining to this Section 4 for at least three (3) years following termination of each employee's employment.

5. **PACE Liaison**. CalOptima PACE Program director or their designee shall be designated as the liaison to coordinate activities between Provider and CalOptima.

6. **Records**. Provider shall retain PACE Program records for the latter of (a) ten (10) years from the final date of the DHCS Contract or the date of completion of any audit; or (b) ten (10) years from the close of the current fiscal year in which the service occurred, in which the record or data was created or applied, and for which the financial record was created, unless a longer period is required by Laws.

This provision shall survive the expiration or termination of the Contract, whether with or without cause, by rescission, or otherwise.

7. **Assignment and Delegation**. The Contract is not assignable, nor are the duties hereunder delegable, by the Provider, either in whole or in part, without the prior written consent of CalOptima and DHCS, provided that consent may be withheld in their sole and absolute discretion. Any assignment or delegation shall be void unless prior written approval is obtained from both DHCS and CalOptima.

8. **Third Party Tort Liability/Estate Recovery**. Provider shall make no claim for the recovery of the value of Covered Services rendered to Members when such recovery would result from an action involving tort liability of a third party, recovery from the estate of a deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Provider shall inform CalOptima of potential third-party liability claims and provide information relative to potential third-party liability claims, in accordance with CalOptima Policies.

9. **Records Related to Recovery for Litigation**. Upon request by CalOptima, Provider shall timely gather, preserve, and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its subcontractors' possession relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall:

(a) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (b) state the privilege being claimed that supports withholding production of the document. Such request shall include a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records, received by Provider or its subcontractors related to the Contract or subcontracts.

10. **DHCS Policies**. Covered Services provided under the Contract shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program and the DHCS Integrated Systems of Care Division ("**ISCD**") (or any successor division to the ISCD).

11. **DHCS Directions**. If required by DHCS, Provider and its Subcontractors shall cease specified activities, which may include referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

12. **Turnover and Phase-Out Requirement**. Provider agrees that, upon termination of the DHCS Contract between CalOptima and DHCS, provider shall make available to CalOptima and DHCS copies of Medical Records, Member files, and any other pertinent information, including information maintained by any Subcontractor, necessary for the efficient case management of Members. Provider further agrees to assist CalOptima with phase-out for the DHCS Contract, which consists of the resolution of all financial and reporting obligations of CalOptima.

13. **Reporting Unusual Incidents or Occurrences**. Provider shall report to CalOptima within twenty four (24) hours any unusual incidents, injuries, or occurrences of which Provider becomes aware relating to Members. For purposes of this section, an unusual incident or injury is one that threatens the welfare, safety or health of any Member and that is not consistent with Provider's routine operation or patient care practices, including a fire, explosion, epidemic outbreak, poisoning, catastrophe, major accident, or like event that occurs in or on the premises of Provider's office or facility which threatens welfare, safety or health of Members.

14. **Emergency Services and Post-Stabilization Delegation**. Responsibility for coverage and payment of Emergency Services and post-stabilization care services have not been delegated to Provider under the Contract.

15. **DHCS Monitoring**. Provider shall comply with all monitoring provisions in CalOptima's contract with DHCS and any monitoring requests by DHCS.

Covered California Program Addendum

This Covered California Addendum shall only apply to the Covered California Program. For avoidance of doubt, this addendum does not apply to CalOptima's Medi-Cal, OneCare, MSSP, or PACE Programs.

1. **Definitions.** In addition to the terms defined elsewhere in this Contract, the following definitions shall apply to this Covered California Program Addendum.

   1.1. **Delegated Entity** means any party that enters into an agreement with a qualified health plan ("**QHP**") issuer to provide administrative services or health care services to qualified

individuals and their dependents.

1.2. **Downstream Entity** means any party that enters into an agreement with a Delegated Entity or with another downstream entity for purposes of providing administrative or health care services related to the agreement between the Delegated Entity and the QHP issuer. The term is intended to reach the entity that directly provides administrative services or health care services to qualified individuals and their dependents.

1.3. **Emergency Medical Condition** means the same as the definition of "emergency medical condition" set forth in HSC § 1317.1(b).

1.4. **Emergency Services** means those Covered Services for inpatient and outpatient care services, as specified in HSC § 1317.1(a), furnished by a provider who is qualified to furnish the services and the services are needed to evaluate or stabilize a Member's Emergency Medical Condition.

1.5. **Medically Necessary** and **Medical Necessity** means the reasonable and necessary Covered Services needed to prevent, diagnoses, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

2. **Compliance.** Provider agrees to be bound by all provisions of the Qualified Health Plan Issuer Contract between CalOptima and Covered California ("**QHP Contract**") that are applicable to the services Provider provides to CalOptima and its Members. Provider agrees to comply with all Laws, including the federal Patient Protection and Affordable Care Act, (P.L. 111–148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111–152), known collectively as the Affordable Care Act; the California Patient Protection and Affordable Care Act, Assembly Bill 1602 and Senate Bill 900 (Chapter 655, Statutes of 2010 and Chapter 659, Statutes of 2010); the Americans with Disabilities Act of 1990 (42 USC §§ 12101 *et seq*.); the Anti-Kickback Statute (42 USC § 1320a–7b); the Public Contracts Anti-Kickback Act (41 USC §§ 8701 *et seq*.); the Stark Law (42 USC § 1395nn); the Knox- Keene Health Care Service Plan Act of 1975 (HSC §§ 1340 *et seq*.); the Drug-Free Workplace Act of 1990 (Government Code §§ 8350 *et seq*.); all Laws relating to child and family support enforcement, including disclosure of information and compliance with earnings assignment orders, as provided in Chapter 8 (commencing with Section 5200) of Part 5 of Division 9 of the Family Code); Public Contract Code Section 10295.3 with regard to benefits for domestic partners; environmental laws, rules, and regulations applicable to its operations, including those relating to certifying compliance with the requirements of the Electronic Waste Recycling Act of 2003, Chapter 8.5, Part 3 of Division 30 (commencing with Section 42460 of the Public Resources Code) relating to hazardous and solid waste; and any and all other State and federal Laws, rules, and regulations applicable to the operation of Covered California, the QHP Contract, and Provider's provision of services under the Contract. Provider will incorporate such applicable requirements in Provider's contracts with its Subcontractors, including the provisions under §4.4.1(d) of the QHP Contract. [QHP Contract §§ 1.2(c), 1.3(b), 1.13, 4.4.1(b)-(d)]

3. **Nondiscrimination in Administration of Services and Benefits.** Provider and its agents and employees shall not, in accordance with the Affordable Care Act Section 1557 (42 USC § 18116), cause an individual to be excluded on the grounds prohibited under Title VI of the Civil Rights Act of 1964 (42 USC §§ 2000d *et seq*.), Title IX of the Education Amendments of 1972 (20 USC §§ 1681 *et seq*.), the Age Discrimination Act of 1975 (42 USC §§ 6101 *et seq*.), Section 504 of the Rehabilitation Act of 1973 (29 USC § 794), or subject to any other applicable Laws, from participation in, be denied the benefits of, or be subjected to discrimination under, any health Product or activity offered through Covered California. [QHP Contract §§ 4.4.1(d)(xv), 1.10(a)]

4. **Conflict of Interest.** Provider agrees to be free from any conflicts of interest with respect to Covered Services provided under the Contract. Provider and its personnel shall not currently have, and shall

not have throughout the Term, any direct interest that may present a conflict in any manner with the performance of services required under the Contract. Provider represents that it is not aware of any conflict of interest or any basis for potential violations with respect to Laws that govern referrals required for the provision of certain Covered Services, including federal and State Anti-Kickback and Anti-Self-Referral Laws. Provider shall immediately (i) identify any conflict of interest that is identified during the Term, and (ii) take any necessary action to assure that any activities are not improperly influenced by a conflict of interest. Provider shall comply with any and all other policies adopted by Covered California and CalOptima regarding conflicts of interest and ethical standards. [QHP §§ 4.4.1(d)(xvi), 1.11]

5. **Nondiscrimination in Workplace.** Provider and its agents, employees, and Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome, mental disability, medical condition (including health impairments related to or associated with a diagnosis of cancer for which a person has been rehabilitated or cured), aged forty (40) or over, marital status, genetic information, sexual orientation, gender identity, or use of family and medical care leave. Provider and its agents and employees shall evaluate and treat employees and applicants for employment in a manner that is free from such discrimination and harassment. Provider and its agents and employees shall comply with the provisions of the California Fair Employment and Housing Act (Gov. Code §§ 12900 *et seq*.) and the applicable regulations promulgated thereunder (2 CCR §§ 10000 *et seq*.). The applicable regulations of the California Fair Employment and Housing Commission implementing Government Code § 12990, set forth in California Code of Regulations Chapter 5 of Division 4 of Title 2, including 2 CCR §§ 11102 *et seq*., are incorporated into this Contract by reference and made a part hereof as if set forth in full. Provider shall give written notice of its nondiscrimination obligations under this clause to labor organizations with which it has a collective bargaining or other agreement. [QHP Contract §§ 4.4.1(d)(xv), 1.10(b)]

6. **Privacy and Security Requirements for Personally Identifiable Data.** Provider agrees to comply with applicable provisions of HIPAA, including the Administrative Simplification Provisions of HIPAA, as codified at 42 USC §§ 1320d *et seq*., HITECH, and any current and future regulations promulgated under HIPAA or HITECH, all as amended from time to time and collectively referred to herein as the "**HIPAA Requirements**." Provider agrees not to use or further disclose any Protected Health Information, other than as permitted or required by the HIPAA Requirements and the terms of this Contract and the QHP Contract. Terms utilized in this section that are not otherwise defined in the Contract shall have the meanings set forth in the HIPAA Requirements. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(a); 45 CFR § 155.260(b)(2)(v)]

   6.1. Provider shall, and shall require that its Subcontractors, maintain technology policies and procedures acceptable to CalOptima that provide reasonable safeguards to protect Protected Health Information and Personally Identifiable Information stored, maintained, or accessed on hardware and software utilized by Provider and its Subcontractors. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(b)(ii)(7)(e)]

   6.2. Provider shall, and shall require that its Subcontractors, comply with all applicable Exchange Protection of Information policies, in accordance with the terms and conditions set forth in Section 10.2 of the QHP Contract, Protection of Information Assets, including executing non-disclosure agreements and other documents required by such policies. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(b)(ii)(7)(f), 10.2]

   6.3. If Provider will have access to Protected Health Information and/or Personally Identifiable Information that is received from, created, or received by CalOptima on behalf of Covered California or in connection with the QHP Contract, Provider agrees to be bound by the same

or more stringent restrictions, terms, and conditions as those that apply to CalOptima pursuant to the QHP Contract with respect to such Protected Health Information and Personally Identifiable Information, provided, however, that any restrictions that are more stringent shall be set forth in the Contract. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(f)(i)]

6.4. Provider shall mitigate to the extent practicable, any harmful effect that is known to Provider of any Security Incident related to Protected Health Information and/or Personally Identifiable Information or of any use or disclosure of Protected Health Information and/or Personally Identifiable Information by Provider in violation of the requirements of the QHP Contract or applicable privacy and security laws and regulations and agency guidance. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(b)(ii)(7)(c)]

6.5. Provider shall cooperate with Covered California in investigating any Breach and/or successful Security Incident involving Protected Health Information and/or Personally Identifiable Information and in meeting Covered California's obligations, if any, under applicable State and federal security breach notification laws, regulatory obligations, or agency requirements. If the cause of the Breach or the successful Security Incident involving Protected Health Information and/or Personally Identifiable Information is attributable to Provider, Provider shall be responsible for Breach notifications and reporting as required under applicable federal and State laws, regulations, and agency guidance. Such notification(s) and required reporting shall be done in cooperation with Covered California and CalOptima. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(e)(iii)]

6.6. In conducting any electronic transaction that is subject to the Electronic Transactions Rule on behalf of CalOptima, Provider agrees to comply with all applicable requirements of the Electronic Transactions Rule set forth in 45 CFR Part 162. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(f)(iv)]

6.7. Provider shall indemnify, hold harmless, and defend Covered California from and against any and all costs (including mailing, labor, administrative costs, vendor charges, and any other costs Covered California determines to be reasonable), losses, penalties, fines, and liabilities arising from or due to a Breach or other non-permitted use or disclosure of Protected Health Information and/or Personally Identifiable Information by Provider or its Subcontractors or agents, including (1) damages resulting from any action under applicable (a) HIPAA Requirements, (b) the QHP Contract requirements, or (c) State law, and (2) the costs of Covered California's actions taken to: (a) notify the affected Individual(s) and other entities of the Breach and to respond to the Breach; (b) mitigate harm to the affected Individual(s); and (c) respond to questions or requests for information about the Breach or other impermissible use or disclosure of Protected Health Information and/or Personally Identifiable Information. [QHP Contract §§ 4.4.1(d)(xxi), 10.1(f)(vi)]

7. **State Agency Reviews**. Provider agrees that Covered California, the California Department of General Services, State Auditors, other State and federal regulatory agencies, or their designated representatives shall, subject to applicable Laws regarding the confidentiality and release of Protected Heath Information of Members, have the right to access, review and to copy any records and supporting documentation pertaining to the performance of the QHP Contract. Provider agrees to maintain such records for possible audit for a minimum of three (3) years after final payment, unless a longer period of records retention is otherwise required. Provider agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. [QHP Contract §§ 4.4.1(d)(xxii), 11.5(c)]

8. **Performance Measurement Standards.** Provider shall comply with all QHP Contract requirements and performance measurement standards, including those related to customer service that are

applicable to Covered Services. CalOptima shall provide the performance measurement standards to Provider. CalOptima may impose penalties for failure to comply or otherwise act in accordance with applicable performance standards of the QHP Contract. [QHP Contract §§ 4.4.1(d)(xix), Article 7]

9. **Medical Records.** Except with respect to any longer periods that may be required under Laws, Provider will maintain a Medical Record documentation system adequate to fully disclose and document the medical condition of each Member, to the extent applicable to the services, and the extent of Covered Services provided to each Member by Provider. Medical Records shall be retained for at least seven (7) years following the year of the final Claims payment. Except as otherwise required by Laws, if an audit, litigation, research, evaluation, claim, or other action involving records has not concluded before the end of the seven (7)-year minimum retention period, Provider shall retain the Medical Records until all issues arising out of the action have been resolved. [QHP Contract §§ 4.4.1(d)(xxii), 11.1]

10. **Claims Data**. Provider shall cooperate with CalOptima's obligations under the QHP Contract to maintain historical Claims data and other records and data relating to the utilization of Covered Services by Members online for two (2) years from the date that the QHP Contract is terminated with respect to Covered Services provided to Members during the term of the QHP Contract. These records shall include the data elements required to produce specific reports mutually agreed upon by Covered California and CalOptima and in such form reasonably required by Covered California that is consistent with industry standards and requirements of DMHC or any other applicable Regulator regarding statistical, financial, and/or data reporting requirements, including information relating to diagnosis, treatment, amounts billed (allowed and paid), dates of service, procedure numbers, deductibles, out-of-pocket costs, and other cost-sharing for each Claim. [QHP Contract §§ 4.4.1(d)(xiv), 11.2(c)]

11. **Financial Records**. Financial records, supporting documents, statistical records, and all other records pertinent to amounts paid to or by Provider in connection with the QHP Contract shall be retained by Provider for at least ten (10) years from the date of the final Claims payment, unless a longer maintenance period is required by Laws or the QHP Contract. Provider shall maintain accurate books, accounts, and records and prepare all financial statements in accordance with the requirements of the QHP Contract as applicable to Provider. This shall include: (i) adequate data customarily maintained and reasonably necessary to properly document each of Provider's transactions with CalOptima during the period the QHP Contract remains in force; and (ii) records of Claims, including medical review and high dollar special audit Claims. At the end of the ten (10) year period, at the option of CalOptima, records shall either be (i) transferred to CalOptima or (ii) destroyed. [QHP Contract §§ 1.12, 4.4.1(d)(xiv), (xxii), 11.2(a), 11.2(b)]

12. **Books and Records Location**. Books and records shall be kept in a secure location at Provider's office(s), and books and records related to the QHP Contract shall be available for inspection and copying by CalOptima, Covered California, Covered California representatives, and such consultants and specialists as designated by Covered California, at any time during normal business hours and upon reasonable notice. If any inquiry, audit, investigation, litigation, claim or other action involving the records is ongoing and has not been finally concluded before the end of the ten (10)-year minimum retention period, the applicable financial records must be retained until all issues arising out of the action have been resolved. [QHP Contract §§ 4.4.1(d)(xxii), 11.3]

13. **Notice.** Provider shall promptly notify CalOptima in writing of any inquiry, audit, investigation, litigation, claim, examination, or other proceeding involving Provider, personnel, or Subcontractors that is threatened or commenced by any governmental authority or other party that a reasonable person might believe could materially affect the ability of CalOptima to perform in accordance with the terms set forth in the QHP Contract. Such notice shall be provided by Provider to CalOptima within ten (10) days of Provider's receipt of notice regarding such action; provided, however, that

any such exchange of information shall be subject to compliance with applicable Laws, and shall not occur to the extent prohibited by order of the court, administrative agency, or other tribunal, or State or federal regulatory authority having jurisdiction over the matter or by the Laws governing the action. This Section 13 shall not be required with respect to disputes relating to claims and other matters noticed to CalOptima in the ordinary course of business pursuant to other terms and conditions set forth in this Contract, the QHP Contract or required by Laws. [QHP Contract §§ 4.4.1(d)(xxii), 11.6]

14. **Scope of Licensure**. All Covered Services must be provided by duly licensed, certified, or accredited providers consistent with the scope of their Licenses and in accordance with applicable Laws, rules, regulations, the standards of medical practice in the community, and the terms set forth in this Contract and the QHP Contract. [QHP Contract § 4.4.1(a)]

15. **QHP Contract Requirements**. Provider agrees to be bound, and to bind each of its Subcontractors, by all provisions of the QHP Contract that are applicable to the Covered Services that Provider and its Subcontractors provide under the Contract [QHP Contract § 4.4.1(d)], including:

    15.1. Coordination with Covered California and other programs and stakeholders.

    15.2. Relationship of the parties as independent contractors [QHP Contract § 1.3(a)] and CalOptima's exclusive responsibility for obligations under the QHP Contract [QHP Contract § 1.3(b)].

    15.3. Participating Provider directory requirements [QHP Contract § 4.4.4].

    15.4. Symphony Provider directory requirements [QHP Contract § 4.4.5].

    15.5. Implementation of processes to enhance stability and minimize disruption to the provider network [QHP Contract § 4.3].

    15.6. Notices, network requirements, and other obligations relating to costs of out-of-network services and other benefits [QHP Contract § 4.4.3].

    15.7. Provider credentialing, including maintenance of licensure and insurance [QHP Contract § 4.4.2].

    15.8. Customer service standards [QHP Contract § 4.6].

    15.9. Utilization managements processes [QHP Contract § 5.3].

    15.10. Maintenance of a corporate compliance program [QHP Contract § 1.2].

    15.11. Enrollment and eligibility determinations and collection practices [QHP Contract Article 2].

    15.12. Appeals and grievances [QHP Contract § 4.6.2].

    15.13. Member and marketing materials [QHP Contract § 3.2].

    15.14. Disclosure of information required by Covered California, including financial and clinical [QHP Contract § 1.12], Quality, Network Management and Delivery System Standards [QHP Contract Article 5], and other data, books, and records [QHP Contract Article 11].

    15.15. Nondiscrimination [QHP Contract § 1.10].

    15.16. Conflict of interest and integrity [QHP Contract § 1.11].

    15.17. Other Laws [QHP Contract § 1.13].

    15.18. Advancing equity, quality, and value to the extent applicable to Participating Providers [QHP Contract Article 5], including disclosure of contracting arrangements with Participating Providers as required pursuant to Attachment 1, Advancing Equity, Quality, and Value, to the

QHP Contract.

15.19. Performance measures, to the extent applicable to Participating Providers [QHP Contract Article 7].

15.20. Continuity of care, coordination, and cooperation upon termination of the QHP Contract and transition of Members [QHP Contract § 4.3.3 and Article 8].

15.21. Security and privacy requirements, including compliance with HIPAA [QHP Contract Article 10].

15.22. Maintenance of books and records [QHP Contract Article 11].

16. **Cooperation**. Provider recognizes that the performance of services under the QHP Contract depends upon the joint effort of Covered California, CalOptima, Provider, and any other authorized Subcontractors. Provider shall coordinate and cooperate with CalOptima and such Subcontractors to the extent necessary to promote compliance with the terms set forth in the QHP Contract. Provider shall also coordinate and comply with requirements of other State agencies that affect the Members, including DHCS, regarding the development and implementation of the California Healthcare Eligibility, Enrollment, and Retention System with respect to eligibility and enrollment considerations or as may be required under inter-governmental agency agreements or other Laws, rules, regulations, or program instructions. [QHP Contract §§ 4.4.1(d)(i), 1.6]

17. **Subcontractor Selection**. Provider shall exercise due diligence in the selection of any Subcontractors that are permitted under the QHP Contract, subject to any CalOptima approval requirement, and in the monitoring of services provided by Subcontractors for compliance with the terms of the QHP Contract and applicable Laws, rules, regulatory requirements, and orders. Provider's obligations pursuant to this Contract and applicable Laws shall not be waived or released if Provider is permitted to subcontract or otherwise delegate services of this Contract. [QHP Contract §§ 1.3(b), 4.4.1(d)(ii)]

18. **Independent Contractors**. Nothing in the QHP Contract or this Contract shall be construed or deemed to create a relationship of employer or employee or partner or joint venture or principal and agent between Covered California and Provider or CalOptima and Provider. The Parties acknowledge that they are independent contractors. [QHP Contract §§ 4.4.1(d)(ii), 1.3(a)]

19. **Provider Directory**. Provider shall provide information to CalOptima to allow CalOptima to comply with its provider directory obligations under the QHP Contract. Provider acknowledges that Covered California may use Provider's data for any noncommercial purposes. [QHP Contract §§ 4.4.1(d)(iii), 4.4.4]

20. **Member Liability**. Provider shall comply with Laws governing liability of Members for Covered Services provided to Members, including those relating to holding a Member harmless from liability if CalOptima fails to pay an amount owed by CalOptima to Provider. Provider shall inform every Member in a manner that allows the Member the opportunity to act upon Provider's proposal or recommendation regarding (i) the use of a non-Participating Provider or (ii) the referral of a Member to a non-Participating Provider for proposed non-Emergency Services. Provider shall disclose to a Member considering accessing non-Emergency Services from a Participating Provider if a non-Participating Provider will be used as part of the Participating Provider's plan of care. Provider is responsible for complying with the Provider Manual and may rely upon the provider directory of CalOptima in fulfilling its obligation under this provision. [QHP Contract §§ 4.4.1(d)(vi), 4.4.3]

21. **Credentialing**. If Provider is delegating activities relating to credentialing and re-credentialing, the process used by Provider must be reviewed and approved by CalOptima and as otherwise required by DMHC or any other applicable Regulator. [QHP Contract §§ 4.4.1(d)(vii), 4.4.2]

22. **Utilization Management**. Provider shall cooperate and comply with and participate in the UM Program established by CalOptima in compliance with Laws, including HSC § 1367.01. [QHP Contract §§ 4.4.1(d)(ix); 5.3]

23. **Eligibility and Enrollment Determinations**. Provider shall comply with all Covered California eligibility and enrollment determinations and shall provide required assistance to CalOptima in its efforts to comply with the terms relating to eligibility, enrollment, and Member marketing materials from the QHP Contract. [QHP Contract §§ 4.4.1(d)(xi), Article 2, Article 3]

24. **Grievances and Appeals**. Provider shall cooperate and comply with the internal review process established by CalOptima to resolve Member written or oral grievances and appeals, including those involving expressions of dissatisfaction regarding Provider. Provider shall comply with State and federal Laws, rules, and regulations relating to the external review process, including independent medical review, available to Members for Covered Services. [QHP Contract §§ 4.4.1(d)(xii), 4.6.2]

25. **Quality, Network Management, and Delivery System Standards**. Provider shall cooperate and comply with programs established by CalOptima consistent with its quality, network management, and delivery system standards obligations under the QHP Contract, including Covered California quality initiatives, the quality rating system, transparency and quality reporting, and quality improvement strategy. This obligation shall include the provision of necessary information to CalOptima to ensure CalOptima's compliance with its required reporting obligations pursuant to Attachment 1, Advancing Equity, Quality, and Value, of the QHP Contract. [QHP Contract §§ 4.4.1(d)(xviii), 5.2]

26. **Customer Service Standards**. Provider shall comply with all applicable QHP Contract customer service standards that are applicable to Provider. [QHP Contract §§ 4.4.1(d)(viii), 4.6]

27. **Continuity of Care**. Provider agrees to comply with policies and procedures implemented by CalOptima to enhance stability and minimize disruption to CalOptima's provider networks. Provider shall provide CalOptima with the information necessary to comply with notice and other requirements in the cases of block transfers, as defined in HSC § 1373.65 and 28 CCR § 1300.67.1.3, and network disruptions pursuant to HSC §§ 1373.23 and 1366.1. In the event of a change related to network disruption, block transfers, or other similar circumstances, Provider shall cooperate with Covered California in planning for the orderly transfer of Members as necessary and as required under Laws, including those relating to continuity of care set forth at HSC § 1373.95 and as otherwise set forth in the QHP Contract. In the event of termination of the QHP Contract or decertification of one or more of CalOptima's QHPs, Provider shall cooperate fully with CalOptima and Covered California to assure the continuity of care for Covered Services. [QHP Contract §§ 4.4.1(d)(v), 4.4.1(d)(xx), 4.3, 4.3.3, Article 8]

28. **Fraud, Waste, and Abuse Programs**. Provider shall maintain compliance and provide CalOptima with a description of its fraud, waste, and abuse detection and prevention programs and its other compliance programs to ensure compliance with its obligations and CalOptima's reporting obligations under the QHP Contract. [QHP Contract §§ 4.4.1(d)(x), 1.2, 1.15]

29. **Insurance**. Provider shall maintain insurance commensurate with the nature of its work and all coverage shall be subject to the requirements set forth in the QHP Contract and applicable Laws. [QHP Contract § 9.1.3]

30. **No Surprises Act**. Provider shall comply with the rules against surprise billing in the Consolidated Appropriations Act of 2021 (P.L. 116–260), (the "**No Surprises Act**"), including complying with applicable cost-sharing rules, prohibitions on balance billing for certain items and services, notice and consent requirements, and requirements related to disclosures about balance billing protections. If Provider is responsible for processing Claims for Covered Services rendered by out-of-network providers, Provider shall process such Claims in accordance with the No Surprises Act. [HSC §

1371.9; 45 CFR §§ 149.410, 149.420, 149.430, 149.440]

31. **CalOptima Accountability.** Notwithstanding any relationship CalOptima may have with Provider, as Delegated Entity, and any Downstream Entity, CalOptima maintains responsibility for its compliance, as well as the compliance of the Provider and any Downstream Entity, with all applicable standards enumerated at 45 CFR § 156.340(a). [45 CFR § 156.340(a)]

32. **Delegated Entity and Downstream Entity Compliance.** If any of CalOptima's issuer activities and obligations, in accordance with 45 CFR § 156.340(a), are delegated to Provider, then Provider, as Delegated Entity, agrees to the following provisions and Provider further agrees that it will require Downstream Entities to comply with the same standards. [45 CFR § 156.340(b)]

    32.1. **Standards for Downstream and Delegated Entities.** The Contract, including, when applicable, any delegated services attachment/addendum, specifies the delegated activities and reporting responsibilities. [45 CFR § 156.340(b)(1)]

    32.2. **Revocation of Delegated Activities.** In the event the HHS or CalOptima determines, in its sole discretion, that Provider or any Downstream Entity have not performed the delegated activities and reporting obligations satisfactorily, consistent with applicable standards enumerated at 45 CFR § 156.340(a), then the delegated activities and reporting obligations shall be revoked. The foregoing does not preclude the employment of other remedies in lieu of revocation of the delegated activities or reporting responsibilities if deemed appropriate by HHS or CalOptima, as applicable. [45 CFR § 156.340(b)(2)]

    32.3. **Compliance with Laws.** Provider will perform such activities and obligations in compliance with all applicable Laws and regulations relating to the standards specified in 45 CFR §156.340(a). [45 CFR § 156.340(b)(3)]

    32.4. **Right to Audit.** Provider and any Downstream Entity shall permit access to the relevant Health Insurance Marketplace authority, the Secretary of HHS, and the OIG, or their designees, to evaluate through audit, inspection, or other means, Provider's or the Downstream Entity's books, contracts, computers, or other electronic systems, including Medical Records and documentation, relating to CalOptima's obligations in accordance with the standards enumerated at 45 CFR § 156.340(a), as applicable, until ten (10) years from the final date of the Contract period. [45 CFR § 156.340(b)(4)-(5)]

33. **Consolidated Appropriations Act of 2021.** The Consolidated Appropriations Act of 2021, Section 201, prohibits CalOptima from entering into a contract with Provider, network or association of providers, third party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict CalOptima from: (i) providing provider-specific cost or quality of care information or data to referring providers, plan sponsors, participants, beneficiaries, or Members, or individuals eligible to become participants, beneficiaries, or Members of the plan or coverage; (ii) electronically accessing de-identified Claims and Encounter Data for each participant, beneficiary, or Member; or (iii) sharing such information, consistent with applicable privacy Laws. Notwithstanding anything to the contrary in this Contract, Provider agrees that CalOptima is in compliance with this provision with respect to this Contract and nothing in this Contract will prohibit CalOptima from complying with this provision.

Knox-Keene Act Addendum

This Knox-Keene Act Addendum shall only apply to the Program(s) governed by the Knox-Keene Act and regulated by the DMHC. For avoidance of doubt, this addendum does not apply to CalOptima's Medi-Cal, OneCare, or PACE Programs.

1. **Timely Access to Services.** Covered Services shall be provided in a timely manner appropriate for the Member's condition that complies with the requirements of Health & Safety Code ("**HSC**") 1367.03 and 28 CCR § 1300.67.2.2 and in a manner that provides continuity of care, including the availability of PCPs who will be responsible for coordinating the provision of health care services for each Member. When it is necessary for a Member or Provider to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Member's health care needs and ensures continuity of care consistent with good professional practice, and State Laws. Provider shall ensure that its hours of operation and provision for after-hour services will be reasonable. To the extent Provider has any role in rendering Emergency Services, Provider will provide or arrange for the provision of emergency health care services twenty-four (24) hours a day, seven (7) days a week. Provider shall provide reporting required by CalOptima and DMHC necessary to ensure compliance with DMHC accessibility and network adequacy standards. Provider will comply with CalOptima's system for monitoring and evaluating accessibility of care, including its system for addressing problems that develop, which shall include waiting times and appointments. [HSC §§ 1367, 1367.03, 1367.035; 28 CCR §§ 1300.67.2(b), (c), and (f), 1300.67.2.2(c)]

2. **Licensure and Certification**. As applicable, Provider and its employed and contracted personnel shall be licensed and certified by their respective board or agency, where licensure or certification is required by law to provide services under the Contract. As applicable, any equipment used by Provider and/or its employed and contracted personnel under the Contract required to be licensed or registered by law shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law, as well. [HSC § 1367(b)-(c)]

3. **Coordination of Member Care.** Provider is responsible for coordinating the provision of health care services to a Member if Provider is acting as the Member's PCP. Provider shall maintain Member Medical Records in a readily available manner that permits sharing with CalOptima of all pertinent information relating to the health care of Members. [28 CCR § 1300.67.1(a), (c)]

4. **Provider Directory Information.** Provider shall inform CalOptima within five (5) Business Days of material changes that would affect Provider's or its Contracted Providers' listing in CalOptima's provider directory, so that CalOptima can comply with HSC § 1367.27. Material changes include:

   4.1. The addition or deletion of a Contracted Provider from Provider's group of providers.

   4.2. A change in Provider's or a Contracted Provider's name, practice location, contact information, practice type or specialty, board certification, NPI number, license number and type, or office email address.

   4.3. Whether Provider or its Contracted Providers are or are not accepting new patients.

   If Provider or one of its Contracted Providers is not accepting new patients and is contacted by a Member or potential Member seeking to become a new patient, Provider shall direct the Member or potential Member to CalOptima for additional assistance in finding a provider and to DMHC to report any inaccuracy with CalOptima's directories.

   Provider shall provide to CalOptima any information necessary for CalOptima to comply with State Laws. If Provider does not comply with this provision or demonstrates a pattern of repeated failure, CalOptima may terminate the Contract. Provider shall additionally inform CalOptima within five (5) business days if a Member or potential Member makes Provider aware of a possible inaccuracy in CalOptima's provider directory, and CalOptima shall promptly investigate and, if necessary, undertake corrective action within thirty (30) business days to ensure the accuracy of its provider directory. [HSC § 1367.27]

5. **Notices to Members of Termination or Block Transfer.** Provider shall cooperate and assist CalOptima in fulfilling CalOptima's obligations under 28 CCR § 1300.67.1.3 regarding block

transfer filings with the DMHC. Any written communications to Members that concern a termination of this Contract or block transfer shall comply with the notification requirements in HSC § 1373.65(f). CalOptima shall be responsible for all notifications to Members as may be required for block transfers. [HSC § 1373.65]

6. **Continuation of Care after Termination for Certain Conditions.** If the Contract is terminated by either Party for any reason other than termination for a medical disciplinary cause or reason, fraud, or other criminal activity, Provider will, at the request of the Member and CalOptima, continue to provide Covered Services to Members with certain medical conditions as described in and pursuant to the HSC § 1373.96, until the services are completed or the time limitations described therein have been reached. The provision of the continued services for Members with these medical conditions is subject to the same contractual terms and conditions that were imposed upon Provider prior to termination, including the rate of compensation. Reimbursement for such services will be at the applicable rates listed in Attachment B, *Compensation*. Upon termination of the Contract, CalOptima is liable for the Covered Services rendered by Provider (other than any permissible co-payments, co-insurance, or deductibles, as set forth in the Member's evidence of coverage) to a Member who retains eligibility under the applicable evidence of coverage or by operation of law and who is under Provider's care at the time of termination of the Contract until the Covered Services the Provider is rendering to the Member are completed or until CalOptima makes reasonable and medically appropriate provisions for the assumption of such services by another Participating Provider. [HSC §§ 1373.95, 1373.96; 28 CCR §§ 1300.67.4(a)(10), 1300.67.8(e)]

7. **Quality Assurance Program.** CalOptima will be responsible for maintaining a quality assurance program in compliance with 28 CCR §§ 1300.67.2.2(d) and 1300.70. Provider will assist CalOptima in maintaining CalOptima's quality assurance program, as applicable, and consistent with CalOptima's quality assurance program policies and procedures. To the extent that any of CalOptima's quality assurance functions are delegated to Provider, Provider shall promptly deliver to CalOptima all information requested for the purpose of monitoring and evaluating Provider's performance of those quality assurance functions and so that CalOptima may comply with Laws. [28 CCR §§ 1300.51(d)J, K.2, 1300.67.2.2(d), 1300.70]

8. **No Inducement to Deny Covered Services.** Provider acknowledges and agrees that this Contract does ***not*** (i) contain any incentive or make any payment that acts directly or indirectly as an inducement to deny, reduce, limit, or delay Medically Necessary health care services, or (ii) provide monetary or other incentives to Provider to induce Provider to provide care to Members in a manner inconsistent with coverage requirements. Provider shall ensure that its contracts with individual providers similarly comply with this Section 8. [HSC §§ 1348.6, 1367.62(a)(3)]

9. **Appeals and Grievances of Members.** CalOptima will be responsible for resolving Member appeals and grievances pursuant to HSC § 1368 and 28 CCR § 1300.68. CalOptima's process to resolve provider grievances are set forth in the Contract and CalOptima Policies. Provider will maintain grievance forms and a description of the grievance procedure at their facilities and will provide grievance forms to Members promptly upon request. Provider shall assist and cooperate with CalOptima in responding to Member grievances and requests for independent medical reviews consistent with CalOptima Policies, including the Provider Manual. [HSC § 1368; 28 CCR §§ 1300.51(d)K.2, 1300.68(a) and (b)]

10. **Language Assistance Program Standards.** Provider shall comply with the language assistance standards promulgated by the DMHC and with CalOptima's language assistance program and shall cooperate with CalOptima in providing any information necessary to assess compliance. [HSC § 1367.04(f); 28 CCR § 1300.67.04]

11. **No Balance Billing.** Except for applicable co-payments, co-insurance, and deductibles, Provider will not invoice or balance bill any Member for the difference between the Provider's billed charges

and the reimbursement paid by CalOptima or its capitated provider for any Covered Service. In addition, in the event CalOptima or its capitated provider fails to pay for Covered Services, Members will not be liable to Provider for any sums owed by CalOptima or its capitated provider. Provider shall not maintain any action at law against a Member to collect sums owed by CalOptima or its capitated provider. [HSC §§ 1379(a)-(c), 1371.9; 28 CCR § 1300.71(g)(4)]

12. **No Surcharges.** Neither Provider nor Provider's agents, trustees, or assignees shall impose or collect a surcharge from a Member for services provided to the Member pursuant to the Contract, nor shall Provider nor Provider's agents, trustees, or assignees maintain any action at law against a Member to collect sums owed by CalOptima to Provider for services provided to the Member pursuant to the Contract. In its agreements with individual providers, Provider shall (i) prohibit individual providers from imposing or collecting a surcharge from a Member for services provided to the Member pursuant to the agreement with Provider and (ii) prohibit the individual provider from maintaining any action at law against a Member to collect sums owed by Provider to the individual provider for services provided to the Member pursuant to the agreement with Provider. Upon notice of any such action or upon notice that Provider or any individual provider has imposed surcharges for Covered Services, CalOptima will take appropriate action. As used in this addendum, the term "**surcharges**" means an additional fee that is charged to a Member for a Covered Service, but that is not approved by the Director of the DMHC ("**Director**"). [HSC § 1379(c); 28 CCR § 1300.67.8(d)]

13. **Reporting or Surcharges and Cost-Sharing.** Provider will report to CalOptima in writing all surcharges, deductibles, co-payments, and co-insurance amounts paid by Members directly to Provider. [HSC § 1385; 28 CCR §§ 1300.51(d)K.2., 1300.67.8(d)]

14. **Third Party Recoveries.** Provider shall cooperate with CalOptima in identifying and providing information necessary to collect from insurers or other third parties who may be liable for injuries caused to a Member. Any recovery or assertion of a lien by Provider from such insurers or third parties shall be conducted subject to Civil Code § 3040 and other Laws.

15. **Claims for Secondary Payment.** CalOptima or its capitated provider will pay Claims in accordance with HSC § 1371 *et seq.* and 28 CCR § 1300.71. Notwithstanding any other provision in this Contract, if CalOptima or CalOptima's capitated provider is not the primary payer under coordination of benefits, Provider may submit Claims to CalOptima or CalOptima's capitated provider within ninety (90) days from the date of payment or date of contest, denial, or notice from the primary payer. Except as otherwise provided by Laws or provided by Government Program Requirements, any Claims that are not submitted by Provider to CalOptima or CalOptima's capitated provider within ninety (90) days from the date of payment or date of contest, denial, or notice from the primary payer shall not be eligible for payment, and Provider hereby waives any right to payment thereof. [HSC § 1371 *et seq.*; 28 CCR § 1300.71]

16. **Good Cause for Late Filing.** If CalOptima or CalOptima's capitated provider denies a Claim because it was filed beyond the Claim filing deadline, CalOptima will, upon Provider's submission of a provider dispute pursuant to 28 CCR § 1300.71.38 and the demonstration of good cause for the delay, accept and adjudicate the Claim according to HSC §§ 1371, 1371.35, and 1300.67.8, whichever is applicable, and the CCR. [28 CCR §1300.71(b)(4)]

17. **Authorization of CalOptima's Right to Offset any Uncontested Notice of Overpayment.** In the event of an Overpayment and prior to any adjustment CalOptima makes in future payments to Provider, CalOptima shall furnish Provider with a separate written notice of the Overpayment that clearly identifies the overpaid amount, Claim, Member's name, Date(s) of Service, and explains the basis for CalOptima's request for reimbursement of the Overpayment, including any interest and penalties on the Claim. If Provider intends to contest CalOptima's notice, Provider must send written notice of Provider's intent to contest within thirty (30) Business Days of Provider's receipt of CalOptima's notice. If CalOptima does not receive a notice of intent to contest notice of the

Overpayment or the requested reimbursement from Provider within the above timeframes, Provider authorizes CalOptima to offset or recoup the requested reimbursement amount from CalOptima's payments to Provider for current or future Claim submissions. [28 CCR § 1300.71(d), (g), and (h)]

18. **Provider Dispute Resolution.** CalOptima shall establish and maintain a provider dispute resolution process to process and resolve any Provider disputes, and that process shall comply with 28 CCR § 1300.71.38 and the statutes and regulations referenced therein. Provider may obtain specific information regarding CalOptima's provider dispute resolution process in CalOptima's policies. Provider has a right to access CalOptima's provider dispute resolution process. CalOptima will inform Provider of any changes to CalOptima's provider dispute resolution procedures. Provider will receive the rights listed in HSC § 1375.7, as amended, if CalOptima makes any changes to the provider dispute resolution process. Provider may utilize CalOptima's provider dispute resolution process or obtain information about the process by writing to Provider Dispute Resolution Claims at the appropriate address outlined in the Provider Manual or calling: (714) 246-8600. CalOptima's provider dispute resolution process, however, does not and cannot serve as an appeal process from any fair hearing proceeding held pursuant to Business and Professions Code § 809.1 *et seq.* See the Provider Manual for current information regarding CalOptima's provider dispute resolution process, including additional ways to submit disputes. [HSC § 1367(h)(1) and (2); 28 CCR §§ 1300.71.38, 1300.71(e)]

19. **Member Confidentiality.** Provider will not disclose medical information regarding a Member unless such disclosure complies with the requirements of the Confidentiality of Medical Information Act ("**CMIA**"), including California Civil Code §§ 56.10, 56.104, 56.107, and 56.109. Provider shall prohibit individual providers from disclosing medical information regarding a Member unless such disclosure complies with the requirements of the CMIA. [HSC §§ 1348.5, 1364.5; 28 CCR §§ 1300.51(d) K.2, 1300.67.8(a); DMHC APL 18-005]

20. **Maintenance and Access to Records.**

    20.1. Provider will prepare and maintain on a current and accurate basis all records, books, and papers related to this Contract ("**Records**") possessed in any medium, including electronic media. Such Records shall be made available for inspection, including through electronic means, and copying by CalOptima and/or the DMHC, as may be necessary for CalOptima's compliance with the provisions of the Knox-Keene Act and the rules.

    20.2. To the extent feasible, all Records shall be located in the State of California and shall not be removed without DMHC's prior consent. If Records are located outside California, Provider shall make such Records available in California or furnish true and accurate copies of such Records.

    20.3. If CalOptima and/or DMHC requests to inspect Records, Provider shall (i) furnish in electronic media Records that are possessed in electronic media, and (ii) conduct a diligent review of the Records and make every effort to furnish those responsive to the request for inspection.

    20.4. To the greatest extent feasible, Records furnished for inspection shall be furnished in a digitally searchable format. Records must be maintained for at least five (5) years from the last date of service, except that if (i) DMHC requests, the Records must be preserved until furnished to DMHC, or (ii) other regulatory requirements require a longer retention period, that longer period will apply.

    20.5. Provider shall cooperate with CalOptima with respect to any DMHC examination of the fiscal and administrative affairs of CalOptima or CalOptima's subcontractors.

    20.6. Provider shall maintain on a current and accurate basis and ensure ready availability of

Medical Records. Upon CalOptima's request, Provider shall make available, at reasonable times, Provider's Records relating to the services provided to Members, to the cost thereof, to payments received by Provider from Members (or from others on their behalf).

20.7. The obligation under this Section 20 shall survive termination of the Contract for any reason.

[HSC §§ 1381, 1382, 1385; 28 CCR §§ 1300.67.1(c), 1300.67.8 (a)-(c), 1300.81, 1300.85, 1300.85.1]

21. **Amendments.** The Provider Manual may be unilaterally amended or modified by CalOptima to maintain consistency or compliance with any Laws, policies, directives, government program requirements, or requirements of an Accreditation Organization upon forty-five (45) Business Days' notice to Provider unless a shorter timeframe is necessary for compliance. CalOptima may otherwise materially amend the Provider Manual only after forty-five (45) Business Days' prior written notice to Provider. If Provider does not deliver a written disapproval to such amendment or modification within the forty-five (45)-day period, the amendment or modification will be deemed accepted by and binding upon Provider. If CalOptima receives a written disapproval within the forty-five (45)-day period, the Parties agree to meet and confer in good faith to determine if a revised amendment or modification can be accepted by and binding upon the Parties. If the Parties cannot agree, Provider has the right to terminate this Contract prior to the effective date of the amendment or modification. [HSC § 1375.7; 28 CCR § 1300.71(m)]

22. **Compliance with Laws.** CalOptima is subject to Chapter 2.2 of Division 2 of HSC and Chapter 2 of Title 28 of the CCR. Any provision of the aforementioned statutes or regulations that is required to be in this Contract shall bind the Parties whether or not expressly set forth in this Contract.

23. **Quality and Utilization.** CalOptima will disclose to Provider CalOptima's quality improvement or UM programs and procedures at least fifteen (15) Business Days prior to Provider executing this Contract. A change to the quality improvement or UM programs or procedures shall be made pursuant to Section 21. Notwithstanding the foregoing, CalOptima may make a change to the quality improvement or UM programs or procedures at any time if the change is necessary to comply with Laws or any accreditation requirements of a private sector Accreditation Organization. [HSC § 1375.7(b)(3)]

24. **Data Usage.** The provisions of this section will apply only to the extent that Provider, now or in the future, acts as a "**Service Provider**" under the California Consumer Privacy Act ("**CCPA**") (Cal. Civ. Code §§ 1798.100 *et seq.*, 1798.140(ag), and the regulations promulgated thereunder). Provider warrants and represents that all **Personal Information** (as defined below) shall not be: (i) retained, used, or disclosed by Provider for any purpose other than for the specific purpose of performing the services specified in the Contract; or (ii) sold, rented, released, disclosed, disseminated, made available, transferred, or otherwise communicated orally, in writing, or by electronic or other means, to another business or third party for monetary or other valuable consideration. Provider shall comply with all applicable provisions of the CCPA. The Parties agree that nothing about the Contract or the services involves a "selling" or a "sale" of Personal Information under Cal. Civ. Code §1798.140(ad). For purposes of this section, "**Personal Information**" has the same meaning as set forth in Cal. Civ. Code § 1798.140(v).

25. **Health Care Providers' Bill of Rights**. Provider is entitled to all protections afforded to Provider under the Health Care Providers' Bill of Rights. [HSC § 1375.7]

26. **Telehealth Services**. If Provider uses telehealth for rendering Covered Services, Provider shall obtain and document Member consent prior to providing telehealth services, as required under Business and Professions Code § 2290.5. As required by HSC § 1374.14, CalOptima shall reimburse the treating or consulting provider for the diagnosis, consultation, or treatment of a Member appropriately

delivered through telehealth services on the same basis and to the same extent that CalOptima is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment. Additionally, a Member who is currently receiving specialty telehealth services for a mental or behavioral health condition through a third-party corporate telehealth provider has the option of continuing to receive that service with a contracted individual professional, clinic, or health facility. If CalOptima delegates responsibilities under HSC § 1374.141 to a contracted entity, the delegated entity shall comply with this section and HSC § 1374.141, as applicable, including obtaining Member consent for use of telehealth services and complying with the records access and sharing requirements. [HSC §§ 1374.14(a)-(b), 1374.141; Business & Professions Code § 2290.5]

27. **Liabilities**. CalOptima and Provider are each responsible for their own acts or omissions and are not liable for the acts or omissions of, or the costs of defending, others. Any provision to the contrary in the Contract is void and unenforceable. Nothing in this section shall preclude a finding of liability on the part CalOptima or Provider based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases for liability. [HSC § 1371.25]

28. **Reporting.** Provider agrees to submit all information or reports required under this Contract or requested by CalOptima or DMHC to comply with Laws in a form acceptable to CalOptima or DMHC, including providing necessary information and reports under HSC § 1367.0061.

29. **Mental Health Parity Requirements**. As applicable, Provider shall comply with all Laws and CalOptima Policies on the provision of Medically Necessary Treatment of Mental Health and Substance Use Disorder, as defined by HSC § 1374.72(a) ("**MH/SUD Services**"). As applicable, Provider shall adopt and use CalOptima Policies when providing MH/SUD Services or, if Provider establishes its own policies, Provider shall obtain CalOptima's prior written approval and shall ensure Provider's policies comply with applicable requirements of HSC §§ 1374.72 and 1374.721, and 28 CCR § 1300.74.72 and 1300.74.721.

30. **Modifications to Required Information**. CalOptima shall provide a minimum of forty-five (45) days' prior written notice before instituting any changes, amendments, or modifications to the disclosures made pursuant to 28 CCR § 1300.71(l) and (o). [28 CCR § 1300.71(m)]

ATTACHMENT E
LOBBYING CERTIFICATION FORMS

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including Subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

@@Provider Name@@	{{Name_es_:signer1: }}
Name of Contractor	Printed Name of Person Signing for Contractor
	{{_es_:signer1:signature}}
Contract / Grant Number	Signature of Person Signing for Contractor
{{_es_:signer1:date }}	{{_es_:signer1:title }}
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

@@Custom Field{Lobby Check Box}@@

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: {{[]}} contract {{[]}} grant {{[]}} cooperative agreement {{[]}} loan {{[]}} loan guarantee {{[]}} loan insurance	2. Status of Federal Action: {{[]}} bid/offer/application {{[]}} initial award {{[]}} post-award	3. Report Type: initial {{[]}} initial filing {{[]}} material change For Material Change Only: Year {{Yr_es_signer1}} quarter {{Qtr_es_signer1}} date of last report

4. Name and Address of Reporting Entity: {{RepEntNm_es_signer1 }} Prime Subawardee Tier, if known: {{Tier_es_signer1 }}	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: {{RepEntNm_es_signer1 }}
Congressional District, If known: {{CongDist_es_signer1 }}	Congressional District, If known: {{CongDist _es_signer1 }}
6. Federal Department/Agency: {{FedDept_es_signer1 }}	7. Federal Program Name/Description: {{FedProg_es_signer1 }} CDFA Number, if applicable: {{CDFA _es_signer1 }}
8. Federal Action Number, if known: {{FedDept_es_signer1 }}	9. Award Amount, if known: {{AwardAmt_es_signer1 }}
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): {{LobEntNm_es_signer1 }} {{LobEntAd_es_signer1 }} (attach Continuation Sheets(s))	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): {{LobEntNm2_es_signer1}} SF-LLL-A, If necessary)
Amount of Payment (check all that apply): ${{Amt_es_signer1}} actual planned Form of Payment (check all that apply): a. {{[]}} cash b. {{[]}} in-kind, specify: Nature Value {{Value_es_:signer1 }}	13. Type of Payment (Check all that apply): {{[]}} a. retainer {{[]}} b. one-time fee {{[]}} c. commission {{[]}} d. contingent fee {{[]}} e deferred {{[]}} f. other, specify: {{Other_es_signer1}}

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:
{{SrvcPerf_es_:signer1:multiline(4) }}

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes {{[]}} No {{[]}}

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the	Signature: {{_es_:signer1:signature:showif(lobby=Checked)}} Print Name: {{Name_es_:signer1:showif(lobby=Checked)}} Title: {{_es_:signer1:title:showif(lobby=Checked)}}

Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Telephone No.: {{Mobile_es_:signer1:phone:showif(lobby=Checked)}} Date: : {{_es_:signer1:date:showif(lobby=Checked)}}
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL

{{lobby_es_:checkbox:signer1}}

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks “Subawardee,” then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., “RFP-DE-90401.”

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503

ATTACHMENT A
COVERED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 **Program Participation**. Provider will participate in the following Programs:

[Y/N]	**Medi-Cal**
[Y/N]	**OneCare (Medicare Advantage DSNP)**
[Y/N]	**PACE**
[Y/N]	**Covered California/ On Exchange and Off Exchange**

ARTICLE 2
DEFINITIONS

2.1 **Definitions**. The capitalized words or phrases not otherwise defined in this Contract shall have the following meanings in this Attachment A:

2.1.1 There are no additional defined terms [or include additional definitions as needed for specialty type].

ARTICLE 3
SERVICES

3.1 **Covered Services**. Covered Services under this Contract are those items and services defined under an applicable Program and CalOptima Policies, required to be furnished to Members by Provider under this Contract (as further detailed in this Attachment A), and, as applicable, Authorized (with the exception of Emergency Services), including:

3.1.1 [add specific Covered Services description]

ARTICLE 4
GENERAL PROVIDER RESPONSIBILITIES

4.1 **Days to Appointment**. Provider shall offer appointments for Covered Services in accordance with Laws and, as applicable to the Provider's scope of practice, shall ensure that: (i) appointments for urgent care Covered Services, including non-physician mental health or substance use disorder services, that do not require prior Authorization are scheduled within forty-eight (48) hours; (ii) appointments for urgent care Covered Services that require prior Authorization are scheduled within ninety-six (96) hours; (iii) appointments for non-Emergency Services or non-urgent primary care Covered Services, including OB/GYN primary care services, are scheduled within ten (10) Business Days; (iv) appointments for non-Emergency Services or non-urgent specialist Covered Services are scheduled within fifteen (15) Business Days; (v) appointments for non-urgent ancillary Covered Services for diagnosis or treatment of an injury or illness are scheduled within fifteen (15) Business Days; and (vi) health assessments and general physical examinations and all preventative Covered Services are scheduled within thirty (30) days of Member's request for an appointment. If Provider supplies maternity Covered Services, Provider shall utilize the most current standards and guidelines of the American College of Obstetricians and Gynecologists as the minimum measure of quality for perinatal services. Provider shall also have a process in place for follow-up on

Back to Agenda Back to Item

Member missed appointments.

4.2 **Office Waiting Times**. Provider shall ensure that office wait times are a maximum of forty-five (45) minutes.

4.3 **Health Education and Prevention**. Provider shall provide Members with health education during office visits in accordance with CalOptima Policies. Provider shall also refer Members to CalOptima's health education referral line for classes provided to Members.

4.4 **Coordination of Care**. Provider shall coordinate the provision of Covered Services to Members by counseling Members and their families regarding Member needs, monitoring progress of Members' care, and coordinating utilization of services with Member's PCP.

4.5 **Treatment Options**. Provider shall discuss treatment options with Members, including the option of foregoing treatment, in a culturally competent manner. Provider shall ensure that Members with disabilities have access to effective communication methods when making care decisions and shall allow Members the opportunity to refuse treatment and express preferences for future treatment.

4.6 **COD-Administrative Members**. Provider shall also provide services to COD-Administrative Members under this Contract. The scope of such services shall be defined in CalOptima Policies, as well as Article 3 of this Attachment A. In the event of a conflict between CalOptima Policies and Article 3, CalOptima Policies shall control with respect to COD-Administrative Members.

4.7 **Model of Care**. Provider shall comply with CalOptima's model of care, as specified for the Program.

4.8 **Personal Care Coordinator**. Provider shall cooperate with CalOptima's personal care coordinator ("**PCC**") in accordance with CalOptima's PCC program, policies, and guidance.

4.9 **Interdisciplinary Care**. Provider shall participate with CalOptima's Interdisciplinary Care Team and contribute to the Individualized Care Plan for each Member in accordance with CalOptima Policies and the applicable Program requirements.

ARTICLE 5
INSURANCE

5.1 **Professional Liability**. Provider, at its sole cost and expense, shall ensure that it and Subcontractors maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts of at least [$1,000,000] per incident/[$3,000,000] aggregate per year.

5.2 **Provider Commercial General Liability/Commercial Crime Liability/Automobile Liability**. Provider, at its sole cost and expense, shall maintain such policies of commercial general liability, commercial crime liability, and automobile liability and other insurance as shall be necessary to insure it and its business address(es), customers (including Members), employees, Agents, and representatives against any claim or claims for damages arising by reason of (i) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder; (ii) the use of any property of the Provider; and (iii) activities performed in connection with the Contract, with minimum coverage of:

5.2.1 Commercial General Liability of [$1,000,000] per incident/[$2,000,000] aggregate per year.

5.2.2 Commercial Crime Liability of [$250,000] aggregate per year.

5.2.3 Automobile Liability of [$500,000] combined single limit. Applicable only if Provider transports Members.

5.3 **Workers Compensation Insurance/Employer's Liability**. Provider, at its sole cost and expense, shall maintain workers compensation insurance within the limits established and required by the State and employer's liability insurance with minimum limits of liability of$1,000,000 Bodily injury each accident; $1,000,000 Bodily injury policy limit; and $1,000,000 Bodily injury each employee.

5.4 **Cyber Liability Insurance**. Provider, at its sole cost and expense, shall maintain cyber lability insurance with following the minimum limits covering first and third-party claims involving privacy violations, data breaches, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion, and network security: [$1,000,000] each occurrence/claim and [$1,000,000] aggregate. Such coverage shall provide for costs of legal fees, forensic expenses, regulatory fines and penalties, notification expenses, credit monitoring and ID theft repair, public relations expenses, and costs of liability and defense.

ATTACHMENT B
COMPENSATION

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts for Covered Services provided to Members under this Contract:

1. **General Terms**. Upon submission of a Clean Claim, CalOptima shall pay Provider pursuant to this Contract, CalOptima Policies, Government Contracts, and Laws.

   1.1 Medically Necessary Services. This Contract does not provide incentives, nor will it be construed to provide incentives, for Providers to reduce or withhold Medically Necessary services. Provider will not alter care delivery practices, adopt billing practices, or take any other actions for the sole or primary purpose of reducing Medically Necessary services. Provider will ensure the continuity of services in the event of non-payment from CalOptima in accordance with Laws and Government Contract requirements.

   1.2 Due Date. If a due date provided for under this Contract is a weekend or State or federal holiday, any such report, objection, or payment will be due the following Business Day.

   1.3 File Transfer. The Parties agree to deliver the confidential data utilizing a secure file transfer protocol ("**SFTP**") process. The Parties will establish a SFTP site and provide the credentials necessary to access and push files to the site.

   1.4 Supplemental Pay-for-Performance Payment. CalOptima may authorize supplemental payments to Provider yearly or quarterly based on Provider's quality performance and achievement specified program goals, as determined by CalOptima in its sole discretion in accordance with applicable laws and CalOptima Policies. CalOptima shall not pay Provider any supplemental payments if this Contract terminates.

2. **Payment**.

   2.1 Medi-Cal.

      2.1.1 For Covered Services provided to Medi-Cal Members, CalOptima shall reimburse Provider as follows:

         2.1.1.1 **Professional Services: XXX% of the current CalOptima Medi-Cal Fee Schedule**, as defined in CalOptima Policies, in effect for the date of service.

         2.1.1.2 **Non-Professional services shall be paid at XXX% of the current CalOptima Medi-Cal Fee Schedule**, as defined in the CalOptima Policies, in effect for the date of service.

      2.1.2 *Targeted Rate Increase Services*. If applicable, for services subject to the TRI provided by a qualified professional, CalOptima will reimburse Provider at the greater of the contracted rates, outlined above plus any applicable supplemental payments, or the Medi-Cal TRI fee schedule rate in effect for the date of service; provided, however, in no event will Provider be reimbursed at less than the Medi-Cal TRI fee schedule in effect for the date of service. Reimbursement for

TRI services shall comply with DHCS Program requirements, Laws, and CalOptima Policies.

2.2 OneCare.

2.2.1 For Covered Services provided to OneCare Members, CalOptima shall reimburse Provider as follows:

2.2.1.1 **XXX % of the Medicare Allowable Fee Schedule**, in effect for the date of service.

2.3 PACE.

2.3.1 For Covered Services provided to PACE Members, CalOptima shall reimburse Provider as follows:

2.3.1.1 **XXX% of the Medicare Allowable Fee Schedule,** in effect for the date of service.

2.4 Covered California.

2.4.1 For Covered Services provided to Covered California Members, CalOptima shall reimburse Provider as follows:

2.4.1.1 **XXX% of the Medicare Allowable Fee Schedule**, in effect for the date of service.

2.5 Claims Requirements. Provider shall submit all Claims to CalOptima, and CalOptima shall pay all Claims, in accordance with Medi-Cal or Medicare billing rules, guidelines, and payment policies. Services not contained in the Current Medi-Cal or Medicare Fee Schedule at the time of services are not reimbursed under this Contract.

2.6 Services with Unestablished Fees. If a fee is determined to be "By Report & Unlisted" under the applicable CalOptima fee schedule, payment shall be made under the following guidelines:

2.6.1 "By Report & Unlisted" codes that CalOptima has provided Authorization for Provider to provide such services

[Alternative Language 1 will be paid at XX% of Provider's full billed charges and must follow applicable Medi-Cal or Medicare billing rules and guidelines when reimbursed at Medi-Cal or Medicare rates]

[Alternative Language 2 will be billed and paid at Medi-Cal or Medicare rules and guidelines when reimbursed at Medi-Cal or Medicare rates. When billing CalOptima for these codes, Provider shall include documentation of Covered Services provided, as required by this Contract, CalOptima Policies, and Laws.]

[Alternative Language 3

2.6.1 When total billed charges for a claim line are less than $XXX total, regardless of the number of units billed, payment shall be made at XX% of Provider's usual, customary, and reasonable billed charges

2.6.2 When total billed charges for a claim line meet or exceed $XXX total, regardless of the number of units billed, payment shall be made per the applicable billing rules and guidance: Medicare for Medicare rates and Medi-Cal for Medi-Cal rates. Provider shall include all necessary documentation of the Covered Services provided, as required by the Contract, CalOptima Policies, and applicable laws and regulations.]

2.7 Vaccines. If applicable to the services rendered by Provider under this Contract, CalOptima shall not reimburse Provider for the cost of vaccines that are available under the Centers for Disease Control and Prevention's Vaccines for Children program, which provides free vaccines for eligible populations, including Medi-Cal-covered children ages eighteen (18) years and younger. For all other vaccines, CalOptima will reimburse Provider at the current Medi-Cal Fee schedule for vaccines that are recommended by the DHCS Early and Periodic Screening, Diagnostic and Treatment/American Academy of Pediatrics for ages nineteen (19) and over when billing is submitted on a CMS-1500, UB-04 claim form or the electronic equivalent.

3. **Payment Procedures**.

3.1 Claims Submission. Provider shall submit to CalOptima an accurate, complete, descriptive, and timely Claim that includes the Member's name and identification number, description of services, and date(s) of service. Provider may not submit a Claim before the delivery of service. Provider shall submit all Claims to CalOptima as directed in the applicable CalOptima Policies. Provider is not eligible for payment on Claims submitted after ninety (90) days from the date of service, unless CalOptima is required to follow a different minimum Claims submission timeframe pursuant to Laws or Government Contracts. When CalOptima is the secondary payer, Provider is not eligible for payment for Claims submitted after ninety (90) days from the date the primary payer adjudicated the Claim, unless CalOptima is required to follow a different minimum Claims submission timeframe pursuant to Laws or Government Contracts. Provider is solely responsible for reimbursing its Contracted Providers for providing Covered Services for Provider under this Contract and shall ensure that all Contracted Providers agree to accept payment from Provider as payment in full for Covered Services provided to Members.

3.2 Payment Codes and Modifiers. Provider shall utilize current payment codes and modifiers for Medi-Cal or Medicare when billing CalOptima. CPT or HCPCS codes not contained in the Medi-Cal or Medicare fee schedule at the time of service are not reimbursable.

3.3 Claims Requiring Additional Justification. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Provider for additional justification, and these will be handled on a case-by-case basis.

3.4 Prompt Payment. CalOptima shall make payments to Provider in the time and manner set forth in CalOptima Policies and Laws.

3.5 Claims Deficiencies. CalOptima shall deny payment for any Claim that fails to meet requirements set forth in CalOptima Policies and Laws for Claims processing, and CalOptima shall notify Provider of any denial pursuant to CalOptima Policies and Laws.

3.6 Claims Auditing. Provider acknowledges CalOptima's right to conduct post-payment billing audits under this Contract. Provider and its Contracted Providers will cooperate with CalOptima's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting records and other related data. CalOptima will use established industry standards and federal and State guidelines to determine the appropriateness of the billing, coding, and payment. This section will survive any termination of the Contract.

3.7 Crossover Claims. The Medi-Cal reimbursement rates in this Contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims, CalOptima will reimburse Provider in accordance with CalOptima Policies, Laws, DHCS Contract, and Program requirements. California law limits Medi-Cal reimbursement for a Crossover Claim to an amount that, when combined with the Medicare or other health coverage ("**OHC**") payment, does not exceed Medi-Cal's maximum allowed for similar services as required by Welfare and Institutions Code § 14109.5. "**Crossover Claim(s)**" means claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or OHC is the primary payor for dates of service "**Dual Eligible Members**" are Members who are eligible for both Medicare or OHC and Medi-Cal benefits.

4 Sequestration. As applicable to OneCare or PACE, if CMS reduces payment to CalOptima under the applicable CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Provider, reduce payment to Provider under this Attachment B by the same percentage that CMS reduced payment to CalOptima for OneCare or PACE, respectively. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) for a Program during the Term.

5 **Directed Payments for Qualifying Medi-Cal Covered Services**. CalOptima shall administer directed payments for the Proposition 56 Medi-Cal Physician Supplemental Payment Program ("**Prop 56 Program**") for qualifying Medi-Cal Covered Services relevant to this Contract in accordance with CalOptima Policy FF.2012 and this Section 5.

5.1 For purposes of this Section 5, "**Qualifying Services**" means services described by the Prop 56 Program, which may be revised to include additional CPT codes, rate adjustments, and extensions. Services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

5.2 CalOptima shall forward to Professional rendering Qualifying Services an additional payment for the Qualifying Services in accordance with applicable laws and CalOptima Policies.

5.3 CalOptima shall make payments to Professional for Qualifying Services in conjunction with the payment of the Claim for the service. Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable.

5.4 Professional acknowledges that DHCS has indicated that payments to eligible providers will be verified by DHCS. If that future DHCS reconciliation of the Prop 56 Program

payments identifies invalid payments, Professional shall return such Prop 56 Program payments to CalOptima immediately upon notice from CalOptima.

5.5 As long as the State of California extends the Prop 56 Program payments to CalOptima, CalOptima will continue to make Prop 56 Program payments to Professional, which may be subject to Board approval and changes to the program, as necessary and appropriate to comply with applicable laws.

ATTACHMENT A
COVERED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 **Program Participation**. Provider will participate in the following Programs:

[Y/N]	**Medi-Cal**
[Y/N]	**OneCare (Medicare Advantage DSNP)**
[Y/N]	**MSSP**
[Y/N]	**PACE**
[Y/N]	**Covered California/On Exchange and Off Exchange**

ARTICLE 2
DEFINITIONS

2.1 **Definitions**. The capitalized words or phrases not otherwise defined in this Contract shall have the following meanings in this Attachment A:

2.1.1 There are no additional defined terms.[or include additional definitions as needed for provider type]

ARTICLE 3
SERVICES

3.1 **Covered Services**. Covered Services under this Contract are limited to the following:

3.1.1 [*add specific Covered Services description*]

ARTICLE 4
GENERAL PROVIDER RESPONSIBILITIES

4.1 **Office Waiting Times**. Provider shall ensure that office wait times are a maximum of forty-five (45) minutes.

4.2 **Health Education and Prevention**. Provider shall provide Members with health education during office visits in accordance with CalOptima Policies. Provider shall also refer Members to CalOptima's health education referral line for classes provided to Members.

4.3 **Coordination of Care**. Provider shall coordinate the provision of Covered Services to Members by counseling Members and their families regarding Member needs, monitoring progress of Members' care, and coordinating utilization of services with Member's PCP.

4.4 **Treatment Options**. Provider shall discuss treatment options with Members, including the option of foregoing treatment, in a culturally competent manner. Provider shall ensure that Members with disabilities have access to effective communication methods when making care decisions and shall allow Members the opportunity to refuse treatment and express preferences for future treatment.

4.5 **COD-Administrative Members**. Provider shall also provide services to COD-Administrative

Members under this Contract. The scope of such services shall be defined in CalOptima Policies, as well as Article 3 of this Attachment A. In the event of a conflict between CalOptima Policies and this Article 3, CalOptima Policies shall control with respect to COD-Administrative Members.

4.6 **Model of Care**. Provider shall comply with CalOptima's model of care, as specified for the Program.

4.7 **Personal Care Coordinator**. Provider shall cooperate with CalOptima's personal care coordinator ("**PCC**") in accordance with CalOptima's PCC program, policies, and guidance.

4.8 **Interdisciplinary Care**. Provider shall participate with CalOptima's Interdisciplinary Care Team and contribute to the Individualized Care Plan for each Member in accordance with CalOptima Policies and the applicable Program requirements.

ARTICLE 5
INSURANCE

5.1 **Professional Liability**. Provider, at its sole cost and expense, shall ensure that it and Subcontractors maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts of at least $1,000,000 per incident/$3,000,000 aggregate per year.

5.2 **Provider Commercial General Liability/Commercial Crime Liability/Automobile Liability**. Provider, at its sole cost and expense, shall maintain such policies of commercial general liability, commercial crime liability, and automobile liability and other insurance as shall be necessary to insure it and its business address(es), customers (including Members), employees, Agents, and representatives against any claim or claims for damages arising by reason of (i) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder; (ii) the use of any property of the Provider; and (iii) activities performed in connection with the Contract, with minimum coverage of:

5.2.1 Commercial General Liability of $1,000,000 per incident/$2,000,000 aggregate per year.

5.2.2 Commercial Crime Liability of $250,000 aggregate per year.

5.2.3 Automobile Liability of $500,000 combined single limit. Applicable only if Provider transports Members.

5.3 **Workers Compensation Insurance/Employer's Liability**. Provider, at its sole cost and expense, shall maintain workers compensation insurance within the limits established and required by the State and employer's liability insurance with minimum limits of liability of [$1,000,000] Bodily injury each accident; [$1,000,000] Bodily injury policy limit; and [$1,000,000] Bodily injury each employee

5.4 **Cyber Liability Insurance**. Provider, at its sole cost and expense, shall maintain cyber lability insurance with following the minimum limits covering first and third-party claims involving privacy violations, data breaches, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion, and network security: [$1,000,000] each occurrence/claim and [$1,000,000] aggregate. Such coverage shall provide for costs of legal fees, forensic expenses, regulatory fines and penalties, notification expenses, credit monitoring and ID theft repair, public relations expenses, and costs of liability and defense.

ATTACHMENT B
COMPENSATION

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts for Covered Services provided to Members under this Contract:

1. **General Terms**. Upon submission of a Clean Claim, CalOptima shall pay Provider pursuant to this Contract, CalOptima Policies, Government Contracts, and Laws.

   1.1 Medically Necessary Services. This Contract does not provide incentives, nor will it be construed to provide incentives, for Providers to reduce or withhold Medically Necessary services. Provider will not alter care delivery practices, adopt billing practices, or take any other actions for the sole or primary purpose of reducing Medically Necessary services. Provider will ensure the continuity of services in the event of non-payment from CalOptima in accordance with Laws and Government Contract requirements.

   1.2 Due Date. If a due date provided for under this Contract is a weekend or State or federal holiday, any such report, objection, or payment will be due the following Business Day.

   1.3 File Transfer. The Parties agree to deliver the confidential data utilizing a secure file transfer protocol ("**SFTP**") process. The Parties will establish a SFTP site and provide the credentials necessary to access and push files to the site.

   1.4 Supplemental Pay-for-Performance Payment. CalOptima may authorize supplemental payments to Provider yearly or quarterly based on Provider's quality performance and achievement specified program goals, as determined by CalOptima in its sole discretion in accordance with applicable laws and CalOptima Policies. CalOptima shall not pay Provider any supplemental payments if this Contract terminates.

2. **Payment**.

   2.1 Medi-Cal.

      2.1.1 For Covered Services provided to Medi-Cal Members, CalOptima shall reimburse Provider as follows: [Below may be replaced by other DHCS/Medi-Cal payment methodologies for non-medical providers]

         2.1.1.1 **Professional Services: XXX% of the current CalOptima Medi-Cal Fee Schedule**, as defined in CalOptima Policies, in effect for the date of service.

         2.1.1.2 **Professional services shall be paid at XXX% of the current CalOptima Medi-Cal Fee Schedule**, as defined in the CalOptima Policies, in effect for the date of service.

      2.1.2 *Targeted Rate Increase Services*. If applicable, for services subject to the TRI provided by a qualified professional, CalOptima will reimburse Provider at the greater of the contracted rates, outlined above plus any applicable supplemental

Back to Agenda Back to Item

payments, or the Medi-Cal TRI fee schedule rate in effect for the date of service; provided, however, in no event will Provider be reimbursed at less than the Medi-Cal TRI fee schedule in effect for the date of service. Reimbursement for TRI services shall comply with DHCS Medi-Cal Program requirements, Laws, and CalOptima Policies.

2.2 OneCare.

2.2.1 For Covered Services provided to OneCare Members, CalOptima shall reimburse Provider as follows:

2.2.1.1 **XXX % of the Medicare Allowable Fee Schedule,** in effect for the date of service.

2.3 PACE.

2.3.1 For Covered Services provided to PACE Members, CalOptima shall reimburse Provider as follows:

2.3.1.1 **XXX% of the Medicare Allowable Fee Schedule**, in effect for the date of service.

2.4 MSSP.

2.4.1 For Covered Services provided to MSSP Members, CalOptima shall reimburse Provider as follows:

HCPCS Code	Type of Service	Unit Type	Unit Rate

2.4.2 *Claims Requirements for MSSP.* Upon receipt of Clean Claim, CalOptima shall pay Provider within thirty (30) days for services Authorized the previous month. CalOptima shall not pay Provider for time required for Provider to travel to or from the Member's home, unless travel is included as part of the Authorized services provided, *e.g.* shopping or transportation/escort. In such instances, Provider may also request reimbursement for mileage at the current CalOptima reimbursement rate. Provider shall submit to CalOptima each month an invoice referencing a Service Authorization Form (SAF) number for Authorized services provided the prior month. Invoices are due within fifteen (15) days after the end of the month in which Provider provided the Authorized services.

2.5 Covered California.

2.5.1 For Covered Services provided to Covered California Members, CalOptima shall reimburse Provider as follows:

2.5.1.1 [INSERT PAYMENT STRUCTURE, ADDING SUBSECTIONS AS NECESSARY]

Back to Agenda Back to Item

2.6 Claims Requirements. Provider shall submit all Claims to CalOptima, and CalOptima shall pay all Claims, in accordance with Medi-Cal or Medicare billing rules, guidelines, and payment policies. Services not contained in the Current Medi-Cal or Medicare Fee Schedule at the time of services are not reimbursed under this Contract.

2.7 Services with Unestablished Fees. If a fee is determined to be "By Report & Unlisted" under the applicable CalOptima fee schedule, payment shall be made under the following guidelines:

2.7.1 "By Report & Unlisted" codes that CalOptima has provided Authorization for Provider to provide such services

[Alternative Language 1 will be paid at XX% of Provider's full billed charges and must follow applicable Medi-Cal or Medicare billing rules and guidelines when reimbursed at Medi-Cal or Medicare rates]

[Alternative Language 2 will be billed and paid at Medi-Cal or Medicare rules and guidelines when reimbursed at Medi-Cal or Medicare rates]. When billing CalOptima for these codes, Provider shall include documentation of Covered Services provided, as required by this Contract, CalOptima Policies, and Laws.]

Alternative Language 3

[2.6.1 When total billed charges for a claim line are less than $XXX total, regardless of the number of units billed, payment shall be made at XX% of Provider's usual, customary, and reasonable billed charges

2.6.2 When total billed charges for a claim line meet or exceed $XXX total, regardless of the number of units billed, payment shall be made per the applicable billing rules and guidance: Medicare for Medicare rates and Medi-Cal for Medi-Cal rates. Provider shall include all necessary documentation of the Covered Services provided, as required by the Contract, CalOptima Policies, and applicable laws and regulations.]

2.8 Vaccines. If applicable to the services rendered by Provider under this Contract, CalOptima shall not reimburse Provider for the cost of vaccines that are available under the Centers for Disease Control and Prevention's Vaccines for Children program, which provides free vaccines for eligible populations, including Medi-Cal-covered children ages eighteen (18) years and younger. For all other vaccines, CalOptima will reimburse Provider at the current Medi-Cal Fee schedule for vaccines that are recommended by the DHCS Early and Periodic Screening, Diagnostic and Treatment/American Academy of Pediatrics for ages nineteen (19) and over when billing is submitted on a CMS-1500, UB-04 claim form or the electronic equivalent

3. **Payment Procedures**.

3.1 Claims Submission. Provider shall submit to CalOptima an accurate, complete, descriptive, and timely Claim that includes the Member's name and identification number, description of services, and date(s) of service. Provider may not submit a Claim before the delivery of

service. Provider shall submit all Claims to CalOptima as directed in the applicable CalOptima Policies.. Provider is not eligible for payment on Claims submitted after ninety (90) days from the date of service, unless CalOptima is required to follow a different minimum Claims submission timeframe pursuant to Laws or Government Contracts. When CalOptima is the secondary payer, Provider is not eligible for payment for Claims submitted after ninety (90) days from the date the primary payer adjudicated the Claim, unless CalOptima is required to follow a different minimum Claims submission timeframe pursuant to Laws or Government Contracts. Provider is solely responsible for reimbursing its Contracted Providers for providing Covered Services for Provider under this Contract and shall ensure that all Contracted Providers agree to accept payment from Provider as payment in full for Covered Services provided to Members.

3.2 Payment Codes and Modifiers. Provider shall utilize current payment codes and modifiers for Medi-Cal or Medicare, as applicable, when billing CalOptima. CPT or HCPC codes not contained in the Medi-Cal or Medicare fee schedule, as applicable, at the time of service are not reimbursable.

3.3 Claims Requiring Additional Justification. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Provider for additional justification, and these will be handled on a case-by-case basis.

3.4 Prompt Payment. CalOptima shall make payments to Provider in the time and manner set forth in CalOptima Policies and Laws.

3.5 Claims Deficiencies. CalOptima shall deny payment for any Claim that fails to meet requirements set forth in CalOptima Policies and Laws for Claims processing, and CalOptima shall notify Provider of any denial pursuant to CalOptima Policies and Laws.

3.6 Claims Auditing. Provider acknowledges CalOptima's right to conduct post-payment billing audits under this Contract. Provider and its Contracted Providers will cooperate with CalOptima's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting records and other related data. CalOptima will use established industry standards and federal and State guidelines to determine the appropriateness of the billing, coding, and payment. This section will survive any termination of the Contract.

3.7 Crossover Claims. The Medi-Cal reimbursement rates in this Contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims, CalOptima will reimburse Provider in accordance with CalOptima Policies, Laws, DHCS Contract, and Program requirements. California law limits Medi-Cal reimbursement for a Crossover Claim to an amount that, when combined with the Medicare or other health coverage ("**OHC**") payment, does not exceed Medi-Cal's maximum allowed for similar services as required by Welfare and Institutions Code § 14109.5. "**Crossover Claim(s)**" means claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or OHC is the primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's Programs. "**Dual Eligible Members**" are Members who are eligible for both Medicare or OHC and Medi-Cal benefits.

3.8 Sequestration. As applicable to OneCare or PACE, if CMS reduces payment to CalOptima under the applicable CMS Contract by more than two percent (2%) at any time during the

Back to Agenda Back to Item

Term, CalOptima may, upon written notice to Provider, reduce payment to Provider under this Attachment B by the same percentage that CMS reduced payment to CalOptima for OneCare or Pace, respectively. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) for a Program during the Term.

ATTACHMENT A
COVERED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS

1.1 **Program Participating**. Provider will participate in the following Programs:

[Y/N]	**Medi-Cal**
[Y/N]	**OneCare (Medicare Advantage DSNP)**
[Y/N]	**PACE**
[Y/N]	**Covered California/ On Exchange and Off Exchange**

ARTICLE 2
DEFINITIONS

2.1 **Definitions**. The capitalized words or phrases not otherwise defined in this Contract shall have the following meanings in this Attachment A:

2.1.1 "**Behavioral Health Services**" means the mental health and substance use disorder services provided through the Mental Health Plan or CalOptima and/or their Subcontractors.

2.1.2 "**CHDP**" means the State's Child Health and Disability Prevention program, as defined in the Health and Safety Code § 12402.5 *et seq*., that covers pediatric preventive services for eligible children receiving Medi-Cal benefits. CHDP services are provided according to the recommended schedule and standards published by the American Academy of Pediatrics ("**AAP**").

2.1.3 "**Emergency Medical Condition**" a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

2.1.4 "**Family Planning**" means Covered Services provided to Members of childbearing age to enable them to determine the number and spacing of their children and to help reduce maternal and infant deaths and diseases by promoting the health and education of potential parents, including (i) medical and surgical services performed by and under the direct supervision of a licensed physician for the purposes of Family Planning; (ii) laboratory and radiology procedures, drugs, and devices prescribed by a licensed physician and/or associated with Family Planning procedures; (iii) patient visits for the purpose of Family Planning; (iv) Family Planning counseling services provided during a regular patient visit; (v) tubal ligations; (vi) vasectomies; (vii) contraceptive drugs or devices; and (viii) treatment for complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.

Back to Agenda Back to Item

2.1.5 "**HRA**" means the health risk assessment tool that identifies a Member's primary, acute, long-term supports and services, behavioral health and functional needs.

2.1.6 "**ICP**" means the individualized care plan developed by a Member, their ICT, and/or CalOptima.

2.1.7 "**ICT**" means CalOptima's interdisciplinary care team comprised of the primary care provider and care coordinator and other providers at the discretion of the Member who work with the Member to develop, implement and maintain the ICP.

2.1.8 "**Medi-Cal Specialty Mental Health Services**" means the services specified in 9 CCR § 1810.247 provided through an MHP (not including the Medi-Cal managed care Behavioral Health Services specified in Welfare & Institutions Code § 14132.03 and required to be provided by CalOptima).

2.1.9 "**MHP**" means the mental health plan contracted with DHCS to provide Medi-Cal Specialty Mental Health Services. The Orange County Health Care Agency is the MHP for Medi-Cal Specialty Mental Health Services for Medi-Cal beneficiaries in Orange County, California.

2.1.10 "**Outpatient Mental Health Services**" means outpatient mental health services for Members with mild to moderate mental health conditions, including individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies, and supplements.

2.1.11 "**Pediatric Preventive Services**" means child services that incorporate CHDP and the AAP guidelines for health supervision.

2.1.12 "**SBIRT**" means the screening, brief intervention, and referral to treatment services provided by a PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs.

2.1.13 "**Sensitive Services**" means those services related to Family Planning, sexually transmitted disease, abortion, and human immunodeficiency virus testing.

2.1.14 "**Specialist**" means a Participating Provider licensed by the State to practice in the designated specialty.

ARTICLE 3
SERVICES

3.1 **Covered Services**. Covered Services under this Contract are the primary care physician ("**PCP**") services covered under the Member's respective Program, including health promotion, disease prevention, health maintenance, counseling, patient education, and the diagnosis and treatment of illnesses within Provider's normal scope of practice (collectively "**PCP Services**"). PCP Services

Back to Agenda Back to Item

include the following:[1]

3.1.1 For each Member, all diagnostic and therapeutic professional services; laboratory and other diagnostic tests and procedures; and supplies, drugs, and inoculations customarily provided on an outpatient basis by and within the competence of a PCP, including:

3.1.1.1 Periodic evaluation of all body systems and preventive services, and acute and chronic care.

3.1.1.2 Definitive diagnoses and treatment.

3.1.1.3 Post-treatment and referrals follow-up.

3.1.1.4 Treatment that considers the Member as a whole, considering medical, psychological, social, and emotional issues

3.1.1.5 Preventive medicine, including periodic physical examinations, immunizations, vaccines, and diagnostic tests.

3.1.1.6 "On call", twenty-four (24)-hour accessibility.

3.1.2 Specific PCP Services. PCP Services include the following:

3.1.2.1 Routine office laboratory microscopy.

3.1.2.2 First contact care for persons with previously undifferentiated health concerns.

3.1.2.3 Office visits and examinations (diagnosis and treatment of illness and injury).

3.1.2.4 Adult and pediatric health maintenance.

3.1.2.5 Specimen collection.

3.1.2.6 Nutritional counseling.

3.1.2.7 Interpretation of laboratory results.

3.1.2.8 Miscellaneous supplies related to treatment in Provider's office (i.e., bandages, arm slings, splints, suture trays, gauze, tape, and other routine medical supplies).

3.1.2.9 Telephone consultations.

3.1.2.10 Family planning.

3.1.2.11 Minor surgery (e.g., lacerations)

3.1.2.12 Pregnancy tests.

[1] These listed services are based on routine uncomplicated cases where care is ordinarily provided by a PCP. This list provides guidelines and is not intended to be all inclusive. Provider should use this list with clinical discretion.

3.1.2.13 Urinalysis.

3.1.2.14 In-office injections of medical or pharmaceutical agents.

3.1.2.15 Twenty-four hours a day, seven days a week on-call coverage.

3.1.2.16 In-office electrocardiograms (EKGs).

3.1.2.17 In-office inhalation treatments.

3.1.2.18 Well woman exams under ICD diagnosis codes X12.4 or Z01.42.

3.1.2.19 Vaccines, and immunizations excluding vaccines for children.

3.1.2.20 Child Health and Disability Prevention Program Covered Services.

3.1.3 Health Education and Prevention. Provider shall provide Members with health education during office visits in accordance with CalOptima Policies. Provider shall also refer Members to CalOptima Health's health education referral line for classes provided to Members.

3.1.4 Coordination and Continuation of Care. Provider shall coordinate the provision of Covered Services to Members by counseling Members and their families regarding Member's medical needs, initiating referrals of Members for specific Covered Services, monitoring progress of Members' care, and coordinating the utilization of services. Provider's referrals for Covered Services, including from Specialists, must follow CalOptima Policies for Authorization. All Authorizations shall be made through CalOptima's UM program. When a referral is necessary for a Member, Provider agrees to refer the Member to other Participating Providers in all circumstances except when an Authorization has been granted in advance by CalOptima to refer to a non-Participating Provider, or when necessary due to an Emergency Medical Condition. Provider shall forward the results of diagnostic procedures and consultations for Member in a timely manner to ensure that the Member's care is efficiently coordinated.

3.1.5 Health Risk Assessments. Provider must complete HRAs in accordance with requirements from Programs, Government Contracts, Laws, and CalOptima Policies.

3.1.6 Initial Health Assessments.

3.1.6.1 Provider shall have a process in place to ensure each Member is scheduled for an initial health assessment ("**IHA**") within one hundred twenty (120) days following enrollment with CalOptima, unless otherwise directed by CalOptima and/or the Member's PCP determines that the Member's medical records contains complete IHA information from the previous 12 months. At a minimum, IHAs shall be initially completed and periodically re-administrated for all Members in accordance with DHCS's Population Health Management Program Guide and CalOptima Policies and shall include:

3.1.6.1.1 Administration of the Staying Healthy Assessment Tool;

3.1.6.1.2 A medical history of the Member's physical and mental health;

3.1.6.1.3 Weight and height data, blood pressure, and preventive health screens, services, and tests required under CalOptima Policies;

3.1.6.1.4 Assessment and discussion of appropriate preventive measures, identification or risks, and arrangement of future follow-up appointments, as indicated;

3.1.6.1.5 Health education; and

3.1.6.1.6 Diagnosis and plan for treatment of any diseases.

Provider shall perform the IHA within the primary care medical setting in a way that is culturally and linguistically appropriate for the Member and documented in the Member's medical record. The IHA shall include the identification, assessment, and development of care plans, as appropriate for Members with special health care needs.

3.1.6.2 For Members under twenty-one (21) years of age, the IHA and periodic health assessments shall comply with the following:

3.1.6.2.1 The IHA and periodic health assessments shall include a dental screening/oral health assessment for all Members under twenty-one (21) years of age and include annual dental referrals made with the eruption of the child's first tooth or at twelve (12) months of age, whichever occurs first. Provider shall refer all Members between the ages of three (3) and twenty-one (21) to a dentist in accordance with the most recent recommendations of the AAP, as part of the periodic health assessment. Provider shall ensure that Members are referred to appropriate Medi-Cal dental providers and provide Medically Necessary federally required adult dental services and fluoride varnish.

3.1.6.2.2 Provider shall arrange for provision of (i) all necessary immunizations to ensure that the Member is up to date for their age group, (ii) an adverse childhood experiences screening, and (iii) any other DHCS-required age-specific screenings, including developmental screenings.

3.1.6.2.3 Where a request is made for preventive services within the first one hundred twenty (120) days of enrollment, Provider must schedule the appointment for the Member to have a visit within ten (10) Business Days of the Member's request, unless Member declines a visit within ten (10) Business Days of the request and chooses another appointment date.

3.1.6.2.4 Reporting to CalOptima, as part of Provider's Encounter Data reporting, all preventative services provided to Members.

3.1.6.3 If the Member refuses IHA services, Provider must document that refusal in the Member's Medical Record in accordance with CalOptima Policies, indicating that IHA services were advised and the Member (if an emancipated

Back to Agenda Back to Item

minor) or the Member's parent(s) or guardians voluntarily refused such services.

3.1.6.4 CalOptima may establish minimum performance requirements for completion of the IHA. Provider's failure to perform at or in excess of minimum performance requirements shall subject Provider to sanctions in accordance with this Contract and CalOptima Policies. Provider shall ensure that IHA is recorded in the Member's Medical Record.

3.1.7 Pediatric Preventive Service Appointments. Provider shall provide periodic pediatric screenings and assessments, including for vision and hearing, in accordance with the AAP schedule and CalOptima Policies and provide according to the latest guidelines published by the AAP and Advisory Committee on Immunization Practices ("**ACIP**"). If there is a conflict in the recommendations, the higher standard will be recognized. Provider shall ensure adult Members receive periodic health assessments and recommended immunizations according to the guidelines published by the United States Preventive Services Task Force and ACIP. Vaccinations that are not part of the standard protocol for pediatrics and adults shall be administered according to CalOptima Policies. Provider shall coordinate all Pediatric Preventive Services with the Orange County CHDP Program.

3.1.8 Obstetrical Services for Medi-Cal Members. If Provider provides obstetrical services, Provider must complete the Program-specific CalOptima Pregnancy Notification Report ("**PNR**") for all pregnant Members. PNRs must be received by CalOptima within five (5) days following initiation of obstetrical-related services.

3.1.9 Newborn Services. Provider shall provide all Covered Services to any newborn child or children born to a Member for the month of birth and the following month under the Capitation Payment for the Member who gave birth to the child.

3.1.10 Alcohol and Substance Use Disorder Treatment Services. Provider shall provide SBIRT services to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs and refer Members to CalOptima for alcohol and substance use disorder treatment when there is a need beyond SBIRT. Provider shall document SBIRT services in Members' Medical Records.

3.1.11 Mental and Behavioral Health. Provider shall coordinate mental health and Behavioral Health Services, including Medi-Cal Specialty Mental Health Services, with other providers in accordance with CalOptima Policies, Government Contracts, Laws, and Program requirements.

3.1.12 ICT Participation. Provider shall participate with the ICT to contribute to the ICP in accordance with Program guidelines and CalOptima Policies.

3.1.13 Outpatient Mental Health Services. Provider may provide Outpatient Mental Health Services within the scope of its practice. Provider shall refer Members with mild to moderate impairment in functioning requiring mental health Covered Services beyond the scope of Provider practice to CalOptima for referral to mental health Specialists. Provider shall refer Members with significant impairment in functioning and Members requiring emergency or inpatient mental health care to the Orange County Health Care Agency or another agency as appropriate.

3.1.14 [insert additional PCP services that are Covered Services under the Contract].

3.2 **Non-PCP Services**. Provider shall furnish Non-PCP Services to eligible Members, and those services shall be reimbursed in accordance with Section 2 of Attachment B. Excluding Emergency Services, Provider must obtain Authorization prior to providing all Non-PCP Services to qualify for reimbursement in accordance with CalOptima Policies. Provider shall also obtain Authorization from Provider to provide any Covered Services to Members that are not assigned to Provider by CalOptima.

3.3 **UM Program and Medical Necessity**. The actual provision of any Covered Services are subject to CalOptima Health's Policies and UM program and the Medical Necessity of the service. Provider shall provide assessment and evaluation services ordered by a court or legal mandate. Disputes about Medical Necessity can be appealed pursuant to CalOptima Health Policies.

ARTICLE 4
GENERAL PROVIDER RESPONSIBILITIES

4.1 **Days to Appointment**. Provider shall offer appointments for Covered Services in accordance with Laws and, as applicable to the Provider's scope of practice, shall ensure that: (i) appointments for urgent care Covered Services, including non-physician mental health or substance use disorder services, that do not require prior Authorization are scheduled within forty-eight (48) hours; (ii) appointments for urgent care Covered Services that require prior Authorization are scheduled within ninety-six (96) hours; (iii) appointments for non-Emergency Services or non-urgent primary care Covered Services, including OB/GYN primary care services, are scheduled within ten (10) Business Days; (iv) appointments for non-Emergency Services or non-urgent specialist Covered Services are scheduled within fifteen (15) Business Days; (v) appointments for non-urgent ancillary Covered Services for diagnosis or treatment of an injury or illness are scheduled within fifteen (15) Business Days; and (vi) health assessments and general physical examinations and all preventative Covered Services are scheduled within thirty (30) days of Member's request for an appointment. If Provider supplies maternity Covered Services, Provider shall utilize the most current standards and guidelines of the American College of Obstetricians and Gynecologists as the minimum measure of quality for perinatal services. Provider shall also have a process in place for follow-up on Member missed appointments.

4.2 **Office Waiting Times**. Provider shall ensure that office wait times are a maximum of forty-five (45) minutes.

4.3 **Treatment Options**. Provider shall discuss treatment options with Members, including the option of foregoing treatment, in a culturally competent manner. Provider shall ensure that Members with disabilities have access to effective communication methods when making care decisions and shall allow Members the opportunity to refuse treatment and express preferences for future treatment.

4.4 **Model of Care**. Provider shall comply with the model of care specified in each Program.

4.5 **Personal Care Coordinator**. Provider shall cooperate with CalOptima's personal care coordinator ("**PCC**") in accordance with CalOptima's PCC program, policies, and guidance.

4.6 **Interdisciplinary Care**. Provider shall provide all information requested by the ICT, including Medical Necessity documentation, that pertains to a Member's condition and drug therapy regimen, untoward effects, or allergic reactions.

Back to Agenda Back to Item

4.7 **Prescription Drug Compliance**. Provider shall comply with CalOptima's Approved Drug List and its associated drug utilization or disease management guidelines and protocols. Medications not included on the Approved Drug List require prior Authorization by CalOptima in accordance with CalOptima Policies. Provider shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist. Provider shall obtain Authorization in accordance with CalOptima Policies and provide CalOptima with all information requested by CalOptima, including for Authorizations, Medical Necessity documentation, a Member's condition and drug therapy regimen, and untoward effects/allergic reactions. Provider shall participate in any of CalOptima's pharmacy cost containment programs, as applicable.

4.8 **EDI Exchange**. Provider shall participate in the exchange of electronic transactions with CalOptima, including electronic claims submission (EDI), verification of eligibility and enrollment through electronic means, and submission of electronic Authorization transactions in accordance with CalOptima Policies.

4.9 **Sensitive Services Information**. If Provider supplies Sensitive Services, including Family Planning Services, Provider shall comply with Laws relating to Members' Family Planning information and records, and Provider is solely responsible for developing and implementing policies and procedures to ensure compliance with such confidentiality requirements. Provider shall not release Family Planning information and records to any third party without the prior written consent of the Member. Notwithstanding the foregoing, provider shall provide Family Planning information to CalOptima and/or authorized representatives of the State or federal government to maintain consistency of the Member's Medical Record.

4.10 **Referrals**.

4.10.1 SPD. Provider shall refer to CalOptima all Members in the Seniors and Persons with Disability (SPD) aid codes, which is the two-character code, defined by the State that identifies the aid category under which a Member is eligible to receive Covered services, who require a customized wheelchair and/or a modification to a customized wheelchair or seating system.

4.10.2 WIC. Provider shall make referrals to the Women, Infants and Children Food Supplementation Program ("**WIC**") in accordance with WIC program policies and procedures.

ARTICLE 5
INSURANCE

5.1 **Professional Liability**. Provider, at its sole cost and expense, shall ensure that it and Subcontractors maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts of at least [$1,000,000] per incident/[$3,000,000] aggregate per year.

5.2 **Provider Commercial General Liability/Commercial Crime Liability/Automobile Liability**. Provider, at its sole cost and expense, shall maintain such policies of commercial general liability, commercial crime liability, and automobile liability and other insurance as shall be necessary to insure it and its business address(es), customers (including Members), employees, Agents, and representatives against any claim or claims for damages arising by reason of (i) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder; (ii) the use of any property of the Provider; and (iii) activities performed in connection with the Contract, with minimum coverage of:

Back to Agenda Back to Item

5.2.1 Commercial General Liability of [$1,000,000] per incident/[$2,000,000] aggregate per year.

5.2.2 Commercial Crime Liability of [$250,000] aggregate per year.

5.2.3 Automobile Liability of [$500,000] combined single limit. Applicable only if Provider transports Members.

5.3 **Workers Compensation Insurance/Employer's Liability**. Provider, at its sole cost and expense, shall maintain workers compensation insurance within the limits established and required by the State and employer's liability insurance with minimum limits of liability of 1,000,000 Bodily injury each accident; $1,000,000 Bodily injury policy limit; and $1,000,000 Bodily injury each employee.

5.4 **Cyber Liability Insurance**. Provider, at its sole cost and expense, shall maintain cyber lability insurance with following the minimum limits covering first and third-party claims involving privacy violations, data breaches, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion, and network security: [$1,000,000] each occurrence/claim and [$1,000,000] aggregate. Such coverage shall provide for costs of legal fees, forensic expenses, regulatory fines and penalties, notification expenses, credit monitoring and ID theft repair, public relations expenses, and costs of liability and defense.

ARTICLE 6
CALOPTIMA RESPONSIBILITIES

6.1 **Pediatric Preventive Services Notifications**. CalOptima shall be responsible for notifying Members of Pediatric Preventive Service and CHDP screening requirements based on the schedule established by the AAP.

6.2 **Approved Drug List**. CalOptima shall publish and maintain an Approved Drug List pursuant to CalOptima Policies.

6.3 **Communication Channels**. CalOptima will assign a representative to serve as Provider's primary contact with CalOptima. The representative will coordinate contracting, education/training, and communication and will provide assistance related to this Contract.

ATTACHMENT B
COMPENSATION

CalOptima shall reimburse Provider, and Provider shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts for Covered Services provided to Members under this Contract:

1. **General Terms**. Upon submission of a Clean Claim, CalOptima shall pay Provider pursuant to this Contract, CalOptima Policies, Government Contracts, and Laws

1.1 Medically Necessary Services. This Contract does not provide incentives, nor will it be construed to provide incentives, for Providers to reduce or withhold Medically Necessary services. Provider will not alter care delivery practices, adopt billing practices, or take any other actions for the sole or primary purpose of reducing Medically Necessary services. Provider will ensure the continuity of services in the event of non-payment from CalOptima in accordance with Laws and Government Contract requirements.

1.2 Due Date. If a due date provided for under this Contract is a weekend or State or federal holiday, any such report, objection, or payment will be due the following Business Day.

1.3 File Transfer. The Parties agree to deliver the confidential data utilizing a secure file transfer protocol ("**SFTP**") process. The Parties will establish a SFTP site and provide the credentials necessary to access and push files to the site.

1.4 Supplemental Pay-for-Performance Payment. CalOptima may authorize supplemental payments to Provider yearly or quarterly based on Provider's quality performance and achievement specified program goals, as determined by CalOptima in its sole discretion in accordance with applicable laws and CalOptima Policies. CalOptima shall not pay Provider any supplemental payments if this Contract terminates.

2. **Payment**.

2.1 Medi-Cal.

2.1.1 For Covered Services provided to Medi-Cal Members, CalOptima shall reimburse Provider for Covered Services as follows:

2.1.1.1 **Professional Services: XXX% of the CalOptima Medi-Cal Fee Schedule**, as defined in CalOptima Policies, in effect for the date of service.

2.1.1.2 **Non-Professional Services: Non-professional services shall be paid at XXX% of the CalOptima Medi-Cal Fee Schedule**, as defined in the CalOptima Policies, in effect for the date of service.

2.1.2 *Targeted Rate Increase Services*. If applicable, for services subject to the TRI provided by a qualified professional, CalOptima will reimburse Provider at the greater of the contracted rates, outlined above plus any applicable supplemental payments, or the Medi-Cal TRI fee schedule rate in effect for the date of service; provided, however, in no event will Provider be reimbursed at less than the Medi-Cal TRI fee schedule in effect for the date of service. Reimbursement for TRI

services shall comply with DHCS Program requirements, Laws, and CalOptima Policies.

2.2 OneCare.

2.2.1 For Covered Services provided to OneCare Members, CalOptima shall reimburse Provider as follows:

2.2.1.1 **XXX % of the Medicare Allowable Fee Schedule**, in effect for the date of service.

2.3 PACE.

2.3.1 For Covered Services provided to PACE Members, CalOptima shall reimburse Provider as follows:

2.3.1.1 **XXX% of the Medicare Allowable Fee Schedule**, in effect for the date of service.

2.4 Covered California.

2.4.1 For Covered Services provided to Covered California Members, CalOptima shall reimburse Provider as follows:

2.4.1.1 [INSERT PAYMENT STRUCTURE, ADDING SUBSECTIONS AS NECESSARY]

2.5 Claims Requirements. Provider shall submit all Claims to CalOptima, and CalOptima shall pay all Claims, in accordance with Medi-Cal or Medicare billing rules, guidelines, and payment policies. Services not contained in the Current Medi-Cal or Medicare Fee Schedule at the time of services are not reimbursed under this Contract.

2.6 Services with Unestablished Fees. If a fee is determined to be "By Report & Unlisted" under the applicable CalOptima fee schedule, payment shall be under the following guidelines:

2.6.1 "By Report & Unlisted" codes that CalOptima has provided Authorization for Provider to provide such services

[Alternative Language 1 will be paid at XX% of Provider's full billed charges and must follow applicable Medi-Cal and Medicare billing rules and guidelines when reimbursed at Medi-Cal or Medicare rates.].

[Alternative Language 2 will be billed and paid at Medi-Cal or Medicare rules and guidelines when reimbursed at Medi-Cal or Medicare rates. When billing CalOptima for these codes, Provider shall include documentation of Covered Services provided, as required by this Contract, CalOptima Policies, and Laws.]

[Alternative 3

2.6.1 When total billed charges for a claim line are less than $XXX total, regardless of the number of units billed, payment shall be made at XX% of Provider's usual, customary, and reasonable billed charges

2.6.2 When total billed charges for a claim line meet or exceed $XXX total, regardless of the number of units billed, payment shall be made per the applicable billing rules and guidance: Medicare for Medicare rates and Medi-Cal for Medi-Cal rates. Provider shall include all necessary documentation of the Covered Services provided, as required by the Contract, CalOptima Policies, and applicable laws and regulations.]

2.7 Vaccines. If applicable to the services rendered by Provider under this Contract, CalOptima shall not reimburse Provider for the cost of vaccines that are available under the Centers for Disease Control and Prevention's Vaccines for Children program, which provides free vaccines for eligible populations, including Medi-Cal-covered children ages eighteen (18) years and younger. For all other vaccines, CalOptima will reimburse Provider at the current Medi-Cal Fee schedule for vaccines that are recommended by the DHCS Early and Periodic Screening, Diagnostic and Treatment/American Academy of Pediatrics for ages nineteen (19) and over when billing is submitted on a CMS-1500, UB-04 claim form or the electronic equivalent.

3. **Payment Procedures**.

3.1 Claims Submission. Provider shall submit to CalOptima an accurate, complete, descriptive, and timely Claim that includes the Member's name and identification number, description of services, and date(s) of service. Provider may not submit a Claim before the delivery of service. Provider shall submit all Claims to CalOptima as directed in the applicable CalOptima Policies. Provider is not eligible for payment on Claims submitted after ninety (90) days from the date of service, unless CalOptima is required to follow a different minimum Claims submission timeframe pursuant to Laws or Government Contracts. When CalOptima is the secondary payer, Provider is not eligible for payment for Claims submitted after ninety (90) days from the date the primary payer adjudicated the Claim, unless CalOptima is required to follow a different minimum Claims submission timeframe pursuant to Laws or Government Contracts. Provider is solely responsible for reimbursing its Contracted Providers for providing Covered Services for Provider under this Contract and shall ensure that all Contracted Providers agree to accept payment from Provider as payment in full for Covered Services provided to Members.

3.2 Payment Codes and Modifiers. Provider shall utilize current payment codes and modifiers for Medi-Cal or Medicare when billing CalOptima. CPT or HCPCS codes not contained in the Medi-Cal or Medicare fee schedule at the time of service are not reimbursable.

3.3 Claims Requiring Additional Justification. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Provider for additional justification, and these will be handled on a case-by-case basis.

3.4 Prompt Payment. CalOptima shall make payments to Provider in the time and manner set forth in CalOptima Policies and Laws.

3.5 Claims Deficiencies. CalOptima shall deny payment for any Claim that fails to meet requirements set forth in CalOptima Policies and Laws for Claims processing, and CalOptima shall notify Provider of any denial pursuant to CalOptima Policies and Laws.

3.6 Claims Auditing. Provider acknowledges CalOptima's right to conduct post-payment billing audits under this Contract. Provider and its Contracted Providers will cooperate with CalOptima's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting records and other related data. CalOptima will use established industry standards and federal and State guidelines to determine the appropriateness of the billing, coding, and payment. This section will survive any termination of the Contract.

3.7 Crossover Claims. The Medi-Cal reimbursement rates in this Contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims, CalOptima will reimburse Provider in accordance with CalOptima Policies, Laws, DHCS Contract, and Program requirements. California law limits Medi-Cal reimbursement for a Crossover Claim to an amount that, when combined with the Medicare or other health coverage ("**OHC**") payment, does not exceed Medi-Cal's maximum allowed for similar services as required by Welfare and Institutions Code § 14109.5. "**Crossover Claim(s)**" means claims for Dual Eligible Members where Medi-Cal is the secondary payer and Medicare or OHC is the primary payor for dates of service. "**Dual Eligible Members**" are Members who are eligible for both Medicare or OHC and Medi-Cal benefits.

3.8 Sequestration. As applicable to OneCare or PACE, if CMS reduces payment to CalOptima under the applicable CMS Contract by more than two percent (2%) at any time during the Term, CalOptima may, upon written notice to Provider, reduce payment to Provider under this Attachment B by the same percentage that CMS reduced payment to CalOptima for OneCare or PACE, respectively. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) for a Program during the Term.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2026
Regular Meeting of the CalOptima Health Board of Directors

Report Item

20. Approve the three-year pilot Whole Child Model Transition Program, inclusive of an Adult Primary Care Provider Incentive Payment Model, to support California Children's Services Members Transitioning from Pediatric to Adult Care

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481
Kelly Giardina, Executive Director, Clinical Operations, (657) 900-1013

Recommended Actions

1. Approve an enhanced three-year pilot Whole Child Model Transition Program to support California Children's Services members transitioning from pediatric to adult care.
2. Approve the Adult Primary Care Provider Incentive Payment Model, including:
   a. One-time payment for acceptance of complex transitioning members;
   b. Payments for successful specialist transitions; and
   c. Payments for participation in Integrated Care Team meetings.
3. Approve the implementation of the Adult Primary Care Provider Incentive Model across all delegated health networks for a three-year pilot period to begin no earlier than January 1, 2027, and to end no later than July 1, 2030.
4. Authorize the Chief Executive Officer, or designee, to draft and execute contract amendments for participating in the CalOptima Health Community Network adult Primary Care Providers and contracted health networks, and to finalize program design and implementation, including the refinement of eligibility criteria, performance metrics, and payment mechanisms.

Background

California Children's Services (CCS) members enrolled in the Whole Child Model (WCM) transition to adult care at age 21 and frequently experience significant disruptions in continuity of care. This transition, commonly referred to as the "cliff," is driven by fragmentation within the adult provider system, a lack of provider readiness to manage medically complex transitioning members, and the loss of established pediatric care relationships. Despite coverage of medical services, the lack of targeted fiscal support for adult-serving providers contributes to systemic gaps that heighten the risk of unmet continuity of care needs, delays in obtaining services, and avoidable acute care utilization.

CalOptima Health launched the "Come to the Table" collaborative to address these challenges by strengthening coordinated, systemwide communication and enhancing the sharing of best practices. The initiative connects health networks (HNs), pediatric and adult providers, community-based organizations, and key partners to align transition planning and enhance provider engagement across the continuum of care. A key priority of the collaborative is to improve coordination between pediatric providers and accept adult primary care providers (PCPs), supporting timely member acceptance, well-structured handoffs, and continuity of clinical management for complex individuals. It was through this collaborative effort – where systemwide challenges and solutions were jointly examined – that the PCP incentive model took shape. To further highlight the significance of these incentive payments, the

Back to Agenda

Department of Health Care Services' (DHCS) recent contract amendment now emphasizes that managed care plans are required to identify and support transition plans for CCS members at ages 17 and 20.

Discussion

Program Design

The proposed WCM Transition Program establishes a structured, provider-led framework to support CCS members as they move from pediatric to adult care. The WCM Transition Program focuses on high-complexity members beginning at age 19 and prioritizes early engagement and coordinated transition planning between pediatric providers and accepting adult PCPs. The engagement and coordinated transition planning provided by the WCM Transition Program will be in addition to the engagement and coordinated transition planning that CalOptima Health is required to provide by DHCS and CCS.

Core components of the WCM Transition Program include:

- Formalized handoffs between pediatricians and adult PCPs, including shared clinical information and transition planning;
- Ongoing Integrated Care Team (ICT) meetings to support multidisciplinary coordination;
- Defined expectations for adult PCP acceptance and engagement, including integration with specialty providers; and
- Active participation of members, families, and caregivers throughout the transition process to support informed decision-making and continuity of care.

CalOptima Health will implement the WCM Transition Program for a three-year pilot period, accompanied by a formal evaluation to assess outcomes, provider participation, and long-term scalability.

PCP Incentive Model Framework

Staff has designed the Adult PCP Incentive Payment Model to directly address barriers to provider participation by compensating adult PCPs for the additional time, coordination, and clinical complexity associated with accepting transitioning CCS members.

CalOptima Health will implement the incentive model across all delegated HNs, including individual practitioners within the CalOptima Health Community Network and group-level HNs. This approach ensures consistent provider engagement and equitable access for members and will operate for a three-year pilot period, aligned with the overall program evaluation timeline.

The Adult PCP Incentive Payment Model supports:

- Timely acceptance of members by adult PCPs across all HNs;
- Active coordination between pediatric providers and accepting adult PCPs during the transition period; and
- Ongoing engagement in care coordination activities, including ICT participation and specialist integration.

Back to Agenda

The proposed approach integrates financial incentives with structured care coordination and stakeholder engagement to address longstanding gaps in the transition from pediatric to adult care. Staff anticipates the WCM Transition Program to do the following:

- Improve continuity of care through strengthened coordination between pediatric and adult PCPs;
- Increase adult PCP participation and readiness to manage complex transitioning members;
- Enhance member, family, and caregiver experience and engagement during the transition process; and
- Reduce avoidable emergency department visits and inpatient utilization through improved continuity of care and access.

Fiscal Impact

Based on projected transition volumes, staff estimates the total cost for the three-year pilot WCM Transition Program at approximately $3.0 million. Staff budgeted the funding for the WCM Transition Program through June 30, 2027. To the extent there is any additional fiscal impact, staff will address such impact in separate CalOptima Health Board actions. Management will include expenses for the period of July 1, 2027, and after in future operating budgets.

Rationale for Recommendation

Approval of the WCM Transition Program and Adult PCP Incentive Program will address a critical, well-documented gap in continuity of care for high-risk members aging out of CCS pediatric services.

The proposed model aligns with clinical and financial incentives to foster early provider engagement, strengthen accountable handoffs between pediatric and adult providers, and support sustained coordination throughout the transition. By intentionally incorporating family and caregiver involvement, the WCM Transition Program and Adult PCP Incentive Program further promote informed decision-making and reinforce continuity of care during this highly vulnerable period for these members.

This approach advances CalOptima Health's strategic priorities by strengthening provider network capacity, improving health outcomes for medically complex populations, and reducing avoidable utilization through enhanced care coordination.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

None.

/s/ Michael Hunn *07/28/2026*
Authorized Signature **Date**

Back to Agenda

CalOptima Health Board Action Agenda Referral

Action To Be Taken August 6, 2026
Regular Meeting of the CalOptima Health Board of Directors

Report Item

21. Authorize Actions Related to Contracting for Hair Removal Services for Transgender and Gender Diverse Members in the CalOptima Health Direct Medi-Cal Program

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 923-8834
Michael Gomez, Executive Director, Network Operations, (714) 347-3292

Recommended Action

Authorize the Chief Executive Officer, or designee, to negotiate and execute Professional Services Contracts and amendments to existing contracts with qualified providers for the reimbursement of hair removal services for transgender and gender diverse members in the CalOptima Health Direct Medi-Cal program, effective on or after September 1, 2026.

Background and Discussion

On October 26, 2020, the California Department of Health Care Services (DHCS) released All Plan Letter (APL) 20-018 (superseding APL 16-013 released on October 6, 2016) providing managed care plans (MCPs) with guidance regarding access to transgender services. The APL specifies that MCPs must provide medically necessary covered services to all members and must analyze transgender service requests under the applicable medical necessity standard for services to treat gender dysphoria.

As outlined in the APL, "nationally recognized medical experts in the field of transgender health care have identified the following core services in treating gender dysphoria: mental health services; psychotherapy; hormone therapy; and a variety of surgical procedures and treatments that bring primary and secondary gender characteristics into conformity with the individual's identified gender. Surgical procedures and treatments that bring secondary gender characteristics into conformity with an individual's identified gender may include, but are not limited to, sex reassignment surgery, facial gender confirmation surgery, body contouring, **hair removal**, and voice therapy and vocal surgery, if these services are determined to be medically necessary to treat a member's gender dysphoria, or if the services meet the statutory definition of reconstructive surgery." [1]

Currently, CalOptima Health lacks formal agreements with qualified providers for hair removal services for transgender and gender diverse members in the CalOptima Health Direct Medi-Cal program. In the absence of such agreements and a fixed reimbursement framework, CalOptima Health reimburses providers through single-case letters of agreement. Staff has established definitive rate structures based on prior reimbursement patterns and rate proposals presented by community providers. These rates will support the development of formal contracts with qualified providers to ensure timely access to medically necessary hair removal services for CalOptima Health Direct Medi-Cal members requiring transgender services.

Therefore, staff requests authority to negotiate and execute Professional Services Contracts with qualified providers for the provision of hair removal services for transgender and gender diverse members,

[1] APL-20-018, available to view at APL 20-018 (ca.gov) (emphasis added).

Back to Agenda

including establishing market-appropriate pricing parameters to ensure rates are consistent with prevailing industry standards and are fiscally responsible for CalOptima Health.

Fiscal Impact

Based on historical utilization, staff estimates the annual fiscal impact for reimbursement of hair removal services for transgender and gender diverse CalOptima Health Direct Medi-Cal members not to exceed $15,000 or $12,500 for the period of September 1, 2026, through June 30, 2027. There is no net fiscal impact because the forecasted expense trend included in the Fiscal Year 2026-27 Operating Budget will be sufficient to cover the anticipated costs. Staff will monitor the actual cost and utilization of the benefit as implementation occurs.

Rationale for Recommendation

The recommended action will support continued access for CalOptima Health Direct Medi-Cal members to a network of providers enabling members to receive medically necessary services.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. Draft Professional Services Contract

/s/ Micheal Hunn — *07/28/2026*
Authorized Signature — **Date**

Back to Agenda

Attachment to the August 6, 2026, Board of Directors Meeting – Agenda Item # 21

CONTRACTED/ IMPACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Mr. Electrolysis	404 Westminster Ave, Unit 2	Newport Beach	CA	92663
Transgender Health and Wellness Center	6800 Indiana Ave, Suite 150	Riverside	CA	92506
Sung M.D., dba True Dermatology	180 Newport Center Dr., Suite 225	Newport	CA	92660

Back to Agenda Back to Item

PROFESSIONAL SERVICES CONTRACT
GENERAL PROVISIONS

This Professional Services Contract (the "Contract") is entered into by and between Orange County Health Authority, a Public Agency, dba CalOptima Health ("**CalOptima**") and **«Provider_Name_as_listed_on_W9» ("Professional")**, with respect to the following:

RECITALS

A. CalOptima was formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended by Ordinance Nos. 00-8 and 05-008, as a result of the efforts of the Orange County health care community as amended.

B. CalOptima has entered into a contract with the State of California, Department of Health Care Services ("DHCS") ("DHCS Contract"), pursuant to which it is obligated to arrange and pay for the provision of health care services to certain Medi-Cal eligible beneficiaries in Orange County (referred to herein as the "Medi-Cal Program").

C. CalOptima has entered into a contract with the Centers for Medicare and Medicaid Services ("CMS") to operate a Program of All-Inclusive Care for the Elderly ("PACE") as a PACE Organization for the purposes set forth in sections 1894 and 1934 of the Social Security Act, and to offer eligible individuals services through PACE.

D. CalOptima has entered into a contract with the Department of Health and Human Services ("HHS"), Centers for Medicare and Medicaid Services ("CMS"), ("CMS Contract") to operate a Medicare Advantage ("MA") plan and to offer Medicare covered items and services to eligible individuals (referred to herein as the "OneCare Program". CalOptima may only enroll those dual eligible individuals who meet all applicable Medicare Advantage eligibility requirements, and who are eligible to be enrolled in CalOptima's Medi-Cal Managed Care plan, as described in the contract between CalOptima and DHCS.

E. Professional is a provider of the items and services described in this Contract and has all certifications, licenses and permits necessary to furnish such items and services.

F. CalOptima desires to engage Professional to furnish, and Professional desires to furnish, certain items and services to CalOptima Members eligible as described herein.

G. Professional intends to provide services under this Contract identified in Attachment A.

H. CalOptima and Professional desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, the parties agree to the terms and conditions set forth in these General Provisions and all Attachments, and Addendums attached or incorporated by reference in these General Provisions as follows:

ARTICLE 1
ATTACHMENTS, ADDENDUMS, PROVIDER MANUAL, POLICIES

Documents Constituting Contract. This Contract includes, and the parties agree to be bound by, each of the following:

1.1 Attachments.

1.1.1 Attachment A, Contracted Services, contains the CalOptima Programs, Physician Services and description of the responsibilities and performance requirements of Professional pursuant to this Contract based upon the type of Covered Services to be provided by Professional under this Contract.

1.1.2 Attachment B, Compensation, contains the specific payment rate(s) and/or fee(s) to be paid to Professional for the delivery of Covered Services and the compensation method to be

employed pursuant to this Contract, which terms shall control in the event of a conflict with these General Provisions.

1.1.3 Attachment C, Intentionally Left Blank.

1.1.4 Attachment D, Special Provisions, if attached to this Contract sets forth Special Provisions which are Professional specific terms and conditions as deemed needed and appropriate by CalOptima. If Special Provisions conflict with the General Provisions or any other Attachments, the Special Provisions shall govern.

1.1.5 Attachment E, Disclosure Form, Professional shall complete any changes to Professional's ownership, as identified in Article 3, Section 3.13, on Attachment E, Disclosure Form.

1.2 Addendums.

1.2.1 The Addendums are terms and conditions that apply specifically to items and services provided to Members under the CalOptima Programs as follows:

1.2.1.1 Addendum 1: Medi-Cal Program Requirements

1.2.1.2 Addendum 2: PACE Program Requirements

1.2.1.3 Addendum 3: OneCare Program Requirements

1.2.1.4 Addendum 4: Certification Regarding Lobbying

1.3 Policies. CalOptima has established, and from time to time may establish and revise, Policies and Procedures for activities related to management of Covered Services ("Policy" or "Policies"). The Policies cover, by way of example and not limitation, the following areas: network management, quality management, utilization review, credentialing, peer review, claims billing and reimbursement, member rights and responsibilities and grievances and appeals. Professional shall abide by all of the Policies that apply to the activities of Professional under this Contract. CalOptima shall set forth or describe the Policies in the Provider Manual, provider newsletters or other written communications to Professional. CalOptima shall make available to Professional new or revised Policies of which Professional must comply with those Policies.

1.4 Provider Manual. "Provider Manual" means CalOptima's Provider Manual which contains guidelines, Policies and procedures and other information relative to performance under this Contract. CalOptima will revise the Provider Manual from time to time. The Provider Manual may be revised by CalOptima by issuing updates, newsletters or bulletins, all of which will be effective upon receipt by Professional or as otherwise specified in such updates, newsletters or bulletins.

ARTICLE 2
DEFINITIONS

The following definitions, and any additional definitions set forth in Attachments, Addendums and Schedules attached hereto, apply to the terms set forth in this Contract:

2.1 "Accreditation Organization" means any organization including without limitation, the National Committee for Quality Assurance (NCQA), The Joint Commission (TJC) and/or other entities engaged in accrediting, certifying and/or approving CalOptima, Professional and/or their respective programs, centers or services.

2.2 "Adult Expansion Member" means a Member enrolled in aid codes L1 and M1 as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y).

2.3 "Advance Directive" means a written instruction (such as that required under the Federal Patient Self-Determination Act, 42 U.S.C. Sections 1395cc(f) and 1396a(w), and implementing regulations, the California Health Care Decisions Law, Probate Code Sections 4600 et seq., or durable power of attorney for health care), relating to the provision of medical care when an individual is incapacitated.

2.4 "Appeal" means a Member's actions, both internal and external to CalOptima, requesting review of the denial, reduction or termination of benefits or services from CalOptima. Appeals relating to CalOptima Covered Services shall proceed pursuant to the laws and regulations governing Medi-Cal appeals, and appeals relating to Medicare covered benefits and services shall proceed pursuant to laws and regulations relating to Medicare appeals.

2.5 "Approved Drug List" means CalOptima's continually updated list of medications and supplies that may be obtained without prior authorization.

2.6 "Assigned Members" means Members that CalOptima has assigned to a Primary Care Provider on the date of service according to CalOptima's electronic Member management information systems. CalOptima shall make no warranties or representations regarding the number of Members, if any, who will be assigned to the Primary Care Provider or the duration of the Primary Care Provider's participation in the program.

2.7 "Behavioral Health Services" means the mental health services provided through the Mental Health Plan or CalOptima or their Subcontractors, and substance use disorder services.

2.8 This section is intentionally left blank

2.9 "California Children's Services (CCS)" means those services authorized by the CCS Services Program for the diagnosis and treatment of the CCS Services Eligible Conditions of a specific Member.

2.10 "California Children's Services (CCS) Eligible Condition(s)", means a physically handicapping condition defined in Title 22 CCR Section 41515.2 through 41518.9.

2.11 "California Children's Services (CCS) Program" means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (21) years who have CCS Eligible Conditions.

2.12 "CalOptima Direct" or "COD" means a Medi-Cal program CalOptima administers for CalOptima beneficiaries not enrolled in a Health Network. COD consists of two components:

2.12.1 CalOptima Direct Members who are assigned to CalOptima's Community Network in accordance with CalOptima Policy. Members are assigned to Primary Care Providers (PCP) as their medical home, and their care is coordinated through their PCP in the Community Network.

2.12.2 "CalOptima Direct—Administrative" or "COD-Administrative," provides services to Members who reside outside of CalOptima's service area, are transitioning into a contracted Health Network, have a Medi-Cal Share of Cost, or are eligible for both Medicare and Medi-Cal. These Members are free to select any Medi-Cal enrolled practitioner for physician services and will not be assigned to a PCP.

2.13 "CalOptima Policies" means CalOptima Policies and Procedures relevant to this Contract, as amended from time to time at the sole discretion of CalOptima.

2.14 "CalOptima Program(s)" means the Medi-Cal, PACE, and OneCare Programs administered by CalOptima. Professional participates in the specific CalOptima program(s) identified on Attachment A.

2.15 "CalOptima's Regulators" means those government agencies that regulate and oversee CalOptima's and its Downstream Entities' activities and obligations under this Contract including, without limitation, the Department of Health and Human Services Office of Inspector General, the Centers for Medicare and Medicaid Services, the Comptroller General of the United States, the California Department of Health Care Services, and the California Department of Managed Health Care and other government agencies that have authority to set standards and oversee the performance of the parties to the Contract.

2.16 "Care Management Services" means (i) providing Physician Services including health assessments, Identification of risks, initiation of intervention and health education deemed Medically Necessary, consultation, referral for consultation and additional health care services; (ii) coordinating Medically Necessary Covered Services with other benefits not covered under this Contract; (iii) maintaining a Medical Record with documentation of referral services, and follow-up as medically indicated; (iv) ordering of therapy, admission to hospitals and coordinated hospital discharge planning that includes necessary post-discharge care; (v) participating in disease management programs as applicable (vi) coordinating a Member's care with all outside agencies pertinent to their needs as addressed in the MOUs and CalOptima Policies; and (vii) coordinating care for Members transitioning from CalOptima Direct to a Health Network.

2.17 "CCS Provider(s)" or "CCS-Paneled Provider(s)", means any of the following providers when used to treat Members for a CCS condition:

(a) A medical provider that is paneled by the CCS Program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800 of Chapter 3 of Part 2 of Division 106.

(b) A licensed acute care hospital approved by the CCS Program.

(c) A special care center approved by the CCS Program.

2.18 "Child Health and Disability Prevention" or "CHDP" means a California program defined in the Health and Safety Code Section 12402.5, et seq. that covers pediatric preventive services for eligible children receiving Medi-Cal benefits. The CHDP components are incorporated into CalOptima's Pediatric Preventive Services Program, which is often referred to as CHDP. These services are provided according to the recommended schedule and standards published by the American Academy of Pediatrics (AAP).

2.19 "Claim" means a request for payment submitted by Professional in accordance with this Contract and CalOptima Policies.

2.20 "Clean Claim" means a Claim that has no defects or improprieties, contains all required supporting documentation, passes all system edits, and does not require any additional reviews by medical staff to determine appropriateness of services provided as further defined in the applicable CalOptima Program(s).

2.21 **"**Community Network" means CalOptima's direct health network that serves members who are enrolled in it pursuant to CalOptima Policies. Community Network Members are assigned to Primary Care Providers as their medical home, and their care is coordinated through the PCP.

2.22 "Compliance Program" means the program (including, without limitation, the compliance manual, code of conduct and CalOptima Policies) developed and adopted by CalOptima to promote, monitor and ensure that CalOptima's operations and practices and the practices of its Board members, employees, contractors and Providers comply with applicable law and ethical standards. The Compliance Program includes CalOptima's Fraud, Waste and Abuse ("FWA") plan

2.23 "Concentration Languages" means those languages spoken by at least 1,000 Members whose primary language is other than English in a ZIP code, or at least 1,500 such Members in two contiguous ZIP codes.

2.24 "Coordination of Benefits" or "COB" refers to the determination of order of financial responsibility which applies when two or more health benefit plans provide coverage of items and services for an individual.

2.25 "Covered Services" means those services provided under the Fee-for-Service Medi-Cal program, as set forth in Article 4, Chapter 3 (beginning with Section 51301), Subdivision 1, Division 3, Title 22, CCR, and Article 4 (beginning with Section 6840), Subchapter 13, Chapter 4, Division 1 of Title 17, CCR, which (i) are included as Covered Services under the State Contract; and (ii) are Medically Necessary, as described in Attachment A (which may be revised from time to time at the discretion of CalOptima), along with chiropractic services (as defined in Section 51308 of Title

22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR) and effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Covered Services shall also include CCS Services (as defined in Subdivision 7 of Division 2 of Title 22 of the California Code of Regulations), which shall be covered for Members, notwithstanding whether such benefits are provided under the Fee-for-Service Medi-Cal Program.

2.26 "Downstream Entity" means all of Professional's Practitioners and other persons or entities with which Professional has entered into a written subcontract (acceptable to CMS) to perform administrative functions and/or health care services to satisfy Professional's obligations to CalOptima under this Contract, continuing down to the ultimate provider of services. The term "Professional" as used in the terms of this Contract shall also include its Subcontractors when such Subcontractors are Subcontractors as defined herein even if not expressly referenced in the particular provision.

2.27 "Effective Date" means the effective date of commencement of the Contract as provided in Article 10.

2.28 "Emergency Medical Condition" means a medical condition which is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

2.28.1 placing the health of the individual (or, in the case of a pregnant woman, the health of the woman and her unborn child) in serious jeopardy; or

2.28.2 serious impairment to bodily functions; or

2.28.3 serious dysfunction of any bodily organ or part.

2.29 "Emergency Services" means those health care services (including inpatient and outpatient) that are Covered Services and for which Practitioners are duly licensed and qualified to furnish that are needed to evaluate or stabilize an Emergency Medical Condition.

2.30 "Encounter Data" means the record of a Member receiving any items(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated or any other risk basis payment methodology submitted to CMS. The encounter data record shall incorporate HIPAA security, privacy, and transaction standards and be submitted in ASCX12N 837 or any successor format required by CalOptima's Regulators.

2.31 "Family Planning" means Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to: 1) medical and surgical services performed by and under the direct supervision of a licensed physician for the purposes of Family Planning; 2) laboratory and radiology procedures, drugs and devices prescribed by a licensed physician and/or associated with Family Planning procedures; 3) patient visits for the purpose of Family Planning; 4) Family Planning counseling services provided during a regular patient visit; 5) tubal ligations; 6) vasectomies; 7) contraceptive drugs or devices; and, 8) treatment for complications resulting from previous Family Planning procedures. Family Planning does not include services for the treatment of infertility or reversal of sterilization.

2.32 "Formulary" or "CalOptima Formulary" shall mean, the CalOptima Approved Drug List, the Disposable Medical Equipment/Supplies List, the CalOptima OneCare Formulary, and any additional Formularies as may be designated by CalOptima and provided to PBM. There is no applicable Formulary for the PACE program.

2.33 “Government Agencies” means Federal and State agencies that are parties to the Government Contracts, including HHS/CMS, DHCS, DMHC and their respective agents and contractors, including quality improvement organizations (QIOs).

2.34 “Government Contract(s)” means the written contract(s) between CalOptima and the Federal and/or State government pursuant to which CalOptima administers and pays for covered items and services under a CalOptima Program.

2.35 “Government Guidance” means Federal and State operational and other instructions related to the coverage, payment and/or administration of CalOptima Programs.

2.36 “Grievance” means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration, or Appeal made by a Member.

2.37 “Health Network” means a physician group, physician-hospital consortium or health care service plan, such as an HMO, which is contracted with CalOptima to provide items and services to Members on a capitated basis.

2.38 “HealthCare Effectiveness Data and Information Set” or “HEDIS” means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).

2.39 "Health Risk Assessment” or “HRA” means the assessment tool which identifies a Member’s primary, acute, Long-Term Supports and Services (LTSS), Behavioral Health and functional needs.

2.40 “Hospital Services” means those Medically Necessary inpatient and outpatient hospital services, including medical services and supplies, that are Covered Services.

2.41 “Hospitalist” means a CalOptima-contracted Physician responsible for providing all Primary Care Provider services within his or her scope of practice for Members receiving inpatient care at identified hospitals.

2.42 “Individualized Care Plan” or “ICP” means the plan of care developed by a Member and/or his/her Interdisciplinary Care Team or CalOptima.

2.43 “Interdisciplinary Care Team” or “ICT” means a team comprised of the primary care provider and Care Coordinator and other providers at the discretion of the Member that work with the Member to develop, implement and maintain the ICP.

2.44 “Licenses” means all licenses and permits that Professional is required to have in order to participate in the CalOptima Programs and/or furnish the items and/or services described under this Contract.

2.45 “Long Term Care Facility” means a facility that is licensed to provide skilled nursing facility services, intermediate care facility services or sub-acute care services.

2.46 “Medi-Cal” is the name of the Medicaid program for the State of California (i.e., the program authorized by Title XIX of the Federal Social Security Act and the regulations promulgated thereunder).

2.47 “Medi-Cal Specialty Mental Health Services” mean those services specified in Title 9 CCR Section 1810.247 provided through a MHP (and not including the Medi-Cal Managed Care Behavioral Health Services specified in Welfare & Institutions Code Section 14132.03 required to be provided by CalOptima).

2.48 “Medical Necessity” or “Medically Necessary” means reasonable and necessary services to protect life, to prevent illness or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22, CCR Section 51303 (a) and 42 CFR 438.210 (a)(5). When determining the Medical Necessity for a Medi-Cal beneficiary under the age of 21, “Medical Necessity” is expanded to include the standards set forth in 42 USC Section 1396d (r), and W&I Code Section 14132(v).

2.49 "Medical Record" means any record kept or required to be kept by any Provider that documents all of the medical services received by the Member, including, without limitation, inpatient, outpatient, emergency care, and Referral requests and authorizations, as required to be kept pursuant to applicable State and Federal laws and CalOptima Policies.

2.50 "Medicare" means the Federal health insurance program defined in Title XVIII of the Federal Social Security Act and regulations promulgated thereunder.

2.51 "Medicare Secondary Payer" or "MSP" means the Medicare coordination of benefits (COB) requirements as incorporated in MA regulations.

2.52 "Member" means any person who has been determined to be eligible to receive benefits from, and is enrolled in, one or more CalOptima Program. Member may also be referred to as Member or Participant depending on the CalOptima Program.

2.53 "Memorandum/Memoranda of Understanding" or "MOU" means an agreement(s) between CalOptima and an external agency(ies), which delineates responsibilities for coordinating care to CalOptima Members.

2.54 "Mental Health Plan" or "MHP" means the entity that has contracted with DHCS to provide Medi-Cal Specialty Mental Health Services. The Orange County Health Care Agency is the MHP for Medi-Cal Specialty Mental Health Services for residents of Orange County, California.

2.55 "Minimum Provider Standards" means the minimum participation criteria established by CalOptima for specified Practitioners that must be satisfied in order for a Practitioner to submit claims and/or receive reimbursement from the CalOptima program for items and/or services furnished to CalOptima Members as identified in CalOptima Policies.

2.56 "Model of Care" means the component of CalOptima's quality improvement framework that is evidence-based, includes certain clinical and non-clinical elements, and is in addition to the comprehensive care coordination requirements specified in CalOptima Policies.

2.57 "Non-Covered Services" means those items and services that are not covered benefits under a particular CalOptima Program in accordance with the Evidence of Coverage or Member handbook and applicable State and Federal laws and regulations.

2.58 "Non-Participating Provider" means a Provider of health care services who has not entered into a written agreement with CalOptima, either directly or through another organization, to provide Covered Services to Members.

2.59 "Non-Physician Medical Practitioner" (Mid-Level Practitioner) means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.

2.60 "Outpatient Mental Health Services" means outpatient services that CalOptima will provide for members with mild to moderate mental health conditions including: individual or group mental health evaluation and treatment (psychotherapy); psychological testing when clinically indicated to evaluate mental health condition; psychiatric consultation for medication management; and outpatient laboratory, supplies and supplements.

2.61 "Participating Provider" means a Provider of health care services who has entered into a written agreement with CalOptima to provide Covered Services to Members.

2.62 "Pediatric Preventive Services" means well child services which incorporate CHDP and the American Academy of Pediatrics Guidelines for Health Supervision.

2.63 "Personal Care Coordinator" or "PCC" is a dedicated non-licensed care coordinator, assigned to each Medi-Cal member with an active SPD aid code, supervised by a licensed person for the CalOptima PCC Program.

2.64 "PCC Program" means the Personal Care Coordinator Program identified in CalOptima Policies.

2.65 "Physician" means a person with an unrestricted license to practice medicine or osteopathy in the state in which they practice, or a group practice, independent practice association or other formal business arrangement comprised of persons with such licensure.

2.66 "Physician Services" means those services within Professional's scope of practice and license and which are Covered Services and furnished by a Practitioner under the direct supervision of a Physician, to Members pursuant to this Contract, as identified in Attachment A.

2.67 "Practitioner" means a licensed practitioner, including a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine, Doctor of Chiropractic Medicine (DC), and a Doctor of Dental Surgery (DDS) or a Non-Physician Medical Practitioner furnishing Covered Services under medical benefits, as described in CalOptima Policies and who is contracted under this Contract.

2.68 "Preclusion List" means the CMS-compiled list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

2.69 "Primary Care Provider (PCP)" means a Participating Provider who is a physician, clinic, a nurse practitioner or physician's assistant who:

a) is licensed by the State of California, or the state in which the PCP practices, to practice in the fields of general medicine, internal medicine, family practice, pediatrics, or obstetrics and gynecology; and

b) assumes primary responsibility for supervising, coordinating and providing initial primary and preventive care to Members, initiating referrals for specialty care, following specialty care, and maintaining continuity of care.

2.70 "Primary Care Provider Services" means Covered Services provided by a Primary Care Provider to assigned Members as set forth in Attachment A of this Contract.

2.71 "Prior Authorization" means the process by which CalOptima approves, usually in advance of the rendering, requested medical and other services pursuant to the utilization management program for the CalOptima Programs.

2.72 "Program of All-Inclusive Care for the Elderly" or "PACE" means a program that features a comprehensive medical and social services delivery system using an Interdisciplinary Team (IDT) approach in an adult day health center that is supplemented by in-home and referral services, in accordance with the Member's needs. The IDT is the group of individuals to which a PACE participant is assigned who are knowledgeable clinical and non-clinical PACE center staff responsible for the holistic needs of the PACE participant and who work in an interactive and collaborative manner to manage the delivery, quality, and continuity of participants' care. All PACE program requirements and services will be managed directly through CalOptima.

PACE Services shall include the following:

a) All Medicare-covered items and services

b) All Medi-Cal covered items and services; and

c) Other services determined necessary by the IDT to improve and maintain the participant's overall health status.

2.73 "Provider" means a physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization or other person or institution that furnishes health care items or services.

2.74 "Provider Manual" means the comprehensive online document, as amended from time to time, that describes CalOptima's Policies and procedures affecting Professional services under this contract.

2.75 "QMI Program" means CalOptima Quality Management and Improvement Program.

2.76 "Referral" means the process by which a Physician directs a Member to seek and obtain Covered Services from a health professional or for care at a facility.

2.77 "Screening, Brief Intervention, and Referral to Treatment (SBIRT)" means services provided by a Primary Care Provider to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs."

2.78 "Sensitive Services" means those services related to Family Planning, sexually transmitted disease (STD), abortion, and human immunodeficiency virus (HIV) testing.

2.79 "Service Area" means the geographic area that is within Orange County, California.

2.80 "Specialist Provider" means a Participating Provider of health care services who:

a) is licensed by the State of California, or the state in which the Specialist Practitioner practices, to practice in the designated specialty; and

b) assumes responsibility for providing specialty services to Members and relating pertinent information to the referring provider.

2.81 "Specialist Physician Services" means Covered Services, as set forth in Attachment A of this Contract.

2.82 "Stabilize" or "Stabilized" means with respect to an Emergency Medical Condition, to provide such medical treatment of the condition, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the individual from a facility, or in the case of a pregnant woman, the woman has delivered the child and the placenta.

2.83 "Subcontract" means a contract entered into by Professional with a party that agrees to furnish items and/or services to CalOptima Members, or administrative functions or services related to Professional fulfilling its obligation to CalOptima under the terms of this Contract if, and to the extent, permitted under this Contract.

2.84 "Subcontractor" means a person or entity who has entered into Subcontract with Professional for the purposes of filling Professional's obligations to CalOptima under the terms of this Contract. Subcontractors may also be referred to as Downstream Entities.

2.85 "Termination Date" means the date identified in Section 7.1 of this Contract.

2.86 "Threshold Languages" means those languages as determined by CalOptima from time to time based upon State requirements per MMCD Policy Letter 99-03, or any update or revision thereof.

2.87 "UM Program" means CalOptima's Utilization Management Program.

2.88 "Urgent Care" means services that are not Emergency Services and are generally services to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury for which treatment cannot be delayed as specifically defined by the rules and regulations governing the applicable CalOptima Program.

2.89 "Whole Child Model Program" or "WCM" means CalOptima's WCM program whereby CCS will be a Medi-Cal managed care plan benefit with the goal being to improve health care coordination for the whole child, rather than handle CCS Eligible Conditions separately.

2.90 "Targeted Rate Increase" or "TRI" means the set of provider rate increases authorized by Assembly Bill 118 (Chapter 42, Statutes of 2023) as implemented by DHCS. The TRI applies to eligible network providers, as defined by DHCS. The first phase of TRIs are effective for dates of service beginning January 1, 2024. For services on the Medi-Cal TRI fee schedule from eligible network providers, CalOptima and its delegates must pay the greater of the DHCS published TRI fee schedule or the then current contractual rates inclusive of any Proposition 56 supplemental payment previously due to Professional. The TRI applies to both fee-for-service and other provider payment

arrangements such as capitation payments. In the case of capitation and other prospective payment arrangements, the expected fee-for-service equivalency of those rates must be the same or greater than the TRI fee schedule rate.

ARTICLE 3
FUNCTIONS AND DUTIES OF PROFESSIONAL

3.1 Provision of Services. Professional shall furnish Physician Services identified in Attachment A to eligible Members in accordance with the terms of this Contract and CalOptima Policies.

3.1.1 Professional agrees that, to the extent feasible, Physician Services provided by it will be made available and accessible to Members promptly and in a manner which ensures continuity of care.

3.1.2 Throughout the term of this Contract, and subject to the conditions of the Contract, Professional shall maintain the quantity and quality of its services and personnel in accordance with the requirements of this Contract, to meet Professional's obligation to provide Physician Services hereunder.

3.1.3 In accordance with Section 3.23 of this Contract, Professional and its Subcontractors shall furnish Physician Services to Members under this Contract in the same manner as those services are provided to other patients, and may not impose any limitations on the acceptance of Members for care or treatment that are not imposed on other patients.

3.1.4 Only Practitioners who CalOptima has determined meet applicable CalOptima credentialing criteria may be listed as contracted. This Contract may be amended for the addition or deletion of Practitioners credentialed by CalOptima upon Professional giving CalOptima written notice of such addition or deletion at least forty-five (45) days prior to the effective date of such addition or deletion. Professional shall provide an updated list of its Practitioners as needed or upon request from CalOptima.

3.2 UM Program. Professional shall comply with CalOptima's UM Program including:

3.2.1 Professional acknowledges and agrees that CalOptima has implemented and maintains a UM Program that addresses evaluations of Medical Necessity and processes to review and approve the provision of items and services, including Physician Services, to Members. Professional shall comply with the requirements of the UM Program including, without limitation, those criteria applicable to the Physician Services as described in this Contract.

3.2.2 Professional shall comply with all Prior Authorization, concurrent and retrospective review and authorization requirements as set forth in CalOptima Policies and Provider Manual.

3.2.3 Professional shall permit CalOptima's UM Department staff and other qualified representatives of CalOptima to conduct on site reviews of the Medical Records of Members as applicable. CalOptima staff shall notify Professional prior to conducting such on site reviews and shall wear appropriate identification.

3.3 Transfer of Care. Upon request by a CalOptima Member, Professional shall assist the CalOptima Member in the orderly transfer of such CalOptima Member's medical care. In doing so, Professional shall make available to the new provider of care for the Member, copies of the Medical Records, patient files, and other pertinent information necessary for efficient medical case management of Member. In no circumstance shall a CalOptima Member be billed for this service.

3.4 CCS Eligible Services. If Professional is not a CCS-paneled Physician authorized by CCS to provide the specific CCS-eligible Services required by Members, Professional agrees to cooperate with CalOptima in the referral of Members with CCS-eligible conditions to an appropriately authorized CCS paneled Physician.

3.5 Eligibility. Professional shall verify a Member's eligibility for the applicable CalOptima Program benefits upon receiving a request for Covered Services. For Members in the Medi-Cal Program with share of cost (SOC) obligations, Professional shall collect SOC in accordance with CalOptima Policies.

3.6 Licensure/Certification of Employees and Practitioners. Each of Professional's Practitioners furnishing services under this Contract shall maintain in good standing at all times during this Contract, the necessary licenses or certifications required by State and Federal law or any Accreditation Organization to provide or arrange for the provision of Covered Services to Members.

3.7 Government Program Registration. Professional represents and warrants that it has registered with Medi-Cal and Medicare as applicable, and shall maintain, during the term of this Contract, registration to provide services to beneficiaries covered by these programs.

3.8 Good Standing. Professional and Professional's Practitioners represents it is in good standing with State licensing boards (applicable to its business), DHCS, CMS and the HHS Officer of Inspector General ("OIG"). Professional agrees to furnish CalOptima with any and all correspondence with, and notices from, these agencies of investigations and/or the issuance of criminal, civil and/or administrative sanctions (threatened or imposed) related to licensure, fraud and or abuse (execution of grand jury subpoena, search and seizure warrants, etc.), and/or Participation Status.

3.9 Notices and Citations. Professional shall notify CalOptima in writing of any report or other writing of any State or Federal agency and/or Accreditation Organization that regulates Professional that contains a citation, sanction and/or disapproval of Professional or Professional's Practitioner's failure to meet any material requirement of State or Federal law or any material standards of an Accreditation Organization.

3.10 Professional Standards. All Physician Services provided or arranged for under this Contract shall be provided or arranged by duly licensed, certified or otherwise authorized Practitioners in a manner that (i) meets the cultural and linguistic requirements of this Contract; (ii) within professionally recognized standards of practice at the time of treatment; (iii) in accordance with the provisions of CalOptima's UM and QMI Programs; and (iv) in accordance with the requirements of State and Federal law and all requirements of this Contract.

3.11 Marketing Requirements. Professional shall comply with CalOptima's marketing guidelines relevant to the pertinent CalOptima Program(s) and applicable laws and regulations.

3.12 Identification of Professional. Professional agrees that CalOptima may list the name, address, and telephone number of Professional and a description of Professional's facilities and services in CalOptima's roster of Participating Providers, which is given to Members and/or prospective Members. However, CalOptima is not obligated to list the name of any particular Provider in the roster. Professional and CalOptima agree that the use of the other party's trademarks or logos is prohibited without prior written approval of that party.

3.13 Disclosure of Professional Ownership. Professional shall fully and accurately complete the disclosure form in Attachment E and submit the disclosure form to CalOptima prior to the Effective Date. Provider Shall promptly notify CalOptima of any changes to the information contained in the disclosure form and submit an updated disclosure form to CalOptima within thirty (30) days of any such change.

3.14 Clinical Laboratory Improvement Amendments. Professional shall only use laboratories with a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratories with certificates of waiver

shall provide only the types of tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

3.15 Newborn Services. Professional shall provide all Physician Services to any newborn child or children born to a Member for the month of birth and the following month. Newborn services shall be billed under the mother's identification and paid per the compensation rates defined in Attachment B.

3.16 Advanced Directives. Professional shall maintain written Policies and Procedures related to Advanced Directives in compliance with State and Federal laws and regulations. Professional shall document patient records with respect to the existence of an Advanced Directive in accordance with applicable law. Professional shall not discriminate against any Member on the basis of that Member's Advanced Directive status. Nothing in this Contract shall be interpreted to require a Member to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services.

3.17 QMI Program and Reporting. Professional acknowledges and agrees that CalOptima is accountable for the quality of care furnished to its Members in all settings, including services furnished by Professional. Professional agrees, when reasonable and within capability of Professional, that it is subject to the requirements of CalOptima's quality management and improvement ("QMI") program and that it shall participate in QMI program, as required by CalOptima. Such activities may include the provision of requested data and the participation in assessment and performance audits and projects (including those required by CalOptima's Regulators) that support CalOptima's efforts to measure, continuously monitor, and evaluate the quality of items and services furnished to Members. Professional shall cooperate with CalOptima and CalOptima's Regulators in any complaint, appeal, or other review of Covered Services (e.g., medical necessity) and shall accept as final all decisions regarding disputes over Covered Services by CalOptima or such Regulators, as applicable, and as required under the applicable CalOptima Program.

3.17.1 Provider agrees that CalOptima may use performance data for quality and reporting purposes, including quality improvement activities, public reporting to consumers, and performance data reporting to Regulators, as identified in CalOptima Policies and required by Regulators and applicable laws.

3.17.2 Provider agrees that CalOptima may make publicly available, as frequently as CalOptima deems necessary, reports of Provider's compliance with the Contract's requirements and performance metrics, including Members' access to care, the quality of care received by Members, and Provider's other performance trends, as applicable to Provider's obligations hereunder.

3.17.3 As long as CalOptima's disclosures under this Section 2.12 otherwise comply with applicable laws, no CalOptima disclosure under this Section 2.12 shall constitute a breach of this Contract

3.18 CalOptima Oversight. Professional understands and agrees that CalOptima is responsible for the monitoring and oversight of all duties of Professional under this Contract, and that CalOptima has the authority and responsibility to: (i) implement, maintain and enforce CalOptima Policies governing Professional's duties under this Contract and/or governing CalOptima's oversight role; (ii) conduct audits, inspections and/or investigations in order to oversee Professional's performance of duties described in this Contract; (iii) require Professional to take corrective action if CalOptima or a Government Agency determines that corrective action is needed with regard to any duty under this Contract; and/or (iv) revoke the delegation of any duty, if Professional fails to meet CalOptima standards in the performance of that duty. Professional shall cooperate with CalOptima in its oversight efforts and shall take corrective action as CalOptima determines necessary to comply

with the laws, accreditation agency standards, and/or CalOptima Policies governing the duties of Professional or the oversight of those duties.

3.19 CalOptima's Compliance Program and Other Guidance. Professional, its employees, board members, owners, and Practitioners furnishing services under this Contract shall comply with the requirements of CalOptima's Compliance Program, including the Fraud Waste and Abuse plan, Provider Manual and CalOptima Policies, as may be amended from time to time. CalOptima shall make its Compliance Plan and Code of Conduct available to Professional and Professional shall make them available to Professional's Practitioners. Professional agrees to comply with, and be bound by, any and all MOUs, CalOptima financial bulletins and contract interpretation bulletins, which provide changes, updates and clarifications regarding CalOptima financial Policies and contract interpretations.

3.19.1 Prior to performing services under this contract, Provider shall complete and submit to CalOptima, any DHCS/CMS-required training and/or CalOptima required attestations related to such training and other compliance obligations.

3.20 Equal Opportunity. Professional and its Subcontractors will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Professional and its Subcontractors will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. Professional and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973, and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state Professional's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

Professional and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of Professional, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

Professional and its Downstream Entities will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of Professional's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

Professional and its Subcontractors will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

Professional and its Subcontractors will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

In the event of Professional's and its Subcontractors noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and Professional may be declared ineligible for further federal and state contracts, in accordance with procedures authorized in Federal Executive Order No. 11246 as amended, and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

Professional will include the provisions of this section in every Subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor, issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each Subcontractor or vendor. Professional will take such action with respect to any Subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions, including sanctions for noncompliance, provided, however, that in the event Professional becomes involved in, or are threatened with litigation by a Subcontractor or vendor as a result of such direction by DHCS, Professional may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

3.21 Compliance with Applicable Laws. Professional shall observe and comply with all Federal and State laws and regulations, and requirements established in Federal and/or State programs in effect when the Contract is signed or which may come into effect during the term of the Contract, which in any manner affects Professional's performance under this Contract. Professional understands and agrees that payments made by CalOptima are, in whole or in part, derived from Federal funds, and therefore Professional is subject to certain laws that are applicable to individuals and entities receiving Federal funds. Professional agrees to comply with all applicable Federal laws, regulations, reporting requirements and CMS instructions, including Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Americans with Disabilities Act. Professional agrees to include the requirements of this section in its Subcontracts. In making payments to Participating Providers and Non-Participating Providers, Professional shall comply with all applicable Federal and State laws and Government Guidance related to claims payment.

3.22 No Discrimination/Harassment (Employees). During the performance of this Contract, Professional and its Subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religion, creed, color, national

origin, ancestry, physical disability (including Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS)), mental disability, medical condition, marital status, age (over 40), gender, sexual orientation, or the use of family and medical care leave and pregnancy disability leave. Professional shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and harassment. Professional and its Subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq.) and the applicable regulations promulgated thereunder (Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Professional and its Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

3.23 No Discrimination (Member). Neither Professional nor its Subcontractors shall discriminate against Members because of race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status, physical or mental disability, or identification with any other persons or groups defined in Penal Code 422.56, in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); Civil Code Section 51 (all types of arbitrary discrimination); Section 1557 of the Patient Protection and Affordable Care Act; and all rules and regulations promulgated pursuant thereto, and all other laws regarding privacy and confidentiality.

For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (a) denying any Member any Covered Services or availability of a Physician, (b) providing to a Member any Covered Service which is different or is provided in a different name or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated, (c) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service, (d) restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, (e) treating a Member differently than others similarly situated in determining compliance with admission, enrollment, quota, eligibility, or other requirements or conditions that individuals must meet in order to be provided any Covered Service, or in assigning the times or places for the provision of such services.

Professional and its Subcontractors agrees to render Covered Services to Members in the same manner, in accordance with the same standards, and within the same time availability as offered to non-CalOptima patients. Professional and its Subcontractors shall take affirmative action to ensure that all Members are provided Covered Services without discrimination, except where medically necessary. For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include, but not be limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

Professional and its Subcontractors shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Policies.

3.24 Fraud and Abuse Reporting. Professional shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, relating to the rendering of Covered Services by Professional, whether by Professional, Professional's employees, Subcontractors, and/or Members within five (5) working days of the date when Professional first becomes aware of or is on notice of such activity.

3.25 Participation Status. Participation Status means whether or not a person or entity is or has been suspended, precluded, or excluded from participation in Federal and/or State health care programs and/or felony conviction (if applicable) as specified in CalOptima's Compliance Program and CalOptima Policies. Professional shall have Policies and Procedures to verify the Participation Status of Professional's Practitioners. In addition, Professional attests and agrees as follows:

3.25.1 Professional and Professional's Practitioners shall meet CalOptima's Participation Status requirements during the term of this Contract.

3.25.2 Professional shall immediately disclose to CalOptima, including, but not limited to, any pending investigation involving, or any determination of, suspension, exclusion or debarment of Professional or Professional's Practitioners occurring and/or discovered during the term of this Contract.

3.25.3 Professional shall take immediate action to remove any employee of Professional that does not meet Participation Status requirements from furnishing items or services related to this Contract (whether medical or administrative) to CalOptima Members which may include but not limited to adverse decisions and licensure issues.

3.25.4 Professional shall include the obligations of this Section in its Subcontracts.

3.25.5 CalOptima shall not make payment for a healthcare item or service furnished by an individual or entity that does not meet Participation Status requirements or is included on the Preclusion List. CalOptima shall provide written notice to the Member who received the services and the excluded provider or provider listed on the Preclusion List that payment will not be made, in accordance with CMS requirements.

3.26 Physical Access for Members. Professional's facilities shall comply with the requirements of Title III of the Americans with Disabilities Act of 1990, and shall ensure access for the disabled, which includes, but is not limited to, ramps, elevators, restrooms, designated parking spaces, and drinking water provision.

3.27 Smoke Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medi-Cal; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party. By signing this Contract, Professional certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994. Professional further agrees that it will insert this certification into any Subcontracts entered into that provide for children's services as described in the Act.

3.28 Member Rights. Professional shall ensure that each Member's rights, as set forth in state and federal law and CalOptima Policies and the Provider Manual, are fully respected and observed.

3.29 Professional – Member Communication. Professional shall freely communicate with patients and Members about their treatment, regardless of benefit coverage limitations. In addition, Professional, acting within the lawful scope of practice, shall freely communicate and encourage its health care professionals to freely communicate the following to patients and Members regardless of benefit coverage:

The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

3.29.1 Any information the Member needs in order to decide among all relevant treatment options.

3.29.2 The risks, benefits, and consequences of treatment or non-treatment.

3.29.3 The Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3.30 Credentialing Warranties and Requirements. Professional acknowledges that its participation in this Contract is expressly conditioned upon Professional's compliance with CalOptima's credentialing requirements and standards, including, but not limited to the following:

3.30.1 Before the Effective Date, Professional's Practitioners shall have submitted credentialing applications to CalOptima, in form and substance satisfactory to CalOptima.

3.30.2 Professional warrants and represents that, as of the Effective Date and continuing through the term of this Contract, Professional's Practitioners shall meet the credentialing standards listed below:

3.30.3 Professional's Practitioners continue to meet all applicable CalOptima credentialing and recredentialing standards, including CalOptima's Board Certification policy; and

3.30.4 Professional's Physician Providers have clinical privileges in good standing and without restriction at a CalOptima-contracted hospital designated by each Physician Provider as the primary admitting facility.

3.30.5 During the entire term of this Contract, Professional's Practitioners shall maintain their professional competence and skills commensurate with the medical standards of the community, and as required by law and this Contract, shall attend and participate in approved continuing education courses.

3.30.6 Professional's Practitioners shall be credentialed and recredentialed through CalOptima's credentialing process. Notwithstanding Professional's Practitioners' representations in any pre-application questionnaire, in this Contract and/or in connection with any Health Network credentialing application, CalOptima reserves the right to verify any and all credentialing and recredentialing requirements and any other credentialing standards that CalOptima, in its sole judgment, deems necessary and appropriate to Professional's Practitioners' eligibility to participate in CalOptima's Programs. Professional's Practitioners' participation in CalOptima's Programs is subject to CalOptima's approval of Professional's Practitioners' credentialing application. The procedure and criteria for review of Professional Practitioners' credentials and Professional's initial and continued eligibility shall be established by CalOptima, and may be amended from time to time. This Contract may be terminated by CalOptima at any time a significant portion of Professional's Practitioners fail to meet the standards for continued eligibility to participate in CalOptima's Programs.

3.31 Downstream Entity Contracts. For any services under this Contract that are provided by a Downstream Entity subcontracted by Professional, Professional shall ensure that such Subcontracts are in compliance with 42 CFR Sections 422.504, 423.505, and 438.6(1). Such Subcontracts shall include all language required by DHCS and CMS.

3.32 Accuracy of Provider Directory. Professional shall notify CalOptima within five (5) business days when either of the following occur:

3.32.1 The Professional is not accepting new Members.

3.32.2 If the Professional had previously not accepted new Members, the Professional is currently accepting new Members.

3.33 Whole Child Model Program Compliance. Professional shall be responsible for identifying children with qualifying medical and surgical conditions and coordinating appropriate referrals of children with CCS Eligible Conditions as defined in Title 22, CCR Sections 41515.2 through 41518.9. For the identification of Members eligible for CCS Services, Professional shall perform appropriate baseline health assessments and diagnostic evaluations that provide sufficient clinical detail to establish, or raise a reasonable likelihood, that Member has a CCS Eligible Condition."

3.34 CCS Provider Compliance.

3.34.1 Only CCS-Paneled Providers may treat CCS Eligible Conditions when a Member's CCS Eligible Condition requires treatment.

3.34.2 If Professional is a CCS-Paneled Provider, Professional agrees to provide services for the Whole Child Model Program in accordance with this Contract and CalOptima Policies

3.34.2.1 Effective July 1, 2019, or such later date as the CalOptima Whole Child Model Program becomes effective, Professional shall provide all Medically Necessary services previously covered by the CCS Program as Covered Services for Members who are eligible for the CCS Program, and for Members who are determined medically eligible for CCS by the local CCS Program.

3.34.2.2 To ensure consistency in the provision of CCS Covered Services, Professional shall use all current and applicable CCS Program guidelines, including CCS Program regulations. When applicable CCS clinical guidelines do not exist, Professional shall use evidence-based guidelines or treatment protocols that are medically appropriate given the Members' CCS Eligible Condition.

3.35 Provider Terminations. In the event that a provider, including a PCP, is terminated or leaves Professional, Professional shall ensure that there is no disruption in services provided to Members who are receiving treatment for a chronic or ongoing medical condition or LTSS, Professional shall ensure that there is no disruption in services provided to the CalOptima Member.

3.36 Government Claims Act. Professional shall ensure that Professional and its agents and Subcontractors comply with the applicable provisions of the Government Claims Act (California Government Code section 900 et. seq.), including, but not limited to Government Code sections 910 and 915, for disputes arising under this Contract, and in accordance with CalOptima Policy AA.1217.

3.37 Certification of Document and Data Submissions. All data, information, and documentation provided by Professional to CalOptima pursuant to this Contract and /or CalOptima Policies, which are specified in 42 CFR section 438.604 and/or as otherwise required by CalOptima and/or CalOptima's Regulators, shall be accompanied by a certification statement on the Professional's letterhead signed by the Professional's Chief Executive Officer or Chief Financial Officer (or an individual who reports directly to and has delegated authority to sign for such Officer) attesting

that based on the best information, knowledge, and belief, the data, documentation, and information is accurate, complete, and truthful.

3.38 Reports and Data. In addition to any other reporting obligations under this Contract, Professional shall submit reports and data relating to services covered under this Contract as required by CalOptima, including, without limitations, to comply with requests from Government Agencies to CalOptima. CalOptima shall reimburse Professional for reasonable costs for producing and delivering such reports and data." 3.39 Hospital Referrals. Professional shall refer Members to providers that have hospital privileges at CalOptima contracted facilities, whenever possible.

3.39 Hospital Referrals. Professional shall refer Members to providers that have hospital privileges at CalOptima contracted facilities, whenever possible.

3.40 Information and Cyber Security. Professional must have policies, procedures, and practices that address its information and cyber security measures, safeguards, and standards, including at least the following:

3.40.1 Access Controls. Access controls, including Multi-Factor Authentication, to limit access to Professional's information systems and any CalOptima information that Professional maintains or can access.

3.40.2 Encryption. Use of encryption to protect any CalOptima information, in transit and at rest, that Professional maintains or can access.

3.40.3 Security. Safeguards for the security of the information systems and CalOptima information that Professional maintains or can access, including hardware and software protections such as network firewall provisioning, intrusion and threat detection controls designed to protect against malicious code and/or activity, physical security controls, and personnel training programs that include phishing recognition and proper data management hygiene.

3.40.4 Software Maintenance. Software maintenance, support, updates, upgrades, third-party software components and bug fixes such that the software is, and remains, secure from vulnerabilities in accordance with the applicable industry standards.

3.40.5 Network Security. Network security that conforms to generally recognized industry standards and best practices.

For the purpose of this Section 3.40, "**Multi-Factor Authentication**" means authentication through verification of at least two (2) of the following types of authentication factors: (i) knowledge factors, such as a password; (ii) possession factors, such as a token or text message on a mobile phone; (iii) inherence factors, such as a biometric characteristic; or (iv) any other industry standard and commercially accepted authentication factors.

3.41 Health Networks. Professional acknowledges and agrees that CalOptima has delegated financial responsibility to Health Networks for certain Covered Services rendered to Members enrolled in Health Networks. Professional agrees to extend to Health Networks the same terms contained in this Contract, including rates, for Covered Services provided to Members enrolled in Health Networks and to contract with a Health Network under the same terms as this Contract, at the request of a Health Network. Regardless of whether Professional is contracted with a Health Network, Professional also agrees to look to the applicable Health Network for payment for Covered Services rendered by Professional that are the financial responsibility of the Health Network pursuant to the Health Network's contract with CalOptima.

ARTICLE 4
FUNCTIONS AND DUTIES OF CALOPTIMA

4.1 Payment. CalOptima shall pay Professional for the provision of Covered Services provided to CalOptima Members according to the terms of this Contact and CalOptima authorization guidelines. Professional agrees to accept the compensation set forth in Attachment B as payment in full from CalOptima for such Covered Services. Upon submission of a Clean Claim, CalOptima shall pay Professional pursuant to CalOptima Policies and Attachment B. Notwithstanding the foregoing, Professional may also collect other amounts (e.g., co-payments, deductibles, Other Health Coverage (OHC), and/or third party liability payments) where expressly authorized to do so under the CalOptima Program(s) and applicable law.

4.2 Service Authorization. CalOptima shall provide a written authorization process for Covered Services pursuant to Policies and the Provider Manual.

4.3 CalOptima Guidance. CalOptima shall make available to Professional, all applicable Provider Manuals, financial bulletins and CalOptima Policies applicable to Covered Services under this Contract.

4.4 Limitations of CalOptima's Payment Obligations. Notwithstanding anything to the contrary contained in this Contract, CalOptima's obligation to pay Professional any amounts shall be subject to CalOptima's receipt of the funding from the Federal and/or State governments.

4.5 Identification Cards. CalOptima shall provide Members with identification cards identifying Members as being enrolled in a CalOptima program.

4.6 Care Management Services. CalOptima shall offer its assistance for Care Management Services for Members through its Care Management Department.

4.7 Pediatric Preventive Services (CHDP) Notifications. CalOptima shall be responsible for notifying Members of Pediatric Preventive Service (CHDP) screening requirements based on the schedule established by the AAP.

4.8 Approved Drug List. CalOptima shall publish and maintain an Approved Drug List pursuant to CalOptima Policies.

4.9 Review Of Prescriptions Not On Approved Drug List. CalOptima shall review prescriptions for medications not listed on the Approved Drug List in a timely manner.

4.10 Member Materials. CalOptima shall furnish Professional written materials to provide to Members, as appropriate.

4.11 Communication Channels. CalOptima will assign a CalOptima representative to serve as Professional's primary contact with CalOptima. The CalOptima representative will coordinate contracting, education/training, and along with facilitating communication between CalOptima and Professional will provide assistance with terms, conditions, and Policies related to this Contract.

4.12 Training and Education. CalOptima agrees to provide Participating Provider education, training and orientation in accordance with DHCS and CMS requirements.

4.13 Directed Payments for Qualifying Medi-Cal Covered Services. Effective July 1, 2020, CalOptima shall administer directed payments for qualifying Medi-Cal Covered Services relevant to this Contract in accordance with CalOptima Policy FF.2012, including, without limitations, those described in Attachment B-1 of this Contract.

ARTICLE 5
INSURANCE AND INDEMNIFICATION

5.1 Indemnification. Each party to this Contract agrees to defend, indemnify and hold each other, and the Government Agencies harmless, with respect to any and all Claims, costs, damages and expenses, including reasonable attorney's fees, which are related to or arise out of the negligent or

willful performance or non-performance by the indemnifying party, of any functions, duties or obligations of such party under this Contract. Neither termination of this Contract nor completion of the acts to be performed under this Contract shall release any party from its obligation to indemnify as to any claims or cause of action asserted so long as the event(s) upon which such claims or cause of action is predicated shall have occurred prior to the effective date of termination or completion.

5.2 Professional Liability. Professional, at its sole cost and expense, shall ensure that Practitioners providing professional services under this Contract shall maintain professional liability insurance coverage with minimum per incident and annual aggregate amounts which are at least equal to the community minimum amounts in Orange County, California, for the specialty or type of service which Professional provides. For Professional insurance, minimums shall be no less than $1,000,000 per incident/$3,000,000 aggregate per year.

5.3 Comprehensive General Liability ("CGL")/Automobile Liability. Professional at its sole cost and expense shall maintain such Policies of comprehensive general liability and other insurance as shall be necessary to insure it and its business addresses, customers (including Members), employees, agents, and representatives, including automobile liability insurance if motor vehicles are owned, leased or operated in furtherance of providing services under this Contract, against any claim or claims for damages arising by reason of a) personal injuries or death occasioned in connection with the furnishing of any Covered Services hereunder, b) the use of any property of the Professional, and c) activities performed in connection with the Contract, with minimum coverage of $1,000,000 per incident/$3,000,000 aggregate per year.

5.4 Workers Compensation Insurance. Professional at its sole cost and expense shall maintain workers compensation insurance within the limits established and required by the State of California and employers' liability insurance with minimum limits of liability of $1,000,000 per occurrence/$1,000,000 aggregate per year.

5.5 Insurer Ratings. All above insurance shall be provided by an insurer:

5.5.1 rated by Best's with a rating of B or better; and

5.5.2 "admitted" to do business in California or an insurer approved to do business in California by the California Department of Insurance and listed on the Surplus Lines Association of California List of Eligible Surplus Lines Insurers (LESLI) or licensed by the California Department of Corporations as an Unincorporated Interindemnity Trust Arrangement as authorized by the California Insurance Code 12180.7.

5.6 Captive Risk Retention Group/Self Insured. Where any of the insurances mentioned above are provided by a Captive Risk Retention Group or are self insured, such above provisions may be waived at the sole discretion of CalOptima, but only after CalOptima reviews the Captive Risk Retention Group's or self-insured's audited financial statements and approves the waiver.

5.7 Cancellation or Material Change. Insurance required in this Article shall not be canceled or materially changed during the term of this Contract.

5.8 Certificates of Insurance. Prior to execution of this Contract, Professional shall provide Certificates of Insurance to CalOptima showing the required insurance coverage and further, to the extent that no expenditure by Professional is required, providing that CalOptima is named as an additional insured on the Comprehensive General Liability Insurance and Automobile Liability Insurance with respect to the performance hereunder and that coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

5.9 Cyber Liability Insurance. Professional at its sole cost and expense shall maintain cyber liability insurance with the minimum limits listed below covering first and third-party claims involving

privacy violations, data breaches, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion, and network security. Such coverage shall provide for costs of legal fees, forensic expenses, regulatory fines and penalties, notification expenses, credit monitoring and ID theft repair, public relations expenses, and costs of liability and defense.

5.9.1 Cyber Liability Insurance Requirements: $1,000,000 each occurrence/claim and $1,000,000 aggregate.

ARTICLE 6
RECORDS, AUDITS AND REPORTS

6.1 Disclosure of Records. Professional and its Subcontractors agree to maintain and make available contracts, books, documents, records, electronic systems, including, Medical Records, (collectively, the "records") to CalOptima, the U.S. Department of Health and Human Services ("HHS"), CMS, the Comptroller General, the U.S. Government Accountability Office ("GAO"), any Quality Improvement Organization ("QIO") or Accrediting Organizations, including NCQA, their designees, and other representatives of regulatory or Accrediting Organizations, for inspection, evaluation and auditing. For purposes of utilization management, quality improvement and other CalOptima administrative purposes, CalOptima and the regulatory and other officials referred to above, shall have access to, and copies of, at reasonable time upon request, the Medical Records, books, charts, and papers relating to the provision of health care services to Members, the cost of such services, and payments received by the Provider from Members (or from others on their behalf). Copies of the Medical Record shall be provided at no charge to CalOptima. Unless a longer time is required under applicable law, the records described herein shall be maintained for at least ten (10) years from the final date of the Contract, or from the completion of any audit, whichever is later.

6.2 Medical Records. Professional shall establish and maintain for each Member who has obtained Covered Services, Medical Records which are organized in a manner which contain such demographic and clinical information as is necessary to provide and ensure accurate and timely documentation as to the medical problems and Covered Services provided to the Member. Such Medical Records shall be consistent with State and Federal laws and CalOptima Program requirements and shall include a historical record of diagnostic and therapeutic services recommended or provided by, or under the direction of, the Professional. Such Medical Records shall be in such a form as to allow trained health professionals, other than the Professional, to readily determine the nature and extent of the Member's medical problem and the services provided, and to permit peer review of the care furnished to the Member.

6.3 Records Retention. Professional shall maintain books and records in accordance with the time and manner requirements set forth in Federal and State laws and CalOptima Programs as identified in the CalOptima Program Addenda to this Contract. Where the Professional furnishes Covered Services to a Member in more than one CalOptima Program with different record retention periods, then the greater of the record retention requirements shall apply.

6.4 Audit, Review and/or Duplication. Audit, review and/or duplication of data or records shall occur within regular business hours, and shall be subject to Federal and State laws concerning confidentially and ownership of records. Professional shall pay all duplication and mailing costs associated with such audits.

6.5 Confidentiality of Member Information. Professional, its Practitioners, and Downstream Entities agree to comply with applicable Federal and State laws and regulations governing the confidentiality of Member medical and other information, including, but not limited to the following:

6.5.1 Health Insurance Portability and Accountability Act (HIPAA). Professional shall comply with HIPAA statutory and regulatory requirements ("HIPAA requirements"), whether existing now or in the future within a reasonable time prior to the effective date of such requirements. Professional shall comply with HIPAA requirements as currently established in CalOptima Policies. Professional shall also take actions and develop capabilities as required to support CalOptima compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

6.5.2 Members Receiving State Assistance. Notwithstanding any other provision of this Contract, names and identification numbers of Members receiving public assistance are confidential and are to be protected from unauthorized disclosure in accordance with applicable State and Federal laws and regulations. For the purpose of this Contract, Professional shall protect from unauthorized disclosure all information, records, data and data elements collected and maintained for the operation of the Contract and pertaining to Members.

6.5.3 Declaration of Confidentiality. If Professional and its Subcontractors have access to computer files or any data confidential by statute, including identification of eligible members, Professional and Subcontractors agree to sign a declaration of confidentiality in accordance with the applicable Government Contract and in a form acceptable to CalOptima and DHCS, DMHC and/or CMS, as applicable.

6.6 Member Request For Medical Records. Professional shall furnish a copy of a Member's Medical Records to another treating or consulting Practitioner at no cost to the Member when such a transfer of records:

6.6.1 Facilitates the continuity of that Member's care; or

6.6.2 A Member is transferring from one Provider to another for treatment; or

6.6.3 A Member seeks to obtain a second opinion on the diagnosis or treatment of a medical condition; or

6.6.4 A Member's records are needed to access Medi-Cal covered services not included in this Contract, including, but not limited to mental health programs (such as Department of Developmental Services), California Children Services, and Local Educational Agency "LEA"; or

6.6.5 A Member's records are needed to access Medicare covered services not included in this Contract, including, but not limited to hospice care.

ARTICLE 7
TERM AND TERMINATION

7.1 Term. The term of this Contract shall become effective on the Effective Date and continue in effect for five (5) years and five (5) additional one-year automatic extensions except as directed otherwise by the Board.

7.2 Termination for Default. CalOptima may, in its sole discretion, terminate this Contract whenever CalOptima determines that the Professional (a) has repeatedly and inappropriately withheld Covered Services to a CalOptima Member(s), (b) has failed to perform its contracted duties and responsibilities in a timely and proper manner including, without limitation, service procedures and standards identified in this Contract, (c) has committed acts that discriminate against CalOptima Members on the basis of their health status or requirements for health care services; (d) has not provided Covered Services in the scope or manner required under the provisions of this Contract; (e) has engaged in prohibited marketing activities; (f) has failed to comply with CalOptima's

Compliance Program, including Participation Status requirements; (g) has committed fraud or abuse relating to Covered Services or any and all obligations, duties and responsibilities under this Contract; or (h) has materially breached any covenant, condition, or term of this Contract. A termination as described above shall be referred to herein as "Termination for Default." In the event of a Termination for Default, CalOptima shall give Professional prior written notice of its intent to terminate with a thirty (30)-day cure period if the Termination for Default is curable, in the sole discretion of CalOptima. In the event the default is not cured within the thirty (30)-day period, CalOptima may terminate the Contract immediately following such thirty (30)-day period. The rights and remedies of CalOptima provided in this Article are not exclusive and are in addition to any other rights and remedies provided by law or under the Contract. The Professional shall not be relieved of its liability to CalOptima for damages sustained by virtue of breach of the Contract by the Professional.

7.3 Professional's Appeal Rights. Professional may appeal CalOptima's decision to terminate the Contract for default as provided in Section 7.2 by filing a complaint pursuant to CalOptima Policies. Professional shall exhaust this administrative remedy, including requesting a hearing according to CalOptima Policies, and shall comply with applicable CalOptima Policies governing judicial claims, before commencing a civil action. Professional's rights and remedies provided in this Article shall not be exclusive and are in addition to any other rights and remedies provided by law or this Contract.

7.4 Immediate Termination. CalOptima may terminate this Contract immediately upon the occurrence of any of the following events and delivery of written notice: (i) the suspension or revocation of any license, certification or accreditation required by Professional and/or Professional's Practitioners; (ii) the determination by CalOptima that the health, safety, or welfare of Members is jeopardized by continuation of this Contract; (iii) the imposition of sanctions or disciplinary action against Professional or against Professional Practitioners in their capacities with the Professional by any Federal or State licensing agency; (iv) termination or non-renewal of any Government Contract; (v) the withdrawal of HHS' approval of the waiver granted to the CalOptima under Section 1915(b) of the Social Security Act. If CalOptima receives notice of termination from any of the Government Agencies or termination of the Section 1915(b) waiver, CalOptima shall immediately transmit such notice to Professional.

7.5 Termination for Insolvency. If the Professional becomes insolvent, the Professional shall immediately so advise CalOptima, and CalOptima shall have, at its sole option, the right to terminate the Contract immediately. In the event of the filing of a petition for bankruptcy by or against the Professional, the Professional shall assure that all tasks related to the Contract are performed in accordance with the terms of the Contract.

7.6 Modifications or Termination to Comply with Law. CalOptima reserves the right to modify or terminate the Contract at any time when modifications or terminations are (a) mandated by changes in Federal or State laws, (b) required by Government Contracts, or (c) required by changes in any requirements and conditions with which CalOptima must comply pursuant to its Federally-approved Section 1915(b) waiver. CalOptima may also modify the Contract at any time if such a change would be in the best interest of Members. CalOptima shall notify Professional in writing of such modification or termination immediately and in accordance with applicable Federal and/or State requirements and Professional shall comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible.

7.7 Termination Without Cause. Either party may terminate this Contract, without cause, upon ninety (90) days' prior written notice to the other party as provided herein.

7.8 Rate Adjustments. The payment rates may be adjusted by CalOptima during the Contract period to reflect implementation of Federal or State laws or regulations, changes in the State budget, the

Government Contract(s) or the Government Agencies' Policies, and/or changes in Covered Services. If the Government Agency(ies) has provided CalOptima with advance notice of adjustment, CalOptima shall provide notice thereof to Professional as soon as practicable.

7.9 Obligations Upon Termination. Upon termination of this Contract, it is understood and agreed that Professional shall continue to provide authorized Professional Services to Members who retain eligibility and who are under the care of Professional at the time of such termination, until the services being rendered to Members are completed, unless CalOptima, in its sole discretion, makes reasonable and medically appropriate provisions for the assumption of such services. Professional shall continue to provide Professional Services to hospitalized Members or coordinate with contracted Hospitalist to provide services in accordance with generally accepted medical standards and practices until the earlier of the Member's discharge from hospital; or alternate coverage is arranged for by CalOptima.

7.9.1 Payment for any continued Covered Services provided to Members shall be paid as follows:

a) Medi-Cal eligible beneficiaries as described in this Section shall be paid at the same amount paid by DHCS for the same services rendered to beneficiaries in the Medi-Cal FFS program.

b) PACE program beneficiaries as described in this Section shall be paid at the lesser of the Medicare fee schedule or the contracted rates set forth in the respective CalOptima' Program's Attachment B.

7.9.2 Prior to the termination or expiration of this Contract and upon request by CalOptima or one of its Government Agencies to assist in the orderly transfer of Members' medical care, Professional shall make available to CalOptima and/or such Government Agency, copies of any pertinent information, including information maintained by Professional necessary for efficient case management of Members. Costs of reproduction shall be borne by CalOptima or the Government Agency, as applicable. For purposes of this section only, "under the care of Professional" shall mean that a Member has an authorization from CalOptima to receive services from the Professional issued prior to the Termination, all of the services authorized under that authorization have not yet been completed, and the time period covered by the authorization has not yet expired.

7.10 Approval by and Notice to Government Agencies. Professional acknowledges that this Contract and any modifications and/or amendments thereto are subject to the approval of applicable Federal and/or State agencies. CalOptima and Professional shall notify the Federal and/or State agencies of amendments to, or termination of, this Contract. Notice shall be given by first-class mail, postage prepaid to the attention of the State or Federal contracting officer for the pertinent CalOptima Program. Professional acknowledges and agrees that any amendments or modifications shall be consistent with requirements relating to submission to such Federal and/or State agency for approval.

ARTICLE 8
GRIEVANCES AND APPEALS

8.1 Grievances. CalOptima has established a fast, fair and cost-effective complaint system for provider complaints, grievances and appeals. Provider, including Professional, shall have access to this system for any issues arising under this Contract, as provided in CalOptima Policies related to the applicable CalOptima Program(s). Professional complaints, grievances, appeals, or other disputes regarding any issues arising under this Contract shall be resolved through such system.

8.2 Member Grievances and Appeals. Member grievances, complaints, and/or appeals shall be resolved in accordance with Federal and/or State laws, regulations and Government Guidance and as set forth in CalOptima Policies relating to the applicable CalOptima Program. Professional agrees to

cooperate in the investigation of the issues and be bound by CalOptima's grievance decisions and, if applicable, State and/or Federal hearing decisions or any subsequent appeals.

ARTICLE 9
MISCELLANEOUS GENERAL PROVISIONS

9.1 Assignment and Assumption. Professional acknowledges and agrees that a primary goal of CalOptima is to ensure the provision of quality healthcare services to CalOptima Members and that CalOptima and Professional have entered into this Contract for the benefit of CalOptima Members. Accordingly, CalOptima retains the rights set forth in this Section. Except as specifically permitted hereunder, this Contract is not assignable by the Professional, either in whole or in part, without the prior written consent of CalOptima, provided that CalOptima's consent may be withheld in its sole and absolute discretion. For purposes of this Section and this Contract, assignment includes, without limitation, (a) the change of more than twenty-five percent (25%) of the ownership or equity interest in Professional (whether in a single transaction or in a series of transactions), (b) the change of more than twenty-five percent (25%) of the directors or trustees of Professional, (c) the merger, reorganization, or consolidation of Professional with another entity with respect to which Professional is not the surviving entity, and/or (d) a change in the management of Professional from management by persons appointed, elected or otherwise selected by the governing body of Professional (e.g., the Board of Directors) to a third-party management person, company, group, team or other entity.

9.2 Documents Constituting Contract. This Contract and its attachments, schedules, addenda and exhibits and all CalOptima Policies applicable to Covered Services and CalOptima Members (and any amendments thereto) shall constitute the entire agreement between the parties. It is the express intention of Professional and CalOptima that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Contract which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

9.3 Force Majeure. Both parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Contract as a result of a catastrophic occurrence or natural disaster including, but not limited to an act of war, and excluding labor disputes.

9.4 Governing Law and Venue. This Contract shall be governed by and construed in accordance with all laws of the State of California and Federal laws and regulations applicable to the CalOptima Programs and all contractual obligations of CalOptima. Professional shall bring any and all legal proceedings against CalOptima under this Contract in California State courts located in Orange County, California, unless mandated by law to be brought in federal court, in which case such proceeding shall be brought in the Central District Court of California.

9.5 Headings. The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

9.6 Independent Contractor Relationship. CalOptima and Professional agree that the Professional, in performance of this Contract, shall act in an independent capacity and not as officers or employees of CalOptima. Professional's relationship with CalOptima in the performance of this Contract is that of an independent contractor. Professional's personnel performing services under this Contract shall be at all times under Professional's exclusive direction and control and shall be employees or Participating Providers of Professional and not employees of CalOptima. Professional shall pay all wages, salaries and other amounts due its employees and Participating Providers in connection with this Contract and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters.

9.7 No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, CalOptima and the Professional hereby acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability thereof.

9.8 No Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions, or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner which does not constitute a waiver of immunity or privilege under applicable law.

9.9 Notices. Any notice required to be given pursuant to the terms and provisions of this Contract, unless otherwise indicated herein, shall be in writing and shall be sent by Priority, Certified or Registered mail, return receipt requested, postage prepaid, addressed to the party to whom Notice is to be given, at such party' address set forth below or such other address provided by Notice. Notice shall be deemed given seventy-two (72) hours after mailing.

If to CalOptima:

CalOptima
Director of Contracting
505 City Parkway West
Orange, CA 92868

If to Professional:

{{*Name on Notice_es_:signer1: }}

Name

{{*Title on Notice_es_:signer1: }}

Title

{{*Address on Notice_es_:signer1 }}

Address

9.10 Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, said party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good faith with respect to such matters for the purpose of making such reasonable adjustments as may be necessary to perform the objectives of this Contract.

9.11 Prohibited Interests. Professional covenants that, except as provided by law, for the term of this Contract, no director, officer, or employee of CalOptima during his/her tenure has any interest, direct or indirect, in this Contract or the proceeds thereof.

9.12 Regulatory Approval. Notwithstanding any other provision of this Contract, the effectiveness of this Contract, amendments thereto, and assignments thereof, is subject to the approval of applicable Governmental Agencies and the conditions imposed by such agencies.

9.13 Authority to Execute. The persons executing this Contract on behalf of the parties warrant that they are duly authorized to execute this Contract, and that by executing this Contract, the parties are formally bound.

9.14 Severability. In the event any provision of this Contract is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

9.15 Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5. Professional agrees to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 USC 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 USC 1251 et seq.), as amended.

9.16 Lobbying Restrictions and Disclosure Certification. Professional shall complete and submit the lobbying disclosure form required by federal law, when applicable, as set forth in Addendum 4.

9.16.1 (Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.)

9.16.2 Certification and Disclosure Requirements

9.16.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Addendum 4, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 9.16.3 of this provision.

9.16.2.2 Each recipient shall file a disclosure (in the form set forth in Addendum 4, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant, which would be prohibited under Paragraph 9.16.3 of this provision if paid for with appropriated funds.

9.16.2.3 Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph 9.16.2.2 herein. An event that materially affects the accuracy of the information reported includes:

9.16.2.3.1 A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

9.16.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

9.16.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

9.16.2.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 9.16.2.1 of this provision a contract, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or grant shall file a certification, and a disclosure form, if

required, to the next tier above.

9.16.2.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 19.16.2.1 of this provision. That person shall forward all disclosure forms to DHCS program contract manager.

9.16.3 Prohibition—Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

9.17 Debarment Certification. Professional agrees to comply with applicable Federal suspension and debarment regulations including, but not limited to 7 CFR 3017, 45 CFR 76, 40 CFR 32, or 34 CFR 85.

9.17.1 Professional certifies to the best of its knowledge and belief, that it and its principals:

(i) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(ii) have not within a three-year period preceding this Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(iii) are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in sub-provision (ii) herein;

(iv) have not within a three-year period preceding this Contract had one or more public transactions (Federal, State or local) terminated for cause or default;

(v) shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under Federal regulations (i.e., 48 CFR 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

(vi) will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

9.17.2 If Professional is unable to certify to any of the statements in this certification, the Professional shall submit an explanation to CalOptima.

9.17.3 The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

9.17.4 If Professional knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

9.18 Dispute Resolution.

9.18.1 Meet and Confer. For any dispute not subject to or resolved by the provider appeals process, or if either party has a dispute it seeks to address informally, the parties shall use reasonable efforts to informally meet and confer to try and resolve the dispute. The parties shall meet and confer within thirty (30) days of a written request submitted by either party in an effort to settle any dispute. At each meet-and-confer meeting, each party shall be represented by persons with final authority to settle the dispute. If either party fails to meet within the thirty (30)-day period, that party shall be deemed to have waived the meet-and-confer requirement, and at the other party's option, the dispute may proceed immediately to arbitration under Section 9.18.2.

9.18.2 Arbitration. If the parties are unable to resolve any dispute arising out of or relating to this Contract under Section 9.18.1, either party may submit the dispute for resolution exclusively through confidential, binding arbitration, instead of through trial by court or jury, in Orange County, California. The parties may agree in writing prior to commencing the arbitration on the dispute resolution rules and arbitration service that will be used to resolve the dispute. If the parties cannot reach such an agreement, the arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") in accordance with the commercial dispute rules then in effect for JAMS; provided, however, that this Contract shall control in instances where it conflicts with JAMS's (or the applicable arbitration service's) rules. The arbitration shall be conducted on an expedited basis by a single arbitrator. The parties prefer that the arbitrator be a retired judge of the California Superior, Appellate, or Supreme Court or of a United States court sitting in California. If no such retired judge is available, the arbitrator may be an attorney with at least fifteen (15) years of experience, including at least five (5) years in managed health care. If the parties are unable to agree on the arbitrator within thirty (30) days of the date that the arbitration service accepts the arbitration, the arbitrator shall be selected by the arbitration service from a list of four potential arbitrators (all of whom shall be on arbitration services' panel of arbitrators) submitted by the parties, two from each side; provided, however, that nothing stated in this section shall prevent a party from disqualifying an arbitrator based on a conflict of interest. In making decisions about discovery and case management, it is the parties' express agreement and intent that the arbitrator at all times promote efficiency without denying either party the ability to present relevant evidence. In reaching and issuing decisions, the arbitrator shall have no jurisdiction to make errors of law and/or legal reasoning. The parties shall share the costs of arbitration equally, and each party shall bear its own attorneys' fees and costs.

9.18.3 Exclusive Remedy. With the exception of any dispute that under Laws may not be settled through arbitration, arbitration under Section 9.18.2 is the exclusive method to resolve a dispute between the Parties arising out of or relating to this Contract that is not resolved through the provider appeals or meet-and-confer processes.

9.18.4 Waiver. By agreeing to binding arbitration as set forth in Section 9.18.2, the parties acknowledge that they are waiving certain substantial rights and protections which otherwise may be available if a dispute between them was determined by litigation in a court, including the right to a jury trial, attorneys' fees, and certain rights of appeal.

ARTICLE 10
EXECUTION

Subject to the State of California and United States providing funding for the term of this Contract and for the purposes with respect to which it is entered into, and execution of the Government Contracts, and the approval of this Contract by the Government Agencies, this Contract shall become effective on the first day of the first month following execution of this Contract by both parties, (the "Effective Date").

IN WITNESS WHEREOF, the parties have executed this Contract as follows:

Professional	CalOptima
{{_es_:signer1:signature}}	{{_es_:signer2:signature}}
Signature	Signature
{{*Name_es_:signer1 }}	{{N_es_:signer2:fullname }}
Print Name	Print Name
{{*_es_:signer1:title }}	{{*_es_:signer2:title }}
Title	Title
{{*_es_:signer1:date }}	{{*_es_:signer2:date }}
Date	Date

ATTACHMENT A
CONTRACTED SERVICES

ARTICLE 1
CALOPTIMA PROGRAMS AND SERVICES

1.1 CalOptima Program. Professional shall furnish Covered Services to eligible Members in the following CalOptima Programs:

X Medi-Cal Program (Community Network and COD Administrative)

X PACE Program

X OneCare Program (Medicare Advantage)

1.2 Physician Services. Professional shall furnish:

X Specialist Provider Covered Services to eligible Members in the CalOptima program, who are referred to Professional in accordance with CalOptima referral Policies.

ARTICLE 2
GENERAL RESPONSIBILITIES

In addition to the CalOptima Provider Manual, the following general responsibility shall apply. Refer to the Provider Manual for specific program instructions and guidelines.

2.1 Physician Services. Physician Services for CalOptima Members are those Covered Services set forth in the CalOptima Program in which the Member is assigned.

Services include, but are not limited to, health promotion, disease prevention, health maintenance, counseling, patient education, and the diagnosis and treatment of acute and chronic illness, and that are: (a) included as covered services under the applicable Government Contract, (b) within Professional's normal scope of practice, and (c) Medically Necessary.

2.1.1 The actual provision of any Physician Service is subject to CalOptima's Utilization Management Policies and Procedures and the Medical Necessity of the service. Professional shall provide assessment and evaluation services ordered by a court or legal mandate.

2.1.2 Decisions concerning whether to provide or authorize covered Physician Services shall be based solely on Medical Necessity. Disputes between the Professional and Members about Medical Necessity can be appealed pursuant to CalOptima Policies.

2.2 Days to Appointment. Professional shall ensure that appointments for non-Emergency or non-Urgent Care Covered Services are scheduled within ten (10) business days for Primary Care Provider and fifteen (15) business days for Specialist Physician of a Member's request; that health assessments and general physical examinations and all preventative Covered Services are scheduled within thirty (30) calendar days of Member's request for an appointment, and that, if Professional supplies maternity Covered Services, Physician Group shall ensure that the most current standards or guidelines of the American College of Obstetricians and Gynecologists (ACOG) are utilized as the minimum measure of quality for perinatal services. Professional shall also have a process in place for follow-up on Member missed appointments.

2.3 Office Waiting Times. Professional shall ensure that office wait times will be kept to a maximum of forty-five (45) minutes.

2.4 Health Education and Prevention. Professional shall provide Members with health education during office visits in accordance with CalOptima Policies. Professional shall also refer

Members to CalOptima's health education referral line for classes provided to Members.

2.5 Coordination and Continuation of Care. Referrals for Medically Necessary specialty Covered Services must follow CalOptima Policies and Provider Manual for Prior Authorization. All Prior Authorizations shall be made through CalOptima's Utilization Management Department. Professional agrees to refer Members to other Participating Providers in all circumstances except when an authorization has been granted in advance by CalOptima to refer to a Non-Participating Provider, or when necessary due to an Emergency Medical Condition.

2.6 Approved Drug List Compliance. Professional shall comply with the CalOptima Approved Drug List and its associated drug utilization or disease management guidelines and protocols. Medications not included on the Approved Drug List shall require Prior Authorization by CalOptima. The prescribing Physician must obtain authorization in accordance with CalOptima's Policies. The prescribing Physician shall provide CalOptima with all information necessary to process Prior Authorization requests.

2.6.1 Professional shall prescribe generically available drugs instead of the parent brand product whenever therapeutically equivalent generic drugs exist.

2.6.2 Professional shall participate in any CalOptima pharmacy cost containment programs as developed.

2.6.3 Professional shall provide all information requested by CalOptima, including, but not limited to Medical Necessity documentation, which pertains to a Member's condition and drug therapy regimen, untoward effects or allergic reactions.

2.7 Obstetrical Services for Medi-Cal Members. If Professional provides obstetrical services, Professional is required to complete the program specific CalOptima Pregnancy Notification Report (PNR) for all pregnant CalOptima Members. PNRs must be received by CalOptima within five (5) days following initiation of obstetrical-related services.

2.8 Referrals. Professional shall refer Members to Participating Providers in accordance with CalOptima referral Policies.

2.9 Professional shall coordinate the provision of Covered Services to Members by counseling Members and their families regarding Member's medical needs, initiating referrals of Members for specific Covered Services to Participating Providers, monitoring progress of Members' care and coordinating utilization of services to facilitate the return of Member's care to their assigned PCP as soon as medically appropriate.

2.10 Professional shall discuss treatment options with Members, including the option of foregoing treatment, in a culturally competent manner. Professional shall ensure that Members with disabilities have access to effective communication methods when making health care decisions, and shall allow Members the opportunity to refuse treatment and express preferences for future treatment.

2.11 Professional shall use best efforts to participate in the exchange of electronic transactions with CalOptima, including, but not limited to electronic claims submission (EDI), verification of eligibility and enrollment through electronic means and submission of electronic Prior Authorization transactions in accordance with CalOptima Policy and Procedure.

2.12 PCP should be informed of the progress of a referred Member's care. Professional shall forward the results of diagnostic procedures and consultations to Member's assigned PCP in a timely manner in order to ensure that the Member's care is efficiently coordinated and that the responsibility for care is returned to PCP as soon as medically appropriate.

2.13 Additional Responsibilities of Primary Care Provider for Medi-Cal Members

2.13.1 PCP shall be responsible for coordinating care of certain services including:

a) PCP shall document all Pediatric Preventive Services (CHDP) on the CMS-1500, UB-04 claim form, or electronic equivalent. PCP shall submit the CMS-1500, UB-04 claim form, or electronic equivalent to CalOptima within thirty (30) calendar days following the month of service.

b) PCP providing Pediatric Preventive Services agrees to coordinate with the Orange County CHDP Program.

c) PCP shall comply with CalOptima's Policies and for periodicity and content of pediatric health assessments.

d) PCP shall make referrals to the Women, Infants and Children Food Supplementation Program ("WIC") in accordance with WIC program Policies and Procedures.

e) PCP shall make referrals to the Regional Center of Orange County when appropriate.

f) PCP shall refer all Members between the ages of three (3) and twenty-one (21) to a dentist in accordance with the most recent recommendations of the AAP, as part of periodic health assessment.

g) PCP may provide Outpatient Mental Health Services within the scope of his/her practice. PCP shall refer Members with mild to moderate impairment in functioning requiring mental health Covered service beyond or outside the scope of PCP's practice to CalOptima for referral to CalOptima's contracted mental health specialists. PCP shall refer Members with significant impairment in functioning and Members requiring emergency or inpatient mental health care, to the Orange County Health Care Agency (HCA) or other agency as appropriate.

h) PCP shall refer Members requiring alcohol and drug treatment to CalOptima for referral to Short-Doyle Medi-Cal alcohol and drug treatment programs.

i) PCP shall refer all Members in the Seniors and Persons with Disability (SPD) aid codes, which is the two-character code, defined by the State of California, which identifies the aid category under which a Member is eligible to receive Medi-Cal covered services, who require a customized wheelchair and/or a modification to a customized wheelchair or seating system to CalOptima.

2.13.2 Appointment Pediatric Preventive Covered Services. Primary Care Provider shall schedule periodic pediatric screenings in accordance with the American Academy of Pediatrics (AAP) periodic schedule. Immunizations are to be provided according to the latest guidelines published by the AAP and Advisory Committee on Immunization Practices (ACIP). If there is a conflict in the recommendations, the higher standard will be recognized. Adults shall receive periodic health assessments according to the guidelines published by the United States Preventive Services Task Force. Vaccinations, which are not part of the standard pediatric protocol, shall be administered according to CalOptima Policies.

2.13.3 Alcohol and Substance Use Disorder Treatment Services. Physician shall ensure the SBIRT services by a Member's PCP to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. PCP shall refer Members to substance use disorder treatment when there is a need beyond SBIRT. Physician shall document SBIRT services in Members Medical Record.

2.14 Professional shall also provide services to COD-Administrative Members under this Contract. The scope of such services shall be as defined in the CalOptima Medi-Cal Provider Manual and CalOptima Policy, rather than as set forth in Article 2 of this Attachment A.

2.15 Health Risk Assessments (HRAs) - Professional will be required to complete HRAs in accordance with each of CalOptima Programs requirements and CalOptima Policy.

2.16 Professional shall comply with CalOptima's Model of Care specified for each of CalOptima programs.

2.17 Professional shall cooperate and coordinate Mental Health and Behavioral Health in accordance with each of CalOptima's Programs and CalOptima Policy.

2.18 Professional shall cooperate with CalOptima's Personal Care Coordinator or "PCC" in accordance with CalOptima's PCC Program Policies and guidance.

2.19 Professional shall participate with CalOptima's Interdisciplinary Care Team "ICT" and contribute to the Individualized Care Plan or "ICP" in accordance with CalOptima's Program guidelines, Policies and Procedures.

2.20 Initial Health Assessment Appointment. If Professional is a Member's Primary Care Provider, Professional shall have a process in place to ensure each Member is scheduled for an initial health assessment within one hundred twenty (120) calendar days following enrollment with CalOptima, unless otherwise directed by CalOptima Policies. At a minimum, an initial health assessment shall include administration of the Staying Healthy Assessment Tool, a medical history, weight and height data, blood pressure, preventive health screens and tests which are required under CalOptima Policies, discussion of appropriate preventive measures, and arrangement of future follow-up appointments as indicated. The initial health assessment shall include the identification, assessment and development of care plans as appropriate for Members with special health care needs. The initial and periodic health assessment appointments shall include a dental screening/oral health assessment for all Members under twenty-one (21) years of age and include annual dental referrals made with the eruption of the child's first tooth or at twelve (12) months of age, whichever occurs first. Professional shall ensure that Members are referred to appropriate Medi-Cal dental Providers and provide Medically Necessary Federally Required Adult Dental Services (FRADs) and fluoride varnish. CalOptima may establish minimum performance requirements for completion of the initial health assessment. Professional's failure to perform at or in excess of minimum performance requirements shall subject Professional to sanctions in accordance with this Contract and CalOptima Policies. Physician shall ensure that health assessment information shall be recorded in the Member's Medical Records.

ATTACHMENT B
COMPENSATION

CalOptima shall reimburse Professional, and Professional shall accept as payment in full from CalOptima, the lesser of billed charges or the following amounts for Covered Services provided to Members under this Contract:

1. **General Terms**. Upon submission of a Clean Claim, CalOptima shall pay Professional pursuant to this Contract, CalOptima Policies, Government Contracts, and applicable laws.

1.1 Medically Necessary Services. This Contract does not provide incentives, nor will it be construed to provide incentives, for Providers to reduce or withhold Medically Necessary services. Professional will not alter care delivery practices, adopt billing practices, or take any other actions for the sole or primary purpose of reducing Medically Necessary services. Professional will ensure the continuity of services in the event of non-payment from CalOptima in accordance with applicable laws and Government Contract requirements.

1.2 Due Date. If a due date provided for under this Contract is a weekend or State or federal holiday, any such report, objection, or payment will be due the following business day.

1.3 File Transfer. The Parties agree to deliver the confidential data utilizing a secure file transfer protocol ("**SFTP**") process. The Parties will establish a SFTP site and provide the credentials necessary to access and push files to the site.

1.4 Supplemental Pay-for-Performance Payment. CalOptima may authorize supplemental payments to Professional yearly or quarterly based on Professional's quality performance and achievement specified program goals, as determined by CalOptima in its sole discretion in accordance with applicable laws and CalOptima Policies. CalOptima shall not pay Professional any supplemental payments if this Contract terminates.

2. **Payment – Primary Care Services**

2.1 Medi-Cal Program.

For Medi-Cal Members, CalOptima shall reimburse Professional for Covered Services as follows:

- **Professional Services:** [redacted] as defined in CalOptima Policies, in effect for the date of service.
- **Non Professional** services shall be paid at [redacted] as defined in the CalOptima Policies, in effect for the date of service.
- Unless specified otherwise in this Contract, Medi-Cal billing rules and payment policies and guidelines for billing and payment will apply.
- By Report Codes shall be billed and paid according to Section 2.4.
- Services not contained in the Medi-Cal fee schedule at the time of service are not reimbursable, except as provided in Section 2.4.
- Targeted Rate Increase Services. If applicable, for services subject to the TRI provided by a qualified professional, CalOptima Health will reimburse Professional at the

greater of the contracted rates, outlined above plus any applicable supplemental payments, or the Medi-Cal TRI fee schedule rate in effect for the date of service; provided, however, in no event will Professional be reimbursed at less than the Medi-Cal TRI fee schedule in effect for the date of service. Reimbursement for TRI services shall comply with DHCS Program requirements, applicable laws, and CalOptima Policies.

2.2 OneCare Program.

For OneCare Members, CalOptima shall reimburse Professional for Covered Services as follows:

- [redacted] in effect for the date of service.
- Unless specified otherwise in this Contract, Medicare billing rules and payment policies and guidelines for billing and payment will apply.
- By Report Codes shall be billed and paid according to Section 2.4.
- Services not contained in the Medicare Fee Schedule at the time of service are not reimbursable, except as provided in Section 2.4.
- Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the term of the Contract, CalOptima may, upon written notice to Professional, reduce payment to Professional under this Attachment B by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the term of the Contract.

2.3 PACE Program.

For PACE Members, CalOptima shall reimburse Professional for Covered Services as follows:

- [redacted] in effect for the date of service.
- Unless specified otherwise in this Contract, Medicare billing rules and payment policies and guidelines for billing and payment will apply.
- By Report Codes shall be billed and paid according to Section 2.4.
- Services not contained in the Medicare Fee Schedule at the time of service are not reimbursable, except as provided in Section 2.4.
- Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the term of the Contract, CalOptima may, upon written notice to Professional, reduce payment to Professional under this Attachment B by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the term of the Contract.

2.4 Services with Unestablished Fees. If a fee has not been established by Medi-Cal, when providing services to a Medi-Cal Member, or Medicare, when providing services to a OneCare or PACE Member, for a particular procedure and CalOptima has provided

Authorization for Professional to provide such service, CalOptima shall reimburse Professional under the following guidelines:

2.4.1 "By Report & Unlisted" codes that CalOptima has provided Authorization for Professional to provide such services will be paid at forty percent (40%) of Professional's full billed charges and must follow applicable Medi-Cal or Medicare billing rules and guidelines. When billing CalOptima for these codes, Professional shall include documentation of Covered Services provided, as required by this Contract, CalOptima Policies, and applicable laws.

3. Payment – Specialist Services.

3.1 Medi-Cal Program.

For Medi-Cal Members, CalOptima shall reimburse Professional for Covered Services as follows:

CPT Code	Service	Unit Definition	Per Unit Rate
17380	Electrolysis	30 minutes	[redacted]
17999	Laser Hair Removal (All areas)	60 minutes	

- **Professional Services:** [redacted] as defined in CalOptima Policies, in effect for the date of service.
- **Non Professional** services shall be paid at [redacted] as defined in the CalOptima Policies, in effect for the date of service.
- Unless specified otherwise in this Contract, Medi-Cal billing rules and payment policies and guidelines for billing and payment will apply.
- By Report Codes shall be billed and paid according to Section 3.4.
- Services not contained in the Medi-Cal fee schedule at the time of service are not reimbursable, except as provided in Section 3.4.
- Targeted Rate Increase Services. If applicable, for services subject to the TRI provided by a qualified professional, CalOptima will reimburse Professional at the greater of the contracted rates, outlined above plus any applicable supplemental payments, or the Medi-Cal TRI fee schedule rate in effect for the date of service; provided, however, in no event will Professional be reimbursed at less than the Medi-Cal TRI fee schedule in effect for the date of service. Reimbursement for TRI services shall comply with DHCS Program requirements, applicable laws, and CalOptima Policies.

3.2 OneCare Program.

For OneCare Members, CalOptima shall reimburse Professional for Covered Services as follows:

- [redacted] in effect for the date of service.

- Unless specified otherwise in this Contract, Medicare billing rules and payment policies and guidelines for billing and payment will apply.
- By Report Codes shall be billed and paid according to Section 3.4.
- Services not contained in the Medicare Fee Schedule at the time of service are not reimbursable, except as provided in Section 3.4.
- Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the term of the Contract, CalOptima may, upon written notice to Professional, reduce payment to Professional under this Attachment B by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the term of the Contract.

3.3 PACE Program.

For PACE Members, CalOptima shall reimburse Professional for Covered Services as follows:

- [redacted] in effect for the date of service.
- Unless specified otherwise in this Contract, Medicare billing rules and payment policies and guidelines for billing and payment will apply.
- By Report Codes shall be billed and paid according to Section 3.4.
- Services not contained in the Medicare Fee Schedule at the time of service are not reimbursable, except as provided in Section 3.4.
- Sequestration. If CMS reduces payment to CalOptima under the CMS Contract by more than two percent (2%) at any time during the term of the Contract, CalOptima may, upon written notice to Professional, reduce payment to Professional under this Attachment B by the same percentage that CMS reduced payment to CalOptima. This provision applies each time CMS reduces payment to CalOptima by more than two percent (2%) during the term of the Contract.

3.4 Services with Unestablished Fees. If a service is determined to be 'By Report & Unlisted" under the applicable CalOptima fee schedule, payment shall be made under the following guidelines:

3.4.1 When total billed charges for a claim line are less than $500 total, regardless of the number of units billed, payment shall be made at 30% of Professional provider's usual, customary, and reasonable billed charges.

3.4.2 When total billed charges for a claim line meet or exceed $500 total, regardless of the number of units billed, payment shall be made per the applicable billing rules and guidance: Medicare for Medicare rates and Medi-Cal for Medi-Cal rates. Professional shall include all necessary documentation of the Covered Services provided, as required by the Contract, CalOptima Policies, and applicable laws and regulations.

4. Payment Procedures.

4.1 Health Network. If a Health Network is financially responsible under its contract with CalOptima for the services a Professional rendered to a Member, Professional shall look

solely to Health Network for payment for those services, and CalOptima and Member shall not be liable to Professional for those services.

4.2 Claims Submission. Professional shall submit to CalOptima an accurate, complete, descriptive, and timely Claim that includes the Member's name and identification number, description of services, and date(s) of service. Professional may not submit a Claim before the delivery of service. In accordance with CalOptima Policies, Professional shall submit all Claims electronically or by mail to CalOptima at Attention: Accounting Department, 505 City Parkway West, Orange, CA 92868. Professional is solely responsible for reimbursing its Contracted Providers for providing Covered Services for Professional under this Contract and shall ensure that all Contracted Providers agree to accept payment from Professional as payment in full for Covered Services provided to Members.

4.3 Payment Codes and Modifiers. Professional shall utilize current payment codes and modifiers when billing CalOptima. CPT or HCPC codes not contained in the Medi-Cal or Medicare fee schedule at the time of service are not reimbursable.

4.4 Claims Requiring Additional Justification. If the billed charges are determined to be unallowable, in excess of usual and customary charges, or inappropriate pursuant to a medical review by CalOptima, CalOptima will contact Professional for additional justification, and these will be handled on a case-by-case basis.

4.5 Prompt Payment. CalOptima shall make payments to Professional in the time and manner set forth in CalOptima Policies and applicable laws.

4.6 Claims Deficiencies. CalOptima shall deny payment for any Claim that fails to meet requirements set forth in CalOptima Policies and applicable laws for Claims processing, and CalOptima shall notify Professional of any denial pursuant to CalOptima Policies and applicable laws.

4.7 Claims Auditing. Professional acknowledges CalOptima's right to conduct post-payment billing audits under this Contract. Professional and its Contracted Providers will cooperate with CalOptima's audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting records and other related data. CalOptima will use established industry standards and federal and State guidelines to determine the appropriateness of the billing, coding, and payment. This section will survive any termination of the Contract.

4.8 Coordination of Benefits (COB). Professional acknowledges that Medi-Cal is the payor of last resort. Professional shall coordinate benefits with other programs or entitlements recognizing where Other Health Coverage ("**OHC**") is primary coverage in accordance with CalOptima Program requirements.

4.9 Crossover Claims. The Medi-Cal reimbursement rates in this Contract will not apply to Crossover Claims for Dual Eligible Members. For Crossover Claims, CalOptima will reimburse Professional in accordance with CalOptima Policies, Government Contracts, Medi-Cal and Medicare program requirements, and state and federal laws and regulations. California law limits Medi-Cal program reimbursement for a Crossover Claim to an amount that, when combined with the Medicare or OHC payment, does not exceed Medi-Cal's maximum allowed for similar services as required by Welfare and Institutions Code § 14109.5. "**Crossover Claim(s)**" means claims for Dual Eligible Members where Medi-

Cal is the secondary payer and Medicare or OHC is the Primary payor for dates of service during which the Dual Eligible Member was not assigned to one of CalOptima's programs. "**Dual Eligible Members**" means Members who are eligible for both Medicare or OHC and Medi-Cal benefits.

5. Directed Payments for Qualifying Medi-Cal Covered Services.

CalOptima shall administer directed payments for the Proposition 56 Medi-Cal Physician Supplemental Payment Program ("**Prop 56 Program**") for qualifying Medi-Cal Covered Services relevant to this Contract in accordance with CalOptima Policy FF.2012 and this Section 5.

5.1 For purposes of this Section 5, "**Qualifying Services**" means services described by the Prop 56 Program, which may be revised to include additional CPT codes, rate adjustments, and extensions. Services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.

5.2 CalOptima shall forward to Professional rendering Qualifying Services an additional payment for the Qualifying Services in accordance with applicable laws and CalOptima Policies.

5.3 CalOptima shall make payments to Professional for Qualifying Services in conjunction with the payment of the Claim for the service. Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable.

5.4 Professional acknowledges that DHCS has indicated that payments to eligible providers will be verified by DHCS. If that future DHCS reconciliation of the Prop 56 Program payments identifies invalid payments, Professional shall return such Prop 56 Program payments to CalOptima immediately upon notice from CalOptima.

5.5 As long as the State of California extends the Prop 56 Program payments to CalOptima, CalOptima will continue to make Prop 56 Program payments to Professional, which may be subject to Board approval and changes to the program, as necessary and appropriate to comply with applicable laws.

ATTACHMENT B-1
SUPPLEMENTAL COMPENSATION
PROPOSITION 56 FUNDING

This Attachment B-1 provides the terms and conditions, in addition to any state and federal laws, regulations, or guidance, under which CalOptima shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program.

The California Healthcare, Research and Prevention Tobacco Tax Act (Prop 56), allocates a specified portion of the tobacco tax revenue to fund health care expenditures. Medicaid agencies are required to make supplemental payments to Professional for certain procedures as set forth in amendments to the State Medicaid Plan.

CalOptima agrees to make certain Prop 56 increases to Professionals who render Qualifying Services

1. Definitions: The following terms shall have the following meanings for purposes of this Attachment B-1:
   - 1.1 "Eligible Contracted Provider" shall mean a Provider who is contracted with Professional to provide Medi-Cal services to CalOptima members. Federally Qualified Health Centers, Rural Health Clinics, American Indian Health Programs, and cost-based reimbursement clinics, however, do not qualify as Eligible Contracted Providers.
   - 1.2 "Qualifying Services" shall mean services described by the Proposition 56 Medi-Cal Physician Supplemental Payment Program, which may be revised to include additional CPT codes, rate adjustments, and extensions.
   - 1.3 Notwithstanding the above, services provided to Members who are dually eligible for Medi-Cal and Medicare Part B are not Qualifying Services.
2. CalOptima shall administer the Prop 56 increase in accordance with applicable state and federal requirements and CalOptima policies. CalOptima shall forward to Eligible Contracted Providers rendering Qualifying Services an additional payment for the Qualifying Services in accordance with this Attachment in addition to any payment paid by CalOptima to the Eligible Contracted Professional under their existing contractual arrangements.
3. CalOptima shall make payments to Eligible Contracted Providers for Qualifying Services in conjunction with the payment of the claim for the service. Payments for Qualifying Services may be made retrospectively or in conjunction with the claim payment as applicable
4. Professional acknowledges that DHCS has indicated that payments to Eligible Contracted Providers will be verified by DHCS. In the event that future DHCS reconciliation of the Prop 56 Increase Payments identifies invalid payments, Professional shall return such Prop 56 Increase Payments to CalOptima immediately upon notice from CalOptima.
5. As long as the State of California extends the Prop 56 increase payments to CalOptima, CalOptima will continue to make Prop 56 increase payments to Professional, which may be subject to Board approval and the changes to the program, as necessary and appropriate to comply with the law and regulatory guidance.
6. Notwithstanding other provisions of this Attachment B-1, CalOptima shall administer the Proposition 56 Medi-Cal Physician Supplemental Payment Program pursuant to Article 4, Section 4.13 of the Contract.

ATTACHMENT C

PROFESSIONAL / PRACTITIONER

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Back to Agenda Back to Item

ATTACHMENT D
SPECIAL PROVISIONS

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Back to Agenda Back to Item

ATTACHMENT E
DISCLOSURE FORM

Pursuant to DHCS APL 23-006, Medi-Cal managed care plans like CalOptima must comply with the ownership and control disclosure requirements as set forth in 42 CFR § 455.104 by collecting information on whether their Subcontractors are persons with ownership or control interest or managing employees. Professional shall complete and return this form to CalOptima in accordance with CalOptima instructions prior to the Effective Date and submit updates to this form to CalOptima within thirty (30) days of any change to this form.

The undersigned hereby certifies that the following information regarding «Provider_Name_as_listed_on_W9» (the "Professional") is true and correct as of the date set forth below:

Form of Professional (Corporation, Partnership, Sole Proprietorship, Individual, etc.):

{{*Company Type1_es_:signer1:multiline(4) }}

Officer(s)/Director(s)/General Partner(s)/Managing Employees:

{{*Owner1_es_:signer1:multiline(4) }}

Co-Owner(s):

{{*Co-Owner1_es_:signer1:multiline(4) }}

Individuals with an Ownership or Control Interest owning more than five percent (5%) of the Professional's stock: Please list all individuals with an ownership or control interest. Include each person's name, address, date of birth (DOB), and Social Security Number (SSN). Indicate the title (*e.g.* chief executive officer, owner) and if an owner, the percentage of ownership.

Name	Title	% Ownership	DOB	SSN
{{*Indv1_es_:signer1:multiline}}	{{*Tlt1_es_:signer1:multiline}}	{{*O%1_es_:signer1:pct(>=0,<=100)}}	{{*dob1_es_:signer1:isdate}}	{{*SN1_es_:signer1:num}}
{{Ind2_es_:signer1:multiline}}	{{Tlt2_es_:signer1:multiline}}	{{O%2_es_:signer1:pct(>=0,<=100)}}	{{dob2_es_:signer1:isdate}}	{{SN2_es_:signer1:num}}
{{Ind3_es_:signer1:multiline}}	{{Tlt3_es_:signer1:multiline}}	{{O%3_es_:signer1:pct(>=0,<=100)}}	{{dob3_es_:signer1:isdate}}	{{SN3_es_:signer1:num}}

Corporation with and Ownership or Controlling Interest holding more than five percent (5%) of the Professional's debt: Please list all corporations with an ownership or control interest in the applicant. Include the Tax Identification Number (TIN), the percent of ownership in the applicant, the P.O. Box address(es). Attach additional pages as needed.

Name of Corporation	TIN	% Ownership	P.O. Box
{{*Ownership(%)1_es_:signer1:multiline }}	{{*TN1_es_:signer1}}	{{*O%4_es_:signer1:pct(>=0,<=100)}}	{{*PO1_es_:signer1:multiline}}
{{Ownership(%)2_es_:signer1:multiline }}	{{TN2_es_:signer1}}	{{O%5_es_:signer1:pct(>=0,<=100)}}	{{PO2_es_:signer1:multiline}}
{{Ownership(%)3_es_:signer1:multiline }}	{{TN3_es_:signer1}}	{{O%6_es_:signer1:pct(>=0,<=100)}}	{{PO3_es_:signer1:multiline}}

[*signature page follows*]

Date: {{*_es_:signer1:date }}

Signature: {{*_es_:signer1:signature }}

Name: {{*Name_es_:signer1 }}

(Please type or print)

Title: {{*_es_:signer1:title }}

(Please type or print)

«Provider_Name_as_listed_on_W9»

Back to Agenda Back to Item

ADDENDUM 1
MEDI-CAL PROGRAM REQUIREMENTS

CALIFORNIA REGULATORY REQUIREMENTS

This Addendum 1 sets forth the Medi-Cal program requirements and other California statutory and regulatory provisions applicable to this Contract. In the event of a conflict between this Addendum 1 and any other provision in the Contract, the provisions in this Addendum 1 control.

1. Definitions.

1.1 "**Downstream Subcontractor**" means an individual or an entity that has an agreement with a Subcontractor or a Downstream Subcontractor that includes a delegation of Professional's and Subcontractor's duties and obligations under the Contract.

1.2 "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one or more of the following: (i) placing the Member's health in serious jeopardy; (ii) serious impairment of bodily functions; (iii) serious dysfunctions to any bodily organ or part; or (iv) death.

1.3 "**Health Equity**" means the reduction or elimination of health disparities, health inequities, or other disparities in health that adversely affect vulnerable populations.

1.4 "**Laws**" means, without limitation, federal, state, tribal, or local statutes, codes, orders, ordinances, and regulations applicable to this Addendum 1.

1.5 "**Quality Improvement and Health Equity Transformation Program**" or "**QIHETP**" means the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in Laws, Government Program Requirements.

2. Compliance with Laws. This Contract shall be governed by and construed in accordance with all Laws and applicable regulations governing the DHCS Contract, including the Knox Keene Act, Health and Safety ("**H&S**") Code §§ 1340 *et seq*., unless otherwise excluded under the DHCS Contract; 28 CCR §§ 1300.43 *et seq*; Welfare & Institutions ("**W&I**") Code §§ 14000 and 14200 *et seq*.; and 22 CCR §§ 53800 *et seq*., 53900 *et seq*. Professional will comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program, including all applicable requirements specified in the DHCS Contract, Laws, sub-regulatory guidance, and DHCS All Plan Letters ("**APLs**") and policy letters, and CalOptima Policies. Professional shall comply with all monitoring requirements of the Contract, the DHCS Contract, and any other monitoring requests by DHCS and CalOptima. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.4), (A.5), (A.11), (B.7), (B.8), and (B.11)]

3. Provider Data. As applicable, Professional and its Subcontractors will submit to CalOptima complete, accurate, reasonable, and timely provider data, Program Data, Template Data, and any other reports or data as requested by CalOptima to meet its reporting requirements to DHCS. Professional shall submit all provider data to CalOptima in the form, format, and timeframe requested by CalOptima. Professional will make corrections to provider data as requested by CalOptima. Professional data shall include all data required under the Contract – including reports and provider rosters. For purposes of this section, (1) "**Program Data**" means data that includes but is not limited to: Grievance data, Appeals data, medical exemption request denial reports and other continuity of care data, out-of-network request data, and PCP assignment data as of the last calendar day of the reporting month; and (2) "**Template Data**" means data reports submitted to DHCS by CalOptima, which includes, but is not limited to: data of Member populations, health

care benefit categories, or program initiatives. [DHCS Contract, Exhibit A, Attachment III, §§ 1.2.5, 2.1.4, 2.1.5, 2.1.6, 3.1.5(A.6) and (B.10)]

4. Encounter Data. As applicable, Professional will submit to CalOptima complete, accurate, reasonable, and timely Encounter Data needed by CalOptima in order to meet its reporting requirements to DHCS in compliance with applicable DHCS APLs, including APL 14-020 and any superseding or amendment APLs. All Encounter Data shall be submitted to CalOptima no later than ninety (90) days from the Date of Service in the form and format as designated by CalOptima. Professional will cooperate as requested by CalOptima if corrections to Encounter Data are required for CalOptima to comply with reporting requirements to DHCS. [DHCS Contract, Exhibit A, Attachment III, §§ 2.1.2, 3.1.5(A.6) and (B.10)]

5. Reports. Professional and its Subcontractors agree to submit all reports required and requested by CalOptima to comply with applicable laws in a form acceptable to CalOptima. [DHCS APL 19-001, Attachment A, Requirement 6]

6. California Health and Human Services ("**CalHHS**") Data Exchange. Professional shall (i) execute the CalHHS Data Sharing Agreement ("**DSA**"), (ii) comply with the DSA requirements, including the CalHHS policies and procedures incorporated into the DSA, and (iii) participate in the real-time exchange of, or provision of access to, health information between and among other DSA participants, including CalOptima and any other Participating Providers providing services to Members. [H&S Code § 130290]

7. Additional Subcontracting Requirements. If Professional is allowed to subcontract services under this Contract and does so subcontract, then Professional shall, upon request, provide copies of such Subcontracts to CalOptima and/or DHCS.

   7.1 Subcontracts for Provision of Covered Services. Professional shall maintain copies of all contracts it enters into related to ordering, referring, or rendering Covered Services under the Contract. Professional will ensure that such contacts are in writing. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.7)]

   7.2 Subcontracts. Professional shall require all Subcontracts and downstream Subcontracts that relate to the provision of Covered Services be in writing and include all applicable provisions of the Contract and this Medi-Cal Program Addendum including:

      7.2.1 The services to be provided by the Subcontractor, term of the Subcontract (beginning and ending dates), methods of extension, renegotiation, termination, and full disclosure of the method and amount of compensation or other consideration to be received by the Subcontractor.

      7.2.2 As applicable, Section 2, *Compliance with Laws*; Section 3, *Provider Data*; Section 4, *Encounter Data*; Section 7, *Additional Subcontractor Requirements*; Section 8, *Records Retention*; Section 9, *Access to Books and Records*; Section 10, *Records Related to Recovery for Litigation*; Section 11, *Transfer*; Section 12, *Unsatisfactory Performance*; Section 13, *Hold Harmless*; Section 14, *Prohibition on Member Claims and Member Billing*; Section 15, *Prospective Requirements*; Section 16, *Network Provider Training*; Section 17, *Language Assistance and Interpreter Services*; Section 18, *Fraud, Waste, and Abuse Reporting*; Section 19, *Provider Identified Overpayments*; Section 20, *Health Care Provider's Bill of Rights*; Section 21, *Provider Grievances*; Section 22, *Effective Dates*; Section 23, *Assignment and Sub-delegation*; Section 24, *Quality Improvement & Utilization Management*; Section 26, *Emergency Services and Post-Stabilization Delegation*; Section 29, *Amendment and Termination*; Section 30, *Delegated Activities*; Section 31, *Utilization Data*; Section 59, *DHCS Beneficiary*; and any other section

of this Attachment E that is applicable to the obligations Subcontractor has undertaken.

7.2.3 An agreement that Subcontractors shall notify Professional of any investigations into Subcontractor's professional conduct, or any suspension of or comment on a Subcontractor's professional licensure, whether temporary or permanent.

7.2.4 An agreement requiring Subcontractor to sign a Declaration of Confidentiality pursuant to Section 6.5.3 of the Contract, which shall be signed and filed with DHCS prior to the Subcontractor being allowed access to computer files or any other data or files, including identification of Members.

[DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.12)]

8. Records Retention. Professional and Subcontractors shall maintain and retain all books and records of all items and services provided to Members, including Encounter Data, in accordance with good business practices and generally accepted accounting principles for a term of at least ten (10) years from the final date of the DHCS Contract, or from the date of completion of any audit, whichever is later. Records involving matters which are the subject of litigation shall be retained for a period of not less than ten (10) years following the termination of litigation. Professional's books and records shall be maintained within, or be otherwise accessible within the State and pursuant to H&S Code § 1381(b). Such records shall be maintained in chronological sequence and in an immediately retrievable form that allows CalOptima and/or representatives of any regulatory or law enforcement agency immediate and direct access and inspection of all such records at the time of any onsite audit or review.

This provision shall survive the expiration or termination of this Contract.

[DHCS Contract, Exhibit A, Attachment III, §§ 1.3.4.D, 3.1.5(A.9) and (B.14); H&S Code § 1381; 28 CCR 1300.81]

9. Access to Books and Records. Professional agrees, and shall ensure its Subcontractors agree in Subcontracts, to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining directly or indirectly to the goods and services furnished under the terms of the Contract available for the purpose of an audit, inspection, evaluation, examination or copying at any time (i) in accordance with inspections and audits as directed by CalOptima, Regulators, the Department of Justice ("**DOJ**"), Office of Attorney General Division of Medi-Cal Fraud and Elder Abuse ("**DMFEA**"), DHCS's External Quality Review Organization contractor, and any other State or federal entity and their duly authorized designees statutorily entitled to have oversight responsibilities over CalOptima and/or Professional and its Subcontractors; (ii) at all reasonable times at Professional's and Subcontractor's respective places of business or at such other mutually agreeable location in the State; and (iii) in a form maintained in accordance with the general standards applicable to such book or record keeping. Professional and Subcontractors shall provide access to all security areas and facilities and cooperate and assist State representatives in the performance of their duties. If DHCS, CMS, DMFEA, or DOJ or any other authorized State or federal agency, determines there is a credible allegation of fraud against Professional, CalOptima reserves the right to suspend or terminate the Professional from participation in the Medi-Cal program; immediately suspend payments to Professional; seek recovery of payments made to Professional or any Subcontractor; impose other sanctions provided under the DHCS Contract, and conduct additional monitoring.

As permitted under applicable laws, Professional and Subcontractors shall cooperate in the audit process by signing any consent forms or documents required by but not limited to: DHCS, DMHC, the DOJ, Attorney General, Federal Bureau of Investigation, Bureau of Medi-Cal Fraud, and/or

CalOptima to release any records or documentation Professional may possess in order to verify Professional's records.

This provision shall survive the expiration or termination of this Contract and Subcontractors. [DHCS Contract, Exhibit A, Attachment III, § 1.3.4(D), § 3.1.5 (A.8) and (B.13); Exhibit E, § 1.1.22(B); APL 19-001, Attachment A; APL 17-001]

10. Records Related to Recovery for Litigation. Upon request by CalOptima, Professional shall timely gather, preserve and provide to CalOptima, DHCS, CMS, DMFEA, and any authorized State or federal agency in the form and manner specified by such entity, any information subject to any lawful privileges, in Professional's or its Subcontractors' possession, relating to threatened or pending litigation by or against CalOptima or DHCS. If Professional asserts that any requested documents are covered by a privilege, Professional shall: (i) identify such privileged documents with sufficient particularity to reasonably identify the documents while retaining the privilege; and (ii) state the privilege being claimed that supports withholding production of the document. Professional agrees to promptly provide CalOptima with copies of any documents provided to any party in any litigation by or against CalOptima or DHCS. Professional acknowledges that time is of the essence in responding to such requests. Professional shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production requests, or requests for records received by Professional or its Subcontractors related to this Contract or Subcontracts. Professional further agrees to timely gather, preserve, and provide to DHCS any records in Professional's or its Subcontractor's possession. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.10) and (B.15); Exhibit E, § 1.1.27]

11. Transfer. Professional agrees and will require its Subcontractors to assist CalOptima in the transfer of Member care if in the event of: (i) termination of the DHCS Contract for any reason in accordance with the terms of the DHCS Contract; (ii) termination of this Contract for any reason; or (iii) a Subcontract terminates for any reason. Such assistance will include making available to CalOptima and DHCS copies of each Member's medical records and files, and any other pertinent information necessary to provide affected Members with case management and continuity of care. Such records will be made available at no cost to CalOptima, DHCS, or Members. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.11) and (B.16); Exhibit E, § 1.1.17(B)]

12. Unsatisfactory Performance. Professional agrees that the Contract or Professional's participation in the Medi-Cal program will be terminated, or subject to other remedies, if DHCS or CalOptima determine that Professional has not performed satisfactorily. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.12)]

13. Hold Harmless. Professional and its Subcontractors shall accept CalOptima's payment as described in this Contract as payment in full for all Covered Services and Administrative Services. Professional and its Subcontractors agree to hold harmless both the State and Members in the event that CalOptima cannot or will not pay for obligations undertaken by Professional pursuant to this Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.13) and (B.18)]

14. Prohibition on Member Claims and Member Billing. Professional and its Subcontractors will not bill or otherwise collect reimbursement from a Member for any services provided under this Contract. Professional and its Subcontractors will ensure that Members are not balance billed for any service provided out of network. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.14); 3.3.6; 5.2.7]

15. Prospective Requirements. CalOptima will inform Professional of prospective requirements added by State or federal law, or DHCS to the DHCS Contract that would impact Professional's obligations before the requirement becomes effective. Professional agrees to comply with the new requirements within thirty (30) calendar days of the effective date, unless otherwise instructed by

CalOptima or DHCS. Professional will ensure Subcontractors are (i) informed of prospective requirements that would impact their obligations before the requirements become effective and (ii) agree to comply with new requirements within thirty (30) calendar days of the effective date, unless otherwise instructed by CalOptima or DHCS. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.15), (B.22), and (B.23)]

16. Network Provider Training. Professional shall participate in training required by CalOptima in order for CalOptima to comply with the DHCS Contract. Such provider training may include, utilization management training, quality of care for children (early periodic screening, diagnosis and testing) training, Member's rights, and advanced directives. Training will also include training on cultural competency and linguistic programs as outlined in this section. Professional shall ensure that all Subcontractors receive all applicable training. [DHCS Contract, Exhibit A, Attachment III, §§ 2.3(F), 3.2.5, 5.1.1, 6.1.3(C)]

    16.1 Diversity, Health Equity, Cultural Competency, and Sensitivity Training. Professional shall ensure that annual diversity, Health Equity, cultural competency/humility, and sensitivity training is provided for employees and staff at key points of contact, pursuant to the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.16) and (B.24); 5.2.11(C)]

    16.2 Cultural/Linguistic Training Programs. Professional shall participate in and comply with any applicable performance standards, policies, procedures, and programs established from time to time by CalOptima and federal and State agencies and provided or made available to Professional with respect to cultural and linguistic services, including attending training programs and collecting and furnishing cultural and linguistic data to CalOptima and federal and State agencies. [DHCS Contract, Exhibit A, Attachment III, § 5.2.11]

17. Language Assistance and Interpreter Services. Professional and its Subcontractors will comply with language assistance standards developed pursuant to H&S Code § 1367.04 and the DHCS Contract. Professional agrees to provide or arrange for the provision of interpreter services for Members. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.17) and (B.25); 5.1.3(F)]

18. Fraud, Waste, and Abuse Reporting. Professional shall report suspected fraud, waste, or abuse to CalOptima in accordance with the Contract. Professional agrees to provide CalOptima with all information reasonably requested by CalOptima, DHCS, or other State and federal agencies with jurisdiction in order for CalOptima to comply with fraud, waste, or abuse investigations and reporting requirements. In the course of a fraud, waste, or abuse investigation, CalOptima may share with Professional information that DHCS has disclosed to CalOptima ("**FWA Confidential Data**"). Professional acknowledges and agrees to maintain FWA Confidential Data confidentially. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.2(D), 3.1.5(A.18) and (B.26),]

19. Provider Identified Overpayments. In addition to Overpayment requirements under the Contract, Professional shall report in writing to CalOptima when it has received an Overpayment, identify the reason for the Overpayment, and promptly return the overpayment to CalOptima as outlined within sixty (60) days of the date Professional identified the Overpayment. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.6, 3.1.5(A.19) and (B.27)]

20. Health Care Providers' Bill of Rights. Notwithstanding anything in this Contract to the contrary, Professional shall be entitled to the protections of the Health Care Providers' Bill of Rights, as set forth in H&S Code § 1375.7, in the administration of this Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(A.20)]

21. Provider Grievances. Professional has the right to submit a dispute or grievance through CalOptima's formal process to resolve provider disputes and grievances pursuant to H&S Code §1367(h)(1). CalOptima's process to resolve Professional disputes or grievances are set forth in

this Contract and the CalOptima Policies. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.5(A.20), 3.2.2(B)]

22. Effective Dates. This Contract and its amendments will become effective only as set forth in the DHCS Contract, which requires filing and approval by DHCS of template contracts and amendments, and Subcontractor and Downstream Subcontractor agreements and amendments. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.2, 3.1.5(B.4)]

23. Assignment and Sub-delegation. Professional agrees that any assignment or delegation of an obligation or responsibility under this Contract by Professional to a Subcontractor shall be void unless prior written approval is obtained from CalOptima and DHCS. Professional further agrees that assignment or delegation by a Subcontractor is void unless prior written approval is obtained from DHCS. CalOptima or DHCS may withhold consent at their sole and absolute discretion. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.5) and (B.6); APL 19-001, Attachment A, Requirement 14]

24. Quality Improvement & Utilization Management. Professional agrees to cooperate and participate in CalOptima's QMI program including participating in QI Program, UM Program, QIHETP, and population needs assessments. [DHCS Contract, Exhibit A, Attachment III, §§ 2.2.4, 3.1.5(B.19)]

25. Vaccines. CalOptima shall not reimburse Professional for the cost of vaccines that are available under the Vaccines for Children (VFC) program, a federal program, which provides free vaccines for eligible populations, including Medi-Cal covered children, age eighteen (18) years and younger. For all other vaccines, CalOptima will reimburse Professional at the current Medi-Cal Fee schedule for vaccines that are recommended by the CHDP/AAP for ages nineteen and over when billing is submitted on a CMS-1500, UB-04 claim form, or electronic equivalent.

26. Emergency Services and Post-Stabilization Delegation. Responsibility for coverage and payment of Emergency Services and post-stabilization care services have not been delegated to Professional under the Contract. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.9)].

27. Telehealth. When providing any Covered Services through telehealth and/or subsequently billing for telehealth Covered Services, Professional shall ensure that it complies with all applicable statutory and regulatory requirements, including H&S Code § 1374.13; W&I Code §§ 14132.72, 14132.100, and 14132.725; Business & Professions Code § 2290.5, and DHCS APL 23-007 (and any successor guidance) (collectively "**Telehealth Requirements**"). These Telehealth Requirements include (i) obtaining and documenting Member consent to use telehealth; (ii) ensuring the services can be appropriately delivered via telehealth; (iii) offering telehealth services via in-person, face-to-face interactions, as well, or arranging for referrals and facilitating in-person care so that a Member does not have to independently contact a different Provider; (iv) establishing all new patients through telehealth using an approved methodology; (v) complying with all privacy and confidentiality laws in rendering services; and (vi) satisfying the required documentation and coding requirements, as further outlined in CalOptima Policies. Claims for Covered Services provided through telehealth may not be reimbursable under the Contract if Professional did not comply with these Telehealth Requirements.

28. Electronic Prescriptions. Professional and any Subcontractors who may issue prescriptions under Business & Professions Code § 4040(a) shall have the capacity to prescribe electronically and shall issue electronic prescriptions in accordance with Business & Professions Code § 688.

29. Amendment and Termination. Professional agrees to notify DHCS if this Contract or an agreement with a Subcontractor is amended or terminated for any reason. For purposes of this section, notice is considered given when the notice is properly addressed and deposited in the United States Postal

Service as first-class registered mail, postage prepaid. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.17); APL 19-001, Attachment A, Requirement 13]

30. Delegated Activities. If Professional is specifically delegated by CalOptima, delegated activities and reporting requirements will be further set forth in a separate attachment or addendum to this Contract. Such delegation may include, claims processing, utilization management, quality improvement, Health Equity activities, credentialing activities, and any other obligation that CalOptima is permitted to delegated to Professional, to the extent agreed upon between CalOptima and Professional. Professional agrees to perform and will require its Subcontractors to perform the obligations and functions of CalOptima undertaken pursuant to the Contract, including but not limited to reporting responsibilities, in compliance with CalOptima's obligations under the DHCS Contract in accordance with 42 CFR § 438.230(c)(1)(ii). Professional agrees to the revocation of the delegated activities and/or obligations, and/or any other specific remedies in instances where DHCS or CalOptima determine that Professional has not performed satisfactorily. If CalOptima delegates quality improvement activities, the Parties agree that the Contract will include provisions that address, at a minimum: (i) quality improvement responsibilities, and specific delegated functions and activities of CalOptima and Professional; (ii) CalOptima's oversight, monitoring, and evaluation processes and Professional's agreement to such processes; (iii) CalOptima's reporting requirements and approval processes, including, Professional's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly; and (iv) CalOptima's actions/remedies if Professional's obligations are not met. [DHCS Contract, Exhibit A, Attachment III, §§ 3.1.1, 3.1.5(B.1), (B.8), (B.20), and (B.28); APL 19-001, Attachment A, Requirement 22]

31. Utilization Data. If and to the extent that the Professional is responsible for the coordination of care for Members, CalOptima shall share with Professional, in accordance with the appropriate Declaration of Confidentiality signed by Professional and filed with DHCS, any utilization data that DHCS has provided to CalOptima, and Professional shall receive the utilization data provided by CalOptima and use solely for the purpose of Member care coordination. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.21); APL 19-001, Attachment A, Requirement 23]

32. Medical Decisions. Professional will ensure that medical decisions or any course of treatment in the provision of Covered Services by Professional, Subcontractors, or Downstream Subcontractors are not unduly influenced by fiscal and administrative management. [DHCS Contract, Exhibit A, Attachment III, § 1.1.5]

33. Capacity, Licensure, and Enrollment. Professional and its Subcontractors shall furnish to Medi-Cal Members those Medically Necessary Covered Services that Professional and Subcontractor is authorized to provide under this Contract, consistent with the scope of Professional's and/or Subcontractor's license, certification, and/or accreditation, and in accordance with professionally recognized standards. Professional and its Subcontractors agree to comply with required provider screening, enrollment, and credentialing and recredentialing requirements. Professional warrants that it has and shall maintain through the Term adequate staff to comply with its obligations under the Contract and will require its Subcontractors to maintain adequate staff as well. [DHCS Contract, Exhibit A, Attachment III, § 1.3.3]

34. Medi-Cal Enrollment. If Professional is a provider type that is not able to enroll in Medi-Cal through the DHCS, Professional shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of 22 CCR § 51000.35.

35. Prohibition Against Payment to Excluded Providers. Professional agrees that CalOptima is prohibited from contracting with individuals excluded from participation in State or federal programs and agrees that CalOptima shall not pay Professional if Professional is excluded from

State or federal programs, as outlined in Section 9.17 of the Contract. Professional further agrees to not contract with or make payments to Subcontractors excluded from State or federal programs. [DHCS Contract, Exhibit A, Attachment III, §§ 1.3.4, 3.3.18]

36. Ownership Disclosure Statement. Prior to commencing services under this Contract, Professional shall provide CalOptima with the disclosures required by 42 CFR §§ 438.608(c)(2), 438.602(c), and 455.105, including the names of the officers and owners of Professional holding more than five percent (5%) of the stock issued by Professional, and major creditors holding more than five percent (5%) of the debt of Professional by completing the form in Attachment E, and Professional shall notify CalOptima whenever changes occur to the information provided therein. Professional shall promptly notify CalOptima of any change in the required disclosures. [DHCS Contract, Exhibit A, Attachment III, § 1.3.5; Exhibit E, § 1.1.11(A.5)]

    36.1 If a Subcontractor is not eligible to enroll in Medi-Cal, Professional shall provide an accurate, current, signed copy of the DHCS Medi-Cal Disclosure Form, DHCS-6216, or such other disclosure form as DHCS may otherwise specify to meet the requirements of 22 CCR § 51000.35 for the Subcontractor.

37. Performance Improvement Projects. Professional and Subcontractors shall comply with all applicable performance standards and participate in performance improvement projects ("**PIP**s"), including any collaborative PIP workgroups, as may be directed by CMS, DHCS, or CalOptima. [DHCS Contract, Exhibit A, Attachment III, § 2.2.9(A)-(B)]

38. No Punitive Action. CalOptima will not take punitive action against Professional if Professional requests an expedited resolution of or supports a provider or Member appeal. CalOptima will not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member (i) for the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, including any information the Member needs in order to decide among all relevant treatment options; (ii) for the risks, benefits, and consequences of treatment or non-treatment; (iii) for the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment; and (iv) to express preferences about future treatment decisions. [DHCS Contract, Exhibit A, Attachment III, §§ 3.2.7, 4.6.5(A)]

39. Claims Processing. CalOptima will process claims in accordance with the DHCS Contract, H&S §§ 1371 through 1371.36 and their implementing regulations, and as outlined in the CalOptima Policies. If Professional is responsible for claims payments, Professional will pay claims consistent with this provision. [DHCS Contract, Exhibit A, Attachment III, § 3.3.5]

40. Cost Avoidance/Other Health Coverage. Professional acknowledges that Medi-Cal is a payor of last resort except for services in which Medi-Cal is required to be the primary payer. Accordingly, CalOptima shall not pay claims for services provided to a Member who has third-party coverage without proof that Professional has first exhausted all other payment sources. Professional shall not refuse to provide Covered Services to Members when OHC is indicated in the Member's Medi-Cal eligibility record. Professional shall review the Member's eligibility record for third party coverage, and if the Member has third-party coverage, Professional must notify the Member to seek the service from the third-party coverage. [DHCS Contract, Exhibit E, § 1.1.25(G)]

41. Public Record. Notwithstanding any other term of the Contract, this Contract and all information received in accordance with the DHCS Contract will be public record on file with DHCS, except as specifically provided by Laws. DHCS ensures the confidentiality of information and contractual provisions filed with DHCS to the extent the information and provisions are specifically exempted by Laws. [DHCS Contract, Exhibit A, Attachment III, § 3.1.11]

42. Provider Preventable Condition. CalOptima will not pay Professional for a provider preventable condition as described in 42 C.F.R. § 438.3(g). As a condition of payment, provider shall comply with reporting requirements on provider preventable conditions in the form and frequency required by DHCS in APL 17-009 or any superseding APL. [DHCS Contract, Exhibit A, Attachment III, § 3.3.17]

43. Member Rights. Professional and Subcontractors will not retaliate or take any adverse action against a Member for exercising the Member's rights under the DHCS Contract. [DHCS Contract, Exhibit A, Attachment III, § 5.1.1(A.1.r)]

44. Medical Records. All medical records shall be maintained in accordance with CalOptima Policies. Professional shall ensure that an individual is delegated the responsibility of securing and maintaining medical records at each Subcontractor site. [DHCS Contract, Exhibit A, Attachment III, § 5.2.14]

45. Timely Access/Standards of Accessibility. Professional and Subcontractors will comply with applicable standards of accessibility and timely access requirements as outlined in the Contract and in CalOptima Policies. Professional and Subcontractors will comply with CalOptima's procedures for monitoring Professional's and Subcontractor's compliance with this section. [DHCS Contract, Exhibit A, Attachment III, § 5.2.5]

46. Minor Consent Services. Professional and its Subcontractors are prohibited from disclosing, and agree not to disclose, any information related to minor consent services without the express consent of the minor Member. Professional and its Subcontractors will comply with CalOptima's requirements for services to minor Members as outlined in the CalOptima Policies. [DHCS Contract, Exhibit A, Attachment III, § 5.2.8(D)]

47. Emergency Preparedness Requirements. Professional agrees to cooperate with and comply with CalOptima's Emergency requirements, policies and procedures, and training to ensure continuity of care for Members during an Emergency. For purposes of this section, "**Emergency**" means unforeseen circumstances that require immediate action or assistance to alleviate or prevent harm or damage caused by a public health crisis, natural and man-made hazards, or disasters. Professional will (i) annually submit to CalOptima evidence of adherence to CMS Emergency Preparedness Final Rule 81 Fed. Reg. 63859 and 84 Fed. Reg. 51732; (ii) advise CalOptima of Professional's Emergency plan; and (iii) notify CalOptima within twenty-four (24) hours of an Emergency if Professional closes down, is unable to meet the demands of a medical surge, or is otherwise affected by an Emergency. [DHCS Contract, Exhibit A, Attachment III, §§ 6.1, 6.1.3(C)]

48. State's Right to Monitor. Professional and Subcontractors shall comply with all monitoring provisions of this Contract, the DHCS Contract, and any monitoring requests by CalOptima and Regulators. Without limiting the foregoing, CalOptima and authorized State and federal agencies will have the right to monitor, inspect, or otherwise evaluate all aspects of the Professional's operation for compliance with the provisions of this Contract and Laws. Such monitoring, inspection, or evaluation activities will include inspection and auditing of Professional, Subcontractor, and Professional's and Subcontractors' facilities, management systems and procedures, and books and records, at any time, pursuant to 42 CFR § 438.3(h). The monitoring activities will be either announced or unannounced. To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Professional. Access will be undertaken in such a manner as to not unduly delay the work of the Professional and/or the Subcontractor(s). [DHCS Contract, Exhibit D(f) § 8; Exhibit E, § 1.1.22(B)]

49. Laboratory Testing. Professional agrees that if any performance under this Contract includes any tests or examination of materials derived from the human body for the purpose of providing

information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC § 263a and the regulations thereto. [DHCS Contract, Exhibit D(f), § 18]

50. Third Party Tort Liability. Professional and Subcontractors shall make no claim for the recovery of the value of Covered Services rendered to a Member when such recovery would result from an action involving tort liability of a third party, recovery from the estate of deceased Member, worker's compensation, class action claims or casualty liability insurance awards and uninsured motorist coverage. Professional shall identify and notify CalOptima, within five (5) calendar days of discovery, which shall in turn notify DHCS, of any action by the CalOptima Member that may result in casualty insurance payments, tort liability, Workers' Compensation awards, class action claims, or estate recovery that could result in recovery by the CalOptima Member of funds to which DHCS has lien rights under W&I Code Article 3.5 (commencing with Section 14124.70), Part 3, Division 9. [DHCS Contract, Exhibit E, §§ 1.1.25 and 1.1.26]

51. Changes in Availability or Location of Services. Any substantial change in the availability or location of services to be provided under this Contract requires the prior written approval of DHCS. Professional's proposal to reduce or change the hours, days, or location at which the services are available shall be given to CalOptima at least seventy-five (75) days prior to the proposed effective date. [Exhibit A, Attachment III, § 5.2.9]

52. Confidentiality of Medi-Cal Members.

52.1 Professional and its Subcontractors shall have policies and procedures in place to guard against unlawful disclosure of protected health information, personally identifying information, and any other Member confidential information in accordance with 45 CFR Parts 160 and 164, Civil Code §§ 1798 *et seq.* Professional and its Subcontractors shall obtain prior written authorization from the Member in order to disclose such information unless exempted by 22 CCR § 51009. [DHCS Contract, Exhibit A, Attachment III, § 5.1.1(B)]

52.2 In accordance with 42 CFR § 431.300 *et seq*., as well as W&I Code § 14100.2 and regulations adopted thereunder, Professional and its employees, agents, and Subcontractors shall protect from unauthorized disclosure the names and other identifying information, records, data, and data elements concerning persons either receiving services pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to Professional, its employees, and/or agents as a result of services performed under this Contract, except for statistical information not identifying any such persons. Professional and its employees, agents, and Subcontractors shall not use or disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima.

52.2.1 Professional and its employees, agents, and Subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Professional may release medical records in accordance with Laws pertaining to the release of this type of information. Professional is not required to report requests for medical records made in accordance with Laws.

52.2.2 With respect to any identifiable information concerning a Member under this Contract that is obtained by Professional or its Subcontractors, Professional will, at the termination or expiration of this Contract, return all such information to

CalOptima or maintain such information according to written procedures sent to the Professional by CalOptima for this purpose.

52.2.3 For purposes of this Section 52.2, identity shall include the name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

[DHCS Contract, Exhibit D(f) § 14; Exhibit E, § 1.1.23]

53. Debarment Certification. By signing this Contract, Professional agrees to comply with applicable federal suspension and debarment regulations, including 2 CFR 180 and 2 CFR 376.

53.1 By signing this Contract, Professional certifies to the best of its knowledge and belief, that it and its principals:

53.1.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

53.1.2 Have not within a three (3)-year period preceding this Contract been convicted of or had a civil judgment rendered against them for: (i) commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state, or local) transaction or contract under a public transaction; (ii) a violation of federal or State antitrust statutes; or (iii) commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, obstruction of justice, or the commission of any other offense indicating a lack of business integrity or business honesty that seriously affects its business honesty;

53.1.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state, or local) with commission of any of the offenses enumerated in Section 53.1.2, above;

53.1.4 Have not within a three (3)-year period preceding the Effective Date had one or more public transactions (federal, state, or local) terminated for cause or default;

53.1.5 Have not, within a three (3)-year period preceding this Contract, engaged in any of the violations listed under 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376;

53.1.6 Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (*i.e.*, 48 CFR Part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State; and

53.1.7 Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

53.2 If the Professional is unable to certify to any of the statements in this Section 53, Professional shall submit an explanation to CalOptima prior to the Effective Date and then immediately upon any change in the certifications above during the Term.

53.3 The terms and definitions in this Section 53 not otherwise defined in the Contract have the meanings set out in 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376.

53.4 If the Professional knowingly violates this certification, in addition to other remedies available to the federal government, CalOptima may terminate this Contract for cause.

[DHCS Contract, Exhibit (D)(f) § 20]

54. DHCS Directions. If required by DHCS, Professional and its Subcontractors shall cease specified services for Members, which may include referrals, assignment of beneficiaries, and reporting, until further notice from DHCS. [DHCS Contract, Exhibit (D)(f) § 34]

55. Lobbying Restrictions and Disclosure Certification.

55.1 This Section 55 is applicable to federally funded contracts in excess of one hundred thousand dollars ($100,000) per 31 USC § 1352. If this Section 55 is applicable to the Contract, Professional shall comply with the requirements in this Section 55, as well as complete the disclosure forms in Attachment E prior to the Effective Date.

55.2 Certification and Disclosure Requirements.

55.2.1 If this Contract is subject to 31 USC § 1352 and exceeds one hundred thousand dollars ($100,000) at any tier, Professional shall file the certification and disclosure forms in Attachment E prior to the Effective Date.

55.2.2 Professional shall file a disclosure (in the form set forth in Attachment E, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if Professional has made or has agreed to make any payment using non-appropriated funds (to include profits from any covered federal action) in connection with a contract or grant or any extension or amendment of that contract or grant that would be prohibited under Section 55.3 if paid for with appropriated funds.

55.2.3 Professional shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by Professional under Section 55.2.2. An event that materially affects the accuracy of the information reported includes:

55.2.3.1 A cumulative increase of twenty-five thousand dollars ($25,000) or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

55.2.3.2 A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

55.2.3.3 A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

55.2.4 Each Subcontractor who requests or receives from Professional or Subcontractor a contract, subcontract, grant, or subgrant exceeding one hundred thousand dollars ($100,000) at any tier under this Contract shall file a certification, and a disclosure form, if required, to the next tier above that Subcontractor.

55.2.5 All disclosure forms (but not certifications) completed under this Section 55.2 and Attachment E shall be forwarded from tier to tier until received by CalOptima. CalOptima shall forward all disclosure forms to DHCS program contract manager.

55.3 Prohibition. 31 USC § 1352 provides in part that no appropriated funds may be expended by the recipient of a federal contract, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract, the making of any federal grant, the making of any federal loan,

entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

[DHCS Contract, Exhibit (D)(f) § 37.b]

56. Air or Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of one hundred thousand dollars ($100,000) must comply with the following provisions unless said agreement is exempt by Laws. If applicable, Professional agrees to comply with all standards, orders, or requirements issued under the Clean Air Act (42 USC §§ 7401 *et seq*.), as amended, and the Clean Water Act (33 USC §§ 1251 et seq.), as amended. [DHCS Contract, Exhibit (D)(f) § 12]

57. Smoke-Free Workplace. Public Law 103-227, also known as the Pro-Children Act of 1994, requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of eighteen (18), if the services are funded by federal programs either directly or through State or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to one thousand dollars ($1,000) for each violation and/or the imposition of an administrative compliance order on the responsible party. Professional shall comply with the applicable requirements of the Pro-Children Act. Professional further agrees that it will insert this certification into any Subcontracts, if required by the Pro-Children Act. [DHCS Contract, Exhibit (D)(f) § 21]

58. Domestic Partners. Pursuant to H&S Code § 1261, if Professional is licensed pursuant to H&S Code § 1250, Professional agrees to permit a Member to be visited by a Member's domestic partner, the children of the Member's domestic partner, and the domestic partner of the Member's parent or child. [H&S Code § 1261]

59. Conflict of Interest. Professional agrees to avoid conflicts of interest or the appearance of a conflict of interest and shall (i) comply with conflict of interest avoidance requirements of the DHCS Contract; (ii) comply with any conflict avoidance plan issued by CalOptima; and (iii) notify CalOptima within ten (10) working days of becoming aware of any potential, suspected, or actual conflict of interest. [DHCS Contract, Exhibit H]

60. DHCS Beneficiary. Professional expressly agrees and acknowledges that (i) DHCS is a direct beneficiary of the Contract and any Subcontractor or Downstream Subcontractor agreement with respect to the obligations and functions undertaken under the Contract; and (ii) DHCS may directly enforce any and all provisions of the Subcontractor agreement or Downstream Subcontractor agreement. [DHCS Contract, Exhibit A, Attachment III, § 3.1.5(B.29)]

61. Employment Non-Discrimination. During the performance of this Contract, neither Professional nor any Subcontractors shall unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, medical condition, mental disability, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, military and veteran status. Professional and Subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free of such discrimination and shall comply with the provisions of the Fair Employment and Housing Act (Government Code §§ 12900 *et seq*.) and the applicable regulations promulgated thereunder (2 CCR §§ 11000 *et seq*.). The applicable

regulations of the Fair Employment and Housing Commission implementing Government Code § 12990, set forth in Chapter 5 of Division 4 of Title 2 of the CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. Professional and Subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. Professional shall include the non-discrimination and compliance provisions of this Section 61 in all Subcontracts. [DHCS Contract, Exhibit E. § 1.1.28]

61.1 Professional and all Subcontractors shall comply with federal nondiscrimination requirements in Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; Sections 504 and 508 of the Rehabilitation Act of 1973, as amended; Titles II and III of the Americans with Disabilities Act of 1990, as amended; Section 1557 of the Patient Protection and Affordable Care Act of 2010; and federal implementing regulations promulgated under the above-listed statutes. Professional and all Subcontractors shall comply with California nondiscrimination requirements, including, without limitation, the Unruh Civil Rights Act, GC sections 7405 and 11135, W&I Code section 14029.91, and State implementing regulations. [DHCS Contract, Exhibit E. §1.1.29]

62. Member Non-Discrimination. Neither Professional nor Subcontractors shall discriminate against Members or Potential Members on the basis of any characteristic protected under federal or State nondiscrimination law, including sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code § 422.56, including the statutes identified in Section 61 above. For the purpose of this Contract, if based on any of the foregoing criteria, the following constitute unlawful discriminations: (i) denying any Member any Covered Services or availability of a Facility; (ii) providing to a Member any Covered Service that is different or is provided in a different manner or at a different time from that provided to other similarly situated Members under this Contract, except where medically indicated; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; (iv) restricting or harassing a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; (v) assigning times or places for the provision of services on the basis of the sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code § 422.56, to the Members to be served; (vi) treating a Member or potential Member differently from others in determining whether they satisfy any admission, Enrollment, quota, eligibility, membership; or adding other requirements or conditions which Members must meet in order to be provided any Covered Service; (vii) utilizing criteria or methods of administration which have the effect of subjecting individuals to discrimination; (viii) failing to make auxiliary aids available, or to make reasonable accommodations in policies, practices, or procedures, when necessary to avoid discrimination on the basis of disability; and (ix) failing to ensure meaningful access to programs and activities for limited English proficiency Members and potential Members.

62.1 Professional shall take affirmative action to ensure all Members are provided Covered Services without unlawful discrimination, except where needed to provide equal access to limited English proficiency Members or Members with disabilities, or where medically indicated. For the purposes of this Section 62, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's

offspring, but which causes no adverse effects on the carrier. Such genetic handicap shall include Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

62.2 Professional shall act upon all complaints alleging discrimination against Members in accordance with CalOptima's Member Complaint Policy and shall forward copies of all such grievances to CalOptima, attention Grievance & Appeals Resolution Services, within five (5) days of receipt of same.

62.3 Professional shall require all Subcontractors to cooperate with CalOptima's Member Complaint Policy and time requirements to Appeal within designated time frames.

[DHCS Contract, Exhibit E § 1.1.30]

63. Program Integrity and Compliance Program. Professional will comply with CalOptima's program integrity and compliance program. [DHCS Contract, Exhibit A, Attachment III, § 1.3]

64. Federally Qualified Health Centers ("**FQHC**"), Rural Health Centers ("**RHC**"), or Indian Health Services ("**IHS**") Facility.

64.1 If Professional is an FQHC or an RHC, Professional will cooperate with and provide to CalOptima any information necessary for CalOptima to meet its obligations to DHCS pertaining to FQHCs and RHCs, including (i) submitting documentation of services provided, reimbursement level, and payment amounts; (ii) certifying that this Contract is offered to Professional on the same terms and conditions as those offered to other network providers providing similar services and that reimbursement is not less than the level and amount of payment which the entity would make for the service if they were furnished by a provider that is not an FQHC; (iii) allowing DHCS review and audit of CalOptima's records pertaining FQHC and RHC reimbursement.

64.2 If Professional is an FQHC or an RHC, Professional acknowledges and agrees that CalOptima is not required to pay Professional the Medi-Cal per-visit rate for the clinic. The Parties agree that any financial incentive arrangements that Professional and CalOptima enter into will comply with DHCS guidance including DHCS Contract, Attachment III, § 3.3.7(B.7) and applicable APLs.

64.3 To the extent Professional is an Indian Health Services facility that qualifies as an FQHC and RHC; Professional agrees and acknowledges that the terms of this section applicable to FQHCs and RHCs also apply to Professional.

64.4 If Provider is an Indian Health Services provider, CalOptima shall comply with all applicable provisions of DHCS APL 24-002, including any successor guidance, ("**APL 24-002**") and the Laws referenced therein, and if any other provision of this Contract conflicts with APL 24-002, the provisions of DHCS APL 24-002 shall control and supersede the conflicting provisions of this Contract.

[DHCS Contract, Exhibit A, Attachment III, § 3.3.7(B)]

65. Lead Screening. If Professional is a school-based mental health and substance use disorder provider, Professional shall ensure the provision of a blood lead screening test to Members at ages one (1) and two (2) in accordance with 17 CCR §§ 37000-37100 and applicable APLs. As applicable, Professional will follow the Childhood Lead Poising in Prevention Branch guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including making referrals to the local public health department. Professional shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide the test in the Member's medical record. If the blood lead screen test is refused, proof of voluntary refusal of the test in the form of a signed statement by the Member's parent or guardian shall be documented in the Member's medical record. If the responsible party refuses to sign this statement, the refusal

shall be documented in the Member's medical record. Documented attempts that demonstrate Professional's unsuccessful efforts to provide the blood lead screen test shall be considered towards meeting this requirement. [DHCS Contract, Exhibit A, Attachment III, §5.3.4(D)]

ADDENDUM 2
PACE PROGRAM REQUIREMENTS

This Addendum 2 sets forth the PACE program requirements and other California statutory and regulatory provisions applicable to this Contract. In the event of a conflict between this Addendum 2 and any other provision in the Contract, the provisions in this Addendum 2 control.

1. **Definitions**. PACE is a program that features a comprehensive medical and social services delivery system using an interdisciplinary team ("**IDT**") approach in an adult day health center that is supplemented by in-home and referral services, in accordance with Members' needs. The IDT is the group of individuals to which a PACE participant is assigned who are knowledgeable clinical and non-clinical PACE center staff responsible for the holistic needs of Members and who work in an interactive and collaborative manner to manage the delivery, quality, and continuity of participants' care. All PACE program requirements and services will be managed directly through CalOptima. PACE services shall include the following:

   1.1 All Medicare-covered items and services;

   1.2 All Medi-Cal-covered items and services; and

   1.3 Other services determined necessary by the IDT to improve and maintain the Members' overall health statuses..

2. **State Termination**.

   2.1 CalOptima may terminate the Contract as it applies to providing services to Members if CalOptima's PACE Agreement or DHCS Contract with DHCS terminates for any reason. CalOptima shall notify Provider of any such termination immediately upon its provision of notice of termination of the PACE Agreement or DHCS Contract, or upon receipt of a notice of termination of the PACE Agreement from DHCS or CMS, or the DHCS Contract from DHCS.

3. **Provider Responsibilities**.

   3.1 Service Area. Provider shall make PACE services available at a location accessible to Members within Orange County, California.

   3.2 Services Authorized. Provider shall furnish only those services Authorized by the CalOptima PACE IDT. A primary care provider referral is deemed an IDT Authorization.

   3.3 Interdisciplinary Team Meeting Participation. If necessary for the benefit of Member care delivery or planning, Provider shall participate in CalOptima PACE IDT meetings. Such participation may be by telephone, unless in-person attendance at such meetings is reasonably warranted under the circumstances.

   3.4 Payment in Full. Provider shall accept CalOptima's payment as payment in full for services provided to Members and shall not seek any reimbursement for services directly from Members, Medi-Cal, Medicare, or another insurance carrier or provider. Provider shall not seek any type of cost-share amount from Members for PACE Covered Services. Members shall not be liable to Provider for any sum owed by CalOptima, and Provider agrees not to maintain any action at law or in equity against Members to collect sums that are owed by CalOptima. Surcharges to Members by Provider are prohibited. Whenever CalOptima receives notice of any such surcharge, CalOptima shall take appropriate action, and Provider shall reimburse Members as appropriate.

   3.5 Hold Harmless. Provider will not bill the State, CMS, or Members if CalOptima does not pay for services performed by Provider pursuant to the Contract.

3.6 Reporting. Provider shall provide such information and written reports to CalOptima, DHCS, and HHS as may be necessary for compliance by CalOptima with its statutory obligations and to allow CalOptima to fulfill its contractual obligations to DHCS and CMS.

3.7 Coverage of Non-Network Providers. Provider agrees that should arrangements be made by Provider with another physician/provider who is not under contract with CalOptima to provide Covered Services required under the Contract, such physician/provider shall (i) accept Provider's fees from CalOptima as full payment for services delivered to Members; (ii) comply with the applicable provisions of the Contract; (iii) bill services provided through Provider's office, unless Provider has made other billing arrangements with CalOptima' (iv) not bill Members under any circumstances' and (v) cooperate with and participate in CalOptima's quality assurance and improvement program.

3.8 Compliance with the Law. Provider shall comply with the applicable provisions of 42 CFR Part 460, including 42 CFR § 460.70.

4. **Provider Personnel**. Provider's employees and any Contracted providers, providing direct patient care to PACE Members shall:

4.1 Provider shall ensure its employees and Contracted Providers providing direct patient care to PACE Members comply with all State and federal requirements for direct patient care staff in their respective setting, including:

4.1.2 Having not been convicted of criminal offenses related to their involvements with Medicare, Medicaid, Medi-Cal, or other health insurance or health care programs, or social service programs under Title XX of the Act;

4.1.3 Not a pose any potential risk to Members because of conviction or physical, sexual, drug or alcohol abuse;

4.1.4 Be free of communicable diseases; and

4.1.5 Agree to abide by the requirements, philosophy, practices and protocols of CalOptima's PACE Program and 22 CCR § 78413.

4.2 Provider shall provide documentation within one (1) business day to CalOptima, upon request, a list of all Provider personnel employed or contracted with during the requested period, including first and last name, job title, date of hire, date of termination (if terminated within the requested period), type of employment (full-time, part-time, volunteer, contractor, or other), and whether the position required a license.

4.3 Provider shall ensure its records contain the following for each employee:

4.3.1 An employment application, a full name, social security number, date of employment, date of birth, home address, educational background, and previous employment experience, including dates employed.

4.3.2 Proof that each employee received in-service training in first aid and in cardiopulmonary resuscitation within the first six (6) months of employment.

4.3.3 A background check completed prior to the employee's date of hire.

4.3.4 An OIG exclusion check completed prior to their date of hire.

4.3.5 Documentation that each employee has current and active licensure if licensure is required for their position.

4.3.6 A chest x-ray or test for tuberculosis infection for each employee, as recommended by the federal Centers for Disease Control and Prevention and licensed by the

federal Food and Drug Administration, performed not more than twelve (12) months prior to employment or within seven (7) days of employment.

4.3.7 A health examination signed by the examining physician or person lawfully authorized to perform such examination which indicates the employee is physically qualified to perform duties, is free from any condition that would create a hazard to self or others, and medically cleared of communicable diseases before engaging in direct Member contact.

4.3.8 Documentation that each employee completed the following CalOptima trainings:

4.3.8.1 Orientation to the PACE Program, including the Member Bill of Rights, service determination requests, and the grievance and appeals processes.

4.3.8.2 Skills competencies completed both ***before*** providing any independent care to Members, as well as annually.

4.4. Provider shall have written policies implementing the requirements of this Section 4 and retain employee records pertaining to this Section 4 for at least three (3) years following termination of each employee's employment.

5. **PACE Liaison**. CalOptima PACE Program director or their designee shall be designated as the liaison to coordinate activities between Provider and CalOptima.

6. **Records**. Provider shall retain PACE Program records for the latter of (i) ten (10) years from the final date of the DHCS Contract or the date of completion of any audit; or (ii) ten (10) years from the close of the current fiscal year in which the service occurred, in which the record or data was created or applied, and for which the financial record was created, unless a longer period is required by Laws.

This provision shall survive the expiration or termination of the Contract, whether with or without cause, by rescission, or otherwise.

7. **Assignment and Delegation**. The Contract is not assignable, nor are the duties hereunder delegable, by the Provider, either in whole or in part, without the prior written consent of CalOptima and DHCS, provided that consent may be withheld in their sole and absolute discretion. Any assignment or delegation shall be void unless prior written approval is obtained from both DHCS and CalOptima.

8. **Third Party Tort Liability/Estate Recovery**. Provider shall make no claim for the recovery of the value of Covered Services rendered to Members when such recovery would result from an action involving tort liability of a third party, recovery from the estate of a deceased Member, Workers' Compensation, or casualty liability insurance awards and uninsured motorist coverage. Provider shall inform CalOptima of potential third-party liability claims and provide information relative to potential third-party liability claims, in accordance with CalOptima Policies.

9. **Records Related to Recovery for Litigation**. Upon request by CalOptima, Provider shall timely gather, preserve, and provide to CalOptima, in the form and manner specified by CalOptima, any information specified by CalOptima, subject to any lawful privileges, in Provider's or its subcontractors' possession relating to threatened or pending litigation by or against CalOptima or DHCS. If Provider asserts that any requested documents are covered by a privilege, Provider shall: (i) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and (ii) state the privilege being claimed that supports withholding production of the document. Such request shall include a response to a request for documents submitted by any party in any litigation by or against CalOptima or DHCS. Provider acknowledges that time may be of the essence in responding to such request. Provider shall use all reasonable efforts to immediately notify CalOptima of any subpoenas, document production

requests, or requests for records, received by Provider or its subcontractors related to the Contract or subcontracts.

10. **DHCS Policies**. Covered Services provided under the Contract shall comply with all applicable requirements of the DHCS Medi-Cal Managed Care Program and the DHCS Long-Term Care Division.

11. **DHCS Directions**. If required by DHCS, Provider and its Subcontractors shall cease specified activities, which may include referrals, assignment of beneficiaries, and reporting, until further notice from DHCS.

12. **Turnover and Phase-Out Requirement**. Provider agrees that, upon termination of the DHCS Contract between CalOptima and DHCS, provider shall make available to CalOptima and DHCS copies of Medical Records, Member files, and any other pertinent information, including information maintained by any Subcontractor, necessary for the efficient case management of Members. Provider further agrees to assist CalOptima with phase-out for the DHCS Contract, which consists of the resolution of all financial and reporting obligations of CalOptima.

13. **Reporting Unusual Incidents or Occurrences**. Provider shall report to CalOptima within twenty-four (24) hours any unusual incidents, injuries, or occurrences of which Provider becomes aware relating to Members. For purposes of this section, an unusual incident or injury is one that threatens the welfare, safety or health of any Member and that is not consistent with Provider's routine operation or patient care practices, including a fire, explosion, epidemic outbreak, poisoning, catastrophe, major accident, or like event that occurs in or on the premises of Provider's office or facility which threatens welfare, safety or health of Members.

Back to Agenda Back to Item

ADDENDUM 3
ONECARE PROGRAM REQUIREMENTS

This Addendum 3 sets forth the OneCare program requirements and other California statutory and regulatory provisions applicable to this Contract. In the event of a conflict between this Addendum 3 and any other provision in the Contract, the provisions in this Addendum 3 control.

1. Hold Harmless. Professional agrees to hold harmless Members in case CalOptima cannot or will not pay for services under the Contract. This provision shall not prohibit collection of any applicable SOC billed in accordance with the terms of Members' evidence of coverage. Professional further agrees that this hold harmless provision shall survive the termination of the Contract regardless of the cause giving rise to the termination, shall be construed to be for the benefit of Members, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between CalOptima or Professional and Members or persons acting on their behalf that relates to liability for payment for Covered Services.

2. Accountability. Any services or other activity under the Contract performed by Professional and any of its Subcontractors will be performed in accordance with CalOptima's contractual obligations to CMS and DHCS, including the requirements at 42 C.F.R. § 438.414 in relation to the grievance system.

3. Coordination of Benefits Requirements. Professional shall coordinate with CalOptima for proper determination of COB and to bill and collect from other payers and third-party liens such charges for which the other payer is responsible. Professional agrees to establish procedures to effectively identify, at the time of service and as part of their claims payment procedures, individuals and services for which there may be a financially responsible party other than Medicare and the OneCare Product. Professional will bill and collect from other payers such amounts for Covered Services for which the other payer is responsible.

4. Submission and Prompt Payment of Claims. Professional agrees to submit claims to CalOptima in such format as CalOptima may require (but at minimum the CMS forms 1500, UB 04 or other form as appropriate) within ninety (90) days after the services are rendered. CalOptima reserves the right to deny claims that are not submitted within ninety (90) days of the date of service. CalOptima shall provide payment to Professional within forty-five (45) business days of CalOptima's receipt of a Clean Claim from Professional, or CalOptima will contest or deny Professional's claim within forty-five (45) business days following CalOptima's receipt thereof.

5. Claims Payment. CalOptima will not pay Professional for a provider preventable condition. As a condition of payment, Professional will comply with the applicable reporting requirements on provider preventable conditions as described at 42 CFR § 447.26(d) and as may be specified by CalOptima or DHCS. Professional shall comply with such reporting requirements to the extent that Professional directly furnishes services.

6. Cost-Sharing. Professional agrees that Members will not be held liable for Medicare Part A and B cost-sharing. Medicare Parts A and B services must be provided at zero cost-sharing to Members. Professional and any of its contracted providers must not impose cost-sharing requirements on Members that would exceed the amounts permitted under Medi-Cal, 42 U.S.C. § 1395w-22(a)(7), and 42 C.F.R. section 422.504(g)(1)(iii). Professional shall (i) accept reimbursement from CalOptima under the Contract as payment in full for services rendered to Members, or (ii) bill Member's Medi-Cal managed care health plan, as applicable, for any additional Medicare payments that may be reimbursed by Medi-Cal. Professional will also comply with requirements outlined in W&I Code § 14019.4 related to Medi-Cal services.

7. Federal Funds. Professional acknowledges that payments Professional receives from CalOptima are, in whole or part, from federal funds. Therefore, Professional and any of its Subcontractors are

subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 80; the Age Discrimination Act of 1975, as implemented by 45 CFR Part 91; the ADA; Section 504 of the Rehabilitation Act of 1973, as implemented by 45 CFR Part 84, and any other regulations applicable to recipients of federal funds.

8. Compliance with Medicare Laws. Professional will comply with all applicable federal and State laws (including Medicare laws), regulations, and CMS instructions, including laws and regulations designed to prevent or ameliorate FWA, including applicable provisions of federal criminal law, the False Claims Act (31 USC § 3729 *et seq*.), and the anti-kickback statute (Section 1128(B)(b) of the Social Security Act), and HIPAA administrative simplification rules at 45 C.F.R. Parts 160, 162 and 164. Further, Professional agrees that any services provided by Professional will be consistent with and will comply with CalOptima's contract with CMS ("**CMS Contract**").

9. Language Assistance. Professional will provide services in a culturally competent manner and agrees to arrange for the provision of interpreter services for Members at all Professional sites.

10. Reporting. Professional agrees to provide relevant reports, data, and information necessary for CalOptima to meet its obligations under the OneCare Product and Laws, including 42 CFR §§ 422.516 and 422.310. In addition, Professional shall report to CalOptima all cases of suspected fraud and/or abuse, as defined in 42 CFR § 455.2, relating to the rendering of Covered Services by Professional, whether by Professional, Professional's employees, Subcontractors, and/or Members within five (5) working days of the date when Professional first becomes aware of or is on notice of such activity.

11. Offshore Activities. Unless CalOptima has provided prior written authorization, all services provided by Professional pursuant to the Contract must be performed within the United States, the District of Columbia, or the United States territories.

12. Excluded Individuals/Program Integrity. Professional acknowledges and agrees that it is not excluded and shall not employ or contract for the provision of services pursuant to the Contract with any individual or entity (hereafter, "**Person**") whom Professional knows is excluded from participation in the Medicare or Medicaid programs under Section 1128 or 1128A of the Social Security Act. Professional hereby certifies that no such excluded Person currently is employed by or under contract with Professional. Professional shall ensure that the Persons it employs or contracts for the provision of services pursuant to the Contract are in good standing and not on the preclusion list, as defined in 42 CFR § 422.2. Professional shall promptly after discovery disclose to CalOptima any exclusion, or other event that makes a Professional employee or downstream entity ineligible to perform work related to federal health care programs, in accordance with 42 CFR § 422.752(a)(8). Professional agrees to be bound by the provisions set forth at 2 CFR Part 376.

13. Emergency Medical Treatment and Labor Act. Professional must comply with the federal Emergency Medical Treatment and Labor Act ("**EMTALA**"), as applicable, and ensure that there are no conflicts with hospital actions required to comply with EMTALA.

14. Punitive Action. CalOptima will not take punitive action against Professional if Professional requests an expedited resolution or supports a Member's appeal. CalOptima will not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is their patient for a Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered, for any information a Member needs in order to decide among all relevant treatment options, for the risks, benefits, and consequences of treatment or non-treatment, for a Member's

right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

15. Indemnity. Professional is not required to indemnify CalOptima for any expenses and liabilities, including judgments, settlements, attorney's fees, court costs, and any associated charges, incurred in connection with any claim or action brought against CalOptima based on CalOptima's management decisions, utilization review provisions, other policies, guidelines, or actions.

16. Member Billing Prohibitions. Professional (i) shall not impose cost-sharing requirements on Members that would exceed the amounts permitted under the Medi-Cal Program, Social Security Act § 1852(a)(7), and 42 CFR § 422.504(g)(1)(iii); (ii) shall not bill any Member for Medicare cost-sharing amounts, including deductibles, coinsurance, and copayments, as mandated under Social Security Act § 1902(n)(3)(B); (iii) agrees to accept reimbursements from CalOptima as payment in full for services rendered to Members, or to bill Medi-Cal or CalOptima, as applicable and in accordance with Laws, for any additional Medicare payments that may be reimbursed by Medi-Cal; and (iv) shall comply with W&I Code § 14019.4.

Back to Agenda Back to Item

ADDENDUM 4
CERTIFICATION REGARDING LOBBYING

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including Subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

«Provider_Name_as_listed_on_W9»	{{N_es_:signer1:fullname }}
Name of Contractor	Printed Name of Person Signing for Contractor
	{{_es_:signer1:signature}}
Contract / Grant Number	Signature of Person Signing for Contractor
{{_es_:signer1:date }}	{{_es_:signer1:title }}
Date	Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001 P.O.
Box 997413
Sacramento, CA 95899-7413

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type: initial
{{[]}} contract {{[]}} grant {{[]}} cooperative agreement {{[]}} loan {{[]}} loan guarantee {{[]}} loan insurance	{{[]}} bid/offer/application {{[]}} initial award {{[]}} post-award	{{[]}} initial filing {{[]}} material change For Material Change Only: Year {{Yr_es_signer1}} quarter {{Qtr_es_signer1}} date of last report

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
{{RepEntNm_es_signer1 }} Prime Subawardee Tier, if known: {{Tier_es_signer1 }}	{{RepEntNmSub_es_signer1 }}
Congressional District, If known: {{CongDist_es_signer1 }}	Congressional District, If known: {{CongDistSub_es_signer1 }}
6. Federal Department/Agency: {{FedDeptAgen_es_signer1 }}	7. Federal Program Name/Description: {{FedProg_es_signer1 }} CDFA Number, if applicable: {{CDFA_es_signer1 }}
8. Federal Action Number, if known: {{FedDeptNo_es_signer1 }}	9. Award Amount, if known: {{AwardAmt_es_signer1 }}
10. a. Name and Address of Lobbying Entity (If individual, last name, first name, MI): {{LobEntNm_es_signer1 }} {{LobEntAd_es_signer1 }} (attach Continuation Sheets(s)	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI): {{LobEntNm2_es_signer1}} SF-LLL-A, If necessary)
Amount of Payment (check all that apply): ${{Amt_es_signer1}} actual planned Form of Payment (check all that apply): a. {{[]}} cash b. {{[]}} in-kind, specify: Nature Value {{Value_es_:signer1 }}	1. Type of Payment (Check all that apply): {{[]}} a. retainer {{[]}} b. one-time fee {{[]}} c. commission {{[]}} d. contingent fee {{[]}} e deferred {{[]}} f. other, specify: {{Other_es_signer1}}

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in item 11:
{{SrvcPerf_es_:signer1:multiline(4) }}

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: Yes {{[]}} No {{[]}}

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $19,000 and not more than $100,000 for each such failure.	Signature: {{_es_:signer1:signature:showif(lobby=Checked)}} Print Name: {{Name_es_:signer1:showif(lobby=Checked)}} Title: {{_es_:signer1:title:showif(lobby=Checked)}} Telephone No.: {{Mobile_es_:signer1:phone:showif(lobby=Checked)}} Date: : {{_es_:signer1:date:showif(lobby=Checked)}}

Federal Use Only

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Standard Form-LLL

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.

Identify the status of the covered federal action.

Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.

Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.

If the organization filing the report in Item 4 checks “Subawardee,” then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.

Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.

Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.

Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., “RFP-DE-90401.”

For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.

10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

10. (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).

Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.

Check the appropriate box(es). Check all boxes that apply. If other, specify nature.

Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials, identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.

Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.

The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, D