



CalOptima Health

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

OCTOBER 2, 2025
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

Isabel Becerra, Chair

Maura Byron

Blair Contratto

Catherine Green, R.N.

Veronica Kelley, DSW, LCSW

Supervisor Vicente Sarmiento, Vice Chair

Supervisor Doug Chaffee

Norma García Guillén

Brian Helleland

José Mayorga, M.D.

Supervisor Janet Nguyen, Alternate

CHIEF EXECUTIVE OFFICER

Michael Hunn

OUTSIDE GENERAL COUNSEL

James Novello

Kennaday Leavitt

CLERK OF THE BOARD

Sharon Dwiers

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).

Participate via Zoom Webinar at: https://us02web.zoom.us/webinar/register/WN_qZrpnxNhSs-5PWc4w19qMA
Join the Meeting.

Webinar ID: 839 9407 1069

Passcode: 402075 -- Webinar instructions are provided below.

CALL TO ORDER

Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

1. [CalOptima Health 30th Anniversary Recognition](#)

MANAGEMENT REPORTS

2. [Chief Executive Officer Report](#)

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

3. Minutes
 - a. [Approve Minutes of the September 4, 2025 Regular Meeting of the CalOptima Health Board of Directors](#)
 - b. [Receive and File Minutes of the May 22, 2025 Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee](#)
4. [Approve Reappointment to the CalOptima Health Board of Directors' Investment Advisory Committee](#)
5. [Approve New CalOptima Health Pharmacy Policies in Accordance with Covered California Regulatory Requirements for Department of Managed Health Care Filing](#)
6. [Approve New CalOptima Health Enrollment Policy in Accordance with Covered California Regulatory Requirements for Department of Managed Health Care Filing](#)
7. [Approve CalOptima Health's Fiscal Year 2025–26 Public Policy Priorities and Authorize Related Advocacy Efforts](#)
8. [Adopt Board Resolution No. 25-1002-02, Ensuring Orange County Residents Who Are Entitled to Medi-Cal Coverage Have Access to Health Care](#)
9. [Authorize the Chief Executive Officer to Execute a Contract Amendment with Cornerstone onDemand Inc. for Continued Use of Systems and Services](#)
10. [Authorize the Chief Executive Officer to Execute a Contract Amendment with SilkRoad Technology Inc. for Continued Use of Systems and Services](#)
11. [Authorize the Chief Executive Officer to Execute a Contract Amendment with Computer Technology Corp for Continued Use of Credentialing Systems and Services](#)
12. [Authorize the Chief Executive Officer to Execute a Contract Amendment with Ceridian for Continued Use of Ceridian Human Resources Systems and Services](#)

13. Authorize the Chief Executive Officer to Execute a Contract Amendment with Change Healthcare Solutions, LLC for Continued Use of Print/Fulfillment, Electronic Data Interchange Clearinghouse, Remittance Advice, and Check Printing Systems and Services
14. Adopt Resolution No 25-1002-01 to Add Three Additional Seats and Rename Three Seats on the CalOptima Health Board of Directors' Member Advisory Committee
15. Increase Stipend Amount for Members or Authorized Family Members on the CalOptima Health Whole-Child Model Family Advisory Committee
16. Receive and File:
 - a. August 2025 Financial Summary
 - b. Compliance Report
 - c. Government Affairs Reports
 - d. CalOptima Health Community Outreach and Program Summary

REPORTS/DISCUSSION ITEMS

17. Accept, Receive, and File the Fiscal Year 2024-25 CalOptima Health Audited Financial Statements
18. Approve Modifications to CalOptima Health Policy GG.1516: Hospital Acute Administrative Days
19. Approve Actions Related to the Medi-Cal Eligibility Outreach Strategy
20. Approve Actions Related to Wellness Prevention Foundation, dba Wellness and Prevention Center allcove® San Juan Capistrano Mental Health Youth Center
21. Approve Actions Related to the Housing and Homelessness Incentive Program – Funding Allocations
22. Approve Actions Related to the Housing and Homelessness Incentive Program – Notice of Funding Opportunities

CLOSED SESSION

- CS-1. Pursuant to Government Code section 54956.87, subdivision (b) HEALTH PLAN TRADE SECRETS: Covered California
- CS-2. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Government Code section 54956.9(d)(2) and (e)(1): 4 potential cases

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

TO REGISTER AND JOIN THE MEETING

Please register for the Regular Meeting of the CalOptima Health Board of Directors on October 2, 2025 at 2:00 p.m. (PST)

To **Register** in advance for this webinar:

https://us02web.zoom.us/webinar/register/WN_qZrpnxNhSs-5PWc4wI9qMA

To **Join** this webinar:

<https://us02web.zoom.us/j/83994071069?pwd=yG4daTEwb5abZXtMZSpgarwRbHRGAo.1>

Phone one-tap:

+16699009128,,83994071069#,,, *402075# US (San Jose)

+16694449171,,83994071069#,,, *402075# US

Join via audio:

+1 669 900 9128 US (San Jose)

+1 669 444 9171 US

+1 719 359 4580 US

+1 253 205 0468 US

+1 253 215 8782 US (Tacoma)

+1 346 248 7799 US (Houston)

+1 360 209 5623 US

+1 386 347 5053 US

+1 507 473 4847 US

+1 564 217 2000 US

+1 646 558 8656 US (New York)

+1 646 931 3860 US

+1 689 278 1000 US

+1 301 715 8592 US (Washington DC)

+1 305 224 1968 US

+1 309 205 3325 US

+1 312 626 6799 US (Chicago)

Webinar ID: 839 9407 1069

Passcode: 402075

International numbers available: <https://us02web.zoom.us/j/knL6PDzC>



PRESENTATIONS/INTRODUCTIONS

1. CalOptima Health 30th Anniversary Recognition



MEMORANDUM

DATE: September 26, 2025

TO: CalOptima Health Board of Directors

FROM: Michael Hunn, Chief Executive Officer

SUBJECT: CEO Report — October 2, 2025, Board of Directors Meeting

COPY: Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; and Whole-Child Model Family Advisory Committee

A. Covered California Monthly Update

CalOptima Health continues to prepare for the launch of a Covered California line of business, effective January 1, 2027. Following the Board’s approval on June 5, staff submitted an initial filing on June 16 to the California Department of Managed Health Care (DMHC) to expand the scope of CalOptima Health’s current Knox-Keene Act license, which is required to offer a commercial insurance product. Since then, we have interfaced with DMHC on two rounds of comments and are working on exhibits for our second filing in late October. With the conclusion of the Deloitte Consulting LLP operational gap analysis, staff have initiated several new workstreams to discuss and implement solutions to achieve operational readiness during the next year. On September 15, Covered California issued the draft 2027 Qualified Health Plan application. Our teams are currently reviewing and developing strategies to respond in April 2026. Lastly, CalOptima Health continues to negotiate provider contracts and execute amendments with several existing vendors to include Covered California in their scopes of service.

B. Program of All-Inclusive Care for the Elderly (PACE) Celebrates 12-Year Anniversary

There are currently 171 PACE organizations across the United States, 28 in California and three in Orange County. As the first PACE program to open in Orange County, CalOptima Health PACE is proud to be celebrating our 12-year anniversary this month. We are currently serving more than 525 participants, and in a recent survey, participants rated CalOptima Health PACE as one of the top five PACE organizations. Our current advertising campaign distinguishes CalOptima Health PACE as the premier PACE program in Orange County. The tagline is “Senior Care to Keep You Active and Living at Home” and emphasizes that CalOptima Health PACE is a leader in complete care for Orange County seniors. It increases awareness of our PACE program through advertising that includes print, outdoor, radio, television, digital display, social media, programmatic video (YouTube), search engine marketing and direct mail. Using a unique, personal approach, the campaign features photography of our actual PACE participants enjoying the benefits of the program.

C. CalOptima Health 30th Anniversary Member Wellness Fair

On Saturday, October 18, from 9 a.m. to 1 p.m., we are hosting a special wellness fair for our members in celebration of our 30th anniversary. The event will be held at our 505 building and will include

dental and vision screenings, flu vaccines, food and diaper distribution, Medi-Cal and CalFresh enrollment, and community organization resources. We will be sending text messages to our members inviting them to attend.

D. OneCare Annual Election Period Coming Soon

The annual election period (AEP) for CalOptima Health OneCare (HMO D-SNP), a Medicare Medi-Cal Plan, will open October 15 and will run through December 7. To be eligible for OneCare a member must be:

- Age 21 and older
- Living in Orange County
- Enrolled in Medicare Parts A and B
- Receiving Medi-Cal benefits

Starting in 2026, the OneCare Flex Plus plan will be consolidated into the OneCare Complete plan due to changes in the federal Medicare program. All existing OneCare Flex Plus members will be transitioned into OneCare Complete.

- CalOptima Health OneCare Complete — Our original plan offers \$0 copays on medical and hospital services and generic prescription drugs. It includes many extras, such as a fitness benefit, comprehensive dental, more vision care, a flex card for over-the-counter (OTC) items and for those who qualify, food and produce.

As an Exclusively Aligned Enrollment D-SNP, OneCare can accept enrollment from members every month due to the Special Election Period (SEP) for dual-eligibles.

E. Affordable Housing Complex Breaks Ground in Costa Mesa

Recently, I celebrated the groundbreaking of a new affordable housing complex in Costa Mesa. American Family Housing, an Orange County-based developer, received a nearly \$500,000 grant through our Housing and Homelessness Incentive Program to renovate a former motel site into the Avon River Apartments. Once complete, it will offer 76 brand-new, fully remodeled rental homes for households at risk of homelessness or those transitioning out of homelessness.

F. CalOptima Health Continues to Monitor KPC Quality Issues

CalOptima Health continues oversight of KPC hospitals, addressing regulatory compliance, patient experience and quality outcomes. Corrective action plans from recent California Department of Public Health and Centers for Medicare & Medicaid Services reviews are in progress, with certification efforts focused on reinstating Stroke Receiving Center status and elevating Chapman Global's rating. Performance highlights include strong infection prevention, zero sentinel events and improved ED metrics, though challenges remain in discharge efficiency, sepsis, maternal outcomes and specialty access. Patient surveys show progress in nurse communication but ongoing concerns with environment and responsiveness. A CalOptima Health site visit is scheduled for October 1 to validate care quality.

G. U.S. House Committee Requests Medi-Cal Information on Undocumented Beneficiaries

On September 3, the U.S. House Committee on Oversight and Government Reform sent a letter to Governor Gavin Newsom and state leadership requesting documents and communications related to California's Medicaid program (Medi-Cal) to be sent to the committee no later than September 17. Among the eight separate requests are the names of all state and local programs that provide health coverage and other services for undocumented immigrants, the cost of every Medi-Cal-covered procedure and benefit performed on or received by that population, and all processes related to the

verification of enrollment eligibility in California's full-scope and emergency Medi-Cal programs, including any related to the verification of immigration status. The state has not yet shared an update on the status of its response.

H. CalOptima Health Gains Media Coverage

- On September 1, [New Santa Ana](#) ran an article sharing news about our no-cost mental health support, which is available in person, via telehealth or by app.
- News on the groundbreaking of the Costa Mesa Avon River Apartments with 76 affordable housing units ran in the following media outlets:
 - [August 29](#) and [September 2](#) in the Daily Pilot/TimesOC online. The news also ran on September 7 in the print edition.
 - August 29 on [ABC7 Eyewitness News](#)



Fast Facts

October 2025

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

Membership Data* (as of August 31, 2025)

Total CalOptima Health Membership	Program	Members
	Medi-Cal	873,410
	OneCare (HMO D-SNP)	17,873
	Program of All-Inclusive Care for the Elderly (PACE)	529

891,812

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

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

	Dashboard	YTD Actual	Actual vs. Budget (\$)	Actual vs. Budget (%)
Operating Income/(Loss)	●	\$30.4M	\$23.0M	311.7%
Non-Operating Income/(Loss)	●	\$21.7M	\$5.3M	32.4%
Covered California Start-up Expenses	●	(\$0.7M)	\$0.8M	52.1%
Bottom Line (Change in Net Assets)	●	\$51.3M	\$29.1M	131.0%
<i>Medical Loss Ratio (MLR)</i> (Percent of every dollar spent on member care)	●	91.0%	---	(2.0%)
<i>Administrative Loss Ratio (ALR)</i> (Percent of every dollar spent on overhead costs)	●	5.3%	---	1.0%

Notes:

- For additional financial details, refer to the financial packages included in the Board of Directors meeting materials.
- Adjusted MLR (without the estimated provider rate increases funded by reserves) is 86.5%.

Reserve Summary (as of August 31, 2025)

	Amount (in millions)
Board Designated Reserves*	\$1,599.1
Statutory Designated Reserves	\$133.7
Capital Assets (Net of depreciation)	\$102.4
Unspent Balance of Allocated Resources	\$396.8
Unspent Balance of Board Approved Provider Rate Increase**	\$280.6
Unallocated Resources*	\$339.2
Total Net Assets	\$2,851.9

* Total of Board-designated reserves and unallocated resources can support approximately 177 days of CalOptima Health's current operations.

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

**Total Annual
Budgeted Revenue**

\$4.7 Billion

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

CalOptima Health Fast Facts

October 2025

Personnel Summary (as of September 6, 2025, pay period)

	Filled	Open	Vacancy % Medical	Vacancy % Administrative	Vacancy % Combined
Staff	1,353.5	81.75	36.67%	63.33%	5.7%
Supervisor	85	2	0%	100%	2.3%
Manager	111	15	20%	80%	11.9%
Director	74	12.5	20%	80%	12.5%
Executive	21	1	---	100%	4.55%
Total FTE Count	1,644.5	112.3	32.48%	67.52%	6.39%

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

Provider Network Data (as of September 22, 2025)

	Number of Providers
Primary Care Providers	1,290
Specialists	7,657
Pharmacies	496
Acute and Rehab Hospitals	43
Community Health Centers	71
Long-Term Care Facilities	225

Treatment Authorizations (as of July 31, 2025)

	Mandated	Average Time to Decision
Inpatient Concurrent Urgent	72 hours	36.59 hours
Prior Authorization – Urgent	72 hours	12.23 hours
Prior Authorization – Routine	5 days	1.56 days

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

Member Demographics (as of August 31, 2025)

Member Age		Language Preference		Medi-Cal Aid Category	
0 to 5	8%	English	54%	Expansion	38%
6 to 18	22%	Spanish	31%	Temporary Assistance for Needy Families	37%
19 to 44	34%	Vietnamese	9%	Seniors	12%
45 to 64	20%	Other	2%	Optional Targeted Low-Income Children	7%
65 +	16%	Korean	1%	People With Disabilities	5%
		Farsi	1%	Long-Term Care	<1%
		Chinese	1%	Other	<1%
		Arabic	<1%		
		Russian	<1%		

**REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS**

September 4, 2025

A Regular Meeting of the CalOptima Health Board of Directors (Board) was held on September 4, 2025, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person, and via Zoom webinar as allowed for under Assembly Bill 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health’s website under View Past Meeting Materials. Chair Isabel Becerra called the meeting to order at 2:01 p.m., and Director Brian Helleland led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra, Chair; Supervisor Vicente Sarmiento, Vice Chair; Maura Byron; Supervisor Doug Chaffee; Blair Contratto (at 2:48 p.m.); Norma García Guillén (at 2:03 p.m.); Catherine Green, R.N.; Brian Helleland; Veronica Kelley (non-voting); Jose Mayorga, M.D.

(All Board members participated in person)

Members Absent: None.

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; Sharon Dwiers, Clerk of the Board

The Clerk noted for the record that staff would like to pull Agenda Item 4 from the Consent Calendar for a separate vote due to a recusal. In addition, staff would also like to continue Agenda Items 9 and 16 to a future meeting.

PRESENTATIONS/INTRODUCTIONS

None.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

Michael Hunn, CEO, presented his report and started by welcoming everyone, including those individuals listening to the meeting remotely.

Mr. Hunn began his report with a brief review of the Fast Facts, reporting current enrollment at 904,000 members. He noted that the financial metrics are mostly positive, with only one red indicator under “Other Net Operating Income.” Mr. Hunn noted that this shortfall is attributed to slightly lower-than-expected investment income and a \$2.5 million reserve set aside for community reinvestment. He added that this is considered a minor issue and is expected to return to green status next month. Mr. Hunn reported that additional financial details, including reserves, are included in the Fast Facts, along with updates on personnel, provider network data, treatment authorizations for direct members, and member demographics.

Mr. Hunn provided an update on CalOptima Health's transportation vendor, ModivCare. On August 21, 2025, ModivCare appeared in bankruptcy court, where the court approved their first-day motions. These included continuing employee wages and benefits, paying critical vendors, and accessing \$100 million in financing to maintain operations. ModivCare, which handles approximately 80,000 member trips per month, continues to operate normally. No transportation providers have withdrawn from partnerships, and trip scheduling remains stable. Customer service teams have been equipped with consistent messaging to reassure members. CalOptima Health staff will continue monitoring call volumes and any transportation-related grievances to ensure service continuity.

Mr. Hunn responded to Board members' comments and questions.

ADVISORY COIMMITTEE UPDATES

2. Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) Update

Christine Tolbert, MAC Chair, highlighted recent activities from the joint MAC and PAC meeting held on August 14, 2025.

Ms. Tolbert reported that the MAC approved a recommendation to revise its seat composition in alignment with a recent Department of Health Care Services (DHCS) All Plan Letter, mentioned in the last Board report. She added that staff will be submitting these changes to the Board for consideration at its October meeting. In addition to reconfiguring seats while maintaining the current diverse membership, the MAC is also recommending increasing the stipend for Medi-Cal and OneCare members (or their authorized family members) who hold a member seat. The proposed increase is from \$50 to \$100, with the option to receive the stipend by check or gift card. Currently, stipends are issued by check only.

Ms. Tolbert reported that the PAC recommended approval of the appointment of Dr. Jonathan Megerian to the open physician seat during the PAC's August 14, 2025, meeting. Final approval of this appointment is on today's agenda for the Board's consideration.

Ms. Tolbert shared that the MAC and PAC will be hearing several updates at the upcoming October 9, 2025, joint meeting, including a presentation on OneCare's medical and dental coverage, as well as subsidized housing. She added that Dr. Michael Rose is also expected to provide an update on the Community Reinvestment Plan, which both committees were introduced to approximately six months ago.

Ms. Tolbert also reported that pending Board approval of the revised MAC seat composition, as required by DHCS, staff will begin recruitment for the new seats with a goal to have the seats filled before the December meeting. Ms. Tolbert added that the PAC continues to recruit for an allied health representative.

Ms. Tolbert thanked the Board for the opportunity to provide feedback on behalf of the MAC and PAC members.

PUBLIC COMMENTS

- William Manalo, ShuttleMED, Inc.: Oral report regarding non-emergency medical transportation (NEMT) issues with ModivCare.
- Matthew Sprowls, NEMT Provider: Oral report regarding ModivCare.

Vice Chair Sarmiento asked if staff could provide an update on the transportations grievances and efforts to improve member satisfaction with regard to their transportation needs.

Mr. Hunn responded to the Board's inquiry, noting that staff will update the Board on the transportation issues and efforts are underway to improve member satisfaction regarding transportation at the next Board meeting.

CONSENT CALENDAR

3. Minutes

- a. Approve Minutes of the August 7, 2025, Regular Meeting of the CalOptima Health Board of Directors

4. Approve New and Revised CalOptima Health Finance Policies in Accordance with Covered California Regulatory Requirements for the Department of Managed Health Care Filing
This item was pulled from the Consent Calendar for a separate vote due to a recusal.

5. Approve Actions Related to Covered California Administrative Services Agreements

6. Approve Modifications to Policy GA.5004: Travel and Other Reimbursable Expenses

7. Approve Modifications to CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers

8. Approve Modifications to CalOptima Health Policy GG.1508: Authorization and Processing of Referrals

9. Approve Modifications to CalOptima Health Policy GG.1516: Hospital Acute Administrative Days

This item was continued to a future meeting.

10. Approve Amendments to CalOptima Health Policies Related to CalOptima Health Care Network Primary Care Provider Transitions

11. Authorize the Chief Executive Officer or Designee to Execute a Contract Amendment with Ankura Consulting Group, LLC to Implement Grant Management Recommendations and Complete Grant Close-Out Reviews

12. Adopt Resolution No. 25-0904-01 Approving Updated CalOptima Health Human Resources Policies

13. Authorize Employee and Retiree Group Health Insurance and Wellness Benefits for Calendar Year 2026

14. Approve Appointment to the CalOptima Health Board of Directors' Provider Advisory Committee

15. Receive and File:

- a. July 2025 Financial Summary
- b. Compliance Report
- c. Government Affairs Reports
- d. CalOptima Health Community Outreach and Program Summary
- e. Board Approved Initiatives Quarter Four FY 2025 Impact Summary

Action: *On motion of Supervisor Chaffee, seconded and carried, the Board of Directors approved the Consent Calendar Agenda Items 3 through 15, minus Agenda Items 4 and 9, as presented. (Motion carried 8-0-0; Director Contratto absent)*

CONSENT CALENDAR

4. Approve New and Revised CalOptima Health Finance Policies in Accordance with Covered California Regulatory Requirements for the Department of Managed Health Care Filing

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 discussion and vote.

Action: *On motion of Supervisor Chaffee, seconded and carried, the Board of Directors: 1.) Approved new CalOptima Health Policy CC.1800: Medical Group/Independent Physician Association (IPA) Compensation, effective January 1, 2027; and 2.) Approved modifications to CalOptima Health Policies FF.3002: Financial Oversight and FF.3003: Minimum Medical Loss Ratio, effective January 1, 2027, for Covered California. (Motion carried 7-0-0; Director Mayorga recused; Director Contratto absent)*

REPORTS/DISCUSSION ITEMS

16. Approve New CalOptima Health PACE Policy PA.9003: PACE Letters of Support

This item was continued to a future meeting.

17. Authorize Medi-Cal Eligibility Outreach Strategy in Response to Upcoming Federal and State Legislative Changes

Vice Chair Sarmiento motioned to approve this item with comments, noting that it is a great item. He thanked the members of the Legislative Ad Hoc Committee for their ongoing work. He also thanked Veronica Carpenter and other staff for their efforts in coordinating meetings with advocates and supporting the committee's work since its formation in March 2025.

Vice Chair Sarmiento reported that over the summer, the ad hoc committee collaborated closely with staff to advocate on behalf of CalOptima Health members, submitting numerous coalition letters to both

Washington and Sacramento. With the recent passage of H.R. 1, the committee has grown increasingly concerned about the implications of its implementation, particularly the need to educate members, especially those in hard-to-reach communities, about changes in eligibility. In response to these concerns, the committee recommends reallocating the \$800,000 in the current agenda item to develop a comprehensive toolkit and messaging strategy. This would help ensure members understand how to access healthcare, what changes to expect, and when those changes will take effect. The goal is to create the most robust outreach effort possible.

Vice Chair Sarmiento reported that with the evolving policy landscape, the committee also recommends that Board Chair Becerra establish a new Policy and Budget Assessment Ad Hoc Committee to ensure expenditures align with legislative priorities. Additionally, it was recommended by the Legislative Ad Hoc Committee members that the current Legislative Ad Hoc Committee could sunset and be replaced with a standing Legislative Committee. This would align with practices in other public agencies and reflect the ongoing and significant impact of state and federal legislation. He asked James Novello, Outside General Counsel, Kennaday Leavitt, to come back to the Board with any needed changes to the CalOptima Health Bylaws to create a standing Legislative Committee.

Vice Chair Sarmiento also noted the importance of using trusted community-based nonprofits to help implement outreach efforts and asked staff to return to the Board with a request for proposals for these types of organizations, as they already have established relationships and understand the needs of the community.

Vice Chair Sarmiento added that he hopes the reallocation of dollars will help prevent members from losing important health care coverage and enable them to better navigate the upcoming changes impacting their Medi-Cal coverage and moved the item.

After continued discussion and Board support, the following action was taken.

Action: ***On motion of Vice Chair Sarmiento, seconded and carried, the Board of Directors: 1.) Authorized implementation of a Medi-Cal Eligibility Outreach Strategy in response to upcoming federal and state legislative changes; 2.) Authorized closing the Board-approved initiative for the Adult Expansion Outreach Strategy to promote enrollment of eligible adults ages 26-49 into full-scope Medi-Cal, regardless of immigration status and appropriate the unspent remaining balance of \$800,000 to implement the Medi-Cal Eligibility Outreach Strategy; and 3.) Authorized the Chief Executive Officer to execute agreements for expenditures as necessary to implement proposed activities. (Motion carried 8-0-0; Director Contratto absent)***

18. Approve Modifications to CalOptima Health Purchasing Policy

After considerable discussion, the Board approved a motion to continue this item to a future meeting.

Action: ***On motion of Vice Chair Sarmiento, seconded and carried, the Board of Directors continued this item to a future meeting. (Motion carried 9-0-0)***

19. Approve Action Related to Providence Medical Foundation Medi-Cal Contract

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

After a robust discussion regarding certain services not covered by Providence St. Joseph Hospital as a faith-based organization, the Board took the following action:

Action: On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Authorized the Chief Executive Officer, or designee, to execute a new Shared Risk Group contract with Providence Medical Foundation for Medi-Cal, effective November 1, 2025. (Motion carried 7-1-0; Supervisor Chaffee voting no; Director Helleland recused)

CLOSED SESSION

The Board adjourned to Closed Session at 3:17 p.m. CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION Pursuant to Government Code section 54956.9(d)(4): 1 case.

The Board returned to Open Session at 4:51 p.m., and the Clerk re-established a quorum.

ROLL CALL

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

(All Board members participated in person)

Members Absent: None.

CLOSED SESSION

Chair Becerra noted for the record that the Board met in Closed Session and received an update from its Legal Ad Hoc Committee that it had completed its investigation and submitted its findings to the Board for review. The Board is currently in the process of evaluating the information and determining next steps regarding confidentiality, privilege and the potential release of any materials. A decision is expected by the end of the year. The Board appreciates the patience of all stakeholders as the Board undertakes this important review with the diligence it requires.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Director Kelley acknowledged on behalf of her colleague Carmen Katsarov, Executive Director of Behavioral Health at CalOptima Health, that September is National Suicide Prevention Awareness Month. She noted that the teal and purple ribbons that staff provided to the Board and staff at today's Board meeting also represent National Recovery Month, recovery from addiction.

Director Contratto thanked the Legal Ad Hoc Committee for the incredible amount of work they have done. She noted that she is fortunate to work alongside three individuals who have dedicated so much of their own time to helping the Board better understand the important issues they have investigated. Director Contratto thanked the Legal Ad Hoc Committee members for their commitment and contributions.

Supervisor Chaffee thanked staff for their work, noting that it is valued. He also highlighted a couple of upcoming events. First, a Fishing Derby taking place on Saturday, September 20, 2025, and noted that he is grateful that CalOptima Health will have a table at the event and Michael Hunn, CEO will be in attendance. Second, the Fourth District is preparing for their third Gun Buyback Program, scheduled for November 8, 2025. He noted that this initiative is led by the Garden Grove Police Department, and he hopes to see participation from other Orange County Supervisors as well.

Director Mayorga thanked his fellow Board members as the Board continues to engage in important discussions and navigate the complex issues before it, including those addressed today. He emphasized the critical need for funding and support to help CalOptima Health's members and the communities it serves face the challenges ahead. He added that the impact to individuals is significant and shared that this past Wednesday morning, he was in the clinic seeing patients and once again he was reminded of the struggles they face, not just medically, but in their daily lives. He noted that the non-medical determinants of health continue to have a profound effect on patient well-being. Director Mayorga noted that it is difficult to help patients manage these broader issues alone, which is why the Board's collective efforts along with CalOptima Health staff are so important. He added that he looks forward to ideas and solutions so that CalOptima Health can better support and mitigate the challenges its members face in the future.

Chair Becerra thanked staff for the incredible work happening behind the scenes, not only to make today's meeting possible, but also for the ongoing management and oversight of the many services CalOptima Health provides to the community. CalOptima Health staff's dedication does not go unnoticed. Chair Becerra shared that tomorrow, September 5, 2025, the Coalition of Orange County Community Health Centers is hosting its third-quarter Coffee Connections event. The event brings community health centers and partners together for a session focused on scenario planning. The goal is to begin proactively addressing the many changes coming from the federal, state, and even county levels, and to explore how the community can remain sustainable and continue to thrive. Chair Becerra noted that as Director Mayorga noted earlier, individuals in the community are hurting and so are the safety net providers who serve them. Many are at risk of not being able to sustain their operations under the current and upcoming pressures. That is why this kind of forward-thinking planning is so critical. This important conversation kicks off in Costa Mesa, and she wanted to give that a quick shout-out.

ADJOURNMENT

Hearing no further business, Chair Becerra adjourned the meeting at 4:58 p.m.

Sharon Dwiars
Clerk of the Board

MINUTES
REGULAR MEETING
OF THE
CALOPTIMA HEALTH BOARD OF DIRECTORS’
FINANCE AND AUDIT COMMITTEE

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

May 22, 2025

A Regular Meeting of the CalOptima Health Board of Directors’ (Board) Finance and Audit Committee (FAC) was held on May 22, 2025, at CalOptima Health, 505 City Parkway West, Orange, California. The meeting was held in person and via Zoom webinar as allowed for under Assembly Bill 2449, which took effect after Governor Newsom ended the COVID-19 state of emergency on February 28, 2023. The meeting recording is available on CalOptima Health’s website under Past Meeting Materials.

Chair Isabel Becerra called the meeting to order at 3:03 p.m., and Director Blair Contratto led the Pledge of Allegiance.

ROLL CALL

Members Present: Isabel Becerra, Chair (Virtual); Blair Contratto; Brian Helleland

Members Absent: None

Others Present: Michael Hunn, Chief Executive Officer; Nancy Huang, Chief Financial Officer; Richard Pitts, D.O., Ph.D., Chief Medical Officer; Troy R. Szabo, Outside General Counsel, Kennaday Leavitt; Sharon Dwiers, Clerk of the Board

The Clerk noted that Chair Becerra would be attending virtually under emergency circumstance.

Action: On motion of Director Contratto, seconded and carried, the committee approved the emergency attendance of Chair Isabel Becerra. (Motion carried 2-0-0)

The Clerk noted that staff would like to hear Agenda Item 8, Moss Adams 2025 Financial Audit Planning, prior to hearing the Reports/Discussion Items on the agenda.

MANAGEMENT REPORTS

1. Chief Financial Officer Report

Nancy Huang, Chief Financial Officer, provided two verbal updates for the meeting. The first update was to highlight changes from the Governor’s May Revise budget for Fiscal Year (FY) 2025-26 and the second update was related to CalOptima Health’s 2026 business insurance renewal.

For the first update, Ms. Huang noted that Governor Newsom released his May Revise on May 14, 2025, with an estimated state budget deficit of \$12 billion. The proposal included changing Medi-Cal eligibility, expansion, delay or reduction to new and existing programs, and elimination of optional benefits. The outcome will become clear before the state’s budget deadline on June 15, 2025. Based on the current information available, Ms. Huang stated that any changes from the May Revise or federal level Medicaid program changes will be considered in future budget revision proposals.

For the second update, Ms. Huang provided a high-level overview for business insurance policy year 2025-2026. For the upcoming policy year, there were no significant changes or additional coverage to consider. The total premium for the renewal was approximately \$4 million, reflecting a 2.6% increase from the current policy year, amounting to about \$100,000. This increase was primarily due to higher claim exposure to the managed care E&O coverage line. Sufficient funding was included in both the current and next year's budget for this policy renewal.

2. Cybersecurity Update

James Steele, Senior Director, Information Security, presented an update on CalOptima Health's cybersecurity. He noted that CalOptima Health has experienced zero major cybersecurity incidents in the last three months. Mr. Steele reported, however, that CalOptima Health received one notable internal cybersecurity threat during quarter two, highlighting an unsuccessful compromise attempt to a vulnerable device that was contained within 20 minutes. He also reported that there was a third-party cybersecurity incident, which had no impact on CalOptima Health's internal systems.

Mr. Steele also reviewed three recent cybersecurity news articles from various healthcare journals. For the first article, *HIPAAtrek: Why is Healthcare a Prime Target for Cyberattacks in 2025*, Mr. Steele noted that Healthcare continues to be a prime target for cyberattacks in 2025 because of high-value data, outdated technology, and variable cybersecurity maturity across the sector. For the second article, *The Record: Dialysis Company DaVita Reviewing Data Leak by Ransomware Gang*, Mr. Steele noted that the DaVita breach compromised 400,000 patients' data and raised alarms about ransomware's growing impact on the continuity and quality of patient care. Finally, for the third article, *The HIPAA Journal: Surge in Vulnerability Exploitation and Healthcare Espionage Breaches*, Mr. Steele noted that the 2025 Verizon Data Breach Investigations Report highlights that attackers heavily exploit VPN devices as entry points into healthcare systems, contributing to a sharp rise in ransomware and social engineering breaches.

Mr. Steele introduced a policy for artificial intelligence (AI) and Machine Learning (ML). He noted that CalOptima Health had developed an initial AI policy to ensure it stays current with AI advancements. The policy is expected to evolve as laws and technology continue to change. Key highlights of the policy include a patient-centered approach, where AI augments rather than replaces human decision-making, and a strong emphasis on privacy, security, and human oversight to prevent bias. The policy will be presented to the full Board for final review during the June Board meeting.

Mr. Steele further provided details regarding CalOptima Health's cybersecurity metrics. He noted that there was a single data loss event that was managed by the CalOptima Health privacy team. Cybersecurity tools filtered out 60% of nearly 4 million received emails due to malicious content, blocked 162 phishing campaigns, and prevented 940 malicious applications from being downloaded. Mr. Steele also noted that a recent penetration test revealed no major surprises, and several high-risk issues were already remediated. Furthermore, in quarter 3, a maturity assessment and Office of Civil Rights risk assessment will be conducted.

INVESTMENT ADVISORY COMMITTEE UPDATE

3. Treasurer's Report

Ms. Huang presented the Treasurer's Report for the period of January 1, 2025, through March 31, 2025. The portfolio totaled approximately \$3.5 billion as of March 31, 2025. Of the total portfolio amount, \$2.3 billion was included in CalOptima Health's short-term operating account and \$1.2 billion was included in CalOptima Health's Board-designated reserves. Ms. Huang noted that the Board-designated reserve level was 2.69 times the consolidated monthly revenue, and the TNE reserve level was 103% of the minimum California Department of Managed Healthcare requirement. Meketa Investment Group Inc. (Meketa), CalOptima Health's investment advisor, confirmed that all investments complied with the annual investment policy and Government Code section 53600. The total fund return for the quarter was 1.337% higher than the previous quarter's 0.8%. Furthermore, year-to-date the portfolio returned 5.62% and an estimated \$100 million investment return is projected for the next year. Following Board approval, \$460 million was transferred from short-term operating accounts to tier one accounts, increasing the reserve level to 3.86 times the consolidated capitation revenue by April's end. The new compliance level will be reported back to the Board at its August meeting.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

4. Approve the Minutes of the February 20, 2025, Regular Meeting of the CalOptima Health Board of Directors' Finance and Audit Committee and Receive and File Minutes of January 27, 2025, Regular Meeting of the CalOptima Health Board of Directors' Investment Advisory Committee

5. Recommend Board of Directors' Approval of a New CalOptima Health Policy IT.1002: Artificial Intelligence and Machine Learning

Action: On the motion of Director Helleland, seconded and carried, the committee approved the Consent Calendar as presented. (Motion carried 3-0-0)

As the Clerk noted at the top of the Agenda, the committee heard Information Item, Agenda Item 8., immediately after the Consent Calendar.

INFORMATION ITEMS

8. Moss Adams 2025 Financial Audit Planning

Ms. Huang introduced independent auditor Moss Adams' partner, Aparna Venkateswaran, who provided a brief overview of the audit planning process for FY 2025-26.

Ms. Venkateswaran outlined the scope of services, which included auditing financial statements for the year ending June 30, 2025, and assisting with non-attest services like drafting financial statements and completing the data collection form for the Multipurpose Senior Services Program. She emphasized their responsibility to form and express an opinion on the financial statements, adhering to government auditing standards. Ms. Venkateswaran also mentioned that any significant matters arising during the audit would be communicated promptly. Ms. Venkateswaran turned the presentation over to her colleague, Ashley Merda.

Ms. Merda reported that the audit will focus on several key risk areas, which are typical for a health plan. The first area is medical claims liability and claims expenses, as this represents the largest estimate in the

financial statements. The audit team will evaluate internal controls over claims payments and systems, test the data used by the third-party actuary, assess the actuary's qualifications, and perform a retrospective review of prior year estimates to ensure continued accuracy.

Another area of focus is capitation revenue and receivables. Since revenue is inherently a risk, the team will develop independent expectations using membership data and current state rates. The team will also review management's methodology for any specific revenue reserves and verify receivables by checking subsequent cash receipts from the state to confirm their validity.

Additionally, the audit will examine amounts due from the State of California (the Department of Health Care Services). This includes reviewing management's estimates for accruals, understanding the nature of amounts payable to the state, and testing any complex inputs used in those estimates.

These risk areas are consistent with prior years and standard for health plans. The team also invited the FAC members to share any concerns or areas they believe should receive additional attention during the audit.

Ms. Venkateswaran and Ms. Merda responded to committee members' comments and questions.

REPORTS/DISCUSSION ITEMS

6. Recommend Board of Directors Approval of the CalOptima Health Fiscal Year 2025-26 Operating Budget

Ms. Huang presented the operating budget proposal for FY 2025-2026. She began with consolidated budget highlights and major operating budget assumptions, followed by a quick overview of CalOptima Health's digital transformation and some non-operating items included in the budget package. Ms. Huang noted significant uncertainties in the upcoming medical budget due to potential federal changes in Medicaid work requirements, managed care organization tax revenue challenges, immigration policies, and adjustments to the Federal Medical Assistance Percentage. At the state level, changes and reductions from the May Revise are expected to have an impact on CalOptima Health's budget. Additionally, there may be rate reduction pressures due to the state budget deficit in managed care capitation reimbursement.

Michael Hunn, Chief Executive Officer, emphasized the significant impact that upcoming federal and state changes will have on CalOptima Health's operations and its 910,000 members in Orange County. He highlighted the potential disruptions to coverage, access to care, network stability, and the overall healthcare infrastructure. Mr. Hunn noted that the fiscal pressures will require significant adjustments to CalOptima Health's approach and management to ensure a stable network and downstream care for those who may lose coverage.

Mr. Hunn noted that the CalOptima Health budget for FY 2025-2026 is based on current contracts and state directions, but adjustments will be made as federal and state revenue and reimbursement details become clearer. Mr. Hunn stressed the importance of transparency with the Board and the public throughout this process. He also reiterated CalOptima Health's mission to serve members with dignity and respect, maintaining quality, access, efficiency, and financial stability.

Ms. Huang reviewed the details of the FY 2025-26 operating budget for all lines of business and non-operating items. She noted that CalOptima Health is proposing a \$4.77 billion budget for next fiscal year, which includes an average enrollment forecast of 885,000 and a total revenue projected to be \$4.7 billion. Ms. Huang also noted that of that amount, about \$4.4 billion will be spent on medical costs with CalOptima

Health's medical loss ratio at 93.35%. The total administrative budget is forecasted at \$280 million for FY 2025-26, with an administrative loss ratio budgeted at 5.95%. Overall, CalOptima Health is projecting a positive margin for the upcoming operating budget, which is expected to be \$32.6 million, approximately 0.7% for the next fiscal year. Ms. Huang highlighted a decrease in average monthly enrollment of about 16,000 members from the current year and a \$400 million revenue increase driven by draft rates and member mix adjustments. Medical costs are projected to increase by \$126 million (3%) due to cost trends and higher acuity. Administrative expenses are expected to rise by \$27 million, mainly in salaries and benefits. Ms. Huang also noted that large variances in revenue and expenses are related to hospital directed payments, which are treated as passthroughs and not included in the budget estimate.

Ms. Huang explained the four major components of CalOptima Health's budget: enrollment, revenue, medical costs, and administrative expenses. She highlighted that enrollment peaked at nearly 1 million during the COVID-19 pandemic but started declining after Medi-Cal redeterminations began in July 2023. Despite fluctuations due to factors including undocumented adult expansion and the Kaiser transition, enrollment has stabilized around 910,000 in recent years. For fiscal year 2026, CalOptima Health is projecting a total enrollment of approximately 867,000, a 5% decrease from June 2025. This forecast is based on historical trends and state-provided enrollment assumptions, excluding potential policy changes in Medi-Cal eligibility. The projected decrease is mainly due to normal redetermination efforts.

Furthermore, Ms. Huang discussed the key revenue assumptions and medical cost analysis for the budget. For revenue, CalOptima Health used the calendar year 2025 draft rates for Medi-Cal lines of business, assuming no increase from 2025 to 2026. For the OneCare program, the assumptions included increases based on the 2025 base rate and projected 2026 rate. The PACE program is projected to see a small increase from combined Medi-Cal and Medicare funding sources.

Ms. Huang explained that in terms of medical costs, the total estimated budget for fiscal year 2025-2026 would be around \$4.4 billion. This included \$1.5 billion for provider capitation, \$1.8 billion for claims (professional, facilities, and ancillary), and \$600 million for long-term care services. Prescription drug costs are projected to increase by \$23 million, totaling \$137 million for OneCare and PACE members. Ms. Huang explained that the only line projected to decrease was for community support services and other medical costs, estimated to go down by \$143 million due to better control and utilization of medically tailored meals. This reduction is based on recent cost estimates and the current year's experience.

Ms. Huang highlighted key points regarding the medical expenditures and administrative budget for FY 2025-2026. The budget includes a Board-approved 30-month provider rate increase starting July 2024 and ending December 2026. Additionally, the budget incorporates the first year of the provider targeted rate increase (TRI) phase one, implemented in January 2024. The total administrative budget is approximately \$279 million, reflecting a \$27.4 million increase from the previous year. This increase includes \$11.7 million for salaries and wages, driven by merit increases, employee benefit premiums, and new positions. Non-salary expenses are projected to rise by \$13 million, with significant contributions from IT infrastructure and digital transformation projects. The current year's actual expenditures are running below budget by \$30 million, demonstrating conservative financial management. CalOptima Health is preparing for potential tougher times ahead by maintaining a conservative approach to expenditures.

Ms. Huang also presented the budget for Covered California, projecting a total operating budget of \$10.7 million for fiscal year 2025-2026. This includes \$4.2 million for salaries and wages to support 35 new full-time employees, \$5 million for professional fees, \$600,000 for purchase services, and \$500,000 for printing and other operating expenses. She clarified that not all this amount is new funding, as some had been previously approved by the Board for qualified health plan application support and consulting services. For

example, \$2.1 million of the previously approved \$3.25 million for consulting services is included in this proposal. Additionally, \$550,000 of the \$1.5 million approved for rate development and bid submission is part of \$10.7 million. Ms. Huang emphasized the importance of transparency and tracking expenditures separately. She clarified that the Board would review and approve the Covered California budget as part of the overall budget package, but it will be presented as a separate line item.

Finally, Ms. Huang discussed the digital transformation budget for year four, requesting \$5.1 million, a reduction from the \$15 million-\$20 million requested in previous years. This transition reflects a shift from the Digital Transformation Strategy (DTS) budget to operating expenses. The Board had previously authorized a \$100 million restricted reserve for the digital transformation strategy, which CalOptima Health now proposes extending from three to five years to allow more time for project completion. Additionally, non-operating expenditure includes \$1.2 million for tenant improvements and \$500,000 for the construction of the Street Medicine Center. Estimated investment income for the next FY is projected at \$100 million, resulting in a net of \$98 million for FY 2025-2026.

Ms. Huang, Yunkyung Kim, Chief Operating Officer, and Mr. Hunn provided additional details and responded to committee members' comments and questions.

The committee thanked Ms. Huang and her team for their hard work in preparing the FY 2025-26 operating budget.

Action: ***On motion of Director Contratto, seconded and carried, the committee recommended that the Board of Directors: 1.) Approve the CalOptima Health Fiscal Year 2025-26 Budget, as reflected in Attachment A: Fiscal Year 2025-26 Operating Budget for All Lines of Business and Non-Operating Items; and 2.) Authorize the expenditures and appropriate the funds for the items listed in Attachment B: Administrative Budget Details; Attachment B1: Covered California Administrative Budget Details; and Attachment B2: Digital Transformation Administrative Budget Details, which shall be procured in accordance with CalOptima Health Policy GA.5002: Purchasing. (Motion carried; 3-0-0)***

7. Recommend the Board of Directors Approve the CalOptima Health Fiscal Year 2025-26 Routine Capital, Covered California, and Digital Transformation Year Four Capital Budgets

Ms. Huang presented the FY 2025-26 capital budget, which included three main components: routine capital items, support for Covered California implementation, and updates to the digital transformation strategy. She noted that the total routine capital request is \$28.5 million, with 60% allocated to IT-related projects such as infrastructure, hardware, software, network application management, and enterprise data system integration. Additionally, \$11.2 million is requested for building and office improvements, including the 500-building build-out and Street Medicine Center improvements. For Covered California, the budget includes \$3.7 million for projects like an application management system, regulatory enrollment transaction and reporting capacity, and an online billing and collection platform. Ms. Huang concluded that the digital transformation project requires a two-year extension to complete, with no additional funds requested beyond the original \$100 million allocation. The remaining balance at the end of FY 2025-26 is expected to be approximately \$300,000.

Action: ***On motion of Director Contratto, seconded and carried, the committee recommended that the Board of Directors: 1.) Extend the Digital Transformation Strategy for two years, through June 30, 2027, to complete ongoing and new***

projects; 2.) Approve the CalOptima Health Fiscal Year 2025-26 Routine Capital, Covered California, and Digital Transformation Year Four Capital Budgets; and 3.) Authorize the expenditures and appropriate the funds for the following items, which shall be procured in accordance with CalOptima Health Board of Directors-approved policies: a.) Attachment A: Fiscal Year 2025-26 Routine Capital Budget by Project; b.) Attachment A1: Fiscal Year 2025-26 Covered California Capital Budget by Project; and c.) Attachment A2: Update to Digital Transformation Years One through Three and Year Four Capital Budgets by Project. (Motion carried; 3-0-0)

The following Information Items were accepted as presented.

INFORMATION ITEMS

9. March 2025 Financial Summary

10. Quarterly Operating and Capital Budget Update

11. Update on CalOptima Health Business Insurance Renewal for Policy Year 2025-26

This update was covered under the Chief Financial Officer's Report.

12. CalAIM Program Summary

13. Quarterly Reports to the Finance and Audit Committee

a. Net Asset Analysis

b. Enrollment Trend Report

c. Shared Risk Pool Performance Report

d. Health Network Financial Compliance Review Update

COMMITTEE MEMBER COMMENTS

Committee members thanked staff for the work that went into preparing the FY 2025-26 budgets and the details provided in the meeting materials and presentations.

ADJOURNMENT

Hearing no further business, Chair Becerra adjourned the meeting at 5:11 p.m.

/s/ Sharon Dwiers

Sharon Dwiers

Clerk of the Board

Approved: September 18, 2025

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2025

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

4. Approve Reappointment to the CalOptima Health Board of Directors' Investment Advisory Committee

Contact

Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action

Approve reappointment of Rick Fulford to the Board of Directors' Investment Advisory Committee for a two (2)-year term beginning November 3, 2025.

Background

At a Special Meeting of the Board of Directors (Board) held on September 10, 1996, the Board authorized the creation of the CalOptima Health Investment Advisory Committee (IAC), established qualifications for committee members, and directed staff to proceed with the recruitment of the volunteer members of the IAC.

When creating the IAC, the Board specified that the IAC would consist of five (5) members, including one (1) member who would automatically serve by virtue of his or her position as CalOptima Health's Chief Financial Officer. The remaining four (4) members would be Orange County residents who possess experience in one (1) or more of the following areas: investment banking, investment brokerage and sales, investment management, financial management and planning, commercial banking, or financial accounting.

At the September 5, 2000, meeting, the Board approved expanding the composition of the IAC from five (5) members to seven (7) members in order to have more diverse opinions and backgrounds to advise CalOptima Health on its investment activities.

Discussion

The candidate recommended for reappointment, Rick Fulford, has consistently provided leadership and service to CalOptima Health through his participation as an IAC member.

Rick Fulford retired in 2021 from Pacific Investment Management Company LLC (PIMCO), where he was Head of Defined Contribution (401(k) Business) and led a thirty (30)-person team. During his twenty-one (21)-year tenure at PIMCO, he served as Executive Vice President, Head of Public Pension, and Executive Vice President, Client Management, in London, England. Mr. Fulford holds an MBA from the University of California, Irvine, a B.S. in Civil Engineering from California Polytechnic State University, San Luis Obispo, a Chartered Financial Analyst Designation, and a Professional Civil Engineer License.

Fiscal Impact

There is no fiscal impact. An individual appointed to the IAC assists CalOptima Health in suggesting updates to and ensuring compliance with CalOptima Health's Board-approved Annual Investment Policy, and monitors the performance of CalOptima Health's investments, the investment advisor, and investment managers.

Rationale for Recommendation

The individual recommended for appointment to CalOptima Health's IAC has extensive experience that meets or exceeds the specified qualifications for membership on the IAC.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Investment Advisory Committee
Board of Directors' Finance and Audit Committee

Attachment

None

/s/ Michael Hunn
Authorized Signature

09/25/2025
Date

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2025

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

5. Approve New CalOptima Health Pharmacy Policies in Accordance with Covered California Regulatory Requirements for Department of Managed Health Care Filing

Contact

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Recommended Actions

1. Approve New CalOptima Health Policy CC.1902: Prior Authorization Process
2. Approve New CalOptima Health Policy CC.1901: Pharmacy Benefit Manager (PBM) Delegation Oversight
3. Approve New CalOptima Health Policy CC.1900: Formulary Management and Pharmacy & Therapeutics Committee

Background

CalOptima Health must obtain approval to operate a Covered California product under its Knox-Keene Act license from the California Department of Managed Health Care (DMHC). Obtaining a Knox-Keene Act license or expanding an existing license is a regulatory filing process that all plans must comply with to offer an individual market health plan. While CalOptima Health is currently licensed with DMHC for the OneCare Medicare product, CalOptima Health must submit a filing to expand its current Knox-Keene Act license to participate in the individual market. On June 16, 2025, CalOptima Health submitted the initial filing to DMHC to expand the scope of CalOptima Health's current Knox Keene Act license to enable CalOptima Health to offer a Covered California product. This filing process with the DMHC is ongoing.

As part of CalOptima Health's delivery of services, on May 1, 2025, the CalOptima Health Board of Directors (Board) authorized the extension of the current service contract with MedImpact Health Care Systems to provide pharmacy services. The contract was signed and executed on August 28, 2025.

Discussion

The DMHC filing process is a multi-phased process that CalOptima Health must complete by early 2026 to obtain the proper approvals to operate an individual market health plan. The process requires the submission of more than 90 supporting exhibits that demonstrate compliance with the requirements of the Knox-Keene Act.

Several of the required documents that must be submitted to DMHC are policies and procedures that demonstrate compliance with statutory and regulatory requirements. Staff have evaluated the policies and procedures that are needed to demonstrate compliance. In the area of pharmacy operations, staff recommends approval of three new policies and procedures to demonstrate compliance related to responsibilities delegated to a Pharmacy Benefit Manager (PBM) for prior authorization (PA), Pharmacy and Therapeutics (P&T) Committee, and oversight functions.

Policies & Procedures Summary – Pharmacy Prior Authorization

The DMHC filing requires submission of a description of the pharmacy utilization management program including:

- Coordinating benefits;
- Criteria for decisions; and
- Policies for referrals, denials, authorizations, and second opinions.

This new policy demonstrates compliance with DMHC requirements regarding:

- Using California's Prescription Drug PA or Step Therapy Exception Request Form and/or an electronic PA form or process that meets the National Council for Prescription Drug Programs' SCRIPT standard for electronic PA transactions ("Electronic Request Form or Process").
- The review process for PAs, step therapy exception, and formulary exception requests for prescription drugs.
- Coverage for pain management medications for terminally ill patients.
- Establishing timeframes for decision-making, notification letters, Independent Medical Review (IMR), and grievances and appeals.

To meet the authorization requirements, Policy CC.1902: Prior Authorization Process establishes a process for the PBM to review PA, step therapy exception, and formulary exception requests for medication coverage. Additionally, the policy outlines the DMHC timeframe requirements for decisions, notification letters, IMR, and grievances and appeals.

This new policy demonstrate compliance with the following statutory requirements and DMHC guidance:

- Title 28, California Code of Regulations (CCR) §§1300.67.24, 1300.67.241.
- California Health & Safety (H&S) Code §§ 1367.241, 1367.244, 1367.206, 1367.241, 1367.01, 1367.22(a), 1367.215, 1367.21, 1368.015.
- Title 45 of the Code of Federal Regulations (CFR), § 156.122(c).

Staff seeks Board approval of the attached new policy, effective January 1, 2027.

Policies & Procedures Summary – Delegation Oversight and Pharmacy & Therapeutics Committee

The DMHC filing requires submission of policies and procedures detailing how the plan oversees and monitors each of its administrative services vendors for any delegated functions.

Staff propose two new policies to demonstrate compliance with these requirements:

- CC.1901: Pharmacy Benefit Manager (PBM) Delegation Oversight; and
- CC.1900: Formulary Management and Pharmacy & Therapeutics Committee.

Statutory and regulatory requirements mandate that CalOptima Health comply with DMHC requirements for providing prescription drug benefits, including when it delegates pharmacy management functions. Policies and procedures must be in place to provide oversight and monitoring of the delegated functions.

To meet the oversight requirements of the PBM, Policy CC.1901: Pharmacy Benefit Manager (PBM) Delegation Oversight establishes procedures for managing and overseeing the PBM, including delegated activities; pre-contractual audit; performance monitoring for credentialing of pharmacies, electronic prescribing, pharmacy network management, prior authorization services, and prescription adjudication; corrective action plans; and reporting to regulatory agencies, as required.

In addition, Policy CC.1900: Formulary Management and Pharmacy & Therapeutics (P&T) Committee describes the requirements for ensuring that the P&T committee, under the PBM, develops, maintains, and reviews the formulary and operates in full compliance with federal and state requirements, as well as ensures alignment with Covered California benefit standards.

These new policies demonstrate compliance with the following statutory and regulatory requirements:

- 45 CFR § 156.122.
- 28 CCR §1300.67.205.
- H&S Code §§ 1342.75, 1367.41, 1367.24(e), 1367.241, 1381.
- Covered California Qualified Health Plan Issuer Model Contract.

Staff seeks Board approval of the attached two new policies, effective January 1, 2027.

Fiscal Impact

The recommended action is operational in nature. Any anticipated costs will be included in future Covered California operating budgets.

Rationale for Recommendation

Approval of the three new policies and procedures related to pharmacy operations will support CalOptima Health's application to expand its Knox-Keene Act license to operate an individual market plan.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Attachment 1: CalOptima Health Policy CC.1902: Prior Authorization Process
2. Attachment 2: CalOptima Health Policy CC.1901: Pharmacy Benefit Manager (PBM) Delegation Oversight
3. Attachment 3: CalOptima Health Policy CC.1900: Formulary Management and Pharmacy & Therapeutics Committee

/s/ Michael Hunn
Authorized Signature

09/25/2025
Date



Policy: CC.1902
Title: **Prior Authorization Process**
Department: Medical Management
Section: Pharmacy Management

CEO Approval: /s/

Effective Date: 01/01/2027
Revised Date: Not Applicable

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☐ Medi-Cal
☐ OneCare
☐ PACE

I. PURPOSE

This policy describes the process by which CalOptima Health's Pharmacy Benefit Manager (PBM) reviews Prior Authorization (PA) requests for coverage of medication use for CalOptima Health Covered California Members.

II. POLICY

- A. This process shall be used by PBM to review pre-service, concurrent and retrospective PA requests for coverage of medication use on behalf of Members of CalOptima Health's Covered California commercial lines of business that are regulated by the California Department of Managed Health Care.
- B. A PA is any determination (*i.e.*, an approval or denial) made by the PBM, including, but not limited to the following:
1. Formulary Medications with PA Restrictions
 2. Non-Formulary Medication Exceptions
 3. Quantity Limit Overrides
 4. Age Edit Overrides
 5. Specialty Edit Overrides
 6. Excluded Medications
 7. Step Therapy Exceptions
 8. Safety Edit Overrides (e.g. opioid dose edit)
- C. A Member, Member's Authorized Representative, Member's Prescriber or Provider of health care services for the Member, may request Prior Authorization review by telephone, facsimile, mail or

electronically submitting a Medication Request Form (Form No. 61-211) (hereinafter Medication Request Form).

- D. The PBM has an expeditious process in place to authorize Step Therapy exceptions and formulary exception requests when Medically Necessary, as described in Section III.C and D of this policy.
- E. A decision to modify or deny authorization requests can only be made by licensed physicians or other licensed health care professionals (competent to evaluate the specific clinical issues involved in the health care services requested).
- F. The Prescriber will be notified in the same manner as the request was submitted, or another mutually agreeable accessible method of notification, within seventy-two (72) hours for non-urgent requests or twenty-four (24) hours for Urgent Requests, or thirty (30) calendar days for retrospective requests, from PBM's receipt of a completed Medication Request Form.
- G. If the PBM fails to respond to the request within the required timeframe, the authorization request shall be deemed approved for the duration of the prescription, including refills.

III. PROCEDURE

- A. The PBM's PA Request Form shall meet the following standards:
 - 1. The PBM shall utilize only California's Prescription Drug Prior Authorization or Step Therapy Exception Request Form (the "Medication Request Form") and/or an electronic PA form or process that meets the National Council for Prescription Drug Programs' (NCPDP) SCRIPT standard for electronic PA transactions ("Electronic Request Form or Process").
 - 2. CalOptima Health and the PBM shall make the Medication Request Form (Form No. 61-211) and/or Electronic Request Form or Process electronically available on their respective websites.
 - 3. The PBM shall accept the Medication Request Form or Electronic Request Form or Process through any reasonable means of transmission, including, but not limited to paper, electronic, or another mutually agreeable accessible method of transmission.
 - 4. The Medication Request Form shall apply to medication requests for coverage regardless of how the benefit is classified.
- B. Prescription drug PA or Step Therapy exception request procedures conducted telephonically, through a web portal, or any other manner of transmission shall not require the Prescriber to provide more information than is required by the Medication Request Form or the Electronic Request Form or Process.
- C. A Prescriber may request an expedited medication review for an exigent (urgent) circumstance. An exigent circumstance is defined as a health condition that may seriously jeopardize the Member's life, health or ability to regain maximum function, or when a Member is undergoing a current course of treatment using a non-formulary drug, a formulary drug with PA, or a drug requiring Step Therapy.
- D. A Prescriber may request urgent medication review if all of the following criteria are met:
 - 1. The Prescriber designates the request as urgent.
 - 2. The requested medication is being used to treat an acute or life-threatening condition.

3. The PBM shall not downgrade any cases flagged as urgent to non-urgent.

E. The PBM's Prior Authorization Request, Step Therapy Exception Request and Formulary Exception Request review process meets the following requirements:

1. A Member, Member's Authorized Representative, Member's Prescriber or Provider of health care services for the Member, may request PA review by telephone, facsimile, mail or electronically submitting a Medication Request Form.
2. The Prescriber will be notified in the same manner as the request was submitted, or another mutually agreeable accessible method of notification, within seventy-two (72) hours for non-urgent requests, or within twenty-four (24) hours for Urgent Requests, or thirty (30) calendar days for retrospective requests, from receipt of a completed Medication Request Form.
3. If the authorization request is incomplete or clinically relevant material information necessary to make a decision is not included, the PBM shall make reasonable and diligent efforts to obtain the necessary information within the defined time frames from sources which may include, but are not limited to, the Prescriber, the Member, and other healthcare Providers.
 1. The PBM shall notify the Prescriber within seventy-two (72) hours of receipt of a non-urgent request, or within twenty-four (24) hours of receipt of an Urgent Request, what additional or clinically relevant material information is needed to approve or deny the authorization request, or to Appeal the denial thereof. Once the requested information is received from the Prescriber, the applicable time period to approve or deny a PA or Step Therapy exception request, or to Appeal, shall begin to elapse.
 2. The PBM shall request only the Minimum Amount of Material Information necessary to approve or disapprove the prescription drug authorization request. If state or federal law requires additional information for dispensing restricted prescription drugs, that information shall be submitted as part of Section 3 of Medication Request Form.
 3. For non-urgent requests, the Prescriber will be given up to forty-five (45) calendar days to respond to a request for additional information before PBM decisioning the case. For Urgent Requests, the Prescriber will be given up to five (5) calendar days to respond to the request of additional information before decisioning the case.
4. The PBM must respond within the applicable time frames. The response must include one of the following:
 1. The request is approved.
 2. The request is denied and the reason for the denial (*e.g.*, not medically necessary, not a covered benefit).
 3. The Member is no longer eligible for coverage.
 4. The request was not submitted on the required form and the Prescriber should resubmit the request on the Medication Request Form (Form No. 61-211).
 5. Request for additional or clinically relevant material information missing in the prior request.

5. A final decision shall be made within twenty-four (24) hours for Urgent Requests and seventy-two (72) hours for non-urgent requests upon expiration of the pending time or receipt of the requested information.
 6. Only licensed physicians or other licensed health care professionals (competent to evaluate the specific clinical issues involved in the health care services requested) may deny or modify requests for authorization of prescription drugs for a Member for reasons of Medical Necessity. The physician or other health care professional must have a current and unrestricted license to practice within the scope of their profession in the state of California.
 7. If the PBM fails to respond within the required timeframe, the authorization request shall be deemed approved for the duration of the prescription, including refills.
- F. The PBM shall grant a Step Therapy exception request, if the Prescriber submits necessary justification and supporting clinical documentation demonstrating that the required prescription drug is inconsistent with good professional practice for provision of Medically Necessary covered services to the Member, taking into consideration the Member's needs and medical history, along with the professional judgment of the Member's Prescriber. The basis of the Prescriber's determination may include, but is not limited to the following:
1. The Prescriber submits necessary justification and supporting clinical documentation.
 2. The required prescription drug is contraindicated or is likely, or expected, to cause adverse reaction or physical/mental harm to the Member in comparison to requested prescription, based on known clinical characteristics of the Member and known characteristics and history of the Member's prescription drug regimen.
 3. The required prescription drug is expected to be ineffective based on known clinical characteristics of the Member and known characteristics and history of the Member's prescription drug regimen.
 4. The Member has tried the required prescription drug while covered by their current or previous health care coverage or Medicaid and the prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect or adverse reaction. The PBM may require submission of documentation demonstrating the Member tried the prescription before it was discontinued.
 5. The required prescription drug is not clinically appropriate for the Member because the required drug is expected to: worsen a comorbid condition; decrease capacity to maintain a reasonable functional ability in performing daily activities; or pose a significant barrier to adherence to, compliance with, the Member's drug regimen or plan of care.
 6. The Member is stable on the prescription drug selected by the Prescriber for the medical condition under consideration while covered by their current or previous health coverage.
 7. Any other reason indicated through Prescriber submissions of supporting clinical documentation that the required prescription drug is inconsistent with good professional practice.
- G. The PBM may require a Member to try an AB-rated generic equivalent or interchangeable biologic product before providing coverage for the equivalent branded prescription drug if required per clinical guidelines. This provision does not prohibit or supersede a Step Therapy exception request as described in Section III.F and required by Health & Safety Code § 1367.206.

H. PBM's Obligations Relating to Drug Previously Approved for Member's Medical Condition:

1. The PBM shall not limit or exclude coverage of a prescription drug previously approved for coverage by the plan for the Member's medical condition if the Prescriber continues to prescribe the drug and the drug is appropriately prescribed for treating the Member's medical condition and is considered safe and effective for treating the Member's medical condition. The process by which a Prescriber may obtain PA for Medically Necessary non-formulary drugs will not apply to a non-formulary drug that has been prescribed in accordance with this section.
 2. In circumstances where the Member is changing plans, the PBM shall not require the Member to repeat Step Therapy when that Member is already being treated for a medical condition by a prescription drug provided that the drug is appropriately prescribed and is considered safe and effective for the Member's condition.
- I. The PBM shall not limit or exclude coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which the drug has been approved for marketing by the FDA, provided that all of the following conditions have been met:
1. The drug is approved by the FDA.
 2. The drug is prescribed by a contracting licensed health care professional for the treatment of a life-threatening condition, or the drug is prescribed by a contracting licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is Medically Necessary to treat that condition, and the drug is on CalOptima Health's formulary, if any.
 3. The drug has been recognized for treatment of that condition by any of the following:
 - a. The American Hospital Formulary Service's Drug Information.
 - b. One of the following compendia, if recognized by CMS as part of an anticancer chemotherapeutic regimen: the Elsevier Gold Standard's Clinical Pharmacology, the National Comprehensive Cancer Network Drug and Biologics Compendium, or the Thomson Micromedex DrugDex.
 - c. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing evidence presented in a major peer reviewed medical journal.

J. Coverage for Pain Management Medications for Terminally Ill Patients:

1. The PBM shall approve or deny requests by Providers for authorizations of appropriately prescribed pain management medications for Members who have been determined to be Terminally Ill in a timely fashion, appropriate for the nature of the Member's condition, not to exceed 72 hours of the PBM's receipt of the information requested by the PBM to make the decision.
2. Only licensed physicians or health care professionals (competent to evaluate the specific clinical issues involved in the health care services requested) may make decisions to deny pain management PA request for Terminally Ill Members.

- 1 3. If the request is denied, or if additional information is required, the PBM shall contact the
2 requesting Provider within one working day of the PBM's determination, with an explanation of
3 the determination, and the reason for the denial or the need for additional information.
4
- 5 4. The requested treatment shall be deemed authorized if the PBM fails to respond within the
6 required timeframe.
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- 8 K. For authorizations that have been approved, the notification letter shall include the approved
9 medication, quantity, and the timeframe of the approval. The Member will be notified in writing,
10 and the Prescriber shall be notified initially by telephone, email, or facsimile, followed by a written
11 notification, within twenty-four (24) hours for Urgent Requests and seventy-two (72) hours for non-
12 urgent requests, of the PBM's receipt of all information reasonably necessary to make a
13 determination.
14
- 15 L. For authorizations that have been denied or modified, the Member will be notified in writing and
16 Prescriber shall be notified initially by telephone, email, or facsimile, followed by a written
17 notification, within twenty-four (24) hours for Urgent Requests and seventy-two (72) hours for non-
18 urgent requests, of the PBM's receipt of all information reasonably necessary to make a
19 determination or the time to receive additional information has lapsed, whichever comes first.
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- 21 M. The PBM's denial notification letters shall:
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- 23 1. Include an accurate and clear and concise explanation of the specific reasons for the PBM's
24 denial.
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 - 26 2. Include a description of the criteria and/or guidelines used for the PBM's decision.
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 - 28 3. Include a reference to the specific plan provision on which the determination was based and that
29 a copy of plan provision or guideline can be obtained free of cost.
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 - 31 4. Include an accurate and clear written explanation that specifically identifies the missing material
32 information necessary to approve the case, if applicable.
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 - 34 5. Include any alternative drugs or treatment offered by the plan, if applicable.
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 - 36 6. Include to the Prescriber, the name and the direct telephone number or telephone extension of
37 the professional responsible for the decision.
38
 - 39 7. Include a description of how the Prescriber may request an Appeal for Adverse Benefit
40 Determination.
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 - 42 8. Include a description of how the Member, Member's Authorized Representative or Prescriber
43 may obtain a copy of the guideline, rule, or protocol utilized to render the decision free of
44 charge.
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 - 46 9. Include information on how the Member or Member's Authorized Representative may file a
47 Grievance or Appeal with CalOptima Health if the Member objects to the disapproval,
48 including any alternative drug or treatment offered by the PBM.
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 - 50 10. If PBM denies coverage of an experimental or investigative therapy to a Member with a life
51 threatening or seriously debilitating condition, it shall notify the Member in writing of the
52 opportunity to request an Independent Medical Review (IMR) within five business days of the
53 decision to deny coverage.

11. Include information on how the Member or Member's Authorized Representative may file a Grievance seeking an Independent Medical Review (IMR) request review.
12. Include the following paragraph in denial letters in 12-point type:
 - a. The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a Grievance against your health plan, you should first telephone your health plan at 714-246-8500 and use your health plan's Grievance process before contacting the department. Utilizing this Grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by your health plan, or a Grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, Coverage Decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.
13. If the PBM grants an expedited formulary exception request, the PBM shall not limit or exclude coverage of the nonformulary drug for the duration of the exigency, if the Prescriber continues to prescribe the drug and the drug is appropriately prescribed for treating the Member's medical condition.
14. If the PBM grants a nonurgent formulary exception request, the PBM provides coverage of the nonformulary drug for the duration of the prescription, including refills.

N. Independent Medical Review (IMR) request review process:

1. All IMR request reviews of a denial of a request are completed by an independent review organization.
2. If the independent review organization reverses the denial of a PA, Step Therapy request, or formulary exception, the decision is binding on the PBM shall apply for the duration of the prescription, including refills, or in the case of an expedited exception request, the PBM will provide coverage for the duration of the exigency.
3. If the Member, the Member's Authorized Representative, or the Prescriber requests an IMR request review for a non-urgent request, the PBM shall notify the Member or the Member's Authorized Representative and the Prescriber of the PBM's coverage determination within seventy-two (72) hours of the PBM receiving the request.
4. If the Member, the Member's Authorized Representative, or the Prescriber requests an IMR request review for an exigent PA, Step Therapy exception, or formulary exception request, the PBM shall notify the Member, the Member's Authorized Representative and the Prescriber of the PBM's coverage determination within twenty-four (24) hours of the PBM receiving the request.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. California Health & Safety Code §§ 1367.241, 1367.244, 1367.206, 1367.241, 1367.01, 1367.22(a), 1367.215, 1367.21, 1368.015
B. 28 California Code of Regulations § 1300.67.24, 1300.67.241
C. Title 45, Code of Federal Regulations, Section 156.122 (c)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/02/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1902	Step Therapy and Prior Authorization Requirements	Covered California

1 IX. GLOSSARY

2

Term	Definition
Adverse Benefit Determination	Any of the following actions: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a “clean claim” at 42 CFR section 447.45(b) is not an Adverse Benefit Determination. 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals. 6. For a resident of a rural area with only one managed care plan, the denial of the Member’s request to obtain services outside the network. 7. The denial of a Member’s request to dispute financial liability.
Appeal	A request for reconsideration or Appeal made following an initial Grievance decision.
Authorized Representative/Legal Representative	An individual who is (1) the legal representative or otherwise legally able to act on behalf of a Member, as the law of the State in which the Member resides may allow; (e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity), or (2) appointed in writing by a competent Member to act on behalf of the member for a limited purpose (e.g., DMHC Independent Medical Reviews, filing Grievances and Appeals, claims adjudications). The DMHC Authorized Assistant Form may be used to appoint an authorized assistant to assist the Member with Independent Medical Review or complaint, provided a power of attorney for health care decisions or other legal document is submitted by an individual seeking to represent a Member who does not have legal capacity to appoint an authorized assistant.
CalOptima Health	For purposes of this policy, CalOptima Health means CalOptima Health Direct, including CalOptima Health Direct-Administrative and CalOptima Health Community Network (CHCN)
Coverage Decision	The approval or denial of health care services by CalOptima Health or a Health Network substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the Member’s CalOptima plan contract. A “coverage decision” does not encompass a CalOptima Health or Health Network decision regarding a disputed health care service.
Coverage Decision Letter	Written notice of action within the timeframes for each type of action as provided in Health & Safety Code § 1367.01.

Term	Definition
Department of Managed Health Care (DMHC)	California state agency that regulates and oversees health maintenance organizations (HMOs) and other managed care plans.
Grievance	Any expression of dissatisfaction 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.
Independent Medical Review (IMR)	A review of CalOptima Health's denial of a Member's request for health care service as not Medically Necessary, experimental, or investigational by an independent physician(s) who is contracted with the DMHC. The IMR decision is binding on CalOptima Health pursuant to Health and Safety Code § 1374.30 and Title 28, California Code of Regulations §1300.74.30
Medically Necessary or Medical Necessity	Health care and related services and supplies provided to a Member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or Provider; and (iv) not more costly than an alternative service, or suite of services, and at least as likely to produce equivalent results. For treatment of a mental health or substance use disorder, Medical Necessity shall include: A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) In accordance with the generally accepted standards of mental health and substance use disorder care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; and (iii) Not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other Provider, as required by Health and Safety Code §1374.72 (a)(3)(A).
Member	An individual enrolled in a CalOptima Health program.
Medication Request Form	Prescription Drug Prior Authorization or Step Therapy Exception Request Form (61-211).
Minimum Amount of Material Information	The information generated by or in the possession of the Prescriber related to the Member's clinical condition that enables an individual with the appropriate training, experience, and competence in prescription drug PA processing to determine if the prescription drug PA or Step Therapy exception request should be approved or disapproved.

Term	Definition
Pharmacy Benefit Management (PBM)	The entity that performs certain functions and tasks, including, but not limited to, pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement between the PBM and CalOptima Health.
Prescriber	As defined in the Business and Professions Code, Section 4039, physicians, dentists, optometrists, pharmacists, podiatrists, registered nurses, and physician's assistants authorized by a currently valid and unrevoked license to practice their respective professions in their state.
Prior Authorization	A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services.
Provider	A licensed health care facility or as stipulated by local or international jurisdictions, a program, agency or health care professional that delivers Covered Services.
Step Therapy	A utilization management process which requires a trial of a first-line formulary medication prior to receiving the second-line medication. If it is Medically Necessary for a Member to use the medication as initial therapy, the Prescriber can request coverage by submitting a PA request.
Terminally Ill	An incurable or irreversible condition that has a high probability of causing death within one (1) year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan Provider.
Urgent Request	A request for pharmaceutical services where application of the time frame for making routine or non-life-threatening care determinations: 1. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, or 2. In the opinion of a practitioner with knowledge of the Member's medical or behavioral condition, would subject the M



Policy: CC.1901
Title: **Pharmacy Benefit Manager (PBM) Delegation Oversight**
Department: Medical Management
Section: Pharmacy Management

CEO Approval: /s/

Effective Date: 01/01/2027

Revised Date: Not Applicable

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☐ Medi-Cal
☐ OneCare
☐ PACE

I. PURPOSE

This policy establishes procedures for CalOptima Health's oversight of Pharmacy Benefit Manager (PBM) delegated functions for its Covered California line of business, ensuring compliance with federal regulations (45 CFR § 156.122), the Knox-Keene Act, and applicable California Department of Managed Health Care (DMHC) requirements.

II. POLICY

- A. CalOptima Health may delegate certain pharmacy management functions to a PBM under a written Delegation agreement but retains ultimate responsibility for regulatory compliance and performance.
- B. Oversight of a PBM shall include ongoing monitoring of the PBM's performance, adherence to applicable regulatory requirements, including DMHC standard formulary requirements, and utilization management (UM) processes, related to prescription drugs, and CalOptima Health policies and procedures.
- C. This policy applies to all PBM-delegated activities related to CalOptima Health's Covered California line of business, including but not limited to Delegation of the following functions:
 1. Formulary development and maintenance aligned with Essential Health Benefits (EHB) benchmark requirements.
 2. UM program, including prior authorization (PA), step therapy, and quantity limits requirements.
 3. Pharmacy network contracting and adequacy requirements.
 4. Claims adjudication accuracy requirements.
 5. Medication safety and Drug Utilization Review (DUR) documented per applicable requirements.

6. All regulatory required reporting, including but not limited to PA approval/denial timeliness, DUR reporting and network pharmacy geo-access reporting.

III. PROCEDURE

- A. Pre-contractual Audit: Prior to executing a contract or Delegation agreement with a potential vendor, an initial evaluation may be conducted to determine the ability of the potential vendor to assume responsibility for delegated activities and to maintain CalOptima Health standards, applicable federal and state requirements, and accreditation requirements.
1. CalOptima Health will assess the following in the initial evaluation:
 - a. The PBM holds a valid state license.
 - b. No pending disciplinary actions against PBM or PBM's network pharmacies.
 - c. The PBM's ability to perform the required tasks, including ability to meet Covered California reporting requirements, and applicable contractual and regulatory requirements.
 - d. Policies and procedures specific to the delegated function(s), including assessing for compliance with CalOptima Health's policies and procedures.
 - e. Operational capacity to perform the delegated function(s).
 - f. The PBM has resources (administrative and financial) sufficient and qualified to perform the required function(s).
 - g. The PBM's annual compliance and Fraud, Waste, and Abuse (FWA) training and testing, if applicable.
 2. Additional evaluations may be conducted. If the PBM is not in full compliance with delegated standards, the PBM's action plans and timeline to achieve full compliance are reviewed.
 - a. The need for an onsite visit and/or file audit is at the sole discretion of CalOptima Health.
 - b. CalOptima Health determines the frequency and format of contact with the vendor to verify compliance with established, revised, or new State, CMS, and accreditation requirements.
 - c. The vendor is required to comply with CalOptima Health reporting requirements.
 3. Results of the pre-contractual audit are documented in an audit report and presented to the Office of Compliance for review and/or approval.
- B. Contract/Delegation Agreement: The contract/Delegation agreement specifies the following:
1. Delegated functions and responsibilities, performance standards, and service level agreements;
 2. Reporting requirements, including frequency and requirements for compliance with applicable laws and regulations; and
 3. The process for evaluating the PBM's performance and remedies available to CalOptima Health for inadequate performance, including revocation of delegated functions and/or imposition of other sanctions.

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- C. Once Delegation is approved and a contract is executed, the PBM must submit data as contractually required and permit CalOptima Health and the DMHC access to relevant records. The PBM will also be required to maintain records in accordance with applicable regulatory requirements.
 - D. A PBM may not further delegate its contractually assigned functions without CalOptima Health's prior written approval. If CalOptima Health permits a PBM to further delegate functions to a subcontractor, a monitoring schedule and process of the subcontractor's compliance requirements will be determined by CalOptima Health.
 - E. CalOptima Health may retain full control over clinical programs and formulary management or may choose to delegate one or more functions.
 - F. CalOptima Health ensures all benefit and formulary requests are implemented through the following steps:
 - 1. Completion of benefit/formulary request forms submitted to the PBM by CalOptima Health;
 - 2. Review, submission, and validation of benefit/formulary requests;
 - 3. User acceptance testing completion by the PBM and PBM Pharmacy Applications team;
 - 4. Monitoring of completion of benefit/formulary request setup by the PBM; and
 - 5. Post-implementation audit by CalOptima Health Pharmacy Management team.
 - G. If a new PBM is selected to manage CalOptima Health's pharmacy network during the contract year, CalOptima Health shall notify the DMHC and obtain approval prior to the effective date of change.
 - H. CalOptima Health will delegate the following administrative and healthcare oversight services to its contracted PBM:
 - 1. Credentialing and Recredentialing Pharmacies: The PBM is responsible for ensuring that pharmacies are capable of serving CalOptima Health Members and adhering to CalOptima Health's policies and procedures. The PBM ensures all contracted pharmacies are credentialed per National Committee for Quality Assurance/URAC standards.
 - 2. Electronic Prescribing: The PBM provides infrastructure to support e-prescribing activities. The electronic prescription program connects all certified electronic prescription software, surescripts, pharmacy, and physician providers. The system is able to submit or receive medication history inquiry and response based on National Council for Prescription Drug Program's prescriber/pharmacist interface SCRIPT standard implementation guide. The standard guide is based on the "E-prescribing Foundation Standards" which include:
 - a. Prescription standards;
 - b. Eligibility standards;
 - c. Medication history;
 - d. Prescription fill status notification;

- e. Formulary and benefits; and
 - f. Provider identifier.
3. Pharmacy Network Development: The PBM contracts with the pharmacy provider network according to the requirements by DMHC, DHCS, and CMS. The PBM has been delegated to establish and maintain procedures for new and existing pharmacies. The PBM ensures compliance of their call center with metric standards (abandonment rate, speed of answer, hours of operation).
 4. Prescription Adjudication Services: The PBM has been delegated to provide all pharmacy services that CalOptima Health Members are entitled to under the CalOptima Health Plan. The PBM will comply with the Knox-Keene Act of 1975 (Knox-Keene), Health and Safety Code Section 1385.004 and accompanying laws regulating managed care plans. The PA systems meet standard and urgent request timelines per state law.
 5. PA and Transition Notification Requirements: The PBM reviews and makes decisions on the PA requests as defined in Health and Safety Code Section 1385.001. The PBM manages the prescription drug coverage provided by the health care service plan and the processing of prior authorization requests. Requests for prior authorization, non-formulary, quantity limit, or step therapy exceptions may be submitted electronically, by phone or fax. Before payment can be approved for drugs requiring prior authorization, the conditions for approval must be met and the prior authorization must be entered into the system.
- I. Monitoring and Oversight
1. PBM Account Manager serves as a liaison between CalOptima Health and the PBM.
 2. Conference calls with the PBM are conducted on at least a weekly basis and more frequently as needed to address processes and PBM related issues.
 3. CalOptima Health shall perform administrative and clinical services oversight of the PBM and the contracted pharmacies.
 4. CalOptima Health shall audit the configuration of the benefit plan, by comparing the submitted formulary file against the formulary file in the adjudication system.
 5. CalOptima Health shall monitor the PBM's compliance with claims adjudication accuracy policy including information systems support for claims processing, formulary display, and real-time benefit checks.
 6. CalOptima Health shall audit the PBM's paid and rejected claims to assure proper payment and identify any inappropriately adjudicated claims.
 7. CalOptima Health delegates pharmacy contracting for pharmaceutical manufacturer rebate and discounts contracting and administration to the PBM.
 8. The PBM maintains the Maximum Allowable Cost (MAC) list and reviews and responds to MAC appeals in accordance with State and Federal regulations.
 9. The PBM maintains pharmacy prescription claims adjudication services, regardless of the submission type (automated via PBM batch file, or, manually submitted).

10. CalOptima Health will monitor PBM to ensure compliance with CalOptima Health's quality assurance system, including monitoring for early identification and swift correction of problems in the accessibility and availability of outpatient prescription drug benefits.

11. CalOptima Health will conduct quarterly and annual monitoring of the PBM as follows:

- a. Review PBM reports on formulary changes, prior authorization timeliness, step therapy compliance, and grievances.
- b. Validate PBM adherence to Covered California requirements, including Essential Health Benefit (EHB) benchmark formulary standards.
- c. Quarterly and annual formulary reports can be generated.
- d. Evaluate compliance with CalOptima Health's policies and procedures, 45 CFR § 156.122, California Health & Safety Code §§ 1367.41, 1367.241, 28 California Code of Regulations Sections 1300.67.24, 1300.67.241, and other applicable regulatory requirements.
- e. Review accuracy of the DMHC Standard Formulary Template submission.
- f. Assess network adequacy and claims adjudication accuracy.

J. Corrective Action Plans (CAPs):

1. If deficiencies are identified, CalOptima Health shall require the PBM to submit a CAP within thirty (30) days of identifying the deficiency and will monitor CAP implementation until deficiencies are corrected in accordance with CalOptima Health Policy HH.2005: Corrective Action Plan.

K. Reporting to DMHC and Covered California:

1. Material deficiencies or compliance failures will be reported by CalOptima Health per regulatory requirements.

L. Document Retention:

1. CalOptima Health shall retain records for a minimum of ten (10) years, or longer if required by law. Such records include records of all PBM Delegation agreements, monitoring reports, audits, and CAPs.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. 45 CFR § 156.122 – Prescription Drug Benefit Standards
- B. California Health & Safety Code §§ 1367.24(e), 1367.241, 1381
- C. Cal. Code Regs., Title 28, § 1300.67.24, 1300.67.241 – Standard Formulary Template
- D. Covered California: QHP Contract requirements

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/02/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1901	Pharmacy Benefit Manager (PBM) Delegation Oversight	Covered California

For 20251002 BOD Review

1 IX. GLOSSARY

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Term	Definition
Abuse	Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medi-Cal program.
Delegation	Process by which CalOptima Health expressly grants, by formal written agreement, to another entity the authority to carry out a function that CalOptima Health would otherwise be required to perform in order to meet its obligations under its contract with DHCS and Covered California.
Drug Utilization Review	A system of monitoring and evaluating the use of prescription drugs to ensure appropriate and effective therapy for Medi-Cal beneficiaries.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Member	An individual enrolled in a CalOptima Health program.
Pharmacy Benefit Management	The entity that performs certain functions and tasks, including, but not limited to, pharmacy credentialing, contracting, and claims processing in accordance with the terms and conditions of the PBM Services Agreement between the PBM and CalOptima Health.
Waste	The overutilization or inappropriate utilization of services and misuse of resources.

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Policy: CC.1900
 Title: **Formulary Management and Pharmacy & Therapeutics Committee**
 Department: Medical Management
 Section: Pharmacy Management

CEO Approval: /s/

Effective Date: 01/01/2027

Revised Date: Not Applicable

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☐ Medi-Cal
☐ OneCare
☐ PACE

I. PURPOSE

The purpose of this policy is to establish the requirements for the Pharmacy and Therapeutics (P&T) committee for CalOptima Health's Covered California product when P&T responsibilities are delegated to CalOptima Health's contracted Pharmacy Benefit Manager (PBM). This policy ensures that the delegated P&T committee (P&T Committee) operates in full compliance with federal requirements under the Affordable Care Act (ACA), 45 CFR § 156.122, and state requirements under the Knox-Keene Health Care Service Plan Act (KKA), as enforced by the Department of Managed Health Care (DMHC).

II. POLICY

- A. The P&T Committee, under the PBM, must develop, maintain, and review CalOptima Health's formulary in a manner that is clinically sound, evidence-based, transparent, and aligned with Covered California Essential Health Benefits standards, while supporting safe, effective, and cost-conscious access to prescription medications for Members.
- B. CalOptima Health is responsible for conducting an annual review of the delegation agreement and for providing active oversight of P&T Committee functions.
- C. Oversight activities must verify that the delegated committee operates in compliance with all applicable federal and state statutes and regulations, including 45 CFR § 156.122, California Health and Safety Code § 1367.41, the KKA, and Title 28 of the California Code of Regulations.
- D. CalOptima Health shall ensure that the P&T Committee develops, maintains, and reviews formularies for CalOptima Health in accordance with evidence-based standards, promoting safe, clinically appropriate, and cost-effective access to prescription medications. Documentation of oversight activities, findings, and corrective actions must be maintained for audit and regulatory review.
- E. CalOptima Health shall publish the Formulary and monthly updates to the Formulary on CalOptima Health's website in a manner that is accessible and searchable by Members or Prescribers, and a

printed version shall be made available upon request if Members or Prescribers do not have fax, email or internet access, pursuant to federal law or regulations.

F. On an annual basis, CalOptima Health Pharmacy Management, with the participation of physicians and pharmacists, shall review and update the Formulary and pharmaceutical management procedures.

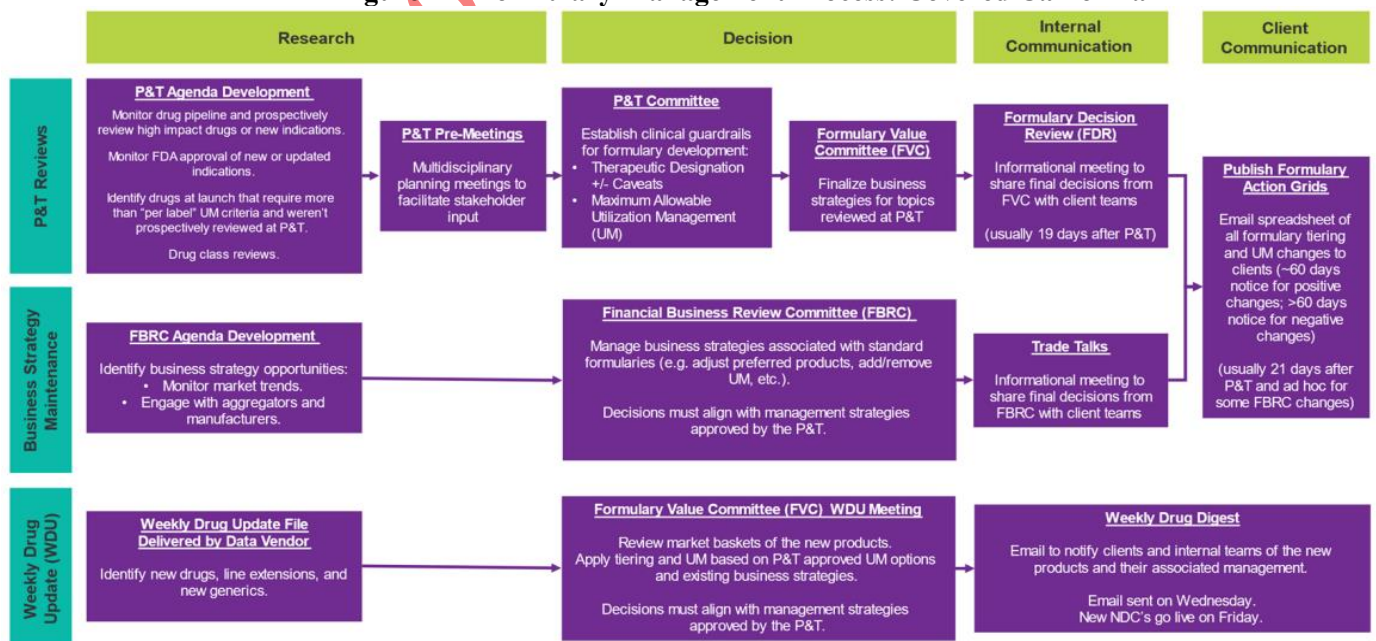
G. Committee Roles and Responsibilities

1. The P&T Committee is a standing committee of the PBM and is responsible for review, guidance, and clinical recommendations for the therapeutic use of drugs.
2. The formulary will match or exceed the drug categories/classes per the United States Pharmacopeia (USP) Medicare Model Guidelines (MMG) as the state's benchmark plan (Kaiser Foundation Health Plan Small Group HMO 30 plan) or at least one drug per category/class, whichever is higher and as required by 45 CFR 156.122.
3. The P&T Committee serves in an advisory capacity to PBM management and to the medical and clinical professionals of PBM clients on matters pertaining to the clinical management of drug use, including recommendations pertaining to drug selection (*e.g.*, specific agents or classes of agents, clinical practice guidelines, Prior Authorization guidelines, or coverage of specific drug therapies as they relate to appropriateness of use).
4. In furtherance of these responsibilities, the P&T Committee shall:
 - a. Recommend therapeutic designations and appropriate prescribing guidelines to assist with the placement of products on drug formulary(ies) by the Formulary Administration and Strategy (FAS) Department and the Financial Business Review Committee (FBRC). FAS and the FBRC will abide by all recommended Therapeutic Designations and Prescribing Guidelines of the P&T Committee.
 - b. Interface with other PBM and CalOptima Health quality and utilization management committees as appropriate.
 - c. Provide ongoing review and monitoring of the safety, effectiveness, and quality of care of drugs contained within the PBM/ CalOptima Health formularies and in the pharmacy benefits management programs of PBM, as needed and specified by the P&T Committee.
 - d. Review and approve drug use review and drug use evaluation programs.
 - e. Review and approve Prior Authorization guidelines.
 - f. Advise PBM on suitable informational programs (*e.g.*, for provider networks, clients benefit plan enrollees, and pharmacy chains).
 - g. Make recommendations for the implementation of effective drug utilization control procedures.
 - h. Additional responsibilities may be established and delegated to the P&T Committee as determined by the Medical Director of PBM.

H. Reporting Relationship

1. The P&T Committee shall be chaired by the Vice President / Medical Director of PBM or, in cases of unavailability, a qualified physician committee member as his/her designee.
2. The P&T Committee functions independently of any other PBM committees, which will abide by all recommended Therapeutic Designations and Prescribing Guidelines of the P&T Committee.
3. In addition, the PBM FAS Department has the responsibility to inform the P&T Committee of the outcomes of any studies or undertakings conducted to ascertain the effectiveness of drug utilization review programs, previously recommended Prior Authorization criteria, or other analyses relating to quality of care, drug safety or cost effectiveness.
4. The process for determining the formulary status and utilization management (UM) strategy of a drug is outlined in Figure 1 below. The P&T Committee determines the Therapeutic Designation and Therapeutic Caveats (see section III.C.4.), as well as the maximum-allowable utilization management criteria for each drug. The FBRC and Formulary Value Committee (FVC) establish business/rebate strategies consistent with P&T Committee-approved standards. FAS then integrates P&T Committee criteria, FBRC/FVC strategy, and business strategy to implement final formulary tiering and UM decisions.
- a. Formulary changes are approved by the FBRC and FVC. They are then routed for implementation and, in parallel, sent to the P&T Committee for review. The P&T Committee Chair/Co-Chair are voting members of both the FBRC and FVC to ensure adherence to P&T Committee-approved criteria.
- a) No drug shall be added to or removed from the formulary without having been reviewed first by the P&T Committee (via either a regular meeting, ad hoc meeting, or interim approval as outlined in section III.B.2).

Figure 1 -- Formulary Management Process: Covered California



III. PROCEDURE

A. Organization

1. Membership

- a. The Vice President, Medical Director (VP/Medical Director) shall act as Chairperson, and the Director of Drug Information shall act as Co-Chairperson of the Committee. The duties of Co-Chair may be delegated to the Manager of Drug Information.
- b. The P&T Committee shall be comprised of at least ten (10), but not more than fifteen (15) voting members (i) that represent a sufficient number of clinical specialties to adequately meet the needs of plan Members, the majority of whom shall be healthcare professionals with unrestricted licenses to practice in their professions in a state or territory of the United States; (ii) whose training and expertise materially contribute to the goals of the P&T Committee; (iii) the majority of whom shall be physicians, pharmacists or other healthcare Providers who are licensed to prescribe drugs; and (iv) a majority of whom are actively practicing in their professions. This policy defines a practicing physician or pharmacist to be an individual who has an active professional license and is currently practicing in the United States. A maximum of two PBM employees may be voting members.
 - i. The P&T Committee shall include at least one (1) actively practicing pharmacist who are experts, defined as a person who has training and/or ongoing clinical practice experience, and who are not employees of PBM.
 - ii. The P&T Committee shall include a licensed psychiatrist.
 - iii. The P&T Committee shall include at minimum one patient representative, as required by 45 CFR § 156.122, who must:
 - a) Represent the patient perspective as a member of the P&T Committee.
 - b) Have relevant experience or participation in patient or community-based organizations.
 - c) Be able to demonstrate the ability to integrate data interpretations with practical patient considerations.
 - d) Have no fiduciary obligation to a health facility or other health agency and have no material financial interest in the rendering of health services.
 - e) Have a broad understanding of one or more conditions or diseases, associated treatment options, and research.
- c. At the discretion of the Chairperson, the P&T Committee may include additional non-voting members who may be employees of PBM or participating representatives of clients of PBM.
- d. The P&T Committee may not include any member who is an employee of any product manufacturer or a representative of any product manufacturer that makes pharmaceutical

products or supplies, in accordance with National Committee for Quality Assurance (NCQA) UM Standards 10 & 11.

2. Conflicts of Interest

- a. The majority of P&T Committee practicing pharmacists and physicians must be independent and free of conflict with respect to CalOptima Health.
- b. At least 20% of the P&T Committee members shall be free of material conflict of interest relative to pharmaceutical and device manufacturers. The PBM Compliance Officer or designee (neither of whom is a member of the P&T Committee) will determine whether any economic arrangement constitutes a material conflict of interest. Such P&T Committee members may have certain nonemployee relationships with pharmaceutical manufacturers (for example consulting, advisory, or research relationships) and still be considered independent and free of conflict provided those relationships do not constitute significant sources of income and they do not otherwise have a conflict of interest that would compromise their independence.
- c. Conflicts of interest for pharmaceuticals and devices may include, but are not limited to, any of the following:
 - i. An ownership interest of greater than 5% between the member and a pharmaceutical manufacturer;
 - ii. A material professional or business relationship with a pharmaceutical manufacturer.
 - iii. A direct or indirect financial incentive for a proposing, suggesting, or objecting to a particular determination involving a medication under consideration by the committee;
 - iv. Incentives to promote the use of a certain product or service;
 - v. A familial or other close or intimate relationship with a person who has such characteristics as noted above.
- d. Conflicts of Interest with Regard to CalOptima Health:
 - i. If a member has a financial interest in CalOptima Health, he or she must disclose that financial interest. The PBM Compliance Officer or designee will review the information to determine whether the financial interest constitutes a conflict of interest.
 - ii. In general, a conflict of interest arises when the P&T Committee member has an economic incentive to limit or exclude formulary access to a pharmaceutical or device because the sponsor must cover the cost and the P&T Committee member realizes a direct or indirect financial consequence from the transaction. An example might be a P&T Committee member who is also an investor in a physician-owned health plan that contracts with PBM.
- e. Conflicts of Interest with Regard to PBM Employees:
 - i. PBM employees who serve on the P&T Committee (Chairperson and Co-Chairperson) must also avoid the appearance of conflict of interest. PBM may not derive direct

economic benefit from formulary restrictions of medications. While it is appropriate to consider cost implications of pharmaceutical pricing, the Chairperson and Co-Chairperson will guide the P&T Committee to make formulary decisions based on scientific evidence and standards of practice to avoid potential conflicts of interest.

f. Disclosure of Conflict of Interest

- i. During each year of his/her term, all members shall complete a conflict-of-interest statement pertaining to any financial or other relationships with any pharmaceutical or device manufacturers or the issuer. In addition, each member shall attest that there have been no changes to the annual conflict-of-interest statement prior to each scheduled committee meeting. If a P&T Committee member has a conflict of interest with respect to CalOptima Health or a pharmaceutical or device manufacturer, that P&T Committee member shall abstain from voting on the issue giving rise to the conflict of interest.
- ii. Members having a financial interest or other connection with a particular pharmaceutical manufacturer that presents a potential conflict of interest, in the discretion of the Chairperson, may be present during discussions of product(s) under review from that pharmaceutical manufacturer; however, he or she may not participate in discussions and will be excluded from voting on product selection of, or policies relating to that particular manufacturer.
- iii. P&T Committee members may have certain non-employee relationships with pharmaceutical manufacturers such as consulting, advisory, or research relationships.
- iv. These P&T Committee members may, nevertheless, be considered free of conflict of interest, provided these relationships do not constitute significant sources of income and they do not otherwise have additional conflicts of interests that would compromise their independence.
- v. The PBM Compliance Officer or designee, in consultation with the Chairperson of the P&T Committee, shall determine whether any of the above named relationships of P&T Committee members constitute a conflict of interest.

3. Conduct of P&T Committee meetings:

- a. A voice roll call will precede each meeting.
- b. Confirmation of members participating by remote means (teleconference) will be noted, and the ability to hear and understand the proceedings will be verified.
- c. The Committee Chair or Co-Chair will declare that a quorum of voting members is present and will note the presence of attendees in the minutes.
- d. The Committee Co-Chair shall be responsible for minutes of the meeting, to be produced in a timely fashion.
- e. At the beginning of each meeting, the following (or reasonably similar) text shall be read into the record of the proceedings by the Chairperson (as required by NCQA UM Standards 2 & 11):

1 “All drugs or drug classes to be presented were reviewed using evidence-based criteria
2 from credible sources including:

3
4 Peer-reviewed medical literature,
5 Accepted national treatment guidelines,
6 Drug compendia in common use,
7 Other authoritative medical sources.
8 Expert opinions have been obtained where necessary.
9

10 The characteristics of each drug (or drug class) evaluated included:
11 Efficacy as well as relative efficacy compared to other similar medications.
12 Drug safety and relative risks of drug versus alternatives.
13 Cost considerations, including drug costs, comparative costs, and projected effect on
14 other medical costs, where applicable.”
15

- 16 f. The Committee involves psychiatrists, pediatricians, and other mental health prescribing
17 practitioners in the development of the formulary for psycho-pharmacologic drugs and
18 pertinent pharmacy management processes, including, but not limited to, cost-control
19 measures, therapeutic substitution, and step-therapy.
20

21 B. Operations

22 1. Frequency of Meetings and Review of Procedures and Criteria:

- 23
24 a. The P&T Committee shall meet at least quarterly.
25
26 b. At least annually, the P&T Committee shall review its procedures and criteria for drug
27 selection, review and non-formulary requests, including exception criteria for transitional
28 beneficiaries.
29

30 2. Formulary Drug List Establishment and Management:

- 31
32 a. Develop and document procedures to ensure appropriate drug review and inclusion.
33
34 b. Base clinical decisions on the strength of scientific evidence and standards of practice,
35 including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes
36 research data, and other such information as it determines appropriate.
37
38 c. Consider the therapeutic advantages of drugs in terms of safety and efficacy when selecting
39 formulary drugs.
40
41 d. Review policies that guide exceptions and other utilization management processes,
42 including drug utilization review, quantity limits, and therapeutic interchange.
43
44 e. Evaluate and analyze treatment protocols and procedures related to the plan's formulary at
45 least annually.
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47 f. Review and approve all clinical Prior Authorization criteria, Step Therapy protocols, and
48 quantity limit restrictions applied to each covered drug.
49
50 g. Review new FDA-approved drugs and new uses for existing drugs.
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- 2 h. Review and confirm compliance with California Health & Safety Code § 1342.75 when
- 3 developing or updating formularies.
- 4
- 5 i. Ensure CalOptima Health's formulary drug list:
- 6
- 7 i. Covers a range of drugs across a broad distribution of therapeutic categories and classes
- 8 and recommended drug treatment regimens that treat all disease states, and does not
- 9 discourage enrollment by any group of enrollees;
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- 11 ii. Provides appropriate access to drugs that are included in broadly accepted treatment
- 12 guidelines and that are indicative of general best practices at the time;
- 13
- 14 iii. Includes at least one U.S. food and Drug Administration (FDA)-approved medication in
- 15 specified categories of medication assisted treatment (MAT) without imposing Prior
- 16 Authorization, Step Therapy, or other utilization management requirements. This policy
- 17 ensures Members have timely, equitable, and cost-effective access to MAT in
- 18 compliance with state and federal regulations;
- 19
- 20 iv. Lists drugs by major therapeutic categories with an indication whether any drugs on the
- 21 list are preferred over other listed drugs;
- 22
- 23 v. Is posted on CalOptima Health's website in a machine-readable file and format that is
- 24 accessible and searchable, and a printed version shall be made available upon request if
- 25 Members or Prescribers do not have fax, email or internet access, pursuant to federal
- 26 law or regulations; and
- 27
- 28 vi. Is updated and posted with any formulary changes on a monthly basis.
- 29
- 30 j. CalOptima Health shall communicate changes and updates relating to the Formulary and
- 31 pharmaceutical management procedures to Members and Prescribers annually, and as
- 32 needed after Formulary updates to notify them:
- 33
- 34 i. Where to find the Formulary, including restrictions and preferences such as Step
- 35 Therapy protocols, on CalOptima Health's website;
- 36
- 37 ii. How to use the Formulary by major therapeutic categories;
- 38
- 39 iii. An explanation of Formulary limits and restrictions and the process for Step Therapy
- 40 protocols;
- 41
- 42 iv. How Prescribing Practitioners must provide information to support a Prior
- 43 Authorization request; and
- 44
- 45 v. Where changes to the Formulary are posted on CalOptima Health's website.
- 46
- 47 3. UM that may be applied on an interim basis upon product launch include:
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- 49 a. "Per label" criteria (e.g., Prior Authorization requiring that the patient's diagnosis aligns
- 50 with the FDA-approved indication, quantity limits (QL) based on the products maximum
- 51 allowable dosing, age limits that align with FDA-approval, etc.)

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- b. Dose consolidation quantity limits (*e.g.*, placing a QL of 1 tab/day on a 20mg tablet when a 40mg tablet is also available and the max dose is 40mg/day).
 - c. 505(b)(2) products and similar (*e.g.*, New Drug Application where only difference is formulation), where a new dosage form/derivative/combination is introduced to the market:
 - i. Previously P&T Committee-approved UM criteria associated with the originator product, and
 - ii. “Physician attestation of patient inability to swallow originator product” and/or step through originator product(s).
 - d. Biosimilar drugs may have a step applied through the reference product, other biosimilars for the same reference product.
4. Drugs coming to market as “line extensions” of existing agents currently available on PBM formularies may be added to the corresponding formulary by the FAS Department without the need for specific P&T Committee review or approval, unless such review of approval is recommended by the Director of FAS or the Director of Drug Information.
5. Annual formulary and UM review
- a. An annual review of the formulary position and UM criteria of all drugs shall be conducted to assess new evidence and ensure ongoing clinical appropriateness. Drugs will typically be grouped by therapeutic class or disease state for these reviews.
 - b. Evidence may include, but is not limited to, clinical trials, professional association guidelines, real world evidence, patient experience, FDA safety alerts, manufacturer updates, etc.
 - c. Additional recommendations of therapeutic classes or disease states to be considered by the P&T Committee may be made by P&T Committee members or petitioned by Providers to the Chairperson.
 - d. Additional recommendations of therapeutic classes or disease states to be considered by the P&T Committee may be made by the FBRC.
6. The P&T Committee shall maintain written documentation of the rationale for all decisions regarding formulary drug list developments or revisions.
7. Monographs of drugs and therapeutic classes or disease states and any Prescribing Guidelines reviewed by the P&T Committee are to include references from government agencies, medical associations, national commissions, peer-reviewed journals, and authoritative compendia used in the compilation of the materials presented and included for documentation and review, in accordance with NCQA UM Standard 10.

48 C. Drug Selection Process

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- 1. Selection Criteria for Recommendations of Drug Status: Drugs presented to the P&T Committee for consideration will be reviewed on the following evidence-based criteria:

- a. Relative therapeutic efficacy.
 - b. Safety/adverse effects/drug interactions, including their likely impact to member's compliance among alternative products when making clinical decisions and concurrent drug utilization review (cDUR) when applicable.
 - c. Efficacy: the potential outcome of treatment under optimal circumstances.
 - d. Strength of scientific evidence and standards of practice through review of relevant information from the peer-reviewed medical literature, accepted national treatment guidelines, and expert opinion where necessary.
 - e. Therapeutic need: the degree to which the agent fulfills an unmet therapeutic need, including, but not limited to, variations in effectiveness/safety based on ethnicity, gender, and socio-economic status.
2. Designation of Drug Formulary Recommendations
 - a. The P&T Committee shall recommend the positioning of drugs for therapeutic classes or disease states for formulary inclusion by applying the criteria above and determining a "Therapeutic Designation" for each drug.
3. Therapeutic Designations (in accordance with NCQA UM Standards 2, 10 & 11)
 - a. Superior: Following evidence-based review outlined above, the drug provides a significant therapeutic advantage, in terms of safety, efficacy, and/or cost effectiveness over other available products within the same treatment modality.
 - b. Novel: Following evidence-based review outlined above, it is determined that the drug represents a new and/or advanced therapeutic option that expands the treatment modality.
 - c. Equivalent: Following evidence-based review outlined above, it is determined that the drug is relatively equivalent in terms of safety, efficacy, and/or cost effectiveness to other available products within the same treatment modality. The drug has not established itself as offering a significant therapeutic advantage that would require it to hold a preferred formulary position.
 - d. Not Essential: Following evidence-based review outlined above, it is determined that the drug is therapeutically disadvantageous, due to either reduced safety, efficacy, and/or cost effectiveness over other available products within the same treatment modality.
4. Therapeutic Caveats
 - a. In addition to applying a therapeutic designation to each drug, the P&T Committee may elect to apply a "therapeutic caveat," which is a clinical comment that provides further direction to the FBRC and FAS Department when making formulary placement determinations. These caveats serve as instructions and are intended to provide more detailed guidance than can be conveyed in a simple therapeutic designation.
5. Product Placement on Formulary (in accordance with NCQA UM Standard 10)

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- a. PBM will adhere to specific regulatory requirements for the CalOptima Health Covered California formulary to ensure accessibility and affordability for Covered California enrollees.
 - b. These requirements include that CalOptima Health offers drug coverage on a four-tier basis using the following categories:
 - i. generics,
 - ii. preferred brand-name drugs,
 - iii. non-preferred brand-name drugs, and
 - iv. specialty medications.
 - c. Each tier is designed to reflect varying cost-sharing levels, promoting the use of lower-cost generics while providing necessary access to higher-tier medications. Additionally, the formulary must be regularly updated to include new FDA-approved drugs, restrict certain medications only for specified conditions, and ensure compliance with state and federal guidelines.
 - d. CalOptima Health will provide clear communication about the formulary to Members, including any limitations or conditions related to coverage.
 - e. Compliance with mental health and substance use disorder parity requirements: The processes, strategies, evidentiary standards, and other factors applied by the P&T Committee in its recommendation for formulary positioning of mental health and substance use disorder drugs and drug classes, as written and in operation, shall be the same as those applied with respect to medical/surgical drugs and drug classes in accordance with federal and state law.
 - f. Processes, strategies, evidentiary standards, and other factors considered by the P&T Committee in determining prescribing guidelines (including, but not limited to, Prior Authorization criteria, quantity limitations, physician specialty limitations, Step Therapy, use of Investigational or Experimental Treatments based on Medical Necessity or medical appropriateness, age limitation and/or gender-based requirements) with respect to mental health and substance use disorder drugs and drug classes, as written and in operation, shall be the same as those applied with respect to medical/surgical drugs and drug classes, in accordance with NCQA UM Standard 2.

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6. Notification of P&T Recommendations

- a. Final recommendations on therapeutic designations and prescribing guidelines will be sent to the FAS Department or FBRC for decisions regarding formulary placement on the PBM standard formularies and subsequently to the appropriate PBM delegating clients after each meeting.
- b. FAS and FBRC will abide by all recommended Therapeutic Designations and Prescribing Guidelines of the P&T Committee.

1 7. Dispensing Limitations

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3 a. Certain drugs may be recommended to be limited to a determined number of doses (*e.g.*,
4 quantity limit) based on criteria, including but not limited to cost, safety (*e.g.* FDA-
5 approved dosing), and/or opportunity for dose consolidation.
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7 8. Selection of Drugs for Step-Therapy

- 9 a. Step-therapy may be recommended when there is a logical succession of drug therapy for a
10 particular medical condition and clinically appropriate alternatives.
11
12 b. In such a succession of agents, the most cost-effective preferred agent might be required to
13 be used first with the prescriber moving to another agent next if the first drug was not
14 successful, the patient was an inappropriate candidate, or the patient had adverse effects.
15
16 c. This process of moving to secondary agents may involve information from prescribers or
17 may be automated by computer review of a patient drug history of which drug(s) had been
18 tried previously.
19

20 9. Selection of Drugs for Prior Authorization (PA)

- 21
22 a. PA is an effective tool to ensure appropriate medication use (*e.g.*, use is in alignment with
23 product label, published peer-reviewed clinical guidelines, expert opinion, etc.).
24
25 i. PA may include various forms of UM strategies, including, but not limited to, the
26 following: indication, Step Therapy, efficacy thresholds, safety parameters (*e.g.*, lab
27 values, diagnostic tests) or other limits (*e.g.*, age, quantity, provider).
28
29 ii. Approval and Renewal Durations: If not otherwise specified by the P&T Committee,
30 the approval and renewal duration of a PA will be twelve (12) months.
31
32 b. PA may be considered based on the following factors:
33
34 i. Cost effectiveness, to ensure the appropriate use of high-cost medications.
35
36 ii. Safety (*e.g.*, complex monitoring requirements, notable safety risks, increased safety
37 risks compared to alternatives require management by a specialist).
38
39 iii. High risk of off-label or experimental use.
40
41 c. PA should not be utilized in situations where the delay incurred for the PA review/approval
42 would be clinically inappropriate (*e.g.*, immediate initiation of therapy is needed to ensure
43 clinical efficacy or to avoid harm).
44

- 45 10. If CalOptima Health covers prescription drugs in excess of the prescription drugs required to be
46 covered, the additional prescription drugs are considered an essential health benefit and subject
47 to requirements including the annual limitation on cost sharing and the restriction on annual and
48 lifetime dollar limits, unless coverage of the drug is mandated by state action and is in addition
49 to an essential health benefit pursuant to 45 CFR § 155.170, in which case the drug would not
50 be considered an essential health benefit.
51

D. Formulary Review (in accordance with NCQA UM Standard 10)

1. PBM utilizes explicit clinical review criteria that are:

- a. Developed with involvement from appropriate prescribers with current knowledge relevant to the criteria.
- b. Based on current, and be consistent with, sound clinical principles and processes.
- c. Evaluated at least annually and updated if necessary by:
 - i. PBM itself.
 - ii. Appropriate, actively practicing physicians and pharmacists, with current knowledge relevant to the criteria, in accordance with NCQA UM Standard 11.
 - iii. Approved by the medical director, senior clinical staff person, or P&T Committee.
- d. If used as the basis of a decision to modify, delay, or deny services in a specific case under review, disclosed to the provider and member in that specific case.
- e. Available to the public upon request, and disclosed for the specific procedures or conditions requested, and may be also made available through electronic communication means.

2. The P&T Committee shall review all PBM proprietary formularies on at least an annual basis to ensure (in compliance with NCQA UM Standard 11):

- a. The placement of drugs and therapeutic drug classes in accordance with P&T Committee policies, procedures and recommendations.
- b. The presence of sufficient drugs and therapeutic drug classes to meet the medical needs of the patient population for which the formulary is intended.
- c. The appropriateness of drug utilization management and control programs such as Drug Use Review (DUR), Drug Use Evaluation (DUE), PA, Step Therapy, quantity limits, and other drug UM and control activities that affect access to Covered Drugs; and
- d. The formulary placement and prescribing guidelines associated with mental health and substance use disorder drugs and drug classes are comparable to and are applied no more stringently than for medical/surgical drugs and drug classes, as required under federal and state law.

3. Review of formulary placement and prescribing guidelines for mental health and substance use disorder parity compliance shall include evaluation of data for all operations measures set forth in PBM's parity compliance analyses, and consideration for any corrective actions that may be appropriate to ensure ongoing compliance with parity requirements.

E. Delegated Responsibilities

1. CalOptima Health has delegated the development and execution of pharmaceutical management procedures to PBM. The development of those procedures mentioned above are to be the responsibility of the P&T Committee or their designee.
 - a. For such plans, PBM will be a resource for information regarding the formulary, preferred drug lists, PA lists, medication requests, restrictions, and copayments, including any deductibles or coinsurance (as applicable).
 - b. The process of the development and execution of pharmaceutical management procedures delegated to PBM will be reviewed at least annually by CalOptima Health.

F. DUR, DUE, & Educational Programs

1. Based upon the information provided during the P&T Committee proceedings, the P&T Committee may recommend target drug or disease state programs (DUR and/or DUE programs) for more intensive data review.
2. The target drug or disease review recommendations will include appropriate monitoring or review criteria.

G. Records Retention.

1. CalOptima Health will maintain, as part of its books and records, and will make available to DMHC as required by Health & Safety Code § 1381 the following information:
 - a. Its complete drug formulary(ies), including a list of the prescription drugs on the formulary by major therapeutic category with an indication of whether any drugs are preferred over other drugs; and
 - b. Records developed by the P&T Committee or by others responsible for developing and overseeing formularies, used to guide the drugs prescribed for the CalOptima Health Members that fully describe the reasoning behind formulary decisions.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. Affordable Care Act (ACA), 45 CFR § 156.122 – Prescription Drug Benefits
- B. Knox–Keene Health Care Service Plan Act of 1975 (California Health & Safety Code §§ 1340 *et seq.*)
- C. California Code of Regulations, Title 28 – DMHC Regulations on Formulary and P&T Committees
- D. 45 CFR § 156.122
- E. California Health & Safety Code § 1367.41
- F. Title 28, California Code of Regulations § 1300.67.205.
- G. California Health & Safety Code § 1342.75
- H. 2025 NCQA Health Plan Accreditation-UM Standards

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
10/02/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1900	Formulary Management and Pharmacy & Therapeutics Committee	Covered California

For 20251002 BOD Review Only

1 IX. GLOSSARY

2

Term	Definition
Covered Drugs	Prescription medications included on the plan's formulary (drug list) that meet the Essential Health Benefit (EHB) benchmark requirements
Investigational or Experimental Treatments	Investigational or Experimental Treatments are for individual Members who meet all of the following criteria: 1. The Member has a life-threatening or seriously debilitating condition; 2. For purposes of this section, "life-threatening" means either or both of the following: a. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted. b. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. 3. For purposes of this section, "seriously debilitating" means diseases or conditions that cause major irreversible morbidity.
Medically Necessary or Medical Necessity	Health care and related services and supplies provided to a Member for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care provider; and (iv) not more costly than an alternative service, or suite of services, and at least as likely to produce equivalent results. For treatment of a mental health or substance use disorder, Medical Necessity shall include: A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) In accordance with the generally accepted standards of mental health and substance use disorder care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; and (iii) Not primarily for the economic benefit of CalOptima Health or the Member or for the convenience of the Member, treating physician or other health care Provider, as required by HSC §1374.72 (a)(3)(A).
Member	An individual enrolled in a CalOptima Health program.
Prior Authorization	A formal process requiring a Provider to obtain advanced approval for the amount, duration, and scope of non-emergent Covered Services.
Step Therapy	A utilization management process which requires a trial of a first-line formulary medication prior to receiving the second-line medication. If it is Medically Necessary for a Member to use the medication as initial therapy, the prescriber can request coverage by submitting a prior authorization request.

3

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2025

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

6. Approve New CalOptima Health Enrollment Policy in Accordance with Covered California Regulatory Requirements for Department of Managed Health Care Filing

Contacts

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

Ladan Khamseh, Executive Director, Operations, (714) 246-8866

Recommended Action

Approve New CalOptima Health Policy: CC.1301: Exchange Enrollment, effective January 1, 2027.

Background

CalOptima Health must obtain approval to operate a Covered California product under its Knox-Keene Act license from the California Department of Managed Health Care (DMHC). Obtaining a Knox-Keene Act license or expanding an existing license is a regulatory filing process that all plans must comply with to offer an individual market health plan. While CalOptima Health is currently licensed with DMHC for the OneCare Medicare product, CalOptima Health must submit a filing to expand its current Knox-Keene Act to participate in the individual market. On June 16, 2025, CalOptima Health submitted the initial filing to DMHC to expand the scope of CalOptima Health's current Knox Keene Act license to enable CalOptima Health to offer a Covered California product. This filing process with the DMHC is ongoing.

Discussion

The DMHC filing process is a multi-phased process that CalOptima Health must complete by early 2026 to obtain the proper approvals to operate an individual market health plan. The process requires the submission of more than 90 supporting exhibits that demonstrate compliance with the requirements of the Knox-Keene Act.

Several of the documents that must be submitted to DMHC are policies and procedures that demonstrate compliance with statutory and regulatory requirements. Staff have evaluated the policies and procedures that are needed to demonstrate compliance. Staff recommends approval of a new policy and procedure to demonstrate compliance with member enrollment, as outlined below.

Policies & Procedures Summary – Member Enrollment

The new proposed policy demonstrates compliance with statutory and regulatory requirements regarding:

- Specifying open enrollment periods, annual enrollment periods, and special enrollment periods specific to the Covered California line of business.
- Maintenance of enrollment records and information packages to new enrollers.
- Fairly and affirmatively offering, marketing, and selling all products made available to individuals in Covered California to individuals purchasing coverage in the individual market outside Covered California.

To meet the enrollment requirements, Policy CC.1301: Exchange Enrollment outlines the process for enrolling an individual into CalOptima Health's Covered California plan. The "Exchange" is a term that is used to generally describe the online marketplace for purchasing health insurance plans established under the Affordable Care Act. In California, the Exchange is called Covered California. CalOptima Health is required to offer identical plans within the Exchange and off-Exchange in the individual market.

This policy includes eligibility criteria, enrollment period procedures during annual open enrollment and special enrollment periods, collection of premium payments, and cancellations. Additionally, the policy outlines commercial insurance timeframes and definitions.

This policy demonstrates compliance with the following statutory requirements and DMHC guidance:

- Covered California Qualified Health Plan Issuer Model Contract, Article 2.
- Health & Safety Code §§ 1357.503, 1366.6, 1399.849.
- Title 10, California Code of Regulations, §§ 6410, 6500, 6502, 6504.
- Title 45, Code of Federal Regulations, §§ 146.121, 147.104, 147.110, 155.420, 155.725.

Staff seeks CalOptima Health Board of Directors approval of the attached new policy, effective January 1, 2027.

Fiscal Impact

The recommended action is operational in nature. Any anticipated costs will be included in future Covered California operating budgets.

Rationale for Recommendation

Approval of the new policy and procedure related to enrollment operations will support CalOptima Health's application to expand its Knox-Keene Act license to operate an individual market plan.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Health Policy CC.1301: Exchange Enrollment
2. Enrollment Information Packet
3. Notice of Coverage and Premium Payment Due Date
4. Notice of Start of 30-Day Grace Period
5. Notice of Start of 3-Month Grace Period
6. Notice of Cancellation for Nonpayment of Premium

/s/ Michael Hunn
Authorized Signature

09/25/2025
Date



Policy: CC.1301
Title: **Exchange Enrollment**
Department: Customer Service
Section: Not Applicable

CEO Approval: /s/

Effective Date: 01/01/2027
Revised Date: Not Applicable

Applicable to: ☐ Administrative
☒ Covered California [Effective 2027]
☐ Medi-Cal
☐ OneCare
☐ PACE

I. PURPOSE

This policy describes procedures for enrolling an individual in CalOptima Health's Covered California plan through the Exchange.

II. POLICY

A. Subject to the provisions of this Policy, an individual is eligible to enroll in CalOptima Health's Covered California plan through the Exchange if they meet the following requirements:

1. Are a citizen or national of the United States, or a non-citizen who is lawfully present in the United States for the entire period for which enrollment is sought.
2. Are not incarcerated, other than incarceration pending the disposition (judgment) of charges.
3. Satisfy applicable residency standards:
 - a. For an individual who is age 21 or older, they must attest that they are not living in an institution; are capable of indicating intent; are not receiving Supplemental Security Income/State Supplemental Program ("SSI/SSP") payments; live in the Service Area and either intends to reside there or has, or is seeking, employment there.
 - b. For an individual who is under age 21, they must attest that they are not living in an institution; are not eligible for Medi-Cal; are not emancipated; are not receiving SSI/SSP; and Service Area is the service area in which the individual (or their parent or caretaker) resides.
 - c. For an individual who is not described in subparagraphs (a) or (b) above, the residency requirements set forth in 42 C.F.R. § 435.403 shall apply.

- 1 d. An individual's eligibility for enrollment shall not be denied or terminated if the
2 individual meets the applicable residency standard but for a temporary absence from
3 the Exchange Service Area and the individual intends to return when the purpose of
4 the absence has been accomplished.
5
- 6 4. Make their initial premium payment, less any Advanced Premium Tax Credit ("APTC")
7 as determined by the Exchange, on or before the Premium Payment Due Date, and
8 CalOptima Health receives such payment on or before such due date;
9
- 10 5. Applies during one of the following enrollment periods:
11
- 12 a. Annual Open Enrollment Period: CalOptima Health shall provide an Annual Open
13 Enrollment Period each year from November 1 through January 31 of the following
14 year.
15
- 16 b. Special Enrollment Period (SEP): CalOptima Health shall enroll a Qualified
17 Individual or Enrollee outside of the open enrollment period if all the following
18 occur: (i) the Qualified Individual or Enrollee experiences one of the Qualifying
19 Events listed below; (ii) the Qualified Individual or Enrollee attests to the event(s)
20 under penalty of perjury; (iii) the Qualified Individual or Enrollee, or their
21 Dependent, applies for a CalOptima Health Covered California plan within 60 days
22 from the date of the Qualifying Event(s), unless a longer period applies pursuant to
23 10 C.C.R. § 6504(f)(1)-(f)(8); and (iv) CalOptima Health receives the initial premium
24 payment on or before the Premium Payment Due Date. If one member of a household
25 experiences a Qualifying Event, all household members shall be eligible for a SEP if
26 otherwise eligible for enrollment through the Exchange. Qualifying Events include
27 the following:
28
- 29 i. The Qualified Individual or their Dependent either:
30
- 31 a) Loses Minimum Essential Coverage ("MEC") (not including voluntary
32 termination);
33
- 34 b) Is enrolled in a non-calendar year group health plan or individual health
35 insurance coverage that expired or will expire, even if there is an option to
36 renew such coverage;
37
- 38 c) Loses access to coverage that provides health care services to a pregnant
39 woman's unborn child (not including voluntary termination); or
40
- 41 d) Loses medically needy or pregnancy-related coverage under Medi-Cal (not
42 including voluntary termination).
43
- 44 ii. The Qualified Individual gains or becomes a Dependent through marriage or
45 domestic partnership, birth, adoption, placement for adoption, placement in foster
46 care, or a valid state or federal court order (e.g., a child support order).
47
- 48 iii. The Qualified Individual loses or is no longer considered a Dependent due to
49 divorce, legal separation, dissolution of a domestic partnership, or death.
50

- 1 iv. The Qualified Individual or their Dependent becomes newly eligible for
2 enrollment through the Exchange because they newly meet eligibility
3 requirements.
4
- 5 v. The Qualified Individual's or their Dependent's enrollment or non-enrollment in
6 a Qualified Health Plan (QHP) is unintentional, inadvertent, or erroneous and
7 resulted from error, misrepresentation, misconduct, or inaction of an officer,
8 employee, or agent of the Exchange or Health and Human Services, its
9 instrumentalities, a QHP Issuer, or a non-Exchange entity providing enrollment
10 assistance or conducting enrollment activities. "Misconduct" includes the failure
11 to comply with applicable standards under Title 10 of the California Code of
12 Regulations or other applicable federal or state laws.
13
- 14 vi. An Enrollee or their Dependent adequately demonstrates that the QHP in which
15 they are enrolled substantially violated a material provision of its contract in
16 relation to the individual.
17
- 18 vii. The Qualified Individual or Enrollee, or their Dependent, is deemed newly
19 eligible or ineligible for the APTC or has a change in eligibility for the Cost
20 Sharing Reduction ("CSR").
21
- 22 viii. The Qualified Individual, or their Dependent, is enrolled in an employer-
23 sponsored plan and becomes newly eligible for the APTC because coverage
24 under the employer-sponsored plan is changing or being discontinued (the
25 individual must terminate existing coverage prior to enrollment).
26
- 27 ix. The Qualified Individual, Enrollee, or Dependent gains access to new QHPs
28 because of a permanent move.
29
- 30 x. A Qualified Individual who gains or maintains status as an Indian may enroll in a
31 QHP or change from one QHP to another once per month. An Indian's Dependent
32 may, at the same time as the Indian, enroll in a QHP or change from one QHP to
33 another once per month.
34
- 35 xi. The Qualified Individual, Enrollee, or Dependent demonstrates that they meet
36 other exceptional circumstances for the SEP. Such circumstances include, but are
37 not limited to, the following:
38
- 39 a) An individual receives a certificate of exemption for hardship based on
40 eligibility standards set forth in 45 C.F.R. § 155.605(d)(1) or 10 C.C.R. §
41 6914 for a month or more during the coverage year; and based on the
42 circumstances of the attested to hardship, they are no longer eligible for a
43 hardship exemption within a coverage year but are outside of an Annual
44 Open Enrollment Period and are otherwise eligible for enrollment in a QHP.
45
- 46 b) An individual has a certificate of exemption, reports a change regarding their
47 eligibility for an exemption, and the change resulting from a re-determination
48 is implemented. The individual and their Dependent(s) shall be eligible for
49 the SEP if otherwise eligible for enrollment in a QHP.
50

- 1 c) An Enrollee provides satisfactory documentary evidence verifying their
2 eligibility for an Insurance Affordability Program or enrollment in a QHP
3 within 30 days following their termination of Exchange enrollment due to a
4 failure to verify such status within the 95-day period specified in 10 C.C.R. §
5 6492(a)(2)(B).
6
7 d) A Qualified Individual, Enrollee, or Dependent experiences a fire, flood, or
8 other natural or human-caused disaster that resulted in a state of emergency
9 declaration in California. The date of the Qualifying Event shall be the date
10 of the declaration.
11
12 e) Where a national public health emergency or pandemic results in a
13 declaration of a state of emergency at the state or national level. The
14 Qualifying Event shall be ongoing throughout the state of emergency.
15
16 xii. The Qualified Individual or Enrollee is a victim of domestic abuse or spousal
17 abandonment, has MEC, and seeks to enroll in coverage separate from the
18 perpetrator of the abuse or abandonment. A Dependent of a victim of domestic
19 abuse or spousal abandonment, who is on the same application as the victim, is
20 eligible to enroll at the same time as the victim.
21
22 xiii. The Qualified Individual or their Dependent (i) applies for coverage on the
23 Exchange during the Annual Open Enrollment Period or due to a Qualifying
24 Event, is assessed as potentially eligible for Medi-Cal or CHIP, and subsequently
25 deemed ineligible for Medi-Cal or CHIP by the State Medi-Cal or CHIP agency
26 either after the open enrollment period has ended or more than 60 days after the
27 Qualifying Event; or (ii) applies for coverage at the State Medi-Cal or CHIP
28 agency during the Annual Open Enrollment Period and is deemed ineligible for
29 Medi-Cal or CHIP after the open enrollment period has ended.
30
31 xiv. The Qualified Individual's or Enrollee's (or their Dependent's) enrollment
32 through the Exchange resulted from a material error related to plan benefits,
33 service area, cost sharing, or premium. A "material error" is one that is likely to
34 have influenced a Qualified Individual's or Enrollee's (or their Dependent's)
35 enrollment in a QHP, as determined by the Exchange.
36
37 xv. The Qualified Individual, Enrollee, or Dependent newly gains access to an
38 Individual Coverage Health Reimbursement Arrangement ("ICHRA") or is
39 newly provided a Qualified Small Employer Health Reimbursement Arrangement
40 ("QSEHRA"). The Qualified Individual, Enrollee, or Dependent shall qualify for
41 the SEP regardless of whether they were previously offered or enrolled in a
42 ICHRA or previously provided a QSEHRA, so long as they are not enrolled in
43 the ICHRA or covered by the QSEHRA on the day immediately prior to the
44 Qualifying Event.
45
46 xvi. The Qualified Individual or their Dependent is enrolled in COBRA continuation
47 coverage subsidized by the employer and/or a government entity, and the
48 employer or government contributions cease.
49
50 xvii. The Qualified Individual, Enrollee, or Dependent is eligible for the APTC and
51 their expected household income is at or below 150% of the Federal Poverty

Level, such that they may enroll in a QHP or change from one QHP to another once per month.

xviii. Any other Qualifying Events under Health & Safety Code § 1399.849(d)(1).

- B. CalOptima Health shall not establish rules for enrollment eligibility, including continued eligibility, in an individual health benefit plan based on the following factors: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, disability, evidence of insurability, or any other health status-related factor as determined by federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act.
- C. CalOptima Health shall not require a Qualified Individual, Enrollee, or Dependent, to complete a health assessment or medical questionnaire prior to enrollment, nor shall CalOptima Health acquire or request information that relates to a health status-related factor prior to enrollment.

III. PROCEDURE

A. Enrollment Process

1. An applicant or their representative may file an application with the Exchange to determine the applicant's eligibility for health insurance coverage by a QHP. The Exchange may accept an application and make an eligibility determination at any point in time during the year.
2. A Qualified Individual may enroll in, and an Enrollee may change their QHP to, a CalOptima Health Covered California plan only during the Annual Open Enrollment Period or a SEP as described above.
3. CalOptima Health shall accept all enrollment information provided by the Exchange in accordance with federal and state privacy and security laws and in an electronic format. Following receipt, CalOptima Health shall:
 - a. Acknowledge receipt of the information to the Exchange;
 - b. Enroll the individual during the applicable enrollment period;
 - c. Notify the individual of their Premium Payment Due Date;
 - d. Abide by the applicable coverage effective date;
 - e. Notify the Exchange of CalOptima Health's timely receipt of the individual's initial premium payment and their coverage effective date;
 - f. Notify the individual of their coverage effective date upon receipt of the individual's initial premium payment; and
 - g. Provide the individual with an enrollment information packet that is compliant with the accessibility and readability standards specified in 10 C.C.R. § 6452.

- 1 4. If an individual applying for coverage through the Exchange requests enrollment
2 assistance from CalOptima Health, CalOptima Health shall either:
3
4 a. Direct the individual to file an application with the Exchange; or
5
6 b. Assist the applicant with applying for and receiving an eligibility determination for
7 coverage through the Exchange's website (CalHEERS). In providing such assistance,
8 CalOptima Health must (i) comply with federal and state privacy and security
9 standards; (ii) comply with the consumer assistance standards set forth in 45 C.F.R. §
10 155.205(d); (iii) inform the applicant of the availability of other QHP products on the
11 Exchange and display the web link to CalHEERS and describe how to access it; and
12 (iv) comply with the requirements of Chapter 12, Article 9, of the California Code of
13 Regulations, Title 10.
14
15 5. In accordance with the premium payment process established by the Exchange,
16 CalOptima Health shall:
17
18 a. Present to consumers, and accept, the following methods of payment: paper checks,
19 cashier's checks, cash, money orders, EFT, and all general-purpose pre-paid debit
20 cards.
21
22 b. Acknowledge receipt of all premium payments to the payee and the Exchange.
23
24 c. Initiate cancellation of enrollment if CalOptima Health does not receive an Enrollee's
25 initial premium payment by the due date.
26
27 d. Send the Exchange the notice of cancellation of enrollment no later than the first day
28 of the month when coverage is effectuated.
29
30 e. Send written notice of the cancellation to the Enrollee within five (5) business days
31 from the date of cancellation of enrollment due to nonpayment of premiums.
32
33 6. CalOptima Health shall reconcile enrollment and premium payment files with the
34 Exchange not less than once a month.
35

36 B. Effective Date of Coverage
37

- 38 1. CalOptima Health shall determine an individual's effective date of coverage by the
39 applicable enrollment period. For plan selections during the Annual Open Enrollment
40 Period, coverage effective dates are as follows:
41
42 a. For a Qualified Individual who enrolls in a CalOptima Health Covered California
43 plan between November 1 through December 31, and CalOptima Health receives the
44 individual's initial premium payment on or before the Premium Payment Due Date,
45 the coverage effective date shall be no later than January 1 of the benefit year.
46
47 b. For a Qualified Individual who enrolls in a CalOptima Health Covered California
48 plan between January 1 through January 31 of the benefit year, and CalOptima
49 Health receives the initial premium payment on or before the Premium Payment Due
50 Date, the coverage effective date shall be no later than February 1 of the benefit year.
51

- 1 2. For plan selections during an SEP, coverage effective dates are as follows:
- 2
- 3 a. The first day of the month following the month in which plan selection occurred.
- 4
- 5 b. Special coverage effective dates shall apply to the following situations:
- 6
- 7 i. In the case of a natural birth, adoption, or placement for adoption or in foster
- 8 care, coverage shall be effective either:
- 9 a) On the date of birth, adoption, or placement for adoption or in foster care;
- 10
- 11 b) On the first day of the month following birth, adoption, placement for
- 12 adoption or in foster care; or
- 13
- 14 c) On the first day of the month following the month in which a plan selection
- 15 was made, at the option of the Qualified Individual or Enrollee.
- 16
- 17 ii. Where a Qualified Individual or their Dependent loses coverage for any of the
- 18 above reasons (as described in 10 C.C.R. § 6504(a)(1)-(a)(8)), or is enrolled in
- 19 COBRA continuation coverage and employer contributions or government
- 20 subsidies completely cease, the coverage shall be effective:
- 21
- 22 a) On the first day of the month following the loss of coverage or the date of the
- 23 Qualifying Event if the plan selection is made on or before the date of the
- 24 loss of coverage or the Qualifying Event;
- 25
- 26 b) On the first day of the month following plan selection if the selection is made
- 27 after the date of the loss of coverage or the Qualifying Event; or
- 28
- 29 c) At the option of a Qualified Individual or Enrollee, on the first day of the
- 30 month in which the loss of coverage or the Qualifying Event occurs,
- 31 provided plan selection is made on or before the last day of the month prior
- 32 to the month of the loss of coverage or the Qualifying Event.
- 33
- 34 iii. Where a Qualified Individual or their Dependent becomes newly eligible for
- 35 enrollment or gains access to new QHPs due to a permanent move, coverage and
- 36 the APTC and CSR shall be effective:
- 37
- 38 a) On the first day of the month following the date of the Qualifying Event if a
- 39 plan selection is made on or before the event; or
- 40
- 41 b) On the first day of the month following plan selection if the selection is made
- 42 after the date of the Qualifying Event.
- 43
- 44 iv. Where a Qualified Individual or Enrollee is eligible for a SEP based on a
- 45 Qualifying Event described in 10 C.C.R. § 6504(a)(5), (a)(6), (a)(11), (a)(13), or
- 46 (a)(14), coverage shall be effective on an appropriate date, including a retroactive
- 47 date, as determined by the Exchange.
- 48
- 49 v. In the case of a child support order or other court order described in 10 C.C.R. §
- 50 6504(a)(2), coverage shall be effective on the date the court order is effective; or

on the first day of the month following plan selection, at the option of the Qualified Individual.

vi. If a Qualified Individual, Enrollee, or Dependent newly gains access to an ICHRA or is newly provided QSEHRA, and a plan selection is made before the day of the Qualifying Event, coverage shall be effective on the first day of the month following the date of the Qualifying Event or, if the event is on the first day of a month, on the date of the Qualifying Event. If the plan selection is made on or after the day of the Qualifying Event, coverage shall be effective on the first day of the month following the plan selection.

vii. At the option of the Qualified Individual, Enrollee, or Dependent who is eligible to select a plan during a period set forth in 10 C.C.R. § 6504(f)(5), the Exchange shall provide the earliest effective date that would have been available based on the applicable Qualifying Event.

C. Premium Payment

1. CalOptima Health shall effectuate an individual's coverage in accordance with the coverage dates specified above, following receipt of the initial premium payment, less any applicable APTC, on or before the Premium Payment Due Date.
2. In cases of retroactive enrollment, the initial premium shall consist of the premium due for all months of retroactive coverage through the first month of coverage following the plan selection date. If CalOptima Health receives a partial premium payment for less than all months of retroactive coverage, only prospective coverage shall be effectuated in accordance with the regular coverage effective date specified above.

IV. OFF-EXCHANGE MIRROR PLANS

- A. CalOptima Health shall offer, market, and sell its plans made available to individuals through the Exchange to individuals purchasing coverage outside the Exchange, as well. These plans are referred to as Off-Exchange Mirror Plans.
- B. CalOptima Health shall provide the following enrollment periods for its Off-Exchange Mirror Plans:
 1. Annual Open Enrollment Period: November 1 through January 31 of the following year.
 2. Special Enrollment Period: Except as specified in subparagraphs (a) and (j) below, a Qualified Individual or Enrollee has 60 calendar days from the date of one of the following Qualifying Events to enroll:
 - a. The Qualified Individual or their Dependent either:
 - i. Loses MEC (not including voluntary termination);
 - ii. Is enrolled in a non-calendar year group health plan or in individual health insurance coverage that expired or will expire, even if there is an option to renew such coverage;

- 1 iii. Loses coverage that provides health care services to a pregnant woman's unborn
2 child (not including voluntary termination); or
3
4 iv. Loses medically needy or pregnancy-related coverage under Medi-Cal (not
5 including voluntary termination).
6
7 b. The Qualified Individual or their Dependent shall have 60 calendar days before and
8 60 calendar days after any of the above Qualifying Events to enroll.
9
10 c. The Qualified Individual gains or becomes a Dependent through marriage or
11 domestic partnership, birth, adoption, placement for adoption, placement in foster
12 care, or a valid state or federal court order (*e.g.*, a child support order). In the case of
13 marriage, at least one spouse must demonstrate that they had MEC for one or more
14 days during the 60 calendar days preceding the date of marriage.
15
16 d. The Qualified Individual loses or is no longer considered a Dependent due to divorce,
17 legal separation, dissolution of a domestic partnership, or death.
18
19 e. The Qualified Individual's or their Dependent's enrollment or non-enrollment in a
20 plan is unintentional, inadvertent, or erroneous and resulted from error,
21 misrepresentation, misconduct, or inaction of an officer, employee, or agent of that
22 plan or a third-party providing enrollment assistance or conducting enrollment
23 activities. "Misconduct" includes the failure to comply with applicable standards
24 under Part 146 of the Code of Federal Regulations, Title 45, or other applicable
25 federal or state laws.
26
27 f. An Enrollee or their Dependent adequately demonstrates that the plan that they are
28 enrolled in substantially violated a material provision of its contract in relation to the
29 individual.
30
31 g. The Qualified Individual, Enrollee, or Dependent gains access to new plans because
32 of a permanent move and had MEC for one or more days during the 60 calendar days
33 preceding the date of the move.
34
35 h. The Qualified Individual or Enrollee is a victim of domestic abuse or spousal
36 abandonment, has MEC, and seeks to enroll in coverage separate from the perpetrator
37 of the abuse or abandonment. A Dependent of a victim of domestic abuse or spousal
38 abandonment, who is on the same application as the victim, is eligible to enroll at the
39 same time as the victim.
40
41 i. The Qualified Individual or their Dependent (i) applies for coverage through the
42 Exchange during the Annual Open Enrollment Period or a Special Enrollment Period,
43 is assessed as potentially eligible for Medi-Cal or CHIP, and then deemed ineligible
44 for Medi-Cal or CHIP by the State Medi-Cal or CHIP agency either after the open
45 enrollment period has ended or more than 60 days after the Qualifying Event; or (ii)
46 applies for coverage at the State Medi-Cal or CHIP agency during the Annual Open
47 Enrollment Period and is deemed ineligible for Medi-Cal or CHIP after the open
48 enrollment period ends.
49

- 1 j. The Qualified Individual, Enrollee, or Dependent newly gains access to an Individual
2 Coverage Health Reimbursement Arrangement (“ICHRA”) or is newly provided a
3 Qualified Small Employer Health Reimbursement Arrangement (“QSEHRA”). The
4 Qualified Individual, Enrollee, or Dependent shall qualify for the SEP regardless of
5 whether they were previously offered or enrolled in a ICHRA or previously provided
6 a QSEHRA, so long as they are not enrolled in the ICHRA or covered by the
7 QSEHRA on the day immediately prior to the Qualifying Event.
8
9 k. The Qualified Individual or their Dependent is enrolled in COBRA continuation
10 coverage subsidized by the employer and/or a government entity, and the employer or
11 government contributions cease. The Qualified Individual or their Dependent shall
12 have 60 calendar days before and 60 calendar days after this Qualifying Event to
13 enroll.
14

15 C. Effective Date of Coverage:
16

- 17 1. For Annual Open Enrollment Period plan selections: The coverage effective date is
18 January 1 for plan selections made between November 1 through December 31, and
19 February 1 for plan selections made between January 1 and January 31 of the benefit
20 year.
21
22 2. For a plan selection during an SEP, the coverage effective date shall be the first day of the
23 month following the month in which the plan was selected. However, special coverage
24 effective dates apply to the following situations:
25
26 a. In the case of a natural birth, adoption, placement for adoption, placement in foster
27 care, or a court order, coverage is effective on the date of birth, adoption, placement
28 for adoption or in foster care, or the effective date of the court order. However,
29 CalOptima Health may permit the Qualified Individual or Enrollee to elect a
30 coverage effective date of the first of the month following plan selection.
31
32 b. In the case of a Qualified Individual or Enrollee eligible for an SEP pursuant to
33 subparagraphs (B)(2)(d), (e) and (h) of this Section IV, coverage is effective on an
34 appropriate date based on the circumstances of the SEP.
35
36 c. If a Qualified Individual, Enrollee, or Dependent newly gains access to an ICHRA or
37 is newly provided a QSEHRA and a plan selection is made before the day of said
38 Qualifying Event, coverage is effective on the first day of the month following the
39 date of the event or, if the event is on the first day of a month, on the date of the
40 event.
41

42 **V. ATTACHMENT(S)**
43

- 44 A. Notice of Coverage and Premium Payment Due Date
45 B. Enrollment Information Packet
46 C. Notice of Cancellation of Enrollment for Nonpayment of Premium
47

48 **VI. REFERENCE(S)**
49

- 50 A. CalOptima Health Qualified Health Plan Contract with the California Health Benefit
51 Exchange

- 1 B. Health & Safety Code §§ 1357.503, 1366.6, 1399.849
2 C. Title 10, California Code of Regulations (C.C.R.), §§ 6410, 6500, 6502, 6504
3 D. Title 45, Code of Federal Regulations (C.F.R.), §§ 146.121, 147.104, 147.110, 155.420,
4 155.725
5

6 **VII. REGULATORY AGENCY APPROVAL(S)**
7

8 None to Date
9

10 **VIII. BOARD ACTION(S)**
11

Date	Meeting
10/02/2025	Regular Meeting of CalOptima Health Board of Directors

15
16 **VIII. REVISION HISTORY**
17

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2027	CC.1301	Exchange Enrollment	Covered California

IX. GLOSSARY

Term	Definition
Advanced Premium Tax Credit (APTC)	Tax credits authorized by Section 36B of the Internal Revenue Code (26 U.S.C. § 36B) and implementing regulations, which are provided on an advance basis to eligible individuals enrolled in a QHP through the Exchange.
Annual Open Enrollment Period	An enrollment period that takes place from November 1 through January 31 every year.
California Health Benefit Exchange (Exchange)	An independent entity within the government of the State of California, doing business as Covered California and established under Government Code § 100500. Covered California selectively contracts with health plans to make available to enrollees of the Exchange health care coverage choices that seek to provide the optimal combination of choice, value, access, quality, and service.
California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS)	The system created pursuant to Government Code §§ 100502 and 100503, as well as 42 U.S.C. § 18031, that enables Enrollees and Qualified Individuals of QHPs to obtain standardized comparative information on the QHPs and apply for eligibility, enrollment, and reenrollment on the Exchange.
Cost Sharing Reduction (CSR)	Reductions in cost sharing for eligible individuals enrolled in a silver level plan on the Exchange, as well as Indians enrolled in a QHP.
Dependent	For purposes of determining <i>eligibility</i> for the APTC or CSR, dependent means a qualifying child or qualifying relative as those terms are defined in 26 U.S.C. § 152 and implementing regulations. For purposes of <i>enrollment</i> in a QHP, including during a SEP, dependent refers to a Qualified Individual's or Enrollee's spouse, registered domestic partner, child under age 26 (unless the child is disabled), parent or stepparent.
Enrollee	A person who is enrolled in a QHP.
Exchange Service Area	The entire geographic area of the State of California.
Federal Poverty Level	The most recently published federal poverty level, updated periodically in the Federal Register by the Secretary of Health and Human Services (HHS) pursuant to 42 U.S.C. § 9902(2), as of the first day of the Annual Open Enrollment Period for coverage by an QHP through the Exchange.
Indian	A person who is a member of a federally recognized Indian tribe.
Insurance Affordability Program	A program that is one of the following: (a) the Medi-Cal program; (b) the State Children's Health Insurance Program (CHIP); (c) a program that makes available to Qualified Individuals coverage in a QHP through the Exchange with the APTC established under Section 36B of the Internal Revenue Code (26 U.S.C. § 36B); or (d) a program that makes available coverage in a QHP through the Exchange with the CSR established under Section 1402 of the Affordable Care Act.
Minimum Essential Coverage (MEC)	Coverage as defined in Section 5000A(f) of the Internal Revenue Code (26 U.S.C. § 5000A(f)) and in 26 C.F.R. § 1.36B-2(c).
Off-Exchange Mirror Plan	A commercial health plan offered outside the Exchange that is identical in coverage and cost to a QHP offered on the Exchange. However, an Off-Exchange Mirror Plan is not eligible for financial assistance (in the form of premium tax credits, CSRs, or otherwise) that is available for plans offered on the Exchange.
Premium Payment Due Date	For purposes of the initial premium or binder payment for Qualified Individuals who are enrolled in a QHP by the Exchange, it is a date no earlier than the last day of the first month of coverage. For purposes of premiums paid for subsequent months of coverage, it is a date no earlier than the last day of the month preceding the prospective coverage month, and no later than the last day of the prospective coverage month.

Term	Definition
Qualified Health Plan (QHP)	A health plan that is certified by the Exchange, provides essential health benefits (as described in 42 U.S.C. § 18022(b) and Health & Safety Code § 1367.005), and is offered by a health insurance issuer that meets all the following criteria: (1) Is licensed and in good standing to offer health insurance coverage in each State in which the issuer offers health insurance coverage. (2) Agrees to offer at least one QHP in the silver level and at least one plan in the gold level in each Exchange in which it participates. (3) Agrees to change the premium rate for each QHP that it offers without regard to whether the plan is offered through an Exchange or directly from the issuer or an agent. (4) Complies with the regulations developed by the Secretary of HHS and such other requirements as an applicable Exchange may establish.
Qualified Health Plan (QHP) Issuer	A licensed health care service plan or insurer that has been selected and certified by the Exchange to offer QHPs through the Exchange.
Qualified Individual	For purposes of enrollment through the Exchange, a “Qualified Individual” is an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market. For purposes of CalOptima Health’s Off-Exchange Mirror Plans, the term refers to an individual purchasing health insurance coverage outside the Exchange.
Qualifying Event	A significant life change that impacts an individual’s health insurance needs or what health insurance plan(s) the individual qualifies for. These events trigger a Special Enrollment Period that allows an individual to select a new plan through the Exchange outside the Annual Open Enrollment Period.
Service Area	The county or counties in which CalOptima Health is approved to operate under the terms of its QHP Contract with the Exchange. The service area may have designated zip codes (under the U.S. Postal Service) within a county that are approved by the Exchange for CalOptima Health to operate under the terms of the QHP Contract.
Special Enrollment Period (SEP)	A period during which a Qualified Individual or Enrollee who experiences certain Qualifying Events may enroll in, or change enrollment in, a QHP through the Exchange outside of the initial and Annual Open Enrollment Periods.

Notice of Coverage and Premium Payment Due Date

Thank you for choosing health coverage with CalOptima Health through the Covered California Health Benefit Exchange. You are currently enrolled in the [specify plan name] for plan year [YYYY], which covers the period [start date] to [end date]. To view plan details, visit [insert website].

You can start receiving services covered by your plan beginning the first day of the first month after you make your first premium payment, even if your member ID card has not arrived. For example, if your initial premium payment is due in February 2027, you are eligible to receive services covered by your plan beginning March 1, 2027.

If you visit a doctor or other health service provider that is participating in the CalOptima Health Covered network *before* you receive your member ID card, the provider may ask you to sign a statement agreeing to pay for services if you cannot prove you have health insurance. Once you receive your member ID card, simply contact the provider and give them your member ID number so that they can bill CalOptima Health directly.

Premium Payment

CalOptima Health will send you a monthly bill for your premium payment (amount due).

The premium payment is due by the [first day of each month].

If CalOptima Health does not receive payment by the [1st of the month] for coverage in the same month, your payment will be considered past due.

You can pay your premium in one of four ways:

- Online, by creating a member log-in and making your first payment through CalOptima Health at [insert website]. Once an online account is created, you can make all premium payments due through the account.
- Call the number on your billing statement or the Customer Service Department toll-free at [insert number] to pay by credit or debit card (pre-paid debit cards accepted).
- Mail a check or money order that includes your member ID number to:

[Plan Name]

[insert address]

- Through your bank, using the Bill Pay (or similar) service to have payments sent electronically to CalOptima Health each month. To get started, follow your bank's online instructions to set up Bill Pay and be sure to enter the correct CalOptima Health Covered account number and mailing address found on your billing

statement. (Refer to “Pay by Mail” for the mailing address and account number details.) Please consult your banking institution to ensure that your payment is received by CalOptima Health on your bill due date. There can be a delay in the date that payment is received, depending on your bank’s method of sending payment. If CalOptima Health does not receive payment from your bank by the bill due date, you may receive notice that your payment is past due (a Notice of Start of Grace Period). CalOptima Health will update your account once payment is received.

Contact Us

CalOptima Health is here to help. If you have questions, call the Customer Service Department at **[insert number]** (TTY 711). CalOptima Health is here Monday-Friday, **[insert hours]**. The call is free.

You can also visit online at any time at **[insert website]**.



CalOptima Health
A Public Agency
505 City Parkway West
Orange, CA 92868
☎ 714-246-8400
📞 TTY: 711
🌐 caloptima.org

[Date]

VIA U.S. MAIL

[Member Name]
[Street Address]
[City ST ZIP Code]

Subject: [Plan Name] Enrollment Packet

Dear [Member Name]:

Welcome to [Plan Name], your new health plan on the Covered California exchange. Now that you are a [Plan Name] member, there are some things you should know:

1. Your [Plan Name] member ID card will arrive in the mail soon. You will use this card to obtain medical care, including prescription medication, and other services under your plan. Your member ID card contains important information, including your unique ID number; the name and phone number of the primary care physician or clinic you are assigned to; the dollar amount you owe when you visit your primary care physician, an urgent care clinic, or the Emergency Department of a hospital; and contact information for the Customer Service Department and CalOptima Health's 24-hour Nurse Advice Line.
2. It is time to schedule a visit with your primary care doctor. Your primary care doctor manages every aspect of your health and will refer you to any needed specialists for specialty care. Regular contact with your primary care doctor, including for your annual wellness visit, is crucial for maintaining your well-being.
3. Through our website – [insert here] – you can:
 - Find member documents, including, but not limited to the following: the Evidence of Coverage and Disclosure Form (EOC) that explains your health care plan; and a Summary of Benefits (SOB) which summarizes your out-of-pocket cost share amount for certain services.
 - Pay your monthly plan premium using a credit or debit card.
 - Find a doctor or other health care provider in the [Plan Name] network.

Important Contact Information

- Call Covered California toll free at **1-800-300-1506** or visit CoveredCA.com when you need to:
 - Update your home address and contact information.
 - Report a change to your income.
 - Update your proof of residency or citizenship.
 - Make a change to your health care coverage.
 - Cancel your coverage.
 - Obtain a copy of your state or federal health insurance tax forms.
- Contact the CalOptima Health Customer Service Department at **[insert phone number]** if you:
 - Have questions about your billing statement or how to pay the monthly premium.
 - Need a new or replacement member ID card.
 - Want to learn more about your benefits and eligibility.
 - Want to change your primary care doctor or find a new provider.
 - Have questions about how services that you received were paid (“claims”) and request an Explanation of Benefits (EOB).

The Customer Service Department is available Monday-Friday, [insert hours], at the toll-free number provided above. TTY users should call **711**.

Sincerely,

[Your Name]

[Title]

Enclosures: Evidence of Coverage / Member Handbook
Summary of Benefits
Provider Directory

cc:



CalOptima Health
A Public Agency
505 City Parkway West
Orange, CA 92868
☎ 714-246-8400
📞 TTY: 711
🌐 caloptima.org

[Date]

VIA U.S. MAIL

[Member Name]
[Street Address]
[City ST ZIP Code]

Subject: Notice of Health Coverage Termination Due to Nonpayment of Premium

Dear [Member Name]:

Our records indicate that you have not paid the premiums required to maintain your health insurance coverage through [Plan Name]. The following amount is past due:

- **Amount:** \$[amount]
- **Coverage Period for Amount Due:** [e.g., October 1, 2024 – December 31, 2024]
- **Last Day of Paid Coverage:** [date]

Payment in full was due by the end of your [30-day or three-month] Grace Period, [insert date]. Despite previous reminders, including a Notice of Start of Grace Period that was mailed to you on [insert date], we have yet to receive the necessary payments. Therefore, health insurance coverage for you (and your dependents) will be terminated effective [insert date – must be no earlier than 5 business days from the date of this notice].

Coverage for the following plan dependents will be terminated as of the above date:

You have the right to appeal [Plan Name's] decision to terminate your coverage. For more information, or for assistance or questions about obtaining other health insurance coverage (e.g., Medi-Cal or Medicare), contact the Customer Service Department at [phone number].

Sincerely,

[Your Name]
[Title]
[Contact Information]

Enclosure: Notice of Potential Eligibility for Other Health Insurance Coverage

cc:

Notice of Potential Eligibility for Other Health Insurance

Your Health Insurance Choices are Different. You May Qualify for Free or Low-Cost Health Insurance.

Because of changes in federal law, you have different health insurance choices that may save you money.

Starting in January 2014, you cannot be denied health insurance because you have health problems or a pre-existing condition. There are new options for low cost or free health insurance for you or your dependents.

Covered California

You can buy **new** health insurance through Covered California. The State of California set up Covered California to help people and families, like you, find affordable health insurance. You can use Covered California if you do not have insurance through your employer, or Medicare. You can also apply for Medi-Cal through Covered California.

You must apply during an open or special enrollment period, except a Medi-Cal application can be made at any time. Open Enrollment begins November 1st of each calendar year and continues through January 31st of the following calendar year. If you have a life change such as marriage, divorce, a new child or loss of a job, you can apply at the time the life change occurs ("Special Enrollment Period").

Through Covered California, you may also get help paying for your health insurance:

- Receive tax credits: You can use your tax credit to help pay your monthly premium.
- Reduce your out-of-pocket costs: Out-of-pocket costs are how much you pay for things like going to the doctor or hospital or getting prescription drugs.

To qualify for help paying for insurance, you must:

- Meet certain household income limits; and
- Be a U.S. citizen, U.S. national or be lawfully present in the United States.
- In addition, other rules and requirements apply.

You can also buy coverage directly from health insurers, health plans or insurance agents during Open Enrollment and Special Enrollment Periods, but the financial help is available only if you select a Covered California product.

Please note that losing your CalOptima Health Covered health insurance due to nonpayment of premiums does not trigger a Special Enrollment Period for Covered California. You must qualify for a Special Enrollment Period due to a different life event, or wait until the next Open Enrollment period to reapply for Covered California coverage.

Medi-Cal

Free or low-cost health insurance is available through Medi-Cal. Medi-Cal is California's health care program for people with low incomes. You can get Medi-Cal if:

- Your income is low; and
- You are a U.S. citizen, U.S. national or lawfully present in the U.S.

Your eligibility is based on your income. It is not based on how much money you have saved or if you own your own home. You do not have to be on public assistance to qualify for Medi-Cal. You can apply for Medi-Cal anytime.

To qualify for Medi-Cal if you are over 65, disabled or a refugee, other rules and requirements apply. You may also qualify for health insurance with Medi-Cal even if you are not a U.S. citizen or national.

For More Information

To learn more about Covered California or Medi-Cal, visit www.CoveredCA.com or call 1-800-300-1506. When you apply for coverage through Covered California, you will find out if you are eligible for Medi-Cal. You can also get more information or apply for Medi-Cal by calling 1-800-430-4263, visiting www.benefitscal.org or www.beneficioscal.org (Spanish) online, or visiting your county human services office in person.

If you are eligible for Medicare and have questions or require enrollment assistance, please call 1-800-MEDICARE. A delay in Medicare enrollment may result in substantial financial implications, such as penalties added to your monthly premium which can increase your overall health care costs over time.



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[Date]

VIA U.S. MAIL

[Member Name]
[Street Address]
[City, ST ZIP Code]

Subject: [[Plan Name]Plan Name] Enrollment Packet

Dear [Member Name]:

Welcome to [Plan Name], your new health plan on the Covered California exchange. Now that you are a [Plan Name] member, there are some things you should know:

1. Your [Plan Name] member ID card will arrive in the mail soon. You will use this card to obtain medical care, including prescription medication, and other services under your plan. Your member ID card contains important information, including your unique ID number; the name and phone number of the primary care physician or clinic you are assigned to; the dollar amount you owe when you visit your primary care physician, an urgent care clinic, or the Emergency Department of a hospital; and contact information for the Customer Service Department and CalOptima Health's 24-hour Nurse Advice Line.
2. It is time to schedule a visit with your primary care doctor. Your primary care doctor manages every aspect of your health and will refer you to any needed specialists for specialty care. Regular contact with your primary care doctor, including for your annual wellness visit, is crucial for maintaining your well-being.
3. Through our website – [insert here] – you can:
 - Find member documents, including, but not limited to the following: the Evidence of Coverage and Disclosure Form (EOC) that explains your health care plan; and a Summary of Benefits (SOB) which summarizes your out-of-pocket cost share amount for certain services.
 - Pay your monthly plan premium using a credit or debit card.
 - Find a doctor or other health care provider in the [Plan Name] network.

Important Contact Information

- Call Covered California toll free at **1-800-300-1506** or visit CoveredCA.com when you need to:
 - Update your home address and contact information.
 - Report a change to your income.
 - Update your proof of residency or citizenship.
 - Make a change to your health care coverage.
 - Cancel your coverage.
 - Obtain a copy of your state or federal health insurance tax forms.
- Contact the CalOptima Health Customer Service Department at **[insert phone number]** if you:
 - Have questions about your billing statement or how to pay the monthly premium.
 - Need a new or replacement member ID card.
 - Want to learn more about your benefits and eligibility.
 - Want to change your primary care doctor or find a new provider.
 - Have questions about how services that you received were paid (“claims”) and request an Explanation of Benefits (EOB).

The Customer Service Department is available Monday-Friday, [insert hours], at the toll-free number provided above. TTY users should call **711**.

Sincerely,

[Your Name]

[Title]

Enclosures: Evidence of Coverage / Member Handbook
Summary of Benefits
Provider Directory

cc:

Notice of Coverage and Premium Payment Due Date

Thank you for choosing health coverage with CalOptima Health through the Covered California Health Benefit Exchange. You are currently enrolled in the [specify plan name] for plan year [XX], which covers the period [start date] to [end date]. To view plan details, visit [insert website].

You can start receiving services covered by your plan beginning the first day of the first month after you make your first premium payment, even if your member ID card has not arrived. For example, if your initial premium payment is due in February 2027, you are eligible to receive services covered by your plan beginning March 1, 2027.

If you visit a doctor or other health service provider that is participating in the CalOptima Health Covered network *before* you receive your member ID card, the provider may ask you to sign a statement agreeing to pay for services if you cannot prove you have health insurance. Once you receive your member ID card, simply contact the provider and give them your member ID number so that they can bill CalOptima Health directly.

Premium Payment

CalOptima Health will send you a monthly bill for your premium payment (amount due).

The premium payment is due by the [first day of each month].

If CalOptima Health does not receive payment by the [1st of the month] for coverage in the same month, your payment will be considered past due.

You can pay your premium in one of four ways:

- Online, by creating a member log-in and making your first payment through CalOptima Health at [insert website]. Once an online account is created, you can make all premium payments due through the account.
- Call the number on your billing statement or the Customer Service Department toll-free at [insert number] to pay by credit or debit card (pre-paid debit cards accepted).
- Mail a check or money order that includes your member ID number to:

CalOptima Health
CalOptima Health Covered
[insert address]

- Through your bank, using the Bill Pay (or similar) service to have payments sent electronically to CalOptima Health each month. To get started, follow your bank's online instructions to set up Bill Pay and be sure to enter the correct CalOptima

Health Covered account number and mailing address found on your billing statement. (Refer to “Pay by Mail” for the mailing address and account number details.) Please consult your banking institution to ensure that your payment is received by CalOptima Health on your bill due date. There can be a delay in the date that payment is received, depending on your bank’s method of sending payment. If CalOptima Health does not receive payment from your bank by the bill due date, you may receive notice that your payment is past due (a Notice of Start of Grace Period). CalOptima Health will update your account once payment is received.

Contact Us

CalOptima Health is here to help. If you have questions, call the Customer Service Department at **[insert number]** (TTY 711). CalOptima Health is here Monday-Friday, **[insert hours]**. The call is free.

You can also visit online at any time at **[insert website]**.



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🌐 caloptima.org

[Date]

VIA U.S. MAIL

[Member Name]
[Street Address]
[City, ST ZIP Code]

Subject: Notice of Start of 30-Day Grace Period Due to Delinquent Premium Payment

Dear [Member Name]:

This letter informs you that your [CalOptima Health Covered] California health coverage is at risk of termination because you have a past due premium payment amount.

Your Premium Payment Due:

- **Amount Due:** \$[amount]
- **Coverage Period for Amount Due:** [e.g., October 1, 2024 – October 31, 2024]
- **Last Day of Paid Coverage:** [date]

Grace Period:

Pursuant to California law, you have thirty (30) consecutive calendar days (your “Grace Period”) to pay the outstanding amount in full and avoid any disruption in your health insurance coverage.

- **Grace Period Begins:** [insert first day after last day of paid coverage, e.g., October 1, 2024]
- **Grace Period Ends:** [insert the date of the 30th day after last day of paid coverage, e.g., October 30, 2024]

How to Make Your Payment:

- **Online:** Please visit [insert website] and submit payment through your online account. For assistance or questions about creating a member account, contact the Customer Service Department at [insert number] (TTY 711).
- **By Mail:** Send a check or money order with your member ID number to [CalOptima Health Covered], [insert address].
- **By Phone:** Call the number on your billing statement, or the Customer Service Department toll-free at [insert number] (TTY 711), to pay by credit or debit card.

Consequences of Non-Payment:

If CalOptima Health does not receive the FULL past due amount by [insert end date of grace period], coverage will end on [insert date, e.g., the day after the grace period ends], and you will be responsible for the cost of services provided after your last day of paid coverage.

Please be advised that this notice affects you and the following plan dependents:

Your Right to Review:

You have the right to request a review of this notice by the California Department of Managed Health Care (DMHC). To submit a request, call the DMHC Help Center at 1-888-466-2219 or send an email to helpline@dmhc.ca.gov.

You may also contact [CalOptima Health] if you have questions or require assistance. We are available to help you maintain your health coverage.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name]
[Title]
[Contact Information]

cc:



CalOptima Health
A Public Agency
505 City Parkway West
Orange, CA 92868
☎ 714-246-8400

📞 TTY: 711

🌐 caloptima.org

[Date]

VIA U.S. MAIL

[Member Name]
[Street Address]
[City, ST ZIP Code]

Subject: Notice of Start of Three-Month Grace Period Due to Delinquent Premium Payment

Dear [Member Name]:

This letter informs you that your [CalOptima Health Covered] California health coverage is at risk of termination because you have a past due premium payment amount.

Your Premium Payment Due:

- **Amount Due:** \$[amount]
- **Coverage Period for Amount Due:** [e.g., October 1, 2024 – October 31, 2024]
- **Last Day of Paid Coverage:** [date]

Grace Period:

Pursuant to California law, you have three (3) months (your “Grace Period”) to pay the outstanding amount in full and avoid any disruption in your health insurance coverage.

- **Grace Period Begins:** [insert first day after last day of paid coverage, e.g., October 1, 2024]
- **Grace Period Ends:** [last day of the three-month period, e.g., December 31, 2024]

How to Make Your Payment:

- **Online:** Please visit [insert website] and submit payment through your online account. For assistance or questions about creating a member account, contact the Customer Service Department at [insert number] (TTY 711).
- **By Mail:** Send a check or money order with your member ID number to [CalOptima Health Covered], [insert address].
- **By Phone:** Call the number on your billing statement, or the Customer Service

Department toll-free at [insert number] (TTY 711), to pay by credit or debit card.

Consequences of Non-Payment:

Your coverage will continue, and CalOptima Health will pay all appropriate claims for covered services provided during the 1st month of the Grace Period. If CalOptima Health does not receive the past due amount by the end of the first month, coverage will be suspended beginning the first day of the second month of the Grace Period, and CalOptima Health will deny all claims for services rendered after that date.

If you pay the past due amount *before* the end of the Grace Period, coverage will be reinstated, and [CalOptima Health] will process claims for services rendered during the 2nd and 3rd months of the Grace Period.

If [CalOptima Health] does not receive the FULL past due amount by [insert end date of grace period], coverage will be terminated. Your last day of coverage will be [insert last day of the 1st month of the 3-month grace period] and [CalOptima Health] will deny all claims for services provided after that date. The providers of those claims may bill you directly and you may be responsible for payment.

Please be advised that this notice affects you and the following plan dependents:

Your Right to Review:

You have the right to request a review of this notice by the California Department of Managed Health Care (DMHC). To submit a request, call the DMHC Help Center at 1-888-466-2219 or send an email to helpline@dmhc.ca.gov.

You may also contact CalOptima Health if you have questions or require assistance. We are available to help you maintain your health coverage.

Thank you for your prompt attention to this matter.

Sincerely,

[Your Name]
[Title]
[Contact Information]

cc:



CalOptima Health

CalOptima Health
A Public Agency
505 City Parkway West
Orange, CA 92868
☎ 714-246-8400
📞 TTY: 711
🌐 caloptima.org

[Date]

VIA U.S. MAIL

[Member Name]
[Street Address]
[City, ST ZIP Code]

Subject: Notice of Health Coverage Termination Due to Nonpayment of Premium

Dear [Member Name]:

Our records indicate that you have not paid the premiums required to maintain your health insurance coverage through [Plan Name]. The following amount is past due:

- **Amount:** \$[amount]
- **Coverage Period for Amount Due:** [e.g., October 1, 2024 – December 31, 2024]
- **Last Day of Paid Coverage:** [date]

Payment in full was due by the end of your [30-day or three-month] Grace Period, [insert date]. Despite previous reminders, including a Notice of Start of Grace Period that was mailed to you on [insert date], we have yet to receive the necessary payments. Therefore, health insurance coverage for you (and your dependents) will be terminated effective [insert date – must be no earlier than 5 business days from the date of this notice].

Coverage for the following plan dependents will be terminated as of the above date:

You have the right to appeal [Plan Name's] decision to terminate your coverage. For more information, or for assistance or questions about obtaining other health insurance coverage (e.g., Medi-Cal or Medicare), contact the Customer Service Department at [phone number].

Sincerely,

[Your Name]
[Title]
[Contact Information]

Enclosure: Notice of Potential Eligibility for Other Health Insurance Coverage

cc:

Notice of Potential Eligibility for Other Health Insurance

Your Health Insurance Choices are Different. You May Qualify for Free or Low-Cost Health Insurance.

Because of changes in federal law, you have different health insurance choices that may save you money.

Starting in January 2014, you cannot be denied health insurance because you have health problems or a pre-existing condition. There are new options for low cost or free health insurance for you or your dependents.

Covered California

You can buy **new** health insurance through Covered California. The State of California set up Covered California to help people and families, like you, find affordable health insurance. You can use Covered California if you do not have insurance through your employer, or Medicare. You can also apply for Medi-Cal through Covered California.

You must apply during an open or special enrollment period, except a Medi-Cal application can be made at any time. Open Enrollment begins November 1st of each calendar year and continues through January 31st of the following calendar year. If you have a life change such as marriage, divorce, a new child or loss of a job, you can apply at the time the life change occurs ("Special Enrollment Period").

Through Covered California, you may also get help paying for your health insurance:

- Receive tax credits: You can use your tax credit to help pay your monthly premium.
- Reduce your out-of-pocket costs: Out-of-pocket costs are how much you pay for things like going to the doctor or hospital or getting prescription drugs.

To qualify for help paying for insurance, you must:

- Meet certain household income limits; and
- Be a U.S. citizen, U.S. national or be lawfully present in the United States.
- In addition, other rules and requirements apply.

You can also buy coverage directly from health insurers, health plans or insurance agents during Open Enrollment and Special Enrollment Periods, but the financial help is available only if you select a Covered California product.

Please note that losing your CalOptima Health Covered health insurance due to nonpayment of premiums does not trigger a Special Enrollment Period for Covered California. You must qualify for a Special Enrollment Period due to a different life event, or wait until the next Open Enrollment period to reapply for Covered California coverage.

Medi-Cal

Free or low-cost health insurance is available through Medi-Cal. Medi-Cal is California's health care program for people with low incomes. You can get Medi-Cal if:

- Your income is low; and
- You are a U.S. citizen, U.S. national or lawfully present in the U.S.

Your eligibility is based on your income. It is not based on how much money you have saved or if you own your own home. You do not have to be on public assistance to qualify for Medi-Cal. You can apply for Medi-Cal anytime.

To qualify for Medi-Cal if you are over 65, disabled or a refugee, other rules and requirements apply. You may also qualify for health insurance with Medi-Cal even if you are not a U.S. citizen or national.

For More Information

To learn more about Covered California or Medi-Cal, visit www.CoveredCA.com or call 1-800-300-1506. When you apply for coverage through Covered California, you will find out if you are eligible for Medi-Cal. You can also get more information or apply for Medi-Cal by calling 1-800-430-4263, visiting www.benefitscal.org or www.beneficioscal.org (Spanish) online, or visiting your county human services office in person.

If you are eligible for Medicare and have questions or require enrollment assistance, please call 1-800-MEDICARE. A delay in Medicare enrollment may result in substantial financial implications, such as penalties added to your monthly premium which can increase your overall health care costs over time.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2025

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

7. Approve CalOptima Health's Fiscal Year 2025–26 Public Policy Priorities and Authorize Related Advocacy Efforts

Contacts

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

Michael Hunn, Chief Executive Officer, (714) 246-8570

Recommended Actions

1. Approve CalOptima Health's Fiscal Year 2025–26 public policy priorities (Priorities);
2. Authorize the Chief Executive Officer, or designee, to:
 - a. Implement legislative and regulatory advocacy efforts in alignment with the Priorities;
 - b. Develop publications and other materials in furtherance of the Priorities for external distribution to policymakers and other stakeholders; and
 - c. Provide regular progress reports regarding advocacy activities to the CalOptima Health Board of Directors.

Background

As part of its Government Affairs program, CalOptima Health staff track and analyze federal, state, and local legislation that may impact CalOptima Health and its members, providers, and stakeholders. Staff also engage with federal and state trade associations, federal and state advocates, and elected officials at all levels of government to educate them on how proposed legislation and regulatory guidance may impact CalOptima Health.

To guide legislative and regulatory advocacy efforts and better represent CalOptima Health's interests in Sacramento and Washington, DC, staff developed the Priorities for consideration by the CalOptima Health Board of Directors (Board). When drafting the Priorities, staff solicited input from CalOptima Health executive leadership and department heads to ensure public policy objectives reflect current organizational goals, including the Board-approved Fiscal Year 2025–27 Strategic Priorities. In determining whether a policy objective should be included within the Priorities, staff consulted its contracted lobbyists and considered whether the objective was: (1) likely to require or be impacted by legislative and/or regulatory action; and (2) likely to be considered by a legislative or regulatory body in Fiscal Year 2025–26.

Discussion

Staff efforts and feedback identified individual policy objectives for inclusion in the Priorities. The policy objectives were grouped into the following policy areas:

1. Access to Care (new);
2. Behavioral Health;
3. California Advancing and Innovating Medi-Cal (CalAIM);
4. Data Sharing;
5. Older Adults;
6. Operations and Administration;

7. Provider Support;
8. Quality Improvement; and
9. Safety Net Financing and Funding.

Staff recommends the Board adopt the Priorities, as well as authorize the Chief Executive Officer (CEO), or designee, to implement legislative and regulatory advocacy efforts in furtherance of the Priorities. Such efforts may include authorizing CalOptima Health's formal positions on proposed legislation and regulations, executing letters of support and opposition to lawmakers and other government officials, meeting with such officials or their staff, and/or directing CalOptima Health's contracted lobbyists to advocate on the agency's behalf.

To facilitate such advocacy efforts, the CEO, or designee, would also be authorized to develop publications, handouts, and other materials that further explain or otherwise communicate the Priorities and any related advocacy positions and then externally distribute such materials to legislators, government officials, and their staffs, as well as community stakeholders.

Any recommendations for formal positions or related advocacy efforts that do not align with the adopted Priorities will be brought to the Board for future consideration.

Fiscal Impact

The recommended actions are operational in nature. To the extent there is any fiscal impact due to increases in required resources, such impact will be addressed in separate Board actions or in future CalOptima Health operating budgets.

Rationale for Recommendation

Legislative and regulatory advocacy continues to be a priority for CalOptima Health given the level of activity on health care-related issues in the U.S. Congress, California State Legislature, and several federal and state agencies. Proactive engagement with trade associations, advocates, and elected officials is critical to influencing policy decisions that are likely to impact CalOptima Health in the next two years. Adoption of the Priorities will enable staff to be more strategic, focused, and effective in their advocacy efforts regarding the agency's policy objectives.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. [CalOptima Health's Fiscal Year 2025–26 Public Policy Priorities](#)

/s/ Michael Hunn
Authorized Signature

09/25/2025
Date

Fiscal Year 2025–26 Public Policy Priorities

Access to Care

- Remove barriers to Medi-Cal enrollment, services and access to care for individuals experiencing homelessness.
- Support policies that allow Section 1115 demonstration waivers to be catalysts for innovations in Medi-Cal, resulting in comprehensive whole-person care.
- Mitigate potential impacts of H.R. 1 (2025) that may restrict the ability of eligible Medi-Cal beneficiaries to newly enroll, maintain enrollment and access high-quality care in the most appropriate setting.
- Support proposals that remove administrative barriers to accessing health and social services benefits.
- Support sustaining coverage expansions and subsidies enacted by the Affordable Care Act.
- Reauthorize and extend the enhanced levels of Advance Premium Tax Credits (APTCs) for purchasing health insurance through Covered California.
- Support the preservation of Covered California enrollment policies that minimize administrative burdens for current and potential beneficiaries

Behavioral Health

- Support improved parity between physical and mental health care, including rates and coverage for preventive services without diagnoses.
- Support increased, sustainable funding streams for behavioral health services.
- Remove barriers to accessing behavioral health services, including mobile crisis and telehealth-only.
- Incentivize all applicable providers to treat behavioral health conditions within their scope of service.
- Promote systematic improvement and increase capacity for complex discharge management of members with behavioral health diagnoses.
- Enhance integration between specialty and non-specialty Medi-Cal mental health services.
- Support policies to prevent and address substance use disorders, including medication surveillance.

California Advancing and Innovating Medi-Cal (CalAIM)

- Allow health plan discretion to determine member and provider eligibility for Enhanced Care Management (ECM) and Community Supports (CS).
- Simplify pathway for Medi-Cal plans to develop and offer additional CS options to members.
- Incorporate CS into covered benefits to ensure long-term funding and sustainability.
- Invest in infrastructure, training and other supports to prepare providers for CalAIM initiatives.
- Support continuous Medi-Cal coverage for justice-involved individuals.
- Streamline health plan assessment and reporting requirements for CalAIM measures and outcomes.
- Support the construction and permitting of supportive housing and recuperative care facilities.

Data Sharing

- Increase funding, guidance, timeline certainty and implementation flexibility for health care entities to launch data-sharing and infrastructure initiatives, including the Data Exchange Framework, interoperability and the expansion of and connection to regional health information exchanges (HIEs).
- Standardize and ease requirements for data sharing and consent management of health records across payors, providers and public agencies to improve care coordination.
- Improve collection and sharing of social determinants of health (SDOH) and demographic data across public agencies, health plans, utility providers and community-based organizations.

Older Adults

- Promote overall integration of the Medi-Cal and Medicare programs.
- Support enrollment of full and partial dual-eligible beneficiaries into exclusively aligned enrollment Dual Eligible Special Needs Plans (EAE D-SNPs).

- Align Medi-Cal and Medicare policies that limit the frequency of plan switching to improve continuity of care.
- Support the creation and sustainability of Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs) consistent with EAE D-SNP enrollment policies.
- Expand access to home- and community-based services, including the Program of All-Inclusive Care for the Elderly (PACE), for older adults, including those experiencing or at risk of homelessness.
- Preserve current flexibilities to virtually assess prospective and current PACE participants.
- Increase PACE funding to address telehealth barriers, such as member access to devices, internet and training.

Operations and Administration

- Preserve the county-organized health system (COHS) and delegated managed care delivery models.
- Oppose requiring COHS to obtain a Knox-Keene Act license.
- Oppose the elimination or carving out of Medi-Cal managed care benefits, such as the Whole-Child Model (WCM).
- Promote efforts to advance health equity and reduce health disparities through current and future Medi-Cal and Medicare initiatives.
- Support 12-month continuous eligibility for all Medi-Cal beneficiaries.
- Reform Medi-Cal Rx policies to improve prior authorization and appeals processes.
- Incentivize health networks to implement same-day prior authorizations.
- Oppose policies that restrict health plan use of prior authorizations.
- Expand the ability for health plans to communicate with members to support care coordination.
- Implement clear, consistent and reasonable timelines for the implementation and evaluation of new covered benefits, programs, initiatives and audits.

Provider Support

- Increase Medi-Cal reimbursement rates, especially for behavioral health services and major organ transplants.
- Remove barriers to provider contracting, including expanding allowable provider types.
- Invest in the development of a diverse health care workforce, including training, education and certification programs, and remove barriers to program enrollment, completion and subsequent hiring.
- Invest in public health infrastructure to better prepare for future pandemics and other health crises.
- Permanently extend Medicare telehealth flexibilities enacted during the COVID-19 pandemic, including use of video and audio-only modalities, virtual establishment of new patients, and payment parity with in-person visits.

Quality Improvement

- Improve alignment between state and federal regulators and the National Committee for Quality Assurance (NCQA), including quality metrics, data collection, network adequacy and value-based programs.
- Incorporate dual-eligible status into risk adjustment, Star Ratings and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores.
- Allow more flexible distance standards for specialty care providers.
- Improve CAHPS survey to account for delegated delivery model and new forms of health care services, including CS and telehealth utilization.

Safety Net Funding and Financing

- Support preserving current Medicaid, Medicare and Marketplace funding levels and oppose reductions in federal funding.
- Support the protection of California's current Federal Medical Assistance Percentage (FMAP) for all populations.
- Support maintaining current levels of provider taxes and state-directed payments.
- Support ongoing funding to community clinics through the federal Community Health Center Fund
- Oppose changes to current Medical Loss Ratio (MLR) methodology.

- Ensure Managed Care Organization (MCO) tax revenue prioritizes funding for the Medi-Cal program.
- Ensure future rate changes are beneficial to CalOptima Health and its contracted providers.
- Incorporate audio-only telehealth encounters into the calculation of Medicare risk adjustment payments.
- Reform the use of risk corridors by increasing transparency, accounting for administrative complexity and reducing the number of overlapping corridors.
- Preserve the use of intergovernmental transfer (IGT) funds to offer non-covered Medi-Cal and Medicare benefits.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2025

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

8. Adopt Board Resolution No. 25-1002-02, Ensuring Orange County Residents Who Are Entitled to Medi-Cal Coverage Have Access to Health Care

Contact

Michael Hunn, Chief Executive Officer, (714) 246-8570

Recommended Action

Adopt Board Resolution No. 25-1002-02, ensuring Orange County residents who are entitled to Medi-Cal coverage have access to health care.

Background

CalOptima Health is the single largest health insurer in Orange County and provides health care access to nearly one in three Orange County residents including low-income children, adults, seniors and people with disabilities. Notably, in 2021, 961,638 Orange County residents were foreign born, according to the 2023–24 Orange County Community Indicators Report. CalOptima Health is committed to reducing health disparities and serving all members, regardless of immigration status, with the excellence, dignity and care they deserve.

On July 17, 2025, news reports stated that the U.S. Centers for Medicare & Medicaid Services agreed to share the personal data of all Medicaid members nationwide with the U.S. Department of Homeland Security (DHS). Medicaid is called Medi-Cal in California. CalOptima Health has not shared or been asked to share member information with federal agencies.

Discussion

Recent federal immigration-related activities and policies, including but not limited to the reported disclosure of Medicaid data to DHS, have caused significant fear which has resulted in significant declines in health care and social services utilization. Nonetheless, in accordance with federal, state and local mandates, CalOptima Health will continue to serve all members, regardless of immigration status, until otherwise required.

In addition, through the Board's Legislative Ad Hoc Committee consisting of Chair Becerra, Vice Chair Sarmiento and Director García Guillén, CalOptima Health has worked to inform members of the recent news and encourage them to continue to receive all necessary health care services. CalOptima Health is focused on providing equitable, culturally responsive and linguistically accessible care that focuses on prevention and aligns with member needs and preferences.

In order to further underscore these efforts, staff recommends that the Board adopt a resolution that reaffirms CalOptima Health's commitment to the following:

- Continuing to provide access to high-quality health care for all currently eligible members
- Supporting the need to protect and not disclose personal information that may lead to

decreased access to health coverage, regardless of immigration status in California

Following the adoption of this resolution, staff will work closely with CalOptima Health's contracted health networks and providers and other stakeholders to support their related efforts to ensure health care access for our members.

Fiscal Impact

The recommended action has no additional fiscal impact.

Rationale for Recommendation

In accordance with its mission, vision and strategic plan approved by the Board, CalOptima Health is prioritizing efforts to maintain and expand access to high-quality health care for all members.

Concurrence

Attachment

1. [Board Resolution No. 25-1002-02, Ensuring Orange County Residents Who Are Entitled to Medi-Cal Coverage Have Access to Health Care](#)

/s/ Michael Hunn
Authorized Signature

09/25/2025
Date

RESOLUTION NO. 25-1002-02

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY d.b.a. CalOptima Health**

**ENSURING ORANGE COUNTY RESIDENTS WHO ARE ENTITLED TO MEDI-CAL
COVERAGE HAVE ACCESS TO HEALTH CARE**

WHEREAS, CalOptima Health is the single largest health insurer in Orange County and covers nearly one in three residents;

WHEREAS, CalOptima Health offers health care access to Orange County's most vulnerable residents including low-income children, adults, seniors, and people with disabilities;

WHEREAS, CalOptima Health's mission is to serve member health with excellence and dignity, respecting the value and needs of each person;

WHEREAS, CalOptima Health's vision is to provide all members with access to high quality care to achieve optimal health and well-being through an equitable and high-quality health care system;

WHEREAS, CalOptima Health is committed to reducing health disparities and serving members with the excellence, dignity, and care they deserve;

WHEREAS, in 2021, 961,638 Orange County residents were foreign born according to the 2023–24 Orange County Community Indicators Report;

WHEREAS, the current federal immigration related activities and policies, including but not limited to the reported disclosure of Medicaid data to U.S. Immigration and Customs Enforcement, have caused significant fear which has resulted in significant declines in health care and social services utilization;

WHEREAS, in accordance with federal, state, and local mandates, CalOptima Health will continue to serve all members, regardless of immigration status, until otherwise required;

WHEREAS, CalOptima Health will continue to advocate for access to care; and

WHEREAS, CalOptima Health is focused on providing equitable, culturally responsive, and linguistically accessible care that focuses on prevention and aligns with member needs and preferences.

NOW, THEREFORE, BE IT RESOLVED:

I. That CalOptima Health reaffirms its commitment to continue to provide access to high-quality health care for all members; and

II. That CalOptima Health reiterates its commitment to supporting the need to protect and not disclose personal information that may lead to decreased access to health coverage, regardless of immigration status in California.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima Health, this 2nd day of October 2025.

AYES: _____

NOES: _____

ABSENT: _____

ABSTAIN: _____

/s/ _____

Printed Name and Title: Isabel Becerra, Chair, Board of Directors

Attest:

/s/ _____

Sharon Dwiers, Clerk of the Board

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2025

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

9. Authorize the Chief Executive Officer to Execute a Contract Amendment with Cornerstone onDemand Inc. for Continued Use of Systems and Services

Contacts

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

Kathleen Linder, Chief Information Officer, (714) 475-9291

Recommended Action

Make an exception to CalOptima Health Policy GA.5002: Purchasing and authorize the Chief Executive Officer to execute a contract amendment without competitive procurement with Cornerstone OnDemand Inc. for an additional three-year term beginning November 2, 2025, with two one-year extension options, each exercisable at CalOptima Health's discretion under the same terms and conditions as the existing contract.

Background and Discussion

CalOptima Health currently uses Cornerstone OnDemand Inc. (Cornerstone) Human Resources (HR) learning management system (LMS). The contract for the system has been in place since November 2, 2020. Staff has included requirements for a new LMS in a separate request for proposals (RFP) for a Human Capital Management (HCM) system. The HCM RFP was issued August 20, 2025, but the evaluation and implementation of a new HCM system will extend beyond the current contract end date of November 2, 2025.

CalOptima Health Policy GA.5002: Purchasing outlines the process for procurement of goods and services. Competitive procurement is the required purchasing method unless competition is not feasible due to an emergency, restricted availability of goods or services, other circumstances exist that would justify waiving the competitive requirements, or the acquisition qualifies for another exception under the policy.

Staff recommends that the CalOptima Health Board of Directors authorize an exception to the purchasing policy due to the circumstances described above to extend the contract with Cornerstone. This extension will allow CalOptima Health adequate time to complete higher priority projects, such as Covered California and Customer Relationship Management, and then complete the RFP, contracting, conversion, and implementation of a new HCM solution that will include LMS functionality. The amendment will be for a term of three years with two one-year extension options. The recommended action will support ongoing operations and compliance until a new HCM system is fully implemented. In the event a new HCM is fully implemented prior to the end of the extended contract term, the contract allows CalOptima Health to terminate early without cause.

Cornerstone is in compliance with current CalOptima Health contract requirements, is not on any exclusion lists (System for Award Management, Office of the Inspector General, Medi-Cal Suspended

CalOptima Health Board Action Agenda Referral
Authorize the Chief Executive Officer to Execute a
Contract Amendment with Cornerstone OnDemand Inc. for
Continued Use of Systems and Services
Page 2

and Ineligible), is not on the Medicare Preclusion List, and is actively listed with the California Secretary of State.

Fiscal Impact

The total annual cost for the contract with Cornerstone is approximately \$160,000. Staff has included operating expenses for the period beginning November 2, 2025, through June 30, 2026, in the CalOptima Health Fiscal Year 2025-26 Operating Budget. Staff will include operating expenses for the period beginning on and after July 1, 2026, in future operating budgets.

Rationale for Recommendation

CalOptima Health requires the continued use of an HR LMS until a new solution is implemented as part of the HCM solution. The extension will allow adequate time to complete higher priority projects and allow an HCM solution to be fully implemented.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. [Entities Covered by this Recommended Action](#)

/s/ Michael Hunn
Authorized Signature

09/25/2025
Date

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Cornerstone OnDemand Inc.	1601 Cloverfield Blvd, Suite 620S	Santa Monica	CA	90404

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2025

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

10. Authorize the Chief Executive Officer to Execute a Contract Amendment with SilkRoad Technology Inc. for Continued Use of Systems and Services

Contacts

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

Kathleen Linder, Chief Information Officer, (714) 475-9291

Recommended Action

Make an exception to CalOptima Health Policy GA.5002: Purchasing and authorize the Chief Executive Officer to execute a contract amendment without competitive procurement with SilkRoad Technology Inc. for an additional three-year term beginning July 1, 2026, with two one-year extension options, each exercisable at CalOptima Health's discretion under the same terms and conditions as the existing contract.

Background and Discussion

CalOptima Health currently uses the SilkRoad Technology Inc. Wingspan Human Resources (HR) performance management (PM) application. The contract has been in place since June 19, 2009. The existing HR PM application cannot sunset as planned because the replacement HR platform selected through a previous request for proposals (RFP) was unable to accommodate CalOptima Health's requirements. Staff has included the requirements for a new HR PM system in a separate request for proposals (RFP) for a Human Capital Management (HCM) system. The HCM RFP was issued August 20, 2025, but the evaluation and implementation of a new HCM system will go beyond the current contract end date.

CalOptima Health Policy GA.5002: Purchasing outlines the process for procurement of goods and services. Competitive procurement is the required purchasing method unless competition is not feasible due to an emergency, restricted availability of goods or services, other circumstances exist that would justify waiving the competitive requirements, or the acquisition qualifies for another exception under the policy.

Staff recommends that the CalOptima Health Board of Directors authorize an exception to the purchasing policy due to the circumstances described above to extend the contract with SilkRoad Technology Inc. The extension will allow adequate time to complete higher priority projects, such as Covered California and Customer Relationship Management, and then complete the RFP, contracting, conversion, and implementation of a new HCM solution which will also include the PM functionality. The amendment will be for a term of three years with two one-year extension options. The recommended action will support ongoing operations and compliance until a new HCM system is fully implemented. In the event a new HCM system is implemented

CalOptima Health Board Action Agenda Referral
Authorize the Chief Executive Officer to Execute a
Contract Amendment with SilkRoad Technology Inc. for
Continued Use of Systems and Services
Page 2

prior to the end of the extended contract term, the contract allows CalOptima Health to terminate early without cause.

SilkRoad Technology Inc. is in compliance with current CalOptima Health contract requirements, is not on any exclusion lists (System for Award Management, Office of the Inspector General, Medi-Cal Suspended and Ineligible), is not on the Medicare Preclusion List, and is actively listed with the California Secretary of State.

Fiscal Impact

The total annual cost for the contract with SilkRoad Technology Inc. is approximately \$140,000. Staff will include operating expenses for the period beginning July 1, 2026, and after in future operating budgets.

Rationale for Recommendation

CalOptima Health requires the continued use of the SilkRoad Technology Inc.'s Wingspan HR PM system until a new solution is implemented. The extension will allow adequate time to complete higher priority projects and allow an HCM solution to be fully implemented,

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. [Entities Covered by this Recommended Action](#)

/s/ Michael Hunn
Authorized Signature

09/25/2025
Date

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
SilkRoad Technology Inc	311 West Monroe Street, Suite 401	Chicago	IL	60606

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2025

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

11. Authorize the Chief Executive Officer to Execute a Contract Amendment with Computer Technology Corp for Continued Use of Credentialing Systems and Services

Contacts

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

Kathleen Linder, Chief Information Officer, (714) 475-9291

Recommended Action

Make an exception to CalOptima Health Policy GA.5002: Purchasing and authorize the Chief Executive Officer to execute a contract amendment without competitive procurement with Computer Technology Corp for continued use of their credentialing system for an additional one-year term through December 16, 2026, with four one-year extension options, each exercisable at CalOptima Health's discretion under the same terms and conditions as the existing contract.

Background and Discussion

CalOptima Health currently uses Computer Technology Corp's Sympler/Visual Cactus credentialing system and services. The contract has been in place since December 16, 2018. The application cannot be discontinued because the Digital Transformation Provider Lifecycle Management (PLM) project that was planned to replace it has been paused to focus resources on the Customer Relationship Management (CRM) implementation. The replacement system will not be deployed prior to the current contract end date of December 16, 2025. The new system implementation date has not been determined at this time.

CalOptima Health Policy GA.5002: Purchasing outlines the process for procurement of goods and services essential to the operations of CalOptima Health. Competitive procurement is the required purchasing method unless competition is not feasible due to an emergency, restricted availability of goods or services, other circumstances exist that would justify waiving the competitive requirements, or the acquisition qualifies for another exception under the policy.

Staff recommends that the CalOptima Health Board of Directors authorize an exception to the purchasing policy due to the need for a credentialing system and the pause of the project to replace the system. The amendment will be for a one-year term through December 16, 2026, with four one-year extension options under the same terms and conditions. The recommended action will support ongoing operations and compliance until a new PLM system is fully implemented.

Computer Technology Corp is in compliance with current CalOptima Health contract requirements, is not on any exclusion lists (System for Award Management, Office of the

CalOptima Health Board Action Agenda Referral
Authorize the Chief Executive Officer to Execute a
Contract Amendment with Computer Technology Corp for
Continued Use of Credentialing Systems and Services
Page 2

Inspector General, Medi-Cal Suspended and Ineligible), is not on the Medicare Preclusion List, and is actively listed with the California Secretary of State.

Fiscal Impact

The total annual cost for the contract with Computer Technology Corp is approximately \$55,000. Staff has included operating expenses for the period beginning December 16, 2025, through June 30, 2026, in the CalOptima Health Fiscal Year 2025-26 Operating Budget. Staff will include operating expenses for the period on and after July 1, 2026, in future operating budgets.

Rationale for Recommendation

CalOptima Health requires the continued use of a credentialing system until the new PLM system is implemented. Approving the recommended action will allow adequate time for CalOptima Health resources to focus on completing the CRM implementation and then re-establish the new PLM system implementation plan.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. [Entities Covered by this Recommended Action](#)

/s/ Michael Hunn
Authorized Signature

09/25/2025
Date

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Computer Technology Corp	4900 College Blvd 66211	Overland Park	KS	66211

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2025

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

12. Authorize the Chief Executive Officer to Execute a Contract Amendment with Ceridian for Continued Use of Ceridian Human Resources Systems and Services

Contacts

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

Kathleen Linder, Chief Information Officer, (714) 475-9291

Recommended Action

Make an exception to CalOptima Health Policy GA.5002: Purchasing and authorize the Chief Executive Officer to execute a contract amendment without competitive procurement with Ceridian for an additional three-year term, beginning July 1, 2026, with two one-year extension options, each exercisable at CalOptima Health's discretion under the same terms and conditions as the existing contract.

Background and Discussion

CalOptima Health currently uses Ceridian's Dayforce Human Resources (HR) application. The HR application contract has been in place since June 29, 2008. The existing HR application cannot sunset as planned because the replacement HR platform selected through a previous request for proposals (RFP) was unable to accommodate CalOptima Health's requirements. An RFP for a Human Capital Management (HCM) system to accommodate CalOptima Health's requirements was issued August 20, 2025, but the evaluation and implementation of a new HCM system will go beyond the current contract end date.

CalOptima Health Policy GA.5002: Purchasing outlines the process for procurement of goods and services. Competitive procurement is the required purchasing method, unless competition is not feasible due to an emergency, restricted availability of goods or services, other circumstances exist that would justify waiving the competitive requirements, or the acquisition qualifies for another exception under the policy.

Staff recommends that the CalOptima Health Board of Directors authorize an exception to the purchasing policy due to the circumstances described above to extend the contract with Ceridian for the existing HR application. This extension will allow CalOptima Health adequate time to complete higher priority projects, such as Covered California and Customer Relationship Management, and then complete the RFP, contracting, conversion, and implementation of a new HCM solution. The amendment will be for a term of three years with two one-year extension options. The recommended action will support ongoing operations and compliance until a new HCM is fully implemented. In the event a new HCM is fully implemented prior to the end of the extended contract term, the contract allows CalOptima Health to terminate early without cause.

CalOptima Health Board Action Agenda Referral
Authorize the Chief Executive Officer to Execute a
Contract Amendment with Ceridian for Continued Use of
Ceridian Human Resources Systems and Services
Page 2

Ceridian is in compliance with current CalOptima Health contract requirements, is not on any exclusion lists (System for Award Management, Office of the Inspector General, Medi-Cal Suspended and Ineligible), is not on the Medicare Preclusion List, and is actively listed with the California Secretary of State.

Fiscal Impact

The total annual cost for the contract with Ceridian is approximately \$500,000. Staff will include operating expenses for the period beginning July 1, 2026, and after in future operating budgets.

Rationale for Recommendation

CalOptima Health requires the continued use of an HR system and service until a new system is implemented. The contract extension will allow adequate time to complete higher priority projects and complete the RFP process, contract for services, and convert to and implement a new system. The amendment will be for a term of three years with two one-year extension options.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. [Entities Covered by this Recommended Action](#)

/s/ Michael Hunn
Authorized Signature

09/25/2025
Date

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Ceridian Corporation	3311 E Old Shakopee Rd	Minneapolis	MN	55425

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2025

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

13. Authorize the Chief Executive Officer to Execute a Contract Amendment with Change Healthcare Solutions, LLC for Continued Use of Print/Fulfillment, Electronic Data Interchange Clearinghouse, Remittance Advice, and Check Printing Systems and Services

Contacts

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

Kathleen Linder, Chief Information Officer, (714) 475-9291

Recommended Action

Make an exception to CalOptima Health Policy GA.5002: Purchasing, and authorize the Chief Executive Officer to execute a contract amendment without competitive procurement with Change Healthcare Solutions, LLC for print/fulfillment, Electronic Data Interchange clearinghouse, remittance advice, and check printing systems and services for an additional three-year term, beginning January 1, 2026, with two one-year extension options, each exercisable at CalOptima Health's discretion under the same terms and conditions as the existing agreement.

Background and Discussion

CalOptima Health currently uses Change Healthcare Solutions, LLC (Change Healthcare) for letter print/fulfillment, Electronic Data Interchange (EDI) clearinghouse, remittance advice (RA), and check printing systems and services. The contract has been in place since October 12, 2000. A solicitation for new vendors for print and fulfillment, RAs, and check printing has been released, and a new contract should be implemented in 2026, at which time the Change Healthcare services for those areas will end. Implementation of this new vendor agreement will go beyond the Change Healthcare contract end date of January 1, 2026. Additionally, implementation of a new EDI clearinghouse vendor in the midst of the Covered California implementation could potentially be disruptive to CalOptima Health's health networks and provider partners and should be deferred until after the successful roll out of Covered California.

CalOptima Health Policy GA.5002: Purchasing outlines the process for procurement of goods and services essential to the operations of CalOptima Health. Competitive procurement is the required purchasing method unless competition is not feasible due to an emergency, restricted availability of goods or services, other circumstances exist that would justify waiving the competitive requirements, or the acquisition qualifies for another exception under the policy.

Staff recommends that the CalOptima Health Board of Directors authorize an exception to the purchasing policy due to the circumstances described above to extend the contract with Change Healthcare. The extension will allow adequate time to complete higher priority projects and to

select, contract, convert, and implement new vendors for each area respectively. The amendment will be for a term of three years with two one-year extension options. The recommended action will support ongoing operations and compliance until new vendors are selected and systems are implemented for the services. In the event new systems are implemented prior to the end of the extended contract term, the contract allows CalOptima Health to terminate early without cause.

Change Healthcare is in compliance with current CalOptima Health contract requirements, is not on any exclusion lists (System for Award Management, Office of the Inspector General, Medical Suspended and Ineligible), is not on the Medicare Preclusion List, and is actively listed with the California Secretary of State.

Fiscal Impact

The total annual cost for the Change Healthcare contract is approximately \$1,060,000. Staff has included operating expenses for the period beginning January 1, 2026, through June 30, 2026, in the CalOptima Health Fiscal Year 2025-26 Operating Budget. Staff will include operating expenses for the period on and after July 1, 2026, in future operating budgets.

Rationale for Recommendation

CalOptima Health requires the continued use of the current print/fulfillment, RA, and check printing vendor until new solutions are implemented. This recommended action will allow adequate time for the completion of a request for proposal, contract for services, and conversion to and implementation of a new system.

CalOptima Health requires that the continued use of the current EDI clearinghouse services be continued until after the successful roll-out of Covered California. This requested action will prevent potential EDI transaction disruptions to CalOptima Health's health networks and providers during the Covered California implementation.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. [Entities Covered by this Recommended Action](#)

/s/ Michael Hunn
Authorized Signature

09/25/2025
Date

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Change Healthcare Solutions, LLC	3055 Lebanon Pike Suite 1000	Nashville	TN	37214

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2025

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

14. Adopt Resolution No. 25-1002-01 to Add Three Seats and Rename Three Existing Seats on the CalOptima Health Board of Directors' Member Advisory Committee

Contact

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

Recommended Actions

1. Adopt Resolution No. 25-1002-01 that:
 - a. Adds three Member Advisory Committee (MAC) members, which includes a Medi-Cal Beneficiaries or Authorized Family Member, a Dental Provider, and a Local Education Agency Representative; and
 - b. Renames the Adult Beneficiaries, Family Support, and Persons with Special Needs seats on the MAC to comply with APL 25-009
2. Authorize modifications to CalOptima Health Policy AA.1219a: Member Advisory Committee Policy and Procedures to reflect the seat additions and the seat name changes.
3. Authorize a stipend increase for Medi-Cal Beneficiaries and OneCare Members or their Authorized Family Member from \$50 to \$100 per meeting attended, including mileage for in-person attendance with an option to receive the stipend as a check or gift card.

Background

The CalOptima Health Board of Directors (Board) established the MAC by resolution on February 14, 1995, to provide input to the Board. The MAC is currently comprised of 17 voting members, with each seat representing a constituency or population that CalOptima Health serves. The Board is responsible for appointing all MAC members.

In May 2025 the Department of Health Care Services (DHCS) issued All-Plan Letter (APL) 25-009 that outlined requirements for Community Advisory Committees, which is known as the Member Advisory Committee at CalOptima Health. The APL emphasized the importance of member, family, and community engagement and provided guidance on how CalOptima Health should implement and maintain this engagement.

Discussion

APL 25-009 clarifies the roles and responsibilities of the MAC. The policy enhances the MAC's function by outlining its purpose, membership structure, and CalOptima Health's duty to support members. The APL also introduces improved processes and engagement channels to enable members to provide input on key areas such as quality of care, health equity, health disparities, population health management, children's services, community reinvestment plans, and community health assessments, in line with DHCS contract requirements.

To align with the Board's policy of promoting member and provider engagement in shaping CalOptima Health programs, staff recommends expanding the MAC from 17 to 20 members. This expansion would add three new seats to meet DHCS requirements for additional member representation: (i) a Dental

Provider representative, (ii) a Local Education Agency representative, and (iii) a Medi-Cal Beneficiaries or Authorized Family Member Representative. Upon Board approval, staff will begin recruiting for the three new seats.

Renaming the Adult Beneficiaries Representative seat to Medi-Cal Beneficiaries or Authorized Family Member Representative, with the new Medi-Cal member seat referenced above, allows for the addition of two more seats for Medi-Cal beneficiaries or their authorized family members. Additional title changes include updating the Family Support Services seat to Family/Caregiver Support Representative seat and updating the Persons with Special Needs seat to Developmental Disabilities Representative seat. All current MAC members meet DHCS eligibility for these updates.

Following a review of other health plans across the state, CalOptima Health staff recommends that the stipend for Medi-Cal members and OneCare members or their authorized family members serving on the MAC be increased from \$50 to \$100 to align with compensation provided by similar advisory committees statewide.

The updated CalOptima Health policy AA.1219a: Member Advisory Committee is attached for reference and approval.

Fiscal Impact

The recommended action increases the stipend amount from \$50 to \$100 per committee meeting attended for each beneficiary/member or family representative on the MAC and adds two additional beneficiary/member representatives to the MAC eligible for the stipend. The total annual increase is \$3,000. The CalOptima Health Fiscal Year 2025-26 Operating Budget for the stipends is sufficient to cover this increase.

Rationale for Recommendation

CalOptima Health staff recommends adding three new MAC seats. The addition of three seats, which includes a Dental Provider, Local Education Agency Representative, and a Medi-Cal Beneficiaries or Authorized Family Member, will increase the MAC from 17 members to 20 members and fulfill the requirements of the CalOptima Health contract with DHCS for 2025 as outlined in APL 25-009. Renaming the current Adult Beneficiaries seat to a Medi-Cal Beneficiaries or Authorized Family Member Representative allows for consistency among the member seats on the MAC and, along with the new Medi-Cal member seat, results in the addition of two Medi-Cal member seat designations.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. [Adopt Resolution No. 25-1002-01](#)
2. [AA.1219a: Member Advisory Committee Policy](#)

/s/ Michael Hunn
Authorized Signature

09/25/2025
Date

RESOLUTION NO. 25-1002-01

RESOLUTION OF THE BOARD OF DIRECTORS ORANGE COUNTY HEALTH AUTHORITY Orange Prevention and Treatment Integrated Medical Assistance d.b.a. CalOptima Health

APPROVE RESOLUTION TO ADD THREE ADDITIONAL SEATS AND RENAME THREE SEATS ON THE CALOPTIMA HEALTH BOARD OF DIRECTOR' MEMBER ADVISORY COMMITTEE

WHEREAS, the CalOptima Health Board of Directors established the Member Advisory Committee (MAC) pursuant to Resolution No. 2-14-95 to represent the constituencies served by CalOptima Health and to advise the Board of Directors and later amended to add and rename seats pursuant to Resolution No. 23-1207-01;

WHEREAS, CalOptima Health staff recommends the addition of the following three seats to the MAC for a total of 20 seats: one Medi-Cal Beneficiaries or Authorized Family Member Representative seat, one Dental Provider seat, and one Local Education seat; and

WHEREAS, CalOptima Health staff recommends changing the name of the current (i) Adult Beneficiaries seat to Medi-Cal Beneficiaries or Authorized Family Member Representative; (ii) Family Support Representative seat to Family/Caregiver Support Representative; and (iii) Persons with Special Needs seat to Developmental Disabilities Representative.

NOW, THEREFORE, BE IT RESOLVED:

That the Board of Directors hereby approves the recommended seat additions and seat name changes effective October 2, 2025. The seats comprising the MAC shall be:

- a. Behavioral/Mental Health
- b. Children
- c. Dental Provider
- d. Developmental Disabilities
- e. Family/Caregiver Support
- f. Foster Children
- g. Local Education Agency
- h. Medi-Cal Beneficiaries or Authorized Family Member
- i. Medi-Cal Beneficiaries or Authorized Family Member
- j. Medi-Cal Beneficiaries or Authorized Family Member
- k. Medi-Cal Beneficiaries or Authorized Family Member
- l. Member Advocate
- m. OneCare Member or Authorized Family Member
- n. OneCare Member or Authorized Family Member
- o. OneCare Member or Authorized Family Member
- p. OneCare Member or Authorized Family Member

- q. Orange County Social Services Agency (Standing Seat)
- r. Persons with Disabilities
- s. Recipients of CalWORKs
- t. Seniors

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima Health, this 2nd day of October, 2025.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/ _____

Title: Chair, Board of Directors

Printed Name and Title: Isabel Becerra, Chair, Board of Directors

Attest:

/s/ _____

Sharon Dwiers, Clerk of the Board



Policy: AA.1219a
Title: **Member Advisory Committee**
Department: Executive Office
Section: Office of the Clerk of the Board

CEO Approval: /s/

Effective Date: 07/01/2015

Revised Date: 09/01/2025

Applicable to: ☐ Administrative
☐ Covered California [Effective 2027]
☒ Medi-Cal
☒ OneCare
☐ PACE

I. PURPOSE

This policy describes the composition and role of CalOptima Health's Member Advisory Committee (MAC) and to establish a process for recruiting, evaluating, and selecting prospective candidates to CalOptima Health's MAC.

The MAC is also referred to by the Department of Health Care Services (DHCS) as the Community Advisory Committee (CAC).

II. POLICY

A. As directed by CalOptima Health's Board of Directors (CalOptima Health Board), the MAC shall report to the CalOptima Health Board and shall provide advice and recommendations to the CalOptima Health Board relative to CalOptima Health's programs, and relevant policies and procedures affecting quality and Health Equity updates. CalOptima Health shall inform MAC members how their input was incorporated: at their bi-monthly meetings.

B. CalOptima Health shall ensure that MAC meetings are accessible to all participants and provide appropriate accommodations allowing attendees to effectively communicate and participate in MAC meetings including providing translation and interpretation services, providing accessibility for individuals with a disability or Limited English Proficiency (LEP), providing transportation to MAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest MAC member participation possible.

C. CalOptima Health shall ensure Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, DHCS contract requirements, and other DHCS guidance, including All Plan Letters (APL) and Policy Letters.

~~B.D.~~ CalOptima Health's Board encourages Member involvement in CalOptima Health's programs.

~~C.E.~~ CalOptima Health shall designate a staff member and maintain a written job description detailing the staff member's responsibilities, which includes having responsibility for managing the operations of the MAC in compliance with all statutory, regulatory, and contractual requirements.

The staff member shall not be considered a member of the MAC for voting purposes and shall not be a CalOptima Health Member.

F. CalOptima Health shall have either a Governing Board Member or the Executive Team in attendance at all scheduled meetings.

~~D.G.~~ MAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima Health Policies GA.8012: Conflicts of Interest and AA.1204: Gifts, Honoraria, and Travel Payments.

H. The composition of the MAC shall ~~continue to~~ reflect ~~and be responsive to~~ the ~~diversity of the~~ diverse health care ~~consumer and include seniors~~ consumers within CalOptima Health's service area, which includes but is not limited to:

1. ~~Seniors~~ and ~~persons~~ Persons with disabilities, ~~persons~~:

2. ~~Persons~~ with chronic conditions (such as asthma, diabetes, congestive heart failure) ~~and limited~~;

3. ~~Limited~~ English proficient Members, ~~and~~; ~~or~~

4. ~~Members~~ from diverse cultural and ethnic backgrounds or their representatives.

~~1.5.~~ All MAC members shall have direct or indirect contact with CalOptima Health Members.

~~E.I.~~ An organization may have no more than one (1) employee or representative on the MAC at any one time.

~~F.J.~~ An individual may participate in no more than one (1) CalOptima Health advisory committee at any one time.

~~G.K.~~ In accordance with CalOptima Health Board Resolution Numbers 2-14-95 (effective February 14, 1995) and ~~23-120725 1002-01~~ (effective ~~December 7, 2023~~ October 2, 2025), MAC shall be comprised of ~~seventeen (17)~~ twenty (20) voting members, each seat representing a constituency served by CalOptima Health.

1. One (1) of the ~~seventeen (17)~~ twenty (20) positions is a standing seat and is held by the Social Services Agency (SSA).

2. The remaining ~~sixteen (16)~~ nineteen (19) members shall serve staggered terms of three (3) years.

a. ~~Two (2)~~ Four (4) of the remaining ~~sixteen (16)~~ nineteen (19) positions shall be dedicated Medi-Cal Beneficiaries or Authorized Family Member seats.

b. Four (4) of the ~~sixteen (16)~~ nineteen (19) positions shall be dedicated to OneCare Member or Authorized Family Member seats.

c. The three (3) year term shall coincide with CalOptima Health's fiscal year (i.e., July 1 through June 30).

d. Effective July 1, 2023, staggered nominations shall occur at a rate of approximately one-third (1/3) of the membership each year.

- 1
2 e. MAC members may serve no more than two (2) consecutive terms or the equivalent of six
3 (6) consecutive years.
4
5 f. MAC members shall be allowed to reapply after a hiatus of six (6) years.
6
7 3. MAC may include, but is not limited to, individuals representing, or that represent the interests
8 of:
9
10 ~~a. Adult beneficiaries;~~
11
12 ~~b.a.~~ Behavioral/Mental Health;
13
14 ~~e.b.~~ Children;
15
16 c. Dental Providers
17
18 d. Developmental Disabilities
19
20 ~~d.e.~~ Family/Caregiver Support ~~Representative~~;
21
22 ~~e.f.~~ Foster ~~children~~ Children;
23
24 ~~f.g.~~ Local Education Agencies;
25
26 ~~g.h.~~ Medi-Cal Beneficiaries or Authorized Family ~~Member beneficiaries~~ Members;
27
28 ~~h.i.~~ Member Advocate;
29
30 ~~i.j.~~ OneCare Member or Authorized Family Member ~~beneficiaries~~;
31
32 ~~j.k.~~ Orange County Social Services Agency (SSA);
33
34 ~~k.l.~~ Persons with ~~disabilities~~ Disabilities;
35
36 ~~l. Persons with Special Needs;~~
37
38 m. Recipients of CalWORKs; ~~or~~ and
39
40 n. Seniors.
41
42 4. The MAC shall carry out duties in accordance with the ~~Department of Health Care Services~~
43 ~~(DHCS)~~ contract requirements. Duties include, but are not limited to:
44
45 a. Identifying and advocating for preventive care practices to be utilized by CalOptima Health;
46
47 b. Involvement in developing and updating cultural and linguistic policy and procedure
48 decisions including those related to Quality Improvement (QI), education, and operational
49 and cultural competency issues affecting Members who speak a primary language other
50 than English. The MAC may also advise on necessary Member or provider targeted
51 services, programs, and trainings;
52

- 1 c. Providing and making recommendations to CalOptima Health regarding the cultural
2 appropriateness of communications, partnerships, and services;
3
4 d. Reviewing Population Needs Assessment (PNA) findings and having a process to discuss
5 improvement opportunities with an emphasis on Health Equity and Social Determinants of
6 Health (SDOH);
7
8 e. CalOptima Health shall ensure that a Community Reinvestment Report submission to
9 DHCS will include signed letters from the MAC, in accordance with CalOptima Health
10 Policy GG.1705: Community Reinvestment; and
11
12 f. Providing input and advice, including, but not limited to, the following:

13
14 i. Meeting agenda development;

15 ii. Culturally appropriate service or program design;

16 iii. Priorities for health education and outreach program;

17 iv. Member satisfaction survey results;

18 v. Findings of the PNA; and/or the Community Health Assessment (CHA)/Community
19 Health Implementation Plan (CHIP);

20 vi. Plan marketing materials and campaigns;

21 vii. Communication of needs for network development and assessment;

22 viii. Community resources and information;

23 ix. Population Health Management (PHM);

24 x. Quality Improvement;

25 xi. Health delivery systems reforms to improve health outcomes, accessibility of
26 services, and coordination of care for Members;

27 xii. Carved out services;

28 xiii. Coordination of care;

29 xiv. Health Equity;

30 xv. Accessibility of services;

31 xvi. Grievance and Appeals; and

32 xvii. Community reinvestment activities;

33 xviii. Development of the covered, Non-Specialty Mental Health Services (NSMHS)
34 outreach and education plan, in accordance with DHCS APL 24-012: Non-Specialty

Mental Health Services: Member Outreach, Education, and Experience Requirements or any superseding APL;

xix. Reforms to improve health outcomes, accessibility of services, and coordination of care for Members; and

~~xvi~~.xx. Inform the development of CalOptima Health's Provider Manual.

5. CalOptima Health shall allow the MAC to provide input on selecting targeted health education, cultural and linguistic, and QI strategies, provide sufficient resources for the MAC to support the required MAC activities outlined above, including supporting the MAC in engagement strategies such as consumer listening sessions, focus groups, and/or surveys.
6. CalOptima Health shall provide a location for MAC meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting accessible to all participants, and providing accommodations to allow all individuals to attend and participate in the meetings.
7. CalOptima Health shall draft written minutes of each MAC meeting and associated discussions. All minutes shall be posted on CalOptima Health's website and submitted to DHCS no later than forty-five (45) calendar days after each meeting.
8. CalOptima Health shall retain minutes for no less than ten (10) years and provide copies to DHCS, upon request.
9. CalOptima Health shall support MAC members in their MAC roles, including but not limited to providing resources to educate MAC members to ensure they are able to effectively participate in MAC meetings, providing transportation to MAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest MAC member participation possible.

~~10. CalOptima Health shall appoint one (1) member of the MAC to serve as CalOptima Health's representative to DHCS' Statewide Consumer Advisory Committee.~~

~~a. appointed MAC representative shall be reimbursed for eligible expenses associated with attending the DHCS Statewide Consumer Advisory Committee in accordance with CalOptima Health Policy GA.5004: Travel and Other Reimbursable Expenses.~~

G. Stipends

1. CalOptima Health may provide a reasonable per diem payment of up to fiftyone hundred dollars (~~\$50100~~) per meeting in the form of a check or a gift card to the Medi-Cal Member or Authorized Family Member beneficiaries representative and the OneCare Member or Authorized Family Member beneficiaries serving on the MAC. CalOptima Health shall maintain a log of each payment provided to the Member or family representative, including type and value, and shall provide such log to DHCS upon request.
2. Representatives of provider organizations, community-based organizations and consumer advocates are not eligible for stipends.

H. The MAC shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.

1. The MAC shall conduct an annual recruitment and nomination process.
 - a. At the end of each fiscal year, approximately one-third (1/3) of the MAC seats' terms expire, alternating between ~~six (6)~~seven (7) vacancies, one (1) year and ~~four (4)~~six (6) vacancies each of the following two (2) years. The standing seat on the MAC is not impacted by term expiration.
2. The MAC shall conduct a recruitment and nomination process if a seat is vacated mid-term.
 - a. Candidates that fill a vacated seat mid-term shall complete the term for that specific seat, which will be less than a full three (3) year term.

I. Special Elections

1. Special elections for the MAC shall occur under the following circumstances:
 - a. A MAC seat is vacant due to the resignation of a sitting MAC member; or
 - b. The current MAC member is deemed unqualified to serve in his or her current capacity as a MAC member.
 - i. Every effort will be made to replace the vacant seat within sixty (60) calendar days from the date the seat is vacated.
2. Any new MAC member appointed to fill an open seat created mid-term shall serve the remainder of the resigning member's term.

J. MAC Vacancies

1. If a vacancy occurs prior to the start of the nomination process, there shall be no need for a special election and the vacant seat shall be filled during that nomination process.
2. If a vacancy occurs after the annual nomination process is complete, a special election may be conducted to fill the open seat, subject to approval by the MAC.

K. On a bi-annual basis, the MAC shall select a Chair and Vice-Chair from its membership to coincide with the annual recruitment and nomination process. Recruitment and selection shall be conducted in accordance with Section III.C-E of this policy.

1. The MAC Chair and Vice-Chair may serve one (1) two (2) year term.
2. The MAC Chair or Vice-Chair may be removed by a majority vote from CalOptima Health's Board.

L. To establish a nomination ad hoc subcommittee, the MAC Chair or Vice-Chair shall ask for three (3) to four (4) members to serve on the ad hoc subcommittee. -MAC members, who are being considered for reappointment, cannot participate in the nomination ad hoc subcommittee.

1. The MAC nomination ad hoc subcommittee shall:

- a. Review, evaluate, and select a prospective Chair, Vice-Chair and a candidate for each of the open seats, in accordance with Section III.C-E of this policy; and
 - b. Forward the prospective Chair, Vice-Chair and slate of candidate(s) to the full MAC for consideration.
2. Following approval from the MAC, the recommended Chair, Vice-Chair and slate of candidate(s) shall be forwarded to CalOptima Health's Board for review and approval.
- M. CalOptima Health's Board shall review and have final approval for all appointments, reappointments, and Chair and Vice-Chair appointments to the MAC.
- N. MAC members shall attend all regularly scheduled meetings unless they have an excused absence. An absence shall be considered excused if a MAC member provides notification of an absence to CalOptima Health staff prior to the MAC meeting. CalOptima Health staff shall maintain an attendance log of the MAC members' attendance at MAC meetings. Upon request from the MAC Chair, the Vice-Chair, the Chief Executive Officer, or the CalOptima Health Board, CalOptima Health staff shall provide a copy of the attendance log to the requester. In addition, the MAC Chair or Vice-Chair shall contact any committee member who has three consecutive unexcused absences.
1. MAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. MAC composition

1. The composition of MAC shall reflect the cultural diversity and special needs of the CalOptima Health population.
2. Specific agency representatives shall serve on the MAC as standing members.
 - a. The SSA representative shall serve as a standing member and shall not be subject to reapplying.

B. MAC meeting frequency

1. The MAC shall hold its first regular meeting promptly after all initial members have been selected by the MAC selection committee and at least quarterly thereafter.
2. The MAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.
3. MAC meetings shall be open to the public, in person or virtually, meeting information shall be posted publicly on CalOptima Health's MAC webpage thirty (30) calendar days prior to the meeting, and in no event later than seventy-two (72) hours prior to the meeting.
4. Attendance by a simple majority of appointed members shall constitute a quorum.
 - a. A quorum must be present for any votes to be valid.

C. MAC recruitment process

- 1 CalOptima Health, in consultation with the Chief Health Equity Officer, shall begin recruitment
2 of potential candidates in February of each year.- In the recruitment of potential candidates, the
3 ethnic and cultural diversity and special needs of the CalOptima Health population shall be
4 considered. Nominations and input from interest groups and agencies shall be given due
5 consideration.
- 6
- 7 2. CalOptima Health shall recruit potential candidates utilizing a variety of notification methods,
8 which may include, but are not limited to, the following:
- 9
- 10 a. Outreach to the respective Member community;
- 11
- 12 b. Placement of vacancy notices on the CalOptima Health Website
- 13
- 14 3. Prospective candidates shall be notified at the time of recruitment regarding the deadline to
15 submit their application to CalOptima Health.
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- 17 4. During the MAC meeting held before June 30 of a recruitment year for the Chair and Vice-
18 Chair, the current Chair or Vice-Chair shall inquire of its membership whether there are
19 interested candidates who wish to be considered as a Chair or Vice-Chair for the upcoming
20 fiscal year. The candidates are requested to submit a letter of interest for these positions.
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- 22 D. CalOptima Health shall conduct a special election with a truncated recruitment process to fill a
23 MAC seat that has been vacated mid-term.
- 24
- 25 E. MAC nomination process
- 26
- 27 1. The MAC Chair or Vice-Chair in consultation with the Chief Health Equity Officer shall
28 request three (3) to four (4) members, who are not being considered for reappointment, to serve
29 on the nomination ad hoc subcommittee.
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- 31 a. At the discretion of the MAC nomination ad hoc subcommittee, a subject matter expert
32 (SME) may be included on the subcommittee to provide consultation and advisement.
- 33
- 34 2. Prior to the MAC nomination ad hoc subcommittee meeting:
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- 36 a. Ad hoc subcommittee members shall individually evaluate and score the application for
37 each of the prospective candidates using the Applicant Evaluation Tool.
- 38
- 39 b. Ad hoc subcommittee members shall individually evaluate and select a Chair and Vice-
40 Chair.
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- 42 c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a
43 prospective candidate's references for additional information and background validation.
- 44
- 45 3. The ad hoc subcommittee shall convene to discuss and select a candidate for each of the
46 expiring seats by using the findings from the Applicant Evaluation Tool, the attendance record
47 if relevant, and the prospective candidate's references.
- 48
- 49 F. MAC selection and approval process for prospective Chair, Vice-Chair -and MAC candidates
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- 51 1. Upon selection of a recommendation for a slate of candidates, the ad hoc subcommittee shall
52 forward its recommendation to the MAC for consideration.

2. Following consideration, the MAC's recommendation for a slate of candidates shall be submitted to CalOptima Health's Board for review and final approval.
 3. Chair and Vice-Chair candidates who submitted a letter of interest will be reviewed at the first MAC meeting of the fiscal year and the members will vote on their candidate of choice for both positions. Candidates must have a quorum of members approving their recommendation in order to be submitted to CalOptima Health's Board for appointment. If the Chair is no longer able to serve on the MAC, the Vice-Chair will automatically assume the Chair seat and will be officially appointed by the Board at an upcoming meeting and a Vice-Chair will be recruited among the members to fulfill the remaining term.
 4. Following CalOptima Health's Board approval of MAC's recommendation, the new MAC members' terms shall be effective July 1.
 - a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following MAC meeting.
 5. CalOptima Health shall provide new MAC members with a new member orientation.
- G. ~~G.~~ CalOptima Health shall complete and submit to DHCS an annual MAC member demographic report by April 1 of each year— and will include the following information including, but not limited to:
1. The demographic composition of the MAC membership;
 2. How CalOptima Health defines the demographics and diversity of its Members and potential Members within the CalOptima Health service area;
 3. The data sources relied upon by CalOptima Health to validate that its MAC membership aligns with CalOptima Health Member demographics;
 4. Barriers and challenges in meeting or increasing alignment between MAC's membership with the demographics of the Members with CalOptima Health's Service Area;
 5. Ongoing, updated, and new efforts and strategies undertaken in MAC's membership recruitment to address the barriers and challenges to achieving alignment between MAC membership with the demographics of the Members within CalOptima Health's Service Area; and
 6. A description of the MAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, CLAS services, resource allocation, and other community-based initiatives, including examples of how MAC input impacted and shaped the CalOptima Health initiatives and/or policies.

IV. ATTACHMENT(S)

- A. Member Advisory Committee - Member Application
- B. Member Advisory Committee - Community Application
- C. Member Advisory Committee - Applicant Evaluation Tool
- D. Member Advisory Committee - Seat Descriptions

V. REFERENCE(S)

- A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- B. CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments
- C. CalOptima Health Policy GA.5004: Travel and Other Reimbursable Expenses
- D. CalOptima Health Policy GA.8012: Conflicts of Interest
- E. CalOptima Health Policy GG.1705: Community Reinvestment
- F. CalOptima Board Resolution 2-14-95
- G. CalOptima Board Resolution 06-0707
- H. CalOptima Board Resolution 11-1103
- I. CalOptima Board Resolution 13-0307
- J. CalOptima Board Resolution 15-08-06-02
- K. CalOptima Board Resolution 16-08-04-02
- L. Department of Health Care Services (DHCS) All Plan Letter (APL): 24-012
- M. Non-Specialty Mental Health Services: Member Outreach, Education, and Experience Requirements
- ~~N.~~ Department of Health Care Services (DHCS) All Plan Letter (APL): Community Advisory Committee

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/15/2014	Department of Health Care Services (DHCS)	Approved as Submitted
08/11/2017	Department of Health Care Services (DHCS)	Approved as Submitted
06/27/2023	Department of Health Care Services (DHCS)	Approved as Submitted
09/05/2024	Department of Health Care Services (DHCS)	File and Use
06/13/2025	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
03/07/2013	Regular Meeting of the CalOptima Board of Directors
08/06/2015	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
05/07/2020	Regular Meeting of the CalOptima Board of Directors
08/06/2020	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
12/07/2023	Regular Meeting of the CalOptima Health Board of Directors
<u>10/02/2025</u>	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2015	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	08/04/2016	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	07/01/2017	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	03/01/2020	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	08/06/2020	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	02/01/2022	AA.1219a	Member Advisory Committee	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	12/01/2022	AA.1219a	Member Advisory Committee	Medi-Cal OneCare
Revised	12/07/2023	AA.1219a	Member Advisory Committee	Medi-Cal OneCare
Revised	03/01/2024	AA.1219a	Member Advisory Committee	Medi-Cal OneCare
Revised	09/01/2024	AA.1219a	Member Advisory Committee	Medi-Cal OneCare
Revised	05/01/2025	AA.1219a	Member Advisory Committee	Medi-Cal OneCare
Revised	<u>09/01/2025</u>	AA.1219a	Member Advisory Committee	Medi-Cal OneCare

For 20251002 BOD Review

IX. GLOSSARY

Term	Definition
Health Equity	The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
Member	A beneficiary enrolled in a CalOptima Health program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Social Drivers of Health (SDOH)	The environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk. Also known as Health Related Social Needs.
Threshold Language	<u>Medi-Cal</u>: The non-English threshold and concentration standard languages in which CalOptima Health is required to provide written translations of Member Information, as determined by DHCS. <u>OneCare</u>: A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.



Policy: AA.1219a
Title: **Member Advisory Committee**
Department: Executive Office
Section: Office of the Clerk of the Board

CEO Approval: /s/

Effective Date: 07/01/2015

Revised Date: 09/01/2025

Applicable to: ☐ Administrative
☐ Covered California [Effective 2027]
☒ Medi-Cal
☒ OneCare
☐ PACE

I. PURPOSE

This policy describes the composition and role of CalOptima Health's Member Advisory Committee (MAC) and to establish a process for recruiting, evaluating, and selecting prospective candidates to CalOptima Health's MAC.

The MAC is also referred to by the Department of Health Care Services (DHCS) as the Community Advisory Committee (CAC).

II. POLICY

- A. As directed by CalOptima Health's Board of Directors (CalOptima Health Board), the MAC shall report to the CalOptima Health Board and shall provide advice and recommendations to the CalOptima Health Board relative to CalOptima Health's programs, and relevant policies and procedures affecting quality and Health Equity updates. CalOptima Health shall inform MAC members how their input was incorporated at their bi-monthly meetings.
- B. CalOptima Health shall ensure that MAC meetings are accessible to all participants and provide appropriate accommodations allowing attendees to effectively communicate and participate in MAC meetings including providing translation and interpretation services, providing accessibility for individuals with a disability or Limited English Proficiency (LEP), providing transportation to MAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest MAC member participation possible.
- C. CalOptima Health shall ensure Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, DHCS contract requirements, and other DHCS guidance, including All Plan Letters (APL) and Policy Letters.
- D. CalOptima Health's Board encourages Member involvement in CalOptima Health's programs.
- E. CalOptima Health shall designate a staff member and maintain a written job description detailing the staff member's responsibilities, which includes having responsibility for managing the operations of the MAC in compliance with all statutory, regulatory, and contractual requirements.

The staff member shall not be considered a member of the MAC for voting purposes and shall not be a CalOptima Health Member.

- F. CalOptima Health shall have either a Governing Board Member or the Executive Team in attendance at all scheduled meetings.
- G. MAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima Health Policies GA.8012: Conflicts of Interest and AA.1204: Gifts, Honoraria, and Travel Payments.
- H. The composition of the MAC shall continue to reflect and be responsive to the diverse health care consumers within CalOptima Health's service area, which includes but is not limited to:
1. Seniors and Persons with disabilities;
 2. Persons with chronic conditions (such as asthma, diabetes, congestive heart failure);
 3. Limited English proficient Members; or
 4. Members from diverse cultural and ethnic backgrounds or their representatives.
 5. All MAC members shall have direct or indirect contact with CalOptima Health Members.
- I. An organization may have no more than one (1) employee or representative on the MAC at any one time.
- J. An individual may participate in no more than one (1) CalOptima Health advisory committee at any one time.
- K. In accordance with CalOptima Health Board Resolution Numbers 2-14-95 (effective February 14, 1995) and 25 1002-01 (effective October 2, 2025), MAC shall be comprised of twenty (20) voting members, each seat representing a constituency served by CalOptima Health.
1. One (1) of the twenty (20) positions is a standing seat and is held by the Social Services Agency (SSA).
 2. The remaining nineteen (19) members shall serve staggered terms of three (3) years.
 - a. Four (4) of the remaining nineteen (19) positions shall be dedicated Medi-Cal Beneficiaries or Authorized Family Member seats.
 - b. Four (4) of the nineteen (19) positions shall be dedicated to OneCare Member or Authorized Family Member seats.
 - c. The three (3) year term shall coincide with CalOptima Health's fiscal year (i.e., July 1 through June 30).
 - d. Effective July 1, 2023, staggered nominations shall occur at a rate of approximately one-third (1/3) of the membership each year.
 - e. MAC members may serve no more than two (2) consecutive terms or the equivalent of six (6) consecutive years.

- 1
2 f. MAC members shall be allowed to reapply after a hiatus of six (6) years.
3
4 3. MAC may include, but is not limited to, individuals representing, or that represent the interests
5 of:
6
7 a. Behavioral/Mental Health;
8
9 b. Children;
10
11 c. Dental Providers
12
13 d. Developmental Disabilities
14
15 e. Family/Caregiver Support;
16
17 f. Foster Children;
18
19 g. Local Education Agencies;
20
21 h. Medi-Cal Beneficiaries or Authorized Family Members;
22
23 i. Member Advocate;
24
25 j. OneCare Member or Authorized Family Member;
26
27 k. Orange County Social Services Agency (SSA);
28
29 l. Persons with Disabilities;
30
31 m. Recipients of CalWORKs; and
32
33 n. Seniors.
34
35 4. The MAC shall carry out duties in accordance with the DHCS contract requirements. Duties
36 include, but are not limited to:
37
38 a. Identifying and advocating for preventive care practices to be utilized by CalOptima Health;
39
40 b. Involvement in developing and updating cultural and linguistic policy and procedure
41 decisions including those related to Quality Improvement (QI), education, and operational
42 and cultural competency issues affecting Members who speak a primary language other
43 than English. The MAC may also advise on necessary Member or provider targeted
44 services, programs, and trainings;
45
46 c. Providing and making recommendations to CalOptima Health regarding the cultural
47 appropriateness of communications, partnerships, and services;
48
49 d. Reviewing Population Needs Assessment (PNA) findings and having a process to discuss
50 improvement opportunities with an emphasis on Health Equity and Social Determinants of
51 Health (SDOH);
52

- 1 e. CalOptima Health shall ensure that a Community Reinvestment Report submission to
2 DHCS will include signed letters from the MAC, in accordance with CalOptima Health
3 Policy GG.1705: Community Reinvestment; and
4
- 5 f. Providing input and advice, including, but not limited to, the following:
6
- 7 i. Meeting agenda development;
 - 8
 - 9 ii. Culturally appropriate service or program design;
 - 10
 - 11 iii. Priorities for health education and outreach program;
 - 12
 - 13 iv. Member satisfaction survey results;
 - 14
 - 15 v. Findings of the PNA and/or the Community Health Assessment (CHA)/Community
16 Health Implementation Plan (CHIP);
 - 17
 - 18 vi. Plan marketing materials and campaigns;
 - 19
 - 20 vii. Communication of needs for network development and assessment;
 - 21
 - 22 viii. Community resources and information;
 - 23
 - 24 ix. Population Health Management (PHM);
 - 25
 - 26 x. Quality Improvement;
 - 27
 - 28 xi. Health delivery systems reforms to improve health outcomes, accessibility of
29 services, and coordination of care for Members;
 - 30
 - 31 xii. Carved out services;
 - 32
 - 33 xiii. Coordination of care;
 - 34
 - 35 xiv. Health Equity;
 - 36
 - 37 xv. Accessibility of services;
 - 38
 - 39 xvi. Grievance and Appeals;
 - 40
 - 41 xvii. Community reinvestment activities;
 - 42
 - 43 xviii. Development of the covered, Non-Specialty Mental Health Services (NSMHS)
44 outreach and education plan, in accordance with DHCS APL 24-012: Non-Specialty
45 Mental Health Services: Member Outreach, Education, and Experience Requirements
46 or any superseding APL;
 - 47
 - 48 xix. Reforms to improve health outcomes, accessibility of services, and coordination of
49 care for Members; and
 - 50
 - 51 xx. Inform the development of CalOptima Health's Provider Manual.
 - 52

5. CalOptima Health shall allow the MAC to provide input on selecting targeted health education, cultural and linguistic, and QI strategies, provide sufficient resources for the MAC to support the required MAC activities outlined above, including supporting the MAC in engagement strategies such as consumer listening sessions, focus groups, and/or surveys.
6. CalOptima Health shall provide a location for MAC meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting accessible to all participants, and providing accommodations to allow all individuals to attend and participate in the meetings.
7. CalOptima Health shall draft written minutes of each MAC meeting and associated discussions. All minutes shall be posted on CalOptima Health's website and submitted to DHCS no later than forty-five (45) calendar days after each meeting.
8. CalOptima Health shall retain minutes for no less than ten (10) years and provide copies to DHCS, upon request.
9. CalOptima Health shall support MAC members in their MAC roles, including but not limited to providing resources to educate MAC members to ensure they are able to effectively participate in MAC meetings, providing transportation to MAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest MAC member participation possible.

G. Stipends

1. CalOptima Health may provide a reasonable per diem payment of up to one hundred dollars (\$100) per meeting in the form of a check or a gift card to the Medi-Cal Member or Authorized Family Member beneficiaries representative and the OneCare Member or Authorized Family Member beneficiaries serving on the MAC. CalOptima Health shall maintain a log of each payment provided to the Member or family representative, including type and value, and shall provide such log to DHCS upon request.
2. Representatives of provider organizations, community-based organizations and consumer advocates are not eligible for stipends.

H. The MAC shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.

1. The MAC shall conduct an annual recruitment and nomination process.
 - a. At the end of each fiscal year, approximately one-third (1/3) of the MAC seats' terms expire, alternating between seven (7) vacancies, one (1) year and six (6) vacancies each of the following two (2) years. The standing seat on the MAC is not impacted by term expiration.
2. The MAC shall conduct a recruitment and nomination process if a seat is vacated mid-term.
 - a. Candidates that fill a vacated seat mid-term shall complete the term for that specific seat, which will be less than a full three (3) year term.

I. Special Elections

1. Special elections for the MAC shall occur under the following circumstances:
 - a. A MAC seat is vacant due to the resignation of a sitting MAC member; or
 - b. The current MAC member is deemed unqualified to serve in his or her current capacity as a MAC member.
 - i. Every effort will be made to replace the vacant seat within sixty (60) calendar days from the date the seat is vacated.
2. Any new MAC member appointed to fill an open seat created mid-term shall serve the remainder of the resigning member's term.

J. MAC Vacancies

1. If a vacancy occurs prior to the start of the nomination process, there shall be no need for a special election and the vacant seat shall be filled during that nomination process.
 2. If a vacancy occurs after the annual nomination process is complete, a special election may be conducted to fill the open seat, subject to approval by the MAC.
- K. On a bi-annual basis, the MAC shall select a Chair and Vice-Chair from its membership to coincide with the annual recruitment and nomination process. Recruitment and selection shall be conducted in accordance with Section III.C-E of this policy.
1. The MAC Chair and Vice-Chair may serve one (1) two (2) year term.
 2. The MAC Chair or Vice-Chair may be removed by a majority vote from CalOptima Health's Board.
- L. To establish a nomination ad hoc subcommittee, the MAC Chair or Vice-Chair shall ask for three (3) to four (4) members to serve on the ad hoc subcommittee. MAC members, who are being considered for reappointment, cannot participate in the nomination ad hoc subcommittee.

1. The MAC nomination ad hoc subcommittee shall:
 - a. Review, evaluate, and select a prospective Chair, Vice-Chair and a candidate for each of the open seats, in accordance with Section III.C-E of this policy; and
 - b. Forward the prospective Chair, Vice-Chair and slate of candidate(s) to the full MAC for consideration.
2. Following approval from the MAC, the recommended Chair, Vice-Chair and slate of candidate(s) shall be forwarded to CalOptima Health's Board for review and approval.

M. CalOptima Health's Board shall review and have final approval for all appointments, reappointments, and Chair and Vice-Chair appointments to the MAC.

N. MAC members shall attend all regularly scheduled meetings unless they have an excused absence. An absence shall be considered excused if a MAC member provides notification of an absence to CalOptima Health staff prior to the MAC meeting. CalOptima Health staff shall maintain an attendance log of the MAC members' attendance at MAC meetings. Upon request from the MAC

Chair, the Vice-Chair, the Chief Executive Officer, or the CalOptima Health Board, CalOptima Health staff shall provide a copy of the attendance log to the requester. In addition, the MAC Chair or Vice-Chair shall contact any committee member who has three consecutive unexcused absences.

1. MAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. MAC composition

1. The composition of MAC shall reflect the cultural diversity and special needs of the CalOptima Health population.
2. Specific agency representatives shall serve on the MAC as standing members.
 - a. The SSA representative shall serve as a standing member and shall not be subject to reapplying.

B. MAC meeting frequency

1. The MAC shall hold its first regular meeting promptly after all initial members have been selected by the MAC selection committee and at least quarterly thereafter.
2. The MAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.
3. MAC meetings shall be open to the public, in person or virtually, meeting information shall be posted publicly on CalOptima Health's MAC webpage thirty (30) calendar days prior to the meeting, and in no event later than seventy-two (72) hours prior to the meeting.
4. Attendance by a simple majority of appointed members shall constitute a quorum.
 - a. A quorum must be present for any votes to be valid.

C. MAC recruitment process

1. CalOptima Health, in consultation with the Chief Health Equity Officer, shall begin recruitment of potential candidates in February of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the CalOptima Health population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.
2. CalOptima Health shall recruit potential candidates utilizing a variety of notification methods, which may include, but are not limited to, the following:
 - a. Outreach to the respective Member community;
 - b. Placement of vacancy notices on the CalOptima Health Website
3. Prospective candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima Health.

- 1 4. During the MAC meeting held before June 30 of a recruitment year for the Chair and Vice-
2 Chair, the current Chair or Vice-Chair shall inquire of its membership whether there are
3 interested candidates who wish to be considered as a Chair or Vice-Chair for the upcoming
4 fiscal year. The candidates are requested to submit a letter of interest for these positions.
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- 6 D. CalOptima Health shall conduct a special election with a truncated recruitment process to fill a
7 MAC seat that has been vacated mid-term.
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16 (SME) may be included on the subcommittee to provide consultation and advisement.
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27 prospective candidate's references for additional information and background validation.
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- 29 3. The ad hoc subcommittee shall convene to discuss and select a candidate for each of the
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31 if relevant, and the prospective candidate's references.
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- 38 2. Following consideration, the MAC's recommendation for a slate of candidates shall be
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43 positions. Candidates must have a quorum of members approving their recommendation in
44 order to be submitted to CalOptima Health's Board for appointment. If the Chair is no longer
45 able to serve on the MAC, the Vice-Chair will automatically assume the Chair seat and will be
46 officially appointed by the Board at an upcoming meeting and a Vice-Chair will be recruited
47 among the members to fulfill the remaining term.
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- 49 4. Following CalOptima Health's Board approval of MAC's recommendation, the new MAC
50 members' terms shall be effective July 1.
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- a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following MAC meeting.

5. CalOptima Health shall provide new MAC members with a new member orientation.

G. CalOptima Health shall complete and submit to DHCS an annual MAC member demographic report by April 1 of each year and will include the following information including, but not limited to:

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2. How CalOptima Health defines the demographics and diversity of its Members and potential Members within the CalOptima Health service area;
3. The data sources relied upon by CalOptima Health to validate that its MAC membership aligns with CalOptima Health Member demographics;
4. Barriers and challenges in meeting or increasing alignment between MAC's membership with the demographics of the Members with CalOptima Health's Service Area;
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6. A description of the MAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, CLAS services, resource allocation, and other community-based initiatives, including examples of how MAC input impacted and shaped the CalOptima Health initiatives and/or policies.

IV. ATTACHMENT(S)

- A. Member Advisory Committee - Member Application
- B. Member Advisory Committee - Community Application
- C. Member Advisory Committee - Applicant Evaluation Tool
- D. Member Advisory Committee - Seat Descriptions

V. REFERENCE(S)

- A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- B. CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments
- C. CalOptima Health Policy GA.5004: Travel and Other Reimbursable Expenses
- D. CalOptima Health Policy GA.8012: Conflicts of Interest
- E. CalOptima Health Policy GG.1705: Community Reinvestment
- F. CalOptima Board Resolution 2-14-95
- G. CalOptima Board Resolution 06-0707
- H. CalOptima Board Resolution 11-1103
- I. CalOptima Board Resolution 13-0307
- J. CalOptima Board Resolution 15-08-06-02
- K. CalOptima Board Resolution 16-08-04-02
- L. Department of Health Care Services (DHCS) All Plan Letter (APL): 24-012
- M. Non-Specialty Mental Health Services: Member Outreach, Education, and Experience Requirements

N. Department of Health Care Services (DHCS) All Plan Letter (APL): Community Advisory Committee

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/15/2014	Department of Health Care Services (DHCS)	Approved as Submitted
08/11/2017	Department of Health Care Services (DHCS)	Approved as Submitted
06/27/2023	Department of Health Care Services (DHCS)	Approved as Submitted
09/05/2024	Department of Health Care Services (DHCS)	File and Use
06/13/2025	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION(S)

Date	Meeting
03/07/2013	Regular Meeting of the CalOptima Board of Directors
08/06/2015	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
05/07/2020	Regular Meeting of the CalOptima Board of Directors
08/06/2020	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
12/07/2023	Regular Meeting of the CalOptima Health Board of Directors
10/02/2025	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2015	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	08/04/2016	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	07/01/2017	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	03/01/2020	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	08/06/2020	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	02/01/2022	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	12/01/2022	AA.1219a	Member Advisory Committee	Medi-Cal OneCare
Revised	12/07/2023	AA.1219a	Member Advisory Committee	Medi-Cal OneCare
Revised	03/01/2024	AA.1219a	Member Advisory Committee	Medi-Cal OneCare
Revised	09/01/2024	AA.1219a	Member Advisory Committee	Medi-Cal OneCare
Revised	05/01/2025	AA.1219a	Member Advisory Committee	Medi-Cal OneCare
Revised	09/01/2025	AA.1219a	Member Advisory Committee	Medi-Cal OneCare

1 IX. GLOSSARY
2

Term	Definition
Health Equity	The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
Member	A beneficiary enrolled in a CalOptima Health program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Social Drivers of Health (SDOH)	The environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk. Also known as Health Related Social Needs.
Threshold Language	<u>Medi-Cal</u> : The non-English threshold and concentration standard languages in which CalOptima Health is required to provide written translations of Member Information, as determined by DHCS. <u>OneCare</u> : A threshold language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program.

3



MEMBER ADVISORY COMMITTEE Member Application

Instructions: Please answer all questions. You may write or type your answers. If you have any questions regarding the application, call 1-714-347-5785.

Name: _____ Phone: _____
Address: _____ Cell: _____
City, State, ZIP: _____ Fax: _____
Email: _____

I hereby submit my application for the following Member Advisory Committee (MAC) member representative seats through 2028 and understand that I will be paid a ~~\$100~~50 stipend for each meeting I attend if I am chosen for one of the following seats:

- ☐ **OneCare Member or authorized family member representative**
- ☐ **Medi-Cal Member or authorized family member**

Current position (e.g., title, student, volunteer, retired, etc.): _____

1a. What is your direct or indirect experience working with the CalOptima Health population you wish to represent on the MAC?

1b. Include any relevant community experience.

2a. What is your understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County?

2b. Include relevant experience related to working with diverse populations.

3. What is your current understanding of managed care systems and/or CalOptima Health?

4a. Please explain why you wish to serve on CalOptima Health's MAC.

4b. Please explain why you would be a qualified representative to serve on the MAC.

5. Please specify which of CalOptima Health's threshold languages you speak fluently:

☐ English ☐ Spanish ☐ Vietnamese ☐ Farsi ☐ Korean ☐ Chinese ☐ Arabic

6. If selected, are you able to commit to a monthly MAC meeting as well as serve on at least one subcommittee? ☐ Yes ☐ No

7. References (professional, community or personal):

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City, State, ZIP: _____	City, State, ZIP: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

Do you agree that you will advocate on behalf of all CalOptima Health members and/or providers during your service on the MAC? ☐ Yes ☐ No

If selected as a representative on MAC, do you agree that you will complete the required annual compliance courses within the appointed time frame? ☐ Yes ☐ No

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains and any further information submitted with it, such as biographical summaries and resumes, are public records, with the exception of your address, email address and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the board materials that are available on CalOptima Health's website and, even if not presented to the Board, will be available on request to members of the public.

Signature

Date

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal or OneCare is a private matter that may only be disclosed by CalOptima Health as necessary to administer the Medi-Cal or OneCare programs, unless other disclosures are authorized by the eligible member. Because the position of Consumer Representative on the Member Advisory Committee requires that the person appointed must be a member, the member's Medi-Cal eligibility will be disclosed to the general public. The member should check the box below and sign this waiver to allow his or her name to be nominated for the advisory committee.

- ☐ **ONECARE MEMBER OR AUTHORIZED FAMILY MEMBER APPLICANT**
- ☐ **MEDI-CAL MEMBER OR AUTHORIZED FAMILY MEMBER APPLICANT**

I understand that by signing below and applying to serve on the MAC, I am disclosing my eligibility for the Medi-Cal and OneCare programs, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.

Member (Printed Name)

Member (Signature)

Date

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Federal HIPAA Privacy Regulations require that you complete this form to authorize CalOptima Health to use or disclose your protected health information (PHI) to another person or organization. Please complete, sign and return the form to CalOptima Health.

Date of Request: _____ Phone: _____
Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima Health, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific):

Medi-Cal or OneCare beneficiary status and any information member chooses to disclose in connection with his or her application for appointment to the CalOptima Health's Member Advisory Committee (MAC).

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow service as beneficiary representative on the CalOptima Health's Member Advisory Committee (MAC).**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the applied-for position.**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

Attn Cheryl Simmons
Office of the Clerk of the Board
CalOptima Health
505 City Parkway West
Orange CA 92868

I understand that a revocation will not affect the ability of CalOptima Health or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

***** Revocation of this authorization will immediately terminate involvement in the MAC.***

RESTRICTIONS:

I understand that certain information (e.g. Medi-Cal or OneCare beneficiary status and name) used or disclosed as a result of my signing this authorization may be further used or disclosed in accordance with the California Public Records Act. Information precluded from the Public Records Act maintained by CalOptima Health will not be used or disclosed unless another authorization is obtained from me or unless such use or disclosure is specifically permitted or required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Submit the completed application, your biography or resume, and signed authorization forms to:

Attn Cheryl Simmons
Office of the Clerk of the Board
CalOptima Health
505 City Parkway West
Orange CA 92868

For questions, call **1-714-347-5785**



MEMBER ADVISORY COMMITTEE Member Application

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Name: _____ Phone: _____
Address: _____ Cell: _____
City, State, ZIP: _____ Fax: _____
Email: _____

I hereby submit my application for the following Member Advisory Committee (MAC) member representative seats through 2028 and understand that I will be paid a \$100 stipend for each meeting I attend if I am chosen for one of the following seats:

- ☐ **OneCare Member or authorized family member representative**
- ☐ **Medi-Cal Member or authorized family member**

Current position (e.g., title, student, volunteer, retired, etc.): _____

1a. What is your direct or indirect experience working with the CalOptima Health population you wish to represent on the MAC?

1b. Include any relevant community experience.

2a. What is your understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County?

2b. Include relevant experience related to working with diverse populations.

3. What is your current understanding of managed care systems and/or CalOptima Health?

4a. Please explain why you wish to serve on CalOptima Health's MAC.

4b. Please explain why you would be a qualified representative to serve on the MAC.

5. Please specify which of CalOptima Health's threshold languages you speak fluently:

☐ English ☐ Spanish ☐ Vietnamese ☐ Farsi ☐ Korean ☐ Chinese ☐ Arabic

6. If selected, are you able to commit to a monthly MAC meeting as well as serve on at least one subcommittee? ☐ Yes ☐ No

7. References (professional, community or personal):

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City, State, ZIP: _____	City, State, ZIP: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

Do you agree that you will advocate on behalf of all CalOptima Health members and/or providers during your service on the MAC? ☐ Yes ☐ No

If selected as a representative on MAC, do you agree that you will complete the required annual compliance courses within the appointed time frame? ☐ Yes ☐ No

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains and any further information submitted with it, such as biographical summaries and resumes, are public records, with the exception of your address, email address and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the board materials that are available on CalOptima Health's website and, even if not presented to the Board, will be available on request to members of the public.

Signature

Date

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal or OneCare is a private matter that may only be disclosed by CalOptima Health as necessary to administer the Medi-Cal or OneCare programs, unless other disclosures are authorized by the eligible member. Because the position of Consumer Representative on the Member Advisory Committee requires that the person appointed must be a member, the member's Medi-Cal eligibility will be disclosed to the general public. The member should check the box below and sign this waiver to allow his or her name to be nominated for the advisory committee.

- ☐ **ONECARE MEMBER OR AUTHORIZED FAMILY MEMBER APPLICANT**
- ☐ **MEDI-CAL MEMBER OR AUTHORIZED FAMILY MEMBER APPLICANT**

I understand that by signing below and applying to serve on the MAC, I am disclosing my eligibility for the Medi-Cal and OneCare programs, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.

Member (Printed Name)

Member (Signature)

Date

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Federal HIPAA Privacy Regulations require that you complete this form to authorize CalOptima Health to use or disclose your protected health information (PHI) to another person or organization. Please complete, sign and return the form to CalOptima Health.

Date of Request: _____ Phone: _____
Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima Health, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific):

Medi-Cal or OneCare beneficiary status and any information member chooses to disclose in connection with his or her application for appointment to the CalOptima Health's Member Advisory Committee (MAC).

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow service as beneficiary representative on the CalOptima Health's Member Advisory Committee (MAC).**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the applied-for position.**

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Attn Cheryl Simmons
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CalOptima Health
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Orange CA 92868

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***** Revocation of this authorization will immediately terminate involvement in the MAC.***

RESTRICTIONS:

I understand that certain information (e.g. Medi-Cal or OneCare beneficiary status and name) used or disclosed as a result of my signing this authorization may be further used or disclosed in accordance with the California Public Records Act. Information precluded from the Public Records Act maintained by CalOptima Health will not be used or disclosed unless another authorization is obtained from me or unless such use or disclosure is specifically permitted or required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Submit the completed application, your biography or resume, and signed authorization forms to:

Attn Cheryl Simmons
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CalOptima Health
505 City Parkway West
Orange CA 92868

For questions, call **1-714-347-5785**



MEMBER ADVISORY COMMITTEE APPLICATION

Instructions: Please answer all questions. You may write or type your answers. Please use a separate sheet if necessary. If you have any questions regarding the application, please call Cheryl Simmons at 714-347-5785.

Name: _____ Work Phone: _____
Address: _____ Cell Phone: _____
City, State, ZIP: _____ Fax: _____
Email: _____ Date: _____

I hereby submit my application for the following Member Advisory Committee (MAC) seat(s) with a term beginning upon appointment by the Board of Directors through June 30, 2028) and I understand that service on the MAC is on a voluntary basis:

- ☐ **Foster Children**
☐ **Member Advocate**

Current position and tenure (i.e., employee, student, volunteer, retired, agency).

Education and/or licenses (if applicable):

What is your direct or indirect experience working with the CalOptima Health population you wish to represent on MAC? Please include any relevant community experience.

Explain your ability and specific plan to reach out for input and communicate with the CalOptima Health population you would represent on the MAC (i.e., primary professional/trade association(s), stakeholder involvement, etc.)

Please list similar committees on which you have served or describe your ability to collaborate in a multidisciplinary way.

What is your understanding, experience, and familiarity with the diverse cultural community in Orange County?

What is your current understanding and experience with CalOptima Health programs?

Please explain why you wish to serve on the MAC and how you might uniquely contribute to this advisory committee on behalf of all CalOptima Health members.

Please specify which of CalOptima Health's threshold languages you speak fluently:

☐ English ☐ Spanish ☐ Vietnamese ☐ Farsi ☐ Korean ☐ Chinese ☐ Arabic

Include a biography or résumé and two references (below) with this application. **Submitting letters of recommendation from your references is preferred but not required.**

- 1) Professional
- 2) Community or Personal

Name: _____

Relationship: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Email: _____

Name: _____

Relationship: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Email: _____

If selected, are you able to commit to attend all regularly scheduled bi-monthly MAC meetings and volunteer to serve on at least one subcommittee? ☐ Yes ☐ No

Do you agree that you will advocate on behalf of all CalOptima Health members and/or providers during your service on the MAC? ☐ Yes ☐ No

If selected as a representative on MAC, do you agree that you will complete the required annual compliance courses within the appointed timeframe? ☐ Yes ☐ No

All Member Advisory Committee Representatives are appointed by the CalOptima Health Board of Directors and are subject to the CalOptima Health Code of Conduct.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published with the contact information removed, as part of the Board materials that are available on CalOptima Health's website, and even if not presented to the Board, will be available on request to members of the public.

Signature

Date

Submit this application, along with a biography or résumé and the preferred but optional letters of recommendation to:

Attn Cheryl Simmons
Office of the Clerk of the Board
CalOptima Health
505 City Parkway West
Orange CA 92868

Phone: 714-347-5785 Fax: 714-571-2479 Email: csimmons@caloptima.org



Applicant Name:

Member Advisory Committee

Position Applying for:

Applicant Evaluation Tool (use one per applicant)

Please rate questions 1 through 5 based on how well the applicant satisfies the following statements where:

5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

<u>Criteria for Nomination Consideration and Point Scale</u>	<u>Possible Points</u>	<u>Awarded Points</u>
1a. Direct or indirect experience working with members the applicant wishes to represent	1–5	
1b. Include relevant community involvement	1–5	
2a. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	
2b. Include relevant experience with diverse populations	1–5	
3. Knowledge of managed care systems and/or CalOptima programs	1–5	
4a. Expressed desire to serve on the MAC	1–5	
4b. Explanation why applicant is a qualified representative	1–5	
5. Ability to speak one of the threshold languages (other than English)	Yes/No	
6. Availability and willingness to attend meetings	Yes/No	
7. Supportive references	Yes/No	

Total Possible Points 35

Name of MAC Evaluator
Total Points Awarded _____

Total Points Awarded _____

MAC Position Description

Behavioral/Mental Health Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health members with behavioral/mental health needs such as:
 - Enhanced Care Management Behavioral Providers
 - Licensed Clinical Social Worker (LCSW)
 - Marriage and Family Therapist (MFT)
 - Mental Health Facility or Hospital Psychiatric Facility
 - Non-Specialty Mental Health Services
 - Psychologists
 - Psychiatrist
 - Registered Psychiatric Nurse (Psych RN)
 - Multi-Specialty Clinics/Group Practice
 - Community Mental Health Center
 - Board Certified Behavior Analyst-D (BCBA-D)
 - Community Based Organization; Peers, Community Health Workers, Wellness Coaches, etc.
- Knowledge of CalOptima Health managed care systems and programs
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Children Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health Medi-Cal children in pursuit of their health and wellness
- Knowledge of CalOptima Health managed care systems and programs
- Minimum three years of experience directly representing CalOptima Health members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Dental Provider Representative - New Seat

Position Descriptions

- Current experience as a Medi-Cal dental provider to collaborate with, and ability to reach out, seek input and advocate for CalOptima Health members in pursuit of their health and wellness
- Knowledge of CalOptima Health managed care systems and programs
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Developmental Disabilities Representative

Position Description

- Current experience working at either the Regional Center or State Council on Developmental Disabilities, with the ability to reach out, seek input and advocate for CalOptima Health persons with Intellectual And Developmental Disabilities (IDD) in pursuit of their health and wellness
- Knowledge of CalOptima Health managed care systems and programs
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Family/Caregiver Support Representative

Position Description

- Current experience in a community-based organization collaborating with, and ability to reach out and seek input and advocate for CalOptima Health families in pursuit of their health and wellness
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Foster Children Representative

Position Description

- Current experience as a foster care provider, former foster youth and/or parents of current/former foster youths, with the ability to collaborate with, and ability to reach out, seek input and advocate for CalOptima Health foster children in pursuit of their health and wellness
- Knowledge of CalOptima Health managed care systems and programs
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Local Education Agency – New Seat

Position Description

- Current experience working in a school district to collaborate with, and ability to reach out, seek input and advocate for CalOptima Health members in a school setting in pursuit of student's health and wellness
- Knowledge of CalOptima Health managed care systems and programs
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Member Advocate Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health members in pursuit of their health and wellness
- Knowledge of CalOptima Health managed care systems and programs
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Medi-Cal Beneficiaries or Authorized Family Member Representative – (Four seats)

Position Description

- Must be a current CalOptima Health Medi-Cal member or authorized family member with current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health Medi-Cal beneficiaries
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Knowledge of CalOptima Health managed care systems and programs
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks
- Eligible for a \$100 stipend

OneCare Member or Authorized Family Member Representative (Four seats)

Position Description

- Must be a current CalOptima Health OneCare member or authorized family member
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Knowledge of CalOptima Health managed care systems and programs
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks
- Eligible for a \$100 stipend

Persons with Disabilities Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health persons with disabilities in pursuit of their health and wellness including but not limited to:
 - CalAIM
 - Home and Community Based Services (HCBS)
 - Long-Term Services and Supports (LTSS)
- Candidate should represent an organization that does advocacy work on behalf of persons with disabilities with either direct medical or non-medical services for Medi-Cal members of all ages
- Knowledge of CalOptima Health managed care systems and programs
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings

- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Recipients of CalWORKs Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health CalWORKs members in pursuit of their health and wellness, including social determinants like housing instability and language access
- Knowledge of CalOptima Health managed care systems and programs
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings and actively contribute
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Seniors Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input, and advocate for CalOptima Health seniors including, but not limited to:
 - Community Based Adult Services (CBAS) Centers
 - Community-Based Organization (CBO)
 - Senior centers
 - Long-Term Services and Supports
 - In-Home Supportive Services
 - Home and Community Based Services (HCBS)
- Knowledge of CalOptima Health managed care systems and programs
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings and actively contribute
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Social Services Representative (Standing Seat)

Position Description

- Represents CalOptima Health members and is appointed by the Orange County Social Services Agency as the safety net provider for CalOptima Health members
- No term limits
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

MAC Chair

Position Description

- Availability and willingness to attend regular and special MAC meetings
- Facilitate all MAC meetings using standard meeting rules of order
- Demonstrate leadership and openness, enabling meeting attendees to achieve preset meeting goals
- Liaison between MAC and the Board of Directors
- Provides MAC Report to CalOptima Health Board of Directors' meetings
- Two-year term
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

MAC Vice-Chair

Position Description

- Availability and willingness to attend regular and special MAC meetings
- Facilitate in absence of the MAC Chair all MAC meetings using standard meeting rules of order
- Demonstrate leadership and openness, enabling meeting attendees to achieve preset meeting goals
- Liaison in absence of the MAC Chair between MAC and the Board of Directors
- Provide MAC Report to CalOptima Health Board of Directors' at meetings when MAC Chair is unavailable
- Two-year term
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

MAC Position Description

Behavioral/Mental Health Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health members with behavioral/mental health needs such as:
 - Enhanced Care Management Behavioral Providers
 - Licensed Clinical Social Worker (LCSW)
 - Marriage and Family Therapist (MFT)
 - Mental Health Facility or Hospital Psychiatric Facility
 - Non-Specialty Mental Health Services
 - Psychologists
 - Psychiatrist
 - Registered Psychiatric Nurse (Psych RN)
 - Multi-Specialty Clinics/Group Practice
 - Community Mental Health Center
 - Board Certified Behavior Analyst-D (BCBA-D)
 - Community Based Organization; Peers, Community Health Workers, Wellness Coaches, etc.
- Knowledge of CalOptima Health managed care systems and programs
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Children Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health Medi-Cal children in pursuit of their health and wellness
- Knowledge of CalOptima Health managed care systems and programs
- Minimum three years of experience directly representing CalOptima Health members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Dental Provider Representative - New Seat

Position Descriptions

- Current experience as a Medi-Cal dental provider to collaborate with, and ability to reach out, seek input and advocate for CalOptima Health members in pursuit of their health and wellness
- Knowledge of CalOptima Health managed care systems and programs
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Developmental Disabilities Representative

Position Description

- Current experience working at either the Regional Center or State Council on Developmental Disabilities, with the ability to reach out, seek input and advocate for CalOptima Health persons with Intellectual And Developmental Disabilities (IDD) in pursuit of their health and wellness
- Knowledge of CalOptima Health managed care systems and programs
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Family/Caregiver Support Representative

Position Description

- Current experience in a community-based organization collaborating with, and ability to reach out and seek input and advocate for CalOptima Health families in pursuit of their health and wellness
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Foster Children Representative

Position Description

- Current experience as a foster care provider, former foster youth and/or parents of current/former foster youths, with the ability to collaborate with, and ability to reach out, seek input and advocate for CalOptima Health foster children in pursuit of their health and wellness
- Knowledge of CalOptima Health managed care systems and programs
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Local Education Agency – New Seat

Position Description

- Current experience working in a school district to collaborate with, and ability to reach out, seek input and advocate for CalOptima Health members in a school setting in pursuit of student's health and wellness
- Knowledge of CalOptima Health managed care systems and programs
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Member Advocate Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health members in pursuit of their health and wellness
- Knowledge of CalOptima Health managed care systems and programs
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Medi-Cal Beneficiaries or Authorized Family Member Representative – (Four seats)

Position Description

- Must be a current CalOptima Health Medi-Cal member or authorized family member with current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health Medi-Cal beneficiaries
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Knowledge of CalOptima Health managed care systems and programs
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks
- Eligible for a [\\$100 stipend](#)

Commented [HD1]: Should this be 100?

OneCare Member or Authorized Family Member Representative (Four seats)

Position Description

- Must be a current CalOptima Health OneCare member or authorized family member
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Knowledge of CalOptima Health managed care systems and programs
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks
- Eligible for a [\\$100 stipend](#)

Commented [HD2]: Should this be 100?

Persons with Disabilities Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health persons with disabilities in pursuit of their health and wellness including but not limited to:
 - CalAIM
 - Home and Community Based Services (HCBS)
 - Long-Term Services and Supports (LTSS)
- Candidate should represent an organization that does advocacy work on behalf of persons with disabilities with either direct medical or non-medical services for Medi-Cal members of all ages
- Knowledge of CalOptima Health managed care systems and programs
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings

- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Recipients of CalWORKs Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Health CalWORKs members in pursuit of their health and wellness, including social determinants like housing instability and language access
- Knowledge of CalOptima Health managed care systems and programs
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings and actively contribute
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Seniors Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input, and advocate for CalOptima Health seniors including, but not limited to:
 - Community Based Adult Services (CBAS) Centers
 - Community-Based Organization (CBO)
 - Senior centers
 - Long-Term Services and Supports
 - In-Home Supportive Services
 - Home and Community Based Services (HCBS)
- Knowledge of CalOptima Health managed care systems and programs
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings and actively contribute
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

Social Services Representative (Standing Seat)

Position Description

- Represents CalOptima Health members and is appointed by the Orange County Social Services Agency as the safety net provider for CalOptima Health members
- No term limits
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County including Limited English Proficiency, Black, Indigenous and People of Color, LGBTQ+ and other underserved members
- Availability and willingness to attend regular, special, and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

MAC Chair

Position Description

- Availability and willingness to attend regular and special MAC meetings
- Facilitate all MAC meetings using standard meeting rules of order
- Demonstrate leadership and openness, enabling meeting attendees to achieve preset meeting goals
- Liaison between MAC and the Board of Directors
- Provides MAC Report to CalOptima Health Board of Directors' meetings
- Two-year term
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

MAC Vice-Chair

Position Description

- Availability and willingness to attend regular and special MAC meetings
- Facilitate in absence of the MAC Chair all MAC meetings using standard meeting rules of order
- Demonstrate leadership and openness, enabling meeting attendees to achieve preset meeting goals
- Liaison in absence of the MAC Chair between MAC and the Board of Directors
- Provide MAC Report to CalOptima Health Board of Directors' at meetings when MAC Chair is unavailable
- Two-year term
- All appointments to the committee will be appointed by the CalOptima Health Board and are subject to OIG/GSA verification and possible background checks

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2025

Regular Meeting of the CalOptima Health Board of Directors

Consent Calendar

15. Increase Stipend Amount for Members or Authorized Family Members on the CalOptima Health Whole-Child Model Family Advisory Committee

Contacts

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

Recommended Actions

Authorize a stipend increase for Whole-Child Model Family Advisory Committee member or authorized family member representatives from \$50 to \$100 per meeting attended, including mileage for in-person attendance with an option to receive the stipend as a check or gift card.

Background

Senate Bill 586 (SB 586) was signed into law on September 25, 2016, and authorized the establishment of the Whole-Child Model (WCM), 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 CalOptima Health Board of Directors (Board) established the Whole-Child Model Family Advisory Committee (WCM FAC) by resolution on November 2, 2017, to report and provide input and recommendations to the CalOptima Health Board relative to the WCM program.

The WCM FAC is comprised of 11 voting members, nine of whom are designated as family representatives and two of whom are designated as community seats representing the interests of children receiving CCS services. While two of the WCM FAC's 11 seats are designated as community seats, WCM FAC candidates representing the community may be considered for up to two additional WCM FAC seats if there are not enough family representative candidates to fill the nine designated seats.

Discussion

CalOptima Health conducted research on member stipends offered by other health plans across California and found that all plans surveyed provided a \$100 stipend either as a check or gift card to members or their authorized family members that serve on health plan committees.

Fiscal Impact

The recommended action increases the stipend amount from \$50 to \$100 per committee meeting attended for each member or family representative on the WCM FAC. The total annual increase is \$1,400. The CalOptima Health Fiscal Year 2025-26 Operating Budget for the stipends is sufficient to cover this increase.

Rationale for Recommendation

As outlined in Policy AA.1271: Whole-Child Model Family Advisory Committee Policy, WCM FAC the members or their authorized family members serving on the committee will receive a stipend for each meeting attended. Increasing the stipend enhances recruitment efforts and offering a choice between a check or gift card better supports member preferences.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. [AA.1271 Whole-Child Model Family Advisory Committee Policy](#)

/s/ Michael Hunn
Authorized Signature

09/25/2025
Date

Policy: AA.1271
 Title: **Whole-Child Model Family Advisory Committee**
 Department: Executive Office
 Section: Office of the Clerk of the Board

CEO Approval: /s/

Effective Date: 06/07/2018

Revised Date: 09/01/2025

Applicable to:

- ☒ Administrative
- ☐ Covered California [Effective 2027]
- ☒ Medi-Cal
- ☐ OneCare
- ☐ PACE

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for the Whole-Child Model (WCM) program and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole-Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima Health's Board of Directors (Board), the WCM FAC shall report to the CalOptima Health Quality Assurance Committee (QAC) and shall provide advice and recommendations to the CalOptima Health Board and CalOptima Health staff in regard to California Children's Services (CCS) provided by CalOptima Health Medi-Cal's implementation of the WCM program and relevant policies and procedures affecting quality and Health Equity updates. CalOptima Health shall inform WCM FAC members how their input was incorporated.

B. CalOptima Health shall ensure that WCM FAC meetings are accessible to all participants and provide appropriate accommodations allowing attendees to effectively communicate and participate in WCM FAC meetings including providing translation and interpretation services, providing accessibility for individuals with a disability or Limited English Proficiency (LEP), providing transportation to WCM FAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest WCM FAC member participation possible.

~~B.C.~~ CalOptima Health's Board encourages Member and community involvement in CalOptima Health programs.

~~C.D.~~ CalOptima Health shall designate a staff member and maintain a written job description detailing the staff member's responsibilities, which include the responsibility to manage the operations of the WCM FAC in compliance with all statutory, regulatory, and contractual requirements.

~~D.E.~~ WCM FAC Members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima Health's conflict of interest code and, in accordance with CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments.

1 E.F. CalOptima Health shall provide timely reporting of information pertaining to the WCM FAC as
2 requested by the Department of Health Care Services (DHCS).
3

4 F.G. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the
5 health care consumers within the Whole-Child Model population. WCM FAC members shall have
6 direct or indirect contact with CalOptima Health Members.
7

8 G.H. An organization may have no more than one (1) employee or representative on the WCM FAC at
9 any one time.
10

11 H.I. An individual may participate in no more than one (1) CalOptima Health Advisory Committee at
12 any one time.
13

14 I.J. In accordance with CalOptima Health Board Resolution No. 17-1102-01, the WCM FAC shall be
15 comprised of eleven (11) voting members representing CCS family members, as well as consumer
16 advocates representing CCS families. Except as noted below, each voting member shall serve a two
17 (2) year term with no limits on the number of terms a representative may serve.
18

- 19 1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following
20 categories, with a priority to family representatives (i.e., if qualifying family representative
21 candidates are available, all nine (9) seats will be filled by family representatives):
22
 - 23 a. Authorized representatives, including parents, foster parents, and caregivers, of a
24 CalOptima Health Member who is a current recipient of CCS services;
25
 - 26 b. CalOptima Health Members eighteen (18) to twenty-one (21) years of age who are current
27 recipients of CCS services; or
28
 - 29 c. Current CalOptima Health Members over the age of twenty-one (21) who transitioned from
30 CCS services.
31
- 32 2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services,
33 including:
34
 - 35 a. Community-based organizations; or
36
 - 37 b. Consumer advocates.
38
- 39 3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based
40 organizations or consumer advocates, an additional two (2) WCM FAC candidates representing
41 these groups may be considered for these seats in the event that there are not sufficient family
42 representative candidates to fill the family member seats.
43
- 44 4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC
45 Member or family member representative.
46
- 47 5. The WCM FAC shall carry out the duties in accordance with DHCS contract requirements.
48 Duties include, but are not limited to:
49
 - 50 a. Identifying and advocating for preventive care practices to be utilized by CalOptima Health;
51

- 1 b. Involvement in developing and updating cultural and linguistic policy and procedure
2 decisions including those related to Quality Improvement (QI), education, and operational
3 and cultural competency issues affecting Members who speak a primary language other
4 than English. The WCM FAC may also advise on necessary Member or Provider targeted
5 services, programs, and trainings;
6
7 c. Providing and making recommendations to CalOptima Health regarding the cultural
8 appropriateness of communications, partnerships, and services;
9
10 d. Reviewing Population Needs Assessment (PNA) findings and maintaining a process to
11 discuss improvement opportunities with an emphasis on Health Equity and Social Drivers
12 of Health (SDOH); and
13
14 e. Providing input and advice including, but not limited to, the following:
15
16 i. Culturally appropriate service or program design;
17
18 ii. Priorities for the health education and outreach program;
19
20 iii. Member satisfaction survey results;
21
22 iv. Findings of the PNA;
23
24 v. Plan marketing materials and campaigns;
25
26 vi. Communication of needs for network development and assessment;
27
28 vii. Community resources and information;
29
30 viii. Population Health Management (PHM);
31
32 ix. Quality;
33
34 x. Health delivery systems reforms to improve health outcomes;
35
36 xi. Carved out services;
37
38 xii. Coordination of care;
39
40 xiii. Health Equity;
41
42 xiv. Accessibility of services; and
43
44 xv. Grievance and Appeals.
45
46 6. CalOptima Health shall allow its WCM FAC to provide input on selecting targeted health
47 education, cultural and linguistic, and QI strategies, provide sufficient resources for the WCM
48 FAC to support the required WCM FAC activities outlined above, including supporting the
49 WCM FAC in engagement strategies such as consumer listening sessions, focus groups, and/or
50 surveys.
51

7. CalOptima Health shall provide a location for WCM FAC meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting accessible to all participants and providing accommodations to allow all individuals to attend and participate in the meetings.
8. CalOptima Health shall draft written minutes of each of its meetings and the associated discussions. All minutes shall be posted on CalOptima Health's website and submitted to DHCS no later than forty-five (45) calendar days after each meeting.
9. CalOptima Health shall retain the minutes for no less than ten (10) years and provide to DHCS, upon request.
10. CalOptima Health shall support the WCM FAC members in their roles on the WCM FAC, including but not limited to providing resources to educate WCM FAC members to ensure they are able to effectively participate in WCM FAC meetings, providing transportation to WCM FAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest WCM FAC member participation possible.
11. A family representative, in accordance with Section II.H.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group. CalOptima Health shall reimburse eligible expenses associated with attending the statewide stakeholder advisory group quarterly meetings in accordance with CalOptima Health Policy GA.5004: Travel and Other Reimbursable Expenses.

J.K. Stipends

1. CalOptima Health may provide a reasonable per-diem payment of up to ~~fifty~~one-hundred dollars (\$~~50~~100) per meeting to a Member or family representative serving on the WCM FAC in the form of a check or a gift card. CalOptima Health shall maintain a log of each payment provided to the Member or family representative, including type and value, and shall provide such log to DHCS upon request.
2. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

K.L. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this policy.

L.M. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.
2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.
 - a. If there is no viable candidate among the applicants, CalOptima Health shall conduct recruitment, per Section III.B.2 of this Policy.
 - b. Every effort will be made to replace the vacant seat within sixty (60) calendar days from the date the seat is vacated.

3. A new WCM FAC member appointed to fill a mid-term vacancy shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

~~M.N.~~ On a bi-annual basis, WCM FAC shall select a Chair and Vice-Chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the Chair and Vice-Chair shall be conducted in accordance with Sections III.B-D of this policy.

1. The WCM FAC Chair and Vice-Chair may serve one (1) two (2) year term.

2. The WCM FAC Chair and/or Vice-Chair may be removed by a majority vote of CalOptima Health's Board.

~~N.O.~~ The WCM FAC Chair or Vice-Chair shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

a. Review, evaluate and select a prospective Chair, Vice-Chair and a candidate for each of the open seats, in accordance with Section III.C-D of this policy; and

b. Forward the prospective slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended slate of candidate(s) shall be forwarded to CalOptima Health Board of Directors' QAC for review and approval of a recommendation to the Board.

~~O.P.~~ CalOptima Health Board of Directors' QAC shall recommend appointments, reappointments, and Chair and Vice-Chair appointments to the WCM FAC to the Board.

~~P.Q.~~ WCM FAC members shall attend all regularly scheduled meetings unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima Health staff prior to the meeting. CalOptima Health staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, for any request from a member of the public, the WCM FAC Chair, the Vice-Chair, the Chief Executive Officer, or the CalOptima Health Board, CalOptima Health staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC Chair or Vice-Chair shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. WCM FAC meetings shall be open to the public, in person or virtually. Meeting information shall be posted publicly on CalOptima Health's WCM FAC webpage thirty (30) calendar days prior to the meeting, and in no event later than seventy-two (72) hours prior to the meeting.
4. Members who attend the WCM FAC meeting are not bound by quorum and a majority of votes will carry a motion.

B. WCM FAC recruitment process

1. CalOptima Health shall begin recruitment of potential candidates in February of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima Health's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.
2. CalOptima Health shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:
 - a. Outreach to family representatives and community advocates that represent children receiving CCS;
 - b. Placement of vacancy notices on the CalOptima Health website; and/or
 - c. Outreach to community stakeholders
3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima Health.
4. During the WCM FAC meeting held before June 30 of a recruitment year for the Chair and Vice-Chair, the current Chair or Vice-Chair shall inquire of its membership whether there are interested candidates who wish to be considered as a Chair or Vice-Chair for the upcoming fiscal year. The candidates are requested to submit a letter of interest for these positions.

C. WCM FAC nomination evaluation process

1. The WCM FAC Chair or Vice-Chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nomination's ad hoc subcommittee.
 - a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.
2. Prior to WCM FAC nomination ad hoc subcommittee meeting:
 - a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.
 - b. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

- 1 3. The ad hoc subcommittee shall convene to discuss and select a candidate for each of the
2 expiring seats by using the findings from the applicant evaluation tool, the attendance record if
3 relevant and the prospective candidate's references.
4

5 D. WCM FAC selection and approval process for WCM FAC candidates:
6

- 7 1. The nomination ad hoc subcommittee shall forward its recommendation for the slate of
8 candidates to WCM FAC for review and approval. Candidates interested in the Chair and Vice-
9 Chair positions shall submit a letter of interest to the Staff to the Advisory Committees
10 indicating their interest in the Chair and the Vice-Chair seats.
11
12 2. Chair and Vice-Chair candidates will be reviewed at the first WCM FAC meeting of the fiscal
13 year and the members will vote on their candidate of choice for both positions. Candidates must
14 have a quorum of members approving their recommendation in order to be submitted to the
15 Board for appointment. Following WCM FAC's approval the proposed Chair, Vice-Chair shall
16 be submitted to CalOptima Health's Board of Directors' QAC for a recommendation and then
17 sent to the Board of Directors for approval. If the Chair is no longer able to serve on the WCM
18 FAC, the Vice-Chair will automatically assume the Chair seat and will be recommended to the
19 QAC who will send the recommendation to the CalOptima Health Board to finalize the
20 appointment by the Board at an upcoming meeting and a Vice-Chair will be recruited among
21 the members to fulfill the remaining term.
22
23 3. The WCM FAC members' terms shall be effective upon final approval by the CalOptima
24 Health Board.
25
26 a. In the case of a selected candidate filling a seat that was vacated mid-term, the new
27 candidate shall attend the next WCM FAC meeting.
28
29 4. WCM FAC members shall attend a new advisory committee member orientation.
30

- 31 E. CalOptima Health shall complete and submit to DHCS an annual WCM FAC member demographic
32 report by April 1 of each year.
33

34 **IV. ATTACHMENT(S)**
35

- 36 A. Whole Child Model Family Advisory Committee Member Application
37 B. Whole Child Model Family Advisory Committee Member Application Cover Letter
38 C. Whole Child Model Family Advisory Committee Member Evaluation Form
39 D. Whole Child Model Family Advisory Committee Community Application
40 E. Whole Child Model Family Advisory Committee Community Application Cover Letter
41 F. Whole Child Model Family Advisory Committee Community Evaluation Form
42

43 **V. REFERENCE(S)**
44

- 45 A. CalOptima Health Board Resolution 17-1102-01
46 B. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
47 C. CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments
48 D. CalOptima Health Policy GA.5004: Travel and Other Reimbursable Expenses
49 E. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015: California Children's
50 Services Whole Child Model Program (Supersedes APL 23-034)

- F. Department of Health Care Services (DHCS) County California Children's Services (CCS)
Numbered Letter (NL) 10-1224: California Children's Services Program Whole Child Model
(Supersedes NL 12-1223)
- G. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
09/07/2018	Department of Health Care Services (DHCS)	Approved as Submitted
07/19/2019	Department of Health Care Services (DHCS)	Approved as Submitted
06/27/2023	Department of Health Care Services (DHCS)	Approved as Submitted
06/27/2023	Department of Health Care Services (DHCS)	File & Use
03/07/2024	Department of Health Care Services (DHCS)	File & Use
09/05/2024	Department of Health Care Services (DHCS)	File & Use
08/11/2025	Department of Health Care Services (DHCS)	File & Use

VII. BOARD ACTION(S)

Date	Meeting
11/02/2017	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
05/02/2019	Regular Meeting of the CalOptima Board of Directors
08/06/2020	Regular Meeting of the CalOptima Board of Directors
12/01/2022	Regular Meeting of the CalOptima Health Board of Directors
04/06/2023	Regular Meeting of the CalOptima Health Board of Directors
<u>10/02/2025</u>	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Title	Program(s)
Effective	06/07/2018	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	05/02/2019	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	08/06/2020	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	12/01/2022	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	04/06/2023	AA.1271	Whole-Child Model Family Advisory Committee	Medi-Cal Administrative
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Action	Date	Policy	Title	Program(s)
Revised	<u>09/01/2025</u>	AA.1271	Whole-Child Model Family Advisory Committee	Administrative Medi-Cal

For 20251002 BOD Review Only

1 IX. GLOSSARY

2

Term	Definition
California Children's Services (CCS) Program	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
Health Equity	The reduction or elimination of Health Disparities, Health Inequities, or other disparities in health that adversely affect vulnerable populations.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Health Medi-Cal Program receiving California Children's Services through the Whole-Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima Health, which was established by CalOptima Health to advise its Board of Directors on issues impacting Members.
Social Drivers of Health (SDOH)	The environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risk. Also known as Health Related Social Needs.
Threshold Languages	The non-English threshold and concentration standard languages in which Contractor is required to provide written translations of Member Information, as determined by DHCS.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions.

3

For 20251002

Policy: AA.1271
 Title: **Whole-Child Model Family Advisory Committee**
 Department: Executive Office
 Section: Office of the Clerk of the Board

CEO Approval: /s/

Effective Date: 06/07/2018

Revised Date: 09/01/2025

Applicable to: ☒ Administrative
☐ Covered California [Effective 2027]
☒ Medi-Cal
☐ OneCare
☐ PACE

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for the Whole-Child Model (WCM) program and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole-Child Model Family Advisory Committee (WCM FAC).

II. POLICY

- A. As directed by CalOptima Health's Board of Directors (Board), the WCM FAC shall report to the CalOptima Health Quality Assurance Committee (QAC) and shall provide advice and recommendations to the CalOptima Health Board and CalOptima Health staff in regard to California Children's Services (CCS) provided by CalOptima Health Medi-Cal's implementation of the WCM program and relevant policies and procedures affecting quality and Health Equity updates. CalOptima Health shall inform WCM FAC members how their input was incorporated.
- B. CalOptima Health shall ensure that WCM FAC meetings are accessible to all participants and provide appropriate accommodations allowing attendees to effectively communicate and participate in WCM FAC meetings including providing translation and interpretation services, providing accessibility for individuals with a disability or Limited English Proficiency (LEP), providing transportation to WCM FAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest WCM FAC member participation possible.
- C. CalOptima Health's Board encourages Member and community involvement in CalOptima Health programs.
- D. CalOptima Health shall designate a staff member and maintain a written job description detailing the staff member's responsibilities, which include the responsibility to manage the operations of the WCM FAC in compliance with all statutory, regulatory, and contractual requirements.
- E. WCM FAC Members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima Health's conflict of interest code and, in accordance with CalOptima Health Policy AA.1204: Gifts, Honoraria, and Travel Payments.

- 1 F. CalOptima Health shall provide timely reporting of information pertaining to the WCM FAC as
2 requested by the Department of Health Care Services (DHCS).
3
- 4 G. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health
5 care consumers within the Whole-Child Model population. WCM FAC members shall have direct
6 or indirect contact with CalOptima Health Members.
7
- 8 H. An organization may have no more than one (1) employee or representative on the WCM FAC at
9 any one time.
10
- 11 I. An individual may participate in no more than one (1) CalOptima Health Advisory Committee at
12 any one time.
13
- 14 J. In accordance with CalOptima Health Board Resolution No. 17-1102-01, the WCM FAC shall be
15 comprised of eleven (11) voting members representing CCS family members, as well as consumer
16 advocates representing CCS families. Except as noted below, each voting member shall serve a two
17 (2) year term with no limits on the number of terms a representative may serve.
18
- 19 1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following
20 categories, with a priority to family representatives (i.e., if qualifying family representative
21 candidates are available, all nine (9) seats will be filled by family representatives):
22
- 23 a. Authorized representatives, including parents, foster parents, and caregivers, of a
24 CalOptima Health Member who is a current recipient of CCS services;
25
- 26 b. CalOptima Health Members eighteen (18) to twenty-one (21) years of age who are current
27 recipients of CCS services; or
28
- 29 c. Current CalOptima Health Members over the age of twenty-one (21) who transitioned from
30 CCS services.
31
- 32 2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services,
33 including:
34
- 35 a. Community-based organizations; or
36
- 37 b. Consumer advocates.
38
- 39 3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based
40 organizations or consumer advocates, an additional two (2) WCM FAC candidates representing
41 these groups may be considered for these seats in the event that there are not sufficient family
42 representative candidates to fill the family member seats.
43
- 44 4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC
45 Member or family member representative.
46
- 47 5. The WCM FAC shall carry out the duties in accordance with DHCS contract requirements.
48 Duties include, but are not limited to:
49
- 50 a. Identifying and advocating for preventive care practices to be utilized by CalOptima Health;
51

- 1 b. Involvement in developing and updating cultural and linguistic policy and procedure
2 decisions including those related to Quality Improvement (QI), education, and operational
3 and cultural competency issues affecting Members who speak a primary language other
4 than English. The WCM FAC may also advise on necessary Member or Provider targeted
5 services, programs, and trainings;
6
7 c. Providing and making recommendations to CalOptima Health regarding the cultural
8 appropriateness of communications, partnerships, and services;
9
10 d. Reviewing Population Needs Assessment (PNA) findings and maintaining a process to
11 discuss improvement opportunities with an emphasis on Health Equity and Social Drivers
12 of Health (SDOH); and
13
14 e. Providing input and advice including, but not limited to, the following:
15
16 i. Culturally appropriate service or program design;
17
18 ii. Priorities for the health education and outreach program;
19
20 iii. Member satisfaction survey results;
21
22 iv. Findings of the PNA;
23
24 v. Plan marketing materials and campaigns;
25
26 vi. Communication of needs for network development and assessment;
27
28 vii. Community resources and information;
29
30 viii. Population Health Management (PHM);
31
32 ix. Quality;
33
34 x. Health delivery systems reforms to improve health outcomes;
35
36 xi. Carved out services;
37
38 xii. Coordination of care;
39
40 xiii. Health Equity;
41
42 xiv. Accessibility of services; and
43
44 xv. Grievance and Appeals.
45
46 6. CalOptima Health shall allow its WCM FAC to provide input on selecting targeted health
47 education, cultural and linguistic, and QI strategies, provide sufficient resources for the WCM
48 FAC to support the required WCM FAC activities outlined above, including supporting the
49 WCM FAC in engagement strategies such as consumer listening sessions, focus groups, and/or
50 surveys.
51

7. CalOptima Health shall provide a location for WCM FAC meetings and all necessary tools and materials to run meetings, including, but not limited to, making the meeting accessible to all participants and providing accommodations to allow all individuals to attend and participate in the meetings.
8. CalOptima Health shall draft written minutes of each of its meetings and the associated discussions. All minutes shall be posted on CalOptima Health's website and submitted to DHCS no later than forty-five (45) calendar days after each meeting.
9. CalOptima Health shall retain the minutes for no less than ten (10) years and provide to DHCS, upon request.
10. CalOptima Health shall support the WCM FAC members in their roles on the WCM FAC, including but not limited to providing resources to educate WCM FAC members to ensure they are able to effectively participate in WCM FAC meetings, providing transportation to WCM FAC meetings, arranging childcare as necessary, and scheduling meetings at times and in formats to ensure the highest WCM FAC member participation possible.
11. A family representative, in accordance with Section II.H.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group. CalOptima Health shall reimburse eligible expenses associated with attending the statewide stakeholder advisory group quarterly meetings in accordance with CalOptima Health Policy GA.5004: Travel and Other Reimbursable Expenses.

K. Stipends

1. CalOptima Health may provide a reasonable per-diem payment of up to one-hundred dollars (\$100) per meeting to a Member or family representative serving on the WCM FAC in the form of a check or a gift card. CalOptima Health shall maintain a log of each payment provided to the Member or family representative, including type and value, and shall provide such log to DHCS upon request.
2. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

L. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this policy.

M. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.
2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.
 - a. If there is no viable candidate among the applicants, CalOptima Health shall conduct recruitment, per Section III.B.2 of this Policy.
 - b. Every effort will be made to replace the vacant seat within sixty (60) calendar days from the date the seat is vacated.

- 1 3. A new WCM FAC member appointed to fill a mid-term vacancy shall serve the remainder of
2 the resigning member's term, which may be less than a full two (2) year term.
3
- 4 N. On a bi-annual basis, WCM FAC shall select a Chair and Vice-Chair from its membership to
5 coincide with the annual recruitment and nomination process. Candidate recruitment and selection
6 of the Chair and Vice-Chair shall be conducted in accordance with Sections III.B-D of this policy.
7
- 8 1. The WCM FAC Chair and Vice-Chair may serve one (1) two (2) year term.
9
- 10 2. The WCM FAC Chair and/or Vice-Chair may be removed by a majority vote of CalOptima
11 Health's Board.
12
- 13 O. The WCM FAC Chair or Vice-Chair shall ask for three (3) to four (4) members from the WCM
14 FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being
15 considered for reappointment cannot participate in the nomination ad hoc subcommittee.
16
- 17 1. The WCM FAC nomination ad hoc subcommittee shall:
18
- 19 a. Review, evaluate and select a prospective Chair, Vice-Chair and a candidate for each of the
20 open seats, in accordance with Section III.C-D of this policy; and
21
- 22 b. Forward the prospective slate of candidate(s) to the WCM FAC for review and approval.
23
- 24 2. Following approval from the WCM FAC, the recommended slate of candidate(s) shall be
25 forwarded to CalOptima Health Board of Directors' QAC for review and approval of a
26 recommendation to the Board.
27
- 28 P. CalOptima Health Board of Directors' QAC shall recommend appointments, reappointments, and
29 Chair and Vice-Chair appointments to the WCM FAC to the Board.
30
- 31 Q. WCM FAC members shall attend all regularly scheduled meetings unless they have an excused
32 absence. An absence shall be considered excused if a WCM FAC member provides notification of
33 an absence to CalOptima Health staff prior to the meeting. CalOptima Health staff shall maintain an
34 attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance
35 log is a public record, for any request from a member of the public, the WCM FAC Chair, the Vice-
36 Chair, the Chief Executive Officer, or the CalOptima Health Board, CalOptima Health staff shall
37 provide a copy of the attendance log to the requester. In addition, the WCM FAC Chair or Vice-
38 Chair shall contact any committee member who has three (3) consecutive unexcused absences.
39
- 40 1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.
41

42 **III. PROCEDURE**

43 **A. WCM FAC meeting frequency**

- 44
- 45 1. WCM FAC shall meet at least quarterly.
46
- 47 2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or
48 after January of each year.
49
- 50

3. WCM FAC meetings shall be open to the public, in person or virtually. Meeting information shall be posted publicly on CalOptima Health's WCM FAC webpage thirty (30) calendar days prior to the meeting, and in no event later than seventy-two (72) hours prior to the meeting.
4. Members who attend the WCM FAC meeting are not bound by quorum and a majority of votes will carry a motion.

B. WCM FAC recruitment process

1. CalOptima Health shall begin recruitment of potential candidates in February of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima Health's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.
2. CalOptima Health shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:
 - a. Outreach to family representatives and community advocates that represent children receiving CCS;
 - b. Placement of vacancy notices on the CalOptima Health website; and/or
 - c. Outreach to community stakeholders
3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima Health.
4. During the WCM FAC meeting held before June 30 of a recruitment year for the Chair and Vice-Chair, the current Chair or Vice-Chair shall inquire of its membership whether there are interested candidates who wish to be considered as a Chair or Vice-Chair for the upcoming fiscal year. The candidates are requested to submit a letter of interest for these positions.

C. WCM FAC nomination evaluation process

1. The WCM FAC Chair or Vice-Chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nomination's ad hoc subcommittee.
 - a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.
2. Prior to WCM FAC nomination ad hoc subcommittee meeting:
 - a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.
 - b. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

- 1 3. The ad hoc subcommittee shall convene to discuss and select a candidate for each of the
2 expiring seats by using the findings from the applicant evaluation tool, the attendance record if
3 relevant and the prospective candidate's references.
4

5 D. WCM FAC selection and approval process for WCM FAC candidates:
6

- 7 1. The nomination ad hoc subcommittee shall forward its recommendation for the slate of
8 candidates to WCM FAC for review and approval. Candidates interested in the Chair and Vice-
9 Chair positions shall submit a letter of interest to the Staff to the Advisory Committees
10 indicating their interest in the Chair and the Vice-Chair seats.
11
12 2. Chair and Vice-Chair candidates will be reviewed at the first WCM FAC meeting of the fiscal
13 year and the members will vote on their candidate of choice for both positions. Candidates must
14 have a quorum of members approving their recommendation in order to be submitted to the
15 Board for appointment. Following WCM FAC's approval the proposed Chair, Vice-Chair shall
16 be submitted to CalOptima Health's Board of Directors' QAC for a recommendation and then
17 sent to the Board of Directors for approval. If the Chair is no longer able to serve on the WCM
18 FAC, the Vice-Chair will automatically assume the Chair seat and will be recommended to the
19 QAC who will send the recommendation to the CalOptima Health Board to finalize the
20 appointment by the Board at an upcoming meeting and a Vice-Chair will be recruited among
21 the members to fulfill the remaining term.
22
23 3. The WCM FAC members' terms shall be effective upon final approval by the CalOptima
24 Health Board.
25
26 a. In the case of a selected candidate filling a seat that was vacated mid-term, the new
27 candidate shall attend the next WCM FAC meeting.
28
29 4. WCM FAC members shall attend a new advisory committee member orientation.
30

- 31 E. CalOptima Health shall complete and submit to DHCS an annual WCM FAC member demographic
32 report by April 1 of each year.
33

34 **IV. ATTACHMENT(S)**
35

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Revised	01/01/2025	AA.1271	Whole-Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	08/01/2025	AA.1271	Whole-Child Model Family Advisory Committee	Medi-Cal Administrative

Action	Date	Policy	Title	Program(s)
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1

For 20251002 BOD Review Only

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3

For 20251002



Whole-Child Model Family Advisory Committee Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a resume or biography listing your qualifications and include signed authorization forms. For questions, please call 714-347-5785.

Name: _____

Primary Phone: _____

Address: _____

Cell Phone: _____

City, State, ZIP: _____

Fax: _____

Date: _____

Email: _____

Please see the eligibility criteria below:*

- ☐ Authorized representatives, which includes parents, foster parents and caregivers, of a CalOptima Health member who is currently receiving CCS services;
- ☐ CalOptima Health members ages 18–21 who are currently receiving of CCS services;
- ☐ Current CalOptima Health members over the age of 21 who had received CCS services before aging out

* Interested candidates for the Whole-Child Model Family Advisory Committee (WCM FAC) member or family member seats must reside in Orange County and be enrolled in CalOptima Health Medi-Cal and/or CCS/WCM or must be a family member of an enrolled CalOptima Health Medi-Cal and CCS/WCM member. The member seat is eligible for a \$~~50~~100 per meeting stipend and round-trip mileage for in-person participation.

CalOptima Health Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____

Relationship: _____

Please tell us whether you have been a CalOptima Health member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

Please provide a brief description of your knowledge or experience with CCS: _____

Please explain why you wish to serve on the WCM FAC: _____

Describe why you would be a qualified representative for service on the WCM FAC: _____

Please specify which of CalOptima Health's threshold languages you speak fluently:

☐ English ☐ Spanish ☐ Vietnamese ☐ Farsi ☐ Korean ☐ Chinese ☐ Arabic
☒ Russian

If selected, are you able to commit to attending WCM FAC quarterly meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Do you agree that you will advocate on behalf of all CalOptima Health members and/or providers during your service on the WCM FAC? ☐ Yes ☐ No

All advisory committee representatives are appointed by the CalOptima Health Board of Directors and are subject to the CalOptima Health Code of Conduct.

Please supply two references (professional, community or personal):

Name: _____

Relationship: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Email: _____

Name: _____

Relationship: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Email: _____

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima Health to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and resumes, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board materials that are available on CalOptima Health's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____

Date: _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima Health as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole-Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

- ☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**
- ☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal Health Insurance Portability and Accountability Act (HIPAA), Privacy Regulations require that you complete this form to authorize CalOptima Health to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima Health.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima Health, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): **Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.**

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow CalOptima Health staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of the CalOptima Health Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for.**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

Office of the Clerk of the Board
CalOptima Health
505 City Parkway West
Orange CA 92868

I understand that a revocation will not affect the ability of CalOptima Health or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole-Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under HIPAA and will not be disclosed by CalOptima Health without separate authorization, unless disclosure is permitted by HIPAA without authorization or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of this authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

Submit this application, along with a biography or resume to:

Attn Cheryl Simmons
Office of the Clerk of the Board
CalOptima Health
505 City Parkway West
Orange CA 92868

Phone: **714-347-5785** Fax: **714-571-2479** Email: csimmons@caloptima.org



Whole-Child Model Family Advisory Committee Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a resume or biography listing your qualifications and include signed authorization forms. For questions, please call 714-347-5785.

Name: _____

Primary Phone: _____

Address: _____

Cell Phone: _____

City, State, ZIP: _____

Fax: _____

Date: _____

Email: _____

Please see the eligibility criteria below:*

- ☐ Authorized representatives, which includes parents, foster parents and caregivers, of a CalOptima Health member who is currently receiving CCS services;
- ☐ CalOptima Health members ages 18–21 who are currently receiving of CCS services;
- ☐ Current CalOptima Health members over the age of 21 who had received CCS services before aging out

* Interested candidates for the Whole-Child Model Family Advisory Committee (WCM FAC) member or family member seats must reside in Orange County and be enrolled in CalOptima Health Medi-Cal and/or CCS/WCM or must be a family member of an enrolled CalOptima Health Medi-Cal and CCS/WCM member. The member seat is eligible for a \$100 per meeting stipend and round-trip mileage for in-person participation.

CalOptima Health Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____

Relationship: _____

Please tell us whether you have been a CalOptima Health member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

Please provide a brief description of your knowledge or experience with CCS: _____

Please explain why you wish to serve on the WCM FAC: _____

Describe why you would be a qualified representative for service on the WCM FAC: _____

Please specify which of CalOptima Health's threshold languages you speak fluently:

☐ English ☐ Spanish ☐ Vietnamese ☐ Farsi ☐ Korean ☐ Chinese ☐ Arabic
☐ Russian

If selected, are you able to commit to attending WCM FAC quarterly meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Do you agree that you will advocate on behalf of all CalOptima Health members and/or providers during your service on the WCM FAC? ☐ Yes ☐ No

All advisory committee representatives are appointed by the CalOptima Health Board of Directors and are subject to the CalOptima Health Code of Conduct.

Please supply two references (professional, community or personal):

Name: _____

Relationship: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Email: _____

Name: _____

Relationship: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Email: _____

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima Health to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and resumes, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board materials that are available on CalOptima Health's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____

Date: _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima Health as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole-Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

- ☐ **MEMBER APPLICANT** — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.
- ☐ **FAMILY MEMBER APPLICANT** — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ Date: _____

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Date of Request: _____ Telephone Number: _____
Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima Health, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): **Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.**

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow CalOptima Health staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of the CalOptima Health Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for.**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

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CalOptima Health
505 City Parkway West
Orange CA 92868

I understand that a revocation will not affect the ability of CalOptima Health or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole-Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under HIPAA and will not be disclosed by CalOptima Health without separate authorization, unless disclosure is permitted by HIPAA without authorization or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of this authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

Submit this application, along with a biography or resume to:

Attn Cheryl Simmons
Office of the Clerk of the Board
CalOptima Health
505 City Parkway West
Orange CA 92868

Phone: **714-347-5785** Fax: **714-571-2479** Email: csimmons@caloptima.org



CalOptima Health Seeks Whole-Child Model Family Advisory Committee Candidates

The Whole-Child Model (WCM) was set up to bring services covered by California Children's Services (CCS) for Medi-Cal-eligible children and youth into a managed care plan benefit in 2018. A provision of the Whole-Child Model requires health plans to establish a family advisory committee.

The CalOptima Health Board of Directors welcomes input and recommendations from members and the community regarding CalOptima Health programs. As part of that, CalOptima Health encourages members and community advocates to become involved in the Whole-Child Model Family Advisory Committee (WCM FAC).

The WCM FAC is made up of members, family of members receiving CCS services and community advocates who serve them. The WCM FAC reports to the Board and is asked to:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Health's Whole-Child Model as directed by the Board and as permitted under applicable law
- Study, research and analyze issues assigned by the Board or generated by staff or the WCM FAC
- Help with communications between interested parties and the Board, and help the Board and staff receive public opinion on issues relating to CalOptima Health's Whole-Child Model
- Give recommendations on issues to the Board for its consideration and approval, as well as help with community outreach for CalOptima Health's Whole-Child Model and the Board.

CalOptima Health is currently seeking candidates to serve as authorized family members on WCM FAC. A ~~\$50~~ 100 stipend will be paid for each meeting attended. The following seats are available:

- ~~Four~~ **Three (43)** Authorized Family Member seats with terms beginning July 1, ~~2025-2026~~ and running through June 30, ~~2027~~**2028**.
- ~~One Authorized Family Member seat to fulfill an existing term through June 30, 2026.~~

Applicants must be one of the following:

- An authorized representative – including parent, foster parent and caregiver – of a CalOptima Health member who is receiving CCS services
- A current CalOptima Health member 18–21 years old receiving CCS services
- A current CalOptima Health member over the age of 21 who was receiving CCS services until aging out

Interested individuals with knowledge of or experience with CCS should send a completed application, biography or resume, and the disclosure forms as soon as possible. Recruitment will remain open until seats are filled. Please send documents to:

Attn Cheryl Simmons
Office of the Clerk of the Board
CalOptima Health
505 City Parkway West
Orange CA 92868

or send via fax to **714-571-2479** or email csimmons@caloptima.org

For questions, please call **714-347-5785**.

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The CalOptima Health Board of Directors welcomes input and recommendations from members and the community regarding CalOptima Health programs. As part of that, CalOptima Health encourages members and community advocates to become involved in the Whole-Child Model Family Advisory Committee (WCM FAC).

The WCM FAC is made up of members, family of members receiving CCS services and community advocates who serve them. The WCM FAC reports to the Board and is asked to:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Health's Whole-Child Model as directed by the Board and as permitted under applicable law
- Study, research and analyze issues assigned by the Board or generated by staff or the WCM FAC
- Help with communications between interested parties and the Board, and help the Board and staff receive public opinion on issues relating to CalOptima Health's Whole-Child Model
- Give recommendations on issues to the Board for its consideration and approval, as well as help with community outreach for CalOptima Health's Whole-Child Model and the Board.

CalOptima Health is currently seeking candidates to serve as authorized family members on WCM FAC. A \$100 stipend will be paid for each meeting attended. The following seats are available:

- **Three (3) Authorized Family Member seats with terms beginning July 1, 2026 and running through June 30, 2028.**

Applicants must be one of the following:

- An authorized representative – including parent, foster parent and caregiver – of a CalOptima Health member who is receiving CCS services
- A current CalOptima Health member 18–21 years old receiving CCS services
- A current CalOptima Health member over the age of 21 who was receiving CCS services until aging out

Interested individuals with knowledge of or experience with CCS should send a completed application, biography or resume, and the disclosure forms as soon as possible. Recruitment will remain open until seats are filled. Please send documents to:

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CalOptima Health
505 City Parkway West
Orange CA 92868

or send via fax to **714-571-2479** or email csimmons@caloptima.org

For questions, please call **714-347-5785**.



Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat:
Authorized Family Member

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

<u>Criteria for Nomination Consideration and Point Scale</u>	<u>Possible Points</u>	<u>Awarded Points</u>
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	<u>30</u>
_____ Name of Evaluator	Total Points Awarded	_____



CalOptima Health

Whole-Child Model Family Advisory Committee Community Application

**Instructions: Please answer all questions. You may handwrite or type your answers.
Attach an additional page if needed.
If you have any questions regarding the application, call 714-347-5785.**

Name: _____ Work Phone: _____
Address: _____ Mobile Phone: _____
City, State ZIP: _____ Fax Number: _____
Date: _____ Email: _____

I hereby submit my application for the following Whole-Child Model Family Advisory Committee (WCM FAC) Community Representative seats, and I understand that service on the WCM FAC is on a voluntary basis with no stipend:

☐ **Community-based organizations**

☐ **Consumer advocate**

All appointments are for a two-year period beginning July 1, 2026 through June 30, 2028. These seats are subject to continued eligibility to hold a Community Representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer):

-
1. Please provide a brief description of your direct or indirect experience working with the CalOptima Health population receiving California Children's Services (CCS) services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima Health?

4. Please explain why you wish to serve on the WCM FAC:

5. Describe why you would be a qualified representative for service on the WCM FAC:

6. Please specify which of CalOptima Health's threshold languages you speak fluently:

☐ English ☐ Spanish ☐ Vietnamese ☐ Farsi ☐ Korean ☐ Chinese ☐ Arabic
☐ Russian

7. If selected, are you able to commit to attending quarterly WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Do you agree that you will advocate on behalf of all CalOptima Health members and/or providers during your service on the WCM FAC? ☐ Yes ☐ No

All advisory committee representatives are appointed by the CalOptima Health Board of Directors and are subject to the CalOptima Health's Code of Conduct.

Please supply two references (professional, community or personal):

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City, State, ZIP: _____	City, State, ZIP: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and resumes, are public records, with the exception of your address, email address and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board materials that are available on CalOptima Health's website, and even if not presented to the Board, will be available on request to members of the public.

Signature

Date

Print Name

Submit this application, along with a biography or resume to:

Attn Cheryl Simmons
Office of the Clerk of the Board
CalOptima Health
505 City Parkway West
Orange CA 92868

Phone: 714-347-5785 Fax: 714-571-2479 Email: csimmons@caloptima.org



CalOptima Health Seeks Whole-Child Model Family Advisory Committee Candidates

The Whole-Child Model (WCM) has been authorized to incorporate services covered by California Children's Services (CCS) for Medi-Cal-eligible children and youth into a Medi-Cal managed care plan benefit. A provision of the Whole-Child Model requires health plans to establish a family advisory committee.

The CalOptima Health Board of Directors welcomes input and recommendations from its members and the community regarding CalOptima Health programs. Accordingly, CalOptima Health encourages members and community advocates to become involved in the Whole-Child Model Family Advisory Committee (WCM FAC).

The WCM FAC is composed of members, family of members receiving CCS services and community advocates who serve them. The committee reports to the Board and are asked to:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Health's Whole-Child Model as directed by the Board and as permitted under applicable law
- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the WCM FAC
- Serve as liaison between interested parties and the Board, and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Health's Whole-Child Model
- Initiate recommendations on issues for study to the CalOptima Health Board for its consideration and approval, as well as facilitate community outreach for CalOptima Health's Whole-Child Model and the Board.

CalOptima Health is seeking candidates to serve as community members on the WCM FAC. The following two-year seats are available:

- **Community-based organizations**
- **Consumer advocate**

All appointments begin July 1, 2026 through June 30, 2028.

Interested individuals with knowledge of or experience with CCS should send the completed application, a biography or resume, and the appropriate disclosure forms as soon as possible. Recruitment will remain open until seats are filled. Please send to:

Attn Cheryl Simmons
Office of the Clerk of the Board
CalOptima Health
505 City Parkway West
Orange CA 92868

Or send via email to csimmons@caloptima.org
or fax to **714-571-2479**

For questions, please call **714-347-5785**.



Applicant Name: _____

WCM Family Advisory Committee
Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: Community Based
Organization or Consumer Advocate

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

<u>Criteria for Nomination Consideration and Point Scale</u>	<u>Possible Points</u>	<u>Awarded Points</u>
1. Direct or indirect experience working with members the applicant wishes to represent	1-5	_____
Include relevant community involvement	1-5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1-5	_____
Include relevant experience with diverse populations	1-5	_____
3. Knowledge of managed care systems and/or CalOptima Health programs	1-5	_____
4. Expressed desire to serve on the WCM FAC	1-5	_____
5. Explanation why applicant is a qualified representative	1-5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
Total Possible Points		<u>35</u>



CalOptima Health

Financial Summary August 31, 2025

**Board of Directors Meeting
October 2, 2025**

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: August 2025

- Notable events/items in August 2025
 - Higher than average disenrollment in August due to redetermination activities
 - Medical expenses included a total reduction of \$13.1 million in Incurred But Not Reported (IBNR) reserve, primarily driven by prior year adjustments related to long-term care and large claims
 - Community Reinvestment reserve of \$7.9 million based on the Department of Health Care Services (DHCS) contract requirements
 - Favorable Net Investment Income driven by increase in value of portfolio due to projected decrease in interest rates

Financial Highlights

August 2025

August 2025					July - August 2025			
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
891,812	902,853	(11,041)	(1.2%)	Member Months	1,796,090	1,809,320	(13,230)	(0.7%)
392,561,825	397,270,146	(4,708,321)	(1.2%)	Revenues	789,019,971	796,644,810	(7,624,839)	(1.0%)
351,033,292	369,659,873	18,626,581	5.0%	Medical Expenses	717,746,794	740,530,773	22,783,979	3.1%
21,103,399	24,677,656	3,574,257	14.5%	Administrative Expenses	41,631,276	50,277,498	8,646,222	17.2%
20,425,134	2,932,617	17,492,517	596.5%	Operating Margin	29,641,901	5,836,539	23,805,362	407.9%
				Non-Operating Income (Loss)				
24,390,390	8,333,340	16,057,050	192.7%	Net Investment Income/Expense	32,307,522	16,666,680	15,640,842	93.8%
(7,901,463)	-	(7,901,463)	(100.0%)	Community Reinvestment	(10,450,081)	-	(10,450,081)	(100.0%)
(22,035)	(138,610)	116,575	84.1%	Other Income/Expense	(162,348)	(277,220)	114,872	41.4%
16,466,892	8,194,730	8,272,162	100.9%	Total Non-Operating Income (Loss)	21,695,094	16,389,460	5,305,634	32.4%
36,892,025	11,127,347	25,764,678	231.5%	Change in Net Assets	51,336,995	22,225,999	29,110,996	131.0%
89.4%	93.1%	(3.6%)		Medical Loss Ratio	91.0%	93.0%	(2.0%)	
5.4%	6.2%	0.8%		Administrative Loss Ratio	5.3%	6.3%	1.0%	
5.2%	0.7%	4.5%		Operating Margin Ratio	3.8%	0.7%	3.0%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
85.0%	88.6%	(3.7%)		*Adjusted MLR	86.5%	88.6%	(2.0%)	
5.4%	6.2%	0.8%		*Adjusted ALR	5.3%	6.3%	1.0%	

*Adjusted MLR/ALR excludes estimated Board-approved Provider Rate increases and Directed Payments, but includes costs associated with CalOptima Health's Digital Transformation Strategy (DTS) budget

FY 2025-26: Management Summary

- Change in Net Assets Surplus or (Deficit)
 - Month To Date (MTD) August 2025: \$36.9 million, favorable to budget \$25.8 million or 231.5% driven by Net Investment Income and lower than forecasted claims expenses
 - Year To Date (YTD) July – August 2025: \$51.3 million, favorable to budget \$29.1 million or 131.0% driven by Net Investment Income and lower than forecasted claims expenses

FY 2025-26: Management Summary (cont.)

○ Enrollment

- MTD: 891,812 members, unfavorable to budget 11,041 or 1.2% due to redetermination activities
- YTD: 1,796,090 member months, unfavorable to budget 13,230 or 0.7%

FY 2025-26: Management Summary (cont.)

○ Revenue

- MTD: \$392.6 million, unfavorable to budget \$4.7 million or 1.2% driven by \$4.5 million in Medi-Cal (MC) Line of Business (LOB) due to unfavorable volume variance
- YTD: \$789.0 million, unfavorable to budget \$7.6 million or 1.0% due primarily to:
 - MC LOB unfavorable volume variance
 - OneCare (OC) LOB lower than anticipated Risk Adjustment Factor (RAF)

FY 2025-26: Management Summary (cont.)

○ Medical Expenses

- MTD: \$351.0 million, favorable to budget \$18.6 million or 5.0% driven by:
 - MLTSS favorable to budget \$16.9 million due primarily to reclassification of MLTSS claims to Facilities Claims due to a system logic update and change in IBNR reserves
- YTD: \$717.7 million, favorable to budget \$22.8 million or 3.1% due to:
 - \$18.0 million of MLTSS and \$6.5 million in Medical Management expenses

FY 2025-26: Management Summary (cont.)

- Administrative Expenses
 - MTD: \$21.1 million, favorable to budget \$3.6 million or 14.5% due to timing of administrative expense activities
 - YTD: \$41.6 million, favorable to budget \$8.6 million or 17.2% due to timing of administrative expense activities

FY 2025-26: Management Summary (cont.)

- Non-Operating Income (Loss)
 - MTD: \$16.5 million, favorable to budget \$8.3 million or 100.9% due primarily to \$16.1 million favorable Net Investment Income, offset by unfavorable Community Reinvestment liabilities of \$7.9 million
 - YTD: \$21.7 million, favorable to budget \$5.3 million or 32.4% due primarily to \$15.6 million favorable Net Investment Income, offset by unfavorable Community Reinvestment liabilities of \$10.5 million

FY 2025-26: Key Financial Ratios

○ Medical Loss Ratio (MLR)

		Actual	Budget	Variance (%)
MTD	MLR	89.4%	93.1%	(3.6%)
	Adjusted MLR*	85.0%	88.6%	(3.7%)
YTD	MLR	91.0%	93.0%	(2.0%)
	Adjusted MLR*	86.5%	88.6%	(2.0%)

○ Administrative Loss Ratio (ALR)

		Actual	Budget	Variance (%)
MTD	ALR	5.4%	6.2%	0.8%
	Adjusted ALR*	5.4%	6.2%	0.8%
YTD	ALR	5.3%	6.3%	1.0%
	Adjusted ALR*	5.3%	6.3%	1.0%

* Adjusted MLR/ALR excludes estimated Board-approved Provider Rate Increases and Directed, but include costs associated with DTS.

FY 2025-26: Key Financials Ratios

(cont.)

○ Balance Sheet Ratios

- Current ratio*: 1.8
- Board Designated Reserve level: 3.78
- Statutory Designated Reserve level: 1.04
- Net-position: \$2.9 billion, including required TNE of \$128.4 million

*Current ratio compares current assets to current liabilities. It measures CalOptima Health's ability to pay short-term obligations.

Enrollment Summary: August 2025

August 2025					July - August 2025				
Actual	Budget	\$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	\$ Variance	% Variance	
152,002	147,415	4,587	3.1%	SPD	304,404	294,581	9,823	3.3%	
254,354	259,527	(5,173)	(2.0%)	TANF Child	511,780	519,674	(7,894)	(1.5%)	
126,680	129,771	(3,091)	(2.4%)	TANF Adult	255,246	260,186	(4,940)	(1.9%)	
2,764	2,512	252	10.0%	LTC	5,364	5,025	339	6.7%	
328,645	336,253	(7,608)	(2.3%)	MCE	664,266	675,135	(10,869)	(1.6%)	
8,965	9,107	(142)	(1.6%)	WCM	18,129	18,227	(98)	(0.5%)	
873,410	884,585	(11,175)	(1.3%)	Medi-Cal Total	1,759,189	1,772,828	(13,639)	(0.8%)	
17,873	17,735	138	0.8%	OneCare	35,844	35,430	414	1.2%	
529	533	(4)	(0.8%)	PACE	1,057	1,062	(5)	(0.5%)	
551	558	(7)	(1.3%)	MSSP*	1,104	1,116	(12)	(1.1%)	
891,812	902,853	(11,041)	(1.2%)	CalOptima Health Total	1,796,090	1,809,320	(13,230)	(0.7%)	

*MSSP enrollment is included in Medi-Cal total

Consolidated Revenue & Expenses:

August 2025 MTD

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	873,410	17,873	529	551		891,812
REVENUES						
Capitation Revenue	\$ 351,750,552	\$ 35,751,896	\$ 4,822,787	\$ 236,590	\$ -	\$ 392,561,825
Total Operating Revenue	351,750,552	35,751,896	4,822,787	236,590	-	392,561,825
MEDICAL EXPENSES						
Provider Capitation	111,547,111	14,319,922				125,867,033
Professional, Facility & Ancillary Claims	146,543,156	7,433,201	2,014,995			155,991,352
Managed Long-Term Services & Supports (MLTSS)	33,315,782		44,761	34,087		33,394,631
Prescription Drugs		9,684,549	587,489			10,272,038
Case Management & Other Medical	21,746,185	2,203,564	1,371,044	187,445		25,508,239
Total Medical Expenses	313,152,234	33,641,236	4,018,290	221,532	-	351,033,292
Medical Loss Ratio	89.0%	94.1%	83.3%	93.6%	0.0%	89.4%
GROSS MARGIN	38,598,318	2,110,660	804,497	15,058	-	41,528,533
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	11,126,311	954,360	178,277	93,602	73,572	12,426,121
Non-Salary Operating Expenses	3,348,537	295,094	79,507	1,465	561,835	4,286,439
Depreciation & Amortization	798,397		886			799,283
Other Operating Expenses	3,147,084	63,497	10,924	6,739		3,228,243
Indirect Cost Allocation, Occupancy	(842,557)	1,181,620	16,670	7,580		363,313
Total Administrative Expenses	17,577,772	2,494,571	286,264	109,386	635,407	21,103,399
Administrative Loss Ratio	5.0%	7.0%	5.9%	46.2%	0.0%	5.4%
Operating Income/(Loss)	21,020,546	(383,911)	518,233	(94,328)	(635,407)	20,425,134
Investments and Other Non-Operating	(7,899,953)					16,466,892
CHANGE IN NET ASSETS	\$ 13,120,594	\$ (383,911)	\$ 518,233	\$ (94,328)	\$ (635,407)	\$ 36,892,025
BUDGETED CHANGE IN NET ASSETS	5,379,113	(1,827,124)	315,832	(114,798)	(820,406)	11,127,348
Variance to Budget - Fav/(Unfav)	\$ 7,741,481	\$ 1,443,213	\$ 202,401	\$ 20,470	\$ 184,999	\$ 25,764,677

Consolidated Revenue & Expenses:

August 2025 YTD

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	1,759,189	35,844	1,057	1,104		1,796,090
REVENUES						
Capitation Revenue	\$ 707,709,200	\$ 71,256,992	\$ 9,565,210	\$ 488,568	\$ -	\$ 789,019,971
Total Operating Revenue	707,709,200	71,256,992	9,565,210	488,568	-	789,019,971
MEDICAL EXPENSES						
Provider Capitation	225,314,306	29,076,055				254,390,360
Professional, Facility & Ancillary Claims	289,986,466	14,538,600	4,003,281			308,528,347
Managed Long-Term Services & Supports (MLTSS)	82,287,021		54,128	76,160		82,417,309
Prescription Drugs		20,500,545	1,156,923			21,657,468
Case Management & Other Medical	42,668,252	4,888,805	2,813,467	382,786		50,753,310
Total Medical Expenses	640,256,044	69,004,005	8,027,800	458,946	-	717,746,794
Medical Loss Ratio	90.5%	96.8%	83.9%	93.9%	0.0%	91.0%
GROSS MARGIN	67,453,156	2,252,987	1,537,411	29,623	-	71,273,177
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	23,062,332	1,970,274	365,220	199,149	126,669	25,723,643
Non-Salary Operating Expenses	6,202,615	715,693	171,851	2,922	612,150	7,705,231
Depreciation & Amortization	1,602,475		1,772			1,604,247
Other Operating Expenses	5,619,522	145,524	18,816	12,137		5,796,000
Indirect Cost Allocation, Occupancy	(1,609,585)	2,363,240	33,339	15,160		802,155
Total Administrative Expenses	34,877,359	5,194,731	590,999	229,368	738,819	41,631,276
Administrative Loss Ratio	4.9%	7.3%	6.2%	46.9%	0.0%	5.3%
Operating Income/(Loss)	32,575,797	(2,941,744)	946,412	(199,745)	(738,819)	29,641,901
Investments and Other Non-Operating	(10,446,969)					21,695,094
CHANGE IN NET ASSETS	\$ 22,128,828	\$ (2,941,744)	\$ 946,412	\$ (199,745)	\$ (738,819)	\$ 51,336,995
BUDGETED CHANGE IN NET ASSETS	10,768,600	(3,686,434)	535,115	(238,160)	(1,542,582)	22,226,001
Variance to Budget - Fav/(Unfav)	\$ 11,360,228	\$ 744,690	\$ 411,297	\$ 38,415	\$ 803,763	\$ 29,110,994

Balance Sheet: As of August 2025

ASSETS

Current Assets

Operating Cash	\$485,883,719
Short-term Investments	1,500,773,614
Capitation Receivable	452,366,783
Receivables - Other	86,860,642
Prepaid Expenses	15,720,349
Total Current Assets	2,541,605,108

Capital Assets

Capital Assets	190,471,783
Less Accumulated Depreciation	(88,028,262)
Capital Assets, Net of Depreciation	102,443,520

Other Assets

Restricted Deposits	300,000
Board Designated Reserves	1,599,085,594
Statutory Designated Reserves	133,740,414
Total Other Assets	1,733,126,007

TOTAL ASSETS **4,377,174,635**

Deferred Outflows **28,626,072**

TOTAL ASSETS & DEFERRED OUTFLOWS **4,405,800,707**

LIABILITIES & NET POSITION

Current Liabilities

Accounts Payable	\$107,236,859
Medical Claims Liability	1,058,343,475
Accrued Payroll Liabilities	25,485,551
Deferred Revenue	52,839,094
Other Current Liabilities	-
Capitation and Withholds	164,213,847
Total Current Liabilities	1,408,118,826

Other Liabilities

GASB 96 Subscription Liabilities	19,540,147
Community Reinvestment	98,548,192
Capital Lease Payable	237,530
Postemployment Health Care Plan	17,284,806
Net Pension Liabilities	5,840,992
Total Other Liabilities	141,451,666

TOTAL LIABILITIES **1,549,570,492**

Deferred Inflows **4,309,519**

Net Position

Required TNE	128,423,137
Funds in Excess of TNE	2,723,497,559
TOTAL NET POSITION	2,851,920,696

TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION **4,405,800,707**

Board Designated Reserve and TNE Analysis: As of August 2025

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	799,596,534				
MetLife Tier One	799,489,059				
Board Designated Reserves	1,599,085,594	1,058,031,035	1,692,849,655	541,054,559	(93,764,062)
Current Reserve Level (X months of average monthly revenue) ¹	3.78	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	66,999,919				
MetLife Tier Two	66,740,495				
Statutory Designated Reserves	133,740,414	128,423,137	141,265,450	5,317,277	(7,525,036)
Current Reserve Level (X min. TNE) ¹	1.04	1.00	1.10		

¹ See CalOptima Health Policy GA.3001: Statutory and Board-Designated Reserve Funds for more information.

Spending Plan: As of August 2025

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
Total Net Position @ 8/31/2025		\$2,851.9			100.0%
Resources Assigned	Board Designated Reserve ¹	\$1,599.1			56.1%
	Statutory Designated Reserve ¹	\$133.7			4.7%
	Capital Assets, net of Depreciation	\$102.4			3.6%
Resources Allocated ³	Homeless Health Initiative ²	\$19.4	\$65.9	\$46.5	0.7%
	Housing and Homelessness Incentive Program ²	25.8	87.4	61.5	0.9%
	Intergovernmental Transfers (IGT) ⁴	44.3	52.1	7.8	1.6%
	Digital Transformation and Workplace Modernization ³	27.1	100.0	72.9	0.9%
	CalFresh Outreach Strategy	0.0	2.0	2.0	0.0%
	CalFresh and Redetermination Outreach Strategy	1.7	6.0	4.3	0.1%
	Coalition of Orange County Community Health Centers Grant	25.7	50.0	24.3	0.9%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	General Awareness Campaign	0.4	4.7	4.3	0.0%
	Member Health Needs Assessment	0.6	1.3	0.7	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	117.7	153.5	35.8	4.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.4%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program Grant	3.0	5.0	2.0	0.1%
	Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program Grant	1.5	2.7	1.2	0.1%
	CalOptima Health Provider Workforce Development Fund Grant	44.5	50.0	5.5	1.6%
	Distribution Event - Naloxone Grant	2.2	15.0	12.8	0.1%
	Garden Grove Bldg. Improvement	9.7	10.5	0.8	0.3%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	1.3%
	Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
	Outreach Strategy for newly eligible Adult Expansion members	2.8	7.6	4.8	0.1%
	Quality Initiatives from unearned Pay for Value Program	18.6	23.3	4.7	0.7%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.2	1.2	1.0	0.0%
	Medi-Cal Provider Rate Increases	280.6	526.2	245.6	9.8%
	Homeless Prevention and Stabilization Pilot Program	0.2	0.3	0.1	0.0%
	OneCare Member Engagement and Education	0.2	0.3	0.0	0.0%
Subtotal:		\$677.4	\$1,236.7	\$559.3	23.8%
Resources Available for New Initiatives	Unallocated/Unassigned ¹	\$339.2			11.9%

¹ Total Designated Reserves and unallocated reserve amount can support approximately 177 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.

⁴ On June 5, 2025, the Board of Directors approved the close out of Board-approved initiatives and transfer of remaining funds back to unallocated reserves.

Homeless Health Initiative and Allocated Funds: As of August 2025

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
HHI - IGT'S	64,131,301	64,131,301	46,500,149	17,631,152	-
HHI - Existing Reserves	1,800,000	1,800,000	-	1,800,000	-
HHIP	40,100,000	40,100,000	-	40,100,000	-
Total	106,031,301	106,031,301	46,500,149	59,531,152	-

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)	2,500,000	-	2,500,000	IGT's
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-	IGT's
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-	IGT's
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522	IGT's
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	925,540	37,721	IGT's
FQHC (Community Health Center) Expansion	21,902	21,902	-	IGT's
HCAP and CalOptima Health Days	9,888,914	4,480,022	5,408,891	IGT's
Vaccination Intervention and Member Incentive Strategy ²	54,649	54,649	-	IGT's
Street Medicine ^{1,3}	14,376,652	7,659,620	6,717,032	IGT's & Existing Reserves
Outreach and Engagement	7,000,000	2,276,015	4,723,985	IGT's
Housing and Homelessness Incentive Program (HHIP) ⁴	40,100,000	-	40,100,000	IGT's & Existing Reserves
Subtotal of Approved Initiatives	106,031,301	46,500,149	59,531,151	
Transfer of funds to HHIP ⁴	(40,100,000)	-	(40,100,000)	
Program Total	65,931,301	46,500,149	19,431,151	

¹On 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 of Director action, to fund 2-year grant agreements to Healthcare in Action (Anaheim), Celebrating Life Community Health Center (Costa Mesa), and AltaMed (Santa Ana).

²On June 5, 2025 the 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.

³On March 19, 2025, CalOptima Health's Board of Directors approved \$4.3 million from existing reserves to fund a new Street Medicine Program (Santa Ana). On March 7, 2024, CalOptima Health's Board of Directors approved \$5.0 million to expand the Street Medicine Program. \$3.2 million remaining from Street Medicine Initiative (from the HHI reserve) and \$1.8 million from existing reserves to fund 2-year agreements with Healthcare in Action (Anaheim) and Celebrating Life Community Health Center (Costa Mesa).

⁴On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of \$40.1 million from HHI to HHIP.

Housing and Homelessness Incentive Program: As of August 2025

Summary by Funding Source:	Total Funds ¹	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	54,930,994	31,937,512	22,993,482	\$18,000,195
Existing Reserves & HHI Transfer	87,384,530	87,384,530	61,550,626	25,833,904	-
Total	160,315,719	142,315,524	93,488,137	48,827,387	18,000,195

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	869,850	530,150	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,696,311	925,000	HHI & DHCS
Infrastructure Projects	5,832,314	5,580,354	251,960	HHI
Capital Projects	108,247,369	73,195,575	35,051,794	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	7,290,657	2,893,873	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	\$133,185,524¹	\$93,488,137	\$39,697,387	

¹Total 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 payments.



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UNAUDITED FINANCIAL STATEMENTS

August 31, 2025

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**CalOptima Health - Consolidated
Financial Highlights
For the Two Months Ending August 31, 2025**

August 2025			
Actual	Budget	\$ Variance	% Variance
891,812	902,853	(11,041)	(1.2%)
392,561,825	397,270,146	(4,708,321)	(1.2%)
351,033,292	369,659,873	18,626,581	5.0%
21,103,399	24,677,656	3,574,257	14.5%
20,425,134	2,932,617	17,492,517	596.5%
24,390,390	8,333,340	16,057,050	192.7%
(7,901,463)	-	(7,901,463)	(100.0%)
(22,035)	(138,610)	116,575	84.1%
16,466,892	8,194,730	8,272,162	100.9%
36,892,025	11,127,347	25,764,678	231.5%
89.4%	93.1%	(3.6%)	
5.4%	6.2%	0.8%	
5.2%	0.7%	4.5%	
100.0%	100.0%		
85.0%	88.6%	(3.7%)	
5.4%	6.2%	0.8%	

Member Months
Revenues
Medical Expenses
Administrative Expenses

Operating Margin

Non-Operating Income (Loss)

Net Investment Income/Expense
Community Reinvestment
Other Income/Expense

Total Non-Operating Income (Loss)

Change in Net Assets

Medical Loss Ratio
Administrative Loss Ratio
Operating Margin Ratio
Total Operating

*Adjusted MLR

*Adjusted ALR

July - August 2025			
Actual	Budget	\$ Variance	% Variance
1,796,090	1,809,320	(13,230)	(0.7%)
789,019,971	796,644,810	(7,624,839)	(1.0%)
717,746,794	740,530,773	22,783,979	3.1%
41,631,276	50,277,498	8,646,222	17.2%
29,641,901	5,836,539	23,805,362	407.9%
32,307,522	16,666,680	15,640,842	93.8%
(10,450,081)	-	(10,450,081)	(100.0%)
(162,348)	(277,220)	114,872	41.4%
21,695,094	16,389,460	5,305,634	32.4%
51,336,995	22,225,999	29,110,996	131.0%
91.0%	93.0%	(2.0%)	
5.3%	6.3%	1.0%	
3.8%	0.7%	3.0%	
100.0%	100.0%		
86.5%	88.6%	(2.0%)	
5.3%	6.3%	1.0%	

*Adjusted MLR /ALR excludes estimated Board-approved Provider Rate increases and Directed Payments, but includes costs associated with CalOptima Health's Digital Transformation Strategy (DTS) budget.

**CalOptima Health - Consolidated
Full Time Equivalent (FTE) Data
For the Two Months Ending August 31, 2025**

Total FTE's MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	1,322	1,406	84
OneCare	168	180	12
PACE	110	119	9
CCA	3	13	10
MSSP	22	24	2
Total	1,625	1,742	117

Total FTE's YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	2,653	2,811	158
OneCare	332	361	29
PACE	223	238	15
CCA	5	20	15
MSSP	44	48	4
Total	3,257	3,477	220

MM per FTE MTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	661	629	(32)
OneCare	107	98	(9)
PACE	5	4	(1)
CCA	0	0	0
MSSP	25	23	(2)
Consolidated	549	518	(31)

MM per FTE YTD			
	Actual	Budget	Fav/Unfav
Medi-Cal	663	631	(32)
OneCare	108	98	(10)
PACE	5	4	(1)
CCA	0	0	0
MSSP	25	23	(2)
Consolidated	551	520	(31)

Open FTE			
	Total	Medical	Admin
Medi-Cal	89	30	59
OneCare	12	3	9
PACE	6	6	0
CCA	17	1	16
MSSP	0	0	0
Total	124	40	84

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses
For the One Month Ending August 31, 2025

MEMBER MONTHS	891,812		902,853		(11,041)	
	Actual		Budget		Variance	
REVENUE	\$	PMPM	\$	PMPM	\$	PMPM
Medi-Cal	\$351,750,552	\$402.73	\$354,988,075	\$401.30	(\$3,237,523)	\$1.43
OneCare	35,751,896	2,000.33	37,249,046	2,100.31	(1,497,150)	(99.98)
PACE	4,822,787	9,116.80	4,783,971	8,975.56	38,816	141.24
MSSP	236,590	429.38	249,054	446.33	(12,464)	(16.95)
Total Operating Revenue	392,561,825	440.18	397,270,146	440.02	(4,708,321)	0.16
MEDICAL EXPENSES						
Medi-Cal	313,152,234	358.54	329,287,533	372.25	16,135,299	13.71
OneCare	33,641,236	1,882.24	35,944,779	2,026.77	2,303,543	144.53
PACE	4,018,290	7,596.01	4,155,485	7,796.41	137,195	200.40
MSSP	221,532	402.05	227,092	406.97	5,560	4.92
Covered CA	-	-	44,984	80.62	44,984	80.62
Total Medical Expenses	351,033,292	393.62	369,659,873	409.44	18,626,581	15.82
GROSS MARGIN	41,528,533	46.56	27,610,273	30.58	13,918,260	15.98
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	12,426,121	13.93	13,496,546	14.95	1,070,425	1.02
Professional Fees	1,925,667	2.16	1,908,619	2.11	(17,049)	(0.05)
Purchased Services	1,885,637	2.11	2,727,453	3.02	841,816	0.91
Printing & Postage	475,134	0.53	627,975	0.70	152,841	0.17
Depreciation & Amortization	799,283	0.90	949,334	1.05	150,051	0.15
Other Expenses	3,228,243	3.62	4,485,861	4.97	1,257,618	1.35
Indirect Cost Allocation, Occupancy	363,313	0.41	481,868	0.53	118,555	0.12
Total Administrative Expenses	21,103,399	23.66	24,677,656	27.33	3,574,257	3.67
NET INCOME (LOSS) FROM OPERATIONS	20,425,134	22.90	2,932,617	3.25	17,492,517	19.65
INVESTMENT INCOME						
Interest Income	13,238,365	14.84	8,333,340	9.23	4,905,025	5.61
Realized Gain/(Loss) on Investments	94,560	0.11	-	-	94,560	0.11
Unrealized Gain/(Loss) on Investments	11,057,464	12.40	-	-	11,057,464	12.40
Total Investment Income	24,390,390	27.35	8,333,340	9.23	16,057,050	18.12
COMMUNITY REINVESTMENT	(7,901,463)	(8.86)	-	-	(7,901,463)	(8.86)
OTHER INCOME/EXPENSE	(22,035)	(0.02)	(138,610)	(0.15)	116,575	0.13
CHANGE IN NET ASSETS	36,892,025	41.37	11,127,347	12.32	25,764,678	29.05
MEDICAL LOSS RATIO	89.4%		93.1%		(3.6%)	
ADMINISTRATIVE LOSS RATIO	5.4%		6.2%		0.8%	

CalOptima Health- Consolidated - Year to Date
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2025

MEMBER MONTHS	1,796,090		1,809,320		(13,230)	
	Actual		Budget		Variance	
REVENUE	\$	PMPM	\$	PMPM	\$	PMPM
Medi-Cal	\$707,709,200	\$402.29	\$711,995,873	\$401.62	(\$4,286,673)	\$0.67
OneCare	71,256,992	1,987.98	74,610,487	2,105.86	(3,353,495)	(117.88)
PACE	9,565,210	9,049.39	9,540,342	8,983.37	24,868	66.02
MSSP	488,568	442.54	498,108	446.33	(9,540)	(3.79)
Total Operating Revenue	789,019,971	439.3	796,644,810	440.3	(7,624,839)	(1.00)
MEDICAL EXPENSES						
Medi-Cal	640,256,044	363.95	659,668,219	372.10	19,412,175	8.15
OneCare	69,004,005	1,925.12	71,952,795	2,030.84	2,948,790	105.72
OneCare Connect					-	0.00
PACE	8,027,800	7,594.89	8,365,607	7,877.22	337,808	282.33
MSSP	458,946	415.71	454,184	406.97	(4,762)	(8.74)
Covered CA		0.00	89,968	80.62	89,968	80.62
Total Medical Expenses	717,746,794	399.62	740,530,773	409.29	22,783,979	9.67
GROSS MARGIN	71,273,177	39.68	56,114,037	31.01	15,159,140	8.67
ADMINISTRATIVE EXPENSES						
Salaries and Benefits	25,723,643	14.32	27,915,279	15.43	2,191,635	1.11
Professional Fees	2,848,246	1.59	3,802,221	2.10	953,975	0.51
Purchased Services	3,856,860	2.15	5,441,270	3.01	1,584,410	0.86
Printing & Postage	1,000,126	0.56	1,255,950	0.69	255,824	0.13
Depreciation & Amortization	1,604,247	0.89	1,898,668	1.05	294,421	0.16
Other Expenses	5,796,000	3.23	9,000,375	4.97	3,204,375	1.74
Indirect Cost Allocation, Occupancy	802,155	0.45	963,736	0.53	161,581	0.08
Total Administrative Expenses	41,631,276	23.18	50,277,498	27.79	8,646,222	4.61
NET INCOME (LOSS) FROM OPERATIONS	29,641,901	16.50	5,836,539	3.23	23,805,362	13.27
INVESTMENT INCOME						
Interest Income	27,559,805	15.34	16,666,680	9.21	10,893,125	6.13
Realized Gain/(Loss) on Investments	939,354	0.52	-	0.00	939,354	0.52
Unrealized Gain/(Loss) on Investments	3,808,363	2.12	-	0.00	3,808,363	2.12
Total Investment Income	32,307,522	17.99	16,666,680	9.21	15,640,842	8.78
COMMUNITY REINVESTMENT	(10,450,081)	(5.82)	-	0.00	(10,450,081)	(5.82)
OTHER INCOME/EXPENSE	(162,348)	(0.09)	(277,220)	(0.15)	114,872	0.06
CHANGE IN NET ASSETS	51,336,995	28.58	22,225,999	12.28	29,110,996	16.30
MEDICAL LOSS RATIO	91.0%		93.0%		(2.0%)	
ADMINISTRATIVE LOSS RATIO	5.3%		6.3%		1.0%	

CalOptima Health - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ending August 31, 2025

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	873,410	17,873	529	551	-	891,812
REVENUES						
Capitation Revenue	\$ 351,750,552	\$ 35,751,896	\$ 4,822,787	\$ 236,590	\$ -	\$ 392,561,825
Total Operating Revenue	351,750,552	35,751,896	4,822,787	236,590	-	392,561,825
MEDICAL EXPENSES						
Provider Capitation	111,547,111	14,319,922				125,867,033
Professional, Facility and Ancillary Claims	146,543,156	7,433,201	2,014,995			155,991,352
Managed Long-Term Services & Supports (MLTSS)	33,315,782		44,761	34,087		33,394,631
Prescription Drugs		9,684,549	587,489			10,272,038
Case Management & Other Medical	21,746,185	2,203,564	1,371,044	187,445		25,508,239
Total Medical Expenses	313,152,234	33,641,236	4,018,290	221,532	-	351,033,292
<i>Medical Loss Ratio</i>	89.0%	94.1%	83.3%	93.6%	0.0%	89.4%
GROSS MARGIN	38,598,318	2,110,660	804,497	15,058	-	41,528,533
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	11,126,311	954,360	178,277	93,602	73,572	12,426,121
Non-Salary Operating Expenses	3,348,537	295,094	79,507	1,465	561,835	4,286,439
Depreciation & Amortization	798,397		886			799,283
Other Operating Expenses	3,147,084	63,497	10,924	6,739		3,228,243
Indirect Cost Allocation, Occupancy	(842,557)	1,181,620	16,670	7,580		363,313
Total Administrative Expenses	17,577,772	2,494,571	286,264	109,386	635,407	21,103,399
<i>Administrative Loss Ratio</i>	5.0%	7.0%	5.9%	46.2%	0.0%	5.4%
Operating Income/(Loss)	21,020,546	(383,911)	518,233	(94,328)	(635,407)	20,425,134
Investments and Other Non-Operating	(7,899,953)					16,466,892
CHANGE IN NET ASSETS	\$ 13,120,594	\$ (383,911)	\$ 518,233	\$ (94,328)	\$ (635,407)	\$ 36,892,025
BUDGETED CHANGE IN NET ASSETS	5,379,113	(1,827,124)	315,832	(114,798)	(820,406)	11,127,348
Variance to Budget - Fav/(Unfav)	\$ 7,741,481	\$ 1,443,213	\$ 202,401	\$ 20,470	\$ 184,999	\$ 25,764,677

**CalOptima Health - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Two Months Ending August 31, 2025**

	Medi-Cal	OneCare	PACE	MSSP	Covered CA	Consolidated
MEMBER MONTHS	1,759,189	35,844	1,057	1,104	-	1,796,090
REVENUES						
Capitation Revenue	\$ 707,709,200	\$ 71,256,992	\$ 9,565,210	\$ 488,568	\$ -	\$ 789,019,971
Total Operating Revenue	707,709,200	71,256,992	9,565,210	488,568	-	789,019,971
MEDICAL EXPENSES						
Provider Capitation	225,314,306	29,076,055				254,390,360
Professional, Facility and Ancillary Claims	289,986,466	14,538,600	4,003,281			308,528,347
Managed Long-Term Services & Supports (MLTSS)	82,287,021		54,128	76,160		82,417,309
Prescription Drugs		20,500,545	1,156,923			21,657,468
Case Management & Other Medical	42,668,252	4,888,805	2,813,467	382,786		50,753,310
Total Medical Expenses	640,256,044	69,004,005	8,027,800	458,946	-	717,746,794
<i>Medical Loss Ratio</i>	<i>90.5%</i>	<i>96.8%</i>	<i>83.9%</i>	<i>93.9%</i>	<i>0.0%</i>	<i>91.0%</i>
GROSS MARGIN	67,453,156	2,252,987	1,537,411	29,623	-	71,273,177
ADMINISTRATIVE EXPENSES						
Salaries & Benefits	23,062,332	1,970,274	365,220	199,149	126,669	25,723,643
Non-Salary Operating Expenses	6,202,615	715,693	171,851	2,922	612,150	7,705,231
Depreciation & Amortization	1,602,475		1,772			1,604,247
Other Operating Expenses	5,619,522	145,524	18,816	12,137		5,796,000
Indirect Cost Allocation, Occupancy	(1,609,585)	2,363,240	33,339	15,160		802,155
Total Administrative Expenses	34,877,359	5,194,731	590,999	229,368	738,819	41,631,276
<i>Administrative Loss Ratio</i>	<i>4.9%</i>	<i>7.3%</i>	<i>6.2%</i>	<i>46.9%</i>	<i>0.0%</i>	<i>5.3%</i>
Operating Income/(Loss)	32,575,797	(2,941,744)	946,412	(199,745)	(738,819)	29,641,901
Investments and Other Non-Operating	(10,446,969)					21,695,094
CHANGE IN NET ASSETS	\$ 22,128,828	\$ (2,941,744)	\$ 946,412	\$ (199,745)	\$ (738,819)	\$ 51,336,995
BUDGETED CHANGE IN NET ASSETS	10,768,600	(3,686,434)	535,115	(238,160)	(1,542,582)	22,226,001
Variance to Budget - Fav/(Unfav)	\$ 11,360,228	\$ 744,690	\$ 411,297	\$ 38,415	\$ 803,763	\$ 29,110,994

CalOptima Health

Highlights – Consolidated, for Two Months Ending August 31, 2025

MONTH TO DATE RESULTS:

- Change in Net Assets is \$36.9 million, favorable to budget \$25.8 million
- Operating surplus is \$20.4 million, with a surplus in non-operating income of \$16.5 million

YEAR TO DATE RESULTS:

- Change in Net Assets is \$51.3 million, favorable to budget \$29.1 million
- Operating surplus is \$29.6 million, with a surplus in non-operating income of \$21.7 million

Change in Net Assets by Line of Business (LOB) (\$ millions):

August 2025				July - August 2025		
<u>Actual</u>	<u>Budget</u>	<u>Variance</u>		<u>Actual</u>	<u>Budget</u>	<u>Variance</u>
21.0	5.4	15.6	Operating Income (Loss)	32.6	10.8	21.8
(0.4)	(1.8)	1.4	Medi-Cal	(2.9)	(3.7)	0.7
0.5	0.3	0.2	OneCare	0.9	0.5	0.4
(0.1)	(0.1)	0.0	PACE	(0.2)	(0.2)	0.0
(0.6)	(0.8)	0.2	MSSP	(0.7)	(1.5)	0.8
20.4	2.9	17.5	Covered CA	29.6	5.8	23.8
			Total Operating Income (Loss)			
			Non-Operating Income (Loss)			
24.4	8.3	16.1	Net Investment Income/Expense	32.3	16.7	15.6
(7.9)	(0.1)	(7.8)	Other Income/Expense	0.0	(10.6)	(0.3)
16.5	8.2	8.3	Total Non-Operating Income/(Loss)	21.7	16.4	5.3
36.9	11.1	25.8	TOTAL	51.3	22.2	29.1

**CalOptima Health - Consolidated
Enrollment Summary
For the Two Months Ending August 31, 2025**

August 2025				Enrollment (by Aid Category)	July - August 2025			
Actual	Budget	\$ Variance	%Variance		Actual	Budget	\$ Variance	%Variance
152,002	147,415	4,587	3.1%	SPD	304,404	294,581	9,823	3.3%
254,354	259,527	(5,173)	(2.0%)	TANF Child	511,780	519,674	(7,894)	(1.5%)
126,680	129,771	(3,091)	(2.4%)	TANF Adult	255,246	260,186	(4,940)	(1.9%)
2,764	2,512	252	10.0%	LTC	5,364	5,025	339	6.7%
328,645	336,253	(7,608)	(2.3%)	MCE	664,266	675,135	(10,869)	(1.6%)
8,965	9,107	(142)	(1.6%)	WCM	18,129	18,227	(98)	(0.5%)
873,410	884,585	(11,175)	(1.3%)	Medi-Cal Total	1,759,189	1,772,828	(13,639)	(0.8%)
17,873	17,735	138	0.8%	OneCare	35,844	35,430	414	1.2%
529	533	(4)	(0.8%)	PACE	1,057	1,062	(5)	(0.5%)
551	558	(7)	(1.3%)	MSSP	1,104	1,116	(12)	(1.1%)
891,812	902,853	(11,041)	(1.2%)	CalOptima Health Total	1,796,090	1,809,320	(13,230)	(0.7%)

				Enrollment (by Network)				
Actual	Budget	\$ Variance	%Variance		Actual	Budget	\$ Variance	%Variance
344,151	351,442	(7,292)	(2.1%)	HMO	690,103	705,102	(14,999)	(2.1%)
164,468	165,118	(650)	(0.4%)	PHC	330,909	331,184	(275)	(0.1%)
66,543	67,651	(1,108)	(1.6%)	Shared Risk Group	134,486	135,518	(1,032)	(0.8%)
298,248	300,373	(2,125)	(0.7%)	Fee for Service	603,691	601,024	2,667	0.4%
873,410	884,585	(11,175)	(1.3%)	Medi-Cal Total	1,759,189	1,772,828	(13,639)	(0.8%)
17,873	17,735	138	0.8%	OneCare	35,844	35,430	414	1.2%
529	533	(4)	(0.8%)	PACE	1,057	1,062	(5)	(0.5%)
551	558	(7)	(1.3%)	MSSP	1,104	1,116	(12)	(1.1%)
891,812	902,853	(11,041)	(1.2%)	CalOptima Health Total	1,796,090	1,809,320	(13,230)	(0.7%)

Note:* Total membership does not include MSSP

CalOptima Health
Enrollment Trend by Network
Fiscal Year 2025

	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															
SPD	20,739	20,738											41,477	40,133	1,344
TANF Child	73,203	72,978											146,181	153,385	(7,204)
TANF Adult	67,587	67,579											135,166	136,903	(1,737)
LTC	3	12											15	2	13
MCE	182,912	181,318											364,230	371,815	(7,585)
WCM	1,508	1,526											3,034	2,861	173
Total	345,952	344,151											690,103	705,102	(14,999)
PHCs															
SPD	4,775	4,791											9,566	9,212	354
TANF Child	129,804	128,525											258,329	257,963	366
TANF Adult	3,936	3,870											7,806	7,973	(167)
LTC													0		0
MCE	21,807	21,373											43,180	43,858	(678)
WCM	6,119	5,909											12,028	12,178	(150)
Total	166,441	164,468											330,909	331,184	(275)
Shared Risk Groups															
SPD	3,418	3,327											6,745	6,362	383
TANF Child	18,444	18,179											36,623	35,977	646
TANF Adult	11,382	11,126											22,508	22,848	(340)
LTC		1											1		1
MCE	34,473	33,658											68,131	69,578	(1,447)
WCM	226	252											478	753	(275)
Total	67,943	66,543											134,486	135,518	(1,032)
Fee for Service (Dual)															
SPD	107,827	107,645											215,472	206,507	8,965
TANF Child		1											1		1
TANF Adult	876	859											1,735	2,240	(505)
LTC	2,311	2,446											4,757	4,455	302
MCE	3,187	3,126											6,313	10,350	(4,037)
WCM	15	26											41	29	12
Total	114,216	114,103											228,319	223,581	4,738
Fee for Service (Non-Dual - Total)															
SPD	15,643	15,501											31,144	32,367	(1,223)
TANF Child	35,975	34,671											70,646	72,349	(1,703)
TANF Adult	44,785	43,246											88,031	90,222	(2,191)
LTC	286	305											591	568	23
MCE	93,242	89,170											182,412	179,531	2,881
WCM	1,296	1,252											2,548	2,406	142
Total	191,227	184,145											375,372	377,443	(2,071)
Grand Totals															
SPD	152,402	152,002											304,404	294,581	9,823
TANF Child	257,426	254,354											511,780	519,674	(7,894)
TANF Adult	128,566	126,680											255,246	260,186	(4,940)
LTC	2,600	2,764											5,364	5,025	339
MCE	335,621	328,645											664,266	675,135	(10,869)
WCM	9,164	8,965											18,129	18,227	(98)
Total MediCal MM	885,779	873,410											1,759,189	1,772,828	(13,639)
OneCare	17,971	17,873											35,844	35,430	414
PACE	528	529											1,057	1,062	(5)
MSSP	553	551											1,104	1,116	(12)
Covered CA	0	0											0	0	0
Grand Total	904,278	891,812											1,796,090	1,809,320	(13,230)

Note:* Total membership does not include MSSP

ENROLLMENT– AUAGUST MONTH:

Overall, August enrollment was 891,812

- Unfavorable to budget 11,041 or 1.2%
- Decreased 12,466 or 1.4% from Prior Month (PM) (July 2025)
- Decreased 24,138 or 2.6% from Prior Year (PY) (August 2024)

Medi-Cal enrollment was 873,410

- Unfavorable to budget 11,175 or 1.3%
- Temporary Assistance for Needy Families (TANF) unfavorable to budget 8,264
- Medi-Cal Expansion (MCE) unfavorable to budget 7,608
- Whole Child Model (WCM) unfavorable to budget 142
- Seniors and Persons with Disabilities (SPD) favorable to budget 4,587
- Long-Term Care (LTC) favorable to budget 252
- Decreased 12,369 or 1.4% from PM

OneCare enrollment was 17,873

- Favorable to budget 138 or 0.8%
- Decreased 98 or 0.5% from PM

PACE enrollment was 529

- Unfavorable to budget 4 or 0.8%
- Increased 1 or 0.2% from PM

MSSP enrollment was 551

- Unfavorable to budget 7 or 1.3%
- Decreased 2 or 0.4% from PM

**CalOptima Health
Medi-Cal
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2025**

Month to Date					Year to Date			
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
873,410	884,585	(11,175)	(1.3%)	Member Months	1,759,189	1,772,828	(13,639)	(0.8%)
				Revenues				
351,750,552	354,988,075	(3,237,523)	(0.9%)	Medi-Cal Capitation Revenue	707,709,200	711,995,873	(4,286,673)	(0.6%)
351,750,552	354,988,075	(3,237,523)	(0.9%)	Total Operating Revenue	707,709,200	711,995,873	(4,286,673)	(0.6%)
				Medical Expenses				
111,547,111	113,663,854	2,116,743	1.9%	Provider Capitation	225,314,306	228,364,736	3,050,430	1.3%
74,476,616	67,673,017	(6,803,599)	(10.1%)	Facilities Claims	141,669,304	135,272,767	(6,396,537)	(4.7%)
72,066,540	75,546,288	3,479,748	4.6%	Professional Claims	148,317,161	150,751,042	2,433,881	1.6%
33,315,782	50,228,012	16,912,230	33.7%	MLTSS	82,287,021	100,315,534	18,028,513	18.0%
11,550,839	9,572,600	(1,978,239)	(20.7%)	Incentive Payments	22,116,253	19,180,657	(2,935,596)	(15.3%)
8,395,347	10,749,748	2,354,401	21.9%	Medical Management	16,951,953	22,066,541	5,114,588	23.2%
1,800,000	1,854,014	54,014	2.9%	Other Medical Expenses	3,600,046	3,716,942	116,896	3.1%
313,152,234	329,287,533	16,135,299	4.9%	Total Medical Expenses	640,256,044	659,668,219	19,412,175	2.9%
38,598,318	25,700,542	12,897,776	50.2%	Gross Margin	67,453,156	52,327,654	15,125,502	28.9%
				Administrative Expenses				
11,126,311	11,790,881	664,570	5.6%	Salaries, Wages & Employee Benefits	23,062,332	24,497,959	1,435,627	5.9%
1,404,146	1,357,129	(47,017)	(3.5%)	Professional Fees	2,158,521	2,699,449	540,928	20.0%
1,546,261	2,171,468	625,206	28.8%	Purchased Services	3,159,923	4,342,936	1,183,013	27.2%
398,130	485,060	86,930	17.9%	Printing & Postage	884,170	970,120	85,950	8.9%
798,397	947,712	149,315	15.8%	Depreciation & Amortization	1,602,475	1,895,424	292,949	15.5%
3,147,084	4,310,555	1,163,472	27.0%	Other Operating Expenses	5,619,522	8,635,919	3,016,396	34.9%
(842,557)	(741,376)	101,181	13.6%	Indirect Cost Allocation, Occupancy	(1,609,585)	(1,482,752)	126,833	8.6%
17,577,772	20,321,429	2,743,657	13.5%	Total Administrative Expenses	34,877,359	41,559,054	6,681,695	16.1%
				Non-Operating Income (Loss)				
(7,901,463)	-	(7,901,463)	(100.0%)	Community Reinvestment	(10,450,081)	-	(10,450,081)	(100.0%)
1,511	-	1,511	100.0%	Other Income/Expense	3,112	-	3,112	100.0%
(7,899,953)	-	(7,899,953)	(100.0%)	Total Non-Operating Income (Loss)	(10,446,969)	-	(10,446,969)	(100.0%)
13,120,594	5,379,113	7,741,481	143.9%	Change in Net Assets	22,128,828	10,768,600	11,360,228	105.5%
89.0%	92.8%	(3.7%)		Medical Loss Ratio	90.5%	92.7%	(2.2%)	
5.0%	5.7%	0.7%		Admin Loss Ratio	4.9%	5.8%	0.9%	

MEDI-CAL INCOME STATEMENT– AUGUST MONTH:

REVENUES are \$351.8 million, unfavorable to budget \$3.2 million:

- Unfavorable volume variance of \$4.5 million
- Favorable price related variance of \$1.2 million due to favorable member mix offset by Proposition 56, Enhanced Care Management (ECM) and Unsatisfactory Immigration Status (UIS) risk corridors

MEDICAL EXPENSES are \$313.2 million, favorable to budget \$16.1 million:

- Favorable volume variance of \$4.2 million
- Favorable price related variance of \$12.0 million:
 - Managed Long-Term Services and Supports (MLTSS) expense favorable variance of \$16.3 million due to reclassification of MLTSS claims to facilities claims due to a system logic update and change in Incurred But Not Reported (IBNR) reserves
 - Professional Claims expense favorable variance of \$2.5 million
 - Medical Management expense favorable variance of \$2.2 million
 - Offset by:
 - Facilities Claims unfavorable variance of \$7.7 million due to reclassification of MLTSS claims to facilities claims and change in IBNR reserves
 - Incentive Payments unfavorable variance of \$2.1 million

ADMINISTRATIVE EXPENSES are \$17.6 million, favorable to budget \$2.7 million:

- Non-Salary expense favorable to budget \$2.1 million
- Salaries, Wages & Employee Benefits expense favorable to budget \$0.7 million

CHANGE IN NET ASSETS is \$13.1 million, favorable to budget \$7.7 million

**CalOptima Health
OneCare
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2025**

Month to Date				Year to Date				
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
17,873	17,735	138	0.8%	Member Months	35,844	35,430	414	1.2%
				Revenues				
25,347,026	27,696,028	(2,349,002)	(8.5%)	Medicare Part C Revenue	50,890,850	55,508,787	(4,617,937)	(8.3%)
10,404,871	9,553,018	851,853	8.9%	Medicare Part D Revenue	20,366,142	19,101,700	1,264,442	6.6%
35,751,896	37,249,046	(1,497,150)	(4.0%)	Total Operating Revenue	71,256,992	74,610,487	(3,353,495)	(4.5%)
				Medical Expenses				
14,319,922	16,134,002	1,814,080	11.2%	Provider Capitation	29,076,055	32,334,208	3,258,154	10.1%
4,900,935	5,090,691	189,756	3.7%	Facilities Claims	9,567,201	10,160,660	593,459	5.8%
2,532,266	2,008,735	(523,531)	(26.1%)	Professional Claims	4,971,399	4,008,355	(963,044)	(24.0%)
9,684,549	10,519,774	835,225	7.9%	Prescription Drugs	20,500,545	20,974,252	473,707	2.3%
769,309	619,124	(150,185)	(24.3%)	Incentive Payments	1,637,586	1,246,326	(391,260)	(31.4%)
1,035,521	1,460,413	424,892	29.1%	Medical Management	2,089,895	3,005,164	915,269	30.5%
398,734	112,040	(286,694)	(255.9%)	Other Medical Expenses	1,161,324	223,830	(937,494)	(418.8%)
33,641,236	35,944,779	2,303,543	6.4%	Total Medical Expenses	69,004,005	71,952,795	2,948,790	4.1%
2,110,660	1,304,267	806,393	61.8%	Gross Margin	2,252,987	2,657,692	(404,705)	(15.2%)
				Administrative Expenses				
954,360	1,147,625	193,265	16.8%	Salaries, Wages & Employee Benefits	1,970,274	2,376,594	406,320	17.1%
(41,998)	117,716	159,714	135.7%	Professional Fees	69,641	235,432	165,791	70.4%
253,004	434,323	181,319	41.7%	Purchased Services	528,239	855,010	326,771	38.2%
84,087	121,107	37,020	30.6%	Printing & Postage	117,813	242,214	124,401	51.4%
63,497	112,453	48,956	43.5%	Other Operating Expenses	145,524	238,542	93,018	39.0%
1,181,620	1,198,167	16,547	1.4%	Indirect Cost Allocation, Occupancy	2,363,240	2,396,334	33,094	1.4%
2,494,571	3,131,391	636,820	20.3%	Total Administrative Expenses	5,194,731	6,344,126	1,149,395	18.1%
(383,911)	(1,827,124)	1,443,213	79.0%	Change in Net Assets	(2,941,744)	(3,686,434)	744,690	20.2%
94.1%	96.5%	(2.4%)		Medical Loss Ratio	96.8%	96.4%	0.4%	
7.0%	8.4%	1.4%		Admin Loss Ratio	7.3%	8.5%	1.2%	

ONECARE INCOME STATEMENT – AUGUST MONTH:

REVENUES are \$35.8 million, unfavorable to budget \$1.5 million:

- Favorable volume related variance of \$0.3 million
- Unfavorable price related variance of \$1.8 million driven by lower than anticipated Risk Adjustment Factor (RAF)

MEDICAL EXPENSES are \$33.6 million, favorable to budget \$2.3 million:

- Unfavorable volume related variance of \$0.3 million
- Favorable price related variance of \$2.6 million
 - Provider Capitation expense favorable variance of \$1.9 million
 - Prescription Drugs expense favorable variance of \$0.9 million

ADMINISTRATIVE EXPENSES are \$2.5 million, favorable to budget \$0.6 million

- Non-Salary expense favorable to budget \$0.4 million
- Salaries, Wages & Employee Benefits expense favorable to budget \$0.2 million

CHANGE IN NET ASSETS is (\$0.4) million, favorable to budget \$1.4 million

**CalOptima Health
PACE
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2025**

Month to Date				Year to Date				
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
529	533	(4)	(0.8%)	Member Months	1,057	1,062	(5)	(0.5%)
				Revenues				
3,630,831	3,641,452	(10,621)	(0.3%)	Medi-Cal Capitation Revenue	7,257,425	7,255,576	1,849	0.0%
889,609	819,777	69,832	8.5%	Medicare Part C Revenue	1,636,296	1,640,495	(4,199)	(0.3%)
302,346	322,742	(20,396)	(6.3%)	Medicare Part D Revenue	671,490	644,271	27,219	4.2%
4,822,787	4,783,971	38,816	0.8%	Total Operating Revenue	9,565,210	9,540,342	24,868	0.3%
				Medical Expenses				
1,371,044	1,535,629	164,585	10.7%	Medical Management	2,813,467	3,162,520	349,053	11.0%
943,516	820,765	(122,751)	(15.0%)	Facilities Claims	1,811,449	1,630,974	(180,475)	(11.1%)
765,559	774,565	9,006	1.2%	Professional Claims	1,572,201	1,539,031	(33,170)	(2.2%)
587,489	711,874	124,385	17.5%	Prescription Drugs	1,156,923	1,414,550	257,627	18.2%
44,761	36,316	(8,445)	(23.3%)	MLTSS	54,128	70,735	16,607	23.5%
305,919	276,336	(29,583)	(10.7%)	Patient Transportation	619,632	547,797	(71,835)	(13.1%)
4,018,290	4,155,485	137,195	3.3%	Total Medical Expenses	8,027,800	8,365,607	337,807	4.0%
804,497	628,486	176,011	28.0%	Gross Margin	1,537,411	1,174,735	362,676	30.9%
				Administrative Expenses				
178,277	177,036	(1,241)	(0.7%)	Salaries, Wages & Employee Benefits	365,220	368,384	3,164	0.9%
227	13,941	13,714	98.4%	Professional Fees	5,019	27,674	22,655	81.9%
86,364	69,662	(16,702)	(24.0%)	Purchased Services	168,689	139,324	(29,365)	(21.1%)
(7,084)	21,787	28,871	132.5%	Printing & Postage	(1,857)	43,574	45,431	104.3%
886	1,622	736	45.4%	Depreciation & Amortization	1,772	3,244	1,472	45.4%
10,924	11,112	188	1.7%	Other Operating Expenses	18,816	22,432	3,616	16.1%
16,670	17,494	824	4.7%	Indirect Cost Allocation, Occupancy	33,339	34,988	1,649	4.7%
286,264	312,654	26,390	8.4%	Total Administrative Expenses	590,999	639,620	48,621	7.6%
518,233	315,832	202,401	64.1%	Change in Net Assets	946,412	535,115	411,297	76.9%
83.3%	86.9%	(3.5%)		Medical Loss Ratio	83.9%	87.7%	(3.8%)	
5.9%	6.5%	0.6%		Admin Loss Ratio	6.2%	6.7%	0.5%	

CalOptima Health
Multipurpose Senior Services Program (MSSP)
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2025

Month to Date					Year to Date			
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
551	558	(7)	(1.3%)	Member Months	1,104	1,116	(12)	(1.1%)
				Revenues				
236,590	249,054	(12,464)	(5.0%)	Revenue	488,568	498,108	(9,540)	(1.9%)
236,590	249,054	(12,464)	(5.0%)	Total Operating Revenue	488,568	498,108	(9,540)	(1.9%)
				Medical Expenses				
187,445	194,133	6,688	3.4%	Medical Management	382,786	388,266	5,480	1.4%
34,087	32,959	(1,128)	(3.4%)	Waiver Services	76,160	65,918	(10,242)	(15.5%)
187,445	194,133	6,688	3.4%	Total Medical Management	382,786	388,266	5,480	1.4%
34,087	32,959	(1,128)	(3.4%)	Total Waiver Services	76,160	65,918	(10,242)	(15.5%)
221,532	227,092	5,560	2.4%	Total Program Expenses	458,946	454,184	(4,762)	(1.0%)
15,058	21,962	(6,904)	(31.4%)	Gross Margin	29,623	43,924	(14,301)	(32.6%)
				Administrative Expenses				
93,602	119,157	25,555	21.4%	Salaries, Wages & Employee Benefits	199,149	246,878	47,729	19.3%
1,457	1,500	43	2.9%	Professional Fees	2,914	3,000	86	2.9%
8	-	(8)	(100.0%)	Purchased Services	8	-	(8)	(100.0%)
6,739	8,520	1,781	20.9%	Other Operating Expenses	12,137	17,040	4,903	28.8%
7,580	7,583	3	0.0%	Indirect Cost Allocation, Occupancy	15,160	15,166	6	0.0%
109,386	136,760	27,374	20.0%	Total Administrative Expenses	229,368	282,084	52,716	18.7%
(94,328)	(114,798)	20,470	17.8%	Change in Net Assets	(199,745)	(238,160)	38,415	16.1%
93.6%	91.2%	2.5%		Medical Loss Ratio	93.9%	91.2%	2.8%	
46.2%	54.9%	8.7%		Admin Loss Ratio	46.9%	56.6%	9.7%	

**CalOptima Health
Covered CA
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2025**

Month to Date				Year to Date				
Actual	Budget	\$ Variance	% Variance		Actual	Budget	\$ Variance	% Variance
-	-	-	0.0%	Member Months	-	-	-	0.0%
				Revenues				
-	-	-	0.0%	Medi-Cal Capitation Revenue	-	-	-	0.0%
-	-	-	0.0%	Total Operating Revenue	-	-	-	0.0%
				Medical Expenses				
-	44,984	44,984	100.0%	Medical Management	-	89,968	89,968	100.0%
-	44,984	44,984	100.0%	Total Medical Expenses	-	89,968	89,968	100.0%
-	(44,984)	44,984	(100.0%)	Gross Margin	-	(89,968)	89,968	(100.0%)
				Administrative Expenses				
73,572	261,847	188,275	71.9%	Salaries, Wages & Employee Benefits	126,669	425,464	298,795	70.2%
561,835	418,333	(143,502)	(34.3%)	Professional Fees	612,150	836,666	224,516	26.8%
-	52,000	52,000	100.0%	Purchased Services	-	104,000	104,000	100.0%
-	21	21	100.0%	Printing & Postage	-	42	42	100.0%
-	43,221	43,221	100.0%	Other Operating Expenses	-	86,442	86,442	100.0%
635,407	775,422	140,015	18.1%	Total Administrative Expenses	738,819	1,452,614	713,795	49.1%
				Non-Operating Income (Loss)				
-	-	-	0.0%	Net Operating Tax	-	-	-	0.0%
-	-	-	0.0%	Net QAF & IGT Income/Expense	-	-	-	0.0%
-	-	-	0.0%	Other Income/Expense	-	-	-	0.0%
-	-	-	0.0%	Total Non-Operating Income (Loss)	-	-	-	0.0%
(635,407)	(820,406)	184,999	22.5%	Change in Net Assets	(738,819)	(1,542,582)	803,763	52.1%
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 Two Months Ending August 31, 2025

Month to Date				Year to Date			
Actual	Budget	\$ Variance	% Variance	Actual	Budget	\$ Variance	% Variance
Revenues							
-	-	-	0.0%	-	-	-	0.0%
-	-	-	0.0%	-	-	-	0.0%
Total Operating Revenue							
Administrative Expenses							
49,834	29,708	(20,126)	(67.7%)	113,745	59,416	(54,329)	(91.4%)
185,353	191,643	6,290	3.3%	370,707	383,286	12,579	3.3%
23,377	25,124	1,747	7.0%	46,748	50,248	3,500	7.0%
95,969	219,809	123,840	56.3%	303,413	439,618	136,205	31.0%
111,535	59,093	(52,442)	(88.7%)	169,268	118,186	(51,082)	(43.2%)
(466,069)	(525,376)	(59,307)	(11.3%)	(1,003,881)	(1,050,752)	(46,871)	(4.5%)
-	1	1	100.0%	-	2	2	100.0%
Total Administrative Expenses							
-	(1)	1	(100.0%)	-	(2)	2	(100.0%)
Change in Net Assets							

CalOptima Health
Building - 500 City Parkway
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2025

Month to Date				Year to Date			
Actual	Budget	\$ Variance	% Variance	Actual	Budget	\$ Variance	% Variance
Revenues							
134,260	118,206	16,054	13.6%	261,751	236,412	25,339	10.7%
134,260	118,206	16,054	13.6%	261,751	236,412	25,339	10.7%
Total Operating Revenue							
Administrative Expenses							
-	-	-	0.0%	-	-	-	0.0%
17,598	19,131	1,533	8.0%	59,291	38,262	(21,029)	(55.0%)
59,781	75,663	15,882	21.0%	118,570	151,326	32,756	21.6%
8,600	9,245	645	7.0%	17,199	18,490	1,291	7.0%
21,190	104,657	83,467	79.8%	114,765	209,314	94,549	45.2%
14,749	31,298	16,549	52.9%	60,498	62,596	2,098	3.4%
(12,911)	(25,416)	(12,505)	(49.2%)	(39,218)	(50,832)	(11,614)	(22.8%)
109,008	214,578	105,571	49.2%	331,106	429,156	98,050	22.8%
Total Administrative Expenses							
25,253	(96,372)	121,625	126.2%	(69,356)	(192,744)	123,388	64.0%
Change in Net Assets							

CalOptima Health
Building - 7900 Garden Grove Blvd
Statement of Revenues and Expenses
For the Two Months Ending August 31, 2025

Month to Date				Year to Date			
Actual	Budget	\$ Variance	% Variance	Actual	Budget	\$ Variance	% Variance
Revenues							
-	-	-	0.0%	-	-	-	0.0%
-	-	-	0.0%	-	-	-	0.0%
Total Operating Revenue							
Administrative Expenses							
-	-	-	0.0%	-	-	-	0.0%
38,880	3,333	(35,547)	(1066.5%)	68,740	6,666	(62,074)	(931.2%)
9,397	9,651	254	2.6%	18,795	19,302	507	2.6%
4,751	-	(4,751)	(100.0%)	9,502	-	(9,502)	(100.0%)
(4,200)	28,533	32,733	114.7%	(1,902)	57,066	58,968	103.3%
(30)	720	750	104.2%	970	1,440	470	32.7%
-	-	-	0.0%	-	-	-	0.0%
48,798	42,237	(6,561)	(15.5%)	96,104	84,474	(11,630)	(13.8%)
(48,798)	(42,237)	(6,561)	(15.5%)	(96,104)	(84,474)	(11,630)	(13.8%)
Change in Net Assets							

OTHER PROGRAM INCOME STATEMENTS – AUGUST MONTH:

PACE

- **CHANGE IN NET ASSETS** is \$0.5 million, favorable to budget \$0.2 million

MSSP

- **CHANGE IN NET ASSETS** is (\$94,328), favorable to budget \$20,470

Covered CA

- **CHANGE IN NET ASSETS** is (\$0.6) million, favorable to budget \$0.2 million

NON-OPERATING INCOME STATEMENTS – AUGUST MONTH:

BUILDING 500 City Parkway

- **CHANGE IN NET ASSETS** is \$25,253, favorable to budget \$121,625
 - Net of \$134,260 in rental income and \$109,008 in expenses

BUILDING 7900 Garden Grove Blvd

- **CHANGE IN NET ASSETS** is (\$48,798), unfavorable to budget \$6,561

INVESTMENT INCOME

- Favorable variance of \$16.1 million compared to budget. Overall net investment income of \$24.4 million due to \$13.2 million in interest income and \$11.2 million of realized and unrealized gain on investments

CalOptima Health
Balance Sheet
August 31, 2025

		August-25	July-25	\$ Change	% Change
ASSETS					
Current Assets					
	Cash and Cash Equivalents	485,883,719	373,963,314	111,920,405	29.9%
	Short-term Investments	1,500,773,614	1,464,311,276	36,462,338	2.5%
	Capitation Receivable	452,366,783	518,034,478	(65,667,695)	(12.7%)
	Receivables - Other	86,860,642	89,705,884	(2,845,242)	(3.2%)
	Prepaid Expenses	15,720,349	13,520,101	2,200,249	16.3%
	Total Current Assets	2,541,605,108	2,459,535,052	82,070,055	3.3%
Board Designated Assets					
	Board Designated Reserves	1,599,085,594	1,584,624,044	14,461,550	0.9%
	Statutory Designated Reserves	133,740,414	132,296,848	1,443,565	1.1%
	Total Designated Assets	1,732,826,007	1,716,920,892	15,905,115	0.9%
Restricted Deposit		300,000	300,000	-	0.0%
Capital Assets, Net		102,443,520	102,691,674	(248,154)	(0.2%)
Total Assets		4,377,174,635	4,279,447,618	97,727,017	2.3%
Deferred Outflows of Resources					
	Advance Discretionary Payment	-	-	-	0.0%
	Net Pension	27,437,072	27,437,072	-	0.0%
	Other Postemployment Benefits	1,189,000	1,189,000	-	0.0%
	Total Deferred Outflows of Resources	28,626,072	28,626,072	-	0.0%
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		4,405,800,707	4,308,073,690	97,727,017	2.3%
LIABILITIES					
Current Liabilities					
	Accounts Payable	107,236,859	105,746,041	1,490,818	1.4%
	Medical Claims Liability	1,058,343,475	1,048,281,485	10,061,990	1.0%
	Accrued Payroll Liabilities	25,485,551	25,282,450	203,101	0.8%
	Deferred Revenue	52,839,094	15,146,239	37,692,855	248.9%
	Other Current Liabilities	-	-	-	0.0%
	Capitation & Withholds	164,213,847	158,732,484	5,481,363	3.5%
	Total Current Liabilities	1,408,118,826	1,353,188,699	54,930,126	4.1%
	GASB 96 Subscription Liabilities	19,540,147	21,561,250	(2,021,103)	(9.4%)
	Community Reinvestment	98,548,192	90,646,728	7,901,463	8.7%
	Capital Lease Payable	237,530	241,474	(3,944)	(1.6%)
	Postemployment Health Care Plan	17,284,806	17,256,358	28,448	0.2%
	Net Pension Liability	5,840,992	5,840,992	-	0.0%
	Total Liabilities	1,549,570,492	1,488,735,501	60,834,991	4.1%
Deferred Inflows of Resources					
	Net Pension	1,321,519	1,321,519	-	0.0%
	Other Postemployment Benefits	2,988,000	2,988,000	-	0.0%
	Total Deferred Inflows of Resources	4,309,519	4,309,519	-	0.0%
Net Position					
	Required TNE	128,423,137	129,265,189	(842,053)	(0.7%)
	Funds in excess of TNE	2,723,497,559	2,685,763,481	37,734,078	1.4%
	Total Net Position	2,851,920,696	2,815,028,671	36,892,025	1.3%
TOTAL LIABILITIES & DEFERRED INFLOWS & NET POSITION		4,405,800,707	4,308,073,690	97,727,017	2.3%

BALANCE SHEET – AUGUST MONTH:

ASSETS of \$4.4 billion increased \$97.7 million from July or 2.3%

- Operating Cash and Short-term Investments increased \$148.4 million due to the receipt of Managed Care Organization (MCO) tax from the State, the prepayment of the Centers for Medicare & Medicaid Services (CMS) OneCare (OC) capitation payment for September and investment income earnings
- Total Designated Assets increased \$15.9 million due to unrealized gains due to the decline in long-term interest rates
- Capitation Receivables decreased \$65.7 million primarily due to the receipt of MCO tax

LIABILITIES of \$1.5 billion increased \$60.8 million from July or 4.1%

- Deferred Revenue increased \$37.7 million due to the prepayment of the CMS OC capitation payment for September
- Medical Claims Liabilities increased \$10.1 million
- Community Reinvestment increased \$7.9 million
- Capitation & Withholds increased \$5.5 million

NET ASSETS of \$2.9 billion, increased \$36.9 million from July or 1.3%

CalOptima Health
Board Designated Reserve and TNE Analysis
as of August 31, 2025

Board Designated Reserves

Investment Account Name	Market Value	CalOptima Policy Compliance Level		Variance	
		Low	High	Mkt - Low	Mkt - High
Payden & Rygel Tier One	799,596,534				
MetLife Tier One	799,489,059				
Board Designated Reserves	1,599,085,594	1,058,031,035	1,692,849,655	541,054,559	(93,764,062)
<i>Current Reserve Level (X months of average monthly revenue) ¹</i>					
	3.78	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	66,999,919				
MetLife Tier Two	66,740,495				
Statutory Designated Reserves	133,740,414	128,423,137	141,265,450	5,317,277	(7,525,036)
<i>Current Reserve Level (X min. TNE) ¹</i>					
	1.04	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
August 31, 2025

	<u>August 2025</u>	<u>July - August 2025</u>
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	36,892,025	51,336,995
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation & Amortization	1,053,815	2,112,319
Changes in assets and liabilities:		
Prepaid expenses and other	(2,200,249)	(4,537,287)
Capitation receivable	68,512,937	209,884,310
Medical claims liability	10,061,990	10,606,135
Deferred revenue	37,692,855	30,784,532
Payable to health networks	5,481,363	10,220,482
Accounts payable	1,490,818	(126,749,648)
Accrued payroll	231,549	(4,324,431)
Other accrued liabilities	5,876,416	13,145,005
Net cash provided by/(used in) operating activities	165,093,520	192,478,411
 GASB 68, GASB 75 and Advance Discretionary Payment Adjustments	 -	 -
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	(36,462,338)	(159,847,013)
Change in Property and Equipment	(805,662)	(5,933,135)
Change in Restricted Deposit & Other	-	-
Change in Board Designated Reserve	(15,905,115)	(16,018,499)
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	(53,173,115)	(181,798,647)
 NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	 111,920,405	 10,679,764
 CASH AND CASH EQUIVALENTS, beginning of period	 373,963,314	 475,203,955
 CASH AND CASH EQUIVALENTS, end of period	 <u>485,883,719</u>	 <u>485,883,719</u>

CalOptima Health
Spending Plan
For the Two Months Ending August 31, 2025

Category	Item Description	Amount (millions)	Approved Initiative	Expense to Date	%
	Total Net Position @ 8/31/2025	\$2,851.9			100.0%
Resources Assigned	Board Designated Reserve ¹	\$1,599.1			56.1%
	Statutory Designated Reserve ¹	\$133.7			4.7%
	Capital Assets, net of Depreciation	\$102.4			3.6%
Resources Allocated³	Homeless Health Initiative ²	\$19.4	\$65.9	\$46.5	0.7%
	Housing and Homelessness Incentive Program ²	25.8	87.4	61.5	0.9%
	Intergovernmental Transfers (IGT) ⁴	44.3	52.1	7.8	1.6%
	Digital Transformation and Workplace Modernization ³	27.1	100.0	72.9	0.9%
	CalFresh Outreach Strategy	0.0	2.0	2.0	0.0%
	CalFresh and Redetermination Outreach Strategy	1.7	6.0	4.3	0.1%
	Coalition of Orange County Community Health Centers Grant	25.7	50.0	24.3	0.9%
	Mind OC Grant (Irvine)	0.0	15.0	15.0	0.0%
	General Awareness Campaign	0.4	4.7	4.3	0.0%
	Member Health Needs Assessment	0.6	1.3	0.7	0.0%
	Five-Year Hospital Quality Program Beginning MY 2023	117.7	153.5	35.8	4.1%
	Skilled Nursing Facility Access Program	10.0	10.0	0.0	0.4%
	In-Home Care Pilot Program with the UCI Family Health Center	2.0	2.0	0.0	0.1%
	National Alliance for Mental Illness Orange County Peer Support Program Grant	3.0	5.0	2.0	0.1%
	Stipend Program for Master of Social Work Students Grant	0.0	5.0	5.0	0.0%
	Wellness & Prevention Program Grant	1.5	2.7	1.2	0.1%
	CalOptima Health Provider Workforce Development Fund Grant	44.5	50.0	5.5	1.6%
	Distribution Event - Naloxone Grant	2.2	15.0	12.8	0.1%
	Garden Grove Bldg. Improvement	9.7	10.5	0.8	0.3%
	CalOptima Health Community Reinvestment Program	38.0	38.0	0.0	1.3%
	Dyadic Services Program Academy	1.0	1.9	0.9	0.0%
	Outreach Strategy for newly eligible Adult Expansion members	2.8	7.6	4.8	0.1%
	Quality Initiatives from unearned Pay for Value Program	18.6	23.3	4.7	0.7%
	Expansion of CalOptima Health OC Outreach and Engagement Strategy	0.2	1.2	1.0	0.0%
	Medi-Cal Provider Rate Increases	280.6	526.2	245.6	9.8%
	Homeless Prevention and Stabilization Pilot Program	0.2	0.3	0.1	0.0%
	OneCare Member Engagement and Education	0.2	0.3	0.0	0.0%
	Subtotal:	\$677.4	\$1,236.7	\$559.3	23.8%
Resources Available for New Initiatives	Unallocated/Unassigned ¹	\$339.2			11.9%

¹ Total Designated Reserves and unallocated reserve amount can support approximately 177 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.

⁴ On June 5, 2025, the Board of Directors approved the close out of Board-approved initiatives and transfer of remaining funds back to unallocated reserves.

CalOptima Health
Key Financial Indicators
As of August 31, 2025

	Item Name	August 2025			
		Actual	Budget	Variance	%
Income Statement	Member Months	891,812	902,853	(11,041)	(1.2%)
	Operating Revenue	392,561,825	397,270,146	(4,708,321)	(1.2%)
	Medical Expenses	351,033,292	369,659,873	18,626,581	5.0%
	General and Administrative Expense	21,103,399	24,677,656	3,574,257	14.5%
	Non-Operating Income/(Loss)	16,466,892	8,194,730	8,272,162	100.9%
	Summary of Income & Expenses	36,892,025	11,127,347	25,764,678	231.5%
Ratios	Medical Loss Ratio (MLR)	Actual	Budget	Variance	
	Consolidated	89.4%	93.1%	(3.6%)	
	Administrative Loss Ratio (ALR)	Actual	Budget	Variance	
	Consolidated	5.4%	6.2%	0.8%	

July - August 2025				
Actual	Budget	Variance	%	
1,796,090	1,809,320	(13,230)	(0.7%)	
789,019,971	796,644,810	(7,624,839)	(1.0%)	
717,746,794	740,530,773	22,783,979	3.1%	
41,631,276	50,277,498	8,646,222	17.2%	
21,695,094	16,389,460	5,305,634	32.4%	
51,336,995	22,225,999	29,110,996	131.0%	
Actual	Budget	Variance		
91.0%	93.0%	(2.0%)		
Actual	Budget	Variance		
5.3%	6.3%	1.0%		

Key:

> 0%	
> -20%, < 0%	
< -20%	

	Investment Balance (excluding CCE)		Current Month	Prior Month	Change	%
	@8/31/2025		3,199,650,807	3,156,008,921	43,641,886	1.4%
Investment	Unallocated/Unassigned Reserve Balance		Current Month @ August 2025	Fiscal Year Ending June 2024	Change	%
	Consolidated		339,238,682	264,975,684	74,262,997	28.0%
	Days Cash On Hand*		177			

*Total Designated Reserves and unallocated reserve amount can support approximately 177 days of CalOptima Health's current operations.

CalOptima Health
Digital Transformation Strategy (\$100 million total reserve)
Funding Balance Tracking Summary
For the Two Months Ending August 31, 2025

	August 2025			
	Actual Spend	Approved Budget	Variance \$	Variance %
Capital Assets (Cost, Information Only):				
Total Capital Assets	512,520	2,273	(510,247)	(22,448.2%)

	July 2025 - August 2025			
	Actual Spend	Approved Budget	Variance \$	Variance %
	527,520	2,273	(525,247)	(23,108.1%)

	All Time to Date			
	Actual Spend	Approved Budget	Variance \$	Variance %
	16,138,471	26,721,647	10,583,176	39.6%

Operating Expenses:				
Salaries, Wages & Benefits	-	-	-	0.0%
Professional Fees	228,137	250,000	21,863	8.7%
Purchased Services	(66,554)	-	66,554	0.0%
GASB 96 Amortization Expenses	-	-	-	0.0%
Other Expenses	392,474	182,292	(210,182)	(115.3%)
Medical Management	229,256	0	(229,256)	0.0%
Total Operating Expenses	783,313	432,292	(351,021)	(81.2%)

	-	-	-	0.0%
	456,274	500,000	43,726	8.7%
	(66,554)	-	66,554	0.0%
	-	-	-	0.0%
	820,314	364,584	(455,730)	(125.0%)
	458,513	0	(458,513)	0.0%
	1,668,547	864,584	(803,963)	(93.0%)

	17,826,058	17,826,058	-	0.0%
	7,257,085	7,300,811	43,726	0.6%
	1,266,115	1,332,669	66,554	5.0%
	2,563,169	2,563,169	-	0.0%
	21,916,055	21,460,325	(455,730)	(2.1%)
	5,960,669	5,502,156	(458,513)	(8.3%)
	56,789,153	55,985,190	(803,963)	(1.4%)

Funding Balance Tracking:	Approved Budget	Actual Spend	Variance
Beginning Funding Balance	100,000,000	100,000,000	-
Less:			
Capital Assets ¹	38,880,374	16,138,471	22,741,903
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	1,668,547	3,518,953
Ending Funding Balance	474,023	27,072,376	26,598,353
Add: Prior year unspent Operating Budget	337,498		
Total Available Funding	811,521		

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 August 31, 2025

Summary by Funding Source:	Total Funds	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
HHI - IGT'S	64,131,301	64,131,301	46,500,149	17,631,152	-
HHI - Existing Reserves	1,800,000	1,800,000	-	1,800,000	-
HHIP	40,100,000	40,100,000	-	40,100,000	-
Total	106,031,301	106,031,301	46,500,149	59,531,152	-

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)	2,500,000	-	2,500,000	IGT's
Clinical Field Team Start-up & Federally Qualified Health Center (FQHC)	1,600,000	1,600,000	-	IGT's
CalOptima Health Homeless Response Team	1,681,734	1,681,734	-	IGT's
Homeless Coordination at Hospitals	10,000,000	9,956,478	43,522	IGT's
CalOptima Health Days, Homeless Clinical Access Program (HCAP) and FQHC Administrative Support	963,261	925,540	37,721	IGT's
FQHC (Community Health Center) Expansion	21,902	21,902	-	IGT's
HCAP and CalOptima Health Days	9,888,914	4,480,022	5,408,891	IGT's
Vaccination Intervention and Member Incentive Strategy ²	54,649	54,649	-	IGT's
Street Medicine ^{1/3}	14,376,652	7,659,620	6,717,032	IGT's & Existing Reserves
Outreach and Engagement	7,000,000	2,276,015	4,723,985	IGT's
Housing and Homelessness Incentive Program (HHIP) ⁴	40,100,000	-	40,100,000	IGT's & Existing Reserves
Subtotal of Approved Initiatives	106,031,301	46,500,149	59,531,151	
Transfer of funds to HHIP ⁴	(40,100,000)	-	(40,100,000)	
Program Total	65,931,301	46,500,149	19,431,151	

¹On 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 of Director action, to fund 2-year grant agreements to Healthcare in Action (Anaheim), Celebrating Life Community Health Center (Costa Mesa), and AltaMed (Santa Ana).

²On June 5, 2025 the 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.

³On March 19, 2025, CalOptima Health's Board of Directors approved \$4.3 million from existing reserves to fund a new Street Medicine Program (Santa Ana). On March 7, 2024, CalOptima Health's Board of Directors approved \$5.0 million to expand the Street Medicine Program. \$3.2 million remaining from Street Medicine Initiative (from the HHI reserve) and \$1.8 million from existing reserves to fund 2-year agreements with Healthcare in Action (Anaheim) and Celebrating Life Community Health Center (Costa Mesa).

⁴On September 1, 2022, CalOptima Health's Board of Directors approved reallocation of \$40.1 million from HHI to HHIP.

CalOptima Health
Summary of Housing and Homelessness Incentive Program (HHIP) and Allocated Funds
As of August 31, 2025

Summary by Funding Source:	Total Funds¹	Allocated Amount	Utilized Amount	Remaining Approved Amount	Funds Available for New Initiatives
DHCS HHIP Funds	72,931,189	54,930,994	31,937,512	22,993,482	\$18,000,195
Existing Reserves & HHI Transfer	87,384,530	87,384,530	61,550,626	25,833,904	-
Total	160,315,719	142,315,524	93,488,137	48,827,387	18,000,195

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	869,850	530,150	HHI
Equity Grants for Programs Serving Underrepresented Populations	4,621,311	3,696,311	925,000	HHI & DHCS
Infrastructure Projects	5,832,314	5,580,354	251,960	HHI
Capital Projects	108,247,369	73,195,575	35,051,794	HHI, DHCS & Existing Reserves
System Change Projects	10,184,530	7,290,657	2,893,873	DHCS
Non-Profit Healthcare Academy	700,000	655,391	44,609	DHCS
Total of Approved Initiatives	\$133,185,524¹	\$93,488,137	\$39,697,387	

¹Total 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.

CalOptima Health
Fiscal Year 2025-26 Budget Allocation Changes
Reporting Changes as of August 31, 2025

Transfer Month	Line of Business	From	To	Amount	Reason to Re-Allocate Funds
July	Medi-Cal	Human Resources - Training & Seminar - New: 7 Habits of Highly Effective People	Human Resources - Cert./Cont. Education - Educational Reimbursement	\$90,000	For Educational Reimbursement
July	Medi-Cal	Human Resources - Professional Fees - Executive Recruiters, Direct Hire & Conversion Fees	Human Resources - Advertising - Combined: Recruitment & Job Postings Network	\$90,000	For LinkedIn Advertising
July	Medi-Cal	IS - Infrastructure - Maintenance HW/SW - Oracle Software License	IS - Infrastructure - Maintenance HW/SW - Server - HP Server Maintenance	\$28,150	For HP Maintenance Coverage
July	Medi-Cal	IS - Application Development - Prof Fees - Development and QA Professional Services	IS - Application Development - Purch Svcs - General - Managed Services for Website Support	\$120,250	For American Eagle maintenance support
August	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Oracle Software License	ITS - Infrastructure - Other Operating Expenses - Server - VMWare	\$140,238	For VMWare
August	Medi-Cal	ITS - Infrastructure - Other Operating Expenses - Palo Alto Firewall	ITS - Infrastructure - Professional Fees - IT Advisory Subscription	\$162,890	For Professional Services
August	Medi-Cal	ITS - Application Development - Automated 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

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.



**Board of Directors Meeting
October 2, 2025**

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 (FWA) 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

- The Financial Analysis team is leading the effort to retrieve relevant provider medical records for submission to Centers for Medicare & Medicaid Services (CMS).
- Medical records have been reviewed, validated and submitted to CMS. Awaiting review from CMS and next steps.

Previously Reported

- June 12, 2025 - CMS notified CalOptima Health 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 will close on September 15, 2025.

Background

- The PY 2019 RADV audit will focus on risk adjusted payments made to Medicare Advantage Organizations (MAO) for the 2019 coverage year that CMS believes may be at higher risk for overpayments.

b. Annual Compliance Program Effectiveness (CPE) Audit (applicable to OneCare)

Update

- August 25, 2025 – Audit Engagement received.
- August 28, 2025 – Pre-Audit deliverables have been submitted to the auditor.

Previously Reported

- Kick off meeting conducted 8/6/25.
- Audit Webinar Week 10/6/25 – 10/10/25.
- Independent consultant conducted two pre-training sessions with CalOptima Health on 8/6/25 and 8/12/25.
- Regulatory Affairs & Compliance (RAC) Medicare requested the business areas to submit the pre-audit deliverables.

Background

- CalOptima Health is required to conduct an independent audit on the effectiveness of its Compliance program on an annual basis, and to share the results with the governing body.
- CalOptima Health engaged an independent consultant to conduct the audit to ensure that its Compliance Program is administering the elements of an effective compliance program as outlines in the CMS Medicare Part C and D Program Audit Protocols.
- The audit will start in early August, 2025 and continue through November, 2025.
- The audit review period will be from 2/3/25 through 8/1/25.

2. Medi-Cal

a. 2025 Department of Health Care Services (DHCS) Routine Medical Audit

Update

- 9/4/25: Final Corrective Action Plan (CAP) updates were submitted to DHCS on 8/1/25 (as previously reported).
- CalOptima Health awaits DHCS determination or feedback on 3 remaining open CAPs.
- **At this time, no additional deliverables are due to DHCS.**

Audit Details and Background – previously reported

- 6/26/25: CalOptima Health submitted its timely CAP response to DHCS.
 - DHCS accepted 1 of the 4 CAPs; 3 CAPs remained open until additional information and future deliverables were provided.
- 8/1/25: Final CAP updates & deliverables submitted to DHCS.
- The DHCS Routine Medical Audit consisted of DHCS’s review of both the Primary (aka “Main Contract”) and Secondary contracts (aka “State Supported Services”). The report findings are as follows:
 - **Primary/Main Contract**
 - **4 Findings** across 3 audit categories.

Category #	Audit Area	# of Findings
1	Utilization Management	1
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	1

- **Secondary Contract - State Supported Services (SSS)**
 - **No Findings**
- October 23, 2024 – DHCS engaged CalOptima Health in its annual, routine medical audit.
 - The audit consisted of an evaluation of CalOptima Health’s compliance with its contract and regulations in six (6) categories:
 - Utilization Management (UM)
 - Case management and coordination of care
 - > New area audited in this category:
 - Enhanced Care Management (ECM)
 - Availability and accessibility
 - Member’s rights
 - Quality management
 - Administrative and organizational capacity
 - > New area audited in this category:
 - Encounters
 - New areas audited
 - Enhanced Care Management (ECM)
 - Encounters
 - The audit was considered a limited-scope audit and required the participation of two (2) CalOptima Health Networks: Children’s Hospital of Orange County Health Alliance (CHOC) and Optum for UM only
 - Onsite interviews were conducted with CalOptima Health staff, including Medical Director, Director of Quality Management, Director of Utilization Management, Member Services Manager, Provider Relations Manager, Health Education Coordinator, Grievance Coordinator, and other staff as necessary.
 - The audit involved a review of pre-onsite documents, staff interviews and medical record review.
- January 27, 2025 through January 29, 2025 – DHCS conducted the onsite visit with an Entrance Conference and conducted staff interviews throughout the rest of the onsite visit.
- 5/27/25: DHCS finalized its draft report and CalOptima Health received its formal CAP Request from DHCS.
 - The report was consistent with the draft report with four findings.

B. REGULATORY NOTICES OF NON-COMPLIANCE

- On August 28, 2025, CMS issued a Notice of Non-Compliance to CalOptima Health OneCare for failure to include four (4) protected class drugs during the July 2025 formulary file submission window.
- A Corrective Action Plan was issued to Pharmacy Management with a due date of September 17, 2025.

C. UPDATES ON HEALTH NETWORK MONITORING AND AUDITS

- None conducted in September 2025.

D. INTERNAL AUDIT DEPARTMENT (IAD)

a. Internal Annual Audits in Process

- 2025 Case Management (OneCare)
- 2025 Claims Administration (Medi-Cal)
- 2025 Claims Administration (OneCare)

b. Ad Hoc Internal Audits

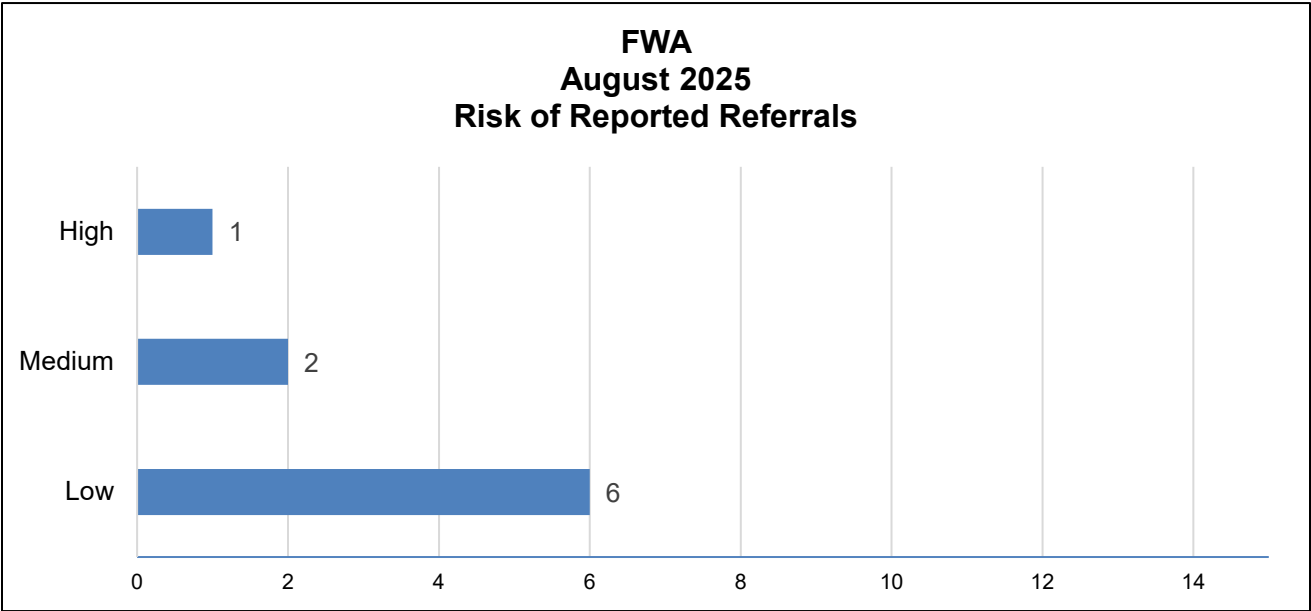
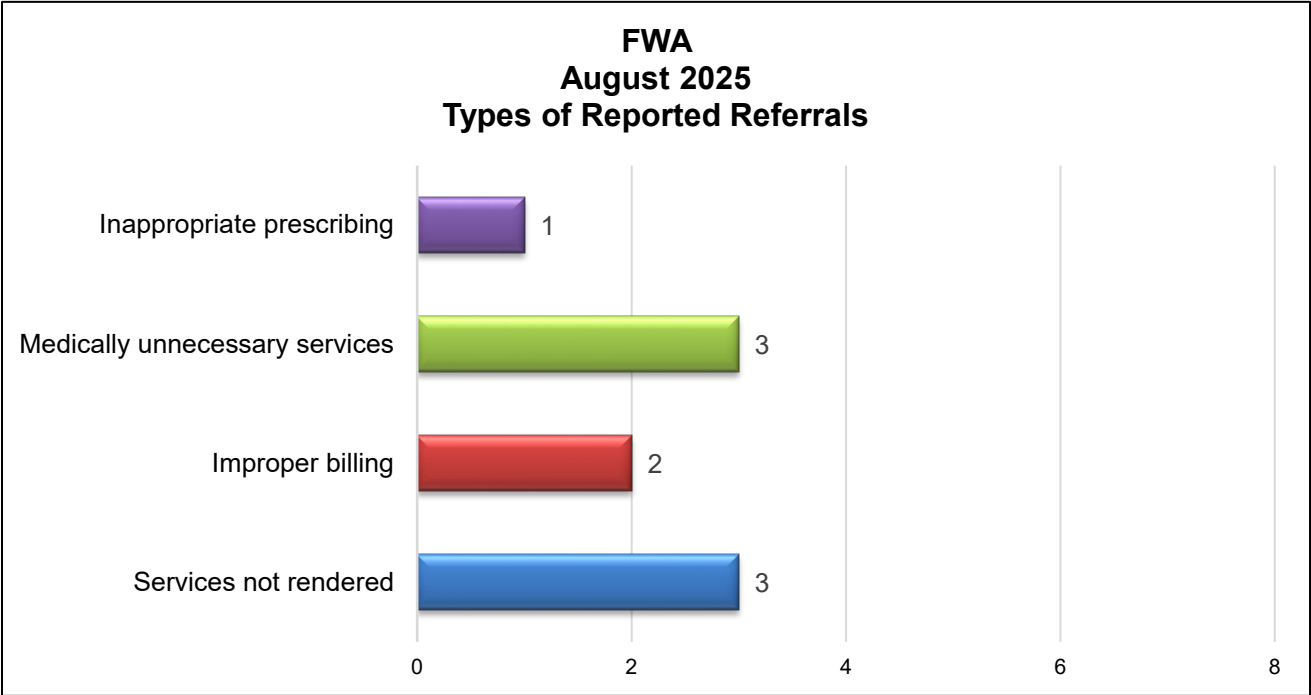
- CalAIM Community Supports Housing Transition and Navigation Services
- CalAIM Community Supports Program Oversight Practices

c. Board-Approved Grants and Initiatives Review

Grants currently under review include:

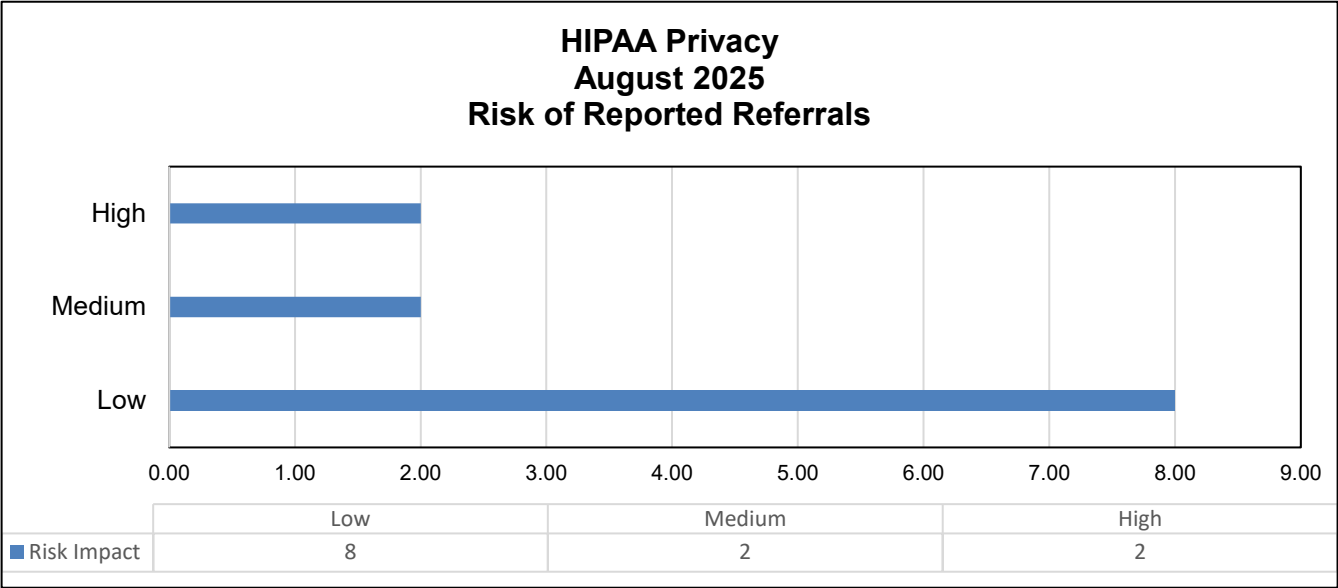
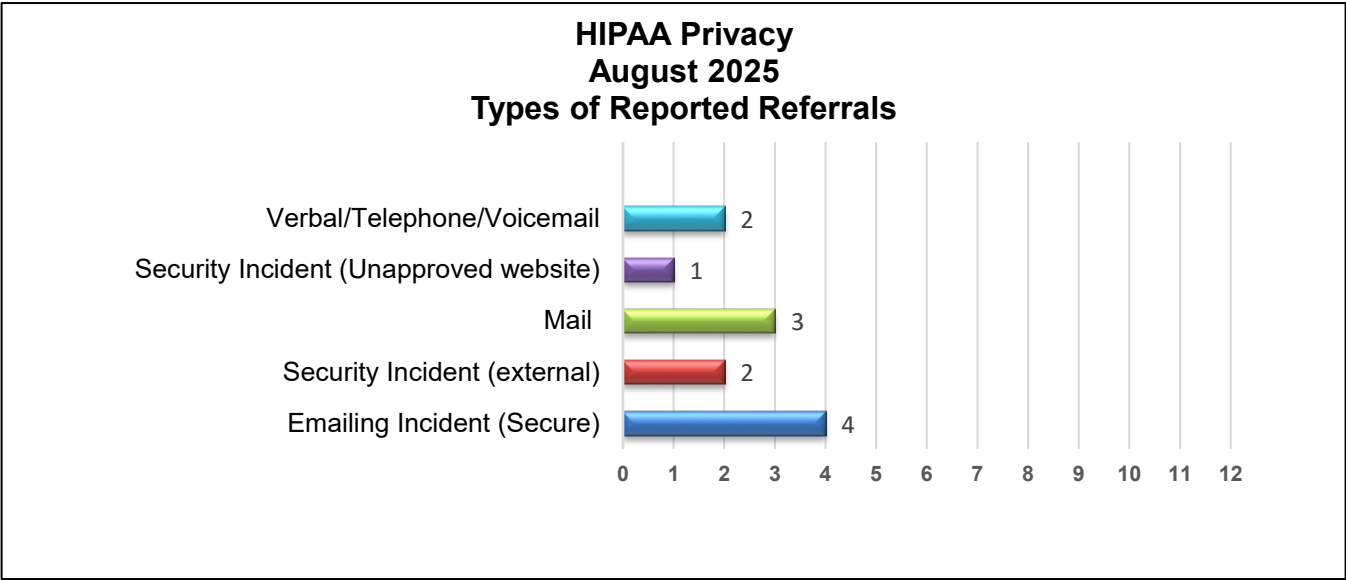
- Be Well/Mind OC, Irvine
 - Grant is in process
 - Review to resume upon close of grant
- Coalition of Orange County Community Health Centers, MAT (Medication Assisted Treatment) Connect
 - Grant has closed
 - Closeout review is in process

E. FRAUD, WASTE & ABUSE (FWA) INVESTIGATIONS



Total Number of New Cases Referred to DHCS (State)	9
Total Number of New Cases Referred to DHCS and CMS	4
Total Number of Referrals Reported	9

F. PRIVACY UPDATE



Total Number of Referrals Reported to DHCS (State)	12
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

MEMORANDUM

TO: CalOptima Health
Board of Directors

FROM: Chamber Hill Strategies

DATE: September 22, 2025

SUBJECT: Board of Directors Report – October 2025

CalOptima Health, Chamber Hill Strategies Maintain and Expand Outreach

CalOptima Health and Chamber Hill Strategies (CHS) continued to be in regular contact with offices representing CalOptima Health and Orange County in Congress. CHS continues to highlight CalOptima Health priorities, initiatives, and events in Orange County, and delegation offices contacted included: Sen. Alex Padilla (D-CA), Sen. Adam Schiff (D-CA), Rep. Lou Correa (D-CA-46), Rep. Young Kim (R-CA-40), Rep. Derek Tran (D-CA-45), Rep. Dave Min (D-CA-47), Rep. Linda Sanchez (D-CA-38), and Rep. Mike Levin (D-CA-49). CHS also continued outreach outside Orange County, which included the Republican Governance Group, a coalition of moderate Republicans in the House of Representatives, chaired by Rep. David Valadao (R-CA-22), regarding efforts to address expiring premium tax credits before the end of the year. CHS is currently in the planning stages for CalOptima Health CEO Michael Hunn's October visit to Washington, D.C. and is targeting key offices for in-person meetings; offices contacted include Sen. Padilla, Rep. Kim, Rep. Correa, and Sen. Bill Cassidy, MD (R-LA)—Sen. Cassidy is a recognized leader on health policy, is Chair of the Senate Health, Education, Labor & Pensions (HELP) Committee, and sits on the Senate Finance Committee. In addition, CHS has been in direct contact with Caprice Knapp, Acting Director, Center for Medicaid & CHIP Services (CMCS), about scheduling an in-person meeting in California to discuss concerns about the burdens and costs associated with the implementation of changes to Medicaid under the One Big Beautiful Bill Act ([H.R. 1, P.L. 119-21](#)).

Funding Bill Passes House but Falls Short in Senate, Potential Shutdown Looms

On September 19, the House passed [H.R. 5371, the Continuing Appropriations and Extensions Act, 2026](#) in a 217-213 vote. H.R. 5371, also referred to as a continuing resolution (CR), would fund the federal government and extend several expiring health provisions through November 21. Among the health provisions and funding set to expire on September 30 are continued funding for community health centers, continuation of telehealth flexibility, and assistance for Medicaid disproportionate share

hospitals (DSH). After House passage, the bill was taken up by the Senate where it fell short in a 44-48 vote. Senate Majority Leader John Thune (R-SD) has pledged to bring H.R. 5371 to the Senate floor again during the week of September 29, but the prospect of a federal shutdown on October 1 looms if Congress cannot reach an agreement on government funding by the September 30 deadline.

Extending Premium Tax Credits Gains Support, Timing and Outlook Unclear

House and Senate Democrats have insisted on including an extension of advanced premium tax credits (APTCs), which are set to expire at the end of 2025, in government funding legislation. House and Senate Republican leaders have stated that they will not include APTCs in this CR—though some Republicans are known to be pushing for an extension of APTCs before year's end. Reps. Jen Kiggans (R-VA-02) and Tom Suozzi (D-NY-03) have [introduced](#) the Bipartisan Premium Tax Credit Extension Act ([H.R. 5145](#)), which would extend APTCs for purchasing coverage under the health insurance marketplace for 1 year through 2026. The bill initially launched with 15 bipartisan cosponsors, including Reps. Young Kim (R-CA-40) and David Valadao (R-CA-22), and has grown its support to 21 cosponsors (12 Republicans, 9 Democrats), including Rep. Josh Harder (D-CA-09).

Rep. Kim Introduces Legislation to Improve Stillbirth Research and Prevention

On September 18, Rep. Young Kim (R-CA-40), along with Rep. Kathy Castor (D-FL-14), [introduced](#) the SHINE for Autumn Act ([H.R. 5469](#)) to improve stillbirth research and data collection. The bill would seek to address gaps in stillbirth data, research, and education through multiple provisions including:

- Providing grants to states to support data collection, assessment, and reporting;
- Strengthening privacy protections; and
- Directing the U.S. Department of Health & Human Services (HHS) to develop best practices and educational materials on stillbirth data collection and prevention strategies.

Rep. Kim also serves as one of the co-chairs of the bipartisan Maternity Care Caucus in the House of Representatives. Sens. Cory Booker (D-NJ) and Steve Daines (R-MT) introduced the bipartisan companion bill ([S. 2858](#)) in the Senate. The bill had strong bipartisan support in the previous Congress (2023-24) and already has significant support with 34 House cosponsors and 17 Senate cosponsors after being introduced on September 18.

Bills to Block Medicaid & HUD Data Sharing with ICE Introduced

On September 11, [Rep. Sydney Kamlager-Dove \(D-CA-37\)](#) and [Rep. Juan Vargas \(D-CA-52\)](#) introduced two bills that would block HHS, the Centers for Medicare & Medicaid Services (CMS), and the Department of Housing & Urban Development (HUD) from sharing personal data with the Department of Homeland Security (DHS) and Immigration & Customs Enforcement (ICE) for immigration enforcement purposes. The legislation is in response to recent actions by HHS, CMS, and HUD to share data of enrollees with DHS and ICE. Rep. Kamlager-Dove's [Limiting ICE's Nationwide Encroachment \(LINE\) Act \(H.R. 5319\)](#) would prohibit HHS and CMS from sharing Medicaid data with DHS and ICE for immigration enforcement purposes, while Rep. Vargas's [Home Together Act \(H.R. 5340\)](#) would prohibit HUD from sharing data with DHS and ICE.

Senate Committee Holds Hearing with Secretary Kennedy

The Senate Finance Committee held a September 4 hearing on the “[President’s 2026 Health Care Agenda](#)” with [U.S. Secretary of Health and Human Services Robert F. Kennedy, Jr.](#) testifying before the Committee. While the stated hearing topic was the Trump Administration’s 2026 health policy agenda, both Democrats and Republicans expressed concerns regarding the Secretary’s positions and recent HHS actions regarding vaccine mandates and guidelines. Other Republicans applauded the Secretary’s commitment and efforts to address the chronic disease epidemic and actions to roll out the Rural Health Transformation Fund that was created under the One Big Beautiful Bill Act (OBBBA, [H.R. 1](#), [Public Law 119-21](#)).

HHS Announces Initiative to Expand Catastrophic Coverage

On September 4, [HHS announced measures](#) to “expand access to more affordable catastrophic coverage... through new hardship exemption guidance,” which HHS states will provide access to affordable catastrophic coverage for those who are not eligible for APTCs or cost-sharing reductions (CSRs) for marketplace coverage. Beginning November 1, individuals will be able to apply for the [hardship exemption](#) in two ways: 1) Online for marketplace coverage at HealthCare.gov or through a certified partner; or 2) Submitting a form by mail. Household income will be reviewed as part of the application process. The Administration has described the policy as an important step to ensure affordable coverage options remain available for lower-income families, particularly those who fall just outside the eligibility thresholds for subsidies for marketplace coverage.

CMS Announces Changes to AHEAD Model to Aid States in Cutting Costs

On September 2, the CMS Innovation Center [announced changes](#) to the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model, which uses total cost of care (TCOC) targets to promote state and regional health system transformation. Participating states are charged with managing health care quality and costs across all payers, including Medicare, Medicaid, and private coverage. The changes to the program seek to give states more tools to manage costs while “advancing the Center’s commitment to promote choice and competition, increase prevention, empower patients, and protect taxpayer dollars.” The changes will take effect in January 2026. Officials also noted that the updated model is aligned with the Administration’s broader goal of shifting the health care system toward value-based care and strengthening multi-payer collaboration.

Make America Healthy Again (MAHA) Strategy Document Released

On September 9, the Make America Healthy Again (MAHA) Commission, chaired by HHS Secretary Robert F. Kennedy, Jr., submitted its [Make Our Children Healthy Again Strategy](#) to the President. The *Strategy* is the follow-up to the release of the [Make Our Children Healthy Again Assessment](#), which was released on May 22 and identified four potential drivers contributing to the rise in chronic childhood disease: 1) Poor diet; 2) Chemical exposure; 3) Lack of physical activity and chronic stress; and 4) Overmedicalization. The *Strategy* outlines a four-pronged approach to address the childhood chronic disease crisis through the following: 1) Advancing research; 2) Realigning incentives; 3) Increasing public awareness; and 4) Fostering private sector collaborations. The *Strategy* underscores the Trump

Administration's intention to elevate children's health and chronic disease as a policy priority, and future policy proposals and actions are expected to build on this framework.

Court Puts Hold on HHS Reorganization

On September 17, the First U.S. Circuit Court of Appeals upheld an injunction halting the Trump Administration's plan to restructure HHS and eliminate thousands of positions. The lawsuit, brought by 23 states, including California, and the District of Columbia, argues the reorganization threatens essential public health programs. If upheld, the decision would significantly limit the Administration's ability to implement structural reforms at HHS without congressional approval. The case is expected to advance further and could be decided by the Supreme Court.

CALOPTIMA HEALTH - STATE LEGISLATIVE REPORT

September 22, 2025

General Update

The Legislature recessed on September 13, one day past the scheduled deadline, after waiving procedural rules to complete action on the most complex measures. Lawmakers approved a late-session package that included AI transparency and chatbot safeguards, a six-bill energy and climate overhaul extending Cap-and-Trade to 2045, CEQA reforms, housing upzoning near transit, and education initiatives on equity and antisemitism prevention.

The Assembly and Senate Suspense hearings were previously held on August 29. These hearings have traditionally been a graveyard where bills die. This year, the Assembly Suspense hearing considered 260 bills, with the Senate considering 425 bills, for a total of 685. Interestingly, both committees had a 73% pass rate with the Assembly moving 191 bills to the floor and the Senate pushing 309 to the floor.

All bills now move to the Governor, who must act by October 13. Speculation about a special session to address budget shortfalls—particularly in health care—has quieted, with leaders signaling they will delay action until cuts can be more directly tied to the Trump Administration.

Leadership also suddenly shifted: Senate President Pro Tem Mike McGuire advanced the transition to Senator Monique Limón, which was originally scheduled to occur in early 2026. There were rumblings about discomfort with the current leadership, which prompted McGuire to advance a resolution on September 13, the last day of session, to transfer power on November 17 to Limón.

Budget Update

Health Omnibus Trailer Bill #2 – AB 144 – This bakes federal immunization standards into state law using the federal guidelines in place as of January 1, 2025, shifting authority to the California Department of Public Health. It ensures Medi-Cal and private coverage are aligned even if federal rules shift.

West Coast Health Alliance (WCHA) – The WCHA was established on September 3 as a coalition of states (originally, CA, Oregon and Washington, with Hawaii joining a day later) that have come together to align and issue public health and vaccine guidance independently of federal guidance. Its mission is to ensure that public health policy (especially around vaccines and respiratory diseases) in those states is driven by science, not politics: safety, efficacy, transparency, access, trust. The goal is to create consistent recommendations that residents of those states can trust, especially as federal guidance may shift or become less predictable.

AB 144 is essentially the legal mechanism by which California is implementing, anchoring, and enabling many of the goals of the WCHA. The Alliance sets out the science-based recommendations regionally; AB 144 ensures that those recommendations have force in California — that people are covered, insurers must comply, providers have authority, and the state can adapt guidance based on scientific advice rather than only federal bodies.

Key Legislation Updates

Medi-Cal: Field Medicine (formerly Street Medicine) – AB 543 (González-D) – Would allow a Medi-Cal member experiencing homelessness (or at-risk) to seek Medi-Cal covered services directly from a field medicine provider, regardless of existing network or primary care provider assignment. The bill sponsor accepted an amendment by the Local Health Plans of California (LHPC) requiring field medicine providers to contract with plans. The bill passed the Assembly floor unanimously and was sent to the Governor on September 12.

Behavioral Health Data Sharing – AB 618 (Krell-D) – Co-sponsored by LHPC and the County Behavioral Health Directors Association, this bill would require sharing of data between Medi-Cal delivery systems, including managed care plans, the county mental health plan and the Medi-Cal drug program for the coordination of behavioral health services. CalOptima Health sent a letter in support of the bill. The bill was held under submission at the Senate suspense hearing on August 29.

Prior Authorization – SB 306 (Becker-D) – Would prohibit health plans from imposing prior authorization on a covered service for a period of one year, if 90% or more of requests for that service were approved in the prior year. The bill was amended in Assembly Appropriations on July 17 at the last minute as a “Special Order of Business.” The amendments exempted Medi-Cal managed care plans, leading LHPC to pull their opposition. The bill passed both houses and was sent to the Governor on September 16.

Community Provider Preference for Enhanced Care Management (ECM) – SB 324 (Menjivar-D) – Senate President Pro Tem Mike McGuire-D is a Principal Co-author. This bill requires a Medi-Cal managed care plan, for purposes of covering the ECM benefit, or if it elects to cover a Community Support, to give preference to contracting with community providers, when they are available in the county and have the applicable ECM or Community Support experience. SB 324 was held under submission at the Assembly suspense hearing on August 29.

California’s Essential Health Benefits (EHB) – SB 62 (Menjivar-D) – Proposed EHB coverage expansion includes fertility treatments (including in-vitro fertilization); annual hearing exams and hearing aids; and mobility devices (walkers, wheelchairs and scooters). SB 62 codifies the proposed changes from the CMS application submittal. The effective date, if approved, is January 2027. The bill passed both houses and was sent to the Governor on September 16.

Proposition Update

Election Rigging Response Act (Proposition 50) – Proposition 50, appearing on the November 4, 2025, special election ballot, is a legislatively referred constitutional amendment that would temporarily shift control of congressional redistricting away from California’s independent Citizens Redistricting Commission and give it to the Legislature. If approved, the new Legislature-drawn congressional map would govern U.S. House elections in 2026, 2028, and 2030 before authority reverts to the commission after the 2030 Census.

Supporters, including Governor Gavin Newsom, frame Proposition 50 as a defensive measure against mid-cycle partisan redistricting in states like Texas, arguing that California must respond to protect fair representation in Congress. Opponents argue Proposition 50 is a partisan power grab that puts redistricting in the hands of politicians, opening the door to gerrymandering. They also warn that it undermines voter-approved reforms, wastes hundreds of millions in taxpayer dollars, and sets a dangerous precedent of changing rules for short-term political gain.

Early polling shows a slight margin of victory for the measure (51%) with about 15% of voters still undecided. Supporters have raised almost \$26 million with the opponents at approximately \$20 million.

Republicans have threatened a “poison pill” initiative for the November 2026 election that would retroactively bar any legislator who voted for allowing Proposition 50 to be banned from running for Congress for 10 years. It is unlikely the retroactivity penalty would withstand legal scrutiny, even if Republicans could secure the over one million valid signatures needed to qualify the measure.

2025–26 Legislative Tracking Matrix

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Behavioral Health			
<u>SB 483</u> 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
<u>SB 626</u> 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.	07/15/2025 Passed Assembly Health Committee; referred to Assembly Appropriations Committee 06/02/2025 Passed Senate floor	CalOptima Health: Watch CAHP: Oppose
<u>SB 812</u> Allen	Qualified Youth Drop-In Center Health Care Coverage: Would require a health plan to provide coverage for mental health and substance use disorders 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
<u>AB 37</u> 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.	03/13/2025 Referred to Assembly Labor and Employment Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>AB 348</u> Krell	Full-Service Partnership: Would establish presumptive eligibility for Full-Service Partnership programs contingent upon meeting criteria and receiving recommendation for enrollment by a licensed behavioral health clinician. <i>Potential CalOptima Health Impact:</i> Increased continuity of care for members with serious mental illness.	09/11/2025 Assembly concurred in amendments; ordered to the Governor 09/03/2025 Passed Senate floor 05/12/2025 Passed Assembly floor	CalOptima Health: Watch
<u>AB 384</u> 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 substance use disorders (SUDs) as well as for any medically necessary services provided to a beneficiary while admitted for that care. <i>Potential CalOptima Health Impact:</i> Modified utilization management (UM) procedures for covered Medi-Cal benefits.	04/22/2025 Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
<u>AB 423</u> Davies	Disclosures for Alcoholism, Drug Abuse Recovery or Treatment Programs and Facilities: Would mandate a business-operated recovery residence to register its location with the California Department of Health Care Services (DHCS). <i>Potential CalOptima Health Impact:</i> Increased oversight for members who have received SUD treatment.	02/18/2025 Referred to Assembly Health Committee	CalOptima Health: Watch
<u>AB 618</u> 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 the DHCS, in consultation with the California Health and Human Services Agency (CalHHS), 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. <i>Potential CalOptima Health Impact:</i> 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	<u>05/07/2025</u> CalOptima Health: SUPPORT LHPC: Sponsor

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>AB 877</u> 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. <i>Potential CalOptima Health Impact:</i> Enhanced transparency and clarity around nonmedical treatment provided for SUDs.	03/03/2025 Referred to Assembly Health Committee	CalOptima Health: Watch
<u>AB 951</u> 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. <i>Potential CalOptima Health Impact:</i> Increased access to care for specific behavioral health treatments.	07/30/2025 Signed into law	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Budget			
<u>H.R. 1</u> 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	<u>05/20/2025</u> CalOptima Health: OPPOSE

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>SB 101</u> Wiener <u>AB 102</u> 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. <i>Potential CalOptima Health Impact:</i> An overview of the FY 2025–26 Enacted State Budget is enclosed.	06/30/2025 Signed into law	CalOptima Health: Watch
<u>AB 100</u> 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. <i>Potential CalOptima Health Impact:</i> Continued funding for current Medi-Cal rates and initiatives through June 30, 2025.	04/14/2025 Signed into law	CalOptima Health: Watch
<u>AB 116</u> Committee on Budget	Health Omnibus Trailer Bill: Consolidates and enacts certain budget trailer bill language containing policy changes needed to implement health-related budget expenditures. 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 PACE provider sanctions, effective immediately <i>Potential CalOptima Health Impact:</i> 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
California Advancing and Innovating Medi-Cal (CalAIM)			
<u>SB 324</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 543</u> Gonzalez	Street Medicine: Would authorize 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, would require 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. <i>Potential CalOptima Health Impact:</i> Continued access to street medicine services for members experiencing homelessness.	09/10/2025 Assembly concurred in amendments; ordered to the Governor 09/09/2025 Passed Senate floor 06/02/2025 Passed Assembly floor	CalOptima Health: Watch CAHP: Watch
Covered Benefits			
<u>SB 40</u> Wiener	Insulin Coverage: Would prohibit 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, would require a health plan to cover all types of insulin without step therapy on and after January 1, 2026. <i>Potential CalOptima Health Impact:</i> Decreased out-of-pocket costs for future members enrolled in Covered California line of business; new UM procedures.	09/09/2025 Senate concurred in amendments; ordered to the Governor 09/03/2025 Passed Assembly floor 05/28/2025 Passed Senate floor	CalOptima Health: Watch CAHP: Oppose

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>SB 62</u> Menjivar <u>AB 224</u> Bonta	Essential Health Benefits (EHBs): Would express 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 the United States Department of Health and Human Services and by January 1, 2027, would require the new benchmark plan include certain additional benefits, including coverage for fertility services, hearing aids and exams, and durable medical equipment. <i>Potential CalOptima Health Impact:</i> New covered benefits for future members enrolled in Covered California line of business.	09/08/2025 Senate concurred in SB 62 amendments; ordered to the Governor 07/15/2025 SB 62 passed Assembly floor 05/27/2025 SB 62 passed Senate floor 09/15/2025 Assembly concurred in AB 224 amendments; ordered to the Governor 09/03/2025 AB 224 passed Senate floor 05/29/2025 AB 224 passed Assembly floor	CalOptima Health: Watch CAHP: Concerns
<u>SB 535</u> Richardson <u>AB 575</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 242</u> Boerner	Genetic Disease Screening: Would expand statewide newborn screenings to include Duchenne muscular dystrophy by January 1, 2027. <i>Potential CalOptima Health Impact:</i> Expanded covered benefits for members.	04/01/2025 Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
<u>AB 298</u> 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. <i>Potential CalOptima Health Impact:</i> Increased costs for CalOptima Health; decreased costs for future members enrolled in Covered California line of business under 21 years of age.	02/10/2025 Referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>AB 350</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 432</u> Bauer-Kahan	Menopause: Would require a health plan that covers outpatient prescription drugs to provide coverage for evaluation and treatment options for symptoms of perimenopause and menopause. Would also require 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. <i>Potential CalOptima Health Impact:</i> New covered benefits for members; increased communications to providers.	09/10/2025 Assembly concurred in amendments; ordered to the Governor 09/09/2025 Passed Senate floor 06/03/2025 Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose
<u>AB 636</u> Ortega	Diapers: Would add diapers as a covered Medi-Cal benefit for the following individuals, contingent upon an 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 <i>Potential CalOptima Health Impact:</i> New covered benefit for pediatric members.	04/01/2025 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			
<u>AB 315</u> 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. <i>Potential CalOptima Health Impact:</i> Expanded member access to HCBA Waiver services.	03/25/2025 Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
<u>AB 974</u> 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 delivery system as a secondary form of health care coverage from mandatory enrollment in a Medi-Cal MCP. <i>Potential CalOptima Health Impact:</i> Decreased number of members.	04/22/2025 Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
<u>AB 1012</u> 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. <i>Potential CalOptima Health Impact:</i> Decreased number of members.	02/21/2025 Introduced	CalOptima Health: Watch
<u>AB 1161</u> 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. <i>Potential CalOptima Health Impact:</i> Extended Medi-Cal eligibility for certain members.	04/29/2025 Passed Assembly Health Committee; referred to Assembly Appropriations Committee 04/08/2025 Passed Assembly Human Services Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Medi-Cal Operations and Administration			
<u>SB 278</u> Cabaldon	Health Data HIV Test Results: Would authorize 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. <i>Potential CalOptima Health Impact:</i> Increased quality oversight of HIV program development.	09/09/2025 Senate concurred in amendments; ordered to the Governor 09/08/2025 Passed Assembly floor 05/29/2025 Passed Senate floor	CalOptima Health: Watch
<u>SB 497</u> Wiener	Legally Protected Health Care Activity: Would prohibit 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. Would also prohibit 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. <i>Potential CalOptima Health Impact:</i> Increased protection of medical information related to gender-affirming care; increased staff training regarding disclosure processes.	09/10/2025 Senate concurred in amendments; ordered to the Governor 09/09/2025 Passed Assembly floor 06/02/2025 Passed Senate floor	CalOptima Health: Watch
<u>SB 530</u> Richardson	Medi-Cal Time and Distance Standards: Would extend current Medi-Cal time and distance standards until January 1, 2029. In addition, would require 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 would not absolve the MCP of responsibility to provide a beneficiary with access, including transportation, to in-person services if the beneficiary prefers. <i>Potential CalOptima Health Impact:</i> Increased oversight of contracted providers; increased reporting to DHCS.	09/10/2025 Senate concurred in amendments; ordered to the Governor 09/09/2025 Passed Assembly floor 05/29/2025 Passed Senate floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>SB 660</u> Menjivar	California Health and Human Services Data Exchange Framework (DxF): Would require 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, would expand DxF to include social services information. <i>Potential CalOptima Health Impact:</i> Increased care coordination with social service providers.	09/10/2025 Senate concurred in amendments; ordered to the Governor 09/09/2025 Passed Assembly floor 06/02/2025 Passed Senate floor	CalOptima Health: Watch
<u>AB 45</u> Bauer-Kahan	Reproductive Data Privacy: Would prohibit 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. Would also authorize an aggrieved person to institute and prosecute a civil action against any person or organization in violation of these provisions. <i>Potential CalOptima Health Impact:</i> Increased safeguards regarding reproductive health information.	09/13/2025 Assembly concurred in amendments; ordered to the Governor 09/12/2025 Passed Senate floor 06/03/2025 Passed Assembly floor	CalOptima Health: Watch
<u>AB 257</u> 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. <i>Potential CalOptima Health Impact:</i> Expanded member access to telehealth specialists.	03/25/2025 Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
<u>AB 316</u> 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. <i>Potential CalOptima Health Impact:</i> Increased liability related to UM procedures.	09/09/2025 Assembly concurred in amendments; ordered to the Governor 09/08/2025 Passed Senate floor 05/19/2025 Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>AB 403</u> 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. <i>Potential CalOptima Health Impact:</i> New reporting requirements to DHCS.	03/25/2025 Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
<u>AB 577</u> 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. <i>Potential CalOptima Health Impact:</i> Increased oversight of contracted PBM and referral processes.	04/29/2025 Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
<u>AB 688</u> Gonzalez	Telehealth for All Act of 2025: Beginning in 2028 and every two years thereafter, would require DHCS to use Medi-Cal data and other data sources to produce analyses in a publicly available Medi-Cal telehealth utilization report. <i>Potential CalOptima Health Impact:</i> New reporting requirements to DHCS.	08/28/2025 Assembly concurred in amendments; ordered to the Governor 08/08/2025 Passed Senate floor 06/02/2025 Passed Assembly floor	CalOptima Health: Watch
<u>AB 980</u> 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. <i>Potential CalOptima Health Impact:</i> Modified UM procedures.	04/22/2025 Re-referred to Assembly Health Committee	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
Older Adult Services			
<u>SB 242</u> 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. <i>Potential CalOptima Health Impact:</i> Expanded Medicare coverage options for dual-eligible members.	04/30/2025 Passed Senate Health Committee; referred to Senate Appropriations Committee	CalOptima Health: Watch CAHP: Oppose
<u>SB 412</u> Limón	Home Care Aides: Would require 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. <i>Potential CalOptima Health Impact:</i> New training requirements for PACE staff.	09/09/2025 Senate concurred in amendments; ordered to the Governor 08/28/2025 Passed Assembly floor 05/08/2025 Passed Senate floor	CalOptima Health: Watch
Providers			
<u>SB 32</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>SB 250</u> Ochoa Bogh	Medi-Cal Provider Directory — Skilled Nursing Facilities: Would require an annually updated provider directory issued by a Medi-Cal MCP to include skilled nursing facilities as a searchable provider type. <i>Potential CalOptima Health Impact:</i> Modifications to CalOptima Health's online provider directory.	09/10/2025 Senate concurred in amendments; ordered to the Governor 09/04/2025 Passed Assembly floor 05/29/2025 Passed Senate floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>SB 306</u> Becker	Prior Authorization Exemption: No later than January 1, 2028, would eliminate prior authorization for the most frequently approved covered health care services, except in cases of fraudulent provider activity or clinically inappropriate care Potential CalOptima Health Impact: Implementation of new UM procedures to assess prior authorization approval rates; decreased number of prior authorizations; decreased care coordination for members.	09/09/2025 Senate concurred in amendments; ordered to the Governor 09/08/2025 Passed Assembly floor 05/28/2025 Passed Senate floor	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
<u>SB 504</u> Laird	HIV Reporting: Would authorize 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 the California Department of Public Health (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.	09/09/2025 Senate concurred in amendments; ordered to the Governor 09/08/2025 Passed Assembly floor 05/08/2025 Passed Senate floor	CalOptima Health: Watch
<u>AB 29</u> 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.	04/01/2025 Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
<u>AB 50</u> Bonta	Over-the-Counter Contraceptives: Would allow 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 would become limited to prescription-only hormonal contraceptives. Potential CalOptima Health Impact: Increased member access to hormonal contraceptives.	09/08/2025 Assembly concurred in amendments; ordered to the Governor 09/08/2025 Passed Senate floor 04/28/2025 Passed Assembly floor	CalOptima Health: Watch

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>AB 55</u> Bonta	Alternative Birth Centers Licensing: Would remove the requirement for alternative birth centers to provide comprehensive perinatal services as a condition of CDPH licensing and Medi-Cal reimbursement. <i>Potential CalOptima Health Impact:</i> Decreased member access to comprehensive perinatal services; reduced operating requirements for alternative birth centers.	09/09/2025 Assembly concurred in amendments; ordered to the Governor 09/08/2025 Passed Senate floor 04/28/2025 Passed Assembly floor	CalOptima Health: Watch LHPC: Support
<u>AB 220</u> 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. <i>Potential CalOptima Health Impact:</i> 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
<u>AB 280</u> Aguiar-Curry	Provider Directory Accuracy: Would require health plans 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 create a standardized format 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. <i>Potential CalOptima Health Impact:</i> Increased oversight of CalOptima Health provider directory; increased coordination with contracted providers; increased penalty payments to DHCS.	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

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>AB 375</u> 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.	04/08/2025 Passed Assembly Business and Professions Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
<u>AB 416</u> Krell	Involuntary Commitment: Would authorize a person to be taken into custody by an emergency physician under the Lanterman-Petris-Short Act and would exempt the emergency physician from criminal and civil liability. Potential CalOptima Health Impact: New legal standards for certain CalOptima Health providers.	09/11/2025 Assembly concurred in amendments; ordered to the Governor 09/03/2025 Passed Senate floor 05/15/2025 Passed Assembly floor	CalOptima Health: Watch
<u>AB 510</u> Addis	Utilization Review Appeals and Grievances: Would require that an appeal or grievance regarding a decision to delay, deny or modify health services be reviewed by a 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.	04/22/2025 Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
<u>AB 512</u> Harabedian	Prior Authorization Timelines: Would shorten 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 <i>urgent</i> requests and three business days via electronic submission or five business days via non-electronic submission for <i>standard</i> 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.	09/10/2025 Assembly concurred in amendments; ordered to the Governor 09/09/2025 Passed Senate floor 06/03/2025 Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>AB 517</u> 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. <i>Potential CalOptima Health Impact:</i> Modified UM procedures for a covered Medi-Cal benefit.	04/08/2025 Passed Assembly Health Committee; referred to Assembly Appropriations Committee	CalOptima Health: Watch
<u>AB 539</u> 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. <i>Potential CalOptima Health Impact:</i> Modified UM procedures for covered Medi-Cal benefits; decreased number of prior authorizations; increased costs.	05/12/2025 Passed Assembly floor; referred to Senate	CalOptima Health: Watch CAHP: Oppose Unless Amended LHPC: Oppose Unless Amended
<u>AB 787</u> 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. <i>Potential CalOptima Health Impact:</i> 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

Bill Number Author	Bill Summary	Bill Status	Position/Notes
<u>AB 1041</u> Bennett	Provider Credentialing: Would require a health plan to credential a provider within 90 days from the receipt of a completed application, or otherwise conditionally approve the credential. A plan would be required to notify the provider whether the application is complete within 10 days of receipt. Additionally, would require a health plan to use the standardized credentialing form on and after January 1, 2028, or six months after the form is developed, whichever is later. <i>Potential CalOptima Health Impact:</i> Expedited and modified credentialing procedures for interested providers.	09/09/2025 Assembly concurred in amendments; ordered to the Governor 09/08/2025 Passed Senate floor 06/03/2025 Passed Assembly floor	CalOptima Health: Watch CAHP: Oppose LHPC: Oppose Unless Amended
Rates & Financing			
<u>SB 339</u> Cabaldon	Medi-Cal Laboratory Rates: Would require Medi-Cal reimbursement rates for clinical laboratory or laboratory services to <i>equal</i> 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. <i>Potential CalOptima Health Impact:</i> 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

Information in this document is subject to change as bills proceed through the legislative process.

CAHP: California Association of Health Plans

LHPC: Local Health Plans of California

Last Updated: September 22, 2025

2025 Federal Legislative Dates

January 3	119th Congress, 1st Session convenes
July 25–September 1	Summer recess for House
August 2–September 1	Summer recess for Senate
December 19	1st session adjourns

Source: Floor Calendars, United States Congress: <https://www.congress.gov/calendars-and-schedules>

2025 State Legislative Dates

January 6	Legislature reconvenes
January 10	Proposed budget must be submitted by Governor
February 21	Last day for legislation to be introduced
April 10–20	Spring recess
May 2	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house
May 9	Last day for policy committees to hear and report to the Floor any non-fiscal bills introduced in that house
May 23	Last day for fiscal committees to hear and report to the Floor any bills introduced in that house
June 2–6	Floor session only
June 6	Last day for each house to pass bills introduced in that house
June 15	Budget bill must be passed by midnight
July 18	Last day for policy committees to hear and report bills in their second house to fiscal committees or the Floor
July 18–August 17	Summer recess
August 29	Last day for fiscal committees to report bills in their second house to the Floor
September 2–12	Floor session only
September 5	Last day to amend bills on the Floor
September 12	Last day for each house to pass bills; interim recess begins upon adjournment
October 12	Last day for Governor to sign or veto bills passed by the Legislature

Source: 2025 Legislative Deadlines, California State Assembly: <http://assembly.ca.gov/legislativedeadlines>

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	



Fiscal Year 2025–26 Enacted State Budget

On May 14, 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
<u>Unsatisfactory Immigration Status (UIS)-Member Impacts</u>
Freeze on <i>new</i> 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; <i>currently enrolled</i> individuals are not affected
Implementation of \$30/month premiums for UIS individuals ages 19–59, effectively 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
<u>All-Member Impacts</u>
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 will continue 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 to pass legislation, and Gov. Newsom has until October 12 to either sign or veto that passed legislation.

CalOptima Health Community Outreach Summary — September and October 2025

Background

CalOptima Health is committed to serving the community by sharing information with current and potential members and 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

This October marks a remarkable milestone as CalOptima Health celebrates 30 years of serving Orange County. As the community health plan, we remain steadfast in our mission to remove barriers to care, enhance coordination, and support our members with in achieving better health outcomes. Through continued collaboration with our providers and community stakeholders, we have built a foundation for a stronger and more equitable health system. Guided by our motto "Better Together", we recognize that meaningful change happens when we work hand-in-hand with our community.

To commemorate our milestone anniversary, CalOptima Health will host a 30th Anniversary Health and Wellness Fair "Transforming the Health of Our Community" for our members on Saturday, October 18, from 9 a.m. to 1 p.m. at our headquarters in Orange. This special event will bring together community partners and mobile units to offer preventive screenings and health resources, while also offering family-friendly activities to engage members of all ages. Attendees will have the opportunity to connect directly with our Health Networks and CalOptima Health departments, including Customer Service, Behavioral Health Integration, Culture and Linguistics, PACE, OneCare and CalAIM to learn more about the comprehensive services and programs available to support their health and well-being.

This celebration is more than just an anniversary; it reflects our continued commitment to improving the lives of our members and serving our community. By connecting members with health services, community resources, and opportunities for engagement, we reaffirm our promise to foster a healthier, stronger Orange County for the next 30 years and beyond.

Summary of Public Activities

As of September 10, CalOptima Health plans to participate in, organize or convene 112 public activities in September and October. There were 64 public activities in September, including 15 virtual community/collaborative meetings, 42 community events, six community-based presentations and one Health Network Forum. In October, there will be 48 public activities, including 14 virtual community/collaborative meetings, 32 community events, 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 one endorsement 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. More information about policy requirements can be found at:

<https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx>.

1. Letter of support for the University of California, Irvine's (UCI), application for the study titled "Comparing Food is Medicine Strategies to Improve Health Outcomes for Medicaid Recipients" led by Dr. Oliko Vardishvili.

For additional information or questions, contact CalOptima Health Community Relations Director Tiffany Kaaiakamanu at 714-222-0637 or tkaaiakamanu@caloptima.org.

Community events hosted by CalOptima Health and community partners in September and October 2025:

September 2025



September 2, 4–6 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



September 3, 10–11 a.m., CalOptima Health Medi-Cal Overview in English

Living Waters Christian Fellowship, 9801 Talbert Ave., Fountain Valley

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community



September 3, 10 a.m.–Noon, CalOptima Health Medi-Cal Overview in English

Anaheim High School, 811 W. Lincoln Ave., Anaheim

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community



September 3, 4:45–6:45 p.m., Back-to-School Night, hosted by Hope School

Hope School, 7901 Knott Ave., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 3, 5:30–7 p.m., Back-to-School Night, hosted by Centralia Elementary School

Centralia Elementary School, 195 N. Western Ave., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 4, 4–6 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



CalOptima Health-hosted
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation

**September 4, 4:45–6 p.m., Back-to-School Night, hosted by Juliette Low School of Arts**

Juliette Low School of Arts, 215 N. Ventura St., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

**September 5, 10:30 a.m.–1:40 p.m., Resource Fair, hosted by Garden Grove Unified School District**

Edgar Elementary School, 6202 Cerulean Ave., Garden Grove

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

**September 7, 10 a.m.–Noon, Grandparents Day, hosted by Second Baptist Church**

Second Baptist Church, 4300 Westminster Ave., Santa Ana

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

**September 9, 4–6 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

**September 9, 5–6 p.m., CalOptima Health Medi-Cal Overview in English**

Walker Jr. High School, 8132 Walker St., La Palma

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community

**September 10, 10 a.m.–Noon, Community Resource Fair, hosted by Equus Workforce Solutions**

Downtown Anaheim Community Center, 250 E. Center St., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

**September 10, 12:30–1:30 p.m., Red Ribbon Week, hosted by La Vista School**

La Vista School, 909 N. State College Blvd., Fullerton

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

**September 11, 9–10:30 a.m., CalOptima Health Medi-Cal Overview in English**

Melinda Hoag Smith Center for Health Living, 307 Placentia Ave., Newport Beach

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community



CalOptima Health-hosted
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation

**September 11, 9:30–10:30 a.m., CalOptima Health Medi-Cal Overview in Spanish**

Anaheim High School, 811 W. Lincoln Ave., Anaheim

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community

**September 12, 4:30–7:30 p.m., 25th Anniversary Magnolia Park Resource Center, hosted by Magnolia Park Resource Center**

Magnolia Park Resource Center, 11402 Magnolia St., Garden Grove

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

**September 12, 5–7 p.m., Open House and Resource Fair, hosted by the Stanton Family Resource Center**

Stanton Family Resource Center, 7800 Katella Ave., Stanton

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

**September 13, 10 a.m.–1 p.m., Older Adult Program and Resource Fair, hosted by the City of Anaheim**

Ponderosa Park Family Resource Center, 320 E. Orangewood Ave., Anaheim

- Registration fee: \$50; included a resource booth.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

**September 13, 10 a.m.–1 p.m., 3rd Annual Wings of Hope Mental Health and Resource Fair, hosted by the City of Anaheim Councilwoman Natalie Rubalcava**

Center Greens Park, 305 E. Broadway, Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public

**September 16, 9–10:30 a.m., CalOptima Health Medi-Cal Overview in Spanish**

Family Resource Center at Warwick Square Apartments, 780 Sy. Lyon St., Santa Ana

- At least one staff member presented (in-person)
- Community-based organization presentation, open to members/community

**September 16, 4–6 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

**September 16, 4:30–6:30 p.m., Back to School Fair, hosted by Portola Middle School**

Portola Middle School, 270 N. Palm Dr., Orange

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



CalOptima Health-hosted



Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation



September 17, 11 a.m.–2 p.m., 4th Annual Reentry Resource Fair, hosted by the Hub for Integration, Reentry and Employment

Honda Center, 2695 E. Katella Ave., Anaheim

- Sponsorship fee: \$1,000; included a resource booth, organization logo on marketing materials, and social media and community newsletter announcement.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 18, 8:30 a.m.–5 p.m., Annual Conference, hosted by Southern California Grantmakers

Westin Bonaventure Hotel and Suites, 404 S. Figueroa St., Los Angeles

- Sponsorship fee: \$2,500; included a resource booth, two conference tickets and organization logo on website.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public



September 18, 8:30 a.m.–5 p.m., 2025 Veteran Health and Wellness Conference, hosted by Orange County Veteran and Military Families Collaborative

Irvine Valley College, 5500 Irvine St., Irvine

- Sponsorship fee: \$3,800; included a resource booth, five-minute speaking opportunity in general session, organization branding throughout event and public acknowledgment from podium.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public



September 18, 4–6 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



September 18, 4–6 p.m., Back to School Health Fair, hosted by Garden Grove Unified School District and the County of Orange Social Service Agency

Los Amigos High School, 16566 Newhope St., Fountain Valley

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 20, 8 a.m.–Noon., Fall 2025 Kids Fishing Derby, hosted by Orange County Supervisor Doug Chaffee

Tri-City Regional Park, 2301 Kraemer Blvd., Placentia

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



CalOptima Health-hosted
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation



September 20, 8 a.m.–Noon, Resource Fair and Flu Shot Clinic, hosted by the Tustin Senior Center

Tustin Senior Center, 200 C. St., Tustin

- Registration fee: \$25; included a resource table.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 20, 8 a.m.–4 p.m., Anaheim Health Fair, hosted by the City of Anaheim

Anaheim Convention Center, 800 W. Katella, Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 20, 9 a.m.–Noon, National Diaper Need Awareness Week, hosted by Community Action Partnership of Orange County in partnership with CalOptima Health

Community Action Partnership of Orange County, 11870 Monarch St., Garden Grove

- At least three staff members attended (in person)
- Health/Resource Fair, open to the public



September 20, 10 a.m.–2 p.m., 3rd Annual Recovery Happens Picnic and Family Fun Day, hosted by Orange County Health Care Agency

Centennial Park, 3000 W. Edinger Ave., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 20, 11 a.m.–1 p.m., Active Living Expo, hosted by Huntington Beach Council on Aging

Senior Center in Central Park, 18041 Goldenwest St., Huntington Beach

- Sponsorship fee: \$1,500; included a resource booth, organization name and logo on the website and event materials, a half-page ad, and logo on the save-the-date banner and organization name on the event banner.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public



September 23, 4–6 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



September 24, 10 a.m.–1 p.m., 5th Annual Resource Fair, hosted by H. Louis Lake Senior Center

H. Louis Lake Senior Center, 11300 Stanford Ave., Garden Grove

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



CalOptima Health-hosted
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation



September 24, 4–6 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



September 24, 3–6 p.m., 23rd Annual Conference, hosted by Vision y Compromiso

Anaheim Marriott, 700 W. Convention Way, Anaheim

- Sponsorship fee: \$2,500; included a resource booth, conference registration for two staff, a program ad and logo placement in conference materials.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public



September 25, 8 a.m.–4 p.m., 2025 Thrive Resource Fair, hosted by the Orange County Department of Education

OCDE Kalmus Event Center, 200 Kalmus Dr., Costa Mesa

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 25, 9 a.m.–2 p.m., OC Same Day Solutions Fair, hosted by the Orange County Office of Care Coordination

Hub Resource Center, 517 W. Struck Ave., Orange

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 25, 4–6 p.m., Anaheim Mobile Family Resource Center, hosted by the City of Anaheim Neighborhood Services

Neighborhood

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 25, 4:15–5:30 p.m., Yearly Community Resource and Health Fair, hosted by Clinton Corner Family Campus

Clinton Corner Family Campus, 13581 Clinton St., Garden Grove

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 27, 8–11 a.m., 3rd Annual Cancer Awareness Community Bike Ride, hosted by Orange County Supervisor Doug Chaffee

Tri-City Regional Park, 2301 Kraemer Blvd., Placentia

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



CalOptima Health-hosted
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation



September 27, 10 a.m.–1 p.m., 3rd Annual Active Older Adult Appreciation Event, hosted by the City of Anaheim Councilmember Carlos Leon

Saint Justin Martyr Catholic Church, 2050 W. Ball Rd., Anaheim

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 27–28, 11 a.m.–6 p.m., 4th Annual Fall Festival, hosted by the City of Westminster

Westminster Civic Center, 8200 Westminster Blvd., Westminster

- Sponsorship fee: \$10,000; included two resource booths, logo on city webpage, festival flyers social media posts, screen and Fall Festival t-shirts. Additionally, a full-page program ad, recognition in newsletters and verbal recognition at event. Lastly, a five-minute speaking opportunity and a complimentary 2026 Tet parade entry.
- At least four staff members attended (in person)
- Health/Resource Fair, open to the public



September 27, 9–11:30 a.m., Walk/Run to End Child Marriage and Human Trafficking, hosted by Global Hope 365

Green Meadow Park, 5701 Trabuco Rd., Irvine

- Sponsorship fee: \$1,000; includes organization name at the event, social media campaign posts and five event tickets.
- At least five staff members attended (in person)
- Health/Resource Fair, open to the public



September 27, Noon–5 p.m., OC Pride 2025, hosted by OC Pride

OC Fair and Event Center, 88 Fair Dr., Costa Mesa

- Registration fee: \$515; included a resource booth.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 27, 1–4 p.m., Embracing Aging Expo, hosted by the City of Westminster

Westminster Senior Center, 8200 Westminster Blvd., Westminster

- Sponsorship fee: \$650; included double booth space, organization listed in event program and website, announcement of sponsorship at event, half a page ad in event program, banner displayed at the senior center and an opportunity for a presentation at a later date.
- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



September 30, 4–6 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



CalOptima Health-hosted
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation

October 2025



October 1, Noon–4 p.m., Mercado Event, hosted by Northgate Gonzalez Market

Northgate Market, 2300 Harbor Blvd., Costa Mesa, 92626

- At least one staff member attended (in person)
- Health/Resource Fair, open to the public



October 2, 8 a.m.–1:30 p.m., Anti-Poverty Summit, hosted by Community Action Partnership of Orange County

UCI Beall Applied Innovation, 5270 California Ave. #100, Irvine

- Sponsorship fee: \$2,500; included six tickets to the summit and an item in the goodie bag. Additionally, recognition in the event app, signage, e-communications, and social media.
- At least two staff members attended (in person)
- Health/Resource Fair, open to the public



October 2, 4–6 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



October 3, 9 a.m.–1 p.m., International Older Adults Celebration, hosted by the City Santa Ana

Jerome Park, 2115 W. McFadden Ave., Santa Ana

- At least two staff members to attend (in person)
- Health/Resource Fair, open to the public



October 3, 9 a.m.–4 p.m., Chuseok (Korean Thanksgiving), hosted by the Korean American Seniors Association of Orange County

Garden Grove Community Center, 11300 Stanford Ave., Garden Grove

- Sponsorship fee: \$1,000; includes a resource booth and premier logo placement.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public



October 4, 8 a.m.–1 p.m., Father Fest, hosted by Orange County Department of Education

Fullerton Arboretum, 1900 Associate Rd., Fullerton

- Sponsorship fee: \$1,000; includes a resource booth, half-page advertisement, organization name on website and written recognition in newsroom.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public



October 4, 9 a.m.–Noon, Senior Wellness Expo, hosted by the City of Yorba Linda

Yorba Linda Community Center, 4501 Casa Loma Ave., Yorba Linda

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public



CalOptima Health-hosted



Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation



October 4, 9:45 a.m.–Noon, 2025 Walk to End Alzheimer's, hosted by Alzheimer's Association of Orange County

Orange Coast College, 2701 Fairview Rd., Costa Mesa

- Sponsorship fee: \$2,500; includes a resource booth.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public



October 4, 9 a.m.–1 p.m., Health Fair Trunk or Treat, hosted by Friends of Family Health Center

Friends of Family Center, 501 S. Idaho St., La Habra

- Sponsorship fee: \$2,000; includes a resource booth, logo on flyer, and shoutouts from the DJ throughout the event.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public



October 4, 9 a.m.–1 p.m., Healthy Living Expo, hosted by the City of Irvine

Irvine Civic Center, 1 Civic Center Plaza, Irvine

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public



October 5, 9 a.m.–1 p.m., Health Fair Trunk or Treat, hosted by Friends of Family Health Center

Friends of Family Center, 501 S. Idaho St., La Habra

- Sponsorship fee: \$2,000; includes a resource booth, logo on flyer, and shoutouts from the DJ throughout the event.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public



October 5, 9 a.m.–3 p.m., Bi-annual Community Health Fair, hosted by the Asian American Women Association of Orange County

St. Cecilia Catholic Church, 1301 Sycamore Ave., Tustin

- Sponsorship fee: \$2,000; includes a resource booth, logo on flyer, and shoutouts from the DJ throughout the event.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public



October 7, 4–6 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



CalOptima Health-hosted
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation

**October 8, 11 a.m.–1 p.m., Health and Wellness Fair, hosted by Golden West College**

Golden West College, 15744 Goldenwest St., Huntington Beach

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

**October 9, 4–6 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

**October 9, 8 a.m.–4:45 p.m., Brave Leaders Bold Moves Summit, hosted by Orange County Grantmakers**

Anaheim Marriott Suites Garden Grove, 12015 Harbor Blvd., Garden Grove

- Sponsorship fee: \$2,500; includes two tickets to the summit, organization name recognition on page and logo visibility on emails and event signage.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

**October 10, 9 a.m.–1 p.m., Senior Summit, hosted by Orange County Supervisor Katrina Foley in partnership with CalOptima Health**

Aliso Viejo Ranch, 100 Park Ave., Aliso Viejo

- At least five staff members to attend (in person)
- Health/Resource Fair, open to the public

**October 11, 8–11:30 a.m., 15th Annual Walk for Independence, hosted by Project Independence**

TeWinkle Park, 970 Arlington Dr., Costa Mesa

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

**October 11, 10 a.m.–1:30 p.m., Older Adult Health Fair, hosted by the City of Anaheim**

Downtown Anaheim Community Center, 250 E. Center St., Anaheim

- Registration fee: \$150; includes resource booth.
- Sponsorship fee: \$500; includes a resource booth, and logo on website and flyer.
- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public

**October 11, 10 a.m.–2 p.m., October DV Awareness Month Resource Fair, hosted by the Orange County Family Justice Center**

Orange County Family Justice Center, 150 W. Vermont Ave., Anaheim

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public



CalOptima Health-hosted
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation



October 11, 4–6 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



October 14, 4–6 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



October 16, 4–6 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



October 18, 9 a.m.–1 p.m., 30th Anniversary Health and Wellness Fair, hosted by CalOptima Health

CalOptima Health, 505 City Parkway W., Orange

- At least 20 staff members to attend (in person)
- Health/Resource Fair, open to the public



October 19, 9 a.m.–2 p.m., Community Resource Fair, hosted by Vital Access Care Foundation and St. Norbert Catholic Church

St. Norbert Catholic Church, 300 E. Taft Ave., Orange

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public



October 21, 4–6 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



October 22, 4–6 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



CalOptima Health-hosted
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation



October 23, 4–6 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



October 23, 4:30–6 p.m., 2025 Trunk or Treat, hosted by the County of Orange Social Service Agency and Orangewood Foundation

Orangewood Foundation, 1575 E. 17th St., Santa Ana

- At least one staff member to attend (in person)
- Health/Resource Fair, open to the public



October 28, 1-2:30 p.m., CalOptima Health Community Connections Meeting, hosted by CalOptima Health

CalOptima Health, 505 City Parkway W., Orange

- At least four staff members to attend
- Steering committee meeting, open to collaborative members



October 28, 4–6 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



October 29, 4–6 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



October 30, 4–6 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

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>



CalOptima Health-hosted
Exhibitor/Attendee



CalFresh Outreach (e.g., colleges, food banks)



Community Presentation

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2025

Regular Meeting of the CalOptima Health Board of Directors

Report Item

17. Accept, Receive, and File the Fiscal Year 2024-25 CalOptima Health Audited Financial Statements

Contact

Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action

Accept, receive, and file the Fiscal Year 2024-25 CalOptima Health consolidated audited financial statements as submitted by independent auditors Baker Tilly US, LLP, previously Moss Adams LLP.

Background

In June 2025, Moss Adams LLP merged with Baker Tilly, and CalOptima Health's services agreement was assigned to Baker Tilly US, LLP (Baker Tilly). The engagement team assigned to complete the annual financial audit for CalOptima Health remained substantially the same. At the May 22, 2025, meeting of the CalOptima Health Finance and Audit Committee, Baker Tilly presented on the 2025 Financial Audit Planning. The audit plan included performing the mandatory annual consolidated financial statement audit and a review of relevant internal controls and compliance for CalOptima Health's major programs.

Discussion

Baker Tilly conducted the interim audit beginning May 27, 2025, and the year-end audit in July and August 2025. The significant audit areas that Baker Tilly reviewed included:

- Medical claims liability and claims expense;
- Capitation revenue and receivables; and
- Amounts due to the State of California or the California Department of Health Care Services.

Baker Tilly auditors conducted their audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS), as well as the Government Auditing Standards.

Results from CalOptima Health's Fiscal Year (FY) 2024-25 Audit were positive. The auditor:

- Made no changes in CalOptima Health's approach to applying critical accounting policies;
- Did not report any significant difficulties during the audit; and
- Did not identify any uncorrected or material misstatements, material weaknesses, or significant control deficiencies.

As such, management recommends that the Board of Directors accept, receive, and file the

CalOptima Health FY 2024-25 consolidated audited financial statements, as presented.

Fiscal Impact

There is no fiscal impact.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Board of Directors' Finance and Audit Committee

Attachments

1. FY 2024-25 CalOptima Health Audited Financial Statements
2. Presentation by Baker Tilly US, LLP

/s/ Michael Hunn
Authorized Signature

09/25/2025
Date

Report of Independent Auditors and Financial Statements with
Supplementary Information

**Orange County Health Authority, A Public Agency dba
Orange Prevention and Treatment Integrated Medical
Assistance dba CalOptima Health**

June 30, 2025 and 2024

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Management's Discussion and Analysis

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

Management's Discussion and Analysis

The intent of management's discussion and analysis of CalOptima Health's financial performance is to provide readers with an overview of the agency's financial activities for the fiscal years ended June 30, 2025, 2024, and 2023. Readers should review this summation in conjunction with CalOptima Health's financial statements and accompanying notes to the financial statements to enhance their understanding of CalOptima Health's financial performance.

Key Operating Indicators

The table below compares key operating indicators for CalOptima Health for the fiscal years ended June 30, 2025, 2024, and 2023:

Key Operating Indicators	2025	2024	2023
Members (at end of fiscal period)			
Medi-Cal program	886,034	901,303	970,590
OneCare	17,664	17,253	17,687
OneCare Connect	-	-	-
PACE	515	496	439
Average member months			
Medi-Cal program	892,630	932,770	940,893
OneCare	17,280	17,488	17,443
OneCare Connect	-	-	14,360
PACE	506	457	434
Operating revenues (in millions)	\$ 5,033	\$ 5,372	\$ 4,239
Operating expenses (in millions)			
Medical expenses	4,621	4,403	3,862
Administrative expenses	260	230	192
Operating income (in millions)	<u>\$ 151</u>	<u>\$ 739</u>	<u>\$ 184</u>
Operating revenues PMPM (per member per month)	\$ 441	\$ 471	\$ 369
Operating expenses PMPM			
Medical expenses PMPM	405	395	336
Administrative expenses PMPM	23	20	17
Operating income PMPM	<u>\$ 13</u>	<u>\$ 56</u>	<u>\$ 16</u>
Medical loss ratio	91.8%	82.0%	91.0%
Administrative expenses ratio	5.2%	4.3%	4.5%
Premium tax revenue and expenses not included above			
Operating revenues (in millions)	\$ 870	\$ 658	\$ 90
Administrative expenses (in millions)	\$ 864	\$ 658	\$ 92

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

Management's Discussion and Analysis

Overview of the Financial Statements

This annual report consists of financial statements and notes to those statements, which reflect CalOptima Health's financial position as of June 30, 2025, 2024, and 2023, and the results of its operations for the fiscal years ended June 30, 2025, 2024, and 2023. The financial statements of CalOptima Health, including the statements of net position, statements of revenues, expenses, and changes in net position, and statements of cash flows, represent the accounts and transactions of the five (5) lines of business – Medi-Cal, OneCare, OneCare Connect, Program of All-Inclusive Care for the Elderly (PACE), Multipurpose Senior Services Program (MSSP), and Covered California start-up costs.

- The statements of net position include all of CalOptima Health's assets, deferred outflows of resources, liabilities, and deferred inflows of resources, using the accrual basis of accounting, as well as an indication about which assets and deferred outflows of resources are utilized to fund obligations to providers and which are restricted as a matter of the CalOptima Health Board of Directors (Board) policy.
- The statements of revenues, expenses, and changes in net position present the results of operating activities during the fiscal years and the resulting increase or decrease in net position.
- The statements of cash flows report the net cash provided by or used in operating activities, as well as other sources and uses of cash from investing, capital, and related financing activities.

The following discussion and analysis address CalOptima Health's overall program activities. CalOptima Health's Medi-Cal program accounted for 90.9 percent, 91.5 percent, and 89.9 percent, of its annual revenues during fiscal years 2025, 2024, and 2023, respectively. OneCare accounted for 8.1 percent, 7.6 percent, and 5.1 percent of its annual revenues during fiscal years 2025, 2024, and 2023, respectively. PACE accounted for 1.1 percent, 0.9 percent, and 1.0 percent of its annual revenues during fiscal years 2025, 2024, and 2023, respectively. OneCare Connect, which ended on December 31, 2022, accounted for 0.0 percent, 0.0 percent, and 4.1 percent of its annual revenues during fiscal years 2025, 2024, and 2023, respectively.

Beginning January 1, 2024, a new law in California provided full-scope Medi-Cal eligibility to adults ages 26 through 49, regardless of immigration status. This initiative, called the Ages 26 through 49 Adult Expansion, is modeled after the Young Adult Expansion, which provided full scope Medi-Cal to young adults 19 through 25, and the Older Adult Expansion, which provided full scope Medi-Cal to adults 50 years of age or older. The enrollment increase from the Adult Expansion program was offset by the transition of Kaiser members out to its own Medi-Cal contract. In its new 2024 contract, the State of California (the State) also required CalOptima Health to commit a percentage of its net position towards investments into the community and an additional percentage if CalOptima Health did not meet specified quality measures established by the State referred to as Community Reinvestment and Quality Achievement.

In June 2025, CalOptima Health filed to expand its Knox-Keene Act License to participate in the State's Health Insurance Marketplace, Covered California. CalOptima Health is preparing to launch a Covered California line of business effective January 1, 2027.

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

Management's Discussion and Analysis

CalOptima Health contracted with Deloitte Consulting LLP to perform an operational gap analysis to ensure operational readiness before entering the Health Insurance Marketplace. Moreover, CalOptima Health continues to negotiate provider contracts and execute contract amendments with several existing vendors to include Covered California in their scopes of service.

2025 and 2024 Financial Highlights

As of June 30, 2025 and 2024, total assets and deferred outflows of resources were approximately \$4,420.8 million and \$4,182.3 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately \$2,800.6 million and \$2,445.1 million, respectively.

Net position increased by approximately \$355.5 million, or 14.5 percent, during fiscal year 2025 and increased by approximately \$775.1 million, or 46.4 percent, during fiscal year 2024.

Table 1a: Condensed Statements of Net Position as of June 30,
(Dollars in Thousands)

Financial Position	2025	2024	Change from 2024	
			Amount	Percentage
ASSETS				
Current assets	\$ 2,576,425	\$ 2,871,751	\$ (295,326)	-10.3%
Board-designated assets and restricted cash	1,717,108	1,138,063	579,045	50.9%
Capital assets, net	79,772	77,270	2,502	3.2%
Intangible right-to-use subscription asset	18,851	19,291	(440)	100.0%
Total assets	4,392,156	4,106,375	285,781	7.0%
DEFERRED OUTFLOWS OF RESOURCES	28,626	75,899	(47,273)	-62.3%
Total assets and deferred outflows of resources	<u>\$ 4,420,782</u>	<u>\$ 4,182,274</u>	<u>\$ 238,508</u>	<u>5.7%</u>
LIABILITIES				
Current liabilities	\$ 1,493,285	\$ 1,547,922	\$ (54,637)	-3.5%
Other liabilities	111,434	170,028	(58,594)	-34.5%
Subscription liability, net of current portion	11,170	10,596	574	100.0%
Total liabilities	1,615,889	1,728,546	(112,657)	-6.5%
DEFERRED INFLOWS OF RESOURCES	4,310	8,646	(4,336)	-50.2%
NET POSITION				
Net investment in capital assets	80,810	78,830	1,980	2.5%
Restricted by legislative authority	129,342	127,853	1,489	1.2%
Unrestricted	2,590,431	2,238,399	352,032	15.7%
Total net position	2,800,583	2,445,082	355,501	14.5%
Total liabilities, deferred inflows of resources, and net position	<u>\$ 4,420,782</u>	<u>\$ 4,182,274</u>	<u>\$ 238,508</u>	<u>5.7%</u>

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health Management's Discussion and Analysis

Current assets decreased \$295.3 million from \$2,871.8 million in 2024 to \$2,576.4 million in 2025, primarily due to a \$510 million transfer of cash and investments to Board-designated assets and restricted cash, and offset by an increase in Managed Care Organization (MCO) tax receivable from the State. Current liabilities decreased \$54.6 million from \$1,547.9 million in 2024 to \$1,493.3 million in 2025, due to recoupment of payables due to the State.

Other liabilities decreased \$58.6 million from \$170.0 million in 2024 to \$111.4 million in 2025 driven primarily by a decrease in net pension liabilities.

Board-designated assets and restricted cash increased by \$579.0 million and \$561.2 million in fiscal years 2025 and 2024, respectively, with the increases primarily driven by policy updates approved by the Board. In April 2025, the Board approved updates to the Board-designated reserve level from between 2.5 months to 3.0 months of consolidated capitation revenue to between 2.5 months to 4.0 months of consolidated capitation revenue.

The Board's policy increased the Board-designated reserves to provide a desired level of funds between 2.5 months and 4.0 months of consolidated capitation revenue to provide additional stability during potential delays of capitation revenue and regulatory updates or program changes in Medi-Cal eligibility or covered services. CalOptima Health's reserve level of Tier One investment portfolios as of June 30, 2025, was at 3.79 times the monthly average consolidated capitation revenue. CalOptima Health's Tier Two investment portfolios are statutory designated reserves to meet the Tangible Net Equity (TNE) requirements. The desired level is between 100 percent to 110 percent of the requirement and CalOptima Health's total reserve level as of June 30, 2025, stood at 102 percent the minimum required TNE. CalOptima Health's total reserve level as of June 30, 2024, was at 103 percent of the minimum required TNE.

CalOptima Health is also required to maintain a \$300,000 restricted deposit as a part of the Knox-Keene Health Care Service Plan Act of 1975 (the Act).

2024 and 2023 Financial Highlights

As of 2024 and 2023, total assets and deferred outflows of resources were approximately \$4,182.3 million and \$3,624.3 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately \$2,445.1 million and \$1,670.0 million, respectively.

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health Management's Discussion and Analysis

Net position increased by approximately \$775.1 million, or 46.4 percent, during fiscal year 2024 and increased by approximately \$250.5 million, or 17.6 percent, during fiscal year 2023.

Table 1b: Condensed Statements of Net Position as of June 30,
(Dollars in Thousands)

Financial Position	2024	2023	Change from 2023	
			Amount	Percentage
ASSETS				
Current assets	\$ 2,871,751	\$ 2,937,296	\$ (65,545)	-2.2%
Board-designated assets and restricted cash	1,138,063	576,852	561,211	97.3%
Capital assets, net	77,270	66,189	11,081	16.7%
Intangible right-to-use subscription asset	19,291	18,018	1,273	0.0%
Total assets	4,106,375	3,598,355	508,020	14.1%
DEFERRED OUTFLOWS OF RESOURCES	75,899	25,969	49,930	192.3%
Total assets and deferred outflows of resources	<u>\$ 4,182,274</u>	<u>\$ 3,624,324</u>	<u>\$ 557,950</u>	<u>15.4%</u>
LIABILITIES				
Current liabilities	\$ 1,547,922	\$ 1,871,529	\$ (323,607)	-17.3%
Other liabilities	170,028	59,440	110,588	186.0%
Subscription liability, net of current portion	10,596	12,173	(1,577)	0.0%
Total liabilities	1,728,546	1,943,142	(214,596)	-11.0%
DEFERRED INFLOWS OF RESOURCES	8,646	11,176	(2,530)	-22.6%
NET POSITION				
Net investment in capital assets	78,830	66,134	12,696	19.2%
Restricted by legislative authority	127,853	107,969	19,884	18.4%
Unrestricted	2,238,399	1,495,903	742,496	49.6%
Total net position	<u>2,445,082</u>	<u>1,670,006</u>	<u>775,076</u>	<u>46.4%</u>
Total liabilities, deferred inflows of resources, and net position	<u>\$ 4,182,274</u>	<u>\$ 3,624,324</u>	<u>\$ 557,950</u>	<u>15.4%</u>

Current assets decreased \$65.5 million from \$2,937.3 million in 2023 to \$2,871.8 million in 2024, primarily in cash and investments. Current liabilities decreased \$323.6 million from \$1,871.5 million in 2023 to \$1,547.9 million in 2024. This was driven primarily from the release of accrued payables due to the State for the COVID-19 risk corridor post the Bridge Period (July 1, 2019 through December 31, 2020), the Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) risk corridors for the period of January 1, 2021 through 2024, the Enhanced Care Management (ECM) risk corridor for the period of January 1, 2022 through 2024, Unsatisfactory Immigration Status (UIS) risk corridor for the period January 1, 2024 through June 30, 2024. In April 2024, the State finalized the calendar year 2021 Proposition 56 risk corridor and a payment was remitted to the State in May 2024 in the amount of \$47.2 million. During fiscal year 2024, CalOptima Health submitted supplemental data requests to the State for the Bridge Period COVID-19 risk corridor and calendar year 2022 ECM risk corridor. The final report has not been received as of this writing.

**Orange County Health Authority, A Public Agency dba Orange
Prevention and Treatment Integrated Medical Assistance dba
CalOptima Health
Management's Discussion and Analysis**

Other liabilities increased \$110.6 million from \$59.4 million in 2023 to \$170 million in 2024 driven primarily by the State's requirement for CalOptima Health to commit a percentage of net position towards investments into the community and an additional percentage if CalOptima Health does not meet State specified quality measures referred to as Community Reinvestment and Quality Achievement.

Board-designated assets and restricted cash increased by \$561.2 million and decreased by \$34.6 million in fiscal years 2024 and 2023, respectively, with the 2024 increase primarily driven by policy updates approved by the Board in May 2024 which updated the Board-designated reserve level from between 1.4 months to 2.0 months of consolidated capitation revenue to between 2.5 months to 3.0 months of consolidated capitation revenue. The Board also established a separate statutory designated reserve to meet the minimum TNE requirement.

The Board's policy augmented the Tier One investment portfolio as Board-designated reserves to provide a desired level of funds between 2.5 months and 3.0 months of consolidated capitation revenue to meet future contingencies. CalOptima Health's reserve level of Tier One investment portfolios as of June 30, 2024, was at 2.82 times the monthly average consolidated capitation revenue. CalOptima Health's Tier Two investment portfolios are statutory designated reserves to meet the TNE requirements. The desired level is between 100 percent to 110 percent the requirement and CalOptima Health's total reserve level as of June 30, 2024, stood at 103 percent of the minimum required TNE.

CalOptima Health is also required to maintain a \$300,000 restricted deposit as a part of the Act.

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health Management's Discussion and Analysis

2025 and 2024 Results of Operations

CalOptima Health's fiscal year 2025 operating and non-operating income resulted in a \$355.5 million increase in net position, \$419.6 million less compared to a \$775.1 million increase in fiscal year 2024. The following table reflects the changes in revenues and expenses for 2025 compared to 2024:

Table 2a: Revenues, Expenses, and Changes in Net Position for
Fiscal Years Ended June 30,
(Dollars in Thousands)

Results of Operations	2025	2024	Change from 2024	
			Amount	Percentage
PREMIUM REVENUES	\$ 5,033,535	\$ 5,372,964	\$ (339,429)	-6.3%
Total operating revenues	5,033,535	5,372,964	(339,429)	-6.3%
MEDICAL EXPENSES	4,621,433	4,403,235	218,198	5.0%
ADMINISTRATIVE EXPENSES	259,859	229,511	30,348	13.2%
Total operating expenses	4,881,292	4,632,746	248,546	5.4%
OPERATING INCOME	152,243	740,218	(587,975)	-79.4%
NON-OPERATING REVENUES AND EXPENSES	203,258	34,858	168,400	483.1%
Increase in net position	355,501	775,076	(419,575)	-54.1%
NET POSITION, beginning of year	2,445,082	1,670,006	775,076	46.4%
NET POSITION, end of year	\$ 2,800,583	\$ 2,445,082	\$ 355,501	14.5%

2025 and 2024 Operating Revenues

The decrease in operating revenues of \$339.4 million in fiscal year 2025 is attributable to a decrease in enrollment of 4.2 percent, a decrease in revenue from State Funded Incentive and Supplemental programs offset by an increase in directed payments of \$249.5 million and an increase in capitated premium rates of \$194.0 million. The decrease is also driven by fiscal year 2024's release in estimated payables to the State for \$646.8 million due to contract updates impacting the COVID-19 risk corridor settlement requirement.

2025 and 2024 Medical Expenses

Provider capitation, comprised of capitation payments to CalOptima Health's contracted health networks, increased by 5.2 percent from fiscal year 2024 to fiscal year 2025. Capitated member enrollment accounted for approximately 67.3 percent of CalOptima Health's enrollment, averaging 612,173 members, during fiscal year 2025 and approximately 70.7 percent of CalOptima Health's enrollment, averaging 672,026 members, during fiscal year 2024. Included in the capitated environment were 93,055 or 15.6 percent and 187,207 or 28.5 percent members in a shared risk network for fiscal years 2025 and 2024, respectively. The decrease is attributable to changes in several health network risk models. Shared risk networks receive capitation for professional services and are claims-based for hospital services.

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health Management's Discussion and Analysis

Provider capitation expenses for the Medi-Cal program totaled \$1,370.8 million in fiscal year 2025, compared to \$1,285.7 million in fiscal year 2024. The increase reflects rate increases with the contracted health networks.

Claims expenses to providers and facilities, including long-term care (LTC) services for the Medi-Cal program increased by 4.2 percent from fiscal year 2024 to fiscal year 2025 due to increased utilization.

In addition to the items mentioned above, total quality assurance fee (QAF) payments received and passed through to hospitals decreased from \$290.7 million to \$106.6 million from fiscal year 2024 to fiscal year 2025 due to the State's timing for QAF payments. These receipts and payments are not included in the statements of revenues, expenses, and changes in net position as these are considered pass through payments.

2025 and 2024 Administrative Expenses

Total administrative expenses were \$259.9 million in 2025 compared to \$229.5 million in 2024. Overall administrative expenses increased by 13.2 percent or \$30.3 million, across all categories. In fiscal years 2025 and 2024, CalOptima Health's administrative expenses were 5.2 percent and 4.3 percent of total operating revenues, respectively.

2025 and 2024 Non-Operating Revenues and Expenses

Non-operating revenue and expenses increased from \$168.4 million of non-operating income of \$34.9 million in fiscal year 2024 to non-operating income of \$203.3 million in fiscal year 2025. The increase is driven primarily by the change in Community Reinvestment expenses \$125.3 million due to updated guidance released by the State in February 2025 and an increase of \$19.7 million from net investment income and a decrease in Grant expenses of \$23.7 million in fiscal year 2025.

As of June 30, 2025, in accordance with State contracts, the balance of the Community Reinvestment was estimated at \$38.2 million, and the balance of the Quality Achievement was estimated at \$49.9 million.

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

Management's Discussion and Analysis

2024 and 2023 Results of Operations

CalOptima Health's fiscal year 2024 operating and non-operating income resulted in a \$775.1 million increase in net position, \$524.6 million more compared to a \$250.5 million increase in fiscal year 2023. The following table reflects the changes in revenues and expenses for 2024 compared to 2023:

Table 2b: Revenues, Expenses, and Changes in Net Position for
Fiscal Years Ended June 30,
(Dollars in Thousands)

Results of Operations	2024	2023	Change from 2023	
			Amount	Percentage
PREMIUM REVENUES	\$ 5,372,964	\$ 4,239,833	\$ 1,133,131	26.7%
Total operating revenues	5,372,964	4,239,833	1,133,131	26.7%
MEDICAL EXPENSES	4,403,235	3,862,196	541,039	14.0%
ADMINISTRATIVE EXPENSES	229,511	192,339	37,172	19.3%
Total operating expenses	4,632,746	4,054,535	578,211	14.3%
OPERATING INCOME	740,218	185,298	554,920	299.5%
NONOPERATING REVENUES AND EXPENSES	34,858	65,198	(30,340)	-46.5%
Increase in net position	775,076	250,496	524,580	209.4%
NET POSITION, beginning of year	1,670,006	1,419,510	250,496	17.6%
NET POSITION, end of year	\$ 2,445,082	\$ 1,670,006	\$ 775,076	46.4%

2024 and 2023 Operating Revenues

The increase in operating revenues of \$1,133.1 million in fiscal year 2024 was attributable to increased premium capitation rates, newly eligible UIS members, and \$93.0 million in revenue from various State programs such as Housing and Homelessness Incentive Program (HHIP), Student Behavioral Health Incentive Program (SBHIP), and California Advancing and Innovating Medi-Cal (CalAIM) Incentive Payment Program (IPP). The increase in operating revenue was also driven by a \$646.8 million release in estimated payables to the State due to contract updates impacting the COVID-19 risk corridor settlement requirement and offset by a net increase in payables to the State of \$47.3 million for the Proposition 56, UIS, and ECM risk corridors.

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health Management's Discussion and Analysis

2024 and 2023 Medical Expenses

Provider capitation, comprised of capitation payments to CalOptima Health's contracted health networks, increased by 11.3 percent from fiscal year 2023 to fiscal year 2024. Capitated member enrollment accounted for approximately 70.7 percent of CalOptima Health's enrollment, averaging 672,026 members, during fiscal year 2024 and approximately 73.4 percent of CalOptima Health's enrollment, averaging 690,882 members, during fiscal year 2023. Included in the capitated environment were 187,207 or 28.5 percent and 232,786 or 33.7 percent of members in a shared risk network for fiscal years 2024 and 2023, respectively. Shared risk networks receive capitation for professional services and are claims-based for hospital services.

Provider capitation expenses totaled \$1,285.7 million in fiscal year 2024, compared to \$1,155.2 million in fiscal year 2023. The increase reflects rate increases with the contracted health networks.

Claims expenses to providers and facilities, including LTC services, increased by 15.4 percent from fiscal year 2023 to fiscal year 2024 due to increased utilization.

In addition to the items mentioned above, total QAF payments received and passed through to hospitals increased from \$0.0 million to \$290.7 from fiscal year 2023 to fiscal year 2024 due to the State's timing for QAF payments. These receipts and payments are not included in the statements of revenues, expenses, and changes in net position as these are considered pass through expenses.

2024 and 2023 Administrative Expenses

Total administrative expenses were \$229.5 million in 2024 compared to \$192.3 million in 2023. Overall administrative expenses increased by 19.3 percent or \$37.2 million, primarily due to an increase in filled positions, cost-of-living and other salary adjustments. In fiscal years 2024 and 2023, CalOptima Health's administrative expenses were 4.3 percent and 4.5 percent of total operating revenues, respectively.

2024 and 2023 Non-Operating Revenues and Expenses

Non-operating revenue and expenses decreased by \$30.3 million from income of \$65.2 million in fiscal year 2023 to income of \$34.9 million in fiscal year 2024. The decrease is driven primarily by favorable investment performance in fiscal year 2024 of \$175.9 million, an increase of \$85.5 million from net investment income of \$90.4 million in fiscal year 2024. The amount is offset by an increase in grant expenses of \$6.5 million, from \$25.5 million in fiscal year 2023 to \$32.0 million in fiscal year 2024 and also a new estimate for Community Reinvestment and Quality Achievement.

As of June 30, 2024, in accordance with State contracts, the balance of the Community Reinvestment was estimated at \$51.4 million, and the balance of the Quality Achievement was estimated at \$55.2 million.

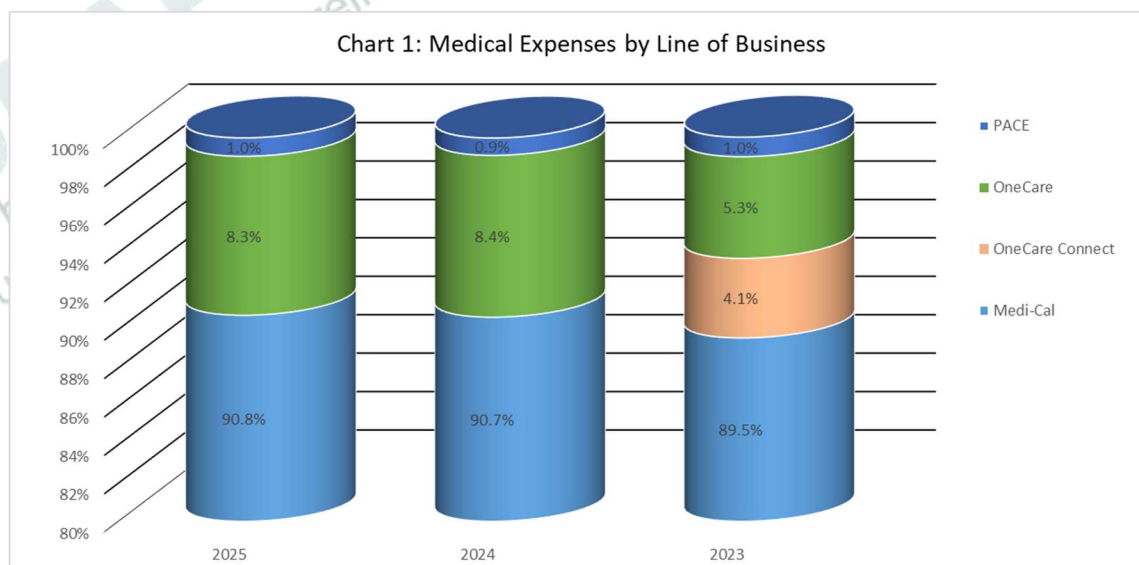
The Board and management have been accelerating efforts to improve access and quality of health care for the most vulnerable residents in Orange County. Those efforts included increasing the number of community investment grants released in the recent fiscal years.

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

Management's Discussion and Analysis

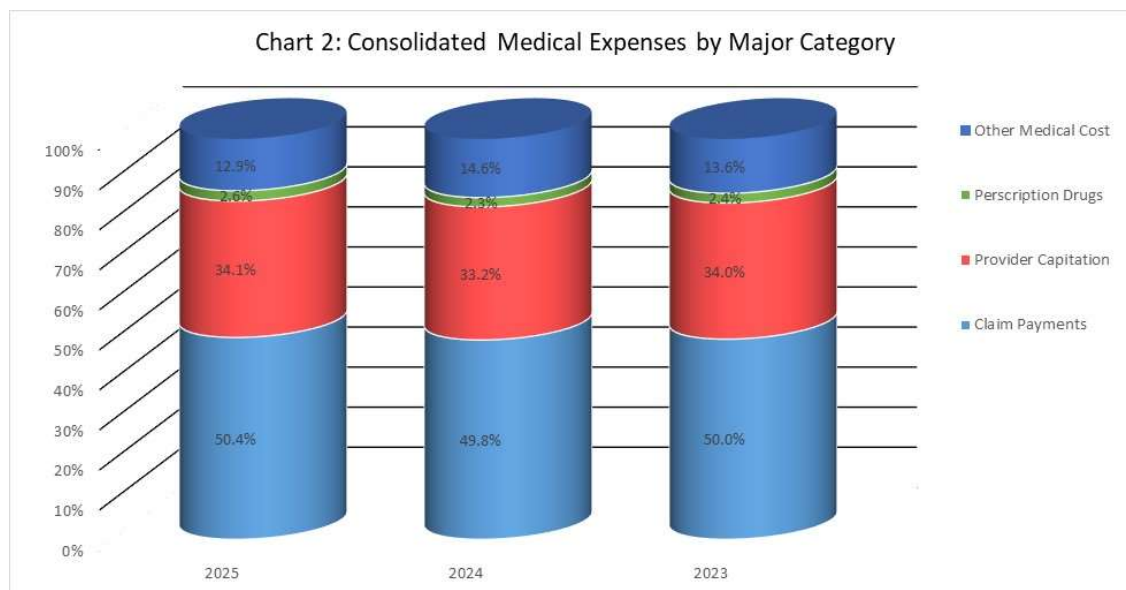
2025, 2024, and 2023 Medical Expenses by Line of Business

Below is a comparison chart of total medical expenses by line of business and their respective percentages of the overall medical expenditures by fiscal year.



2025, 2024, and 2023 Medical Expenses by Major Category

Below is a comparison chart of medical expenses by major category and their respective percentages of the overall medical expenditures by fiscal year.



Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

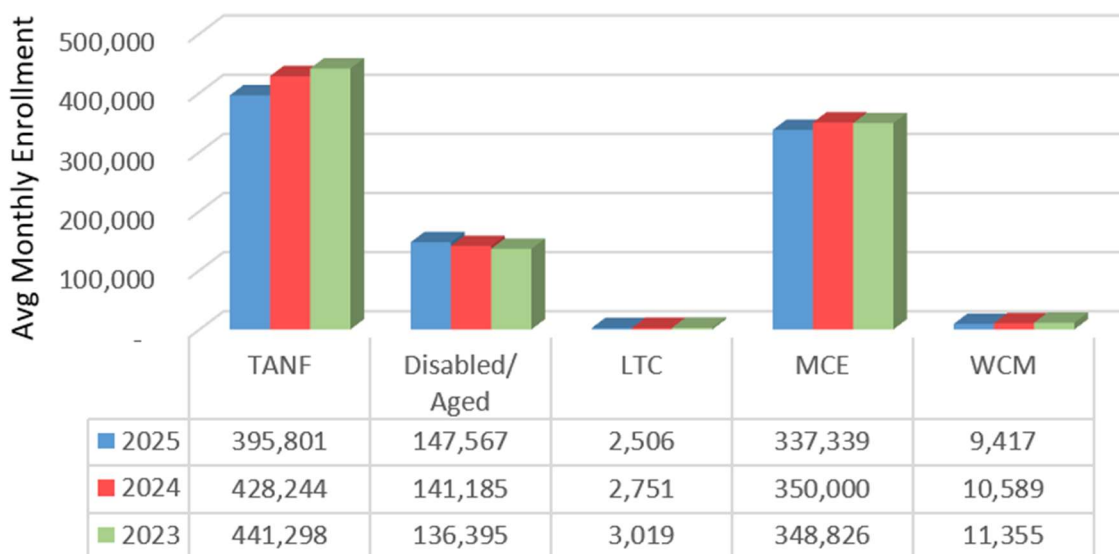
Management's Discussion and Analysis

2025, 2024, and 2023 Enrollment

Medi-Cal

During fiscal year 2025, CalOptima Health served an average of 892,630 Medi-Cal members per month compared to an average of 932,770 members per month in 2024 and 940,893 members per month in 2023. The decrease is attributed to the transition of Kaiser members out to its own Medi-Cal contract beginning January 1, 2024. The chart below displays a comparative view of average monthly membership by Medi-Cal aid category during 2025, 2024, and 2023.

**Chart 3: Medi-Cal Membership by Aid Category
(Shown as Average Member Months)**



Significant aid categories are defined as follows:

Temporary Assistance to Needy Families (TANF) includes families, children, and poverty-level members who qualify for the TANF federal welfare program, which provides cash aid and job-search assistance to poor families. TANF also includes members who migrated from the CalOptima Health, Health Net, and Kaiser Healthy Family programs.

Disabled and Aged includes individuals who have met the criteria for disability set by the Social Security Administration, and individuals aged 65 and older who receive supplemental security income (SSI) checks, are medically needy, or have an income of 100 percent or less of the federal poverty level.

LTC includes frail elderly adults, nonelderly adults with disabilities, and children with developmental disabilities and other disabling conditions that require LTC services.

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health Management's Discussion and Analysis

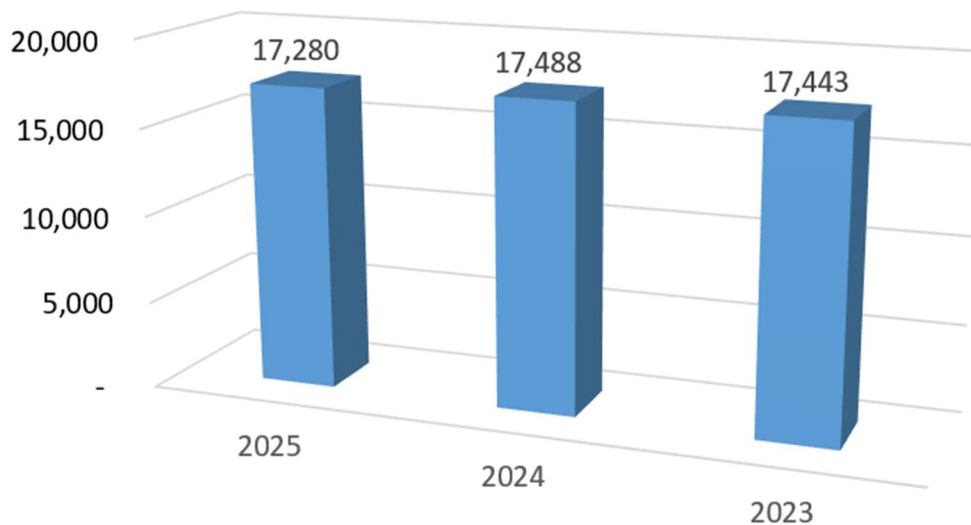
Medi-Cal Expansion (MCE) includes adults without children, ages 19 to 64, who qualify based upon income, as required by the Patient Protection and Affordable Care Act (ACA).

CalOptima Health's Whole Child Model (WCM) program includes children who are California Children's Services (CCS) eligible. These members are receiving their CCS services and non-CCS services under the WCM program.

OneCare

OneCare was introduced in October 2005 as a Medicare Advantage Special Needs Plan. It provides a full range of health care services to members who are eligible for both the Medicare and Medi-Cal programs (i.e., dual eligible). The average member months were 17,280, 17,488, and 17,443 for the years ended June 30, 2025, 2024, and 2023, respectively. The average member month for fiscal year 2023 was calculated using enrollment from January 2023 through June 2023 due to the transition of OneCare Connect members to OneCare beginning January 1, 2023. The chart below displays the average member months for the past three years.

**Chart 4: OneCare Membership by Fiscal Year
(Shown as Average Member Months)**

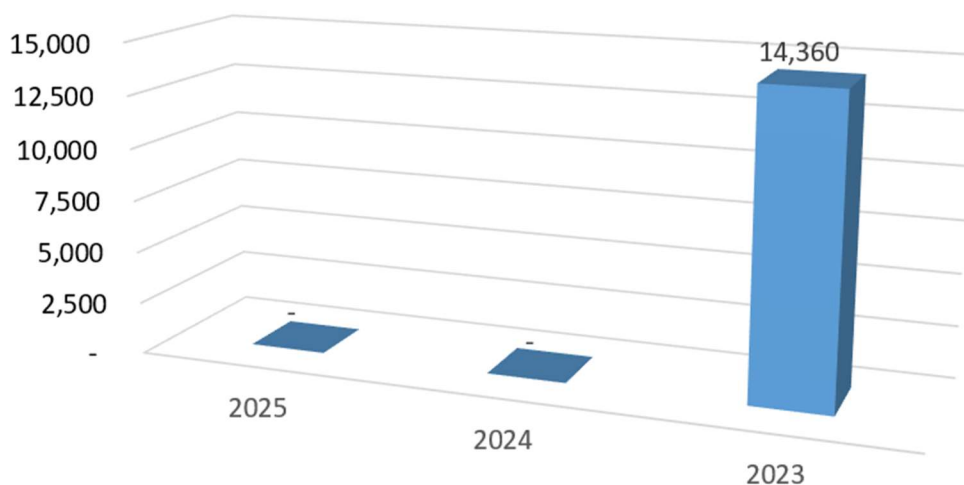


**Orange County Health Authority, A Public Agency dba Orange
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OneCare Connect

CalOptima Health launched the OneCare Connect program to serve dual eligible members in Orange County in July 2015. This program combines members' Medicare and Medi-Cal coverage and adds other benefits and supports. The average member months were 0, 0, and 14,360 for the fiscal years ended June 30, 2025, 2024, and 2023, respectively. For fiscal year 2023, average member months were calculated with enrollment from July 2022 through December 2022 due to the transition of OneCare Connect members to OneCare on January 1, 2023. The chart below displays the average member months for the past three years.

**Chart 5: OneCare Connect Membership by Fiscal Year
(Shown as Average Member Months)**

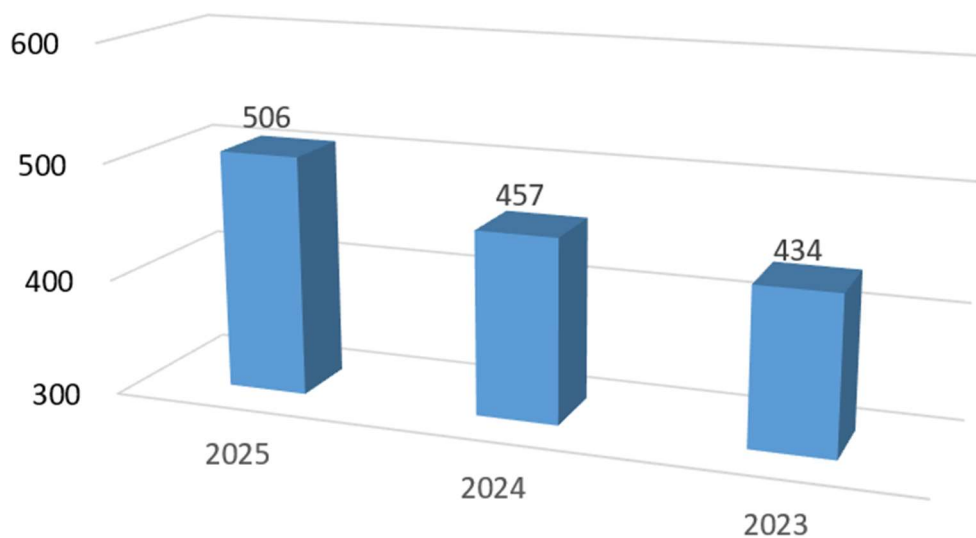


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PACE

PACE began operations in October 2013. It is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them to continue living independently in the community. The average member months were 506, 457, and 434 for the fiscal years ended June 30, 2025, 2024, and 2023, respectively. The chart below displays the average member months for the past three years.

**Chart 6: PACE Membership by Fiscal Year
(Shown as Average Member Months)**



Economic Factors and the State's Fiscal Year 2025-26 Budget

On June 27, 2025, Governor Gavin Newsom signed the fiscal year (FY) 2025-26 state budget bill. The budget addressed a \$11.8 billion General Fund deficit for FY 2025-26 that resulted from a combination of downgraded economic and revenue forecasts, and cost and caseload growth in core state programs. The budget shortfall was closed using spending reductions, revenue, borrowing and funding shifts.

General Fund spending in the budget package was \$228.4 billion, a decrease of \$5.2 billion or 2.2 percent from FY 2024-25. The budget included \$44.9 billion in General Fund spending for the Medi-Cal program, covering approximately 14.9 million beneficiaries in FY 2025-26.

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Some major Medi-Cal initiatives included are:

- Changes to full-scope Medi-Cal coverage for undocumented adults, including a freeze on enrollment for adults 19 and older beginning January 1, 2026, elimination of dental benefits for adults 19 and older, and implementation of \$30 monthly premiums for adults 19-59 beginning July 1, 2027;
- Use of Proposition 35 revenue to support increases in Medi-Cal base capitation rates;
- Continued investment in California Advancing and Innovating Medi-Cal (CalAIM);
- Revision of PACE payment methodology to set capitation rates at the midpoint of the rate range; effective January 1, 2027.
- Elimination of Prospective Payment System reimbursement to Federally Qualified Health Centers and Rural Health Centers for state-only services;
- Elimination of the Skilled Nursing Facility Workforce and Quality Incentive Program;
- Removal of the prohibition on prior authorization for hospice services; and
- Increased efforts related to prescription drugs utilization management and maximizing drug rebates.

The budget projected \$215.7 billion in General Fund revenues and transfers in FY 2025-26, a decrease of \$11.0 billion or 4.9 percent compared to last fiscal year. The three largest General Fund taxes (i.e., personal income tax, sales and use tax, and corporation tax) were projected to decrease by 2.6 percent from FY 2024-25. The State is projected to end FY 2025-26 with \$15.7 billion in total reserves.

DHCS routine annual audit (2024) – In January 2024, the California Department of Health Care Services (DHCS) formally engaged CalOptima Health for its annual medical program audit. The audit covered the provision of Medi-Cal services for the period of February 1, 2023, through February 29, 2024, and assessed CalOptima Health's compliance with its Medi-Cal contract and regulations. In August 2024, CalOptima Health received its audit findings report. The audit report identified ten findings that required corrective actions. CalOptima Health received confirmation of Corrective Action Plan (CAP) acceptance and audit closure on March 26, 2025. This audit is considered closed with no further action required.

DHCS State Supported Services (SSS) audit (2024) – At the time of engagement for its annual routine audit in January 2024, DHCS simultaneously engaged CalOptima Health in an SSS audit related to abortion services. DHCS conducted this audit in conjunction with the DHCS routine annual audit for the period of February 1, 2023, through February 29, 2024, and assessed CalOptima Health's compliance with its Medi-Cal contract and regulations related to SSS. In August 2024, CalOptima Health received its audit findings report which confirmed no findings. This audit is considered closed with no further action required.

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DHCS routine annual audit (2025) – In October 2024, DHCS formally engaged CalOptima Health for its annual medical program audit. The audit covered the provision of Medi-Cal services for the period of February 1, 2024, through January 31, 2025, and assessed CalOptima Health's compliance with its Medi-Cal contract and regulations. In May 2025, CalOptima Health received its audit findings report and request for corrective action. The audit report identified four findings that required corrective actions. As of this writing, CalOptima Health has submitted all required deliverables and awaits DHCS's assessment.

DHCS SSS audit (2025) – At the time of engagement for its annual routine audit in October 2024, DHCS simultaneously engaged CalOptima Health in an SSS audit related to abortion services. DHCS conducted this audit in conjunction with the DHCS routine annual audit for the period of February 1, 2024, through January 31, 2025, and assessed CalOptima Health's compliance with its Medi-Cal contract and regulations related to SSS. In May 2025, CalOptima Health received its audit findings report which confirmed no findings. This audit is considered closed with no further action required.

DHCS focused audit – In December 2022, the DHCS formally engaged CalOptima Health in a focused audit for services related to transportation and behavioral health. The audit covered the provision of services for the period of February 1, 2022, through January 31, 2023. DHCS conducted this focused audit on all managed care plans; the review was not unique to CalOptima Health. In August 2024, CalOptima Health received its audit findings report. The audit report identified two findings that required corrective actions. CalOptima Health received confirmation of CAP acceptance and closure on January 9, 2025. This audit is considered closed with no further action required.

California State Auditor (CSA) audit– In May 2023, the CSA released Report 2022-112. The audit covered certain aspects of CalOptima Health's budget, services, programs, and organizational changes. In accordance with the terms of the audit, CalOptima Health was required to submit 60-day, six-month and one-year status updates to CSA on the implementation of the report's seven recommendations. Following its assessment of the one-year status update, in October 2024, CSA confirmed that CalOptima Health had fully implemented all recommendations without any further actions or responses required.

DMHC routine examination – The California Department of Managed Care (DMHC) conducted a routine financial examination of CalOptima Health's fiscal and administrative affairs across all lines of business pursuant to Section 1382 of the Act. The audit began on January 13, 2025, and was conducted virtually. On February 25, 2025, DMHC issued the Preliminary Findings Report and noted one deficiency related to CalOptima Health's failure to timely file four key personnel/management changes with DMHC. A CAP was issued to the impacted operational area and submitted to DMHC on April 3, 2025. On April 17, 2025, DMHC issued the Final Audit Report and determined CalOptima Health sufficiently corrected the deficiency, and the audit was closed.

Payment Year (PY) 2012 Risk Adjustment Data Validation (RADV) audit – In September 2015, the Centers for Medicare & Medicaid Services (CMS) formally engaged CalOptima Health for its PY 2012 RADV Audit. On May 13, 2025, CMS issued the RADV Audit Report, Payment Error Calculation Methodology, and summary of findings for the audit. The audit results identified a total overpayment amount of \$54,735. CalOptima Health had 60 days to file an appeal if it did not agree with the RADV audit results. After review, CalOptima Health determined it will not file an appeal as the overpayment amount is in alignment with what was reviewed at the time the audit was originally conducted. CalOptima Health is currently awaiting additional communication from CMS regarding the collection of the overpayment amount.

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health Management's Discussion and Analysis

PY 2019 RADV audit – On June 12, 2025, CMS notified CalOptima Health that its OneCare plan was selected for the PY 2019 RADV Audit. CMS will conduct medical record reviews for a sample of OneCare members 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. CalOptima Health is required to submit medical records for the validation of the risk adjustment data. The medical record submission window opened on June 20, 2025, and will close on September 15, 2025. CMS expects to begin issuing PY 2019 audit findings by early 2026.

CMS 1/3 financial audit – On September 21, 2023, CMS notified CalOptima Health that its OneCare plan was selected for the Calendar Year 2022 CMS 1/3 Financial Audit. CMS' contractor, acting in the capacity of CMS agents, conducted the audit by requesting records and supporting documentation for, but not limited to, claims data, solvency, enrollment, base year entries on the bids, medical and/or drug expenses, related-party transactions, general administrative expenses, and Direct and Indirect Remuneration (DIR).

The audit has been completed, and the Agree/Disagree Letter was shared with CalOptima Health, which included three findings and one observation. CalOptima Health provided a response to the auditor on June 4, 2024. On August 19, 2024, the auditor shared that CMS reviewed the Draft Report and downgraded the previous Bid Reconciliation finding to an observation. An updated Agree/Disagree Letter, Management Representation Letter and Subsequent Inquiry Events were submitted to the auditor. On September 12, 2024, CMS issued the Final Audit Report, which included two findings and two observations. A CAP was issued to the impacted operational areas and submitted to CMS on December 10, 2024. On January 21, 2025, CMS issued notice of audit closure as CalOptima Health demonstrated it executed appropriate corrective actions for all the findings identified in the audit report.

Requests for information – This financial report has been prepared in the spirit of full disclosure to provide the reader with an overview of CalOptima Health's operations. If the reader has questions or would like additional information, please direct the requests to CalOptima Health, 505 City Parkway West, Orange, California 92868, or call (714) 347-3237.

Report of Independent Auditors

The Board of Directors

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health (the "Organization"), which comprise the statements of net position as of June 30, 2025 and 2024, and the related statements of revenues, expenses, and changes in net position and cash flows for the years then ended, and the related notes to the financial statements.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the Organization as of June 30, 2025 and 2024, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Organization and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Organization's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Organization's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Organization's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis, schedule of changes in net pension liability and related ratios, schedule of plan contributions, and schedule of changes in total OPEB liability and related ratios, as listed in the table of contents, be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the GASB who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Irvine, California

DATE

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upon for any purpose

Financial Statements

**Orange County Health Authority, A Public Agency dba Orange
Prevention and Treatment Integrated Medical Assistance dba
CalOptima Health
Statements of Net Position
June 30, 2025 and 2024**

	2025	2024
CURRENT ASSETS		
Cash and cash equivalents	\$ 475,203,956	\$ 527,999,319
Investments	1,340,926,602	1,777,895,941
Premiums due from the State of California and CMS	653,537,573	478,436,041
Prepaid expenses and other	106,757,225	87,419,561
Total current assets	<u>2,576,425,356</u>	<u>2,871,750,862</u>
BOARD-DESIGNATED ASSETS AND RESTRICTED CASH		
Cash and cash equivalents	6,677,329	22,817,912
Investments	1,710,130,179	1,114,945,527
Restricted deposit	300,000	300,000
Total board-designated assets and restricted cash	<u>1,717,107,508</u>	<u>1,138,063,439</u>
CAPITAL ASSETS, NET	79,772,146	77,270,145
INTANGIBLE RIGHT-TO-USE SUBSCRIPTION ASSET, net	<u>18,850,560</u>	<u>19,290,669</u>
Total assets	<u>4,392,155,570</u>	<u>4,106,375,115</u>
DEFERRED OUTFLOWS OF RESOURCES		
Net pension	27,437,072	74,549,007
Other postemployment benefit	1,189,000	1,350,000
Total deferred outflows of resources	<u>28,626,072</u>	<u>75,899,007</u>
Total assets and deferred outflows of resources	<u><u>\$ 4,420,781,642</u></u>	<u><u>\$ 4,182,274,122</u></u>

See accompanying notes.

**Orange County Health Authority, A Public Agency dba Orange
Prevention and Treatment Integrated Medical Assistance dba
CalOptima Health
Statements of Net Position
June 30, 2025 and 2024**

	2025	2024
CURRENT LIABILITIES		
Medical claims liability and capitation payable		
Medical claims liability	\$ 382,532,371	\$ 369,433,596
Provider capitation and withholds	153,993,364	176,233,694
Accrued reinsurance costs to providers	15,792,031	7,511,531
Due to the State of California and CMS	865,012,135	937,276,525
Unearned revenue	7,905,444	6,777,509
	<u>1,425,235,345</u>	<u>1,497,232,855</u>
Subscription liability	6,641,757	7,134,744
Accounts payable and other	31,561,522	17,667,439
Accrued payroll and employee benefits and other	<u>29,845,787</u>	<u>25,886,668</u>
Total current liabilities	1,493,284,411	1,547,921,706
COMMUNITY REINVESTMENT	88,098,111	106,676,651
POSTEMPLOYMENT HEALTH CARE PLAN	17,249,000	17,370,000
SUBSCRIPTION LIABILITY, net of current portion	11,170,484	10,595,755
NET PENSION LIABILITY	5,840,992	45,981,359
OTHER LONG-TERM LIABILITIES	<u>245,394</u>	<u>-</u>
Total liabilities	<u>1,615,888,392</u>	<u>1,728,545,471</u>
DEFERRED INFLOWS OF RESOURCES		
Net pension	1,321,519	2,248,445
Other postemployment benefit	<u>2,988,000</u>	<u>6,398,000</u>
Total deferred inflows of resources	<u>4,309,519</u>	<u>8,646,445</u>
NET POSITION		
Net investment in capital assets	80,810,465	78,830,315
Restricted by legislative authority	129,341,855	127,852,909
Unrestricted	<u>2,590,431,411</u>	<u>2,238,398,982</u>
Total net position	<u>2,800,583,731</u>	<u>2,445,082,206</u>
Total liabilities, deferred inflows of resources, and net position	<u>\$ 4,420,781,642</u>	<u>\$ 4,182,274,122</u>

See accompanying notes.

**Orange County Health Authority, A Public Agency dba Orange
Prevention and Treatment Integrated Medical Assistance dba
CalOptima Health**

**Statements of Revenues, Expenses, and Changes in Net Position
Years Ended June 30, 2025 and 2024**

	2025	2024
REVENUES		
Premium revenues	\$ 5,033,535,326	\$ 5,372,963,895
Total operating revenues	5,033,535,326	5,372,963,895
OPERATING EXPENSES		
Medical expenses		
Claims expense to providers and facilities	2,181,804,161	2,094,723,338
Provider capitation	1,506,905,421	1,477,805,330
Other medical	517,084,357	421,684,123
PACE	43,370,651	39,737,377
OneCare	372,267,309	369,285,675
Total medical expenses	4,621,431,899	4,403,235,843
Administrative expenses		
Salaries, wages, and employee benefits	155,054,752	149,096,246
Supplies, occupancy, insurance, and other	46,631,923	39,389,249
Purchased services	29,268,757	22,407,022
Depreciation and amortization	9,606,171	8,008,630
Professional fees	19,297,822	10,609,407
Total administrative expenses	259,859,425	229,510,554
Total operating expenses	4,881,291,324	4,632,746,397
OPERATING INCOME	152,244,002	740,217,498
NON-OPERATING REVENUES (EXPENSES)		
Net investment income and other	194,295,685	174,598,247
Grant expense	(9,627,088)	(33,282,237)
Community reinvestment	18,578,540	(106,676,651)
Rental income, net of related expenses	10,386	219,072
Total non-operating revenues	203,257,523	34,858,431
Increase in net position	355,501,525	775,075,929
NET POSITION, beginning of year	2,445,082,206	1,670,006,277
NET POSITION, end of year	\$ 2,800,583,731	\$ 2,445,082,206

See accompanying notes.

**Orange County Health Authority, A Public Agency dba Orange
Prevention and Treatment Integrated Medical Assistance dba
CalOptima Health
Statements of Cash Flows
Years Ended June 30, 2025 and 2024**

	2025	2024
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation payments received and other	\$ 4,787,297,339	\$ 4,870,608,107
Payments to providers and facilities	(4,622,047,560)	(4,313,806,893)
Payments to vendors	(91,530,982)	(56,642,960)
Payments to employees	(148,420,991)	(195,089,484)
Net cash (used in) provided by operating activities	(74,702,194)	305,068,770
CASH FLOWS USED IN CAPITAL AND RELATED FINANCING ACTIVITIES		
Payments on subscription lease obligations	(9,431,517)	(8,592,862)
Purchases of capital assets	(11,265,905)	(19,216,010)
Net cash used in capital and related financing activities	(20,697,422)	(27,808,872)
CASH FLOWS USED IN INVESTING ACTIVITIES		
Investment income received	202,322,612	201,775,923
Purchases of securities	23,161,166,531	(21,016,264,492)
Sales of securities	(23,311,268,188)	20,326,715,194
Payments of grants to providers	(9,627,088)	(33,282,237)
Collections related to rental income	10,386	219,072
Net cash provided by (used in) investing activities	42,604,253	(520,836,540)
Net change in cash and cash equivalents	(52,795,363)	(243,576,642)
CASH AND CASH EQUIVALENTS, beginning of year	527,999,319	771,575,961
CASH AND CASH EQUIVALENTS, end of year	\$ 475,203,956	\$ 527,999,319
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Operating income	\$ 152,244,002	\$ 740,217,498
ADJUSTMENT TO RECONCILE OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Depreciation and amortization	17,742,390	15,680,860
Changes in assets and liabilities		
Premiums due from the State of California and CMS	(175,101,532)	(81,060,308)
Prepaid expenses and other	(19,337,664)	4,189,106
Medical claims liability	13,098,775	35,439,840
Provider capitation and withholds	(22,240,330)	50,789,672
Accrued reinsurance costs to providers	8,280,500	3,199,438
Due to the State of California and CMS	(72,264,390)	(366,186,657)
Unearned revenue	1,127,935	(55,108,823)
Accounts payable and other	14,868,965	3,901,382
Long term liabilities	245,394	-
Accrued payroll and employee benefits and other	3,959,119	2,554,276
Postemployment health care plan	(3,370,000)	(2,749,000)
Net pension liability	6,044,642	(45,798,514)
Net cash (used in) provided by operating activities	\$ (74,702,194)	\$ 305,068,770
NONCASH CAPITAL FINANCING ACTIVITIES		
Lease right-of-use assets acquired via lease obligations	\$ 8,538,377	\$ 8,818,155
SUPPLEMENTAL SCHEDULE OF NONCASH OPERATING AND INVESTING ACTIVITIES		
Change in unrealized depreciation on investments	\$ 12,997,504	\$ (5,165,292)

See accompanying notes.

**Orange County Health Authority, A Public Agency dba Orange
Prevention and Treatment Integrated Medical Assistance dba
CalOptima Health
Notes to Financial Statements**

Note 1 – Organization

Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment Integrated Medical Assistance dba CalOptima Health, is a County-Organized Health System (COHS) serving primarily Medi-Cal beneficiaries in Orange County, California. Effective August 4, 2022, Orange County Health Authority changed its dba name to CalOptima Health (CalOptima Health or the Organization). Pursuant to the California Welfare and Institutions Code, CalOptima Health was formed by the Orange County Board of Supervisors as a public/private partnership through the adoption of Ordinance No. 3896 in August 1992. The Organization began operations in October 1995.

As a COHS, CalOptima Health maintains an exclusive contract with the State of California (the State) Department of Health Care Services (DHCS) to arrange for the provision of health care services to Orange County's Medi-Cal beneficiaries. Orange County had approximately 886,000 and 901,300 Medi-Cal beneficiaries for the years ended June 30, 2025 and 2024, respectively. CalOptima Health also offers OneCare, a Medicare Advantage Special Needs Plan, via a contract with the Centers for Medicare & Medicaid Services (CMS). OneCare served approximately 17,700 and 17,300 members eligible for both Medicare and Medi-Cal for the years ended June 30, 2025 and 2024, respectively.

CalOptima Health also contracts with the California Department of Aging to provide case management of social and health care services to approximately 500 Medi-Cal eligible seniors under the State's Multipurpose Senior Services Program (MSSP). Effective January 1, 2022, MSSP transitioned from a managed care plan benefit to a carved-out waiver benefit.

The Program of All-Inclusive Care for the Elderly (PACE) provides services to members 55 years of age or older who reside in the PACE service area and meet California nursing facility level-of-care requirements. The program receives Medicare and Medi-Cal funding and serves approximately 500 members.

CalOptima Health, in turn, subcontracts the delivery of health care services through health maintenance organizations and provider-sponsored organizations, known as Physician/Hospital Consortia and Shared Risk Groups. Additionally, CalOptima Health has direct contracts with hospitals and providers for its fee-for-service network.

CalOptima Health is Knox-Keene-licensed for purposes of its Medicare programs and is subject to certain provisions of the Knox-Keene Health Care Service Plan Act of 1975 (the Act) to the extent incorporated by reference into CalOptima Health's contract with DHCS. As such, CalOptima Health is subject to the regulatory requirements of the Department of Managed Health Care (DMHC) under Section 1300, Title 28 of the California Administrative Code of Regulations, including minimum requirements of TNE, which CalOptima Health exceeded as of June 30, 2025 and 2024.

Note 2 – Summary of Significant Accounting Policies

Basis of presentation – CalOptima Health is a COHS plan governed by a 10-member Board of Directors appointed by the Orange County Board of Supervisors. Effective for the year ended June 30, 2014, CalOptima Health began reporting as a discrete component unit of the County of Orange, California. The County made this determination based on the County Board of Supervisors' role in appointing all members of the Board of Directors.

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Basis of accounting – CalOptima Health uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. The accompanying financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board (GASB).

Use of estimates – The preparation of the financial statements in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP) requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and cash equivalents – The Organization considers all highly liquid investments with original maturities of three months or less to be cash and cash equivalents.

Investments – Investments are stated at fair value in accordance with GASB Codification Section 150. The fair value of investments is estimated based on quoted market prices, when available. For debt securities not actively traded, fair values are estimated using values obtained from external pricing services or are estimated by discounting the expected future cash flows using current market rates applicable to the coupon rate, credit, and maturity of the investments.

All investments with an original maturity of one year or less when purchased are recorded as current investments, unless designated or restricted.

Board-designated assets and restricted cash – Board-designated assets based on policy updates approved by the Board in April 2025 include amounts designated by the Board of Directors for the establishment of certain reserve funds for contingencies at a desired level between 2.5 and 4.0 months of consolidated capitation revenue (see Note 3). The Board of Directors also established a separate reserve to meet the statutory requirement for minimum TNE. Restricted cash represents a \$300,000 restricted deposit required by CalOptima Health as part of the Act (see Note 9).

Capital assets – Capital assets are stated at cost at the date of acquisition. The costs of normal maintenance, repairs, and minor replacements are charged to expense when incurred.

Depreciation is calculated using the straight-line method over the estimated useful lives of the assets. Long-lived assets are periodically reviewed for impairment. The following estimated useful lives are used:

	Years
Furniture	5 years
Vehicles	5 years
Computers and software	3 years
Leasehold improvements	15 years or life of lease, whichever is less
Building	40 years
Building components	10 to 30 years
Land improvements	8 to 25 years
Tenant improvements	7 years or life of lease, whichever is less

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Fair value of financial instruments – The financial statements include financial instruments for which the fair market value may differ from amounts reflected on a historical basis. Financial instruments of the Organization consist of cash deposits, investments, premiums receivable, accounts payable, and certain accrued liabilities. The Organization's other financial instruments, except for investments, generally approximate fair market value based on the relatively short period of time between origination of the instruments and their expected realization.

Medical claims liability and expenses – CalOptima Health establishes a claims liability based on estimates of the ultimate cost of claims in process and a provision for incurred-but-not-yet-reported (IBNR) claims, which is actuarially determined based on historical claim payment experience and other statistics. Such estimates are continually monitored and analyzed with any adjustments made as necessary in the period the adjustment is determined. CalOptima Health retains an outside actuary to perform an annual review of the actuarial projections. Amounts for claims payment incurred related to prior years vary from previously estimated liabilities as the claims ultimately are settled.

Provider capitation and withholds – CalOptima Health has provider services agreements with several health networks in Orange County, whereby the health networks provide care directly to covered members or through subcontracts with other health care providers. Payment for the services provided by the health networks is on a fully capitated basis. The capitation amount is based on contractually agreed-upon terms with each health network. CalOptima Health withholds amounts from providers at an agreed-upon percentage of capitation payments made to ensure the financial solvency of each contract. CalOptima Health also records a liability related to quality incentive payments and risk-share provisions. The quality incentive liability is estimated based on member months and rates agreed upon by the Board of Directors. For the risk-share provision liability, management allocates surpluses or deficits, multiplied by a contractual rate, with the shared-risk groups. Estimated amounts due to health networks pertaining to risk-share provisions were approximately \$17,252,000 and \$27,304,000 as of June 30, 2025 and 2024, respectively, and are included in provider capitation and withholds on the statements of net position. During the years ended June 30, 2025 and 2024, CalOptima Health incurred approximately \$1,537,886,000 and \$1,463,590,000, respectively, of capitation expense relating to health care services provided by health networks. Capitation expense is included in the provider capitation and OneCare line items in the statements of revenues, expenses, and changes in net position. Estimated amounts due to health networks as of June 30, 2025 and 2024, related to the capitation withhold arrangements, quality incentive payments, and risk-share provisions were approximately \$153,993,000 and \$176,234,000, respectively.

Premium deficiency reserves – CalOptima Health performs periodic analyses of its expected future health care costs and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is accrued. Investment income is included in the calculation to estimate premium deficiency reserves. CalOptima Health's management determined that no premium deficiency reserves were necessary as of June 30, 2025 and 2024.

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Community reinvestment – Under its contract with DHCS, CalOptima Health is required to commit a percentage of net position toward investments into the community and an additional percentage if CalOptima Health does not meet specified quality measures established by the State, referred to as Community Reinvestment and Quality Achievement, respectively. As of June 30, 2024, in accordance with State contracts, the balance of the community reinvestment and quality achievement accrual was estimated at approximately \$51,439,000 and \$55,238,000, respectively. In February 2025, the Organization received additional clarification from DHCS regarding the inputs required to calculate the Community Reinvestment and Quality Achievement accrual. As a result of the new information, there was a net decrease in liabilities related to Community Reinvestment for the year ended June 30, 2025, of approximately \$18,579,000. As of June 30, 2025, the balance of the community reinvestment and quality achievement accrual was estimated at approximately \$49,932,000 and \$38,166,000, respectively for a total estimated accrual of approximately \$88,098,000.

Additionally, the new information from DHCS indicated that these Community Reinvestment funds should not be allocated towards activities included in the Managed Care Plan (MCP) Contract or services carved out of the MCP Contract but covered under Medi-Cal. Community reinvestment obligations may also not be met through expenditures for activities aimed at improving health care quality as defined by certain federal regulations, administrative functions of the MCP including tasks related to Community Reinvestment planning or implementation, and member incentives or grants.

As a result, the Organization reclassified approximately \$106,677,000 from other medical expenses to other non-operating expenses in the statements of revenues, expenses, and changes in net position for the year ended June 30, 2024. The reclassification represents a change in accounting estimate based on new information and is not considered an accounting error.

Accrued compensated absences – CalOptima Health implemented GASB Statement No. 101, *Compensated Absences* (GASB 101), effective July 1, 2023. The objective of GASB 101 is to better meet the information needs of financial statement users by updating the recognition and measurement guidance for compensated absences. GASB 101 requires that liabilities for compensated absences be recognized for (1) leave that has not been used and (2) leave that has been used but not yet paid in cash or settled through noncash means. A liability should be recognized for leave that has not been used if (a) the leave is attributable to services already rendered, (b) the leave accumulates, and (c) the leave is more likely than not to be used for time off or otherwise paid in cash or settled through noncash means. This statement requires that a liability for certain types of compensated absences—including parental leave, military leave, and jury duty leave—not be recognized until the leave commences. It also requires that a liability for specific types of compensated absences not be recognized until the leave is used. CalOptima Health was in compliance with GASB 101 prior to its issuance; therefore, the implementation of GASB 101 had no effect on the beginning net position of CalOptima Health as of July 1, 2023.

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CalOptima Health's policy permits employees who are regularly scheduled to work more than 20 hours per week to accrue 23 days of paid time off (PTO) based on their years of continuous service, with an additional week of accrual after three years of service and another after 10 years of service. In the event that available PTO is not used by the end of the benefit year, employees may carry unused time off into subsequent years, up to the maximum accrual amount equal to two (2) times the employee's annual accrual. If an employee reaches his or her maximum PTO accrual amount, the employee will stop accruing PTO. Accumulated PTO will be paid to the employees upon separation from service with CalOptima Health. All compensated absences are included in accrued payroll and employee benefits and other on the statements of net position.

Net position – Net position is reported in three categories, defined as follows:

- *Net investment in capital assets* – This component of net position consists of capital assets, subscription-based information technology arrangements (SBITAs), and right of use (ROU) assets including restricted capital assets, net of accumulated depreciation and amortization, and is reduced by the outstanding balances of any bonds, notes, or other borrowings (if any) that are attributable to the acquisition, construction, or improvement of those assets.
- *Restricted by legislative authority* – This component of net position consists of external constraints placed on net asset use by creditors (such as through debt covenants), grantors, contributors, or the laws or regulations of other governments. It also pertains to constraints imposed by law, constitutional provisions, or enabling legislation (see Note 9).
- *Unrestricted* – This component of net position consists of net position that does not meet the definition of "restricted" or "net investment in capital assets."

Operating revenues and expenses – CalOptima Health's statements of revenues, expenses, and changes in net position distinguish between operating and non-operating revenues and expenses. Operating revenues result from exchange transactions associated with arranging for the provision of health care services. Operating expenses are all expenses incurred to arrange for the provision of health care services, as well as the costs of administration. Unpaid claims adjustment expenses are an estimate of the cost to process the IBNR claims and are included in operating expenses. Non-exchange revenues and expenses are reported as non-operating revenues and expenses.

Revenue recognition and due to or from the State and CMS – Premium revenue is recognized in the period the members are eligible to receive health care services. Premium revenue is generally received from the State each month following the month of coverage based on estimated enrollment and capitation rates as provided for in the State contract. As such, premium revenue includes an estimate for amounts receivable from or refundable to the State and for retrospective adjustments. These estimates are continually monitored and analyzed, with any adjustments recognized in the period when determined. OneCare premium revenue is generally received from CMS each month for the month of coverage. Premiums received in advance are recorded in unearned revenue on the statements of net position. Included in premium revenue are retroactive adjustments favorable to CalOptima Health in the amount of approximately \$393,011,000 and \$966,461,000 related to retroactive capitation rate adjustments based on receipt of new information from DHCS during the years ended June 30, 2025 and 2024, respectively.

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These estimates are continually reviewed, and adjustments to the estimates are reflected currently in the statements of revenues, expenses, and changes in net position. Eligibility of beneficiaries is determined by DHCS and validated by the State. The State provides CalOptima Health the validated monthly eligibility file of program beneficiaries who are continuing, newly added, or terminated from the program in support of premium revenue for the respective month.

Premium revenue and related net receivables as a percent of the totals were as follows as of June 30:

	2025		2024	
	Revenue	%	Revenue	%
Revenue				
Medi-Cal	\$ 4,575,205,978	90.9%	\$ 4,918,009,421	91.5%
OneCare	403,654,853	8.0%	407,480,604	7.6%
PACE	54,674,495	1.1%	47,473,870	0.9%
	<u>\$ 5,033,535,326</u>	<u>100.0%</u>	<u>\$ 5,372,963,895</u>	<u>100.0%</u>
	2025		2024	
	Receivables	%	Receivables	%
Receivables				
Medi-Cal	\$ 612,756,130	93.8%	\$ 438,045,910	91.6%
OneCare	11,815,080	1.9%	16,536,135	3.5%
OneCare Connect	23,922,514	3.7%	19,720,151	4.1%
PACE	5,043,849	0.8%	4,133,845	0.9%
	<u>\$ 653,537,573</u>	<u>100.0%</u>	<u>\$ 478,436,041</u>	<u>100.0%</u>

Intergovernmental transfer – CalOptima Health entered into an agreement with DHCS and Governmental Funding Entities to receive an intergovernmental transfer (IGT) through a capitation rate increase of approximately \$160,474,000 and \$147,059,000 during the years ended June 30, 2025 and 2024, respectively. Under the agreement, approximately \$158,986,000 and \$145,317,000 of the funds that were received from the IGT were passed through to Governmental Funding Entities and other contracted providers and organizations during the years ended June 30, 2025 and 2024, respectively. Under GASB, the amounts that will be passed through to Governmental Funding Entities are not reported in the statements of revenues, expenses, and changes in net position. CalOptima Health retains a portion of the IGT to support the administration of the program. Prior IGT funds retained by CalOptima Health from 2011 to 2017, must be used to enhance provider reimbursement rates, strengthen the delivery system, and support the administration of the IGT program. The funds expended must be tied to covered medical services provided to CalOptima Health's Medi-Cal beneficiaries. A retainer in the amount of approximately \$4,505,000 and \$2,918,000 as of June 30, 2025 and 2024, respectively, is included in unearned revenues in the statements of net position.

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Directed Payments – DHCS implemented a hospital Directed Payment program with CalOptima Health. The program implements enhanced reimbursement to eligible and participating network hospitals for contracted services. This hospital Directed Payment program is broken into five types: (1) Private Hospital Directed Payment Program (PHDP), (2) Public Hospital Enhanced Payment Program (EPP), (3) Public Hospital Quality Incentive Program (QIP), (4) Skilled Nursing Facility (SNF) Workforce and Quality Incentive Program (WQIP), and (5) Equity and Practice Transformation (EPT). Under the Directed Payment program, approximately \$383,270,000 and \$314,307,000 of the funds that were received from DHCS were passed through to hospitals as requested by DHCS during the years ended June 30, 2025 and 2024, respectively. The receipts from DHCS are included in premium revenues, and the payments made to the hospitals are included in other medical expenses in the statements of revenues, expenses, and changes in net position.

Medicare Part D – CalOptima Health covers prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments CalOptima Health receives monthly from program premiums, which are determined from its annual bid, represent amounts for providing prescription drug insurance coverage. CalOptima Health recognizes premiums for providing this insurance coverage ratably over the term of its annual contract. CalOptima Health's CMS payment is subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, receipts for reinsurance and low-income cost subsidies, as well as receipts for certain discounts on brand-name prescription drugs in the coverage gap, represent payments for prescription drug costs for which CalOptima Health is not at risk.

The risk corridor provisions compare costs targeted in CalOptima Health's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to CalOptima Health or require CalOptima Health to refund to CMS a portion of the premiums CalOptima Health received. CalOptima Health estimates and recognizes an adjustment to premiums revenue related to these risk corridor provisions based upon pharmacy claims experience to date, as if the annual contract were to terminate at the end of the reporting period. Accordingly, this estimate provides no consideration to future pharmacy claims experience. CalOptima Health records a receivable or payable at the contract level and classifies the amount as current or long-term in the accompanying statements of net position based on the timing of the expected settlement. As of June 30, 2025 and 2024, the Part D payable balance was approximately \$14,205,000 and \$8,808,000, respectively, and is included in the due to the State of California and CMS line item on the accompanying statements of net position. As of June 30, 2025 and 2024, the Part D receivable balance was approximately \$65,330,000 and \$52,167,000, respectively, and is included in the prepaid expenses and other line item on the accompanying statements of net position.

Income taxes – CalOptima Health operates under the purview of the Internal Revenue Code (IRC), Section 501(a), and corresponding California Revenue and Taxation Code provisions. As such, CalOptima Health is not subject to federal or state taxes on related income. Accordingly, no provision for income tax has been recorded in the accompanying financial statements.

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Premium taxes – Effective July 1, 2016, Senate Bill X2-2 (SB X2-2), *Managed Care Organization Tax*, authorized DHCS to implement a Managed Care Organization (MCO) provider tax subject to approval by CMS. This approved tax structure is based on enrollment (total member months) between specified tiers that are assessed different tax rates. During fiscal year 2020, the MCO tax was extended with an effective date of January 1, 2020, through December 31, 2022. Effective December 15, 2023, and retroactive to April 1, 2023, CMS approved the extension of the MCO tax through the end of December 2026. Using the approved structure, each MCO's total tax liability for the years ended June 30, 2025 and 2024, was calculated. CalOptima Health recognized premium tax expense of approximately \$863,939,000 and \$657,657,000 as a reduction of premium revenues in the statements of revenue, expenses, and changes in net position for the years ended June 30, 2025 and 2024, respectively. As of June 30, 2025 and 2024, CalOptima Health's MCO tax liability was approximately \$201,453,000 and \$153,920,000, respectively, and is included in the due to the State of California and CMS line item on the accompanying statements of net position.

Risk corridors – All risk corridors are subject to certain thresholds of medical expenses compared to premium revenues. Variances exceeding the thresholds may require CalOptima Health to refund premium revenues back to DHCS. CalOptima Health estimates and recognizes an adjustment to premium revenues based on actual membership and capitation rates in effect. As of June 30, 2025 and 2024, CalOptima Health recognized a liability of approximately \$204,585,000 and \$304,789,000, respectively, related to the risk corridors, which is included in the due to the State of California and CMS line item on the statements of net position. During the year ended June 30, 2025, the reduction to premium revenue was approximately \$47,635,000 and for year ended June 30, 2024, the increase of premium revenue was approximately \$599,501,700 related to the risk corridors, which is included in premium revenues on the statements of revenues, expenses, and changes in net position. Below is a list of programs with risk corridor accruals as of June 30, 2025 and 2024:

- Research and Prevention Tobacco Tax Act of 2016 (Proposition 56)
- Coordinated Care Initiative (CCI)
- Bridge Period COVID-19
- Enhanced Care Management
- Unsatisfactory Immigration Status (UIS)

The State's fiscal year 2020-21 enacted budget and CalOptima Health's contract included a COVID-19 (previously called Gross Medical Expense) risk corridor for the initial period of July 1, 2019, to December 31, 2020, with the option to extend the risk corridor starting on or after January 1, 2021, should the State determine it necessary to account for the impacts of the COVID-19 public health emergency. During the year ended June 30, 2024, CalOptima Health was made aware that the State would not be enforcing the COVID-19 risk corridor for the periods starting on or after January 1, 2021. As such, the Organization released \$646,800,000 of liabilities relating to the COVID-19 risk corridor during the year ended June 30, 2024.

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Pensions – For purposes of measuring the net pension liability and deferred outflows/inflows of resources related to pensions and pension expense, information about the fiduciary net position of CalOptima Health's Miscellaneous Plan of the Orange County Health Authority (the CalPERS Plan) and additions to or deductions from the Organization's fiduciary net position have been determined on the same basis as they are reported by California Public Employees Retirement Systems (CalPERS). For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Subscription-Based Information Technology Arrangements – CalOptima Health is the end user for various SBITAs. Short-term SBITAs, which have a maximum possible term of 12 months, are recognized as an outflow of resources when payment is made. For SBITAs with subscription terms extending beyond one year, CalOptima Health recognizes a right-to-use subscription asset and a corresponding subscription liability. Initial measurement of the subscription asset/liability is calculated at the present value of payments expected to be paid during the subscription term, discounted using the incremental borrowing rate. The right-to-use asset is amortized on a straight-line basis over the subscription term.

Reclassifications – Certain reclassifications have been made to the prior-year amounts to conform to the current-year presentation.

Recent accounting pronouncements – In April 2024, GASB issued Statement No. 103, *Financial Reporting Model Improvements* (GASB 103). The objective of GASB 103 is to improve key components of the financial reporting model. The purposes of the improvements are to (a) enhance the effectiveness of the financial reporting model in providing information that is essential for decision making and assessing a government's accountability and (b) address certain application issues identified through pre-agenda research conducted by the GASB. GASB 103 effective for CalOptima Health during the year ending June 30, 2026. Management is currently evaluating the impact of adoption of this standard on the financial statements.

In September 2024, GASB issued Statement No. 104, *Disclosure of Certain Capital* (GASB 104). The objective of GASB 104 is to provide users of government financial statements with essential information about certain types of capital assets. GASB 104 requires certain types of capital assets to be disclosed separately in the capital assets note disclosures required by GASB Statement No. 34 as well as certain intangible assets to be disclosed separately by major class. GASB 104 also requires additional disclosures for capital assets held for sale. This Statement requires that capital assets held for sale be evaluated each reporting period. GASB 104 is effective for CalOptima Health during the year ending June 30, 2026. Management is currently evaluating the impact of adoption of this standard on the financial statements.

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Note 3 – Cash, Cash Equivalents, and Investments

Cash and investments are reported in the statements of net position as follows as of June 30:

	2025	2024
Current assets		
Cash and cash equivalents	\$ 475,203,956	\$ 527,999,319
Investments	1,340,926,602	1,777,895,941
Board-designated assets and restricted cash		
Cash and cash equivalents	6,677,329	22,817,912
Investments	1,710,130,179	1,114,945,527
Restricted deposit	300,000	300,000
	<u>\$ 3,533,238,066</u>	<u>\$ 3,443,958,699</u>

Board-designated assets and restricted cash were available for the following purposes as of June 30:

	2025	2024
Board-designated assets and restricted cash		
Contingency reserve fund	\$ 1,716,807,508	\$ 1,137,763,439
Restricted deposit with DMHC	300,000	300,000
	<u>\$ 1,717,107,508</u>	<u>\$ 1,138,063,439</u>

Custodial credit risk deposits – Custodial credit risk is the risk that, in the event of a bank failure, the Organization may not be able to recover its deposits or collateral securities that are in the possession of an outside party. The California Government Code requires that a financial institution secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the state law. As of June 30, 2025 and 2024, no deposits were exposed to custodial credit risk, as the Organization has pledged collateral to cover the amounts.

Investments – CalOptima Health invests in obligations of the U.S. Treasury, other U.S. government agencies and instrumentalities, state obligations, corporate securities, money market funds, and mortgage- or asset-backed securities.

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Interest rate risk – In accordance with its annual investment policy (investment policy), CalOptima Health manages its exposure to declines in fair value from increasing interest rates by matching maturity dates to the extent possible with CalOptima Health's expected cash flow draws. The investment policy limits maturities to five years, while also staggering maturities. CalOptima Health maintains a low-duration strategy, targeting a portfolio duration of three years or less, with the intent of reducing interest rate risk. Portfolios with low duration are less volatile because they are less sensitive to interest rate changes. As of June 30, 2025 and 2024, CalOptima Health's investments, including cash equivalents, had the following modified duration:

Investment Type	June 30, 2025			
	Fair Value	Investment Maturities (in Years)		
		Less Than 1	1–5	More Than 5
U.S. Treasury notes	\$ 1,056,051,175	\$ 91,981,484	\$ 964,069,691	\$ -
U.S. Agency notes	100,608,023	-	100,608,023	-
Corporate bonds	955,165,722	47,590,754	907,574,968	-
Asset-backed securities	265,439,326	13,414,645	252,024,681	-
Mortgage-backed securities	377,695,982	4,129,370	373,566,612	-
Municipal bonds	93,903,321	19,315,252	74,588,069	-
Government-related	2,861,711	-	2,861,711	-
Commercial paper	76,139,294	76,139,294	-	-
Certificates of deposit	102,167,795	79,670,538	22,497,257	-
Cash equivalents	365,324,032	365,324,032	-	-
Cash	13,341,197	13,341,197	-	-
	<u>\$ 3,408,697,578</u>	<u>\$ 710,906,566</u>	<u>\$ 2,697,791,012</u>	<u>\$ -</u>
Accrued interest receivable	<u>21,024,431</u>			
	<u><u>\$ 3,429,722,009</u></u>			

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Investment Type	June 30, 2024			
	Fair Value	Investment Maturities (in Years)		
		Less Than 1	1–5	More Than 5
U.S. Treasury notes	\$ 971,992,504	\$ 314,637,165	\$ 657,355,339	\$ -
U.S. Agency notes	262,740,439	8,391,603	254,348,836	-
Corporate bonds	847,388,142	71,686,337	775,701,805	-
Asset-backed securities	282,066,505	3,051,718	279,014,787	-
Mortgage-backed securities	338,957,054	3,489,987	335,467,067	-
Municipal bonds	34,517,897	1,999,272	32,518,625	-
Government-related	47,509,397	-	47,509,397	-
Commercial paper	11,838,720	11,838,720	-	-
Certificates of deposit	73,825,050	73,825,050	-	-
Cash equivalents	449,240,016	449,240,016	-	-
Cash	17,235,722	17,235,722	-	-
	<u>\$ 3,337,311,446</u>	<u>\$ 955,395,590</u>	<u>\$ 2,381,915,856</u>	<u>\$ -</u>
Accrued interest receivable	<u>22,012,384</u>			
	<u>\$ 3,359,323,830</u>			

Investments with fair values highly sensitive to interest rate fluctuations – When interest rates fall, debt is refinanced and paid off early. The reduced stream of future interest payments diminishes the fair value of the investment. The mortgage-backed and asset-backed securities in the CalOptima Health portfolios are of high credit quality, with relatively short average lives that represent limited prepayment and interest rate exposure risk. CalOptima Health's investments included the following investments that are highly sensitive to interest rate and prepayment fluctuations to a greater degree than already indicated in the information provided above as of June 30:

	2025	2024
Asset-backed securities	\$ 265,439,326	\$ 282,066,505
Mortgage-backed securities	<u>377,695,982</u>	<u>338,957,054</u>
	<u>\$ 643,135,308</u>	<u>\$ 621,023,559</u>

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Credit risk – CalOptima Health’s investment policy conforms to the California Government Code as well as to customary standards of prudent investment management. Credit risk is mitigated by investing in only permitted investments. The investment policy sets minimum acceptable credit ratings for investments from the three nationally recognized rating services: Standard and Poor’s Corporation (S&P), Moody’s Investor Service (Moody’s), and Fitch Ratings (Fitch). For an issuer of short-term debt, the rating must be no less than A-1 (S&P), P-1 (Moody’s), or F-1 (Fitch), while an issuer of long-term debt shall be rated no less than A.As of June 30, 2025, the credit ratings of investments and cash equivalents were as follows:

Investment Type	Fair Value	Minimum Legal Rating	Exempt from Disclosure	Rating as of Year-End					
				AAA or A1/P1	Aa & Aa+	Aa-	A+	A	A-
U.S. Treasury notes	\$ 1,232,188,052	N/A	\$ 1,232,188,052	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
U.S. Agency notes	101,249,488	N/A	101,249,488	-	-	-	-	-	-
Corporate bonds	964,913,168	A-	-	41,172,765	65,791,623	148,143,887	195,576,926	310,128,062	204,099,905
Supranational	2,986,618	AA	-	2,986,618	-	-	-	-	-
Asset-backed securities	265,906,046	AA-	-	259,687,225	6,218,821	-	-	-	-
Mortgage-backed securities	378,464,065	AA-	-	327,529,570	50,934,515	-	-	-	-
Municipal bonds	108,132,906	A-	-	54,909,648	27,573,623	5,087,446	456,838	3,774,131	16,331,220
Certificates of deposit	102,676,170	A1/P1	-	102,676,170	-	-	-	-	-
Commercial paper	259,864,279	A-1	-	85,355,082	-	8,026,305	18,960,096	147,522,796	-
Money market mutual funds	13,341,197	AAA	-	13,341,197	-	-	-	-	-
Total	\$ 3,429,722,009		\$ 1,333,437,540	\$ 887,658,275	\$ 150,518,582	\$ 161,257,638	\$ 214,993,860	\$ 461,424,989	\$ 220,431,125

As of June 30, 2024, the credit ratings of investments and cash equivalents were as follows:

Investment Type	Fair Value	Minimum Legal Rating	Exempt from Disclosure	Rating as of Year-End					
				AAA or A1/P1	Aa & Aa+	Aa-	A+	A	A-
U.S. Treasury notes	\$ 1,083,583,975	N/A	\$ 1,083,583,975	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
U.S. Agency notes	266,216,187	N/A	266,216,187	-	-	-	-	-	-
Corporate bonds	855,910,653	A-	-	47,341,323	51,056,528	187,449,322	167,122,957	218,194,941	184,745,582
Asset-backed securities	282,501,052	AA-	-	273,772,351	8,728,701	-	-	-	-
Mortgage-backed securities	339,644,477	AA-	-	339,644,477	-	-	-	-	-
Municipal bonds	83,090,777	A-	-	38,831,407	27,557,505	13,101,688	726,226	2,873,951	-
Supranational	47,839,438	AA	-	47,839,438	-	-	-	-	-
Repurchase agreement	37,016,342	N/A	-	-	-	-	-	37,016,342	-
Certificates of deposit	75,141,932	A1/P1	-	75,141,932	-	-	-	-	-
Commercial paper	271,143,275	A1	-	-	-	-	-	271,143,275	-
Money market mutual funds	17,235,722	AAA	-	17,235,722	-	-	-	-	-
Total	\$ 3,359,323,830		\$ 1,349,800,162	\$ 839,806,650	\$ 87,342,734	\$ 200,551,010	\$ 167,849,183	\$ 529,228,509	\$ 184,745,582

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Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of CalOptima Health's investment in a single issuer. CalOptima Health's investment policy limits no more than 5% of the total fair value of investments in the securities of any one issuer, except for obligations of the U.S. government, U.S. government agencies, or government-sponsored enterprises, and no more than 10% may be invested in one money market mutual fund. As of June 30, 2025 and 2024, all holdings complied with the foregoing limitations.

The Organization categorizes its fair value investments within the fair value hierarchy established by U.S. GAAP. The hierarchy for fair value measurements is based upon the observability of inputs to the valuation of an asset or liability as of the measurement date.

Level 1 – Quoted prices in active markets for identical assets or liabilities.

Level 2 – Inputs other than quoted prices included within Level 1 that are observable for an asset or liability, either directly or indirectly.

Level 3 – Significant unobservable inputs.

The following is a description of the valuation methodologies used for instruments at fair value on a recurring basis and recognized in the accompanying statements of net position, as well as the general classification of such instruments pursuant to the valuation hierarchy.

Marketable securities – Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. If quoted market prices are not available, then fair values are estimated by using pricing models, quoted prices of securities with similar characteristics, or discounted cash flows. These securities are classified within Level 2 of the valuation hierarchy. In certain cases where Level 1 or Level 2 inputs are not available, securities are classified within Level 3 of the hierarchy.

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The following table presents the fair value measurements of assets recognized in the accompanying statements of net position measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall:

Investment Assets at Fair Value as of June 30, 2025				
	Level 1	Level 2	Level 3	Total
U.S. Treasury notes	\$ 1,056,051,175	\$ -	\$ -	\$ 1,056,051,175
U.S. Agency notes	-	100,608,023	-	100,608,023
Corporate bonds	-	955,165,722	-	955,165,722
Asset-backed securities	-	265,439,326	-	265,439,326
Mortgage-backed securities	-	377,695,982	-	377,695,982
Municipal bonds	-	93,903,321	-	93,903,321
Government-related	-	2,861,711	-	2,861,711
Commercial paper	-	76,139,294	-	76,139,294
Certificates of deposit	-	102,167,795	-	102,167,795
	<u>\$ 1,056,051,175</u>	<u>\$ 1,973,981,174</u>	<u>\$ -</u>	<u>\$ 3,030,032,349</u>

Investment Assets at Fair Value as of June 30, 2024				
	Level 1	Level 2	Level 3	Total
U.S. Treasury notes	\$ 840,085,184	\$ 131,907,320	\$ -	\$ 971,992,504
U.S. Agency notes	-	262,740,439	-	262,740,439
Corporate bonds	-	847,388,142	-	847,388,142
Asset-backed securities	-	282,066,505	-	282,066,505
Mortgage-backed securities	-	338,957,054	-	338,957,054
Municipal bonds	-	34,517,897	-	34,517,897
Government-related	-	47,509,397	-	47,509,397
Commercial paper	-	11,838,720	-	11,838,720
Certificates of deposit	-	73,825,050	-	73,825,050
	<u>\$ 840,085,184</u>	<u>\$ 2,030,750,524</u>	<u>\$ -</u>	<u>\$ 2,870,835,708</u>

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Note 4 – Capital Assets

Capital assets activity during the year ended June 30, 2025, consisted of the following:

	June 30, 2024	Additions	Retirements	Transfers	June 30, 2025
Capital assets not being depreciated					
Land	\$ 15,439,067	\$ -	\$ -	\$ -	\$ 15,439,067
Construction in progress	8,062,076	6,131,045	-	(7,581,533)	6,611,588
	<u>23,501,143</u>	<u>6,131,045</u>	<u>-</u>	<u>(7,581,533)</u>	<u>22,050,655</u>
Capital assets being depreciated					
Furniture and equipment	9,478,750	-	(401,878)	725,582	9,802,454
Computers and software	40,527,864	-	(9,479,889)	6,861,396	37,909,371
Leasehold improvements	5,312,542	-	(13,475)	(5,445)	5,293,622
Building	69,053,311	5,134,860	-	-	74,188,171
	<u>124,372,467</u>	<u>5,134,860</u>	<u>(9,895,242)</u>	<u>7,581,533</u>	<u>127,193,618</u>
Less: accumulated depreciation for					
Furniture and equipment	8,007,586	721,866	(401,878)	-	8,327,574
Computers and software	33,795,436	5,045,050	(9,479,889)	-	29,360,597
Leasehold improvements	5,101,443	35,441	(13,475)	-	5,123,409
Building	23,699,000	2,961,547	-	-	26,660,547
	<u>70,603,465</u>	<u>8,763,904</u>	<u>(9,895,242)</u>	<u>-</u>	<u>69,472,127</u>
Total depreciable assets, net	<u>53,769,002</u>	<u>(3,629,044)</u>	<u>-</u>	<u>7,581,533</u>	<u>57,721,491</u>
Capital assets, net	<u>\$ 77,270,145</u>	<u>\$ 2,502,001</u>	<u>\$ -</u>	<u>\$ -</u>	<u>\$ 79,772,146</u>

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Capital asset activity during the year ended June 30, 2024, consisted of the following:

	June 30, 2023	Additions	Retirements	Transfers	June 30, 2024
Capital assets not being depreciated					
Land	\$ 11,912,499	\$ 3,526,568	\$ -	\$ -	\$ 15,439,067
Construction in progress	3,043,229	11,178,673	-	(6,159,826)	8,062,076
	<u>14,955,728</u>	<u>14,705,241</u>	<u>-</u>	<u>(6,159,826)</u>	<u>23,501,143</u>
Capital assets being depreciated					
Furniture and equipment	8,936,861	-	-	541,889	9,478,750
Computers and software	36,355,519	-	(739,103)	4,911,448	40,527,864
Leasehold improvements	5,296,726	-	-	15,816	5,312,542
Building	63,883,316	4,510,769	(31,447)	690,673	69,053,311
	<u>114,472,422</u>	<u>4,510,769</u>	<u>(770,550)</u>	<u>6,159,826</u>	<u>124,372,467</u>
Less: accumulated depreciation for					
Furniture and equipment	7,351,339	656,247	-	-	8,007,586
Computers and software	29,792,302	4,197,346	(194,212)	-	33,795,436
Leasehold improvements	5,051,949	49,494	-	-	5,101,443
Building	21,043,433	2,656,615	(1,048)	-	23,699,000
	<u>63,239,023</u>	<u>7,559,702</u>	<u>(195,260)</u>	<u>-</u>	<u>70,603,465</u>
Total depreciable assets, net	<u>51,233,399</u>	<u>(3,048,933)</u>	<u>(575,290)</u>	<u>6,159,826</u>	<u>53,769,002</u>
Capital assets, net	<u>\$ 66,189,127</u>	<u>\$ 11,656,308</u>	<u>\$ (575,290)</u>	<u>\$ -</u>	<u>\$ 77,270,145</u>

The Organization recognized depreciation expense of approximately \$8,642,000 and \$7,421,000 during the years ended June 30, 2025 and 2024, respectively. During the years ended June 30, 2025 and 2024, depreciation expense of approximately \$122,000 and \$139,000, respectively, is included within PACE medical expenses on the accompanying statements of revenues, expenses, and changes in net position.

Note 5 – Medical Claims Liability

Medical claims liability consisted of the following as of June 30:

	2025	2024
Claims payable or pending approval	\$ 23,994,131	\$ 38,371,849
Provisions for IBNR claims	<u>358,538,240</u>	<u>331,061,747</u>
	<u>\$ 382,532,371</u>	<u>\$ 369,433,596</u>

The cost of health care services is recognized in the period in which care is provided and includes an estimate of the cost of services that has been IBNR. CalOptima Health estimates accrued claims payable based on historical claims payments and other relevant information. Unpaid claims adjustment expenses are an estimate of the cost to process the IBNR claims and are included in medical claims liability. Estimates are continually monitored and analyzed and, as settlements are made or estimates adjusted, differences are reflected in current operations.

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Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided.

The following is a reconciliation of the medical claims liability for the years ended June 30:

	2025	2024
Beginning balance	\$ 369,433,596	\$ 333,993,756
Incurred		
Current	2,494,882,739	2,394,253,671
Prior	(110,308,536)	(91,115,588)
	<u>2,384,574,203</u>	<u>2,303,138,083</u>
Paid		
Current	2,112,350,368	2,024,213,932
Prior	259,125,060	243,484,311
	<u>2,371,475,428</u>	<u>2,267,698,243</u>
Ending balance	<u>\$ 382,532,371</u>	<u>\$ 369,433,596</u>

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately adjudicated and paid. Liabilities at any year-end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established prior-reporting-period liability. Negative amounts reported for incurred related to prior years, result from claims being adjudicated and paid for amounts less than originally estimated. The results included a decrease of prior-year incurred of approximately \$110,309,000 and \$91,116,000 for the years ended June 30, 2025 and 2024, respectively. Original estimates are increased or decreased as additional information becomes known regarding individual claims.

The amounts accrued in the due to the State of California and CMS line item represent excess payments from DHCS that are primarily due to capitation payments received that do not reflect the current Medi-Cal rates issued by DHCS. DHCS continues to process the recoupments, and the remaining overpayments not yet recouped are included within the due to the State of California and CMS line item on the statements of net position.

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Note 6 – Defined Benefit Pension Plan

Plan description – CalOptima Health's defined benefit pension plan, the CalPERS Plan, provides retirement and disability benefits, annual cost-of-living adjustments (COLAs), and death benefits to plan members and/or beneficiaries. The CalPERS Plan is part of the public agency portion of CalPERS, an agent multiple-employer plan administered by CalPERS, which acts as a common investment and administrative agent for participating public employers within the State. Optional contract provisions are available through the California Public Employees' Retirement Law (PERL). CalOptima Health selects optional benefit provisions by contracting with CalPERS and adopting those benefits through Board of Directors approval (See "Benefits provided" below for more details). CalPERS issues a publicly available financial report that includes financial statements and required supplementary information for CalPERS. Copies of the report can be obtained from CalPERS Executive Office, 400 P Street, Sacramento, California 95814.

Benefits provided – CalPERS provides service retirement and disability benefits, annual cost-of-living adjustments, and death benefits to plan members, who must be public employees and/or beneficiaries. Pension benefits are based on plan members' years of service, age, and final compensation (three-year average) at the time of retirement. Members with five years of total service are eligible to retire at age 50 (Classic Member) or age 52 (New Member) with statutorily reduced benefits. All members are eligible for non-duty disability benefits if they have at least five years of service credit. Optional provisions elected by CalOptima Health include a 3% Cost of Living Allowance (Section 21335), 1959 Survivor Benefit Level 3 (Section 21573), \$5,000 Retired Death Benefit (Section 21623.5), 3-Year Final Compensation Period (Section 20037), Pre-Retirement Death Benefits to Continue After Remarriage of Survivor (Section 21551), and service credit purchase options for military and peace corps service (Section 21024 and 21023.5, respectively).

The CalPERS Plan's provisions and benefits in effect as of June 30, 2025, are summarized as follows:

Hire date	Prior to January 1, 2013	On or after January 1, 2013
Benefit formula	2 % at 60	2% at 62
Benefit vesting schedule	5 years of service	5 years of service
Benefit payments	Monthly for life	Monthly for life
Retirement age	50 plus	52 plus
compensation	1.092%-2.418%	1.0% to 2.5%
Required employee contribution rates	7.00%	8.25%
Required employer contribution rates	8.80%	8.80%

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The following is a summary of plan participants:

	<u>June 30, 2025</u>	<u>June 30, 2024</u>
Active employees	1,657	1,599
Retirees and beneficiaries		
Receiving benefits	277	255
Deferred retirement benefits		
Terminated employees	1,130	1,332
Surviving spouses	8	5
Beneficiaries	3	2

Contributions – Section 20814(c) of the California PERL requires that the employer contribution rates for all public employers be determined on an annual basis by the actuary and shall become effective on the July 1 following notice of a change in the rate. The total plan contributions are determined through CalPERS' annual actuarial valuation process. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. The employer is required to contribute the difference between the actuarially determined rate and the contribution rate of employees. The active employee contribution rate was 8.25% (Classic and PEPR New Members) and 7.0% (Classic Members) of annual pay for the years ended June 30, 2025 and 2024, respectively. The employer's contribution rate is 8.80% and 9.17% of annual payroll for the years ended June 30, 2025 and 2024, respectively.

CalOptima Health's net pension liability for the CalPERS Plan is measured as the total pension liability, less the pension plan's fiduciary net position. For the measurement period ended June 30, 2024 (the measurement date), the total pension liability was determined by rolling forward the June 30, 2023, total pension liability. Total pension liabilities were based on the following actuarial methods and assumptions as of June 30, 2024 and June 30, 2023:

Valuation date	June 30, 2023
Measurement date	June 30, 2024
Actuarial cost method	Entry Age Normal
Actuarial assumptions	
Discount rate	6.90%
Inflation	2.30%
Salary increases	Varies by Entry Age and Service
Investment rate of return	6.8% Net of Pension Plan Investment and Administrative Expenses; Includes Inflation
Mortality rate table	Derived using CalPERS' Membership data for all funds
Post-retirement benefit increase	Contract COLA up to 2.3% until Purchasing Power Protection Allowance Floor on Purchasing Power applies, 2.30% thereafter

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The mortality table used was developed based on CalPERS-specific data. The probabilities of mortality are based on the 2021 CalPERS Experience Study for the period from 2001 to 2019. Pre-retirement and Post-retirement mortality rates include generational mortality improvement using 80% of Scale MP-2020 published by the Society of Actuaries. For more details on this table, please refer to the CalPERS Experience Study and Review of Actuarial Assumptions report from November 2021 that can be found on the CalPERS website.

Changes in the net pension liability during the year ended June 30, 2025, were as follows:

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2024	\$ 317,035,251	\$ 271,053,892	\$ 45,981,359
Changes during the year			
Service cost	24,542,761	-	24,542,761
Interest on the total pension liability	23,886,852	-	23,886,852
Differences between expected and actual experience	20,191,968	-	20,191,968
Contributions from the employer	-	66,553,158	(66,553,158)
Contributions from employees	-	12,197,909	(12,197,909)
Net investment income	-	30,231,438	(30,231,438)
Benefit payments, including refunds of employee contributions	(6,624,673)	(6,624,673)	-
Administrative expenses	-	(220,557)	220,557
Net changes during the year	61,996,908	102,137,275	(40,140,367)
Balance at June 30, 2025	<u>\$ 379,032,159</u>	<u>\$ 373,191,167</u>	<u>\$ 5,840,992</u>

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	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2023	\$ 277,170,471	\$ 236,705,326	\$ 40,465,145
Changes during the year			
Service cost	19,761,157	-	19,761,157
Interest on the total pension liability	19,987,952	-	19,987,952
Differences between expected and actual experience	5,143,171	-	5,143,171
Changes of assumptions	-	-	-
Contributions from the employer	-	14,017,949	(14,017,949)
Contributions from employees	-	10,478,979	(10,478,979)
Net investment income	-	15,053,200	(15,053,200)
Benefit payments, including refunds of employee contributions	(5,027,500)	(5,027,500)	-
Administrative expenses	-	(174,062)	174,062
Net changes during the year	39,864,780	34,348,566	5,516,214
Balance at June 30, 2024	\$ 317,035,251	\$ 271,053,892	\$ 45,981,359

Discount rate and long-term rate of return – The discount rate used to measure the total pension liability was 6.90%. The projection of cash flows used to determine the discount rate assumed that contributions from plan members will be made at the current member contribution rates and that contributions from employers will be made at statutorily required rates, actuarially determined. Based on those assumptions, the Organization's fiduciary net position was projected to be available to make all projected future benefit payments of current plan members. Therefore, the long-term expected rate of return on plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class.

In determining the long-term expected rate of return, CalPERS took into account both short-term and long-term market return expectations. Using historical returns of all of the funds' asset classes, expected compound (geometric) returns were calculated over the next 20 years using a building-block approach. The expected rate of return was then adjusted to account for assumed administrative expenses of 10 basis points.

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The table below reflects long-term expected real rate of return by asset class.

Asset Class	Assumed Return Allocation	Real Return ⁽¹⁾
Global Equity – cap-weighted	30.0%	4.54%
Global Equity – non-cap-weighted	12.0%	3.84%
Private equity	13.0%	7.28%
Treasury	5.0%	0.27%
Mortgage-backed securities	5.0%	0.50%
Investment-grade corporates	10.0%	1.56%
High-yield	5.0%	2.27%
Emerging market debt	5.0%	2.48%
Private debt	5.0%	3.57%
Real assets	15.0%	3.21%
Leverage	-5.0%	-0.59%

(1) An expected inflation of 2.3% was used for this period.

(2) Figures are based on the 2021 Asset Liability Management study.

The following presents the net pension liability of the CalPERS Plan calculated using the discount rate, as well as what the net pension liability would be if it were calculated using a discount rate that is one percentage point lower or one percentage point higher than the current rate:

	June 30, 2025		
	Discount Rate -1%	Current	Discount Rate +1%
	5.90%	6.90%	7.90%
Net pension liability	\$ 71,146,769	\$ 5,840,992	\$ (46,772,150)
	June 30, 2024		
	Discount Rate -1%	Current	Discount Rate +1%
	5.90%	6.90%	7.90%
Net pension liability	\$ 100,402,066	\$ 45,981,359	\$ 2,195,114

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Pension expense and deferred outflows/inflows of resources related to pensions – CalOptima Health recognized pension expense of approximately \$21,364,000 and \$20,970,000 for the years ended June 30, 2025 and 2024, respectively. As of June 30, 2025 and 2024, CalOptima Health recognized deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	June 30, 2025	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions from employers subsequent to the measurement date	\$ 94,666	\$ -
Net differences between projected and actual earnings on plan investments	2,361,239	-
Changes in assumptions	4,311,207	-
Differences between expected and actual experiences	20,669,960	(1,321,519)
	<u>\$ 27,437,072</u>	<u>\$ (1,321,519)</u>
	June 30, 2024	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Contributions from employers subsequent to the measurement date	\$ 1,877,932	\$ -
Net differences between projected and actual earnings on plan investments	12,037,633	-
Changes in assumptions	5,542,981	(495,005)
Differences between expected and actual experiences	5,090,744	(1,753,440)
Additional contribution from employers subsequent to the measurement date	49,999,717	-
	<u>\$ 74,549,007</u>	<u>\$ (2,248,445)</u>

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The deferred outflows of resources related to employer contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability during the year ended June 30, 2025. The differences reported as deferred outflows and deferred inflows of resources related to pensions will be recognized as pension expense as follows:

	Deferred Outflows of Resources
Years Ending June 30,	
2026	\$ 4,916,834
2027	10,567,204
2028	3,511,988
2029	2,692,356
2030	3,370,981
Thereafter	961,524
	<u><u>\$ 26,020,887</u></u>

Note 7 – Employee Benefit Plans

Deferred compensation plan – CalOptima Health sponsors a deferred compensation plan created in accordance with Internal Revenue Code Section 457 (the 457 Plan) under which employees are permitted to defer a portion of their annual salary until future years. CalOptima Health may make discretionary contributions to the 457 Plan as determined by the Board of Directors. For the years ended June 30, 2025 and 2024, no discretionary employer contributions were made.

Defined contribution plan – Effective January 1, 1999, CalOptima Health established a supplemental retirement plan for its employees called the CalOptima Public Agency Retirement System Defined Contribution Supplemental Retirement Plan (PARS Plan). CalOptima Health made discretionary employer contributions to the PARS Plan as authorized by the Board of Directors. PARS vesting occurred over 16 quarters of service. Effective January 30, 2025, CalOptima Health transitioned the PARS plan to a 401(a) Defined Contribution plan administered by Empower. Balance and future contributions were transferred and allocated. Participation eligibility remains the same and CalOptima Health continues to make discretionary employer contributions with Board approval. The vesting schedule changed to a vested percentage of 25% per year over four years. For the years ended June 30, 2025 and 2024, CalOptima Health contributed approximately \$6,858,000 and \$6,587,000, respectively.

Note 8 – Postemployment Health Care Plan

Plan description – CalOptima Health sponsors and administers a single-employer defined-benefit postemployment healthcare plan (the Plan) to provide medical, dental, and vision insurance benefits to eligible retired employees and their beneficiaries. Plan members receiving benefits contribute at the same rate as current active employees. Benefit provisions are established and may be amended by the Board of Directors.

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Effective January 1, 2004, CalOptima Health terminated postemployment healthcare benefits for employees hired on or after January 1, 2004. For employees hired prior to January 1, 2004, the employee's eligibility for retiree health benefits remains similar to the eligibility requirements for the defined benefit pension plan. Surviving spouses are also eligible for this benefit.

During the year ended June 30, 2006, CalOptima Health modified the benefits offered to eligible participants, requiring participants to enroll in Medicare and specifying that CalOptima Health would be responsible only for the cost of Medicare supplemental coverage, subject to cost sharing between the participant and CalOptima Health.

For purposes of measuring the total postemployment retirement liability, deferred outflows of resources and deferred inflows of resources related to other postemployment benefits (OPEB), and OPEB expense, information about the fiduciary net position of CalOptima Health's plan (OPEB Plan) and additions to/deductions from the OPEB Plan's fiduciary net position have been determined on the same basis. For this purpose, benefit payments are recognized when currently due and payable in accordance with the benefit terms. Investments are reported at fair value.

U.S. GAAP requires that the reported results must pertain to liability and asset information within certain defined time frames. For this report, the following time frames are used:

Measurement date	June 30, 2024
Measurement period	July 1, 2023 – June 30, 2024
Valuation date	January 1, 2024

Covered employees – The following numbers of participants were covered by the benefit terms as of June 30:

	2025	2024
Inactives currently receiving benefits	78	78
Active employees	53	60
Inactives entitled to but not yet receiving benefits	6	2
Total	137	140

Contributions – The contribution requirements of plan members and CalOptima Health are established and may be amended by the Board of Directors. CalOptima Health's contribution is based on projected pay-as-you-go financing requirements, with no additional amount to prefund benefits. CalOptima Health contributed approximately \$637,000 for the year ended June 30, 2025. CalOptima Health contributed approximately \$522,000, which related to implied subsidies, for the year ended June 30, 2024. The most recent actuarial report for the Plan was June 30, 2024. As of that point, the actuarial accrued liability and unfunded actuarial accrued liability for benefits was approximately \$17,249,000.

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Actuarial assumptions – CalOptima Health's total postemployment retirement liability was measured as of June 30, 2024, and the assumptions used to calculate the total postemployment retirement liability were determined by an actuarial valuation dated January 1, 2024. The actuarial valuation was rolled forward to determine the total postemployment retirement liability as of June 30, 2024, and is based on the following actuarial methods and assumptions:

Salary increases	2.75% per annum, in aggregate
Medical trend	Non-Medicare – 8.50% for 2025, decreasing to an ultimate rate of 3.45% in 2076 Medicare (Non-Kaiser) – 7.50% for 2025, decreasing to an ultimate rate of 3.45% in 2076 Medicare (Kaiser) – 6.25% for 2025, decreasing to an ultimate rate of 3.45% in 2076
Discount rate	3.93% at June 30, 2024, Bond Buyer 20 Index 3.65% at June 30, 2023, Bond Buyer 20 Index
Mortality, retirement	CalPERS 2000-2019 Experience Study Post-retirement mortality projected fully generational with Scale MP-2021
General inflation	2.50% per annum

Discount rate and long-term rate of return – The discount rate used to measure the total OPEB liability was 3.93% for June 30, 2024. There were no plan investments; as such, the expected long-term rate of return on investment is not applicable.

Changes in the net OPEB liability – Changes in the net OPEB liability during the years ended June 30, 2025 and 2024, were as follows:

Balance at June 30, 2024	<u>\$ 17,370,000</u>
Changes for the year	
Service cost	378,000
Interest	638,000
Assumption changes	(615,000)
Contributions – employer	<u>(522,000)</u>
Net changes	<u>(121,000)</u>
Balance at June 30, 2025	<u><u>\$ 17,249,000</u></u>

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Balance at June 30, 2023	\$ 18,975,000
Changes for the year	
Service cost	472,000
Interest	679,000
Actual vs. expected experience	(3,332,000)
Assumption changes	1,104,000
Contributions – employer	(528,000)
Net changes	(1,605,000)
Balance at June 30, 2024	\$ 17,370,000

Sensitivity of the net OPEB liability to changes in the discount rate – The following presents the net OPEB liability as of June 30, 2025, as well as what the net OPEB liability would be if it were calculated using a discount rate that is one percentage point lower or one percentage point higher than the current discount rate:

	1% Decrease (2.93%)	Current Rate (3.93%)	1% Increase (4.93%)
Total OPEB liability	\$ 19,603,000	\$ 17,249,000	\$ 15,287,000

Sensitivity of the net OPEB liability to changes in health care cost trend rates – The following presents the net OPEB liability as of June 30, 2025, as well as what the net OPEB liability would be if it were calculated using health care cost trend rates that are one percentage point lower or one percentage point higher than the current health care cost trend rates:

	1% Decrease	Current Rate	1% Increase
Total OPEB liability	\$ 14,964,000	\$ 17,249,000	\$ 20,059,000

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For the years ended June 30, 2025 and 2024, CalOptima Health recognized a reduction to OPEB expense of approximately \$2,733,000 and \$2,227,000, respectively. As of June 30, 2025 and 2024, the reported deferred outflows of resources and deferred inflows of resources related to OPEB from the following sources:

	June 30, 2025	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	\$ -	\$ 1,666,000
Changes in assumptions	552,000	1,322,000
Employer contributions made subsequent to measurement date	637,000	-
Total	<u>\$ 1,189,000</u>	<u>\$ 2,988,000</u>

	June 30, 2024	
	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	\$ -	\$ 3,679,000
Changes in assumptions	828,000	2,719,000
Employer contributions made subsequent to measurement date	522,000	-
Total	<u>\$ 1,350,000</u>	<u>\$ 6,398,000</u>

The \$637,000 reported as deferred outflows of resources related to contributions subsequent to the June 30, 2024, measurement date will be recognized as a reduction of the total postemployment retirement liability during the year ended June 30, 2025.

Other amounts reported as deferred inflows of resources related to OPEB will be recognized as expense as follows:

	Deferred Inflows of Resources
Years Ending June 30,	
2026	\$ (1,616,000)
2027	(733,000)
2028	<u>(87,000)</u>
	<u>\$ (2,436,000)</u>

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Notes to Financial Statements**

The required schedule of changes in total OPEB liability and related ratios immediately following the notes to the financial statements presents multiyear trend information about the actuarial accrued liability for benefits.

Note 9 – Restricted Net Position

On June 28, 2000, CalOptima Health became a fully licensed health care service plan under the Act, as required by statutes governing the Healthy Families program. Under the Act, CalOptima Health is required to maintain and meet a minimum level of TNE as of June 30, 2025 and 2024, of \$129,341,855 and \$127,852,909, respectively. As of June 30, 2025 and 2024, the Organization was in compliance with its TNE requirement.

The Act further requires that CalOptima Health maintain a restricted deposit in the amount of \$300,000. CalOptima Health met this requirement as of June 30, 2025 and 2024.

Note 10 – Lease Commitments

CalOptima Health leases office space and equipment under noncancelable, long-term operating leases, with minimum annual payments as follows:

	Minimum Lease Payments
Years Ending June 30,	
2026	\$ 653,016
2027	710,210
2028	768,055
2029	791,097
2030	814,830
Thereafter	1,265,112
	<u>\$ 5,002,320</u>

Rental expense under operating leases was approximately \$713,000 for the years ended June 30, 2025 and 2024.

Note 11 – Contingencies

Litigation – CalOptima Health is party to various legal actions and is subject to various claims arising in the ordinary course of business. Management believes that the disposition of these matters will not have a material adverse effect on CalOptima Health's financial position or results of operations.

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Regulatory matters – The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties. Management believes that CalOptima Health is in compliance with fraud- and abuse-related, as well as other applicable government laws and regulations. Compliance with such laws and regulations could be subject to future government review and interpretation, as well as regulatory actions unknown or unasserted at this time.

The Organization is also subjected to risks and uncertainties arising from potential changes in federal health care policy, funding, and budgetary adjustments affecting Medicare and Medicaid programs. Proposed and potential reductions in Medicaid funding could indirectly impact Medicare beneficiaries by placing additional strain on state budgets. Cuts to Medicaid, including the elimination of the enhanced federal match rate for expansion enrollees or the introduction of work requirements, could result in significant coverage losses, particularly among low-income individuals, persons with disabilities, and those with chronic health conditions. In response to reduced federal funding, states may increase taxes or reduce funding for other essential programs. Potential policy changes under consideration include reductions in the federal Medicaid matching rate, implementation of work requirements, more frequent eligibility redeterminations leading to disenrollments, the adoption of per-capita caps on federal funding, and the elimination of provider taxes that help offset Medicaid costs. If enacted, such changes could compel states to reduce benefits, lower provider reimbursement rates, and increase financial pressures on state budgets, which may adversely affect the Organization's operations, network adequacy, and financial performance. However, the timing, likelihood, and specific impact of these policy changes remain uncertain.

Note 12 – Subscription-Based Information Technology Arrangements

CalOptima Health has several subscription contracts that expire at various dates through 2029, with some having certain renewal options. For those contracts where renewal options are reasonably certain to be exercised, CalOptima Health recognizes renewal option periods in the determinations of its intangible right-to-use subscription assets and subscription liabilities. CalOptima Health uses various rates ranging from 3.25% to 8.50% to determine the present value of the subscription liabilities. The amortization on the intangible subscription asset amounted to approximately \$9,000,000 and \$7,500,000 during the years ended June 30, 2025 and 2024, respectively, and is included in depreciation and amortization on the statements of revenues, expenses, and changes in net position. As of June 30, 2025 and 2024, CalOptima Health recognized approximately \$18,851,000 and \$19,291,000, respectively, in intangible right-to-use subscription assets, which are comprised of the intangible right-to-use subscription asset cost of approximately \$38,940,000 and \$30,372,000, respectively, less accumulated amortization of approximately \$20,089,000 and \$11,081,000, respectively. As of June 30, 2025 and 2024, CalOptima Health recognized approximately \$17,812,000 and \$17,730,000, respectively, in SBITA subscription liabilities.

**Orange County Health Authority, A Public Agency dba Orange
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Notes to Financial Statements**

The future subscription payments under SBITAs as of June 30, 2025, are as follows:

Years Ending June 30,	Subscriptions		
	Principal	Interest	Total
2026	\$ 8,157,581	\$ 1,031,399	\$ 9,188,980
2027	6,946,502	525,573	7,472,075
2028	2,368,462	181,865	2,550,327
2029	2,139,468	13,967	2,153,435
Total undiscounted cash flows	<u>\$ 19,612,013</u>	<u>\$ 1,752,804</u>	21,364,817
Less: present value discount			<u>3,552,576</u>
Total subscription liabilities			<u>\$ 17,812,241</u>

Note 13 – Subsequent Events

In July 2025, the Medicaid Provider Tax, which provided significant funding support to the Organization, was discontinued. While the Organization is currently assessing the full financial effect, management anticipates adjustments to its budgeting and operational plans to mitigate the impact. The Organization continues to monitor developments and assess specific effects resulting from the program's discontinuation.

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Supplementary Information

**Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment
Integrated Medical Assistance dba CalOptima Health
Schedule of Changes in Net Pension Liability and Related Ratios
Years Ended June 30**

	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016
Total pension liability										
Service cost	\$ 24,542,761	\$ 19,761,157	\$ 17,958,280	\$ 16,033,791	\$ 15,223,385	\$ 14,303,164	\$ 13,491,596	\$ 13,118,795	\$ 10,272,406	\$ 8,363,183
Interest	23,886,852	19,987,952	17,450,590	15,591,711	13,770,107	12,107,314	10,431,464	9,136,725	7,702,198	6,620,025
Differences between expected and actual experience	20,191,968	5,143,171	8,006,529	(477,252)	(405,662)	1,904,567	2,812,748	632,642	102,384	1,444,808
Changes in assumptions	-	-	(1,930,719)	-	-	-	(4,737,905)	9,163,547	-	(1,963,270)
Benefit payments, including refunds of employee contributions	(6,624,673)	(5,027,500)	(4,332,714)	(3,311,997)	(3,576,922)	(2,841,212)	(2,748,699)	(2,068,356)	(2,111,578)	(1,676,666)
Net change in total pension liability	61,996,908	39,864,780	37,151,966	27,836,253	25,010,908	25,473,833	19,249,204	29,983,353	15,965,410	12,788,080
Total pension liability – beginning	317,035,251	277,170,471	240,018,505	212,182,252	187,171,344	161,697,511	142,448,307	112,464,954	96,499,544	83,711,464
Total pension liability – ending	379,032,159	317,035,251	277,170,471	240,018,505	212,182,252	187,171,344	161,697,511	142,448,307	112,464,954	96,499,544
Plan fiduciary net position										
Contributions – employer	\$66,553,158	14,017,949	11,688,269	10,742,812	9,608,656	8,661,466	7,588,200	5,234,580	3,787,544	3,033,171
Contributions – employee	12,197,909	10,478,979	8,634,939	7,981,938	7,518,241	6,853,391	6,213,420	5,793,911	4,951,820	4,142,126
Net investment income	30,231,438	15,053,200	(18,576,662)	42,647,021	8,189,430	9,377,613	10,225,467	11,496,425	498,498	1,913,380
Benefit payments, including refunds of employee contributions	(6,624,673)	(5,027,500)	(4,332,714)	(3,311,997)	(3,576,922)	(2,841,212)	(2,748,699)	(2,068,356)	(2,111,578)	(1,676,666)
Other changes in fiduciary net position	(220,557)	(174,062)	(149,157)	(181,370)	(225,629)	(98,234)	(530,428)	(143,264)	(54,828)	(101,246)
Net change in fiduciary net position	102,137,275	34,348,566	(2,735,325)	57,878,404	21,513,776	21,953,024	20,747,960	20,313,296	7,071,456	7,310,765
Plan fiduciary net position – beginning	271,053,892	236,705,326	239,440,651	181,562,247	160,048,471	138,095,447	117,347,487	97,034,191	89,962,735	82,651,970
Plan fiduciary net position – ending	373,191,167	271,053,892	236,705,326	239,440,651	181,562,247	160,048,471	138,095,447	117,347,487	97,034,191	89,962,735
Plan net pension liability – ending	\$ 5,840,992	\$ 45,981,359	\$ 40,465,145	\$ 577,854	\$ 30,620,005	\$ 27,122,873	\$ 23,602,064	\$ 25,100,820	\$ 15,430,763	\$ 6,536,809
Plan fiduciary net position as percentage of the total liability	98.46%	85.50%	85.40%	99.76%	85.57%	85.51%	85.40%	82.38%	86.28%	93.23%
Covered-employee payroll	\$ 149,196,116	\$ 120,641,983	\$ 109,836,572	\$ 103,913,095	\$ 98,088,822	\$ 91,587,145	\$ 85,764,390	\$ 80,217,654	\$ 68,583,296	\$ 55,676,606
Plan net pension liability as a percentage of covered-employee payroll	3.91%	38.11%	36.84%	0.56%	31.22%	29.61%	27.52%	31.29%	22.50%	11.74%

See report of independent auditors.

**Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment
Integrated Medical Assistance dba CalOptima Health
Schedule of Plan Contributions
Years Ended June 30**

	Years Ended June 30,									
	2025	2024	2023	2022	2021	2020	2019	2018	2017	2016
Actuarially determined contributions	\$ 16,553,441	\$ 14,017,949	\$ 11,688,269	\$ 10,742,812	\$ 9,608,656	\$ 8,661,466	\$ 7,588,200	\$ 5,234,580	\$ 3,787,544	\$ 3,033,171
Contributions in relation to the actuarially determined contribution	(66,553,158)	(14,017,949)	(11,688,269)	(10,742,812)	(9,608,656)	(8,661,466)	(7,588,200)	(5,234,580)	(3,787,544)	(3,033,171)
Contribution deficiency (excess)	\$ (49,999,717)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Covered-employee payroll	\$ 149,196,116	\$ 120,641,983	\$ 109,836,572	\$ 103,913,095	\$ 98,088,822	\$ 91,587,145	\$ 85,764,390	\$ 80,217,654	\$ 68,583,296	\$ 55,676,606
Contributions as a percentage of covered-employee payroll	11.10%	11.62%	10.64%	10.34%	9.80%	9.46%	8.85%	6.53%	5.52%	5.45%

See report of independent auditors.

**Orange County Health Authority, A Public Agency dba Orange Prevention and Treatment
Integrated Medical Assistance dba CalOptima Health
Schedule of Changes in Total OPEB Liability and Related Ratios
Periods Ended June 30**

	2024-2025 (Measurement Period 2023–2024)	2023-2024 (Measurement Period 2022–2023)	2022-2023 (Measurement Period 2021–2022)	2021-2022 (Measurement Period 2020–2021)	2020-2021 (Measurement Period 2019–2020)	2019–2020 (Measurement Period 2018–2019)	2018–2019 (Measurement Period 2017–2018)	2017–2018 (Measurement Period 2016–2017)
Changes in total OPEB liability								
Service cost	\$ 378,000	\$ 472,000	\$ 668,000	\$ 1,149,000	\$ 811,000	\$ 832,000	\$ 867,000	\$ 1,012,000
Interest	638,000	679,000	487,000	718,000	922,000	977,000	900,000	770,000
Actual vs. expected experience	-	(3,332,000)	-	(6,241,000)	-	(1,072,000)	-	-
Assumption changes	(615,000)	1,104,000	(3,829,000)	(4,514,000)	4,623,000	938,000	(1,067,000)	(2,923,000)
Benefit payments	(522,000)	(528,000)	(529,000)	(544,000)	(570,000)	(556,000)	(560,000)	(572,000)
Net changes	(121,000)	(1,605,000)	(3,203,000)	(9,432,000)	5,786,000	1,119,000	140,000	(1,713,000)
Total OPEB liability (beginning of year)	17,370,000	18,975,000	22,178,000	31,610,000	25,824,000	24,705,000	24,565,000	26,278,000
Total OPEB liability (end of year)	<u>\$ 17,249,000</u>	<u>\$ 17,370,000</u>	<u>\$ 18,975,000</u>	<u>\$ 22,178,000</u>	<u>\$ 31,610,000</u>	<u>\$ 25,824,000</u>	<u>\$ 24,705,000</u>	<u>\$ 24,565,000</u>
Total OPEB liability	\$ 17,249,000	\$ 17,370,000	\$ 18,975,000	\$ 22,178,000	\$ 31,610,000	\$ 25,824,000	\$ 24,705,000	\$ 24,565,000
Covered-employee payroll	8,283,000	8,536,000	8,864,000	9,126,000	8,513,000	8,353,000	8,150,000	9,135,000
Total OPEB liability as a percentage of covered-employee payroll	208.2%	203.5%	214.1%	243.0%	371.3%	309.2%	303.1%	268.9%

See report of independent auditors.



CalOptima Health

2025 Audit Results

Board of Directors Meeting

October 2, 2025

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Agenda

1. Scope of Services
2. Summary of Audit Process
3. Significant Risks Identified
4. Matters to Be Communicated to the Governing Body
5. Your Service Team



Scope of Services

We have performed the following services for CalOptima Health:

Annual Audit

Annual financial statement audit as of and for the year ended June 30, 2025.

Non-Attest Services

- Assisted management with drafting the financial statements, excluding Management's Discussion and Analysis, as of and for the year ended June 30, 2025.
- Assisted in the completion of the Auditee portion of the Data Collection Form for the single audit as of and for the year ended June 30, 2025.



Summary of Audit Process

Our audit was generally performed in accordance with our initial plan. When the results of a planned audit procedure did not provide sufficient evidence or our original plan was based on an incorrect understanding of a transaction, process, or accounting policy of the entity, we made the necessary adjustments to our audit plan to incorporate the procedures necessary to support our opinion on the financial statements.

We have completed our testing of all significant account balances and classes of transactions.

We will issue our independent auditor's report and will communicate required internal control related matters on September 23, 2025.



Significant Risks Identified

During the planning of the audit we have identified the following significant risks:

Significant Risks	Procedures
Medical claims liability and claims expense	• Tested the internal controls for claims payments and provider capitation systems • Tested the data used by the actuary to estimate the claims liability and reviewed the experience and qualifications of the actuary • Performed a retrospective review of the prior year's claims liability • No exceptions noted for the procedures performed
Capitation revenue and receivables	• Developed independent expectations of revenue using membership data and rates • Obtained an understanding of management's reserve methodology and validated key inputs through our audit procedures • Verified subsequent receipt of cash and other substantive procedures • No exceptions noted for the procedures performed
Amounts due to the State of California or DHCS	• Tested the provider capitation and other accrual calculations and agreed amounts accrued to subsequent payments • Obtained an understanding of the nature of the amounts payable to the State of California • Tested inputs into the estimates used to calculate the amounts due • No exceptions noted for the procedures performed



Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We are responsible for forming and expressing an opinion about whether the financial statements that have been prepared by management, with your oversight, are prepared, in all material respects, in accordance with accounting principles generally accepted in the United States of America. Our audit of the financial statements does not relieve you or management of your responsibilities.



Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS) as well as *Government Auditing Standards*, issued by the Comptroller General of the United States. As part of an audit conducted in accordance with these auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit.



Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

Our audit of the financial statements included obtaining an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control or to identify deficiencies in the design or operation of internal control. Accordingly, we considered the entity's internal control solely for the purpose of determining our audit procedures and not to provide assurance concerning such internal control.



Matters to Be Communicated to the Governing Body

Our responsibility with regard to the financial statement audit under U.S. auditing standards:

We are also responsible for communicating significant matters related to the financial statement audit that are, in our professional judgment, relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.



Matters to Be Communicated to the Governing Body

Significant Accounting Practices:

Our views about qualitative aspects of the entity's significant accounting practices, including accounting policies, accounting estimates, and financial statement disclosures

Baker Tilly Comments

The quality of the entity's accounting policies and underlying estimates are discussed throughout this presentation. There were no changes in the entity's approach to applying the critical accounting policies.

- Significant management estimates that impacted the financial statements include the following: **fair value of investments, capital asset lives, actuarially determined accruals for incurred but not reported (IBNR) medical claims liabilities, other non-IBNR medical liabilities, pension, and other postemployment liabilities.**



Matters to Be Communicated to the Governing Body

Significant Accounting Practices:

Our views about qualitative aspects of the entity's significant accounting practices, including accounting policies, accounting estimates, and financial statement disclosures

Baker Tilly Comments

The disclosures in the financial statements are clear and consistent. Certain financial statement disclosures are particularly sensitive because of their significance to financial statements users. We call your attention to the following notes:

- Note 3 – Cash, Cash Equivalents, and Investments
- Note 5 – Medical Claims Liability
- Note 6 – Defined Benefit Pension Plan
- Note 8 – Postemployment Health Care Plan



Matters to Be Communicated to the Governing Body

Significant Unusual Transactions:

Baker Tilly Comments

No significant unusual transactions were identified during our audit of the entity's financial statements.



Matters to Be Communicated to the Governing Body

Significant Difficulties Encountered During the Audit:

We are to inform those charged with governance of any significant difficulties encountered in performing the audit. Examples of difficulties may include significant delays by management, an unreasonably brief time to complete the audit, unreasonable management restrictions encountered by the auditor or an unexpected extensive effort required to obtain sufficient appropriate audit evidence.

Baker Tilly Comments

No significant difficulties were encountered during our audit of the entity's financial statements.



Matters to Be Communicated to the Governing Body

Disagreements With Management:

Disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the entity's financial statements, or the auditor's report.

Baker Tilly Comments

There were no disagreements with management.



Matters to Be Communicated to the Governing Body

Circumstances that affect the form and content of the auditor's report:

Baker Tilly Comments

There were no circumstances that affected the form and content of the auditor's report.



Matters to Be Communicated to the Governing Body

Other findings or issues arising from the audit that are, in the auditor's professional judgment, significant and relevant to those charged with governance regarding their oversight of the financial reporting process:

Baker Tilly Comments

There were no other findings or issues arising from the audit to report.



Matters to Be Communicated to the Governing Body

Uncorrected Misstatements:

Uncorrected misstatements, or matters underlying those uncorrected misstatements, as of and for the year ended June 30, 2025, could potentially cause future-period financial statements to be materially misstated.

Baker Tilly Comments

No uncorrected misstatements were identified.



Matters to Be Communicated to the Governing Body

Material, Corrected Misstatements:

Material, corrected misstatements that were brought to the attention of management as a result of audit procedures.

Baker Tilly Comments

No material misstatements were identified as a result of our audit.



Matters to Be Communicated to the Governing Body

Representations Requested of Management

We requested certain representations from management that are included in the management representation letter dated September 23, 2025

Baker Tilly Comments

A copy of the management representation letter is available upon request.



Matters to Be Communicated to the Governing Body

Management's Consultation with Other Accountants:

When we are aware that management has consulted with other accountants about significant auditing or accounting matters, we discuss with those charged with governance our views about the matters that were the subject of such consultation.

Baker Tilly Comments

We are not aware of instances where management consulted with other accountants about significant auditing or accounting matters.



Matters to Be Communicated to the Governing Body

Significant issues arising from the audit that were discussed, or the subject of correspondence with management:

Baker Tilly Comments

No significant issues arose during the audit that have not been addressed elsewhere in this presentation.



Matters to Be Communicated to the Governing Body

AU-C 240, Consideration of Fraud in a Financial Statement Audit

AU-C 250, Consideration of Laws and Regulations in an Audit of Financial Statements

AU-C 265, Communicating Internal Control Related Matters Identified in an Audit

AU-C 550, Related Parties

AU-C 560, Subsequent Events and Subsequently Discovered Facts

AU-C 570, The Auditor's Consideration of An Entity's Ability to Continue as a Going Concern

AU-C 600, Audits of Group Financial Statements (Including the Work of Component Auditors)

Baker Tilly Comments

Nothing to note.

- There were no material weaknesses noted and no significant deficiencies to communicate.



Matters to Be Communicated to the Governing Body

AU-C 701, Communicating Key Audit Matters in the Independent Auditor's Report

AU-C 705, Modifications to the Opinion in the Independent Auditor's Report

AU-C 706, Emphasis-of-Matter Paragraphs and Other-Matter Paragraphs in the Independent Auditor's Report

AU-C 720, The Auditor's Responsibilities Relating to Other Information Included in Annual Reports

AU-C 730, Required Supplementary Information

AU-C 930, Interim Financial Information

AU-C 935, Compliance Audits

Baker Tilly Comments

Nothing to note.



Your Service Team



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THANK YOU

[Back to Agenda](#)

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CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2025

Regular Meeting of the CalOptima Health Board of Directors

Report Item

18. Approve Modifications to CalOptima Health Policy GG.1516: Hospital Acute Administrative Days

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Kelly Giardina, MSG, CCM, Executive Director Clinical Operations, (657) 900-1013

Recommended Actions

Approve modifications to CalOptima Health Policy GG.1516: Hospital Acute Administrative Days, effective October 3, 2025.

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, laws, and CalOptima operations.

Below is a description of the impacted policy, followed by a list of substantive changes to the policy, which are reflected in the redline policy included in Attachment 1. The list does not include non-substantive changes that may also be reflected in the redline (*e.g.*, formatting, spelling, punctuation, capitalization, minor clarifying language, and/or grammatical changes).

Policy GG.1516 Hospital Acute Administrative Days establishes the criteria for authorizing Acute Administrative Days (AAD) for CalOptima Health Direct Members. The policy was revised to improve the process for authorizing AAD for CalOptima Health Direct Members. The key changes include:

- **Alignment with Department of Health Care Services (DHCS) Requirements:** Ensuring full compliance with the DHCS administrative day requirements.
- **Updated Utilization Management (UM) Approach:** Enhancing coordination and facilitating more timely transitions to lower levels of care.
- **Removal of Previous Communication Methods:** Replacing the three manual calls and ten electronic requests with a combined new high-touch requirement of ten telephonic outreach calls.
- **Standardization Across Facilities:** Aiming to standardize AAD communication and transition outreach protocols across all hospital facilities.
- **Improved Clinical Oversight:** Supporting timely Skilled Nursing Facility (SNF) transitions and reducing AAD rates through better coordination and real-time clinical updates.

These changes are expected to streamline the process, improve clinical oversight, and ultimately reduce unnecessary administrative days.

Policy Section	Change
Section II B.3.a	Removal of the following language: “ten (10) documented email, Electronic Medical Record or fax blast transition requests” to align with the TAR requirement for AAD.
Section II B.3.b	Removal of the following language: “or three (3) manual call attempts for placement per day” to align with the TAR requirement for AAD.
Section II.B.3.b	Updated language to reflect that all SNF placement requires ten (10) facility calls per weekday, vs SNF Level 1 to align with the TAR requirement for AAD.
Section III. A	Updated language to align with DHCS Acute Administrative Days (AAD) policy language.

Fiscal Impact

The recommended action to approve modifications to CalOptima Health GG.1516 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Health Fiscal Year 2025-26 Operating Budget.

Rationale for Recommendation

To ensure CalOptima Health’s continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, CalOptima Health staff recommends that the CalOptima Health Board of Directors approve and adopt revised CalOptima Health Policy GG.1516: Hospital Acute Administrative Days. The updated policies and procedures in Policy GG.1516 will supersede prior versions.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. [CalOptima Health Policy: GG.1516: Hospital Acute Administrative Days](#)

/s/ Michael Hunn
Authorized Signature

09/26/2025
Date



Policy: GG.1516
Title: **Hospital Acute Administrative Days**
Department: Medical Management
Section: Utilization Management

CEO Approval: /s/

Effective Date: 10/01/2000
Revised Date:

Applicable to: ☐ Administrative
☐ Covered California
☒ Medi-Cal
☒ OneCare
☐ PACE
☐ ~~Administrative~~

I. PURPOSE

This policy defines and establishes the criteria for authorizing Acute Administrative Days for CalOptima Health Direct Members.

II. POLICY

A. CalOptima Health's Utilization Management (UM)- approves Acute Administrative Days following DHCS Treatment Authorization Request criteria for Acute Administrative Days as follows when:

1. A Member no longer meets acute hospital care criteria, and the Member meets Medical Necessity criteria for a transition to a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF) or subacute nursing facility, and the hospital has demonstrated Nursing Facility (NF) placement efforts as outlined in Section II.B.3. of this Policy.
2. A pregnant Member who does not require an acute level of care but has medical or nursing treatment needs that require medical and/or monitoring skills not available in any other setting.
3. A Member with confirmed or suspected Tuberculosis (TB) no longer meets an acute level of care but continues to require isolation to prevent the transmission or spread of TB disease to the community.

B. CalOptima Health considers the following factors when determining if a Member qualifies for Acute Administrative Days:

1. The industry standard criteria for determining level of care: Acute Administrative Days are authorized when a Member no longer meets acute hospital level of care services and meets skilled level of care with the intention to transition to a SNF, ICF or subacute nursing facility.
2. The type of services received by the Member in the acute care facility and the Medical Necessity of such services.

- 1 3. The acute care facility has made reasonable placement efforts, as evidenced by below outreach
2 that includes at a minimum the date and time of contact, reason for denial and name of staff
3 rendering decision:
4

5 ~~a. Ten (10) documented email, EMR or fax blast transition requests, or~~

6
7 ~~b. Three (3) manual call attempts for placement per day.~~

8
9 ~~e.a.~~ Placement efforts, in the form of a call list. The call list should include the facility name and
10 type, contact date, contact name, and the facility's response with a reason the bed is
11 unavailable
12

13 ~~d.b.~~ AAD for ~~NF Level 1~~ SNF placement requires ten (10) facility calls per weekday (Monday
14 through Friday).
15

16 1. Placement calls are not required on weekends and on state holidays (Christmas Eve and
17 New Year's Eve are not considered state holidays).
18

19 2. If there are no calls on Friday, or the call list is insufficient/incomplete, then Friday,
20 Saturday, and Sunday may not be approved.
21

22 3. If there are no calls or an insufficient/incomplete call list on the day prior to a holiday,
23 then that day and the holiday may not be approved
24

- 25 4. Authorized Acute Administrative Days shall be paid in accordance with CalOptima Health
26 Policy FF.1004: Payments for Hospitals Contracted to Serve a CalOptima Health Direct-
27 Administrative Member, CalOptima Health Community Network Member, or a Member
28 Enrolled in a Shared Risk Group.
29

30 III. PROCEDURE 31

- 32 A. ~~Upon identification of Hospitals may request administrative day coverage when a Member who no~~
33 ~~longer meets acute hospital care inpatient criteria and continues but remains hospitalized due to~~
34 ~~remain in an barriers to placement to a SNF, subacute unit or ICF. The hospital must submit the~~
35 ~~request for administrative day coverage within 72 hours of the patient no longer requiring acute care~~
36 ~~Facility, CalOptima Health reviews Acute Administrative Days. The facility is required to submit a~~
37 ~~request with medical as determined by the Member's attending clinician or a denial for continued~~
38 ~~inpatient care is received from the health plan. Retrospective requests for authorization after the 72-~~
39 ~~hour timeframe, are not permitted. All requests must include supporting clinical documentation to~~
40 ~~CalOptima Health's UM Department of the, including Member's medical condition, the type of~~
41 ~~services received, and barriers to discharge and required~~ documentation of reasonable placement
42 efforts.
43

- 44 1. Upon receipt of the above, CalOptima Health's UM Department staff will review the medical
45 documentation, including documentation of required attempts to place Member with CalOptima
46 Health's Medical Director for determination. CalOptima Health shall notify the acute care
47 facility, in writing, of its decision, in accordance with timeframes set forth in CalOptima Health
48 Policy GG.1507: Notification Requirements for Covered Services Requiring Prior
49 Authorization.
50

- 51 2. The acute care facility may appeal CalOptima Health's UM decision, in accordance with
52 CalOptima Health Policies GG.1510: Member Appeal Process and MA.9006: Contracted
53 Provider Complaint Process.

3. Hospital Acute Administrative Days are not covered under the following circumstances:

- a. Custodial level of care;
- b. Lack of timely or adequate discharge planning;
- c. Incomplete documentation of placement efforts;
- d. Social/family issues which delay or prevent placement;
- e. Delay in Nursing Facility (NF) transfer due to awaiting legal conservatorship; or
- f. Member does not require skilled nursing level of care.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- B. CalOptima Health Policy FF.1004: Payment for Hospitals Contracted to Serve a CalOptima Health Direct Member, CalOptima Health Community Network Member, or a Member Enrolled in a Shared Risk Group
- C. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
- D. CalOptima Health Policy GG.1510: Member Appeal Process
- E. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
- ~~F.A. Title 22, California Code of Regulations (CCR), § 51342~~
- ~~G.F. Medi-Cal Provider Manual Part 2, Treatment Authorization Request (TAR) Criteria for Acute Administrative Days (AAD)~~
- G. Title 22, California Code of Regulations (CCR), § 51342

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/10/2014	Department of Health Care Services (DHCS)	Approved as Submitted
12/06/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2000	GG.1516	Acute Administrative Days	Medi-Cal
Revised	07/01/2007	GG.1516	Acute Administrative Days	Medi-Cal
Revised	12/01/2013	GG.1516	Acute Administrative Days	Medi-Cal
Revised	11/01/2015	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	10/01/2016	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	08/01/2017	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	12/01/2018	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	06/01/2020	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	06/01/2021	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	12/31/2022	GG.1516	Acute Administrative Days	Medi-Cal OneCare
Revised	11/01/2023	GG.1516	Hospital Acute Administrative Days	Medi-Cal OneCare
Revised	12/31/2024	GG.1516	Hospital Acute Administrative Days	Medi-Cal OneCare
<u>Revised</u>		<u>GG.1516</u>	<u>Hospital Acute Administrative Days</u>	<u>Medi-Cal</u> <u>OneCare</u>

For 20251002 BOD Review

1 IX. GLOSSARY

2

Term	Definition
Acute Administrative Days	An authorized inpatient day for a Member who no longer meets medical criteria for inpatient services at an acute care hospital, ~~qualifies for Nursing Facility Level of Care~~ and is ~~unable to~~ unsafe for discharge based on ~~securing~~ pending placement, ~~or Social Needs.~~
CalOptima Health Direct (COHD)	A direct health care program operated by CalOptima Health that includes both COHD- Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
Covered Services	<u>Medi-Cal</u>: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis);

Term	Definition
	7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. <u>OneCare</u>: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.

Term	Definition
Intermediate Care Facility (ICF)	<u>Medi-Cal</u>: A ~~health residential facility that is certified and~~ licensed ~~as such~~ by the ~~Department~~State to provide medical services at a lower level of ~~Health Care Services (DHCS)~~ or is a hospital or SNF that ~~care than is provided at Skilled Nursing Facilities (SNFs), and~~ meets the standards specified in ~~Title 22, California Code of Regulations, Section 22 CCR section 51212, and has been certified by DHCS for participation in the . An Medi-Cal program.~~ ~~OneCare~~: Intermediate Care Facility (ICF) ~~for the Developmentally Disabled (ICF/DD)~~ includes the following types: 1. ICF/DD – Habilitative as defined in Health and Safety Code (H&S) section 1250(e); 2. ICF/DD – Nursing as defined in H&S section 1250(h); and 3. ICF/DD as defined in H&S section 1250(g) and does not include the ICF/DD Continuous Nursing Care Program. <u>OneCare</u>: A facility that primarily provides health-related care and services above the level of custodial care but does not provide the level of care available in a hospital or Skilled Nursing Facility.
Medically Necessary or Medical Necessity	<u>Medi-Cal</u>: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. <u>OneCare</u>: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	A beneficiary enrolled in a CalOptima Health program.
Skilled Nursing Facility (SNF)	<u>Medi-Cal</u> : Any facility, place, building, agency, skilled nursing home, convalescent hospital, nursing home, or nursing facility as defined in 22 CCR section 51121, which is licensed as a SNF by California Department of Public

Term	Definition
	Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR section 51215 of these regulations, except that the distinct part of a hospital does not need to be licensed as a SNF, and has been certified and enrolled for participation as a SNF in the Medi-Cal program. <u>OneCare</u>: A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

1
2

For 20251002 BOD Review Only

Policy: GG.1516
Title: **Hospital Acute Administrative Days**
Department: Medical Management
Section: Utilization Management

CEO Approval: /s/

Effective Date: 10/01/2000

Revised Date:

Applicable to: ☐ Administrative
☐ Covered California
☒ Medi-Cal
☒ OneCare
☐ PACE

I. PURPOSE

This policy defines and establishes the criteria for authorizing Acute Administrative Days for CalOptima Health Direct Members.

II. POLICY

A. CalOptima Health's Utilization Management (UM) approves Acute Administrative Days following DHCS Treatment Authorization Request criteria for Acute Administrative Days as follows when:

1. A Member no longer meets acute hospital care criteria, and the Member meets Medical Necessity criteria for a transition to a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF) or subacute nursing facility, and the hospital has demonstrated Nursing Facility (NF) placement efforts as outlined in Section II.B.3. of this Policy.
2. A pregnant Member who does not require an acute level of care but has medical or nursing treatment needs that require medical and/or monitoring skills not available in any other setting.
3. A Member with confirmed or suspected Tuberculosis (TB) no longer meets an acute level of care but continues to require isolation to prevent the transmission or spread of TB disease to the community.

B. CalOptima Health considers the following factors when determining if a Member qualifies for Acute Administrative Days:

1. The industry standard criteria for determining level of care: Acute Administrative Days are authorized when a Member no longer meets acute hospital level of care services and meets skilled level of care with the intention to transition to a SNF, ICF or subacute nursing facility.
2. The type of services received by the Member in the acute care facility and the Medical Necessity of such services.
3. The acute care facility has made reasonable placement efforts, as evidenced by below outreach that includes at a minimum the date and time of contact, reason for denial and name of staff rendering decision:

- a. Placement efforts, in the form of a call list. The call list should include the facility name and type, contact date, contact name, and the facility's response with a reason the bed is unavailable
- b. AAD for SNF placement requires ten (10) facility calls per weekday (Monday through Friday).
 1. Placement calls are not required on weekends and on state holidays (Christmas Eve and New Year's Eve are not considered state holidays).
 2. If there are no calls on Friday, or the call list is insufficient/incomplete, then Friday, Saturday, and Sunday may not be approved.
 3. If there are no calls or an insufficient/incomplete call list on the day prior to a holiday, then that day and the holiday may not be approved
4. Authorized Acute Administrative Days shall be paid in accordance with CalOptima Health Policy FF.1004: Payments for Hospitals Contracted to Serve a CalOptima Health Direct-Administrative Member, CalOptima Health Community Network Member, or a Member Enrolled in a Shared Risk Group.

III. PROCEDURE

- A. Hospitals may request administrative day coverage when a Member no longer meets acute inpatient criteria but remains hospitalized due to barriers to placement to a SNF, subacute unit or ICF. The hospital must submit the request for administrative day coverage within 72 hours of the patient no longer requiring acute care as determined by the Member's attending clinician or a denial for continued inpatient care is received from the health plan. Retrospective requests for authorization after the 72-hour timeframe, are not permitted. All requests must include supporting clinical documentation, including Member's medical condition, the type of services received, barriers to discharge and required documentation of reasonable placement efforts.
 1. Upon receipt of the above, CalOptima Health's UM Department staff will review the medical documentation, including documentation of required attempts to place Member with CalOptima Health's Medical Director for determination. CalOptima Health shall notify the acute care facility, in writing, of its decision, in accordance with timeframes set forth in CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.
 2. The acute care facility may appeal CalOptima Health's UM decision, in accordance with CalOptima Health Policies GG.1510: Member Appeal Process and MA.9006: Contracted Provider Complaint Process.
 3. Hospital Acute Administrative Days are not covered under the following circumstances:
 - a. Custodial level of care;
 - b. Lack of timely or adequate discharge planning;
 - c. Incomplete documentation of placement efforts;

- d. Social/family issues which delay or prevent placement;
- e. Delay in Nursing Facility (NF) transfer due to awaiting legal conservatorship; or
- f. Member does not require skilled nursing level of care.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

- A. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- B. CalOptima Health Policy FF.1004: Payment for Hospitals Contracted to Serve a CalOptima Health Direct Member, CalOptima Health Community Network Member, or a Member Enrolled in a Shared Risk Group
- C. CalOptima Health Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
- D. CalOptima Health Policy GG.1510: Member Appeal Process
- E. CalOptima Health Policy MA.9006: Contracted Provider Complaint Process
- F. Medi-Cal Provider Manual Part 2, Treatment Authorization Request (TAR) Criteria for Acute Administrative Days (AAD)
- G. Title 22, California Code of Regulations (CCR), § 51342

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
03/10/2014	Department of Health Care Services (DHCS)	Approved as Submitted
12/06/2023	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
TBD	Regular Meeting of the CalOptima Health Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	10/01/2000	GG.1516	Acute Administrative Days	Medi-Cal
Revised	07/01/2007	GG.1516	Acute Administrative Days	Medi-Cal
Revised	12/01/2013	GG.1516	Acute Administrative Days	Medi-Cal
Revised	11/01/2015	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	10/01/2016	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	08/01/2017	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	12/01/2018	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	06/01/2020	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect
Revised	06/01/2021	GG.1516	Acute Administrative Days	Medi-Cal OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	12/31/2022	GG.1516	Acute Administrative Days	Medi-Cal OneCare
Revised	11/01/2023	GG.1516	Hospital Acute Administrative Days	Medi-Cal OneCare
Revised	12/31/2024	GG.1516	Hospital Acute Administrative Days	Medi-Cal OneCare
Revised		GG.1516	Hospital Acute Administrative Days	Medi-Cal OneCare

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For 20251002 BOD Review Only

1 IX. GLOSSARY

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Term	Definition
Acute Administrative Days	An authorized inpatient day for a Member who no longer meets medical criteria for inpatient services at an acute care hospital and is unsafe for discharge based on pending placement or Social Needs.
CalOptima Health Direct (COHD)	A direct health care program operated by CalOptima Health that includes both COHD- Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
Covered Services	<u>Medi-Cal</u>: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis);

Term	Definition
	7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. <u>OneCare</u>: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.

Term	Definition
Intermediate Care Facility (ICF)	<u>Medi-Cal</u>: A residential facility certified and licensed by the State to provide medical services at a lower level of care than is provided at Skilled Nursing Facilities (SNFs), and meets the standards specified in 22 CCR section 51212. An Intermediate Care Facility for the Developmentally Disabled (ICF/DD) includes the following types: 1. ICF/DD – Habilitative as defined in Health and Safety Code (H&S) section 1250(e); 2. ICF/DD – Nursing as defined in H&S section 1250(h); and 3. ICF/DD as defined in H&S section 1250(g) and does not include the ICF/DD Continuous Nursing Care Program. <u>OneCare</u>: A facility that primarily provides health-related care and services above the level of custodial care but does not provide the level of care available in a hospital or Skilled Nursing Facility.
Medically Necessary or Medical Necessity	<u>Medi-Cal</u>: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima Health shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. <u>OneCare</u>: Reasonable and necessary medical services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services includes Medi-Cal Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.
Member	A beneficiary enrolled in a CalOptima Health program.
Skilled Nursing Facility (SNF)	<u>Medi-Cal</u>: Any facility, place, building, agency, skilled nursing home, convalescent hospital, nursing home, or nursing facility as defined in 22 CCR section 51121, which is licensed as a SNF by California Department of Public Health (CDPH) or is a distinct part or unit of a hospital, meets the standard specified in 22 CCR section 51215 of these regulations, except that the distinct part of a hospital does not need to be licensed as a SNF, and has been certified and enrolled for participation as a SNF in the Medi-Cal program.

Term	Definition
	<u>OneCare</u>: A facility that meets specific regulatory certification requirements that primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

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For 20251002 BOD Review Only

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2025

Regular Meeting of the CalOptima Health Board of Directors

Report Item

19. Approve Actions Related to the Medi-Cal Eligibility Outreach Strategy

Contacts

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

Deanne Thompson, Executive Director, Marketing and Communications, (657) 550-4736

Recommended Actions

1. Authorize the Chief Executive Officer, or designee(s), to expand and extend the Medi-Cal Eligibility Outreach Strategy to support members and providers through December 31, 2028.
2. Appropriate and allocate up to \$5 million from the \$38 million Community Reinvestment Program commitment for a Community Engagement and Enrollers Notice of Funding Opportunity as part of the Medi-Cal Eligibility Outreach Strategy.
3. Appropriate and allocate up to \$2 million from the remaining balance of the Community Reinvestment Program commitment to fund the County of Orange Social Services Agency (OC SSA) eligibility staff to support enrollment activities at CalOptima Health-hosted and sponsored events to support the Medi-Cal Eligibility Outreach Strategy.
4. Authorize the Chief Executive Officer, or designee(s), to enter into a Memorandum of Understanding with OC SSA to support county eligibility staff participation at CalOptima Health-hosted and/or sponsored events through December 31, 2028.
5. Appropriate \$12 million from the remaining balance of the Community Reinvestment Program commitment for future Board-approved Medi-Cal Eligibility Outreach Strategy activities.

Background

Recent federal and state legislative changes to Medi-Cal eligibility requirements will result in dramatic impacts to Medi-Cal managed care plans and county agencies. Changes include the future implementation of work requirements and more frequent redetermination for certain adult members. This will require a broad, multifaceted outreach and education campaign throughout Orange County to help members retain their Medi-Cal coverage. County and local engagement before full implementation of those changes is crucial to prevent widespread disenrollment, particularly for CalOptima Health's most vulnerable members, such as immigrants. In light of the new requirements, the remaining balance of \$800,000 in funding for the Adult Expansion Outreach Strategy was reallocated at the September 2025 Board of Directors (Board) meeting as the first part of a new, multi-pronged Medi-Cal Eligibility Outreach Strategy. The new outreach strategy aims to identify and reach members in need of information to support continuity of Medi-Cal coverage through the following approaches:

- An integrated media campaign that includes print, radio, digital, and broadcast media outlets throughout Orange County;

- Toolkit materials (e.g., flyers, posters, newsletter articles, and social media posts) in multiple languages for use by providers, community health centers, community-based organizations, and other community stakeholders; and
- Press release(s), social media promotion, and information on the CalOptima Health website.

Similar to CalOptima Health's efforts to bring awareness to the community and its members about Medi-Cal renewal, Medi-Cal expansion, and CalFresh enrollment, CalOptima Health will partner with OC SSA, community-based organizations, providers, and the broader health care community to raise awareness on the upcoming changes to Medi-Cal and CalFresh eligibility requirements.

Discussion

As the next step in the multi-pronged Medi-Cal Eligibility Outreach Strategy, staff recommends a large-scale enrollment, navigation, and education effort to reach members through an equitable approach that may include the following types of trusted messengers:

- Community-based organizations;
- Health care providers;
- Community health workers;
- Hospital navigators;
- Food banks; and
- Faith institutions.

Staff recommends appropriating up to \$19 million in total from the existing Community Reinvestment Program commitment to fund the expanded Medi-Cal Eligibility Outreach Strategy through December 31, 2028. To establish the Community Reinvestment Program, the Board previously approved a commitment of up to \$38 million from undesignated reserves at the October 5, 2023, meeting. Following this action, the Community Reinvestment Program fund will have \$19 million remaining. This expanded and extended Medi-Cal Eligibility Outreach Strategy will work to address equity gaps in access to care, which is a key goal of the Community Reinvestment Program.

More specifically, staff recommends designating \$5 million of the appropriated funding to support community enroller grants through December 31, 2026, with two options for a one-year extension through December 31, 2028. Grantees will be selected through a competitive notice of funding opportunity that will be immediately released.

As an additional approach, staff has been working with OC SSA and proposes designating \$2 million of this newly appropriated funding to continue supporting enrollment activities with county eligibility workers, along with the county's Mobile Resource Vehicles, at events hosted and sponsored by CalOptima Health. This will provide members with on-the-spot assistance to renew and maintain their Medi-Cal coverage. As part of this funding agreement, CalOptima Health would execute a Memorandum of Understanding with OC SSA.

Staff requests the Board to appropriate an additional \$12 million from the Community Reinvestment Program commitment for future Medi-Cal Eligibility Outreach Strategy activities. Staff will return to the Board with proposed activity recommendations at a later date.

Fiscal Impact

Funding for the recommended actions will be supported through a previous Board action. On October 5, 2023, the Board committed up to \$38 million from undesignated reserves for community reinvestment activities for Medi-Cal members. After Board approval of the recommended actions, the remaining balance for the Community Reinvestment Program commitment will be \$19 million.

Rationale for Recommendation

Funding these Medi-Cal Eligibility Outreach Strategy activities will aid CalOptima Health in efforts to conduct robust regional outreach and education campaigns, provide and promote countywide enrollment activities, and increase access to care for Orange County residents.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. [Memorandum of Understanding with the Orange County Social Services Agency](#)
2. [Board Action dated October 5, 2023, Approve Actions Related to the CalOptima Health Community Reinvestment Program for Medi-Cal Members for Calendar Year 2024](#)

/s/ Michael Hunn
Authorized Signature

09/26/2025
Date

A MEMORANDUM OF UNDERSTANDING
BETWEEN
THE COUNTY OF ORANGE SOCIAL SERVICES AGENCY
AND
ORANGE COUNTY HEALTH AUTHORITY DBA CALOPTIMA HEALTH
FOR THE PROVISION OF
PARTICIPATION IN COMMUNITY EVENTS

This Memorandum of Understanding (“MOU”) is entered into by and between the County of Orange, acting through its Social Services Agency (SSA), hereinafter referred to as “COUNTY,” and the Orange County Health Authority, a public agency doing business as CalOptima Health, hereinafter referred to as “CALOPTIMA HEALTH.” This MOU establishes COUNTY’s participation in CALOPTIMA HEALTH community events with the purpose of engaging, enrolling, and renewing Orange County residents in public assistance programs, including Medi-Cal and CalFresh.

COUNTY and CALOPTIMA HEALTH may be referred to individually as “Party” and collectively as “the Parties.” The relationship between COUNTY and CALOPTIMA HEALTH, with regard to this MOU, is based upon the following:

1. CALOPTIMA HEALTH is a local public agency which, by statute, has the responsibility of operating as a County Organized Health System for Orange County, California. CALOPTIMA HEALTH coordinates the provision of health care services in Orange County.
2. This MOU is entered into to allow COUNTY to participate in CALOPTIMA HEALTH community events with the purpose of engaging and enrolling residents in public assistance programs including Medi-Cal and CalFresh.
3. This MOU sets forth the procedures authorized by both the COUNTY’s SSA Director and CALOPTIMA HEALTH’s Chief Executive Officer, to promote engagement and enrollment in Medi-Cal and CalFresh programs at community events hosted, sponsored,

or co-sponsored by CALOPTIMA HEALTH (“CalOptima Events”) for a one (1)-year term, commencing upon approval of MOU by the Orange County Board of Supervisors.

4. This MOU is a legally binding agreement based on the promises of the Parties.

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1. TERM

The term of this MOU is for one (1) year, commencing upon Board of Supervisors approval, unless terminated earlier pursuant to the provisions of Paragraph 15 of this MOU; however, the Parties shall be obligated to perform such duties as would normally extend beyond this term, including, but not limited to, obligations with respect to indemnification, reporting, and confidentiality. COUNTY and CALOPTIMA HEALTH may mutually agree in writing to extend the term of this MOU for up to twelve (12) additional months upon the same terms and conditions.

2. PURPOSE

This MOU establishes COUNTY's participation in CalOptima Events with the purpose of engaging, enrolling, and renewing Orange County residents in public assistance programs, including Medi-Cal and CalFresh.

3. DEFINITIONS

- 3.1 Intake: Process for collecting essential information from a client/applicant to evaluate eligibility for Medi-Cal and CalFresh benefits.
- 3.2 Continuing: Process for evaluating a client's/applicant's ongoing eligibility to the Medi-Cal and CalFresh programs with the purpose of renewing/recertifying the benefits.
- 3.3 Mobile Response Vehicle (MRV): Specialized vehicle that can be deployed to communities to provide social services outreach and support. The MRV is equipped with workstations and Electronic Benefit Transfer card printer.
- 3.4 Electronic Benefit Transfer (EBT): Benefit delivery system that allows CalFresh program recipients to use a card to access their food benefits.
- 3.5 Benefits Identification Card (BIC): Card issued to individuals eligible for Medi-Cal. The card verifies the individuals' Medi-Cal eligibility to healthcare providers.
- 3.6 Eligibility Technician: Eligibility case worker responsible for assessing and determining eligibility to Medi-Cal and CalFresh benefits, in accordance with

laws and policies pertaining to Federal, State, and County assistance programs.

- 3.7 Data Entry Technician: Clerical worker responsible for entering application data into the case management system supporting California's public assistance programs.
- 3.8 Social Services Supervisor I: Supervisor classification responsible for providing eligibility staff with guidance, support, and leadership to ensure accurate and timely issuance of Medi-Cal and CalFresh benefits.
- 3.9 Eligibility Supervisor: Supervisor classification responsible for overseeing Eligibility Technicians with initial and/or continuing eligibility determinations for Medi-Cal and CalFresh programs.

4. CALOPTIMA HEALTH RESPONSIBILITIES

CALOPTIMA HEALTH shall have the following responsibilities under the MOU:

- 4.1 To provide detailed CalOptima Event logistics to COUNTY staff.
- 4.2 To conduct outreach to ensure Medi-Cal recipients are aware of their upcoming Medi-Cal redetermination due date, provide instructions needed for recipients to complete their Medi-Cal redetermination, and collect any updated recipient contact information.
- 4.3 To promote the CalOptima Events and cover costs associated with organizing these events; provided, co-sponsors may bear some of these costs, as applicable.
- 4.4 To provide COUNTY staff with a safe and healthy environment to perform their duties during CalOptima Events in accordance with Attachment A.
- 4.5 To reimburse COUNTY for attending CalOptima Events, as outlined in Paragraph 10 of this MOU.

5. COUNTY RESPONSIBILITIES

COUNTY shall have the following responsibilities under the MOU.

- 5.1 County Eligibility Staff shall provide comprehensive intake services for Medi-Cal and CalFresh applications received at CalOptima Events. Such intake services shall include the following:

- 5.1.1 Assisting with, accepting, and processing applications for Medi-Cal and CalFresh benefits, including determining eligibility and notifying applicants of the approval/denial decision, or pending status when essential information is still needed.
 - 5.1.2 Issuing Electronic Benefits Transfer (EBT) cards to applicants approved to receive benefits. Printing and issuing temporary Benefits Identification Cards (BIC) as required.
- 5.2 COUNTY shall provide ongoing case management for active Medi-Cal and CalFresh cases.
- 5.3 COUNTY Central Operations
 - 5.3.1 COUNTY Central Operations shall provide operational support for CalOptima Events and activities involving SSA staff, including but not limited to the following:
 - 5.3.1.1 Set-up and breakdown of event-related equipment, such as chairs, tables, canopies, and signage.
 - 5.3.1.2 Operate Mobile Response Vehicle(s), including set-up and management of the generator, electrical power supply, and on-site printing equipment.
- 5.4 COUNTY Community Engagement Team
 - 5.4.1 COUNTY Community Engagement Team shall coordinate with CALOPTIMA HEALTH Community Relations Team on CalOptima Event logistics based upon staffing package selected.
 - 5.4.2 Collaborate with internal departments to secure appropriate staffing for scheduled events.
 - 5.4.3 Provide CalOptima Event triage services.
 - 5.4.4 Distribute COUNTY marketing materials and respond to program-related inquiries.
 - 5.4.5 Provide oversight of CalOptima Event operations to ensure

smooth execution and on-site supervision of COUNTY staff.

5.5 COUNTY Accounting Department

5.5.1 Accounting Department shall provide offsite support during CalOptima Events for issuance of EBT cards.

5.6 Designate a contact person to be responsible for oversight and supervision of the terms of this MOU.

5.6.1 The employee assigned to this position shall act as the liaison with CALOPTIMA HEALTH throughout the term of this MOU.

5.6.2 COUNTY shall notify CALOPTIMA HEALTH within five (5) business days, in writing, of changes in personnel assigned as the liaison throughout the term of this MOU. The contact person at COUNTY will be:

SSA Policy Manager

500 N State College Blvd., Suite 100

Orange, CA 92868

6. NON-DISCRIMINATION

6.1 In the performance of this MOU, each Party agrees that it shall not engage nor employ any unlawful discriminatory practices in the admission of clients, provision of services or benefits, assignment of accommodations, treatment, evaluation, employment of personnel, or in any other respect, on the basis of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, §gender identity, gender expression, age, sexual orientation, military and veteran status, or any other protected group, in accordance with the requirements of all applicable federal or State laws.

6.2 Each Party shall furnish any and all information reasonably requested by the other Party as necessary for the other Party to perform obligations under this

MOU, and each Party shall permit the other Party's access, during business hours, to books, records, and accounts in order to ascertain compliance with the MOU, except that such information shall not be furnished which is otherwise confidential under federal or state law, including but not limited to Welfare and Institutions Code §§ 14100.2 and 10850

6.3 Non-Discrimination in Employment

6.3.1 All solicitations or advertisements for employees placed by or on behalf of a Party shall state that all qualified applicants will receive consideration for employment without regard to race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, military and veteran status, or any other protected group, in accordance with the requirements of all applicable federal or State laws. Notices describing the provisions of the equal opportunity clause shall be posted in a conspicuous place for employees and job applicants.

6.3.2 Each Party shall refer any and all employees desirous of filing a formal discrimination complaint to:

California Department of Fair Employment

2218 Kausen Drive, Suite 100

Elk Grove, CA 95758

Telephone: (800) 884-1684

(800) 700-2320 (TTY)

6.4 Non-Discrimination in Service Delivery

6.4.1 Each Party shall comply with Titles VI and VII of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; the Age Discrimination Act of 1975, as

amended; the Food Stamp Act of 1977, as amended, and in particular 7 Code of Federal Regulations (CFR) section 272.6; Title II of the Americans with Disabilities Act of 1990; California Civil Code Section 51 et seq., as amended; California Government Code (CGC) Sections 11135-11139.5, as amended; CGC Section 12940 (c), (h), (i), and (j); CGC Section 4450; Title 22, California Code of Regulations (CCR) Sections 98000-98413; the Dymally-Alatorre Bilingual Services Act (CGC Section 7290-7299.8); Section 1808 of the Removal of Barriers to Interethnic Adoption Act of 1996; and other applicable federal and State laws, as well as their implementing regulations (including Title 45 CFR Parts 80, 84, and 91; Title 7 CFR Part 15; and Title 28 CFR Part 42), and any other law pertaining to Equal Employment Opportunity, Affirmative Action, and Nondiscrimination, as each may now exist or be hereafter amended. Neither Party shall implement any administrative methods or procedures which would have a discriminatory effect or which would violate the California Department of Social Services (CDSS), Manual of Policies and Procedures (MPP) Division 21, Chapter 21-100. If there are any violations of this Paragraph, CDSS shall have the right to invoke fiscal sanctions or other legal remedies in accordance with California Welfare and Institutions Code (WIC) Section 10605, or CGC Sections 11135-11139.5, or any other laws, or the issue may be referred to the appropriate federal agency for further compliance action and enforcement of Subparagraph et seq.

- 6.4.2 Each Party shall provide any and all clients desirous of filing a formal complaint any and all information as appropriate:

6.4.2.1 Pamphlet: “Your Rights Under California Welfare Programs” (PUB 13)

6.4.2.2 Discrimination Complaint Form

6.4.2.3 Civil Rights Contacts

County Civil Rights Contact

Orange County Social Services Agency

Program Integrity

Attn: Civil Rights Coordinator

P.O. Box 22001

Santa Ana, CA 92702-2001

Telephone: (714) 438-8877

State Civil Rights Contact

California Department of Social Services

Civil Rights Bureau

P.O. Box 944243, M/S 8-16-70

Sacramento, CA 94244-2430

Federal Civil Rights Contact

Office for Civil Rights

U.S. Department of Health and Human Services

90 7th Street, Suite 4-100

San Francisco, CA 94103

Customer Response Center: (800) 368-1019

7. CONFIDENTIALITY

7.1 COUNTY and CALOPTIMA HEALTH agree to maintain confidentiality of all records pursuant to WIC Sections 827 and 10850-10853, the DHCS MEDICAL Eligibility Division Information Letter No. 23-17, CDSS MPP, Division 19-000, and all other applicable provisions of law, and regulations promulgated thereunder relating to privacy, security, and confidentiality, as each may now

exist or be hereafter amended.

- 7.2 All records and information concerning any and all persons referred to CALOPTIMA HEALTH by COUNTY or COUNTY's designee shall be considered and kept confidential by CALOPTIMA HEALTH, CALOPTIMA HEALTH's employees, agents, subcontractors, and all other individuals performing services under this MOU. CALOPTIMA HEALTH shall require all of its employees, agents, subcontractors, and all other individuals performing services under this MOU to sign an agreement with CALOPTIMA HEALTH before commencing the provision of any such services, agreeing to maintain confidentiality pursuant to this MOU.
- 7.3 Each Party shall inform all of its employees, agents, subcontractors, and all other individuals performing services under this MOU of this provision and that any person violating the provisions of said California state law may be guilty of a crime.
- 7.4 Each Party agrees that any and all subcontracts entered into shall be subject to the confidentiality requirements of this MOU.
- 7.5 Each Party agrees to maintain the confidentiality of its records with respect to Juvenile Court matters, in accordance with WIC Section 827, all applicable statutes, case law, and Orange County Juvenile Court Policy regarding Confidentiality, as it now exists or may hereafter be amended.
 - 7.5.1 No access, disclosure, or release of information regarding a child who is the subject of Juvenile Court proceedings shall be permitted except as authorized. If authorization is in doubt, no such information shall be released without the written approval of a Judge of the Juvenile Court.
 - 7.5.2 Each Party must receive prior written approval of the Juvenile Court before allowing any child to be interviewed, photographed, or recorded by any publication or organization, or to appear on

any radio, television, or internet broadcast or make any other public appearance. Such approval shall be requested through child's Social Worker.

8. PUBLICITY, LITERATURE, ADVERTISEMENTS AND SOCIAL MEDIA

8.1 Each Party owns all rights to its respective name, logos, and symbols. The use and/or reproduction of a Party's name, logos, or symbols for any purpose, including commercial advertisement, promotional purposes, announcements, displays, or press releases, without that Party's prior written consent is expressly prohibited.

8.2 CALOPTIMA HEALTH may develop and publish information related to this MOU as follows:

8.2.1 So long as that information does not give the appearance that the COUNTY, its officers, employees, or agencies endorse:

8.2.1.1 any commercial product or service; and

8.2.1.2 any product or service provided by CALOPTIMA HEALTH, unless approved in writing by COUNTY; and

8.2.2 If CALOPTIMA HEALTH uses social media (such as Facebook, Twitter, YouTube or other publicly available social media sites) to publish information related to this MOU, CALOPTIMA HEALTH shall develop social media policies and procedures and have them available to the COUNTY. CALOPTIMA HEALTH shall comply with COUNTY Social Media Use Policy and Procedures as they pertain to any social media developed in support of the services described within this MOU. The policy is available on the Internet at <https://cio.ocgov.com/egovernment-policies>.

9. INDEMNIFICATION

9.1 CALOPTIMA HEALTH agrees to indemnify, defend with counsel approved in

writing by COUNTY, and hold U.S. Department of Health and Human Services, the State, COUNTY, and their elected and appointed officials, officers, employees, agents, and those special districts and agencies which COUNTY's Board of Supervisors acts as the governing Board ("COUNTY INDEMNITEES") harmless from any claims, demands, or liability of any kind or nature, including, but not limited to, personal injury or property damage, arising from or related to the services, products, or other performance provided by CALOPTIMA HEALTH pursuant to this MOU. If judgment is entered against CALOPTIMA HEALTH and COUNTY by a court of competent jurisdiction because of the concurrent active negligence of COUNTY or COUNTY INDEMNITEES, CALOPTIMA HEALTH and COUNTY agree that liability will be apportioned as determined by the court. Neither Party shall request a jury apportionment.

- 9.2 COUNTY agrees to indemnify, defend with counsel approved in writing by CALOPTIMA HEALTH, and hold CALOPTIMA HEALTH, and its elected and appointed officials, officers, employees, and agents ("CALOPTIMA INDEMNITEES") harmless from any claims, demands, or liability of any kind or nature, including, but not limited to, personal injury or property damage, arising from or related to the services, products, or other performance provided by COUNTY pursuant to this MOU. If judgment is entered against COUNTY and CALOPTIMA HEALTH by a court of competent jurisdiction because of the concurrent active negligence of CALOPTIMA HEALTH or CALOPTIMA HEALTH INDEMNITEES, CALOPTIMA HEALTH and COUNTY agree that liability will be apportioned as determined by the court.

10. PAYMENT

- 10.1 Pursuant to Government Code Section 54981, CALOPTIMA HEALTH agrees to pay to COUNTY the full costs of performing the services mutually agreed upon in this Agreement. The cost of services includes salaries, wages, overtime pay, benefits, mileage, services, supplies, equipment, and divisional,

departmental, and COUNTY General overhead.

- 10.2 COUNTY shall invoice CALOPTIMA HEALTH for expenditure based on the staffing costs in Attachment B. The maximum funding obligation of CALOPTIMA HEALTH under this MOU for all CalOptima Events shall not exceed the amount of \$250,000; provided, however, that in the event CALOPTIMA HEALTH desires to procure services in excess of the stated amount, the Parties shall enter into an amendment to this MOU for such additional expenditure.
- 10.3 Payments should be released by CALOPTIMA HEALTH within a reasonable time period of approximately thirty (60) days after receipt of the invoice from the COUNTY.
- 10.4 CALOPTIMA HEALTH shall pay COUNTY in accordance with the COUNTY Board of Supervisors approved County Billing Policy, Attachment C. Payments made electronically via a credit card or through a banking system that charges Merchant Fees, Service Fees, or any other Fees shall be the responsibility of the CALOPTIMA HEALTH. If the COUNTY is charged any of the before mentioned fees, CALOPTIMA HEALTH shall be responsible for payment of these fees to the COUNTY.
- 10.5 COUNTY shall charge CALOPTIMA HEALTH late payment penalties in accordance with County Billing Policy.

11. NOTICES

All notices, requests, claims correspondence, reports, statements authorized or required by this MOU, and/or other communications shall be addressed as follows:

COUNTY: County of Orange Social Services Agency
Procurement Services
500 N. State College, Suite 100
Orange, CA 92868

CALOPTIMA HEALTH:

Attn: Contracting Department – Director of Contracting

505 City Parkway West

Orange, CA 92868

All notices shall be deemed effective when in writing and deposited in the United States mail, first class, postage prepaid and addressed as above. Any communications, including notices, requests, claims, correspondence, reports, and/or statements authorized or required by this MOU, addressed in any other fashion shall be deemed not given. The Parties each may designate by written notice from time to time, in the manner aforesaid, any change in the address to which notices must be sent.

12. RESOLUTION OF CONFLICTS

12.1 COUNTY ordinances, regulations, policies, directives, or any other rules (“COUNTY Rules”) shall govern this MOU. If this MOU conflicts with any COUNTY Rules, then the COUNTY Rules shall govern. Both Parties shall seek a resolution of any conflicts for the betterment of the COUNTY as a whole.

12.2 For resolution of conflicts between SSA and CALOPTIMA HEALTH in regard to the provisions of this MOU, the following shall apply.

Step 1: Conference between the SSA Program Manager and the CALOPTIMA HEALTH Manager, or designee.

Step 2: Conference between the SSA Program Manager and/or Deputy Division Director or designee, and a CALOPTIMA HEALTH Director, or designee.

Step 3: Conference between the SSA Assistance Programs Division Director, or designee, and the CALOPTIMA HEALTH Chief Executive Officer, or designee.

Nothing in this Paragraph limits the rights of the Parties under Paragraph .

13. CONFLICT OF INTEREST

Each Party shall exercise reasonable care and diligence to prevent any actions or conditions that could result in a conflict with the best interests of the other Party. This obligation shall apply to each Party; and their respective employees, agents, and subcontractors associated with accomplishing work and services hereunder. Each Party's efforts shall include, but not be limited to establishing precautions to prevent its employees, agents, and subcontractors from providing or offering gifts, entertainment, payments, loans or other considerations which could be deemed to influence or appear to influence the other Party's staff or elected officers from acting in the best interests of the other Party.

14. POLITICAL ACTIVITY

COUNTY agrees that the funds provided herein shall not be used to promote, directly or indirectly, any political party, political candidate, or political activity, except as permitted by law.

15. TERMINATION

15.1 Either Party may terminate this MOU without penalty, immediately with cause or after thirty (30) days' written notice without cause, unless otherwise specified. Notice shall be deemed served on the date of mailing. Cause shall include, but not limited to, any breach of this MOU or applicable law, any partial misrepresentation whether negligent or willful, fraud on the part of the other Party, or discontinuance of the services for reasons within the other Party's reasonable control. Exercise by a Party of the right to terminate this MOU shall relieve both Parties of all further obligations under this MOU.

15.2 In the event of termination of this MOU, cessation of business by CALOPTIMA HEALTH, or any other event preventing either Party from continuing to provide services, neither Party shall withhold the other Party's data or refuse for any reason, to promptly provide to the other Party its data if requested to do so on such media as reasonably requested by the other Party, even if the other Party is then or is alleged to be in breach of this MOU.

15.3 The obligations under this MOU utilize resources, for which funding, or portions of funding, may be contingent upon the State and/or federal budget; receipt of funds from and/or obligation of funds by the State and/or Federal Government; and inclusion of sufficient funding for the services hereunder in the budget approved by the COUNTY's Board of Supervisors and CALOPTIMA HEALTH's Board of Directors for each fiscal year covered by this MOU. If such approval, funding, or appropriations are not forthcoming, or are otherwise limited, either Party may terminate, reduce, or modify this MOU without penalty.

15.4 If any term, covenant, condition, or provision of this MOU or the application thereof is held invalid, void, or unenforceable, the remainder of the provisions in this MOU shall remain in full force and effect and shall in no way be affected, impaired, or invalidated thereby.

16. SIGNATURE IN COUNTERPARTS

The Parties agree that separate copies of this MOU may be signed by each of the Parties, and this MOU will have the same force and effect as if the original had been signed by all Parties. Each Party represents and warrants that the person executing this MOU on behalf of and for that Party is an authorized agent who has actual authority to bind the Party to each and every term, condition and obligation of this MOU and that all requirements of the Party have been fulfilled to provide such actual authority.

17. GENERAL PROVISIONS

17.1 Nothing herein contained shall be construed as creating the relationship of employer and employee, or principal and agent, between COUNTY and any participant participating in this program, or any of CALOPTIMA HEALTH's agents or employees.

17.2 This MOU, with its Attachments(s) incorporated herein by reference represents the entire understanding of the Parties with respect to the subject matter. No change, modification, extension, termination or waiver of this MOU, or any of

the understandings herein contained, shall be valid unless made in writing and signed by duly authorized representatives of the Parties hereto.

- 17.3 This MOU has been negotiated and executed in the State of California and shall be governed by and construed under the laws of the State of California. In the event of any legal action to enforce or interpret this MOU, the sole and exclusive venue shall be a court of competent jurisdiction located in Orange County, California, and the Parties hereto agree to and do hereby submit to the jurisdiction of such court, notwithstanding Code of Civil Procedure Section 394. Furthermore, the Parties specifically agree to waive any and all rights to request that an action be transferred for trial to another county.
- 17.4 In the performance of this MOU, each Party shall comply with all applicable laws and regulations, as each and all may now exist or be hereafter amended.
- 17.5 In the performance of this MOU, neither Party may delegate its duties or obligations nor assign its rights, either in whole or in part, without the prior written consent of the other Party. Any attempted delegation or assignment without prior written consent shall be void.
- 17.6 The various headings, numbers, and organization herein are for the purpose of convenience only and shall not limit or otherwise affect the meaning of this MOU.

WHEREFORE, the Parties hereto have executed the Memorandum of Understanding in the County of Orange, California.

By: _____

Dated: _____

Michael Hunn

Chief Executive Officer

CalOptima Health

COUNTY OF ORANGE

By: _____

Dated: _____

An Tran

Director

County of Orange, Social Services Agency

Approved As to Form

SSA Counsel

County of Orange, California

By: _____

Deputy County Counsel

Dated: _____

ATTACHMENT A

EVENT'S SCHEDULE AND TIMELINES

It is mutually understood that COUNTY will participate in the CalOptima Events set forth in the table below. CalOptima HEALTH and COUNTY may mutually agree in writing to add, change, modify, or delete events as necessary to best serve the needs of the Parties and clients to be served under this MOU.

Event Date	Event Name	Event Site	Lead	Co-Lead	Estimated # of attendees	MRV	Fiscal year
11/22/2025	CalOptima Health Thanksgiving Open House	CalOptima Health, 505 City Pkwy, Orange, CA	CalOptima Health	N/A			2025-2026
TBD (Dec.)	Supervisor Foley's Holiday Event	TBD	BOS District 5	CalOptima Health			2025-2026
12/6/2025	Congressman Lou Correa Holiday Event	TBD	Congressman Lou Correa	CalOptima Health			2025-2026
12/13/2025	CalOptima Health Holiday Event	TBD	CalOptima Health	TBD			2025-2026
1/24/2026	Filipino Community Resource Event	San Jose Ministry, 3700 W. Orange Ave., Anaheim, CA	SSA	CalOptima Health			2025-2026

* The COUNTY Community Engagement team will meet with the CALOPTIMA HEALTH Community Relations team once a month to discuss event logistics and statistics collected at previously held events.

ATTACHMENT B STAFFING

COUNTY will provide the following staffing options in accordance with the CalOptima Event's estimated number of attendees. COUNTY and CALOPTIMA will mutually agree on the staffing options selected within a minimum of fourteen (14) business days before the date of the event.

1. Events with less than 499 attendees

Event Cost Breakdown				
Descriptions	# Required	# of Hours	Hourly Rate	Total OT Cost
Eligibility Technician	4	5	\$ 47.70	\$ 954.00
Eligibility Supervisor	1	5	\$ 60.62	\$ 303.10
Social Services Supervisor I	2	5	\$ 72.57	\$ 725.70
Accounting Office Supervisor II	1	5	\$ 56.21	\$ 281.05
Accounting Assistant II	2	5	\$ 42.12	\$ 421.20
Storekeeper II	2	8	\$ 53.32	\$ 853.12
Fringe Benefits				\$ 54.13
MRV Costs				\$ 600.00
Administrative				\$ 538.85
Employee Mileage				\$ 252.00
	12	Package #1		\$ 4,983.00

2. Events with attendees between 500-999

Event Cost Breakdown				
Descriptions	# Required	# of Hours	Hourly Rate	Total OT Cost
Data Entry Technicians	1	5	\$ 42.27	\$ 211.35
Eligibility Technicians	8	5	\$ 47.70	\$ 1,908.00
Eligibility Supervisor	1	6	\$ 60.62	\$ 363.72
Social Services Supervisor I	4	7	\$ 72.57	\$ 2,031.96
Warehouse Worker IV	1	8	\$ 46.61	\$ 372.88
Sr. Storekeeper	1	8	\$ 56.38	\$ 451.04
Storekeeper II	2	8	\$ 53.32	\$ 853.12
Accounting Office Supervisor II	1	4	\$ 56.21	\$ 224.84
Accounting Assistant II	2	4	\$ 42.12	\$ 336.96
Fringe Benefits				\$ 103.33
MRV Cost				\$ 600.00

Administrative				\$ 1,028.58
Employee Mileage				\$ 441.00
	21	Package #2		\$ 8,927.00

3. Events with attendees between 1,000-2,000

Event Cost Breakdown				
Descriptions	# Required	# of Hours	Hourly Rate	Total OT Cost
Data Entry Technicians	2	5	\$ 42.27	\$ 422.70
Eligibility Technicians	12	5	\$ 47.70	\$ 2,862.00
Eligibility Supervisor	2	6	\$ 60.62	\$ 727.44
Social Services Supervisor I	4	7	\$ 72.57	\$ 2031.96
Warehouse Worker IV	2	8	\$ 46.61	\$ 745.76
Sr. Storekeeper	1	8	\$ 56.38	\$ 451.04
Storekeeper II	2	8	\$ 53.32	\$ 853.12
Accounting Office Supervisor II	1	4	\$ 56.21	\$ 224.84
Accounting Assistant II	2	4	\$ 42.12	\$ 336.96
Fringe Benefits				\$ 132.43
MRV Costs				\$ 600.00
Administrative				\$ 1,318.24
Employee Mileage				\$ 588.00
	28	Package #3		\$ 11,294.00

4. Events with over 2,000 attendees

Event Cost Breakdown				
Descriptions	# Required	# of Hours	Hourly Rate	Total OT Cost
Data Entry Technicians	2	5	\$ 42.27	\$ 422.70
Eligibility Technicians	24	5	\$ 47.70	\$ 5,724.00
Eligibility Supervisor	3	6	\$ 60.62	\$ 1,091.16
Social Services Supervisor I	5	7	\$ 72.57	\$ 2,539.95
Warehouse Worker IV	3	8	\$ 46.61	\$ 1,118.64
Sr. Storekeeper	1	8	\$ 56.38	\$ 451.04
Storekeeper II	2	8	\$ 53.32	\$ 853.12

Accounting Office Supervisor II	1	4	\$ 56.21	\$ 224.84
Accounting Assistant II	2	4	\$ 42.12	\$ 336.96
Fringe Benefits				\$ 195.26
MRV Costs				\$ 600.00
Administrative				\$ 1,943.65
Employee Mileage				\$ 903.00
	43	Package #4		\$ 16,404.00

ATTACHMENT C
COUNTY BILLING POLICY
APPROVED BY BOARD MINUTE ORDER DATED OCTOBER 27, 1992

I. POLICY

All County agencies/departments/districts (County) governed by the Board of Supervisors shall bill contracting entities for materials and/or services provided under contract in accordance with the following standardized billing and collection policy. Billing frequency is dependent on whether the contract is a fixed price or actual cost contract. Payment due date is designed to be both responsive to the County's cash flow needs and reasonable enough as to not require special processing by the contracting entity. If payments are not received by the required due dates, a late payment fee shall be computed and billed to the contracting entity in accordance with the requirements of this procedure.

Nothing herein shall affect the liability, including pre-judgment interest, of the contracting party for services or materials in as much as this is a policy to enact standard billing practices.

II. DEFINITIONS

- A. Contract for the purposes of this policy - A contract is a formal written agreement, a purchase order from the contracting entity, or any other acceptable mutual understanding between the contracting parties.
- B. Received by the County - The phrase "received by the County", as used in Section VI of this policy, refers to the date a payment is received by the County. It is defined as the date the payment is in the County's possession. It is not the date the payment is posted or deposited by the County.

III. FIXED PRICE CONTRACTS

- A. Fixed Price (One-Time/Non-Recurring Contracts) - Invoices that represent a billing for a one-time, non-recurring provision of materials and/or services shall be issued no later than five (5) working days after delivery by the County of the materials and/or services. Examples of such one-time, non-recurring provision of materials and/or services might be a city contracting with the Sheriff for security service at a parade or sporting event; or a city purchasing a computer listing containing certain city-requested data. Payment due date shall be invoice date plus 30 days.
- B. Fixed Price (Ongoing/Recurring Contracts) - Invoices that represent a billing for an ongoing, recurring provision of materials and/or services shall be issued according to the following frequency:
 - 1. Annual Billings that total \$10,000 or less per 12-month period shall be billed via one (1) annual invoice. Annual invoices will be issued for each 12-month period of the contract, or portions thereof. Invoices shall be issued no later than five working days after the beginning of each 12-month period. Payment due date shall be invoice date plus 30 days.

2. Quarterly Billings that are greater than \$10,000 but not more than \$200,000 per 12-month period, shall be billed in quarterly installments. Quarterly invoices will be issued representing the contract amount for each 12-month period of the contract, or portions thereof, prorated into four (4) installments. Invoices shall be issued no later than 30 days after the beginning of each quarter. Payment due date shall be 60 days after the beginning of each calendar quarter.
3. Monthly Billings that are greater than \$200,000 per 12-month period shall be billed in monthly installments. Monthly invoices will be issued representing the contract amount for each 12-month period of the contract, or portions thereof, prorated into 12 installments. Invoices shall be issued on or before the first day of each service month. Payment due date shall be 30 days after the beginning of each service month.

An example of a fixed price contract for ongoing, recurring provision of materials and/or services might be a city contracting with the Sheriff for law enforcement services.

IV. ACTUAL COST CONTRACTS

- A. Actual Cost (One-Time/Non-Recurring Contracts) - Invoices that represent a billing for a one-time, non-recurring provision of materials and/or services shall be issued after delivery by the County of the materials and/or services and no later than 30 days after actual cost data is available. Payment due date shall be invoice date plus 30 days.
- B. Actual Cost (Ongoing/Recurring Contracts) - Invoices that represent a billing for an ongoing, recurring provision of materials and/or services shall be issued on a monthly basis and shall represent the cost of materials and/or services provided to the contracting entity during the previous calendar month. Such invoices shall be issued no later than 30 days after the close of the monthly billing period. If the County agency/department/district does not utilize a monthly billing cycle, the invoice shall be issued no later than 30 days after actual cost data is available. Payment due date shall be invoice date plus 30 days.

Examples of actual cost contracts for the ongoing, recurring provision of materials and/or services might be a city contracting with the County for communications equipment repair or waste disposal at a County landfill.

V. PAYMENT DUE DATES

Notwithstanding the provisions of Sections II and III above, payment due date shall be at least invoice date plus 30 days. If the County is late in issuing an invoice, the contracting entity would always have at least invoice date plus 30 days to pay. If the County is early in issuing an invoice, the contracting entity would still have a payment due date of either 60 days after the beginning of the quarter (quarterly invoices) or 30 days after the beginning of the service month (monthly invoices).

(EXAMPLES: An invoice for October service, dated and issued October 8 (late) would have a payment due date of November 7. An invoice for August service, dated and issued July 20 (early) would have a payment due date of August 30.)

VI. LATE CHARGES

The late payment of any invoiced amount by a contracting entity will cause the County to incur costs not contemplated by the County/contracting entity agreement, the exact amount of such cost will be extremely difficult to ascertain. Such costs include, but are not limited to, costs such as administrative follow-up and processing of delinquent notices, increased accounting costs, etc.

Late charges will be assessed in the following situations:

- Over-the-counter payments will be assessed a late charge if any payment is not received by the County by the payment due date.
- Payments transmitted to the County via the U.S. Mail that have the payer's postage meter mark will be assessed a late charge if any payment is not received by the County by the payment due date plus one day.
- Payments transmitted to the County via the U.S. Mail that have a U.S. Post Office postmark dated after the payment due date will be assessed a late charge.

The late charge assessed in each of these situations shall be three-quarters of one percent (0.75%) of the payment due and unpaid plus \$100.00 for late payments made within 30 days of the payment due date. An additional charge of three-quarters of one percent (0.75%) of said payment shall be added for each additional 30-day period that the payment remains unpaid. Late charges shall be added to the payment and invoiced to the contracting entity in accordance with this policy.

VII. COLLECTIONS

Any invoice remaining unpaid 90 days after the invoice date shall be referred to the Auditor-Controller for subsequent collection action, such as deduction from contracting entity moneys on deposit with the County Treasurer in accordance with Government Code Section 907 and any other applicable provision of law. Non-payment of invoices and applicable late charges will constitute a breach of contract for which the County retains all legal remedies including termination of the contract.

VIII. COST RECOVERY

All County agencies/department/districts shall include all costs of providing contracted services in contract rates. Including all direct costs, allocated indirect costs such as departmental and County (CWCAP) overhead, and cost of capital financing.

IX. EXISTING CONTRACTS

Billing terms and provisions contained in existing contracting entity agreements (existing as of the date this policy is approved by the Board of Supervisors) shall remain in effect for the life of the contract. However, when these existing contracts are renegotiated, they shall contain the billing provisions as set forth in this policy.

X. DEVIATIONS FROM POLICY

Deviations from this policy shall be approved by the Board of Supervisors. Proposed deviations by agencies/departments/districts shall be submitted to the CEO for concurrence in advance of filing an Agenda Item Transmittal (AIT) with the Clerk of the Board. The CEO, or his/her designee, shall advise the agency/department/district of approval or disapproval of the proposed deviations. If a County agency/department/district submits a

contract to the Board of Supervisors for approval, and the billing provisions in the contract deviate from this policy, the agency/department/district shall specifically advise the Board of Supervisors in the AIT of the deviation, the reason for the deviation, and of the CEO's recommendation relative thereto.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 5, 2023

Regular Meeting of the CalOptima Health Board of Directors

Report Item

13. Approve Actions Related to the CalOptima Health Community Reinvestment Program for Medi-Cal Members for Calendar Year 2024

Contacts

Michael Hunn, Chief Executive Officer, (657) 900-1481

Peter Bastone, Chief Strategy Officer, (714) 246-8549

Recommended Actions

1. Direct the Chief Executive Officer, or designees, to make an initial commitment of up to \$38 million from undesignated reserves for the purpose of community reinvestment activities to be implemented in Calendar Year (CY) 2024 for Medi-Cal members.
2. Direct the Chief Executive Officer, or designees, to make subsequent funding allocations to ensure that CalOptima Health complies with the California Department of Health Care Services (DHCS) minimum contract requirements and CalOptima Health's commitment of up to 20% of annual Medi-Cal net operating income for future years.

Background

Starting January 1, 2024, as part of the revised Medi-Cal Managed Care Plan (MCP) contract, DHCS is requiring all MCPs to reinvest a portion of their net income in their local communities through community reinvestment activities, 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.

Beginning January 1, 2024, CalOptima Health will need to meet these required levels of community reinvestment.

In addition, DHCS has also instituted a related 2024 contract requirement for meeting quality metrics. If the plan does not meet required quality outcome metrics, an additional 7.5% of annual net income must be reinvested in the community.

DHCS will release more detailed guidance on these requirements, including requirements for developing the required Community Reinvestment Plan.

Discussion

Based on CalOptima Health's most recent financial performance and the new DHCS contract provisions, staff estimates that the annual fiscal impact, in aggregate, will be approximately 12% to 13% of annual Medi-Cal net operating income. To demonstrate CalOptima Health's commitment to the

Orange County safety net, beginning with CY 2024, CalOptima Health recommends a community reinvestment level of up to 20% of annual Medi-Cal net operating income.

As an initial deposit to establish a fund for the Community Reinvestment Program, staff recommends a commitment of up to \$38 million, calculated from 20% of FY 2022-23 Medi-Cal net operating income of \$188.3 million as reported in CalOptima Health's audited financials. This will allow staff to better prepare and plan for community reinvestment activities prior to the DHCS contract provisions taking effect on January 1, 2024.

Staff will return to the Board at a future meeting to provide information on the Community Reinvestment Plan and to request authorization and allocation of funds for recommended community reinvestment activities under the plan. Addressing equity gaps in quality and access to care will be a key focus of investment.

Fiscal Impact

The recommended action to commit up to \$38 million to community reinvestment activities for Medi-Cal members will be funded from undesignated reserves.

Rationale for Recommendation

The 20% of annual Medi-Cal net operating income investment threshold is recommended to demonstrate CalOptima Health's strong commitment to reinvestment in Orange County, over and above the contractually required thresholds. As demonstrated by recent community reinvestment efforts, CalOptima Health is committed to making significant investments in community organizations to increase quality of care and health equity.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

None.

/s/ Michael Hunn
Authorized Signature

09/29/2023
Date

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2025

Regular Meeting of the CalOptima Health Board of Directors

Report Item

20. Authorize Amendment of the Contract with Camino Health Center to Provide Medical Services at the allcove® San Juan Capistrano Mental Health Youth Center Location

Contacts

Carmen Katsarov, LPCC, CCM, Executive Director, Behavioral Health Integration, (714) 796-6168
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to execute an amendment to the Professional Services Contract with Camino Health Center to establish payment terms to provide medical services at the allcove® San Juan Capistrano Mental Health Youth Center to CalOptima Health's Medi-Cal members who are not assigned for primary care services with Camino Health Center for the period of October 2, 2025, through June 30, 2028.

Background

In May 2020, the California Behavioral Health Services Oversight and Accountability Commission (BHSOAC) awarded \$2,000,000 to the University of California, Irvine (UCI) and the Wellness and Prevention Center (WPC) to launch the first allcove® South Orange County Mental Health Youth Center for individuals ages 12 to 25. However, the state grant left a funding shortfall of \$2,687,528.

The allcove® youth centers are designed to:

- Address the mental health needs of youth in South Orange County
- Reduce suicide and suicidal ideation
- Reduce unemployment through linkage to vocational training programs
- Reduce school failure through linkage to educational support services
- Provide peer support services
- Provide access to selected medical care

On June 1, 2023, the CalOptima Health Board of Directors (Board) authorized a four-year grant agreement with WPC, effective no earlier than that date. The Board allocated up to \$2.7 million from existing reserves to fund the allcove® San Juan Capistrano Mental Health Youth Center. The initial grant agreement covered Fiscal Year (FY) 2023–24 through FY 2026–27, with the goal of having the center operational by June 30, 2024.

On September 5, 2024, the Board approved an extension of the grant agreement due to real estate delays, ensuring continued support through June 30, 2028, or until the project's successful completion.

A soft opening of allcove® San Juan Capistrano Mental Health Youth Center occurred on August 18, 2025, the official ribbon cutting will take place on October 9, 2025.

Discussion

Key components of the allcove® model are ensuring drop-in access to both behavioral and medical services. WPC recently selected Camino Health Center, a Federally Qualified Health Center, to have a dedicated advanced practitioner and medical assistant onsite at the allcove® location two (2) days per week to provide the following required allcove® medical services:

- General health screenings and physical exams
- Vaccinations (e.g., flu, COVID-19)
- Treatment for minor injuries and superficial self-harm to prevent infection
- Management of common illnesses such as colds, cough, sore throat, ear pain, allergies, and headaches
- Care for gastrointestinal issues, urinary tract infections, and skin conditions such as rashes
- Gynecological care, including pelvic exams, menstrual disorder management, and breast exams
- Prescription services for antibiotics and other necessary medications
- Sleep-related concerns and fatigue
- Referrals to higher levels of care when clinically indicated

The current CalOptima Health and Camino Health Center agreement does not allow for reimbursement for services outside of the provider's assigned CalOptima Health direct and delegated members. This issue creates a significant barrier to care for youth who drop in at allcove®. A successful model for the solution already exists. The Board previously approved on August 1, 2019, an alternative payment structure to support the Homeless Clinic Access Program (HCAP) to improve access to care for youth experiencing homelessness. A component of the HCAP model was designed to support a fee-for-service framework outside of health network capitation, and staff propose using a similar framework here.

Staff recommends amending the Professional Services Contract with Camino Health Center to reimburse primary care medical services on a fee-for-service basis at the allcove® location only for members that are not-assigned to Camino Health Center, regardless of the member's primary care assignment or health network affiliation.

Fiscal Impact

The recommended action to establish payment terms with Camino Health Center for medical services delivered at the allcove® San Juan Capistrano Mental Health Youth Center can be supported within the existing CalOptima Health Fiscal Year 2025-26 Operating Budget. While reimbursement on a fee-for-service basis carries a measure of financial risk, staff anticipates that the claims volume for the targeted population in the specified catchment area will be relatively small, with an immaterial fiscal impact expected to be \$20,000 a year. Staff will continue to monitor utilization and expenses and return to the Board with additional recommendations, if needed.

Rationale for Recommendation

This action supports the allcove® drop-in model for CalOptima Health youth members in South Orange County who receive services from Camino Health Center at the allcove® San Juan Capistrano Mental Health Youth Center, resulting in increased access to care services.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Board Action dated August 1, 2019, Consider Development of a CalOptima Homeless Clinic Access Program (HCAP) for Homeless Health Initiative
2. Board Action dated June 1, 2023, Approve Actions Related to Wellness Prevention Foundation, dba Wellness & Prevention Center allcove™ South Orange County Mental Health Youth Center
3. Board Action dated September 5, 2024, Authorize Amendment to the Wellness Prevention Foundation, dba Wellness & Prevention Center allcove™ South Orange County Mental Health Youth Center Grant Award Agreement
4. Entities Covered by this Recommended Board Action
5. Contract Amendment for Camino Health Center

/s/ Michael Hunn
Authorized Signature

09/25/2025
Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 1, 2019

Regular Meeting of the CalOptima Board of Directors

Report Item

17. Consider Development of a CalOptima Homeless Clinic Access Program (HCAP) for Homeless Health Initiative.

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400

Betsy Ha, Executive Director, Quality & Population Health Management, (714) 246-8400

Recommended Actions

1. Authorize modification of the existing “CalOptima Day” Quality Improvement and incentive strategy to include a CalOptima Homeless Clinic Access Program (HCAP) that includes primary and preventive care services at Orange County homeless shelters and other locations in collaboration with Community Health Centers;
2. Authorize the expenditure of up to \$1 million in provider incentives consistent with this proposed expansion of CalOptima Day quality improvement and incentive strategy; and
3. Authorize the hiring of two additional staff at an annual cost not to exceed \$231,087 in support of this expansion of the CalOptima Day quality incentive program.

Background

“CalOptima Day” is one of the Quality Improvement and incentive strategies approved by the Board on December 1, 2016 as part Medi-Cal Quality Improvement Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracting and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditure of Unbudgeted Funds of up to \$1.1Million. CalOptima Day aims to increase access to care, enhance the member experience, and improve quality outcomes in collaboration with health networks and CalOptima Community Network provider offices. CalOptima Days are half- or full-day health and wellness events for high-volume provider offices or clinics chosen by health networks. Staff works with the provider office/clinic to schedule members to receive necessary preventive services on CalOptima Day. The provider office/clinic earns incentives for each completed preventive health visit, as evidenced by billing/encounter reporting using codes in accordance to the Healthcare Effectiveness Data and Information Set (HEDIS) specifications. The intent of these initiatives is to increase access to care and provide CalOptima members with immunizations, well-care visits and/or other services tied to quality measures. CalOptima Days have proven to be an impactful quality activity since they began in 2016. Due to the many benefits linked to CalOptima Days, they are now part of an ongoing quality strategy to improve access to preventive care and performance on quality measures.

During the February, April and June 2019 CalOptima Board meetings, the Board approved various homeless health initiatives, including an implementation plan for the Clinical Field Team Pilot Program (CFTPP) and contracts with Federally Qualified Health Centers (FQHC) and FQHC Look-Alikes (jointly Community Health Centers) selected to participate in the CFTPP.

As part of the CFTPP, CalOptima amended its contracts with five Community Health Centers to provide on-call services at hot spots throughout the county such as parks, encampments and shelters to address urgent clinical needs of individuals experiencing homelessness.

Further, the Board requested that CalOptima staff focus on significantly expanding preventive and primary care services at homeless shelter sites. CalOptima also received stakeholder feedback that such services would also be valuable at other hot spots, such as soup kitchens. CalOptima staff proposes expansion of the CalOptima Day model to provide greater access to preventive and primary care services at these locations in collaboration with interested Community Health Centers, whether they participate in CFTPP or not.

At its June 27, 2019 special meeting, the Board approved funding allocations for \$60 million in new Homeless Health Initiatives. As part of this action, the Board allocated \$10 million to “Clinic health care services in all homeless shelters.”

Discussion

Staff recognizes the need for members experiencing homelessness to have reliable access to preventive and primary care in shelters and at other settings. Many shelters already have established relationships with community providers to provide those services via either an on-site or mobile clinic; however, hours may be limited. These services are sometimes not billed, even when a provider is rendering services to a CalOptima member. This may occur, for example, if the provider is not contracted with the member’s assigned health network or is not the member’s assigned primary care provider (PCP). Further, some Community Health Centers have advised that set up and tear down of mobile clinics is time consuming and may not be cost-effective, even if the clinic is able to bill for the visit. These factors may contribute to limited access to care at shelters and other hot spots.

To address these concerns, CalOptima staff proposes partnering with any interested Community Health Centers to provide preventive and primary health care services at shelters and other hot spots. This may include locations that do not have established schedules with community providers, as well as those that may benefit from expanded schedules. These Community Health Centers will be required to create a regular schedule based on input from the shelters/hot spots, and those schedules will be informed by need, which may include bed count, frequency of resident turnover, other individuals served at the location, existing service schedules, and proximity to community providers. Additionally, the Community Health Centers will be expected to encourage CalOptima members to seek services from their assigned CalOptima providers and coordinate services with other medical and behavioral health care providers.

As proposed, and similar to the CalOptima Day tiered incentive payment model, clinics maintaining a presence at the shelter or hot spot will be compensated up to \$1 million annually in total for all participating providers, excluding CalOptima staff resources, based on expanded hours and services completed for CalOptima members, as well as claims submission.

CalOptima staff proposes to offer eligible providers with a monetary incentive for participating in the HCAP according to two (2) tiers:

- Tier 1: An eligible provider will receive a Tier 1 provider incentive for event participation for a half day (4 hours) or a full day (8 hours).
- Tier 2: An eligible provider may receive a Tier 2 provider incentive, in addition to the Tier 1 provider incentive, if the following levels of services are provided:
 - Eligible provider completes 10 appointments during a half day (4 hours). Appointments may be any combination of well-care or vaccine-only visit.
 - Eligible provider completes 20 appointments during a full day (8 hours). Appointments may be any combination of well-care or vaccine-only visit.

Provider Incentive	Half Day (4 hours)	Full Day (8 hours)
Tier 1	\$800	\$1,600
Tier 2	\$400	\$800

Staff estimates that CalOptima will schedule a combination of 10 half day or full day HCAP events per week, with an average of 15 appointments completed during each event.

CalOptima staff will leverage the coordination and incentive mechanisms already established by the current CalOptima Day strategy. The effectiveness of CalOptima Days is measured by lead measures such as numbers of members accessing services, numbers of CalOptima Days with expanded hours, and lag measures such as HEDIS. A similar program measurement and evaluation discipline will apply to the HCAP.

In addition, management requests additional staffing to coordinate HCAP. Staff recommends the addition of two full-time equivalent positions: a Program Manager and a Quality Analyst. The total estimated annual impact of the addition of the two staff positions is approximately \$231,087.

Fiscal Impact

The recommended action to develop HCAP by modifying the existing CalOptima Day Quality Improvement and incentive strategy is a Homeless Health Initiative budgeted item. Expenses of up to \$1 million annually for provider incentives and \$231,087 annually for staffing expenditures are budgeted under homeless health-related initiatives in the Fiscal Year 2019–20 Operating Budget approved by the Board on June 6, 2019 and will be funded from the “clinic health care services in all homeless shelters” category approved by the Board on June 27, 2019.

Rationale for Recommendation

CalOptima members experiencing homelessness sometimes face unique challenges in accessing the care they need. By partnering with shelters, other hot spots and Community Health Centers to implement the HCAP will help provide members with access to preventive and primary health services that this population segment may not otherwise seek. Early intervention while the members reside in shelters could also help them reacclimate to receiving scheduled care by appointment, hopefully helping to reintroduce them to obtaining health care in a more traditional and cost-effective setting.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Homeless Clinic Access Program Presentation
2. Board approval of Medi-Cal Quality Improvement Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracting and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditure of Unbudgeted Funds of up to \$1.1Million. on December 1, 2016
3. CalOptima Day Fact Sheet

/s/ Michael Schrader
Authorized Signature

7/24/19
Date



CalOptima
Better. Together.

CalOptima Homeless Clinic Access Program

David Ramirez, M.D.
Chief Medical Officer

Betsy Ha, R.N., M.S., LSSMBB
Executive Director, Quality & Population Health Management

Building a Better System of Care

- In response to the homelessness crisis in Orange County, CalOptima has approved the following:
 - Homeless Response Team to coordinate care
 - Deployed the Clinical Field Team in collaboration with Federally Qualified Health Centers (FQHC) to provide urgent care for those unable or unwilling to access the traditional care system
 - Help hospitals meet SB 1152 requirements for homeless-specific discharge planning and care coordination
 - Increased Recuperative Care funding and creation of a Medical Respite Program
- These initiatives focus on the urgent and clinical needs of members unsheltered.

Bridging to Existing System

Nontraditional Settings

- Clinical Field Teams (CFTs)
- Mobile Clinics
- Telehealth

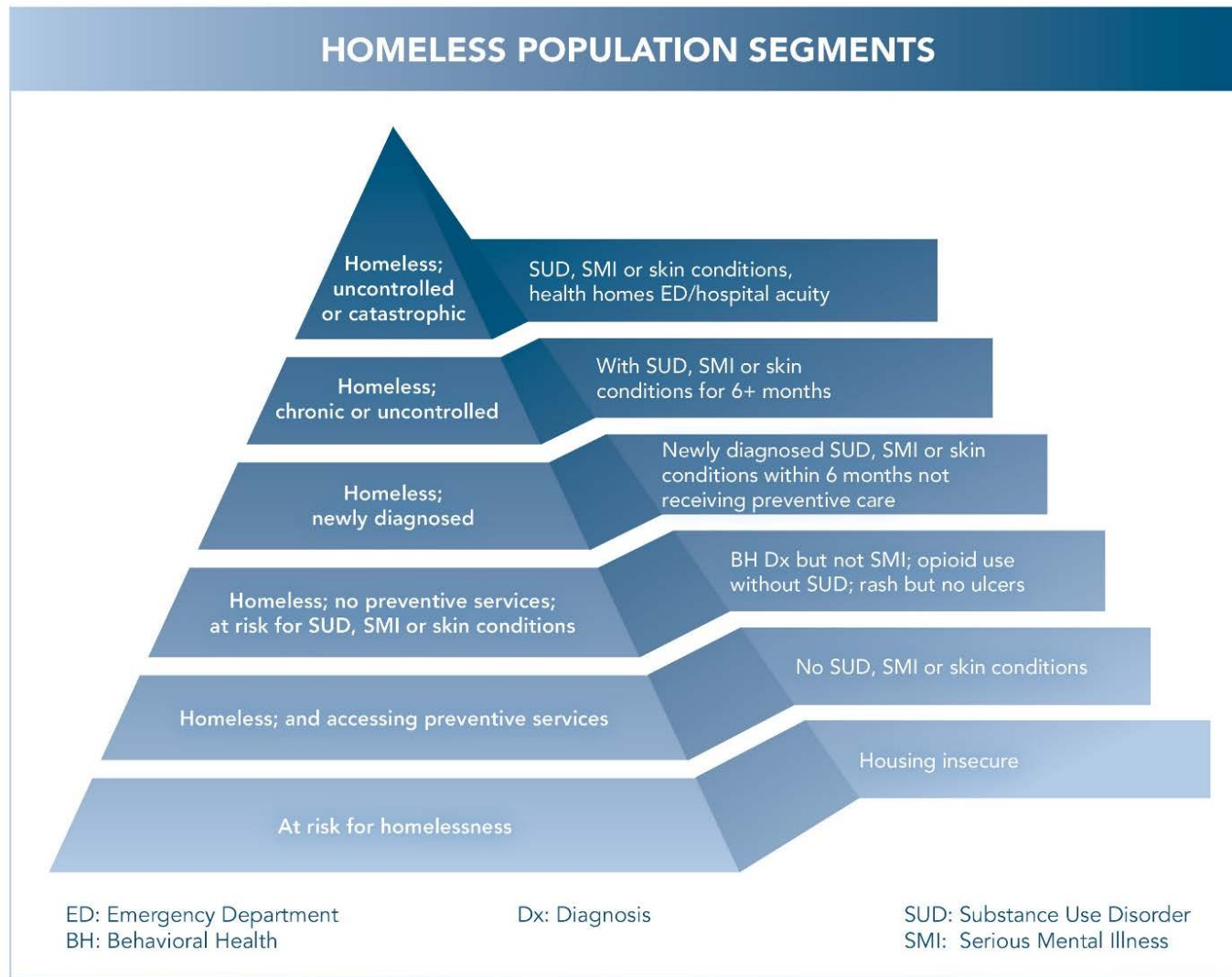
Transitional Settings

- Clinics in Shelters
- On-Site Supportive Services

Existing System

- Clinics
- Office-Based Providers
- Telephonic Case Management

A Population Health Approach

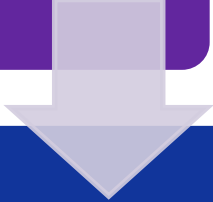


Clinic Health Care Services

- In response to the June 27, 2019, special meeting, the Board approved funding allocations of \$60 million for new homeless health initiatives.
- As part of this action, the Board allocated \$10 million to “Clinic health care services in all homeless shelters.”
- Staff recognizes the need to establish reliable, recurring, preventive and primary care schedules for members experiencing homelessness who are staying in shelters.
- Currently, most shelters in Orange County have inadequate physical health services available either on-site or through mobile clinics

Leveraging Quality Incentives

Modify the “CalOptima Day” Quality Improvement and incentive strategy for Homeless Health Initiative



Develop a CalOptima Homeless Clinic Access Program (HCAP)



Provide CalOptima Homeless Clinic Access Program (HCAP) at Orange County homeless shelters and other appropriate locations

What is CalOptima Day?

- A practice site-based Quality Improvement and incentive strategy used by CalOptima since 2016 to improve member access to care and HEDIS performance results
 - A half or full-day health and wellness event that is co-hosted by CalOptima, a health network, and a clinic or provider office, offering immunizations and well-care visits to our Medi-Cal members.
 - Clinic/providers offices' to only schedule appointments for CalOptima members assigned to the participating health network and clinic/provider office designated CalOptima Days.
 - Providers are incentivized to host the event and can receive up to \$2,400 per CalOptima Day.
 - Members are incentivized with a \$25 gift card for completing a visit.

2018 CalOptima Day Focused Measures

- Well-Care Measures

- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
- Adolescent Well-Care Visits (AWC)

- Immunization Measures

- Childhood Immunization Status (CIS)
 - Combo 10
- Immunizations for Adolescents (AWC)
 - Combo 2

CalOptima Homeless Clinic Access Program (HCAP)

- Increase the availability of preventive and routine health care services at Orange County shelters to create regular clinic schedules informed by need.
- Provide care transition support and encourage CalOptima members to seek services from their assigned CalOptima providers.
- Coordinate services with other medical and behavioral health care providers when needed.

Proposed Quality Measures

- Preventive services, screenings and chronic care HEDIS measures may include but not be limited to:
 - Access to Ambulatory and Preventive Care Services (AAP)
 - Adult BMI Assessment (ABA)
 - Chlamydia Screening (CHL)
 - Cervical Cancer Screening (CCS)
 - Adult Immunization Status (AIS)
 - Comprehensive Diabetes Care (CDC)
 - HbA1C
 - Retinal Eye Exam
 - Blood Pressure

Proposed Provider Incentives

- CalOptima will offer eligible providers a monetary incentive for participating in the CalOptima Homeless Clinic Access Program (HCAP) events according to two (2) tiers:
 - Tier 1: Eligible provider receives a Tier 1 incentive for event participation for a half (4 hours) or full day (8 hours)
 - Tier 2: Eligible provider may receive a Tier 2 provider incentive, in addition to Tier 1, if the following levels or service are provided;
 - Eligible provider completes 10 appointments during half day (4 hours)
 - Eligible provider completes 20 appointments during a full day (8 hours)

Provider Incentive	Half Day (4 Hours)	Full Day (8 Hours)
Tier 1 Incentive	\$800	\$1,600
Tier 2 Incentive	\$400	\$800

Fiscal Impact

- Expenses of up to \$1 million annually for provider incentives and \$231,087 annually for staffing expenditures
- Budgeted under homeless health-related initiatives in the Fiscal Year 2019–20 Operating Budget
- Approved by the Board on June 6, 2019
- Will fund from the “Clinic health care services in all homeless shelters” category approved by the Board on June 27, 2019

Staffing Expenditure

- Hire Program Manager and Quality Analyst
- Perform incentive program management
- Facilitate scheduling
- Provide care transition support
- Monitor quality and access to primary care
- Coordination with internal and external partners
- Quality performance measurement, analysis and reporting

Recommended Action

- Authorize modification of the existing “CalOptima Day” Quality Improvement and incentive strategy to include a CalOptima Homeless Clinic Access Program (HCAP) that includes primary and preventive care services at Orange County homeless shelters and other locations in collaboration with Community Health Centers;
- Authorize the expenditure of up to \$1 million in provider incentives consistent with this proposed expansion of CalOptima Day quality improvement and incentive strategy; and
- Authorize the hiring of two additional staff at an annual cost not to exceed \$231,087 in support of this expansion of the CalOptima Day quality incentive program.

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner



CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016 **Regular Meeting of the CalOptima Board of Directors**

Consent Calendar

5. Consider Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracts and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditures of Unbudgeted Funds of up to \$1.1 Million

Contact

Richard Bock, M.D., Deputy Chief Medical Officer, (714) 246-8400

Recommended Actions

1. Approve the Quality Improvement activities listed on Attachment 1;
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to contract with new vendors and amend existing vendor contracts, as appropriate, for quality improvement-related services, including NCQA consulting and provider coaching services, incentive distribution and tracking services, PSA development services, survey implementation services, and material and print services selected consistent with CalOptima's Board-approved procurement process;
3. Direct staff to develop Member and Provider incentive programs in the amounts listed on Attachment 1., subject to applicable regulatory approval and guidelines, and final approval by the CalOptima Board prior to implementation; and
4. Authorize unbudgeted expenditures not to exceed \$1.1 million to implement these initiatives.

Background

In CalOptima's 2013-2016 Strategic Plan, one of the strategic priorities was related to Quality Programs and Services. As a part of this strategic priority, CalOptima has worked diligently to provide members with access to quality health care services and ensure optimal health outcomes for all our members.

One of the areas of focus within Quality Programs and Services is CalOptima's performance in the National Committee for Quality Assurance (NCQA) accreditation and ratings. The evaluation criterion for the NCQA health plan ratings consists of three dimensions: Prevention, Treatment and Member Satisfaction. According to the most recent NCQA Health Plan Ratings, (NCQA's Medicaid Health Insurance Plan Ratings 2015-2016) CalOptima scored 4 out of 5 on Prevention, 3.5 out of 5 on Treatment, and 2.5 out of 5 in Customer Service. Health Plans are rated on a 5 point scale. CalOptima achieved an overall rating of 4 out of 5. CalOptima has the distinction of being the top rated Medicaid Health plan in California for the past three years. CalOptima is proud to be the only California Medicaid health plan accredited at the "commendable" level by NCQA. Additionally, CalOptima has achieved a 3.5 out of 5.0 "STAR" rating for Medicare by the Centers for Medicare & Medicaid Services (CMS).

Although CalOptima has achieved much success in our quality programs, we have also identified two measures that were below the minimum performance level (MPL) established by the California

Department of Health Care Services (DHCS), and we have prospectively identified other quality measures on the decline that are required for NCQA accreditation and health plan ratings. In order to maintain or exceed our quality performance levels, it is imperative to consider additional interventions which are necessary to achieve these goals, as referenced in our 2016 QI Program Description (Clinical Data Warehouse section, pg 41). These include utilizing multiple levers (direct-to-member, direct-to-provider, incentives, communication strategies, etc.) and programs planned as ongoing strategies throughout the calendar year.

In preparing the CalOptima FY 2016-17 Operating Budget, staff applied the regular budgeting methodology which used the past year's actual run-rate assumptions to allocate funds to various categories, units and lines of business. Upon further review, it became clear that additional funding was necessary to meet existing program commitments for Medi-Cal quality monitoring, reporting and improvement as well as new and expanded quality programs.

Discussion

Maintaining CalOptima's "commendable" accreditation status and rating by NCQA as a top Medicaid plan in California requires ongoing investment in innovative quality initiatives focused on underperforming measures as well as measures aligned with NCQA accreditation, health plan ratings, as well as DHCS and CMS requirements. Funding is also requested to maintain current vendor contracts utilized for quality reporting and to support annually required trainings for quality staff.

Expenditures requested are classified as:

• Budget augmentation for current quality initiatives:	\$ 457,740
• New requests for quality initiatives:	<u>\$ 605,839</u>
Total Request	\$1,063,579

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities provides additional detail on the quality related programs, initiatives and proposed incentives. Member and provider incentive programs will be established by CalOptima. Member incentives will follow the guidelines in CalOptima Policy AA.1208 – Non-Monetary Member Incentives. All member and provider incentive programs will be fully developed and returned for Board approval prior to implementation, as well as regulatory approval, as applicable.

Fiscal Impact

The recommended action to appropriate and authorize expenditures of up to \$1.1 million for Medi-Cal quality improvement and accreditation activities is an unbudgeted item. Management is requesting Board approval to authorize an additional amount of up to \$1.1 million in medical expenses to fund the cost of the quality improvement activities.

CalOptima Board Action Agenda Referral
Consider Approval of Medi-Cal Quality Improvement and Accreditation
Activities During CalOptima FY 2016-17, Including Contracts and
Contract Amendments with Consultant(s), Member and Provider
Incentives, and Expenditures of Unbudgeted Funds of up to \$1.1 Million
Page 2

Rationale for Recommendation

CalOptima staff believes that by partnering with our Health Network and provider community, targeted, impactful interventions will result in improvements in our quality scores, to maintain our NCQA Commendable status.

Concurrence

Gary Crockett, Chief Counsel
Chet Uma, Chief Financial Officer
Board of Directors' Quality Assurance Committee
Board of Directors' Finance and Audit Committee

Attachments

- Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities
- PowerPoint Presentation: Quality Analytics Budget

/s/ Michael Schrader
Authorized Signature

11/22/2016
Date

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities

A. Budget Augmentation for Current Quality Initiatives

Item	Detail	Amount (Not to Exceed)
Surveys & NCQA Fees	• Addition of CG CAHPs - Adult & Child • Fee increases for regular CAHPS • Implement SPD CAHPS • Additional record retrieval for Medical Record Review • Increase in NCQA required fees • Timely Access Survey	\$252,937
NCQA Consultant	• RFP results did not produce viable option; completed bid exception for known entity due to timeframe	\$17,375
Quality Initiatives in Flight	• Flu/pneumococcal shot reminders • Preventive care visits • Pharyngitis kits • Readmissions project (CMS QIP) • Member & provider communications (more non-adherent members; more measures to move) •	\$138,793
	• Member and provider incentives	\$12,380
Required Training	• Annual Inovalon & HEDIS Best Practices training • CME expenses for physician training • Provider education activities • New hire equipment	\$28,480
Miscellaneous		\$7,775
Total		\$457,740

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities

B. New Request for Quality Initiatives

Item	Detail	Amount (Not to Exceed)
Member Programs	- Prenatal/postpartum incentive (Increase volume of outreach; \$10,887) - Breast cancer screening -Downward trend Reminder mailing & incentive; \$99,900 - Cervical cancer screening -Below MPL Reminder mailing & incentive; \$149,900	\$260,687
Provider Programs	- Physician office extended hours pilot project - MPL measures (\$10,000) - Prenatal/postpartum provider office incentive (\$5,000) - PCP office staff incentives for well women visits/screenings (\$75,000) - Physician office extended hours initiative mailing (\$2,500)	\$92,500
Member Experience Initiatives	- Member focus groups, supplemental survey, provider CME (\$72,525) - Practice coaches for member experience (\$18,840)	\$91,365
Provider Toolkits	- AWARE toolkit on antibiotic use (\$5,000) - Provider Outreach/Education on AAB Measure (Below MPL; \$1,500)	\$6,500
Outreach Projects	- PSA for well women visits (Feb & May) - Culturally-specific radio stations (\$99,900) - Child & Adolescent Outreach and Events for Childhood Immunizations (13% decrease; \$44,887) - Educational posters/print ads for physician offices for Women's Wellness Campaign (\$10,000)	\$154,787
Total		\$605,839

Quality Analytics Budget

**Board of Directors' Quality Assurance Committee Meeting
November 16, 2016**

**Board of Directors' Finance and Audit Committee Meeting
November 17, 2016**

**Richard Bock, MD, Deputy CMO
Caryn Ireland, Executive Director, Quality**

FY 2016-2017 Budget

- Budget augmentation for current quality initiatives: \$457,740
 - Surveys & NCQA Fees
 - NCQA Consultant
 - Quality Initiatives in Flight
 - Required Training
 - Miscellaneous
- New requests for quality initiatives: \$605,839
 - Member Programs
 - Provider Programs
 - Member Experience Initiatives
 - Provider Toolkits
 - Outreach Projects

Budget Augmentation for Current Quality Initiatives: \$457,740

- Surveys & NCQA Fees: \$252,937
 - Addition of CG CAHPS – Adult & Child
 - Fee increases for regular CAHPS
 - Implement SPD CAHPS
 - Additional record retrieval for Medical Record Review
 - Increase in NCQA required fees
 - Timely Access Survey

- NCQA Consultant: \$17,375
 - RFP results did not produce viable option; completed bid exception for known entity due to timeframe

- Quality Initiatives in Flight: \$151,173
 - Flu/pneumococcal shot reminders
 - Preventive care visits
 - Pharyngitis kits
 - Readmissions project (CMS QIP)
 - Member communications (more non-adherent members; more measures to move)
 - Member and provider incentives

Budget Augmentation for Current Quality Initiatives (cont.)

➤ Required Training	\$28,480
▪ Annual Inovalon & HEDIS Best Practices training	
▪ CME expenses for physician training	
▪ Provider education activities	
▪ New hire equipment	
➤ Miscellaneous	\$7,775

Funding for Additional Program: \$605,839

- Member Programs \$260,687
 - Prenatal/postpartum incentive (Increase volume of outreach)
 - Breast Cancer Screening (Downward trend)
 - Cervical Cancer Screening (Below MPL)
- Provider Programs \$92,500
 - Physician office extended hours pilot project – MPL measures
 - Prenatal/postpartum provider office incentive
 - PCP office staff incentives for well women visits/screenings
 - Physician office extended hours initiative mailing
- Member Experience Initiatives \$91,365
 - Member focus groups, supplemental survey, provider CME
 - Practice coaches for member experience
- Provider Toolkits \$6,500
 - AWARE toolkit on antibiotic use
 - Provider outreach/education on AAB Measure (Below MPL)
- Outreach Projects: \$154,787
 - PSA for well women visits (Feb & May) – Culturally-specific radio stations
 - Child & adolescent outreach and events for childhood immunizations (13% decrease)
 - Educational posters/print ads for physician offices for Women's Wellness Campaign

Description of Additional Programs	Amount
Member Programs	\$260,687
Prenatal/postpartum incentive (Increase volume of outreach)	\$10,887
Breast cancer screening (Downward trend)	\$99,900
Cervical cancer screening (Below MPL) - Reminder mailing and member incentives	\$149,900
Provider Programs	\$92,500
Physician office extended hours pilot project – MPL measures	\$10,000
Prenatal/postpartum provider office incentive	\$5,000
PCP office staff incentives for well women visits/screenings	\$75,000
Physician office extended hours initiative mailing	\$2,500
Member Experience	\$91,365
Member focus groups (\$50K), supplemental survey (\$20,475), provider CME (\$7K)	\$72,525
Practice coaches for member experience	\$18,840
Provider Tool Kits	\$6,500
AWARE Toolkit on antibiotic use	\$5,000
Provider outreach/education on AAB Measure (Below MPL)	\$1,500
Outreach Projects	\$154,787
PSA for well women visits (Feb & May) – Culturally-specific radio stations	\$99,900
Child & adolescent outreach and events for childhood immunizations (13% decrease)	\$44,887
Educational posters/print ads for physician offices for Women's Wellness Campaign	\$10,000
Total	\$605,839

CalOptima's Mission

To provide members with access to quality health care services delivered in a cost-effective and compassionate manner



QUALITY INITIATIVES

“CalOptima Day” Child and Adolescent Health and Wellness Event

CalOptima strives to provide quality care for our members. This means finding new ways to better serve them. CalOptima is looking for health networks to host CalOptima Day, a one-day health and wellness event at one high-volume provider office or clinic of their choice, offering immunizations and well-care visits to children and adolescent Medi-Cal members.

Criteria for Participation:

- Health networks and the selected provider office or clinic will help market the event as “CalOptima Day.”
- Voluntary participation of one provider office or clinic per health network that serves a high volume of targeted CalOptima Medi-Cal members in Orange County
- Provider office or clinic must be in good standing with CalOptima and have no sanctions or corrective action plans in place at the time of participation.
- Health networks and provider office/ clinic are expected to host a wellness event targeting any or all the measures listed: W15, W34, AWC, CIS and IMA.
- Provider offices and clinics are expected to conduct member outreach efforts including outbound calling, scheduling appointments and record keeping.
- Provider offices/ clinics and the health network are expected to properly code the office visit in accordance to the HEDIS specifications and provide validation to CalOptima this occurred.
- The participating provider or clinic shall provide feedback and a summary report of all vaccinations and well-child visits completed at the event.
- CalOptima will provide gift cards to members as incentives for receiving a recommended immunization(s) during the CalOptima Day event.
- CalOptima will offer participating provider offices or clinics a monetary incentive for hosting the health and wellness event of \$300/hr. for each health event, up to \$2,400/event. Depending on budget, a primary care provider (PCP)/clinic site may conduct more than one event at the discretion of CalOptima.

For more information, email questions to QI_Initiatives@CalOptima.org.

Please note: A limited number of provider offices and/or clinics will be eligible to participate in the Child and Adolescent Health and Wellness Event. Be on the lookout for more opportunities to participate in a CalOptima incentive program.

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2023

Regular Meeting of the CalOptima Health Board of Directors

Report Item

21. Approve Actions Related to Wellness Prevention Foundation, dba Wellness & Prevention Center *allcove*TM South Orange County Mental Health Youth Center.

Contacts

Carmen Katsarov, LPCC, CCM, Executive Director, Behavioral Health Integration, (714) 796-6168
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Recommended Actions

1. Authorize CalOptima Health's Chief Executive Officer to develop and execute a grant agreement for a four-year term with the Wellness & Prevention Foundation, dba Wellness & Prevention Center (WPC), no earlier than July 1, 2023, to support the *allcove*TM South Orange County mental health youth center;
2. Authorize unbudgeted expenditures in an amount up to \$2.7 million from existing reserves to fund the grant agreement with WPC; and
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background

There is a national mental health crisis. In particular, Orange County youth have been greatly impacted from the losses and impacts from COVID-19 as well as the impact of social media. According to the 28th Annual Report on the Conditions of Children in Orange County: (1) suicide is the second leading cause of death for Orange County (OC) 10-19-year-olds; (2) students are more likely to experience chronic sadness or hopeless feelings compared to 2011-2013, increasing 13.4% for 11th, 7.9% for 7th and 4.2% for 9th graders; and (3) in 2017-2019, an estimated 15% of 9th and 11th graders seriously considered attempting suicide in the previous year. This crisis is further aggravated by the mental health workforce shortage. It requires new thinking and approaches to overcome this crisis.

The Mental Health Service Oversight and Accountability Commission (MHSOAC) issued a request for applications to award \$2,000,000 to five separate *allcove*TM projects. In May 2020, MHSOAC announced that grants would be awarded to five projects across California, including two projects in Los Angeles County, and one project in each of San Mateo County, Sacramento County, and Orange County. The Stanford Center for Youth Mental Health and Wellbeing team that created an *allcove*TM model was awarded the technical assistance (TA) contract establishing the Stanford Central *allcove*TM Team (CAT). For Orange County, the University of California, Irvine (UCI) and the WPC responded to the competitive request for applications and received \$2,000,000 in funding to help launch the first *allcove*TM South Orange County (South OC) mental health youth center.

The *allcove*TM model offers an integrated and holistic approach for the delivery of services for youth (ages 12-25) with mild-to-moderate needs. The core service streams of *allcove*TM include mental health care, physical health care, substance misuse support, youth peer and family support, and supported

education and employment. Every *allcove™* center is guided by an active Youth Advisory Group (YAG), composed of young people from the local community who represent diversity in race, ethnicity, gender, sexual orientation, lived experience, ability, and socioeconomic status. An *allcove™* YAG's goal is to ensure that youth voice and experience is included in the development and services of the center. In this approach, *allcove™* will offer case managers and peer support specialists to help coordinate care with the young person's physical health services, health home and other relevant providers of healthcare. If a young person visiting a center needs a higher-level behavioral health service, linkages are made to the county behavioral health system for more intensive intervention.

Discussion

CalOptima Health members, providers, and the Orange County Health Care Agency (OCHCA) continue to report a need for more mental health services in South OC. Granting the development of the first *allcove™* South OC mental health youth center would benefit and address the need for CalOptima Health's Medi-Cal youth beneficiaries in South OC. The mental health youth center can apply the whole-person care approach to Medi-Cal youth beneficiaries. The state grant funding of \$2,000,000 leaves a shortfall of \$2,687,528. CalOptima Health staff requests that the Board approve \$2,687,528 to fund the first *allcove™* South OC mental health youth center for four years from fiscal year 2023-24 through fiscal year 2026-27. This time will allow UCI and WPC to develop a sustainable model and serve as future technical advisors for other community partners to develop and launch additional *allcove™* sites.

Staff will monitor and provide oversight of the grant funds following CalOptima Health Policy AA.1400p: Grant Management, which was approved during the CalOptima Health Board of Directors meeting on May 4, 2023. CalOptima Health will monitor and require *allcove™* to submit a quarterly project summary tied to measurable metrics. The list of metrics is located in Exhibit 1 - Required Reporting Elements.

CalOptima Health will also require progress reporting for activities related to sustainability quarterly for items #1-4 below. If during the time of the grant any services are able to move from grant money to billable services, funding will be adjusted to ensure no duplication:

- 1) By December 31, 2024, contract with and establish billing with CalOptima Health for any applicable CalAIM services.
- 2) By December 31, 2024, contract with and establish billing with CalOptima Health for mental health mild to moderate services
- 3) By June 30, 2026, establish other billing procedures with private health insurance.
- 4) Exploring additional streams for sustainability, including workforce enhancement training through UCI and Orange County Healthcare Agency Mental Health Services Act Prevention and Early Intervention funding.

Fiscal Impact

The recommended actions related to this grant are separate from the normal operating budget process. An appropriation of up to \$2.7 million from existing reserves will fund the four-year grant agreement from July 1, 2023, through June 30, 2027.

Rationale for Recommendation

CalOptima Health staff recommend proceeding with this action to support CalOptima Health's mission and vision for increased options and access for integrated mental health services for youth members in South OC.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. [Entities Covered by this Recommended Action](#)
2. [Exhibit 1](#)

/s/ Michael Hunn
Authorized Signature

05/26/2023
Date

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Wellness & Prevention Foundation dba Wellness & Prevention Center	700 Avenida Pico	San Clemente	CA	92673

Exhibit 1

Grant Funding Breakdown:

UCI and WPC awarded MHSOAC State Grant Funding - \$2,000,000 lasts through June 2026

Funding Categories	Estimated Amount
Personnel (6.1 FTEs) • Operating Agency ED • UCI - Dr. Stephen Schueller • Site Manager • Youth Outreach Specialist • Reception/Administrative Assistant • Clinical Psychology Postdoc • Mental Health Clinician PhD Trainee	\$1,405,557
Pre-opening Office/General Administrative Costs • Furniture • Building improvements • Equipment • Travel • Rent ½ year	\$413,360
UC Facilities and Administrative (F&A) Indirect Rate (10%)	\$181,083
Total:	\$2,000,000

CalOptima Health Non-MHSOAC Grant Funding: Fiscal Years 2023-24 through 2026-2027

Funding Categories	Estimated Amount
Personnel (3.25 FTEs in Yr. 1; 4 FTEs after) • Clinical Coordinator • Project Director Youth Coordinator/Peer Support Lead - youth outreach • Peer Support Specialist • Supported Education and Employment Specialist	1,177,050
Office/General Administrative includes the following: • Equipment maintenance • Staff Development/Training • Furniture maintenance and Rent • Building Improvement • Protective Health Information (PHI) / Electronic Health Records (EHR) maintenance	\$1,099,000
Youth Materials and Advisory Expenses	\$123,500
Indirect Management Overhead: • HR, Insurance, Accounting	\$160,000
Misc / Unanticipated Changes (5%)	\$127,978
Total:	\$2,687,528

Exhibit 1

Outcomes and Services

Process Outcomes:	Expected Due Date
1) Establish intake data collection	9/30/23
2) <i>allcove</i> TM South Orange County soft opening	10/1/23
3) Grand Opening	1/15/24
4) All WPC and UCI staff hired, per funding proposal	1/31/24
5) Have signed agreements with organizations to provide services not covered by WPC or UCI staff	6/30/24
6) Establish full operations of youth served across service streams	8/1/24
7) Conduct equity and inclusion survey (compare to OC population data for LGBTQ+ and race-ethnicity) among youth who engage in services, determine if youth served match the population of OC, and adjust services accordingly	8/1/24
Service Outcomes:	
1) Report the number of CalOptima Health members served compared to overall youth served	
2) 60% of Case Management referrals to resources, within <i>allcove</i> TM and the community continuum of care, will be completed each service year	
3) Net Promoter Score across all service streams of at least 70%	
4) 75% of youth report satisfaction with services and increased hopefulness after attending a session.	
5) 50% reduction in score by treatment end among 80% of <i>allcove</i> TM clients and a 70% reduction in mental health symptoms (includes somatic symptoms, depression, anxiety, substance misuse, and others) among 40% of <i>allcove</i> TM clients using the DSM 5 Cross Cutting Scale.	
6) The number of professional trainings, peer support specialist training, graduate student internships, predoctoral and postdoctoral positions in process or completed	

Required Reporting Elements

Reporting Requirements
1) Estimated number of CalOptima Health members served
2) Total number of CalOptima Health members served in this project
3) Actual number of CalOptima Health members served this reporting period
4) How much progress has been made towards your outcomes/objectives? If progress was not made, please explain.
5) What kind of unexpected successes or challenges have you encountered during this reporting period? If you encountered challenges, how did they mitigate?

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2024

Regular Meeting of the CalOptima Health Board of Directors

Report Item

15. Authorize Amendment to the Wellness Prevention Foundation, dba Wellness & Prevention Center *allcove*TM South Orange County Mental Health Youth Center Grant Award Agreement

Contacts

Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Carmen Katsarov, LPCC, CCM, Executive Director, Behavioral Health Integration, (714) 796-6168

Recommended Actions

1. Authorize CalOptima Health's Chief Executive Officer to amend the grant award agreement with Wellness & Prevention Foundation, dba Wellness & Prevention Center, supporting the *allcove*TM South Orange County mental health youth center to:
 - a. Extend the end date to June 30, 2028, or until completion of the grant project, whichever occurs later; and
 - b. Amend the contract terms related to outcomes reporting, grant payments, and report submissions in light of the extended end date.

Background

The Mental Health Service Oversight and Accountability Commission (MHSOAC) requested applications to award \$2,000,000 to five separate *allcove*TM projects. In May 2020, MHSOAC announced it would award five projects across California. MHSOAC awarded a total of \$2,000,000 to the University of California, Irvine (UCI) and the Wellness & Prevention Foundation, dba Wellness & Prevention Center (WPC) for Orange County to launch the first *allcove*TM South Orange County (OC) mental health youth center. The state grant funding of \$2,000,000 left a shortfall of \$2,687,528.

The *allcove*TM center is driven by a Youth Advisory Group (YAG), composed of young people from the local community who represent diversity in race, ethnicity, gender, sexual orientation, lived experience, ability, and socioeconomic status. An *allcove*TM YAG's goal is to ensure that youth voices and experiences are included in the development and services of the center. The *allcove*TM model is anticipated to offer the following services for youth (ages 12-25) with mild-to-moderate needs: (1) mental health care, (2) physical health care, (3) substance misuse support, (4) youth peer and family support, and (5) supported education and employment.

On June 1, 2023, the CalOptima Health Board of Directors (Board) authorized a four-year grant agreement with WPC effective no earlier than June 1, 2023, to support the *allcove*TM South OC mental health youth center, and authorized up to \$2.7 million from existing reserves to fund the grant agreement.

Discussion

Initially, the grant agreement was for four years from Fiscal Year (FY) 2023-24 through FY 2026-27 to allow UCI and WPC to build and provide services in the *allcove*TM South OC center by June 30, 2024.

Unfortunately, real estate barriers occurred, significantly delaying the original timeline. The **allcove™** team had selected a location to lease back in February 2023, but the lease negotiations were stalled due to the sale of the building; the new owners decided not to offer a new lease. This delay initially placed WPC behind in achieving process outcomes for the grant objectives.

In April 2024, WPC informed CalOptima Health that it was close to announcing WPC had signed a lease for a property located in San Juan Capistrano. As such, CalOptima Health worked with WPC to draft an amendment to the grant agreement to address the following items:

- Extend the end date to June 30, 2028, or until completion of the grant project, whichever occurs later;
- Revise the due dates for the grantee to meet process outcomes;
- Due to the revised end date, amend grant payments from four (4) installments to five (5), adjust grant amounts due to more installments, and add provision that ties payments with submission of acceptable progress reports, final report and attestation; and
- Due to the revised end date, revise the report submission schedule from eight (8) reports to ten (10).

Attachment 1 provides additional information on the revised amounts allocated to each funding category (as provided by the grantee) and revised reporting due dates due to the extended term of the grant agreement. There are no revisions to the funding categories, process and service outcomes descriptions, reporting requirements outside of the due dates, or to the total appropriation of up to \$2.7 million authorized by the Board on June 1, 2023.

Staff will provide oversight of the grant agreement pursuant to CalOptima Health Policy AA.1400p: Grants Management and will return to the Board to provide updates on the status of the grant and additional recommendations, if necessary.

Fiscal Impact

The grant agreement is funded by a previous Board-approved allocation of up to \$2.7 million from existing reserves at the June 1, 2023, meeting. There is no additional fiscal impact.

Rationale for Recommendation

CalOptima Health staff recommend amending the grant agreement to support CalOptima Health's mission and vision for increased options and access to integrated mental health services for youth members in South OC.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Revised Grant Funding Description and Reporting Requirements with the Wellness & Prevention Center (WPC)
2. Previous Board Action Dated June 1, 2023 “Approve Actions Related to Wellness Preventions Foundation, dba Wellness Prevention Center *allcove*TM South Orange County Mental Health Youth Center”
3. CalOptima Health Grant Agreement Wellness & Prevention Foundation (Eff 07.02.23)
4. CalOptima Health Grant Agreement Wellness & Prevention Foundation (Eff 10.01.24)DRAFT
5. Entities Covered by this Recommended Action

/s/ Michael Hunn
Authorized Signature

08/29/2024
Date

Revised Grant Funding Description and Reporting Requirements with the Wellness & Prevention Center (WPC)

Revised WPC grant funding allocation for Fiscal Year 2023-24 through 2027-28

Funding Categories	Original Allocation	Revised Allocation
Personnel (<i>Year 1 – 1.5 FTE, Year 2 – 1.0 FTE, Year 3 – 3 FTE, Year 4 – 3.5FTE</i>) - Clinical Coordinator - Project Director Youth Coordinator/Peer Support Lead - youth outreach - Peer Support Specialist	\$1,177,050	\$833,668
Office/General Administrative includes the following: - Equipment maintenance - Staff Development/Training - Furniture maintenance and Rent - Building Improvement - Protected Health Information (PHI) / Electronic Health Records (EHR) maintenance	\$1,099,000	\$1,485,401
Youth Materials and Advisory Expenses	\$123,500	\$85,675
Indirect Management Overhead: HR, Insurance, Accounting	\$160,000	\$159,454
Miscellaneous / Unanticipated Changes (5%)	\$127,978	\$123,330
Total:	\$2,687,528	\$2,687,528

Revised Reporting Requirements

Process Outcomes	Original Due Date	Revised Due Date
1. Establish intake data collection	9/30/23	2/28/25
2. <i>allcove</i> TM South Orange County soft opening	10/1/23	5/1/25
3. Grand Opening	1/15/24	8/15/25
4. All WPC and UCI staff hired, per funding proposal	1/31/24	6/30/25
5. Have signed agreements with organizations to provide services not covered by WPC or UCI staff	6/30/24	6/30/25
6. Establish full operations of youth served across service streams	8/1/24	1/31/26
7. Conduct equity and inclusion survey (compare to OC population data for LGBTQ+ and race-ethnicity) among youth who engage in services, determine if youth served match the population of OC, and adjust services accordingly	8/1/24	9/30/26

Service Outcomes

- Report the number of CalOptima Health members served compared to overall youth served.
- 60% of Case Management referrals to resources, within *allcove*TM and the community continuum of care, will be completed each service year.
- Net Promoter Score across all service streams of at least 70%.
- 75% of youth report satisfaction with services and increased hopefulness after attending a session.

Service Outcomes

5. 50% reduction in score by treatment end among 80% of *allcove*TM clients and a 70% reduction in mental health symptoms (includes somatic symptoms, depression, anxiety, substance misuse, and others) among 40% of *allcove*TM clients using the DSM 5 Cross Cutting Scale.
6. The number of professional trainings, peer support specialist training, graduate student internships, predoctoral and postdoctoral positions in process or completed.

Reporting Requirements

1. Estimated number of CalOptima Health members served.
2. Total number of CalOptima Health members served in this project.
3. Actual number of CalOptima Health members served this reporting period
4. How much progress has been made towards your outcomes/objectives? If progress was not made, please explain.
5. What kind of unexpected successes or challenges have you encountered during this reporting period? If you encountered challenges, how did they mitigate?

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 1, 2023

Regular Meeting of the CalOptima Health Board of Directors

Report Item

21. Approve Actions Related to Wellness Prevention Foundation, dba Wellness & Prevention Center *allcove*TM South Orange County Mental Health Youth Center.

Contacts

Carmen Katsarov, LPCC, CCM, Executive Director, Behavioral Health Integration, (714) 796-6168
Richard Pitts, D.O., Ph.D., Chief Medical Officer, (714) 246-8491

Recommended Actions

1. Authorize CalOptima Health's Chief Executive Officer to develop and execute a grant agreement for a four-year term with the Wellness & Prevention Foundation, dba Wellness & Prevention Center (WPC), no earlier than July 1, 2023, to support the *allcove*TM South Orange County mental health youth center;
2. Authorize unbudgeted expenditures in an amount up to \$2.7 million from existing reserves to fund the grant agreement with WPC; and
3. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima Health's mission and purpose.

Background

There is a national mental health crisis. In particular, Orange County youth have been greatly impacted from the losses and impacts from COVID-19 as well as the impact of social media. According to the 28th Annual Report on the Conditions of Children in Orange County: (1) suicide is the second leading cause of death for Orange County (OC) 10-19-year-olds; (2) students are more likely to experience chronic sadness or hopeless feelings compared to 2011-2013, increasing 13.4% for 11th, 7.9% for 7th and 4.2% for 9th graders; and (3) in 2017-2019, an estimated 15% of 9th and 11th graders seriously considered attempting suicide in the previous year. This crisis is further aggravated by the mental health workforce shortage. It requires new thinking and approaches to overcome this crisis.

The Mental Health Service Oversight and Accountability Commission (MHSOAC) issued a request for applications to award \$2,000,000 to five separate *allcove*TM projects. In May 2020, MHSOAC announced that grants would be awarded to five projects across California, including two projects in Los Angeles County, and one project in each of San Mateo County, Sacramento County, and Orange County. The Stanford Center for Youth Mental Health and Wellbeing team that created an *allcove*TM model was awarded the technical assistance (TA) contract establishing the Stanford Central *allcove*TM Team (CAT). For Orange County, the University of California, Irvine (UCI) and the WPC responded to the competitive request for applications and received \$2,000,000 in funding to help launch the first *allcove*TM South Orange County (South OC) mental health youth center.

The *allcove*TM model offers an integrated and holistic approach for the delivery of services for youth (ages 12-25) with mild-to-moderate needs. The core service streams of *allcove*TM include mental health care, physical health care, substance misuse support, youth peer and family support, and supported

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Discussion

CalOptima Health members, providers, and the Orange County Health Care Agency (OCHCA) continue to report a need for more mental health services in South OC. Granting the development of the first *allcove™* South OC mental health youth center would benefit and address the need for CalOptima Health's Medi-Cal youth beneficiaries in South OC. The mental health youth center can apply the whole-person care approach to Medi-Cal youth beneficiaries. The state grant funding of \$2,000,000 leaves a shortfall of \$2,687,528. CalOptima Health staff requests that the Board approve \$2,687,528 to fund the first *allcove™* South OC mental health youth center for four years from fiscal year 2023-24 through fiscal year 2026-27. This time will allow UCI and WPC to develop a sustainable model and serve as future technical advisors for other community partners to develop and launch additional *allcove™* sites.

Staff will monitor and provide oversight of the grant funds following CalOptima Health Policy AA.1400p: Grant Management, which was approved during the CalOptima Health Board of Directors meeting on May 4, 2023. CalOptima Health will monitor and require *allcove™* to submit a quarterly project summary tied to measurable metrics. The list of metrics is located in Exhibit 1 - Required Reporting Elements.

CalOptima Health will also require progress reporting for activities related to sustainability quarterly for items #1-4 below. If during the time of the grant any services are able to move from grant money to billable services, funding will be adjusted to ensure no duplication:

- 1) By December 31, 2024, contract with and establish billing with CalOptima Health for any applicable CalAIM services.
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- 3) By June 30, 2026, establish other billing procedures with private health insurance.
- 4) Exploring additional streams for sustainability, including workforce enhancement training through UCI and Orange County Healthcare Agency Mental Health Services Act Prevention and Early Intervention funding.

Fiscal Impact

The recommended actions related to this grant are separate from the normal operating budget process. An appropriation of up to \$2.7 million from existing reserves will fund the four-year grant agreement from July 1, 2023, through June 30, 2027.

Rationale for Recommendation

CalOptima Health staff recommend proceeding with this action to support CalOptima Health's mission and vision for increased options and access for integrated mental health services for youth members in South OC.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. [Entities Covered by this Recommended Action](#)
2. [Exhibit 1](#)

/s/ Michael Hunn
Authorized Signature

05/26/2023
Date

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Wellness & Prevention Foundation dba Wellness & Prevention Center	700 Avenida Pico	San Clemente	CA	92673

Exhibit 1

Grant Funding Breakdown:

UCI and WPC awarded MHSOAC State Grant Funding - \$2,000,000 lasts through June 2026

Funding Categories	Estimated Amount
Personnel (6.1 FTEs) • Operating Agency ED • UCI - Dr. Stephen Schueller • Site Manager • Youth Outreach Specialist • Reception/Administrative Assistant • Clinical Psychology Postdoc • Mental Health Clinician PhD Trainee	\$1,405,557
Pre-opening Office/General Administrative Costs • Furniture • Building improvements • Equipment • Travel • Rent ½ year	\$413,360
UC Facilities and Administrative (F&A) Indirect Rate (10%)	\$181,083
Total:	\$2,000,000

CalOptima Health Non-MHSOAC Grant Funding: Fiscal Years 2023-24 through 2026-2027

Funding Categories	Estimated Amount
Personnel (3.25 FTEs in Yr. 1; 4 FTEs after) • Clinical Coordinator • Project Director Youth Coordinator/Peer Support Lead - youth outreach • Peer Support Specialist • Supported Education and Employment Specialist	1,177,050
Office/General Administrative includes the following: • Equipment maintenance • Staff Development/Training • Furniture maintenance and Rent • Building Improvement • Protective Health Information (PHI) / Electronic Health Records (EHR) maintenance	\$1,099,000
Youth Materials and Advisory Expenses	\$123,500
Indirect Management Overhead: • HR, Insurance, Accounting	\$160,000
Misc / Unanticipated Changes (5%)	\$127,978
Total:	\$2,687,528

Exhibit 1

Outcomes and Services

Process Outcomes:	Expected Due Date
1) Establish intake data collection	9/30/23
2) <i>allcove</i> TM South Orange County soft opening	10/1/23
3) Grand Opening	1/15/24
4) All WPC and UCI staff hired, per funding proposal	1/31/24
5) Have signed agreements with organizations to provide services not covered by WPC or UCI staff	6/30/24
6) Establish full operations of youth served across service streams	8/1/24
7) Conduct equity and inclusion survey (compare to OC population data for LGBTQ+ and race-ethnicity) among youth who engage in services, determine if youth served match the population of OC, and adjust services accordingly	8/1/24
Service Outcomes:	
1) Report the number of CalOptima Health members served compared to overall youth served	
2) 60% of Case Management referrals to resources, within <i>allcove</i> TM and the community continuum of care, will be completed each service year	
3) Net Promoter Score across all service streams of at least 70%	
4) 75% of youth report satisfaction with services and increased hopefulness after attending a session.	
5) 50% reduction in score by treatment end among 80% of <i>allcove</i> TM clients and a 70% reduction in mental health symptoms (includes somatic symptoms, depression, anxiety, substance misuse, and others) among 40% of <i>allcove</i> TM clients using the DSM 5 Cross Cutting Scale.	
6) The number of professional trainings, peer support specialist training, graduate student internships, predoctoral and postdoctoral positions in process or completed	

Required Reporting Elements

Reporting Requirements
1) Estimated number of CalOptima Health members served
2) Total number of CalOptima Health members served in this project
3) Actual number of CalOptima Health members served this reporting period
4) How much progress has been made towards your outcomes/objectives? If progress was not made, please explain.
5) What kind of unexpected successes or challenges have you encountered during this reporting period? If you encountered challenges, how did they mitigate?

GRANT AWARD AGREEMENT
BETWEEN
CALOPTIMA HEALTH
AND
WELLNESS & PREVENTION FOUNDATION, DBA WELLNESS & PREVENTION CENTER

THIS GRANT AWARD AGREEMENT (“**Agreement**”) is made and entered into as of July 1, 2023 (“**Effective Date**”), by and between Orange County Health Authority, a county organized health system for the County of Orange, California dba CalOptima Health (“**CalOptima**”), and Wellness & Prevention Foundation, dba Wellness & Prevention Center (“**Grantee**”), a California 501(c)(3) nonprofit corporation. CalOptima and Grantee may each be referred to herein as a “**Party**” and collectively as the “**Parties**”.

RECITALS

A. CalOptima is a public agency formed pursuant to California Welfare and Institutions Code Section 14087.54 and Orange County Ordinance No. 3896, as amended.

B. CalOptima’s mission is to serve member health with excellence and dignity, respecting the value and needs of each person.

C. CalOptima Health has designated certain Board-approved funds to fund the *allcove*™ South Orange County (South OC) mental health youth center project.

D. Grantee desires to address the youth mental health crisis in South Orange County by supporting the administrative and clinical operations of *allcove*™ South Orange County, in accordance with Grantee’s grant proposal described in Attachment A (“**Grant Project**”).

E. CalOptima finds that the Grant Project is a community program that supports and is compatible with CalOptima’s mission and desires to assist Grantee in undertaking its project by providing financial support described in Attachment B (“**Grant Award**”) in accordance with CalOptima’s policies and procedures, subject to Grantee’s compliance with the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, it is agreed by and between the Parties hereto as follows:

I. GRANTEE OBLIGATIONS

1.1 **Grantee Eligibility**. Grantee hereby warrants that it is, and shall remain throughout the term of this agreement, a local public entity.

1.2 **Grantee Activities**. Grantee agrees (i) to diligently pursue the Grant Project, as specified in Attachment A, attached hereto and incorporated herein by this reference, (ii) to use the Grant Award solely for activities as identified in Attachment A, (“**Grant Activities**”), (iii) to expend funds in accordance with this Agreement and all federal, state, and local statutes and regulations, and

(iv) to return any grant funds determined to have been improperly paid, in order to avoid forfeiture of the entire Grant Award. In the event of any conflict between the Grant Project in Attachment A and the rest of this Agreement, this Agreement, including all Attachments, shall prevail.

1.3 **Unauthorized Use of Funds.** Grantee shall use Grant Funds consistent with this Agreement and the approved Grant Activities. CalOptima retains the right to recover any and all Grant Award funds if it (or any of its regulators) determines that any portion of the Grant Award was not expended as provided under the terms of this Agreement or applicable federal and state laws, regulations, guidance and/or funding source requirements.

1.4 **Limitations on Subcontracting.** The experience, knowledge, capability, and reputation of Grantee, its directors and employees were a substantial inducement for CalOptima to enter into this Agreement. Except as provided herein, Grantee shall not contract with any entity to perform the Grant Project without written approval of CalOptima. Grantee shall be fully responsible to CalOptima for the acts and omissions of its subcontractor(s), if any, as it is for the acts and omissions of persons directly employed by Grantee. In the event that CalOptima approves any subcontracting, nothing contained in this Agreement shall create any contractual relationship between any subcontractor(s) and CalOptima. All persons engaged in the work under the Grant Project by Grantee will be considered employees of Grantee. CalOptima will deal directly with and make payment hereunder solely to Grantee.

1.5 **Subcontracts.** To the extent that subcontracting is authorized by CalOptima under this Agreement, Grantee shall assure that all subcontracts are in writing and include any requirements of this Agreement that are appropriate to the service or activity and assure that the subcontract shall not terminate legal liability of Grantee under this Agreement.

1.6 **Communications Provisions.** Grantee must comply with CalOptima's Guidelines for Endorsements and Use of CalOptima Name or Logo policy.

1.6.1 **Use of CalOptima name or logo:** Grantee shall submit requests to CalOptima's Behavioral Health Integration department, in writing, at least twenty-one (21) calendar days in advance of the date for which use of the name or logo is required. Upon receipt of a complete request for use of the CalOptima name or logo, CalOptima's Behavioral Health Integration department shall review and analyze the request with input from appropriate internal departments. For more information, or to submit a request, send email to: behavioralhealth@caloptima.org. The Behavioral Health Integration department shall submit a request for use of the CalOptima name or logo to the CEO for review and consideration and will notify Grantee in writing after a determination has been made.

1.6.2 **All other uses of CalOptima's name:** Grantees may not use CalOptima's name, including in the title of Grantee's program, without prior written approval from CalOptima.

II. GRANT PAYMENTS

2.1 **Grant Payments.** Payment of the Grant Award to Grantee under this Agreement will be as set forth in Attachment B, incorporated herein by this reference, which shall be payment in full for the Grant Project. Grantee acknowledges and agrees that this is a single Grant Award and that nothing herein obligates CalOptima to any further funding, whether for the Grant Project or future related or unrelated activities. The Parties acknowledge that the source of Grant Award funding is existing reserve funds, and not Department of Health Care Services ("DHCS") funds, and as such the payments made hereunder are not subject to DHCS State Contract terms or federal or state claims processing requirements.

2.2 **Grant Award Use Limitations.** Grantee acknowledges and agrees that the Grant Award may not be used for achievement of milestones that have been previously paid for or will be paid for by the state or federal government or any other source. Further, Grantee acknowledges and agrees that it will not use the Grant Award to reimburse costs or liabilities it incurred prior to the date of the Grant Award.

III. WARRANTIES/COMPLIANCE WITH CALOPTIMA AND REGULATORY AGENCY RULES AND REGULATIONS

3.1 **Compliance with Applicable Laws.** In carrying out the Grant Project, Grantee shall comply with the CalOptima policies and procedures, and all other applicable CalOptima policies, as made available to Grantee on CalOptima website, as well as all federal, state and local laws, rules, and regulations.

3.2 Health Insurance Portability and Accountability Act (HIPAA) Compliance

3.2.1 Grantee and CalOptima shall comply with Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act and any regulations promulgated thereunder ("HIPAA Requirements") in performing their obligations under the Agreement.

3.2.2 If required by HIPAA Requirements, the Parties agree to execute CalOptima Health's HIPAA Business Associate Agreement, which shall be incorporated into this Agreement, and comply with the terms and conditions thereof.

3.3 Confidentiality of Information

3.3.1 Grantee and its employees, agents, and subcontractors shall protect from unauthorized disclosure the names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to Grantee, its employees, agents, or subcontractors as a result of this Agreement. Grantee and its employees, agents, and subcontractors shall not use such identifying information for any purpose other than carrying out Grantee's obligations under this Agreement. Grantee and its employees, agents, and subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. Grantee shall not disclose, except as otherwise specifically permitted by this Agreement or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. For purposes of this provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, including without limitation a finger or voice print or a photograph.

3.3.2 Notwithstanding any other provision of this Agreement, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 C.F.R. Section 431.300 *et seq.*, Welfare and Institutions Code Section 14100.2, and any regulations adopted thereunder. For the purpose of this Agreement, all information, records, data, and data elements collected and maintained for the operation of the Agreement and pertaining to Members shall be protected by Grantee from unauthorized disclosure. Grantee may release Member medical records in accordance with applicable law pertaining to the release of this type of information. Grantee is not required to report requests for medical records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Agreement that is obtained by Grantee, its employees, agents or subcontractors,

Grantee:

(a) Will not use any such information for any purpose other than carrying out the express terms of this Agreement,

(b) Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for medical records in accordance with applicable law,

(c) Will not disclose except as otherwise specifically permitted by this Agreement, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 C.F.R. Section 431.300 *et seq.*, Welfare and Institutions Code Section 14100.2, and regulations adopted there under, and

(d) Will, at the termination of this Agreement, return all such information to CalOptima or maintain such information according to written procedures sent to the Grantee by CalOptima for this purpose.

IV. RECORDS AND REPORTS

4.1 **Maintain Complete Books and Records.** Grantee shall create and maintain such books and records relating to the Grant Activities performed under this Agreement as required by applicable laws and CalOptima policies and procedures. All financial records shall be maintained in accordance with generally accepted accounting principles ("GAAP"). Records generated in the course of carrying out this Agreement shall be maintained for ten (10) years from the date of the grant award, or the date of the completion of any audits related to this Agreement, whichever is later. Grantee shall provide CalOptima or its designated agents, within ten (10) calendar days of a written request, information or copies of records necessary to verify and substantiate compliance with the terms of this Agreement. Grantee shall pay all duplication and postage costs associated with any audits and/or reviews necessary to ensure compliance with this Agreement or CalOptima's regulatory requirements. This Section 4.1 shall survive the termination of this Agreement.

4.2 **Reports.** Grantee shall submit all reports as specified in Attachment C, "Grant Report Schedule," attached hereto and incorporated herein by this reference.

4.3 **Audit.** CalOptima shall have the right to audit, or to have audited by an independent third party, all Grant Project expenses. Grantee shall fully cooperate with CalOptima or its auditor and shall refund to CalOptima any amounts found to have been improperly expended from the Grant Award within thirty (30) days of the notice of such improper expenditures. Grantee shall be entitled to challenge any audit finding through appealing through CalOptima's grievance process.

V. INSURANCE AND INDEMNIFICATION

5.1 **Grantee Comprehensive General Liability ("CGL")/Automobile Liability.** Grantee at its sole cost and expense shall maintain such policies of comprehensive general liability and automobile liability insurance and other insurance as shall be necessary to insure it and its business addresses, customers, employees, agents, and representatives against any claim or claims for damages arising by reason of (a) personal injuries or death occasioned in connection with the carrying out the project, (b) the use of any property of the Grantee, and (c) Grant Activities performed in connection with the Agreement, with minimum coverage of one million dollars (\$1,000,000) per incident/two million dollars (\$2,000,000) aggregate per year.

5.2 **Workers Compensation Insurance.** Grantee at its sole cost and expense shall maintain workers compensation insurance within the limits established and required by the State of California and employer's liability insurance with minimum limits of liability of one million dollars (\$1,000,000) per occurrence/one million dollars (\$1,000,000) aggregate per year.

5.3 **Insurer Ratings.** Insurance required under this Agreement shall be provided by an insurer:

- (a) Rated by Best's Guide Rating with a rating of B or better; and
- (b) 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 Section 12180.7.

5.4 **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.

5.5 **Cancellation or Material Change.** The Grantee shall not of its own initiative cause such insurances as addressed in this Article to be canceled or materially changed during the term of this Agreement without prior notification to CalOptima.

5.6 **Certificates of Insurance.** Prior to execution of this Agreement, Grantee shall provide Certificates of Insurance and additional insured endorsements to CalOptima showing the required insurance coverage and further 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 Grantee's coverage is primary and non-contributory as to any other insurance with respect to performance hereunder.

5.7 **Indemnification.** Grantee shall defend, indemnify and hold harmless CalOptima and its officers, directors, and employees from and against any and all claims (including attorneys' fees and reasonable expenses for litigation or settlement) that are related to or arise out of the Grantee's negligence, willfull performance or non-performance or breach of any duties or obligations of Grantee arising under this Agreement. Neither termination of this Agreement nor completion of the acts to be performed under this Agreement shall release Grantee 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.

5.8 **Notification of Claims.** CalOptima agrees to promptly notify Grantee of any claims or demands which arise and for which indemnification or Grantee's duty to defend hereunder is sought.

5.9 **Termination.** The terms of this Article V. shall survive the termination of this Agreement.

VI. TERM AND TERMINATION

6.1 **Term of Agreement.** This Agreement will commence on the Effective Date and will remain in effect up to and including June 30, 2027, or completion of the Grant Project, whichever occurs last.

6.2 **Termination.** If Grantee fails to fulfill any of its duties and obligations under this Agreement, including but not limited to: (i) committing acts of unlawful discrimination; (ii) engaging in prohibited marketing activities; and, (iii) committing fraud or abuse relating to any obligation, duty or responsibility under this Agreement (such as falsifying data in any reports or paying for services to non-Medi-Cal Member out of grant funds, etc.), CalOptima may terminate this Agreement for cause pursuant to Section 6.3.

6.3 **Termination for Cause.** Notwithstanding and in addition to any other provisions of this Agreement, CalOptima may terminate this Agreement for cause effective upon thirty (30) calendar days' prior written notice. Cause shall include, but shall not be limited to, the actions set forth in Section 6.2. Grantee may appeal CalOptima's decision to terminate the Agreement for cause by filing a complaint pursuant to CalOptima policies and procedures. Grantee shall exhaust this administrative remedy, including requesting a hearing if permitted under CalOptima policies and procedures, for any and all Grantee complaints before commencing any civil action.

CalOptima's rights and remedies provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or this Agreement.

6.4 **Automatic Termination.** This Agreement shall terminate automatically if the DHCS State Contract between CalOptima and DHCS is terminated.

6.5 **Bankruptcy.** CalOptima or Grantee may terminate this Agreement with thirty (30) day written notice to the other Party in the event (i) a petition is filed in a court of record jurisdiction to declare either Party bankrupt or for reorganization under the bankruptcy laws of the United States or any similar statute of a state of the United States, or (ii) if a trustee in bankruptcy or a receiver is appointed for such Party, and such petition, trustee, or receiver, as the case may be, is not dismissed within one hundred and twenty (120) days thereof.

VII. GENERAL PROVISIONS

7.1 **Interpretation of Agreement Language.** CalOptima has the right to final interpretation of the Agreement language when disputes arise. Grantee has the right to appeal disputes concerning Agreement language to CalOptima.

7.2 **Waiver.** Any failure of a Party to insist upon strict compliance with any provision of this Agreement shall not be deemed a waiver of such provision or any other provision of this Agreement. To be effective, a waiver must be in writing that is signed and dated by the Parties.

7.3 **Assignment.** Neither this Agreement nor any of the duties delegated herein shall be assigned, delegated or transferred by Grantee without the prior written consent of CalOptima. CalOptima may assign this Agreement and its rights, interests and benefits hereunder to any entity that has at least majority control of CalOptima or to any entity whose financial solvency has been approved by Grantee, which approval shall not be unreasonably withheld. If required, any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the appropriate state and federal agencies.

7.4 **Independent Parties.** Grantee acknowledges that it is, at all times during the term of this Agreement, acting as an independent contractor under this Agreement and is not as an agent, employee, or partner of CalOptima. Grantee agrees to be solely responsible for all matters relating to compensation of its employees, including, but not limited to, compliance with laws governing workers' compensation, Social Security, withholding and payment of any and all federal, state and local personal income taxes, disability insurance, unemployment, and any other taxes for such persons, including any related employer assessment or contributions required by law, and all other regulations governing such matters, and the payment of all salary, vacation and other employee benefits. At Grantee's expense as described herein, Grantee agrees to defend, indemnify, and hold harmless CalOptima, its directors, executives, officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of Grantee's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "**Employment Claim(s)**"). Grantee shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

7.5 **Integration of Entire Agreement.** This Agreement contains all of the terms and conditions agreed upon by the Parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations, or representations of or between the Parties, either oral or written, relating to the subject matter of this Agreement that are not expressly set forth in this Agreement are null and void and of no further force or effect. All attachments to this Agreement are considered part of this Agreement and are hereby incorporated herein.

7.6 **Independent Agreement.** Nothing in this Agreement shall affect any other contractual relationships between the Parties, such as an agreement for the provision of medical services to Members. No monies paid under this Agreement may be used for the provision of services that are payable under a different contract between the Parties, or for any other purpose beyond the Grant Project as set forth in Attachment A.

7.7 **Invalidity or Unenforceability.** The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other term or provision.

7.8 **Amendment.** CalOptima may amend this Agreement immediately upon written notice to Grantee in the event such amendment is required in order to maintain compliance with applicable state or federal laws. Other amendments to the Agreement shall be effective only upon mutual, written agreement of the Parties.

7.9 **No Waiver of Immunity or Privilege.** 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.

7.10 **Choice of Law.** This Agreement shall be governed by and construed in accordance with the laws of the State of California. The Parties consent to the jurisdiction of the California Courts with venue in Orange County, California.

7.11 **Force Majeure.** Both Parties shall be excused from performance hereunder for any period that they are prevented from meeting the terms of this Agreement as a result of a catastrophic occurrence or natural disaster, including, but not limited to, an act of war, but excluding labor disputes, (a "Force Majeure Event") provided such Party uses commercially reasonable efforts to mitigate its effects and gives prompt written notice to the other Party. The time for the performance shall be extended for the period of delay or inability to perform due to such occurrences up to a period of ten (10) days at which time the Party unaffected by the Force Majeure Event may immediately terminate this Agreement upon written notice to the other Party without liability.

7.12 **Interpretation.** Each Party has had the opportunity to have counsel of its choice examine the provisions of this Agreement, and no implication shall be drawn against any Party by virtue of the drafting of this Agreement.

7.13 **Headings.** The article and section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

7.14 **No Liability of County of Orange.** As required under Ordinance No. 3896, as amended, of the County of Orange, State of California, CalOptima and the Grantee hereby acknowledge and agree that the obligations of CalOptima under this Agreement are solely the obligations of CalOptima, and that the County of Orange, State of California, shall have no obligation or liability therefor.

7.15 **Non-liability of Officials and Employees of CalOptima.** No official or employee of CalOptima shall be personally liable to Grantee in the event of any default or breach by CalOptima, or for any amount that may become due to Grantee, or any obligation under the terms of this Agreement.

7.16 **Time of Essence.** Time is of the essence in the performance of this Agreement.

7.17 **Authority to Execute.** The persons executing this Agreement on behalf of the Parties warrant that they are duly authorized to execute this Agreement, and that by executing this Agreement, the Parties are formally bound.

7.18 **Counterparts.** This Agreement 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.

7.19 **Notices.** All notices shall be in writing and shall be deemed to have been duly given on the date of service if personally served on the Party to whom notice is given, or seventy-two (72) hours after mailing by United States mail first class, Certified Mail or Registered Mail, return-receipt-requested, postage-prepaid, addressed to the party to whom notice is to be given and such Party's address as set forth below or such other address provided by notice.

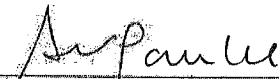
To: CalOptima Health
C/O: Contracting Department- Grant Agreements
505 City Parkway West
Orange, CA 92868

To: Grantee
Wellness & Prevention Center
ATTN: Susan Parmelee, Executive Director
700 Avenida Pico
San Clemente, CA 92673
Email: susan@wpc-oc.org

VIII: SIGNATURES

IN WITNESS WHEREOF, the Parties have, by their duly authorized representatives, executed this Agreement, to be effective the date first written above:

FOR GRANTEE:



SIGNATURE

Susan Parmelee

PRINT NAME

Executive Director

TITLE

June, 28, 2023

DATE

FOR CALOPTIMA:


Yunkyung Kim (Jun 29, 2023 18:11 PDT)

SIGNATURE

Yunkyung Kim

PRINT NAME

Chief Operating Officer

TITLE

Jun 29, 2023

DATE

ATTACHMENT A

Grant Project

A. Executive Summary

We are in the midst of a youth mental health crisis. Over the last decade, depression, anxiety, feelings of hopelessness and loneliness, mental health emergency visits, and suicide attempts and deaths have increased dramatically among American youth. In particular, young girls, racial and ethnic minorities, and LGBTQ+ youth are exhibiting some of the most rapid increases in serious mental health problems. An urgent, equitable, and evidence-based response is needed to address this rapid increase.

This crisis will not be addressed through traditional service delivery streams alone. Instead, we need new models of care that center youth, their needs, and the way they want to engage with care at their core. In California, the Mental Health Service Oversight and Accountability Commission (MHSOAC) has regularly funded projects through the Mental Health Service Act (MHSA) innovation funding to explore new opportunities, but we need impactful and sustainable service streams that meet the needs of youth.

B. Background

The Budget Act of 2019 provided the MHSOAC \$14,589,000 to support the establishment of *allcove* youth drop-in centers which provide mental health and wellness services for youth between 12-25 years of age. The *allcove* model was developed by the Stanford Center for Youth Mental Health and Wellbeing led by Dr. Steven Adelsheim. These centers are designed to meet the mild-to-moderate needs of youth, including mental and behavioral health needs, housing, education, and employment support, and linkage to other services. The Budget Act called for a focus on vulnerable and marginalized youth and populations of youth with known disparities, e.g., Black, Indigenous, and People of Color (BIPOC) youth, LGBTQ+ youth, and youth experiencing homelessness.

In January 2020, the MHSOAC allocated \$10,000,000 to directly fund grants to expand the *allcove* model across California and \$4,589,000 to provide a technical assistance (TA) contractor to support the grantees, ensure program quality, and assist the expansion of *allcove* across the state. A request for applications was issued to award \$2,000,000 to five separate *allcove* projects. In May 2020, the MHSOAC announced that grants would be awarded to five projects across California including Los Angeles County (2), San Mateo County, Sacramento County, and Orange County. The Orange County project was spearheaded by a partnership between the University of California, Irvine (UCI) and the Wellness and Prevention Center (WPC). The Stanford Center for Youth Mental Health and Wellbeing team that created the *allcove* model was awarded the TA contract establishing the Stanford Central *allcove* Team (CAT). Grant contracts were executed between the various *allcove* grantees and the MHSOAC in late 2021 to early 2022 with UCI and the WPC executing their contract in October 2021. MHSOAC funding is intended to establish and operate an *allcove* center in Orange County with fidelity to the *allcove model*. The initial MHSOAC funding lasts through June 2026 providing the centers several years to set up sustainable funding and service streams.

B.1. The *allcove* model. *allcove* offers an integrated and holistic approach for the delivery of services for youth (ages 12-25) with mild-to-moderate needs. The core service streams of *allcove* include: mental health care, physical health care, substance misuse support, youth peer and family support, and supported education and employment.

allcove aims to provide timely and easy access to mental health services within an integrated, prevention and early intervention model of care. By co-locating and integrating medical health care with mental health and substance misuse services at *allcove* centers youth can seamlessly access the necessary support easily, even when symptoms first appear through somatic issues or physical complaints. In addition, by providing

access to both physical health services and mental health services at the same site, the stigma of going to a site for mental health treatment is decreased and the comfort level for youth in accessing on site mental health intervention is improved.

allcove physical health care services are not intended to replace or displace other community-based physical health care, but rather open up enhanced access through a “no-wrong door approach”, allowing *allcove* physical health services providers to interface with the youth’s physical health services health home and other relevant providers of healthcare.

Overarching practice principles of the *allcove* services approach including:

- **Youth-centered care.** The *allcove* model recognizes the youth are experts in their own care and address youth needs through services that are co-designed with youth. *allcove* services are holistic and strengths-based including developmentally-appropriate interventions that are socially and culturally inclusive.
- **Prevention, screening, and early intervention.** *allcove* services attempt to reach youth early with *allcove* centers actively working with the community to build youth resilience, increase early helping seeking, reduce stigma, and increase mental health literacy. *allcove* centers support linkages to care through active partnerships with community-based services. Many of these partnerships include locating services within *allcove* centers for seamless referrals and continuity of care.
- **Rapid, easy, and affordable access.** *allcove* centers provide a wide variety of services for youth ages 12 to 25. *allcove* services are organized around drop-in models, providing care whenever possible when youth show up. *allcove* centers are intended to be located in areas where youth naturally congregate, are accessible by public transportation, and follow a youth-friendly environmental design.
- **Holistic and integrated care.** *allcove* centers provide co-location of core service streams and are staffed by multidisciplinary care teams. The leverage appropriate and responsive service delivery models include brief and single-session interventions and technology-enabled care services.

B.2. Overview of *allcove* South Orange County. *allcove* South Orange is a partnership between the UCI and the WPC. The goal of this partnership is to bring multiple *allcove* youth drop-in centers to Orange County by creating a robust and sustainable infrastructure of service delivery, training, and community partnerships. The near-term goal is to establish and open an *allcove* center in South Orange County (current target San Juan Capistrano or Mission Viejo). This partnership is supported by \$2,000,000 funding from the MHSOAC for a funding period of October 2021 through June 2026. This funding is providing administrative support to open the center, funding for initial facility upgrades and rent, and some of the initial clinical operations. Key components of our *allcove* South Orange County team are our leadership team, youth advisory groups (YAGs), and Community Consortium. The planned hours of operation for *allcove* will be Tuesday through Friday 11AM-7PM, Saturday 10AM-4PM. Total service hours will be 88 hours per week. Services aim to treat mild-to-moderate conditions, with some instances of more severe conditions while attempting to connect to a higher level of care.

C. Scope of Work

We are requesting funding from CalOptima from July 2023 to June 2027 to support the administrative and clinical operations of *allcove* South Orange County. This funding will supplement the MHSOAC funding to support establishment of the full clinical operations and prepare *allcove* South Orange County to create service streams that will be sustainable. The long-term sustainability of the center will be supported through a mix of billable services, workforce development and training funding, and county and state funding.

Our request for CalOptima funding will support 7.5 FTE positions. These positions will support delivery of services in the *allcove* integrated delivery model including mental health care, physical health care, substance misuse support, youth peer and family support, and supported education and employment. Positions include 1.0 Clinical Coordinator, 1.5 Clinical Psychology Postdoctoral Fellows, 1.0 Mental

Health Clinician, 1.0 Youth Coordinator/Peer Support Lead, 2.0 Peer Support Specialists, and 1 Supported Education and Employment Specialists. These staff will be trained in the *allcove* model and attend relevant learning community development opportunities provided through the Stanford CAT. Because we intend funding Year 1 will be at reduced service capacity as we slowly open to anticipate service needs staffing for all positions are at 75% in Year 1 with the exception of postdoctoral fellow trainees which will have to be recruited to follow typical recruiting calendars for these positions. The postdoctoral fellows will spend additional time in training for the *allcove* model as service needs expand.

Although we are requesting funding to support these positions in that can potentially be funded in the future through other funding sources. These funding sources will be explored during FY1 of the project. These sources include:

- Workforce Enhancement Training funding through UCI - Psychology Postdoctoral Positions, Psychiatric Nurse Practitioners, Medical Nurse Practitioners, and others.
- CalAIM funding - potential to support Peer Support Specialists and Career and Academic Support
- Orange County Healthcare Agency MHSA Prevention and Early Intervention Funding - potential to fund Youth Outreach, administration roles, and Peer Support.

D. Grant Objectives:

Process Outcomes:	Expected Due Date
1) Establish intake data collection	9/30/23
2) <i>allcove</i> ™ South Orange County soft opening	10/1/23
3) Grand Opening	1/15/24
4) All WPC and UCI staff hired, per funding proposal	1/31/24
5) Have signed agreements with organizations to provide services not covered by WPC or UCI staff	6/30/24
6) Establish full operations of youth served across service streams	8/1/24
7) Conduct equity and inclusion survey (compare to OC population data for LGBTQ+ and race-ethnicity) among youth who engage in services, determine if youth served match the population of OC, and adjust services accordingly	8/1/24
Service Outcomes:	
1) Report the number of CalOptima Health members served compared to overall youth served	
2) 60% of Case Management referrals to resources, within <i>allcove</i> ™ and the community continuum of care, will be completed each service year	
3) Net Promoter Score across all service streams of at least 70%	
4) 75% of youth report satisfaction with services and increased hopefulness after attending a session.	
5) 50% reduction in score by treatment end among 80% of <i>allcove</i> ™ clients and a 70% reduction in mental health symptoms (includes somatic symptoms, depression, anxiety, substance misuse, and others) among 40% of <i>allcove</i> ™ clients using the DSM 5 Cross Cutting Scale.	
6) The number of professional trainings, peer support specialist training, graduate student internships, predoctoral and postdoctoral positions in process or completed	

ATTACHMENT B

GRANT PAYMENT

CalOptima has made a Grant Award to Grantee in the amount of up to two million seven hundred thousand dollars (\$2,700,000), which shall be the maximum amount payable for the Grant Project and which shall be paid following execution of the Agreement in the time and manner set forth below.

Payments: Payments under this Agreement shall be made in four (4) installments. The first payment shall be made following execution of this Agreement, with the subsequent three payments made annually in the month of July for each year of the grant project.

Payment #1 (Y1)- July 2023: up to \$617,253

Payment #2 (Y2)- July 2024: up to \$690,092

Payment #3 (Y3)- July 2025: up to \$690,092

Payment #4 (Y4)- July 2026: up to \$690,092

All payments following the initial grant payment are contingent upon CalOptima's receipt and approval of progress reports and/or final report which are due as condition of that payment. Such reports must be acceptable to CalOptima and demonstrate progress toward Grant Activities over the project timeline, as provided in Section 4.2 and 4.3 of the Agreement. CalOptima may delay or withhold grant payments at its sole discretion if such reports are not submitted timely or as otherwise required or CalOptima is not satisfied with any submitted reports or Grantee's progress on project objectives.

Return Funds: Grantee shall refund to CalOptima any funds that are found to not have been utilized in accordance with the requirements of this Agreement. CalOptima shall have the right to audit, or to have audited by an independent third party, all Grant Project expenses. Grantee shall fully cooperate with CalOptima or its auditor and shall refund to CalOptima any amounts found to have been improperly expended from the Grant Award within thirty (30) days of the notice of such improper expenditures.

ATTACHMENT C

PROGRESS REPORT SCHEDULE

Purpose of Grant Reports

In an effort to help ensure successful grant outcomes, CalOptima actively monitors and evaluates grant progress and requires that grantees submit semi-annual progress reports as well as a final report. These reports are intended to help both CalOptima and grantee appraise progress toward funding objectives.

Grant Report Requirements

All grant recipients must complete the Grant Report Form provided through written communication with CalOptima's Behavioral Health Integration department. Please note that successful completion of reports are a condition of grant funding and incomplete reports will delay the disbursement of future grant payments.

Reporting Requirements

- 1) Estimated number of CalOptima Health members served.
- 2) Total number of CalOptima Health members served in this project.
- 3) Actual number of CalOptima Health members served this reporting period.
- 4) How much progress has been made towards your outcomes/objectives? If progress was not made, please explain.
- 5) What kind of unexpected successes or challenges have you encountered during this reporting period? If you encountered challenges, how did they mitigate?

Report Submission Schedule

This grant requires the submission of eight (8) reports over the duration of the project timeframe (i.e. July 1, 2023 – June 30, 2027) as follows:

- **Semi-Annual Progress Report** will be due within thirty (30) calendar days after the end of each reporting period.
 - Specific due dates and Reporting Periods Covered:
 - Report #1- Due by 1/31/2024 for Reporting Period 07/01/2023-12/31/2023.
 - Report #2- Due by 7/31/2024 for Reporting Period 01/01/2024-06/30/2024.
 - Report #3- Due by 1/31/2025 for Reporting Period 07/01/2024-12/31/2024.
 - Report #4- Due by 7/31/2025 for Reporting Period 01/01/2025-06/30/2025.
 - Report #5- Due by 1/31/2026 for Reporting Period 07/01/2025-12/31/2025.
 - Report #6- Due by 7/31/2026 for Reporting Period 01/01/2026-06/30/2026.
 - Report #7- Due by 1/31/2027 for Reporting Period 07/01/2026-12/31/2026.
- **Final Report** will be due within thirty (30) calendar days after the end of this Grant Agreement.
 - Specific due date and Reporting Period Covered:
 - Final Report Due by 7/31/2027 for reporting period 7/01/2023 – 6/30/2027.

AMENDMENT 1

TO GRANT AWARD AGREEMENT

This Amendment No. 1 to the Grant Award Agreement (“**Amendment**”) is effective as of October 1, 2024 (“**Amendment Effective Date**”) by and between the Orange County Health Authority, a public agency dba CalOptima Health (“**CalOptima**”), and Wellness & Prevention Foundation, dba Wellness & Prevention & Prevention Center (“**Grantee**”). CalOptima and Grantee may each be referred to herein as a “**Party**” and collectively as the “**Parties**”.

RECITALS

- A. CalOptima and Grantee entered into the Grant Award Agreement (“**Agreement**”), originally effective July 1, 2023, under which CalOptima provided financial support to Grantee’s Grant Project.
- B. CalOptima and Grantee desire to amend the Agreement to revise the grant project.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

- 1. Article IV. TERM AND TERMINATION, Section 6.1, Termination of Agreement shall be deleted in its entirety and replaced with the following Section 6.1:
 - 6.1. This Agreement will commence on the Effective Date and will remain in effect up to and including June 30, 2028, or completion of the Grant Project, whichever occurs last.
- 2. Attachment A, GRANT PROJECT shall be deleted in its entirety and replaced with the new Attachment A GRANT PROJECT.
- 3. Attachment B, GRANT PAYMENT shall be deleted in its entirety and replaced with the new Attachment B, GRANT PAYMENT.
- 4. Attachment C, PROGRESS REPORTS SCHEDULE shall be deleted in its entirety and replaced with a new Attachment C, PROGRESS REPORT SCHEDULE.
- 5. This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Agreement.
- 6. If there is any conflict or inconsistency between this Amendment and the Agreement, the provisions of this Amendment shall control and govern. Except otherwise amended by this Amendment, all of the terms and conditions of the Agreement will remain in full force and effect. After the Amendment Effective Date, any reference to the Agreement shall mean the Agreement as amended and supplemented by this Amendment. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

[signature page follows]

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR GRANTEE:

FOR CALOPTIMA:

Signature

Print Name

Title

Date

Signature

Yunkyung Kim

Print Name

Chief Operating Officer

Title

Date

DRAFT

ATTACHMENT A

GRANT PROJECT

A. Executive Summary

We are in the midst of a youth mental health crisis. Over the last decade, depression, anxiety, feelings of hopelessness and loneliness, mental health emergency visits, and suicide attempts and deaths have increased dramatically among American youth. In particular, young girls, racial and ethnic minorities, and LGBTQ+ youth are exhibiting some of the most rapid increases in serious mental health problems. An urgent, equitable, and evidence-based response is needed to address this rapid increase.

This crisis will not be addressed through traditional service delivery streams alone. Instead, we need new models of care that center youth, their needs, and the way they want to engage with care at their core. In California, the Mental Health Service Oversight and Accountability Commission (MHSOAC) has regularly funded projects through the Mental Health Service Act (MHSA) innovation funding to explore new opportunities, but we need impactful and sustainable service streams that meet the needs of youth.

B. Background

The Budget Act of 2019 provided the MHSOAC \$14,589,000 to support the establishment of *allcove* youth drop-in centers which provide mental health and wellness services for youth between 12-25 years of age. The *allcove* model was developed by the Stanford Center for Youth Mental Health and Wellbeing led by Dr. Steven Adelsheim. These centers are designed to meet the mild-to-moderate needs of youth, including mental and behavioral health needs, housing, education, and employment support, and linkage to other services. The Budget Act called for a focus on vulnerable and marginalized youth and populations of youth with known disparities, e.g., Black, Indigenous, and People of Color (BIPOC) youth, LGBTQ+ youth, and youth experiencing homelessness.

In January 2020, the MHSOAC allocated \$10,000,000 to directly fund grants to expand the *allcove* model across California and \$4,589,000 to provide a technical assistance (TA) contractor to support the grantees, ensure program quality, and assist the expansion of *allcove* across the state. A request for applications was issued to award \$2,000,000 to five separate *allcove* projects. In May 2020, the MHSOAC announced that grants would be awarded to five projects across California including Los Angeles County (2), San Mateo County, Sacramento County, and Orange County. The Orange County project was spearheaded by a partnership between the University of California, Irvine (UCI) and the Wellness and Prevention Center (WPC). The Stanford Center for Youth Mental Health and Wellbeing team that created the *allcove* model was awarded the TA contract establishing the Stanford Central *allcove* Team (CAT). Grant contracts were executed between the various *allcove* grantees and the MHSOAC in late 2021 to early 2022 with UCI and the WPC executing their contract in October 2021. MHSOAC funding is intended to establish and operate an *allcove* center in Orange County with fidelity to the *allcove model*. The initial MHSOAC funding lasts through June 2026 providing the centers several years to set up sustainable funding and service streams.

B.1. The *allcove* model. *allcove* offers an integrated and holistic approach for the delivery of services for youth (ages 12-25) with mild-to-moderate needs. The core service streams of *allcove* include: mental health care, physical health care, substance misuse support, youth peer and family support, and supported education and employment.

allcove aims to provide timely and easy access to mental health services within an integrated, prevention and early intervention model of care. By co-locating and integrating medical health care with mental health and substance misuse services at *allcove* centers youth can seamlessly access the necessary support easily, even when symptoms first appear through somatic issues or physical complaints. In addition, by providing

access to both physical health services and mental health services at the same site, the stigma of going to a site for mental health treatment is decreased and the comfort level for youth in accessing on site mental health intervention is improved.

allcove physical health care services are not intended to replace or displace other community-based physical health care, but rather open up enhanced access through a "no-wrong door approach", allowing *allcove* physical health services providers to interface with the youth's physical health services health home and other relevant providers of healthcare.

Overarching practice principles of the *allcove* services approach including:

- **Youth-centered care.** The *allcove* model recognizes the youth are experts in their own care and address youth needs through services that are co-designed with youth. *allcove* services are holistic and strengths-based including developmentally-appropriate interventions that are socially and culturally inclusive.
- **Prevention, screening, and early intervention.** *allcove* services attempt to reach youth early with *allcove* centers actively working with the community to build youth resilience, increase early helping seeking, reduce stigma, and increase mental health literacy. *allcove* centers support linkages to care through active partnerships with community-based services. Many of these partnerships include locating services within *allcove* centers for seamless referrals and continuity of care.
- **Rapid, easy, and affordable access.** *allcove* centers provide a wide variety of services for youth ages 12 to 25. *allcove* services are organized around drop-in models, providing care whenever possible when youth show up. *allcove* centers are intended to be located in areas where youth naturally congregate, are accessible by public transportation, and follow a youth-friendly environmental design.
- **Holistic and integrated care.** *allcove* centers provide co-location of core service streams and are staffed by multidisciplinary care teams. The leverage appropriate and responsive service delivery models include brief and single-session interventions and technology-enabled care services.

B.2. Overview of *allcove* South Orange County. *allcove* South Orange is a partnership between the UCI and the WPC. The goal of this partnership is to bring multiple *allcove* youth drop-in centers to Orange County by creating a robust and sustainable infrastructure of service delivery, training, and community partnerships. The near-term goal is to establish and open an *allcove* center in South Orange County (current target San Juan Capistrano or Mission Viejo). This partnership is supported by \$2,000,000 funding from the MHSOAC for a funding period of October 2021 through June 2026. This funding is providing administrative support to open the center, funding for initial facility upgrades and rent, and some of the initial clinical operations. Key components of our *allcove* South Orange County team are our leadership team, youth advisory groups (YAGs), and Community Consortium. The planned hours of operation for *allcove* will be Tuesday through Friday 11AM-7PM, Saturday 10AM-4PM. Total service hours will be 88 hours per week. Services aim to treat mild-to-moderate conditions, with some instances of more severe conditions while attempting to connect to a higher level of care.

C. Scope of Work

We are requesting funding from CalOptima from July 2023 to June 2028 to support the administrative and clinical operations of *allcove* South Orange County. This funding will supplement the MHSOAC funding to support establishment of the full clinical operations and prepare *allcove* South Orange County to create service streams that will be sustainable. The long-term sustainability of the center will be supported through a mix of billable services, workforce development and training funding, and county and state funding.

Our request for CalOptima funding will support 7.5 FTE positions. These positions will support delivery of services in the *allcove* integrated delivery model including mental health care, physical health care, substance misuse support, youth peer and family support, and supported education and employment. Positions include 1.0 Clinical Coordinator, 1.5 Clinical Psychology Postdoctoral Fellows, 1.0 Mental

Health Clinician, 1.0 Youth Coordinator/Peer Support Lead, 2.0 Peer Support Specialists, and 1 Supported Education and Employment Specialists. These staff will be trained in the allcove model and attend relevant learning community development opportunities provided through the Stanford CAT. Because we intend funding Year 1 will be at reduced service capacity as we slowly open to anticipate service needs staffing for all positions are at 75% in Year 1 with the exception of postdoctoral fellow trainees which will have to be recruited to follow typical recruiting calendars for these positions. The postdoctoral fellows will spend additional time in training for the allcove model as service needs expand.

Although we are requesting funding to support these positions in that can potentially be funded in the future through other funding sources. These funding sources will be explored during FYI of the project. These sources include:

- Workforce Enhancement Training funding through UCI - Psychology Postdoctoral Positions, Psychiatric Nurse Practitioners, Medical Nurse Practitioners, and others.
- CalAIM funding - potential to support Peer Support Specialists and Career and Academic Support
- Orange County Healthcare Agency MHSA Prevention and Early Intervention Funding - potential to fund Youth Outreach, administration roles, and Peer Support.

D. Grant Objectives:

Process Outcomes:	Expected Due Date
1) Establish intake data collection	2/28/2025
2) <i>allcove</i> TM South Orange County soft opening	5/1/2025
3) Grand Opening	8/15/2025
4) All WPC and UCI staff hired, per funding proposal	6/30/2025
5) Have signed agreements with organizations to provide services not covered by WPC or UCI staff	6/30/2025
6) Establish full operations of youth served across service streams	1/31/2026
7) Conduct equity and inclusion survey (compare to OC population data for LGBTQ+ and race-ethnicity) among youth who engage in services, determine if youth served match the population of OC, and adjust services accordingly	9/30/2026
Service Outcomes: 1) Report the number of CalOptima Health members served compared to overall youth served 2) 60% of Case Management referrals to resources, within <i>allcove</i>TM and the community continuum of care, will be completed each service year 3) Net Promoter Score across all service streams of at least 70% 4) 75% of youth report satisfaction with services and increased hopefulness after attending a session. 5) 50% reduction in score by treatment end among 80% of <i>allcove</i>TM clients and a 70% reduction in mental health symptoms (includes somatic symptoms, depression, anxiety, substance misuse, and others) among 40% of <i>allcove</i>TM clients using the DSM 5 Cross Cutting Scale. 6) The number of professional trainings, peer support specialist training, graduate student internships, predoctoral and postdoctoral positions in process or completed	

ATTACHMENT B

GRANT PAYMENT

CalOptima has made a Grant Award to Grantee in the amount of up to two million seven hundred thousand dollars (\$2,700,000), which shall be the maximum amount payable for the Grant Project and which shall be paid following execution of the Agreement in the time and manner set forth below.

Payments: Payments under this Agreement shall be made in five (5) installments. The first payment shall be made following execution of this Agreement and subsequent payments will be made upon acceptable progress reports.

- Payment #1 (Y1): up to \$617,253 (paid upon execution of grant agreement)
- Payment #2 (Y2): up to \$571,841 (conditional upon acceptable reports #2 and #3)
- Payment #3 (Y3): up to \$475,092 (conditional upon acceptable reports #4 and #5)
- Payment #4 (Y4): up to \$618,592 (conditional upon acceptable reports #6 and #7)
- Payment #5 (Y5): up to \$344,038 (conditional upon acceptable reports #8 and #9)
- Retention (15% withhold of payment #5): up to \$60,712 (conditional upon acceptable final report and attestation)

All payments following the initial grant payment are contingent upon CalOptima's receipt and approval of progress reports and/or final report which are due as condition of that payment. Such reports must be acceptable to CalOptima and demonstrate progress toward Grant Activities over the project timeline, as provided in Section 4.2 and 4.3 of the Agreement. CalOptima may delay or withhold grant payments at its sole discretion if such reports are not submitted timely or as otherwise required or CalOptima is not satisfied with any submitted reports or Grantee's progress on project objectives.

Return Funds: Grantee shall refund to CalOptima any funds that are found to not have been utilized in accordance with the requirements of this Agreement. CalOptima shall have the right to audit, or to have audited by an independent third party, all Grant Project expenses. Grantee shall fully cooperate with CalOptima or its auditor and shall refund to CalOptima any amounts found to have been improperly expended from the Grant Award within thirty (30) days of the notice of such improper expenditures.

ATTACHMENT C

PROGRESS REPORT SCHEDULE

Purpose of Grant Reports

In an effort to help ensure successful grant outcomes, CalOptima actively monitors and evaluates grant progress and requires that grantees submit semi-annual progress reports as well as a final report. These reports are intended to help both CalOptima and grantee appraise progress toward funding objectives.

Grant Report Requirements

All grant recipients must complete the Grant Report Form provided through written communication with CalOptima's Behavioral Health Integration department. Please note that successful completion of reports are a condition of grant funding and incomplete reports will delay the disbursement of future grant payments.

Reporting Requirements

- 1) Estimated number of CalOptima Health members served.
- 2) Total number of CalOptima Health members served in this project.
- 3) Actual number of CalOptima Health members served this reporting period.
- 4) How much progress has been made towards your outcomes/objectives? If progress was not made, please explain.
- 5) What kind of unexpected successes or challenges have you encountered during this reporting period? If you encountered challenges, how did they mitigate?

Report Submission Schedule

This grant requires the submission of ten (10) reports over the duration of the project timeframe (i.e. July 1, 2023 - June 30, 2028) as follows:

- **Semi-Annual Progress Report** will be due within thirty (30) calendar days after the end of each reporting period.
 - o Specific due dates and Reporting Periods Covered:
 - Report #1- Due by 01/31/2024 for Reporting Period 07/01/2023-12/31/2023.
 - Report #2- Due by 07/31/2024 for Reporting Period 01/01/2024-06/30/2024.
 - Report #3- Due by 01/31/2025 for Reporting Period 07/01/2024-12/31/2024.
 - Report #4- Due by 07/31/2025 for Reporting Period 01/01/2025-06/30/2025.
 - Report #5- Due by 01/31/2026 for Reporting Period 07/01/2025-12/31/2025.

- Report #6- Due by 07/31/2026 for Reporting Period 01/01/2026-06/30/2026.
 - Report #7- Due by 01/31/2027 for Reporting Period 07/01/2026-12/31/2026.
 - Report #8- Due by 07/31/2027 for Reporting Period 01/01/2027-06/30/2027.
 - Report #9- Due by 01/31/2028 for Reporting Period 07/01/2027-12/31/2027.
- **Final Report** will be due within thirty (30) calendar days after the end of this Grant Agreement. o Specific due date and Reporting Period Covered:
 - Final Report Due by 07/31/2028 for reporting period 07/01/2023-06/30/2028.

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Wellness & Prevention Foundation dba Wellness & Prevention Center	700 Avenida Pico	San Clemente	CA	92673

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
allcove® San Juan Capistrano Mental Health Youth Center	27125 Calle Arroyo	San Juan Capistrano	CA	92675
Camino Health Center	3033 Camino Capistrano	San Juan Capistrano	CA	92675

AMENDMENT 13 TO PROFESSIONAL SERVICES CONTRACT

This Amendment 13 to the Professional Services Contract (“**Amendment**”) is effective as of October 2, 2025 (“**Amendment Effective Date**”), by and between Orange County Health Authority, a public agency, dba CalOptima Health (“**CalOptima**”), and [REDACTED] (“**Professional**”). CalOptima and Professional may each be referred to herein as a “**Party**” and collectively as the “**Parties**”.

RECITALS

- A. CalOptima and Professional have entered into a Professional Services Contract, originally effective 3/01/2015, (“**Contract**”), by which Professional has agreed to provide or arrange for the provision of Covered Services to Members.
- B. CalOptima and Professional desire to amend the Contract to add Pilot Program on the terms and conditions set forth herein.

AGREEMENT

NOW, THEREFORE, the Parties agree as follows:

- 1. Delete Attachment A, Contracted Services, in its entirety and replace it with a new Attachment A, Contracted Services, attached to this Amendment and incorporated into the Contract by this reference.

This Amendment may be executed in multiple counterparts and counterpart signature pages may be assembled to form a single, fully executed document. Capitalized terms not otherwise defined in this Amendment shall have the same meanings ascribed to them in the Contract.

If there is any conflict or inconsistency between this Amendment and the Contract, the provisions of this Amendment shall control and govern. Except as otherwise amended by this Amendment, all of the terms and conditions of the Contract will remain in full force and effect. After the Amendment Effective Date, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

IN WITNESS WHEREOF, the Parties have executed this Amendment.

FOR PROFESSIONAL:

FOR CALOPTIMA:

{{_es_:signer1:signature}}

{{_es_:signer2:signature}}

Signature

{{*Name_es_:signer1 }}

Signature

{{N_es_:signer2:fullname }}

Print Name

{{*_es_:signer1:title }}

Print Name

{{*_es_:signer2:title }}

Title

{{*_es_:signer1:date }}

Title

{{*_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 OneCare Program (Medicare Advantage)
- X Medi-Cal Program (Community Network and COD Administrative)
- PACE Program

1.2 Physician Services. Professional shall furnish:

- X Primary Care Provider Covered Services to eligible Members in the CalOptima program who are assigned to Professional.
- X Specialist Provider Covered Services to eligible Members in the CalOptima program, who 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) Participating Providers shall document all Pediatric Preventive Services (CHDP) on the CMS-1500, UB-04 claim form, or electronic equivalent. Participating Providers 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 Record.

ARTICLE 3 PILOT PROGRAM

The Pilot Program is to ensure access to Covered Services at the allcove® site address. Professional shall provide Members with Covered Services as defined in Section 3.1.1 of this Attachment A.

- 3.1 In addition to all general responsibilities under Article 2 of this Attachment A, as applicable, Professional shall provide the following:
- 3.1.1 Professional shall:
- Provide the following Covered Services to Members, regardless of the Members PCP assignment or Health Network:
 - General health screenings and physical exams.
 - Vaccinations (e.g., flu, COVID-19).
 - Treatment for minor injuries and superficial self-harm to prevent infection.
 - Management of common illnesses such as colds, cough, sore throat, ear pain, allergies, and headaches.
 - Care for gastrointestinal issues, urinary tract infections (UTIs), and skin conditions such as rashes.

- Gynecological care, including pelvic exams, menstrual disorder management, and breast exams.
 - Prescription services for antibiotics and other necessary medications.
 - Sleep-related concerns and fatigue.
- b) Professional to facilitate referrals to higher levels of care when clinically indicated.
 - c) Professional to submit copies of records to Members PCP.
 - d) Maintain a set service schedule and meet the minimum scheduling requirements of at least two (2) days per week.
 - e) Ensure the site has space to accommodate and provide Covered Services.
 - f) Fulfill all reporting and/or claims submission requirements by using the program specific billing guidelines and/or CalOptima reporting templates.

3.2 Professional Obligations.

3.2.1 Professional shall participate in meetings as requested by CalOptima.

3.3 CalOptima Obligations.

3.3.1 CalOptima shall facilitate a minimum bi-annually or ad hoc meetings with Professional.

3.4 Payment.

3.4.1 For the dates of service no sooner than October 2, 2025, through June 30, 2028 or if terminated earlier. CalOptima shall pay Professional:

- a) [REDACTED]:
 - For Members not assigned to Professional
 - CCN/COD Members not assigned to Professional; and
 - Members in other health networks not assigned to Professional

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2025

Regular Meeting of the CalOptima Health Board of Directors

Report Item

21. 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 following Board-approved grants and transfer the funds of \$14.0 million in aggregate to Housing and Homelessness Incentive Program (HHIP) Priority 3: Partnerships and capacity to support referrals (capital projects):
 - a. Orange County Housing Finance Trust;
 - b. City of Irvine; and
 - c. Mind OC.
2. Approve allocation of up to \$18.0 million in HHIP funds to Priority 3: Partnerships and capacity to support referrals (capital projects).

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.

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 \$110.9 million of those total funds across four priority areas. Some of these commitments have been allocated to projects that 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.

Discussion

Based on nearly three years of substantial community investment and related community feedback, CalOptima Health staff is requesting the Board to rescind three grant awards. These grants were unused or unawarded. Please see below for additional details:

Orange County Housing Finance Trust: On March 2, 2023, the Board approved a \$4.0 million capital grant award to Orange County Housing Finance Trust. The proposed capital project would support the development of accessory dwelling units as affordable housing through a low-cost loan program. The Orange County Housing Finance Trust later determined it would not be able to execute this program and returned the award to CalOptima Health.

City of Irvine: On May 2, 2024, the Board approved a \$5.0 million transitional housing project grant award to the City of Irvine. The grantee was not able to meet the terms of the grant agreement and therefore unable to accept the award.

Mind OC: On May 2, 2024, the Board approved a \$5.0 million transitional housing project grant award to Mind OC. The grantee was not able to meet the terms of the grant agreement and therefore unable to accept the award.

Staff recommend that the rescinded grant awards totaling \$14.0 million be returned to Priority Area 3 for future distribution. In addition, staff request that the Board allocate the remaining \$18.0 million in unallocated HHIP funding to Priority 3: Partnerships and capacity to support referrals (capital).

Should the Board approve the recommended actions, the total allocations to each priority area are shown in the table below. All HHIP available funding would be allocated.

HHIP Funding Priority	Total Amount Allocated (in millions)
Priority 1. Delivery of services and member engagement	\$3.6
Priority 2. Infrastructure to coordinate and meet member housing needs	\$10.4
Priority 3. Partnerships and capacity to support referrals (capital)	\$126.3
Priority 4. Systems Change	\$20.0
Total Amount Requested for Approval	\$160.3

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 \$32.0 million. The total available funding for future NOFOs under Priority Area 3 will be \$42.0 million.

Rationale for Recommendation

CalOptima Health staff is preparing to distribute 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.

CalOptima Health Board Action Agenda Referral
Approve Actions Related to the Housing and
Homelessness Incentive Program – Funding
Allocations
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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
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

/s/ Michael Hunn
Authorized Signature

09/25/2025
Date

CALOPTIMA HEALTH BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2025

Regular Meeting of the CalOptima Health Board of Directors

Report Item

22. Approve Actions Related to the Housing and Homelessness Incentive Program – Notice of Funding Opportunities

Contacts

Kelly Bruno Nelson, Executive Director, Medi-Cal and CalAIM, (657) 550-4741

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

Recommended Actions

1. Upon Board approval of Report Item 21, authorize CalOptima Health staff to develop a Notice of Funding Opportunity (NOFO) Round 7 totaling approximately \$27.8 million to be released in Quarter 3 of 2026:
 - a. \$250,000 for equity grants under Housing and Homelessness Incentive Program (HHIP) Priority Area 2;
 - b. \$25.0 million for capital projects under HHIP Priority Area 3; and
 - c. \$2.5 million for system change grants under HHIP Priority Area 4.
2. Approve the allocation of up to \$7.0 million of HHIP Priority Area 3 funds for general contractor services and furniture, fixtures and equipment for the Street Medicine Support Center at 7900 Garden Grove Boulevard, Garden Grove, California.

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.

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 reserves 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.

Assuming approval of a separate Board action, the Board has allocated all HHIP available funding to an HHIP Priority Area. CalOptima Health has stewarded these funds into significant community investment over the past two years, granting \$110.9 million of those total funds across those four priority areas (as listed in the table below). However, there remains \$49.5 million to be expended.

Breakdown of HHIP Funds Allocated to a Priority and Awarded Through HHIP NOFO Rounds 1-4			
	Amount Allocated to a Priority	Amount Awarded through NOFO/contract	Amount Allocated Pending NOFO
Priority 1. Delivery of services and member engagement	\$3.6	\$3.6	\$0.0
Priority 2. Infrastructure to coordinate and meet member housing needs	\$10.4	\$9.7	\$0.8
Priority 3. Partnerships and capacity to support referrals (capital)	\$126.3	\$84.3	\$42.0
Priority 4. Innovation and Systems Change	\$20.0	\$13.3	\$6.7
Total	\$160.3	\$110.9	\$49.5

*in millions, may not add due to rounding

In December 2024, the Board approved HHIP NOFO Rounds 5 and 6 totaling \$14.6 million in grants that have yet to be implemented, leaving \$34.8 million in HHIP funds allocated to a priority but not yet approved for release through a NOFO.

Discussion

Staff propose to distribute the remaining \$34.8 million as follows: approximately \$27.8 million through NOFO Round 7 and \$7.0 million dedicated to the construction of the Street Medicine Support Center, as presented in the table below.

Notice of Funding Opportunity Round 7 (Quarter 3 2026): \$27.8 million

CalOptima Health staff will solicit proposals for (1) \$250,000 total in Priority 2 funds for equity grants for organizations working in the housing and homelessness sector to serve populations at greater risk for health inequities, (2) \$25.0 million in Priority 3 funds to support permanent and affordable housing development, and (3) \$2.5 million total in Priority 4 systems change grants.

For the street medicine support center: On September 7, 2023, the Board approved \$10.51 million in reserves to support the general contractor services, furniture, fixtures, and equipment for the Street Medicine Support Center. A more concrete and updated proposal has indicated the costs for this project will be \$17.5 million. Therefore, staff recommends allocation of \$7.0 million of HHIP Priority 3 funds to support this center since it is in line with the purpose of the funds. CalOptima Health staff will return to the Board at a later date with a detailed line-item budget outlining how the total \$17.5 million will be expended on the support center.

Together, these two efforts would ensure that all HHIP funds will be allocated to projects and grantees by December 31, 2026.

HHIP Funds Board-Approved to be Awarded Through a NOFO				
	To Be Awarded Through Board-Approved NOFO Rounds 5 and 6	Amount Proposed for NOFO Round 7	Amount Committed to the Street Medicine Support Center	Total Amount Remaining to be Awarded
Priority 1. Delivery of services and member engagement	-	-	-	-
Priority 2. Infrastructure to coordinate and meet member housing needs	\$0.5	\$0.3	-	\$0.8
Priority 3. Partnerships and capacity to support referrals (capital)	\$10.0	\$25.0	\$7.0	\$42.0
Priority 4. Systems Change	\$4.1	\$2.5	-	\$6.7
Total	\$14.6	\$27.8	\$7.0	\$49.5

*in millions, may not add due to rounding

Fiscal Impact

The recommended action to develop a NOFO Round 7 totaling approximately \$27.8 million in HHIP funding has no net fiscal impact on the CalOptima Health Fiscal Year (FY) 2025-26 Operating Budget. The funding will be used to fund equity grants for programs serving underrepresented populations (Priority Area 2), capital projects (Priority Area 3), and system change projects (Priority Area 4).

The recommended action to allocate \$7.0 million of Priority Area 3 funds for general contractor services and furniture, fixtures, and equipment for the Street Medicine Support Center has no net fiscal impact on the CalOptima Health FY 2025-26 Operating Budget.

Rationale for Recommendation

CalOptima Health staff is preparing to distribute the remainder of the HHIP incentive funding by December 31, 2026, the same time at which 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

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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

/s/ Michael Hunn
Authorized Signature

09/25/2025
Date